KANSAS MATERNAL & CHILD HEALTH

Kansas Maternal & Child Health Council

OCTOBER, 2020 MEETING

KANSAS MATERNAL & CHILD HEALTH

Welcome

Recognize New Members & Guests

KARI HARRIS, MD, MCH COUNCIL CHAIR

KANSAS MATERNAL & CHILD HEALTH

Title V MCH Block Grant Application & Public Input Overview

JAMES FRANCIS AND HEATHER SMITH, KDHE

KANSAS MATERNAL & CHILD HEALTH

Title V MCH Health Equity

KELLI MARK, KDHE

What is Health Equity?

The American Public Health Association defines health equity as “everyone having the opportunity to attain their highest level of health.”

What is the difference between health equity and health disparities?

Health disparities are differences in *health status* between people related to social or demographic factors such as race, gender, income or geographic region.

Health inequities are created when *barriers* prevent people from accessing the services/products they need to reach their full potential!

Title V Encompasses Health Equity

Title V Goals:

- Access to quality care, especially for people with low incomes or limited availability of care
- Assistance in the reduction of infant mortality
- Access to comprehensive prenatal and postnatal care for women, especially low-income and at-risk pregnant women
- An increase in health assessments and follow-up diagnostic and treatment services
- Access to preventive and child care services as well as rehabilitative services for certain children
- Family-centered, community-based systems of coordinated care for children with special health care needs

HRSA Maternal & Child Health

KANSAS MATERNAL & CHILD HEALTH

Title V 2021-2025 State Action Plan
Health Equity Objectives & Strategies

KANSAS MATERNAL & CHILD HEALTH

Objectives

- 1.3: Increase the proportion of high-risk pregnant and postpartum women receiving prenatal education and support services through KPCCs
- 6.3: Increase the proportion of MCH-led activities that address social determinants of health to reduce disparities and improve health outcomes for MCH populations

Strategies

- 2.1.1: Increase access to lactation support by African American providers such as breastfeeding peer counselors, doulas, international board-certified lactation consultants and certified lactation counselors that represent high risk populations
- 2.1.2: Support the implementation of community-centered, culturally relevant mother-to-mother, father, and grandparent breastfeeding support clubs for African Americans
- 2.1.3: Broaden the establishment of breastfeeding coalitions for African Americans that connect health care providers and the community to local information and resources
- 6.3.1: Develop guidance and trainings for local health agencies and providers to ensure that providers can promote and address diversity and inclusion, integrate supports in the provision of services for high-risk populations in Kansas, and reduce health disparities through responsive policy change initiatives
- 6.3.2: Integrate chronic disease education and prevention activities into existing community collaboratives to engage in system and environmental changes to address locally identified disparities
- 6.3.3: Implement annual community awareness campaign for the prevention of birth defects, targeting messages to address disparities due to social determinants of health in local communities

Recent Health Equity Activities

Maternal and Child Health Opportunity Project

Kelli Mark, BS; Christina Holt, MA; Ruaa Hassaballa, MPH; Rachel Sisson, MS; Stephen Fawcett PhD

Bureau of Family Health, Kansas Department of Health and Environment

University of Kansas Center for Community Health and Development

Addressing health equity requires identifying and removing obstacles to assure everyone has a fair and just opportunity to be healthy. The Maternal and Child Health Opportunity Project (MCHOP) is intended to support local community efforts to assure equal opportunities to health for all Kansas mothers, children, and their families.

Introduction

State health and university partners worked with seven local MCH agencies to advance efforts to assure equal opportunities for MCH populations, regardless of income, education, age, race/ethnicity, or where people live. The first cohort of the project ended in August 2020.

The Kansas Healthy Communities Action Toolkit provided technical support for implementation. It was used by the project to encourage action in building communities with equal opportunities for healthy living and well-being. The Toolkit provides reflection questions to consider, recommended actions and examples, and resources to support action.

State and Local Partners

STATE SYSTEM PARTNER

Kansas Department of Health and Environment (KDHE), Bureau of Family Health, Title V MCH Program (Kelli Mark, Rachel Sisson)
http://www.kdheks.gov/bfh

TECHNICAL SUPPORT AND EVALUATION PARTNER

Center for Community Health and Development, University of Kansas (KU-CCHD) (Christina Holt, Stephen Fawcett, Ruaa Hassaballa)
http://communityhealth.ku.edu

LOCAL AGENCY PARTNERS

Seven local MCH agencies (public health departments) partnered to complete health equity projects. Priority populations and projects included:

Barton County: Develop a fatherhood initiative, prioritizing currently/previously incarcerated or homeless fathers as well as those living in poverty.

Clay County: Mitigate lead exposure for low-income children.

Cranford County: Decrease the number of low-income/Medicaid-covered pregnant women and new mothers who smoke.

Douglas County: Uncover root causes of disparities between black and white babies born at low birthweight.

Sedgwick County: Reduce infant mortality in Sedgwick by identifying barriers and action steps to address those barriers to bridge the gap for high-risk women to access mental health services in Wichita, KS, including low income/Medicaid-covered pregnant women and new mothers with behavioral health treatment needs.

Reno County: Provide culturally competent prenatal education for uninsured Hispanic/Latino women.

Riley County: Decrease health inequities among uninsured Hispanic/Latino pregnant women by increasing access to culturally competent prenatal education.

Wilson County: Implement trauma-informed care practices in all community schools for low-income youth in foster care.

To learn more about this project, contact Kelli Mark with KDHE at Kelli.M.Mark@ks.gov.

