



Kansas 2025

# **Title V Needs Assessment**

Priorities and State Action Plan **2026 to 2030**





**Kansas Department of Health and Environment**

Bureau of Family Health

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

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

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Kansas Title V Maternal and Child Health Needs Assessment

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# Executive Summary

Kansas, home to nearly three million residents, has over a third living in rural areas where limited healthcare resources impact maternal and child health. The lack of Medicaid expansion, workforce shortages, income inequality, and disparities in education, employment, and food security further contribute to poor health outcomes. Nearly half of Kansas counties lack obstetric services, creating maternity care deserts.

The Maternal and Child Health (MCH) Needs Assessment identifies strengths and challenges within the MCH population, guiding efforts to advance health equity and improve outcomes. It integrates quantitative data from national measures and service data systems like DAISEY, alongside qualitative insights from focus groups, interviews, and community engagement. The assessment examines key issues such as health disparities, access to care, system coordination, behavioral health, and social determinants of health.

The Kansas Title V MCH Program serves a diverse population, providing 135,437 visits to almost 60,000 women and children from 2020 to 2024. Among those served, 64% of children and 70% of adults live below the poverty line. The program delivers essential services, including prenatal care, mental health support, early childhood screenings, and parenting education, to meet the needs of underserved families.

## Key Themes and Focus Areas

The assessment identifies six primary areas affecting MCH outcomes:



**Health disparities and equity** remain a significant concern, particularly for minority populations, rural residents, and low-income individuals who experience worse maternal and infant health outcomes and barriers to care.



**Mental health and substance use disorders** are growing concerns, with rising adolescent suicide rates, increasing substance use disorders, and high rates of perinatal mood disorders among mothers.



**Access to care** is hindered by rural workforce shortages, a lack of obstetric, pediatric, and mental health providers, and Medicaid coverage gaps.



**Violence and injury prevention** efforts are needed as rates of bullying, intimate partner violence, firearm deaths, and child homicides have increased, particularly among certain racial and socioeconomic groups.



**Care coordination and system navigation** challenges create barriers for families seeking services, particularly for children with special health care needs, due to a fragmented healthcare system.



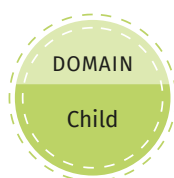
**Social determinants of health**, such as economic barriers, food insecurity, and housing instability, significantly impact maternal and child health outcomes, requiring systemic policy interventions.

## Domain-Specific Findings and Recommendations



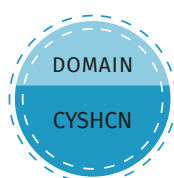
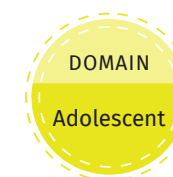
Women and maternal health has seen some improvements. Prenatal care rates (77%) and postpartum visit rates (92%) exceed national averages, and smoking during pregnancy has declined. However, maternal mortality remains high at 22.8 per 100,000, with persistent racial disparities. Violence against women and economic barriers negatively impact health and well-being. Recommendations include expanding prenatal and postpartum care, addressing maternal mortality disparities, enhancing mental health and substance use disorder treatment, and strengthening workforce recruitment in rural areas.

Infant and perinatal health shows strengths such as high breastfeeding rates and comprehensive newborn screening programs. Challenges include a high preterm birth rate of 11% and an infant mortality rate for Black infants of 10.5 per 1,000 live births. Sleep-related deaths remain a concern, and disparities persist. Recommendations include expanding breastfeeding and safe sleep initiatives, improving access to Level III neonatal intensive care units, and strengthening early intervention services.



Child health outcomes are mixed. While high insurance coverage (95%) and reduced household smoking exposure show progress, challenges remain. Over one in four children face food insecurity, physical activity levels are low, and Medicaid disruptions have led to significant coverage losses. Key recommendations include addressing food insecurity, promoting physical activity, improving pediatric care access, ensuring continuous health coverage, and enhancing violence prevention programs.

Adolescent health presents ongoing challenges. Preventive healthcare visits are increasing, and HPV vaccination rates are nearing national averages. However, adolescent suicide rates remain high at 18.7 per 100,000, and firearm deaths among youth at 13.7 per 100,000 exceed national benchmarks. Substance use disorders among adolescents are also a growing concern. Recommendations include expanding behavioral health services, suicide prevention programs, comprehensive sexual health education, and firearm safety education.



Children and youth with special health care needs have high rates of preventive care (92%), but access to medical homes is declining, and developmental follow-up services are inadequate. Only 78% of children with special health care needs are reported to be in good or excellent health. Recommendations focus on expanding care coordination, strengthening access to medical homes, and enhancing developmental screenings and evaluations.

# System-Level Recommendations

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## Advance health equity

Implement targeted interventions for racial and socioeconomic groups experiencing the greatest barriers. Expanding culturally and linguistically appropriate services and increasing funding for community-based organizations will be essential.

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## Improve access to care

Invest in workforce development strategies, improving health care coverage, strengthening telehealth services, and improving referral systems that connect MCH populations to services they need.

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## Enhance care coordination

Integrate community health workers, doulas, and peer support staff into healthcare teams to help families navigate complex health systems.

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## Expand behavioral health services

Focus on maternal and adolescent mental health, suicide prevention efforts, and substance use disorder services.

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## Address social determinants of health

Expand programs that combat food insecurity, housing instability, and economic barriers that affect maternal and child well-being.

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## Strengthen health care systems

Promote multi-sector dialogue and collaboration to ensure preventive, primary, diagnostic and acute care services (including telehealth) are available to all MCH populations, regardless of where they live in the state.

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## Bolster preventive health efforts

Increase vaccination rates, expanding developmental screenings, and promoting early intervention services for children.

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## Utilize data to drive change

Enhance the use of integrated data systems like DAISEY to track progress on health outcomes, identify gaps in care, and inform program decisions.

