Kansas Maternal and Child Health Council (KMCHC) Meeting

Wednesday, January 11, 2023

Member Attendees		Absent	Visitors
Jennifer Adhima	Susan Pence, MD, FAAP	Carrie Akin	Christina Holt
Lauren Alexander	Kate Roggenbaum	Heather Braum	Jerry Schultz
Antje Anji, MD	Cherie Sage	Kelly Berry, PhD	Ryan Reza
Rebecca Adamson, APRN	Cari Schmidt, PhD	Julia Connellis	
Brenda Bandy, IBCLC	Christy Schunn, LSCSW	Drew Duncan	
Kourtney Bettinger, MD, MPH	Sookyung Shin	Kaylee Goss	
Kayzy Bigler	Pam Shaw, MD, FAAP	Scott Latimer	
Cristi Cain	Leslie Thomas	Zac Leeker	
Mariah Chrans	Cassandra Sines	Patricia McNamar, DNP, ARNP, NP-C	
Stephanie Coleman	Juliet Swedlund	Brittney Nichols	
Lisa Chaney	Kelsee Torrez	Ivonne Rivera-Newberry	
Mary Sunshine Delgado, APRN	Cora Ungerer	Katie Schoenhoff	
Stephen Fawcett, PhD	Stephanie Wolf	Kasey Sorell	
Geno Fernandez	Alice Weingartner	David Thomason	
Holly Frye	Daina Zolck	Donna Yadrich	
Kari Harris, MD, FAAP			
Sara Hortenstine			
Elaine Johannes, PhD			
Jamie Kim, MPH			
Steve Lauer, MD, FAAP			
Elizabeth Lewis, MPA, MSN, WHNP-BC00			
Celina Lopez			
Brandi Markert			
Jeni McDonald			
Suzy Moore			
Jill Nelson			

Staff
Mel Hudelson
Denae Hart
Amy Trollinger

Agenda Items	Discussion	Action Items
Welcome	Dr. Harris welcomed KMCHC members and guests introduced themselves.	
Block Grant Review Kayzy Bigler	Kayzy Bigler shared the high-level feedback from the block grant review. When the final summary comes out Kayzy will share that with the Council. Some notable comments include: • They were impressed with restructuring of the aid to local process to make a greater impact. • The KDHE Bureau of Family Health is clearly doing a great job of leading and collaborating on initiatives in the state. • Impressed by the postpartum Medicaid coverage extension to 12 months in Kansas. • A highlight was the partnership with the office of rural health. • Overall organization and presentation of the block grant was praised. • BFH should fully explain the challenges related to staffing changes. • Should consider taking things off the plan and cutting back if needed. The next public comment period will be in June. We will let members know at the next meeting how they can participate. KDHE will bring executive summaries to April meeting.	
MCH Block Grant Evaluation: Reflecting on Success Indicators Steve Fawcett, PhD and Christina Holt, MA	Christina Holt and Steve Fawcett walked the council through the sensemaking process and how data is used to reflect on MCH activities and outcomes. Sensemaking is used to see the patterns that emerge from data, identify key factors for the patterns, and consider implications for adjustments.	
Small Group Discussion by Domain & Focus Area		
Small Group Discussion • What are we seeing in the data? • What does it mean? • What are opportunities for adjustment?		
	Key takeaways for each group are listed below	
Women/Maternal	NOM 24: Percentage of Women with Postpartum Depressive Symptoms After Live Birth	

	What are we seeing in the data? • Potential concerns with under-reporting based on timing of PRAMS or self-report challenges with recognition of symptoms • Screening reimbursement began for EPDS that that could impact reporting of symptoms • Possible pandemic impacting trends • Data trends are not significantly increasing through 2017-2020 and we do not have 2021 data • This data is from PRAMS and there is about a 60% return rate, so that is important to keep in mind. There will be more questions around depression symptoms in the next version. What does it mean? • Systemic barriers to health outcomes are in place • Parental leave policies at federal and local levels would impact the data trend • There are cultural implications of peer/communal support and barriers implications to supporting their family • Socioeconomic status, including affordable and accessible childcare could be a reason for high rates What are opportunities for adjustment? • Increase access to care for behavioral healthcare for postpartum women - KS ranks last in access to mental health services • Enhance use of provider line for temporary support • Medicaid expansion would help increase access • Increase the pipeline of providers by finding ways to train and keep quality providers in the state • Expanded telehealth access to mental health care • Find ways to improve economic hardships on families, cost of living, cost of food to decrease depression	
Perinatal/Infant	## Infant Mortality Patterns and Possible Factors What are we seeing in the data? • Faced changes in managed care in this time frame. • HOPE Act started in 2015 • Unequal distribution of support services across a timespan (i.e. services are only available during a particular/brief period of time or during one intersection, instead of across a longer timespan • There needs to be a greater breakout of data. If the data was in one location it would be easier to see where the issues are.	