What We Did

This was a learning collaborative project. A request for proposals was issued by KDHE to local MCH agencies (existing grantees) inviting them to apply. The KDHE Bureau of Family Health and the University of Kansas Center for Community Health and Development provided support and technical assistance.

The Kansas Healthy Communities Action Toolkit was developed to provide guidance and supports for the community's health equity efforts. The communities were provided capacity-building webinars with peer-to-peer learning and sharing, as well as one-on-one technical assistance. These supports were used to plan their projects, form community collaborations, and support implementation. This participatory model for promoting MCH Opportunity consists of five iterative phases: Engage, Assess, Plan, Act, Evaluate.

Engagement: Relationship-building, trust-building, going to where people are, decreasing barriers, engaging those most affected
Assessment: Gathering information about local issues, prioritizing priority MCH issues, identifying resources and assets
Planning: Working with community partners (e.g., coalitions, schools, hospitals and clinics) to plan strategies for implementation
Taking Action: Identifying, adapting, and implementing best practices or promising approaches
Monitoring and Evaluation: Collecting data to see progress towards implementation, reflect on the effort, and identify impact on groups experiencing health disparities

Monitoring and Evaluation

The Community Check Box Evaluation System (developed and maintained by KU-CCHD) was used for data collection and evaluation of the community activities and interventions. Evaluation questions included:

- What amount (and pattern) of community/system change is facilitated by each grantee and partners?
- What is the distribution of community/system change by type?
- To what extent does the initiative contribute to assuring mothers and children (in particular those with low income or with limited availability of health services) access to quality MCH services?

Select Accomplishments

Cranford County: Increased the number of pregnant women enrolled in smoking cessation program, which thrived in spite of COVID-19. Tobacco Cessation supports were offered through WIC appointments.

Lawrence/Douglas County: Discovered the need for a FTE dedicated to health equity. Were able to identify a candidate from the collaborative work that developed through the project

Riley County: Implemented same-day pregnancy testing in the Family Child Resource Center to minimize transportation barriers, reduce wait times, and promote continuity of care. Interpretive services were provided. Connected pregnant clients with the "Becoming a Mom" (BaM) and other social services as appropriate. Non-pregnant clients were referred to family planning. A Spanish Facebook page was created, and flyers were disseminated to Spanish-speaking communities. BaM classes were offered in Spanish at times convenient for the clients (small groups). Older siblings could attend trainings/appointments, and the interpreter translated forms/handouts.

Sedgwick County: Engaged 34 individuals in structured interviews on perinatal mental health care access, including 15 pregnant and postpartum women. Engaged approximately 10 individuals from different backgrounds in the community workgroup to triangulate themes and develop action steps. Preliminary themes included inconsistency in screening intervals and tools; desire for collaboration between specialties; need for closing the communication loop; and barriers to insurance, including cost and coverage duration.

Wilson County: Worked to engage stakeholders across school districts in the county to strengthen youth resilience through a trauma-informed system of care that built upon existing interventions in schools. Participation was enhanced by holding meetings in varying districts/locations to support travel for all, as well as a Zoom option.

Identified Challenges

Implementation challenges included:

- Changes in political climate
- Some Spanish-only speaking clients were hesitant to seek services due to current climate
- Staff turnover caused interruption in leadership and implementation capacity
- COVID-19 demanded a shift in priorities and resources; created barriers to in-person contact

Highlighted Lessons Learned

- Relationships and trust are key to success of collaborative efforts.
- Rely on trusted relationships/networks to reach those most affected.
- It is critical to engage partners in assessing local needs and planning for improvement; utilizing data is critical to decision making.
- Ongoing communication with stakeholders throughout the project aids support and implementation.
- It is necessary to adapt and exercise flexibility to accommodate changing circumstances (e.g., shift to COVID-19 response and recovery efforts).
- Multi-sectoral collaborative action makes it possible to bring about changes in programs, policies, and practices.
- It is important to address health inequities by focusing on differential exposures and opportunities and differential access to create conditions for health and health equity.

A Glance At Health Disparities Data

Disparities by Geographic Location

- The odds of experiencing preterm birth are 18% greater for women living in a concentrated disadvantage area/neighborhood even if the woman is the same race, ethnicity and age

Disparities by Insurance Status

- Percent of women on Medicaid who smoke during pregnancy was 23.3% in 2017, compared to women not on Medicaid who smoked during pregnancy at 4.1%

Disparities by Race/Ethnicity

- Black Kansans are **more than three times** as likely to experience domestic violence and twice as likely to experience a rape than white Kansans

Data Source:
Kansas Department of Health and Environment. Preterm Birth: https://www.kdheks.gov/c-f/integration_toolkits/Preterm_Birth_Infographic.pdf
Kansas Department of Health and Environment. 2018 Kansas Birth Data, Resident.
Kansas Bureau of Investigation 2018 Annual Report. http://www.kansas.gov/kbi/stats/stats_crime.shtml

DOMAIN Women and Maternal

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

The Kansas MCH program provides women with comprehensive services including prenatal care, home visiting, preventive screening for conditions like depression, and public health education.

A higher percentage of Kansas women...

will have annual well-woman visits.

will receive comprehensive screenings at well-woman visits (tobacco use, substance abuse, mental health, intimate partner violence, pregnancy intention, social determinants of health).

What will success look like?

Brightspots

81% of pregnant women receive prenatal care in the first trimester (near the Healthy People 2020 goal of 85%).