## Conclusion

The MCH Needs Assessment provides a comprehensive roadmap for improving maternal and child health outcomes in Kansas. By addressing health disparities, workforce shortages, behavioral health challenges, and social determinants of health, the Title V MCH Program aims to create a more equitable and effective system of care. Expanded access to healthcare services, enhanced care coordination, and data-driven programmatic efforts will help improve the overall well-being of women, infants, children, and adolescents across the state.

# Introduction

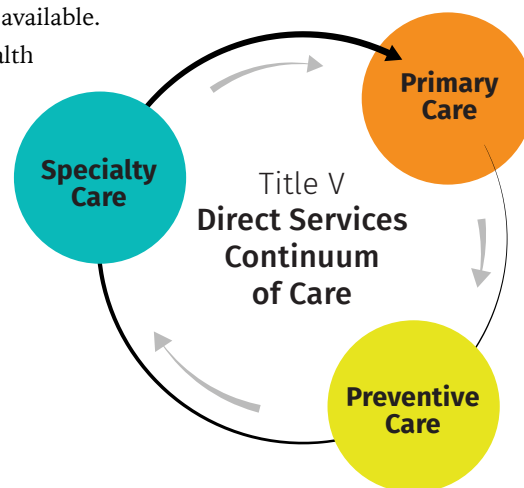
The Title V Maternal and Child Health (MCH) Block grant has, since 1935, provided federal funding to states to ensure access to health services for women and children, with a special emphasis on children and youth with special health care needs. The program enables states to:

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

The program is meant to support a continuum of care including direct services (preventive, primary care, and specialty services) when other funding sources are not available.

It also supports non-clinical services that enable individuals to public health systems and services, which include the core public health functions of assessment, assurance, and policy development. These services are provided across six federally recognized domains, including five MCH population domains and an optional cross-cutting/systems building function:

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



State MCH Programs are expected to conduct comprehensive Needs Assessments every five years to ensure responsiveness of MCH programs and policies to the needs of women and children in the state. *The Kansas 2025 Title V Needs Assessment* is a critical process designed to evaluate the health status, needs, and resources of maternal and child populations. This assessment serves as the foundation for developing priorities, strategies, and actions to address emerging health issues and advance equitable health outcomes.

The Needs Assessment informs state MCH programs and stakeholders in effectively allocating resources to improve access to care, enhance health services, and address disparities impacting women, infants, children, and adolescents, including those with special health care needs.

In Kansas, the unique challenges of a large rural population shape the state's MCH priorities. Limited healthcare provider availability, transportation barriers, broadband access issues, and social stigmas often affect access to preventive, primary care, mental health, and specialty care services.

This assessment integrates quantitative and qualitative data, community feedback, and collaboration with health professionals and community members to identify gaps in care and disparities across demographic groups and the capacity of the current system of care to address the health needs of women and children. Through a life course and health disparity perspective, the assessment aims to promote wellness, health equity, and sustainable systems of care to meet the diverse needs of maternal and child health populations in Kansas.

# Goals and Framework Guiding the Process

The Maternal and Child Health (MCH) program in Kansas is committed to regularly assessing the needs of women, infants, children, and families. In conducting the Needs Assessment, Kansas engages with communities and families to inform the creation of a Five-Year State Action Plan which shapes MCH Programs and supports decision-making around policies and services. The program is also evaluated continuously, using a performance measurement framework to make necessary adjustments between assessments. Led by the Kansas Department of Health and Environment (KDHE) Bureau of Family Health and guided by the core values and principles outlined below, the MCH Needs Assessment is driven by a team of experts in maternal and child health, special health care needs, and epidemiology.

## CORE VALUES

### Prevention and Wellness

This emphasizes activities aimed at health education, reducing modifiable risks, and promoting general well-being, including immunization to prevent infectious diseases.

### Social Determinants of Health

The program acknowledges that the conditions in which individuals live, work, and age (such as income, power, and resources) play a key role in shaping health outcomes. Addressing these factors helps mitigate health inequities.

### Life Course Perspective

This value looks at how events and exposures throughout an individual's life, including generational factors, influence long-term health outcomes.

### Health Equity

The goal is to ensure that everyone has a fair and just opportunity to be healthy, which involves tackling obstacles like poverty and discrimination to reduce unfair and avoidable health disparities.

## GUIDING PRINCIPLES

The guiding principles are critical in shaping the MCH Needs Assessment and broader health initiatives as they reflect the commitment to fostering long-term systemic change and collaboration across different sectors.

### Collaboration

Kansas MCH seeks to reduce barriers across systems by building strong partnerships within and across agencies. This approach enhances service delivery for women, infants, children (including those with special health care needs), and adolescents.

### Relationships

Creating and maintaining collaborative relationships at both the organizational and individual levels is essential. These relationships are fundamental for continuous quality improvement and for promoting positive change in communities.

### Consumer Engagement

Kansas MCH emphasizes the importance of centering the voices of those directly impacted by the system. This ensures that program development, special initiatives, and systemic changes reflect the lived experiences of consumers and families.

### Community Norms

The program encourages broad engagement, especially with parents, caregivers, service providers, and decision-makers. Establishing supportive community contexts is crucial for promoting safe and nurturing environments, which foster lasting change.

The program's commitment to these core values and guiding principles promotes innovative approaches to the development of integrated systems of care, family/consumer and partner engagement, and rigorous, ongoing assessment, monitoring and evaluation.

This Needs Assessment is the cornerstone to the establishment of priorities across all MCH population domains that will guide programming, policy, and systems-building efforts consistent with these core values and guiding principles in the coming five years.

# MCH Population Health and Well-Being Findings



This section of the Needs Assessment identifies both strengths and areas for improvement across populations and MCH domains, ensuring alignment with the program’s overarching goals to improve health outcomes and advance health equity for women, infants, children, adolescents, and children and youth with special health care needs (CYSHCN).