	What does it mean? • Need to enhance skills of providers • Change polices that effect access and barriers • Services should be imbedded in prenatal care, not a passive referral. • There is distrust and lack of trust in those providing services. Who is trusted by those who aren't' seeking services? • Expand the workforce beyond credentialed people who are trusted in those communities that might help ensure equal services (such as CHW's). • We have to change hiring practices so people who look the same and have similar experience are in more positions. Take off questions that limit who can apply. Look to the organizations that are the informal networks that are doing the work in the community. What are opportunities for adjustment? • Prenatal education and home visiting – needs to be "universal"; needs embedded in clinical prenatal care; seen as "part of" PNC; should be the new standard of care in a community; should be "opt out" vs. "opt in" • Hiring practices for diverse workforce - need more peer provided services; need more individuals from the communities (look like, talk like, etc.) in roles/positions to provide these services; expanding service provision beyond being provided by credentialed only providers • Look for already existing, natural environments for service integration	
Child/Adolescent	NOM 16_3 Adolescent Suicide Rate Ages 15 through 19 per 100,000 (3 year rolling average) What are we seeing in the data? • It's rising and we want to know the why and experiences of those who completed suicide. • Rates decreased slightly in 2020 and started to rise in 2016. What happened in 2016? • Rates increased in 5-year time frame (2015 to 2020) • Medical providers are seeing younger suicide attempts and more attempts. • This is bigger than a graph. We need more information. Who, how, possible whys? What does it mean? • Access to social media which creates more opportunity to bully others, and younger children are getting more access • Lack of trauma informed society • Lack of access to care, especially timely care, very few psychiatrists across the state which means diagnosis and treatment is falling on primary care in a lot of areas. • Lack of in-patient services	

	• Lack of affordability when resources do become available • Gun law changes in 2016 • Decreased protective factors for adolescents, less peer connectedness • Stigma in seeking services • Lack of coordinated consistent messaging- There is a state interagency workgroup that has been meeting on this since directly after the AG's Youth Suicide Prevention Task Force that met in 2018. • Lack of recognition that friends or family are struggling with their mental health, especially to the extent they are. • What is also a contributor are the licensing and credentialing of mental health professionals in Kansas. There will be an important (yet difficult) discussion about mental health training programs in Kansas discussed at the state legislature this session. • Medical schools need to do better as well, no mental health or supporting and caring for disability. • Substance use disorder could be seen as an upstream contributor in that parents/caregivers using substances lead to kids with mental health issues and access to substances that provide a way to attempt suicide as well as potential for the kids to become addicted themselves. What are the opportunities for adjustment? • How Injury & Violence Prevention Programs are supporting youth suicide prevention: o KSVDRS is the only state-based reporting system that compiles data on violent deaths, including youth suicides, from multiple sources into a usable, anonymous database. KSVDRS gathers information from death certificates, law enforcement reports and coroner/medical examiner reports. o While the Implementation of Zero Suicide in Health Systems is targeted at those 25 years and older, we have not limited trainings or supports to those providers who serve younger. Zero Suicide supports several trainings by KSPHQ. o As we learned in year 1 of the Zero Suicide program, schools are ravenous for information and training. So, with our Core State Injury Prevention Program, we have provided a little bit of funding to KSPHQ to provide school focused training on youth suicide prevention to include screening, assessment, treatment, resources and crisis intervention skills. Core SIPP also has a request for applications (very small amount of funding) available to schools to support training on and implementation of evidence-based and evidence-informed programs that promote connectedness and social norms with the goal to provide protective factors for youth suicide prevention and mitigation for adverse childhood experiences. o Serving on a state interagency workgroup (BHP usually has their Child/Adolescent Health Consultant also on this workgroup) seeking to provide consistent messaging and support for youth suicide prevention in the state. This is the group that hosted the Youth Suicide Prevention Art Contest the past two years and developed the youth suicide prevention tip sheets.	

	• We also need insurance to cover mental health. Families cannot afford to pay out of pocket. • Community resources need to be developed with families and not just thrown out there at us, thinking it will help. • Routine screening for anxiety and depression • Promoting healthy phone use and family media plans • Better identify risk and protective factors for suicide among youth	

Member Announcements	
	• Systems navigation training for families of children with special needs – Feb 18th in Wichita anyone can attend, $100 stipend to attend. There will be a training in Emporia in March. • Save the date for the First 1,000 Days Summit, March 9 in Topeka. Details here - http://first1000daysks.org/event/first-1000-days-ks-summit/ • There is a March of Dimes App https://www.marchofdimes.org/compassbymarchofdimes • There are many open positions in the Bureau of Family Health, please spread the word. • KU Wichita Pediatrics was awarded federal funding for pediatric training in trauma informed care, mental health and behavioral care. • KSKidsMAP – was awarded funding to increase school-based health and address mental health in schools. KANDID is a new program for autism and will have a workshop in Wichita on June 2 for providers.
Future Meetings	***2023Meeting dates:*** *April 12, July 12, October 11* **Subject to change*