Since 2012 **2%** **DECREASE** in tobacco use among pregnant women.

Kansas

*with positive trends among nearly all demographic groups.

88% of women, ages 18 to 44 years report their health is good, very good, or excellent.

While rates of smoking during pregnancy are decreasing overall, the disparity between pregnant women with Medicaid coverage who smoke (23%) and pregnant women not on Medicaid who smoke (4%) is dramatic.

Almost **one** out of **four** of MCH program participants (24%) who were screened were considered high risk (a score >10) on the Edinburgh Postpartum Depression Scale.

Challenges

<2 in 3 women (age 18 to 44 years) have had a preventive medical visit in the last year, and there are disparities based on income and education levels.

Spotlight on Disparity

37% of **White** (non-Hispanic) pregnancies were unintended.

64% of **Black** (non-Hispanic) pregnancies were unintended.

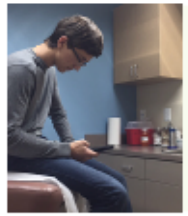
Information for this summary is based on the Kansas 2021-2015 Statewide Maternal and Child Health Needs Assessment & Action Plan.
To view the full report, go to kdheks.gov/c-f/mch.htm

Domain Profiles – Health Equity Data

DOMAIN Adolescent

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

The Kansas MCH program offers adolescents health education on an array of topics (teen pregnancy, tobacco and drug use, etc.); provides mental health supports through counseling, anti-bullying programs and teen suicide prevention initiatives; and supports adolescents with college and career planning.



A higher percentage of...

adolescents will have annual well visits with a primary care provider.

teens and young adults will be screened for mental health conditions by their primary care providers, and provided treatment and referrals when indicated.

What will success look like?

Brightspots

78% of adolescents had a preventive medical visit in the last year. (Age 12 to 17 years)

Nine in 10 adolescents have received at last one dose of the Tdap vaccine. (Age 13 to 17 years)

The teen birth rate (births per 1,000 teens, age 15 to 17 years) decreased significantly from 14.6 in 2013 to 9.5 in 2017.

Challenges

Eight in 10 adolescents are not physically active 60 or more minutes a day. This is reflected in a high percentage (28%) of adolescents in grades 9 to 12 who are overweight or obese.

25% of adolescents (age 12 to 17 years) are bullied.

16% of adolescent girls (grades 9 to 12) experienced sexual dating violence.

both higher than national figures

The adolescent suicide rate (per 100,000) increased from 13.2 in 2013 to 14.5 in 2017, and is trending up faster among females.

Spotlight on Disparity

Well visits for adolescents in the last year, age 12 to 17 years.

59% Hispanic

82% White

Information for this summary is based on the Kansas 2021-2015 Statewide Maternal and Child Health Needs Assessment & Action Plan. To view the full report, go to kdheks.gov/c-f/mch.htm.

Domain Profiles – Health Equity Data

Domain Profiles – Health Equity Data

About one of three pregnancies (36.7%) of non-Hispanic white females were unintended, while almost two-thirds (64.3.%) of non-Hispanic black mothers had not intended to become pregnant.

About 8% of black babies breastfeed exclusively for six months, compared to 16% of white babies breastfeed exclusively for 6 months

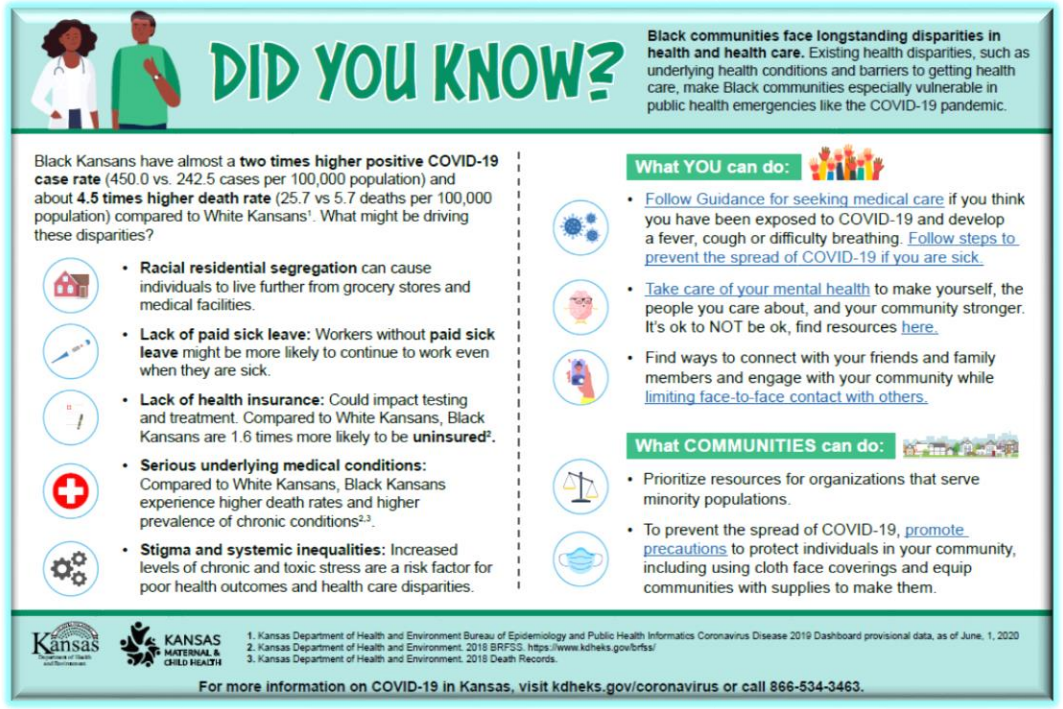
The percent of Kansas children ages 10 through 17 who are obese is twice as high for Hispanics (22.1%) as for non-Hispanic whites (11.9%), and the percentages have been trending upward in both populations.