Strengths and weaknesses were identified through synthesis of quantitative data such as National Performance Measure (NPM) metrics, National Outcome Measures (NOMs) program-specific demographic and service data collected through the Data Application and Integration Solutions for the Early Years (DAISEY) system, and qualitative insights gathered from focus groups, interviews, photovoice sessions, and other community engagement efforts. DAISEY data provide insights into the populations served by the Title V MCH Program and the services delivered, while epidemiologic analyses helped highlight key trends in maternal and child health indicators.

Qualitative perspectives included voices from Kansans with lived experience, a broad array of service providers (including several providers specifically selected because of their focus on working with underserved populations) policymakers, community leaders, and Title V Program staff (both at the state and local level). By integrating these perspectives, the Kansas Title V MCH Program ensures this Needs Assessment reflects the realities of local communities and prioritizes health equity in its planning and delivery of services.

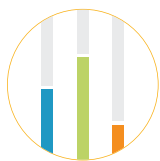
#### IN THIS SECTION

- ◆ A summary of key themes and focus areas driving MCH priorities.
- ◆ High-level recommendations for program and policy changes to align Title V-funded efforts in Kansas with the priority needs of the MCH population.
- ◆ An overview of the statewide context in which the MCH Program operates, including demographic, socioeconomic, and healthcare access considerations.
- ◆ Domain-specific analyses, outlining strengths, challenges, and actionable recommendations.
- ◆ Insights from qualitative data that capture the lived experiences of Kansans.

Through this comprehensive approach, the Title V MCH Program can strengthen its impact, addressing both systemic barriers and targeted needs to improve the health and well-being of Kansans.

## Key Themes and Focus Areas

The Needs Assessment highlights several key themes that have emerged through extensive quantitative analysis and qualitative feedback. These themes underscore the complexity of challenges faced by women, children, and families across the state while identifying opportunities to enhance access to care, health outcomes, and equity.



### Health Disparities and Equity

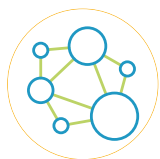
Persistent disparities in maternal and child health outcomes remain a significant concern.

Populations experiencing the greatest challenges include racial and ethnic minorities, individuals living in poverty, those with limited education, and rural residents. A focus on health equity is central to addressing these gaps and improving outcomes for marginalized communities.



### Access to Care

Access to health care services continues to be a pressing challenge, particularly in rural areas where workforce shortages limit the availability of obstetric, pediatric, and mental health care providers. Expanding Medicaid coverage, addressing financial barriers, and improving transportation and telehealth access are critical priorities for ensuring equitable care.



### Care Coordination and System Navigation

Fragmentation within the complex healthcare system creates challenges for families seeking to access care to meet their needs. Strengthening care coordination and improving system navigation resources are essential to reduce gaps in services. Expanding use of community-based workers including community health workers, doulas, and peer support specialists is vital to improving system navigation for families in need.



### Mental Health and Substance Use

Mental health remains a critical focus area, particularly for adolescents and mothers. Rising suicide rates, increasing substance use disorders among youth, and inadequate access to mental health services have emerged as priority concerns. Expanding early intervention and mental health support programs will be key to improving outcomes in this area.



### Violence

Bullying among adolescents is a mental health concern and is particularly prevalent among some subpopulations of youth. Intimate partner violence is a public health issue among Maternal Child Health populations. Homicides associated with intimate partner violence have trended upward in recent years, with a disproportionate number of victims being women. Homicide was the fifth leading cause of death for Kansas children ages 0 through 4 years and the third leading cause of death for children ages 5 through 14 in 2022.



### Social Determinants of Health (SDOH)

Social determinants of health (SDOH), such as housing instability, food insecurity, and economic inequality, greatly impact MCH outcomes. Targeted programs and gradual benefit phase-outs can support families' transitions to independence while improving health and well-being for mothers and children.



### **Preventive Health and Early Childhood Development**

Preventive care is critical to improving long-term health outcomes. Promoting vaccination, safe sleep education, breastfeeding support, and developmental screenings for children are areas of strength that require continued investment. Expanding access to high-quality childcare and early intervention programs is also a key focus to support children's developmental needs.



### **Community Voices and Lived Experiences**

A strong emphasis has been placed on integrating the perspectives of Kansans into this assessment. Through focus groups and interviews, providers, community leaders, and families have shared valuable insights into the strengths and challenges of the healthcare system. These voices highlight the importance of local context and lived experiences in shaping effective solutions.



## Domain-Specific Analyses and Recommendations

The Needs Assessment evaluates all MCH domains. The findings are organized by domain and provide actionable insights that align with the Title V Program’s mission to support health equity, access to services, and high-quality care. Strengths, challenges, and areas of focus are detailed for each domain.

STRENGTHS	CHALLENGES	AREAS OF FOCUS
<b>Women and Maternal Health</b>		
Rates of prenatal care during the first trimester (76%) and postpartum visits (92%) exceed national averages. Smoking during pregnancy has declined to 6%.	Maternal mortality rates remain high (22.8 per 100,000 live births), with disparities among racial and ethnic groups. Access to preventive care is low among uninsured and underinsured women. Violence against women is a concern, with deaths associated with intimate partner violence trending upward in recent years, with over 30 deaths annually from 2017 onward.	Expand access to prenatal and postpartum care, strengthen mental health services for pregnant and postpartum women, and partner with other agencies to address violence against women.
<b>Infant and Perinatal Health</b>		
Kansas exceeds national averages in breastfeeding rates and has robust newborn screening programs.	Preterm birth rates (11%) and infant mortality rates for Black infants (10.5 per 1,000 live births) highlight persistent disparities.	Enhance breastfeeding support, promote safe sleep practices, and target disparities in preterm births and infant mortality.
<b>Child Health</b>		
Only 5% of Kansas children lack health insurance, and 91% are reported to be in very good or excellent health.	Physical activity levels are low, with only 28% of children meeting daily recommendations. Food insecurity affects 27% of children, and childcare capacity meets just 45% of demand. Homicide is a leading cause of death for Kansas children 1-14 years of age. Medicaid unwinding has led to substantial numbers of Kansas children losing CHIP/Medicaid coverage.	Address food insecurity and promote physical activity. Improve access to high-quality childcare and pediatric care. Address violence through prevention, including efforts to promote gun safety. Enhance systems to ensure eligible children are enrolled in CHIP/Medicaid.