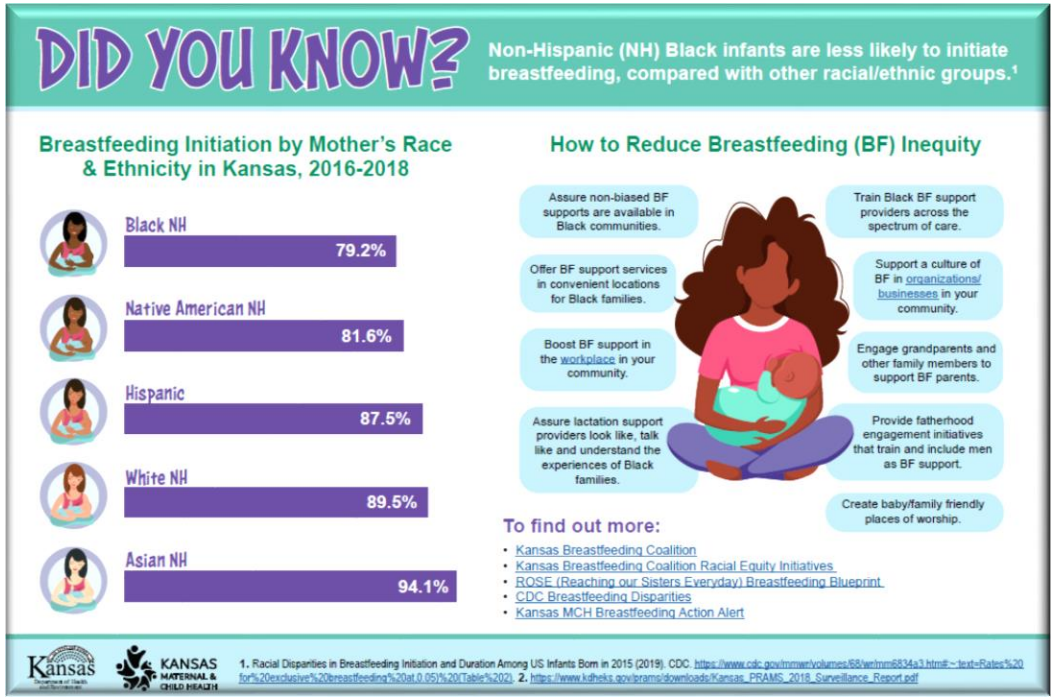
The percent of Hispanic adolescents (ages 12 to 17) who had an adolescent well visit in the last year was considerably lower (59.3%) than the percent of non-Hispanic white adolescents (81.7%).

Two of every 5 Kansas CSHCN (40.0%) had two or more adverse childhood experiences (compared with 15.7% of non-CSHCN).

The MCH workforce does not reflect the racial and ethnic diversity of clients: 15% Hispanic staff compared to +30% Hispanic clients.

Did You Know?





https://www.kdheks.gov/c-f/integration_toolkits.htm

Black Maternal Focus Groups

- Views on health and the healthcare system
- What services they feel are available to them and their children
- What services and support do they feel were lacking during the perinatal period III and neonatal periods related to physical health, social well-being and mental health
- What are the barriers to receiving whole health services, including prenatal and postpartum care
- What tools do they need to help them navigate the healthcare system
- What are their health priorities and biggest needs as mothers

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Family and Consumer Partnerships in Title V

HEATHER SMITH, KDHE AND CASSANDRA SINES, FAMILY DELEGATE

FAC
Family Advisory Council

Expanding Family Leadership
Title V Vision

FAMILY ADVISORY COUNCIL

Advisory

- Expanded FAC
- PDG Family Leadership Team

Expanded FAC

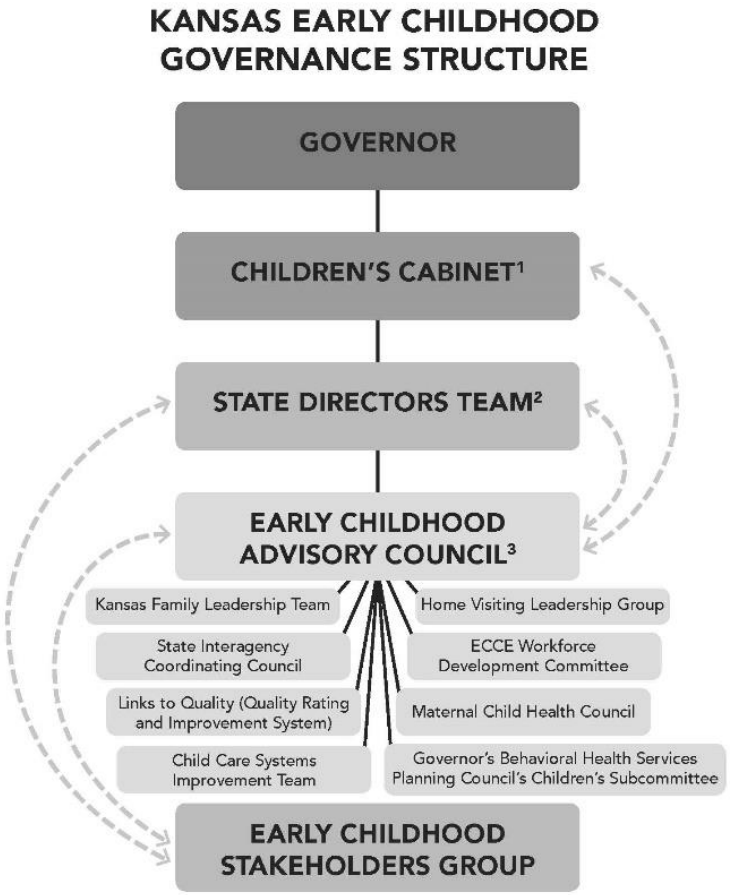
- KMCHC Alignment
  - Shared/integrated planning
  - Cross-cutting agendas & sharing
- All MCH Populations
  - 5 Core Work Groups: Women/Maternal, Early Childhood (0-5), Children (6-11), Adolescences (12-21), CSHCN
  - 2 Additional Work Groups: Youth/Young Adults, Fathers
  - Special Project Ad Hoc Group (comprised of existing FAC members for short-term initiatives)

Advisory

- Expanded FAC
- PDG Family Leadership Team

PDG Family Leadership Team

- Statewide Governance Structure
  - Direct line to Early Childhood Recommendations Panel then to State Directors Team and Children's Cabinet
- FAC Executive Committee
  - One in the same!
  - FAC brings issues/needs to the EC
  - EC discusses and moves up the "chain"



FAC
Family Advisory Council

KMCHC and FAC

FAMILY ADVISORY COUNCIL

	EXPANDED FAC	KMCHC	TITLE V
VISION	We envision a state where individuals and families are (1) engaged in program planning, evaluation, service delivery, and policy development; (2) partners in advocacy; and (3) leaders in their communities.	We envision a state where all are healthy and thriving.	Title V envisions a nation where all mothers, infants, children aged 1 through 21 years, including CSHCN, and their families are healthy and thriving.
PURPOSE	The purpose of this Council is to advise and partner to improve the health of Kansas children and families and assure the needs of families and consumers are central to Title V programming, initiatives, and special projects.	The purpose of this Council is to advise the Secretary of Health and Environment and others on ways to improve the health of families in Kansas, focusing on the MCH population.	The purpose of Title V is to: (A) Provide and assure mothers and children access to quality MCH services; (B) Reduce infant mortality and the incidence of preventable diseases; (C) Provide rehabilitation services for blind and disabled individuals; and (D) Provide and promote family-centered, community-based, coordinated care, and facilitate the development of community-based systems of services.
MISSION	Improve the health and well-being of Kansas mothers, infants, children, and youth, including children and youth with special health care needs, and their families.	Improve the health and well-being of Kansas mothers, infants, children, and youth, including children and youth with special health care needs, and their families.	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.

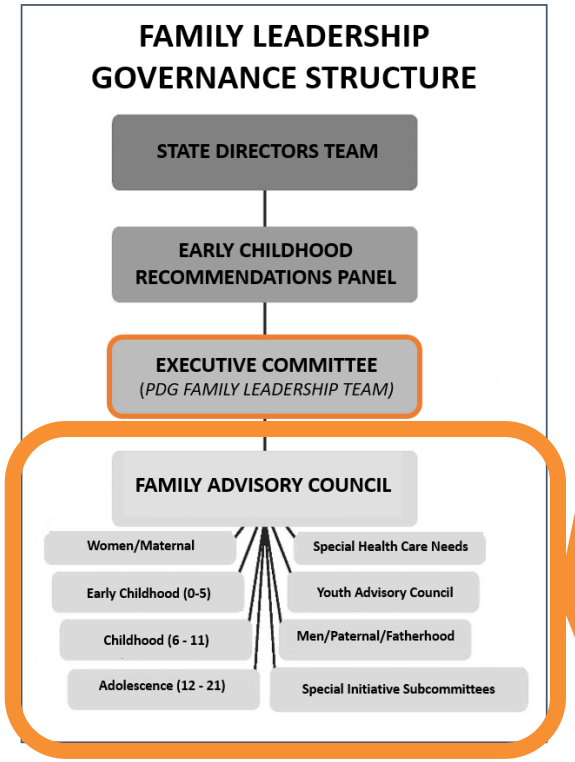
	EXPANDED FAC	KMCHC
MEMBERS	Family and Consumers Work Groups = 5 (Women/Maternal, Early Childhood (B-5), Child (6-11), Adolescence (12-21), CSHCN Executive Committee = 2 members per work group	Mixed Membership (Family/Consumer/Provider/Partners) Work Groups = 7 (Women/Maternal, Perinatal/Infant, Child (1-11), Adolescence (12-21), CSHCN, Workforce Development, Family Strengthening & Supports Executive Committee = 5 members from full Council
SCHEDULING	Quarterly – 3rd Saturday of every 3rd Month • January (virtual 9:30 am to 2 pm) • April (in-person 9:30 am to 4 pm) • July (virtual 9:30 am to 2 pm) • October (in-person 9:30 am to 4 pm)* **every other year this will be a Sat/Sun 2-day retreat weekend*	Quarterly –Wednesdays of every 3rd Month (9 am to 3 pm) • January • April • July • October
AGENDAS	Large Group Work – Will revolve around cross-cutting topics and updates for all populations • Same as the KMCHC agenda in terms of topic/content, speakers may vary depending on topic. Small Group – Will revolve around domain-specific State Action Plan work (based on Charter created during strategic planning meetings)	Large Group Work – Will revolve around cross-cutting topics and updates for all populations • Same as the FAC agenda in terms of topic/content, speakers may vary depending on topic. Small Group – Will revolve around the State Action Plan for the assigned Priority