### Adolescent Health

Rate of preventive health care visits for adolescents are increasing, and HPV vaccination rates are nearing national averages.

Adolescent suicide rates (18.7 per 100,000) and firearm deaths (13.7 per 100,000) exceed benchmarks. Substance use is a significant concern, with almost one in ten Kansas adolescents experiencing a substance use disorder.

Expand mental health and suicide prevention programs, address substance use, and promote firearm safety education.

### Children and Youth with Special Health Care Needs (CYSHCN)

Preventive care rates for CYSHCN are high (92%), exceeding those for non-CYSHCN populations.

Only 78% of CYSHCN are reported to be in good or excellent health. Access to medical homes has declined, and developmental follow-up services are limited for children exiting early intervention programs.

Increase access to medical homes, enhance care coordination, and expand developmental screenings and evaluations.

## CROSS-CUTTING THEMES

The assessment identifies cross-cutting priorities that align with the Title V Program's broader goals.

### *Health Equity*

Address disparities in access, outcomes, and quality of care, particularly for underserved populations.

### *Access to Care*

Expand healthcare services, particularly in rural areas, and improve care coordination for complex needs.

### *Preventive Health*

Promote vaccination, developmental screenings, and early intervention services.

### *Social Determinants of Health*

Address food insecurity, housing instability, and economic barriers to improve family well-being.

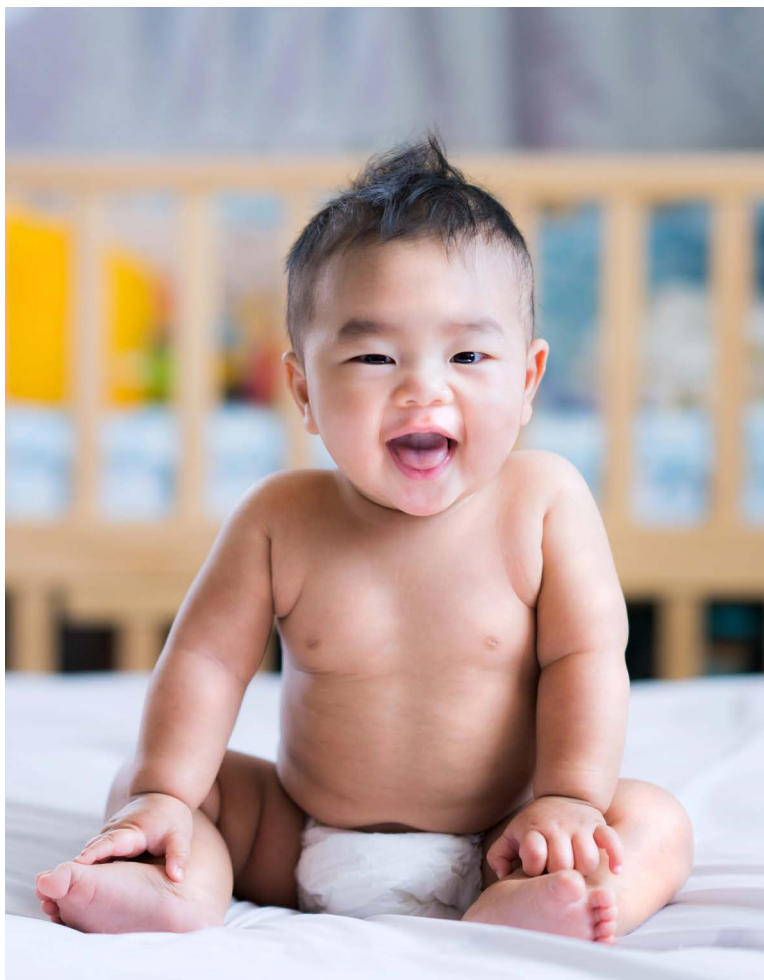
### *Violence*

Expand violence prevention programs, promote family and community resilience, address racial and socioeconomic disparities, and advocate for policies and resources to support families impacted by violence.

## System-Level Recommendations

The findings of this Needs Assessment inform the strategic direction of the Kansas Title V MCH Program. These high-level recommendations aim to address persistent challenges and build on existing successes to improve health outcomes for women, children, and families across the state. Developed through a combination of quantitative data analysis and qualitative input from Kansans, these recommendations provide a roadmap for the program to strengthen its impact.

The recommendations align with the goals of the Title V Program to advance health equity, increase access to care, and improve the overall health and well-being of MCH populations. They focus on expanding healthcare access, enhancing care coordination, addressing social determinants of health, and promoting preventive care and early intervention. By targeting these critical areas, the Title V MCH Program seeks to meet the needs of underserved and vulnerable populations while fostering system-wide improvements.





## Recommendations

These recommendations are designed to guide the Kansas Title V MCH Program in its efforts to address disparities, enhance service delivery, and create a more equitable and effective system of care for maternal and child health.

### *Address Health Disparities and Promote Equity*

- ◆ Implement targeted interventions to reduce racial, ethnic, and socioeconomic disparities in maternal, infant, and child health outcomes.
- ◆ Expand culturally and linguistically appropriate services to ensure equitable access to high-quality care.
- ◆ Reduce disparities in adverse childhood experiences (ACEs) to lessen their impact on long-term health outcomes.
- ◆ Explore opportunities to fund community-based organizations working with the underserved, particularly racial/ethnic minorities and low-income populations that consistently experience poorer health outcomes.
- ◆ Provide opportunities for providers working with underserved populations and people with lived experience to play more meaningful roles in program and policy decisions in the MCH Program.

### *Improve Access to Care*

- ◆ Expand healthcare services in rural and underserved areas by addressing workforce shortages, enhancing telehealth infrastructure, and fostering regional systems of care.
- ◆ Increase Medicaid enrollment and improve access to affordable healthcare for low-income and vulnerable populations.
- ◆ Improve access to prenatal, postpartum, and pediatric care, focusing on closing gaps for underserved and marginalized groups.

### *Enhance Care Coordination*

- ◆ Develop and expand care coordination programs, particularly for children and youth with special health care needs (CYSHCN), to improve continuity of care.
- ◆ Integrate community health workers, doulas, and/or peer support staff into healthcare teams to assist families in navigating the system and accessing services.
- ◆ Establish transitional care programs to support adolescents as they move to adult healthcare systems.

### *Promote Mental Health and Address Substance Use*

- ◆ Expand access to mental health services for adolescents and mothers, prioritizing underserved and rural areas.
- ◆ Implement community-based programs to reduce adolescent suicide rates and address stigma around mental health.
- ◆ Address rising rates of substance use disorders with prevention, treatment, and harm-reduction strategies, with a focus on youth and pregnant/postpartum women.

### ***Address Social Determinants of Health (SDOH)***

- ◆ Expand efforts to combat food insecurity and improve access to affordable, nutritious food for families.
- ◆ Promote initiatives to address housing instability and improve living conditions for vulnerable populations.
- ◆ Reduce economic barriers through targeted programs supporting low-income families.
- ◆ Restructure eligibility policies to include gradual phase-outs of benefits to ease transition of families into independence.

### ***Strengthen Preventive Health and Early Childhood Development***

- ◆ Promote preventive health by increasing vaccination rates, particularly among children and adolescents.
- ◆ Expand safe sleep education and breastfeeding support to reduce sudden unexpected infant deaths (SUID). Consider more targeted approaches that provide tailored support to families at high risk for poor outcomes.
- ◆ Improve access to high-quality childcare and early intervention services, including developmental screenings and follow-up for children with delays or disabilities. Ensure children transition smoothly across early intervention programs.
- ◆ Enhance school and community-based physical activity programs to encourage healthy behaviors for children and adolescents.

### ***Foster a Resilient MCH Workforce***

- ◆ Support workforce development strategies to develop an expanded workforce of Community Health Workers, doulas, lactation consultants, peer support specialists, and paraprofessionals to ensure navigation supports are available for women, children, and adolescents in communities statewide.
- ◆ Increase recruitment and retention of healthcare providers, including obstetricians, pediatricians, mental health professionals, and public health staff.
- ◆ Provide ongoing training and professional development for providers to deliver culturally responsive and trauma-informed care.

### ***Use Data to Drive Change***

- ◆ Enhance data-sharing systems across healthcare, public health, and social service agencies to improve care coordination and address service gaps.
- ◆ Promote the coordinated use of data from systems like DAISEY and other statewide sources to monitor progress on National Performance Measures (NPMs) and National Outcome Measures (NOMs).
- ◆ Develop integrated platforms for cross-sector data analysis to identify disparities, guide resource allocation, and inform evidence-based interventions.
- ◆ Facilitate access to community-level public health data to engage stakeholders, monitor outcomes, and ensure accountability for improving maternal and child health.

# Populations served and services provided

## Populations Served

The following is a summary of the demographic trends among child and adult clients served by Kansas Title V Programs from 2020 to 2024, based on data from the DAISEY platform. For more details, please see [Appendix F.2 MCH Program Demographics \(DAISEY\)](#).

From 2020 to 2024, 135,437 visits were conducted, including 26,725 child clients and 33,122 adult clients. Visits predominantly involved prenatal/pregnant women (35%), children aged 1 to 11 years (18%), and postpartum women (16%).