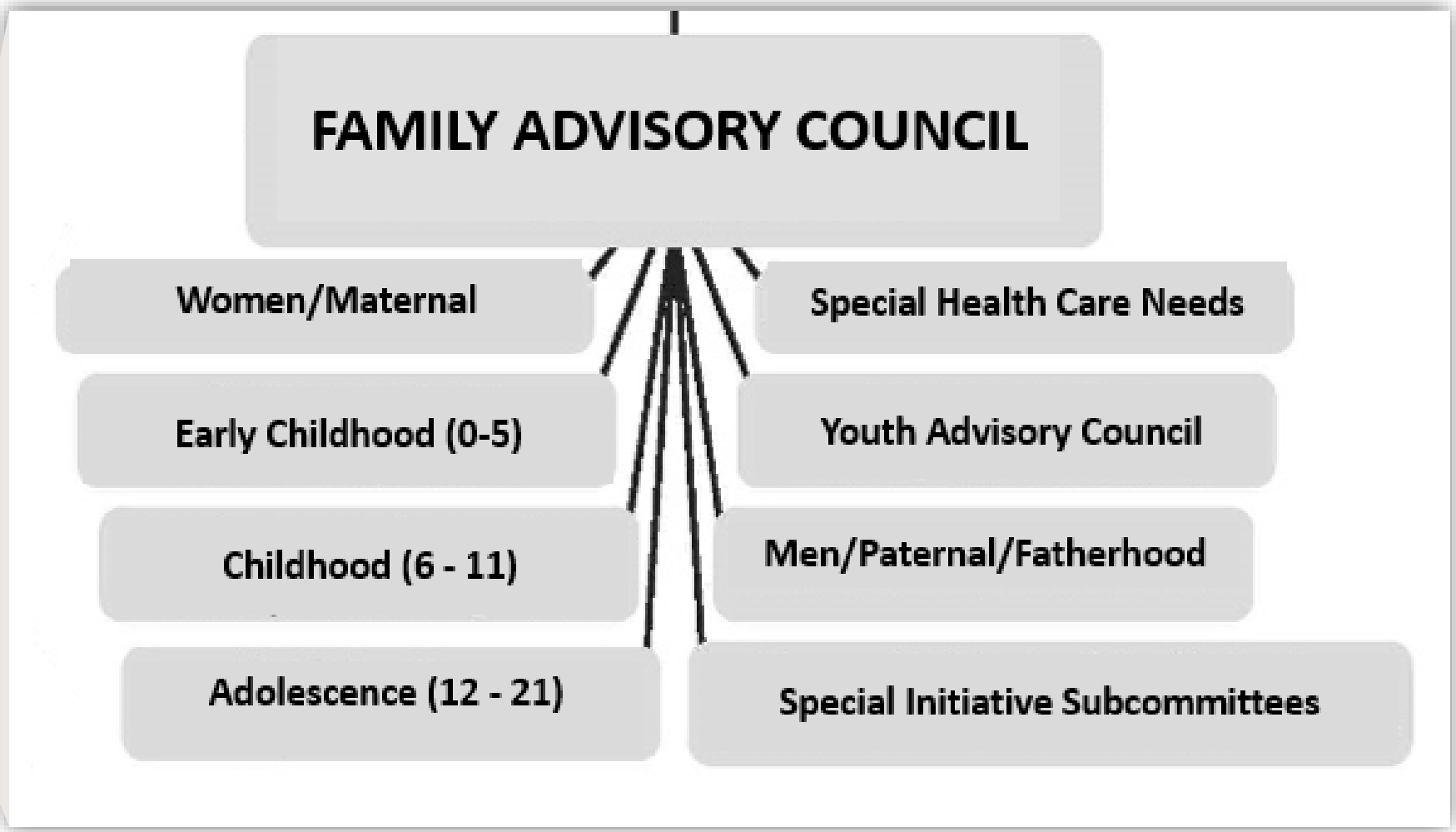
FAC
Family Advisory Council

Expanded FAC Organization/Logistics

FAMILY ADVISORY COUNCIL

How does this all tie together?





	LARGE GROUP	WORK GROUP
AGENDAS	Focused on: • Title V Monitoring and Evaluation • Collaboration and Integration • Cross-Cutting Needs/Concerns • Systems Change • Advocacy • Workforce Development	Focused on: • State Action Plan Objectives and Strategies • Quality Improvement Projects/Activities • Calls to Action • Marketing and Outreach Needs • Integration of Family Strengthening and Supports Principles across the population domain work
MEMBERS	Broad definition of families and consumers across all MCH populations Overall term limit - ??? TBD ??? Strengths Finders/MCH Competency Self-Assessment Mentorship and Leadership Supports/Training	Focused definition of families and consumers for targeted MCH populations Work Group term limit - ??? TBD ??? Peer Connection and Supports Advocacy and Community Change Supports/Training
SUPPORTS	Heather Smith Overall Facilitator, Assures alignment and integration with KMCHC, Supporting You, and other FCP activities, Monitors Title V activities and progress Cora Ungerer Co-Facilitator, Recorder, Logistics, "Official" Communication	Family/Consumer Leader – Chair Selected among membership (existing FAC member if possible) KDHE Staff Content Expert Each group will receive support from BFH program staff with content expertise in the associated population domain. May vary from meeting to meeting depending on member needs and agenda KDHE Staff Recorder (may vary from meeting to meeting)