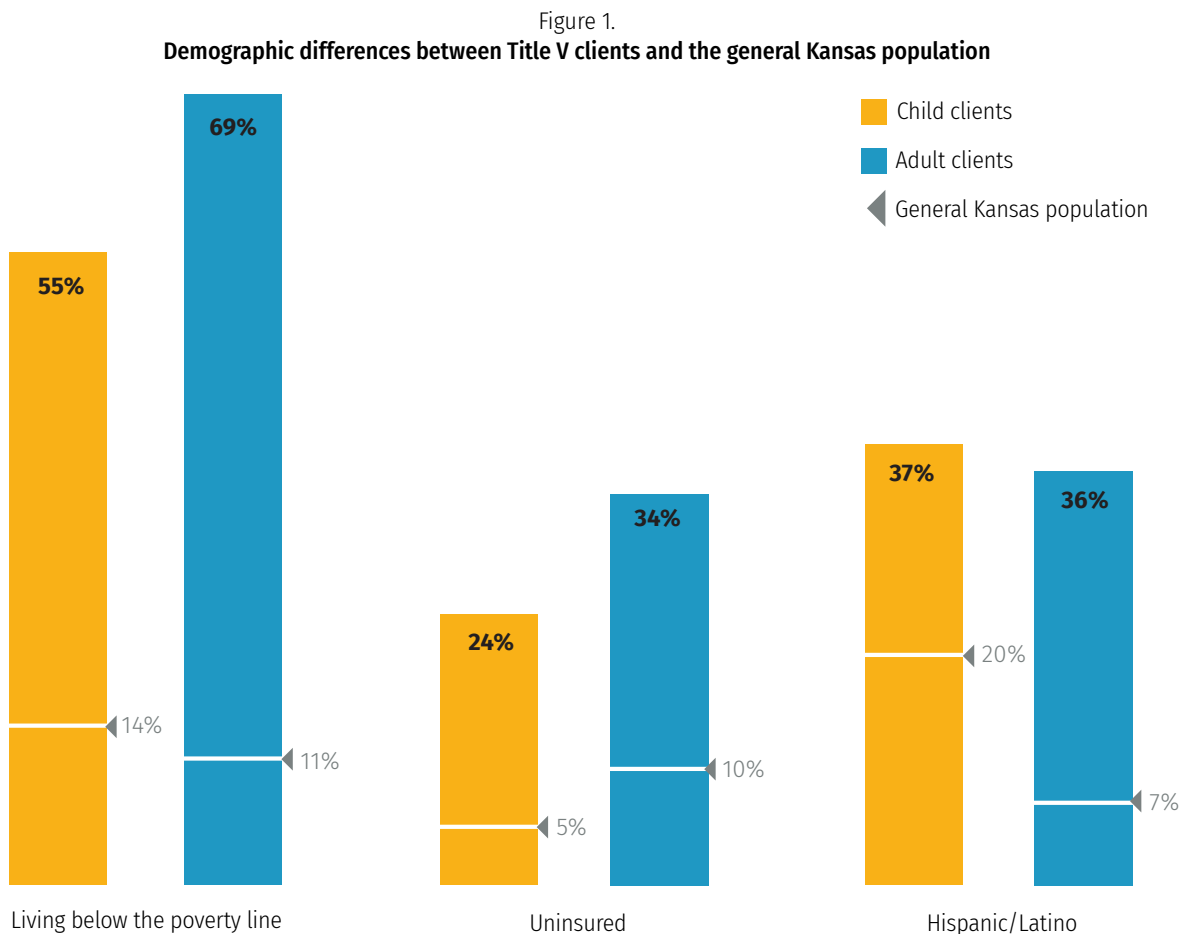
For child clients, 26,725 were served during the reporting period. Gender distribution was nearly equal, with 51% female and 48% male. By age, the largest group was children aged 5 to 14 years, representing 31% of clients, followed by infants under 1 year (28%). Regarding race, 89% of child clients identified as White, though this proportion decreased from 88% in 2020 to 79% in 2024. The percentage of multiracial clients grew significantly, from 5% in 2020 to 13% in 2024. Hispanic or Latino children made up 37% of the client base. Language barriers were evident, as the percentage of Limited English Proficiency (LEP) clients rose from 9% to 14%, with English as the primary language declining from 90% to 85%. Economic challenges were significant, with 64% of children in 2024 living below the poverty line, and 28% being uninsured, an increase from 20% in 2021.

For adult clients, a total of 33,122 individuals were served. Most clients were female (98%), and the largest age group was adults aged 25 to 35 years, representing 45% of the client base. By race, 79% identified as White, but this proportion decreased from 81% in 2020 to 77% in 2024. Multiracial clients rose from 6% to 13%, and Hispanic or Latino adults comprised 36% of clients. Language diversity grew, with LEP rates increasing from 16% to 21%, and the percentage of clients speaking English as their primary language declining from 82% to 77%. Economic struggles were pronounced; 69% of adult clients lived below the poverty line, with rates peaking at 75% in 2020. The uninsured rate was 34%, with a high of 42% in 2021. Employment data showed that nearly half of adult clients (46%) were unemployed. Geographic data revealed a modest increase in clients from rural and frontier areas, from 13% in 2020 to 14% in 2024. Cluster analysis identified subgroups, including racially diverse clients, LEP individuals, and those with significant socioeconomic challenges.



In addition to descriptive analysis of client demographics, CPPR performed a cluster analysis, a statistical technique used to create defined groups of people with similar characteristics within a dataset (although not all individuals included in a cluster will have all of the identifying characteristics for that cluster). The cluster analysis of Kansas Title V clients from the DAISEY dataset identified distinct groups among both child and adult clients based on key demographic characteristics. Among children, four clusters emerged: Non-Hispanic children, diverse-aged White Hispanic children, Hispanic Children with Limited English Proficiency (LEP), and older non-Hispanic White children. Each group exhibited unique age, racial, and language characteristics, highlighting the diversity within the population. For adult clients, three main clusters were identified. These clusters included a racially diverse (all non-White and non-Black) cluster, a large group of White clients with varying Hispanic ethnicity representation, and a distinct cluster of Black clients. Additionally, targeted programs such as Becoming a Mom, the Pregnancy Maintenance Initiative (PMI), and Teen Pregnancy Targeted Case Management (TPTCM) revealed further stratifications based on marital status, language proficiency, insurance coverage, and racial diversity. Detailed information is available in [Appendix F.2 MCH Program Demographics](#).

Comparing Title V clients to the general Kansas population reveals significant differences between the two groups. Among child clients, 55% lived below the poverty line, compared to 14% in the general population, and 24% were uninsured, compared to 5%. Hispanic children accounted for 37% of Title V clients, compared to 20% of the general child population. Similarly, adult Title V clients experienced significantly higher poverty rates (69% vs. 11%) and uninsured rates (34% vs. 10%). Hispanic adult clients accounted for 36% compared to 7% of the general Kansas population.



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## Services Provided

Core MCH services such as education, parenting support, and prenatal care have consistently represented the most utilized Title V-funded services, with education provided to over 50% of adult participants. However, mental health services, especially for perinatal mood and anxiety disorders, have expanded significantly in recent years, reaching 21% of clients by 2024. Services that support client socioeconomic needs, including transportation and food assistance, also increased. Traditional programs like breastfeeding education (46%) and maternal depression screening (29%) remained consistent, though smoking cessation services saw reduced participation.

## Key Programs

**Becoming a Mom:** A comprehensive prenatal education program offered primarily in group settings in multiple locations statewide. Course completion rates peaked at 74% in 2021 but declined to 58% by 2024. Sessions address prenatal care, infant feeding, and safe sleep practices, and the Kansas program has been marked by strong participant satisfaction.