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Domain Group Work

Domain Groups

Facilitators and Recorders

CSHCN: Kayzy Bigler and Kelly Totty

Workforce Development: Carrie Akin and Taylor Atwood

Family Partnerships & Support: Heather Smith and Cora Ungerer

Ground Rules

1. Stay present (phones on silent/vibrate, limit side conversations).
2. Invite everyone into the conversation. Take turns talking.
3. ALL feedback is valid. There are no right or wrong answers.
4. Value and respect different perspectives (providers, families, agencies, etc.)
5. Be relevant. Stay on topic.
6. Allow facilitator to move through priority topics.
7. Avoid repeating previous remarks.
8. Disagree with ideas, not people. Build on each other's ideas.
9. Capture "side" topics and concerns; set aside for discussion and resolution at a later time.
10. Reach closure on each item and summarize conclusions or action steps.

Small Group Work

- Are the objectives and strategies in the new State Action Plan for your domain reflective of how Title V efforts and resources should be focused over the next five years? Is anything missing?
- What programs or initiatives already exist that KDHE should know about that align with the objectives in this domain? What strategies and activities are already underway that advance these objectives?
- Looking at the objectives for this domain, where should we focus first, and what can we accomplish in the next year to move these forward?
- Action Item: What is my commitment as a council member and the organization I represent to advance this plan?

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Small Group Breakouts

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Announcements & Closing Remarks

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Next Meeting Date

JANUARY 13, 2021

KANSAS MATERNAL & CHILD HEALTH

Optional Listening Session: Health Equity

SITUATION UPDATE & LISTENING SESSION

Today's Dialogue:

Assuring Equal Opportunities for Maternal and Child Health

Steve Fawcett and Christina Holt

KU Center for Community Health and Development

Kansas Maternal and Child Health Council

7 October 2020

KU THE UNIVERSITY OF KANSAS

WHO Collaborating Centre for Community Health and Development

COMMUNITY TOOL BOX

Shared Value of Health Equity
Kansas Title V State Action Plan 2021-2025

“Everyone has a fair and just opportunity to be healthier.”

--Robert Wood Johnson Foundation

Objective 6.3: Increase the proportion of MCH-led activities that address social determinants of health to reduce disparities and improve health outcomes for MCH populations

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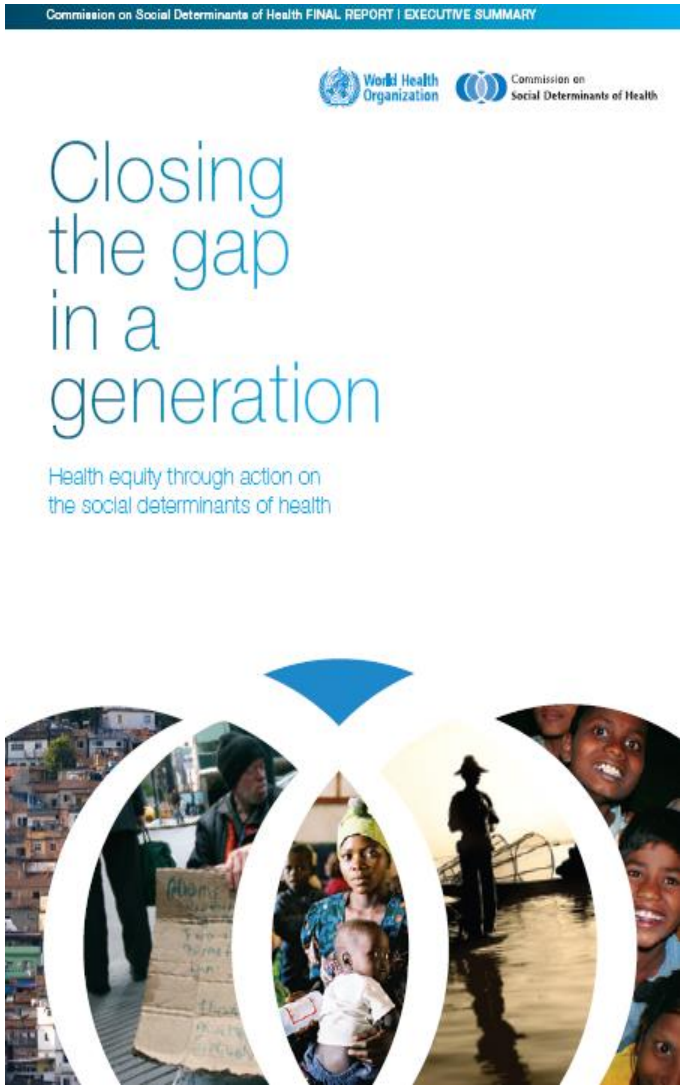
Overview of Today's MCH Equity Session

- How social determinants produce inequities
- Dialogue:
  - What **examples** have you observed of how social determinants produce inequities?
  - **What can we do to assure more equal conditions** for all mothers and children to be healthy?
  - What is a **step your organization takes (or could take)** to assure more equal conditions for all mothers/ children?
- Wrap up/Take away lessons

Health Inequities—def.

"Systematic inequalities in health between social groups that are deemed to be avoidable by reasonable means."

--Sir Michael Marmot



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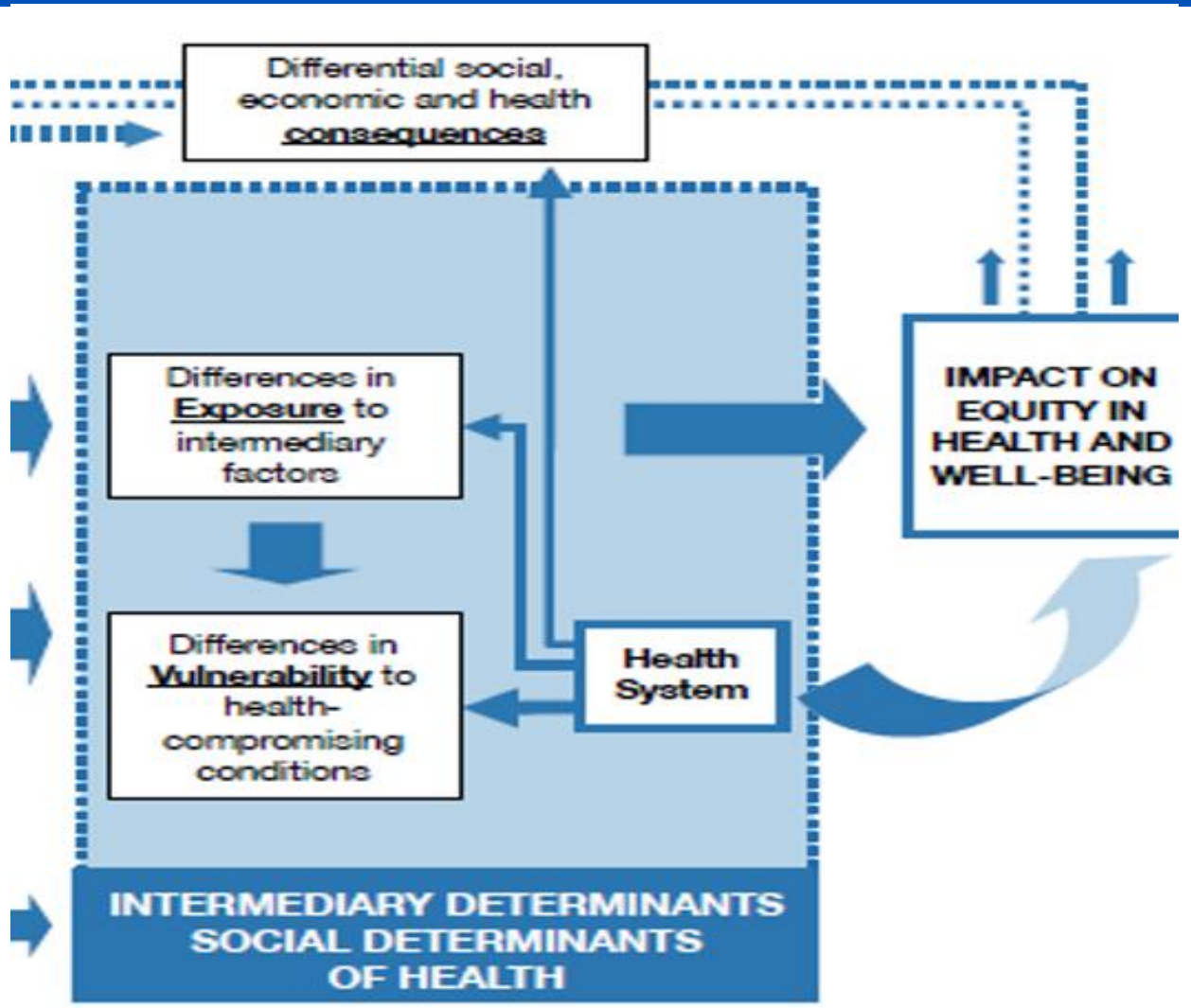
Social Determinants of Health
(CDC definition)

"Conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes."

- Can produce unfair and avoidable differences in health status

How are health inequities produced?
3 Mechanisms (intermediary determinants)



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Intermediary Social Determinants— Mechanisms that produce health inequities

- **Unequal opportunities**
  - unfair differences in chances to engage, experience, or benefit from
- **Unequal exposure to harmful conditions**
  - differences in experiencing events and situations that can harm health (e.g., trauma, stress, environmental toxins)
- **Unequal capabilities**
  - differences in knowledge, skills, and abilities to protect and promote health
- **Unequal vulnerabilities**
  - differences in potential to be harmed (e.g., due to conditions, lack of power, presence of disability)
- **Unequal access**
  - differences in ability to receive or obtain needed services and supports (e.g., due to time, effort, financial costs, discrimination)

Understanding & Addressing SDOH: Unintended pregnancies

Type of Determinant	Example of how this produces health inequities	What we can do to assure more equal conditions
Unequal opportunities (e.g., to engage, experience, benefit from)		
Unequal exposure to harmful conditions		
Unequal capabilities (e.g., knowledge, skills, abilities)		
Unequal vulnerabilities (e.g., conditions, power, disability)		
Unequal access (e.g., time, effort, costs, discrimination)		

Dialogue: Step your organization takes (or could take)

- What is a **step your organization takes (or could take)** to assure more equal conditions for all mothers and children?
  - assure equal opportunities
  - reduce harmful exposures
  - strengthen capabilities
  - protect those with vulnerabilities
  - assure equal access

Wrap up for Today's Session

- TAKE AWAYS for today's session (whole group dialogue)
- Agreements and next steps
- Other communications