### **Pregnancy Maintenance Initiative (PMI):**

Focusing on prenatal support through case management and agency coordination. In recent years there has been a growing emphasis in the program on connecting clients to socioeconomic supports such as healthcare coverage.

### **Teen Pregnancy Targeted Case Management (TPTCM):**

Serving KanCare-eligible pregnant and parenting teens up to 21 (up to 12 months postpartum) that emphasizes prenatal and parenting education. Services are provided by local agencies in selected Kansas communities to reduce negative consequences of teenage pregnancy for KanCare-enrolled teens and their children, and to increase levels of self-sufficiency and goal-directedness among program clients.



**Trends and Challenges:** Mental health and injury prevention services grew, reflecting a shift toward holistic care, but areas like substance abuse counseling and smoking cessation require attention. Regionally, service delivery varied, with Northeast Kansas leading in maternal depression screenings (43%), while other areas showed lower engagement.

**Referrals:** Child immunizations were the most common referral (48%), peaking at 60% in 2022, while adult referrals frequently involved WIC (35%) and breastfeeding support (25%).



## Recommendations

Based on the analysis of demographic and service trends detailed above, the following recommendations aim to enhance the effectiveness and reach of the Kansas Title V MCH Program.

### *Address Growing Diversity and Language Barriers*

- ◆ **Expand Multilingual Services:** Increase the availability of resources and staff fluent in Spanish and other commonly spoken languages to address the rising percentage of clients with Limited English Proficiency (LEP). Consider hiring cultural navigators to build trust with diverse populations.
- ◆ **Culturally Tailored Outreach:** Develop culturally relevant education and outreach materials that align with the unique needs of Hispanic, multiracial, and other minority groups who are increasingly represented in the client base.

### *Enhance Access for Underserved Populations*

- ◆ **Insurance and Financial Assistance:** Partner with local organizations to provide uninsured clients with expanded access to Medicaid enrollment assistance and financial counseling services. Address 28% of uninsured child clients and 35% of uninsured adult clients by targeting outreach in underserved areas.
- ◆ **Regional Service Equity:** Expand high-demand services like immunizations, maternal depression screenings, and prenatal education in regions where service rates for these preventive services are lower, such as Northwest and Southeast Kansas, to reduce geographic disparities in service provision.

### *Strengthen Behavioral and Mental Health Support*

- ◆ **Scale Up Mental Health Services:** Expand screenings for perinatal mood and anxiety disorders and behavioral health counseling, which currently serves only 21% of clients. Increase training for staff to address maternal depression and related conditions using tools like the EPDS, PHQ-9, and GAD-7 screeners.
- ◆ **Integrate Substance Abuse Programs:** Develop enhanced outreach for substance abuse counseling, currently underutilized, and integrate these services into existing maternal and behavioral health initiatives.

### *Increase Engagement in Preventive Health Programs*

- ◆ **Revitalize Smoking Cessation Programs:** Address the decline in smoking cessation program engagement through updated strategies, such as peer-led support groups, digital resources, and outreach campaigns and other intervention strategies. Given marked disparities in tobacco use, interventions should be principally focused on high-risk areas and populations.
- ◆ **Promote Early Child Screenings:** Expand developmental and health screenings for children, including vision, hearing, and dental services, particularly in rural and underserved communities.

### *Strengthen Socioeconomic Supports*

- ◆ **Enhance Food and Transportation Assistance:** Build on the growing demand for food and transportation support by partnering with community organizations to streamline service delivery.
- ◆ **Promote Social Determinants of Health Screenings:** Institutionalize screenings for social determinants of health across all programs to identify and address barriers to care.

### *Optimize Program-Specific Services*

- ◆ **Becoming a Mom Program:** Focus on improving attendance and completion rates by implementing hybrid delivery models that combine in-person and virtual sessions. Offer incentives, such as childcare or transportation vouchers, to boost participation.
- ◆ **PMI and TPTCM Programs:** Expand WIC services and prenatal support within these programs, given their demonstrated value. Enhance behavioral health and parenting support services to address gaps in client needs.

### *Enhance Data Collection and Reporting*

- ◆ **Standardize Data Across Regions:** Address missing data issues, particularly in regions like Northwest Kansas, to enable more accurate evaluation of service effectiveness and client needs.
- ◆ **Utilize Data for Continuous Improvement:** Leverage detailed demographic and service utilization data to identify trends and tailor services to meet evolving client needs.

### *Foster Community Engagement*

- ◆ **Increase Father Involvement:** Expand programs promoting father engagement in parenting and family dynamics to strengthen family support structures.
- ◆ **Build Community Partnerships:** Collaborate with local organizations, schools, and religious institutions to extend the program's reach and engage harder-to-reach populations.

### *Invest in Staff Training and Capacity*

- ◆ **Cultural Humility Training:** Train staff to deliver culturally appropriate care, ensuring inclusivity and responsiveness to the needs of diverse populations.
- ◆ **Expand Workforce Capacity:** Increase staffing in areas of high demand, particularly mental health services and rural outreach programs, to reduce service gaps.

## Statewide Context for Maternal and Child Health

With a population of nearly 3 million, Kansas ranks 35<sup>th</sup> in the United States for population. It remains a rural state, with over one million residents living in rural and frontier areas. The population density of the state as a whole is 36 persons per square mile (Kansas University Institute for Policy and Social Research, 2023). Of the 105 counties in Kansas, 35% (37) are designated as frontier, with a population density of less than 6 persons per square mile (Kansas Department of Health and Environment, 2023a).

Urban and semi-urban counties in the Northeast and South Central regions account for over 80% of the MCH population. Rural areas face significant challenges, including limited transportation, healthcare access, and socioeconomic disparities that disproportionately impact the MCH population, 26% of whom reside in rural areas.

The Kansas population is 86% White and non-Hispanic, but some counties, particularly in the Southwest region and the Kansas City metro area of Wyandotte County, are minority-majority regions, with considerable racial/ethnic diversity. Socioeconomic disparities further influence MCH outcomes, with rural regions experiencing higher poverty rates and urban centers grappling with food insecurity and homelessness. Kansas ranks below the national average in its food environment index (7.1 out of 10) and income support, with Temporary Assistance for Needy Families (TANF) policies limiting benefits to 24 months, far below the federal 60-month standard. Additionally, Kansas has not expanded Medicaid, leaving over 71,000 low-income residents without coverage, and contributing to declines in CHIP/Medicaid enrollment, with nearly 57,000 children losing coverage in 2023.

### TANF Benefit Limits

Kansas benefits are limited to 24 months—less than half the national standard.

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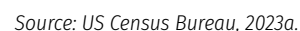
## Demographics

### Racial and Ethnic Diversity

The majority of the population in the state is classified as White and non-Hispanic, constituting 86% of the total population, which is higher than the national average of 75% (US Census Bureau, 2023b). Racial/ethnic diversity varies greatly across the state. Four counties in southwest Kansas (Finney, Ford, Grant, and Seward) have populations that are less than 50% white, as does Wyandotte County (the Kansas City, Kansas, metro area) in the northeast (Kansas Health Matters, n.d.-b) ([Figure 2. Diversity Index by County](#)). Wyandotte County has one of the state's highest diversity indexes (70.8), and another large urban county, Sedgwick County (the Wichita metro area) also has a relatively high diversity index of 55.0 (Kansas Health Matters, 2024). The percentage of non-white residents varies among MCH regions, with the highest percentage (32%) in the Southwest, followed by the two regions home to the state's urban communities, the Northeast with 22% and South Central with 21% ([Appendix F, Table F1.5. Additional Demographics by MCH Region](#)). In terms of counties with high percentages of women aged 15 to 44 who are non-White, Wyandotte County has the highest percentage, with 35%, followed by Geary, Riley, Montgomery, and Johnson counties. For by-county details about population density, income inequality, and distribution of women of reproductive age, see [Appendix D. MCH Population Health and Well-Being Map Data](#).

**Diversity index by county, 2020.**

Scale: 0 = no diversity, 100 = high diversity



## Socioeconomic Determinants of Health

Kansas 2025 Title V Needs Assessment

## *Economic Environment*

Historically, agriculture has been a cornerstone of the Kansas economy, making the state a national leader in producing wheat, sorghum, and beef since the early 1900s (Kansas Historical Society, 2023). While agriculture remains vital, it also exposes the state to fluctuations in commodity prices, market uncertainties, and weather-related risks, including droughts and floods. These environmental factors can significantly disrupt farm incomes and rural economies. Additionally, Kansas faces slow population growth rate compared to national averages, with some rural and frontier regions experiencing population decline (Hunt & Panas, 2018). This demographic trend presents challenges for sustainable economic growth, as a shrinking population can lead to reduced consumer demand, labor shortages, and diminished tax revenues for essential public services.

The outmigration of educated youth seeking better job opportunities exacerbates economic issues in Kansas (Johnson, 2024). This “brain drain” results in a shortage of skilled workers and entrepreneurs, stifling innovation and economic development. While the unemployment rate has been relatively low—around 3%—it varies significantly across different regions and sectors (Federal Reserve Bank of St Louis, 2024). Furthermore, concerns about stagnant wages persist, with the average weekly wage below the national average in 101 of 105 counties (Kansas Department of Labor, 2024). The minimum wage in Kansas, set at \$7.25, does not provide a livable income. A survival budget for a family with two adults, one infant, and one preschool-aged child necessitates a combined hourly wage of \$27.40 (United Way, 2023). Kansas ranks in the middle of U.S. states regarding poverty rates and related socioeconomic indicators. Approximately 12% of households live at or below 100% of the federal poverty level (FPL), translating to less than \$30,000 annual income for a family of four. Additionally, 27% of households earn above 100% FPL but struggle to afford basic needs (United Way, 2023). Rates of poverty differ across the state, with rural areas often experiencing higher rates than urban centers. In urban settings like Wichita and Kansas City, issues including homelessness and inner-city poverty are prevalent. Conversely, rural areas face challenges like limited job opportunities and inadequate access to healthcare and infrastructure.

Food insecurity is often a concern for low-income families, both in rural and urban areas of the state. The Food Environment Index is a measure that evaluates factors contributing to a healthy food environment on a scale from 0 (worst) to 10 (best). This index reflects the availability and affordability of healthy foods in a community and is associated with health outcomes including obesity, premature death, asthma, and increased health care costs. This index considers two main components: Proximity to Healthy Foods assesses how close individuals live to grocery stores or supermarkets that typically provide healthier food options compared to convenience stores. Income and Cost Barriers accounts for whether individuals can afford healthy food, acknowledging that low-income households may struggle to consistently access nutritious options due to financial limitations. Kansas scored 7.1 out of a possible 10 on the food environment index (worse than the national average of 7.7) (County Health Rankings, 2024). This ranged from 5.4 to 9.3 across counties in the state, without any discernable pattern among rural and urban counties. There is a notable cluster of counties with lower food index scores in the southeast corner of the state, generally the state’s poorest area, but there are counties across the state, both rural and urban, with low scores.

5.4  9.3



Relative wealth can influence health outcomes more significantly than absolute wealth levels (Beach, 2021), and research shows that income inequality correlates with negative social outcomes, including poorer health, reduced life expectancy, and increased crime rates (Polacko, 2021). By monitoring income inequality, policymakers can gain insights into the underlying social determinants of health and well-being and devise targeted interventions to address these issues.

Kansas 2025 Title V Needs Assessment

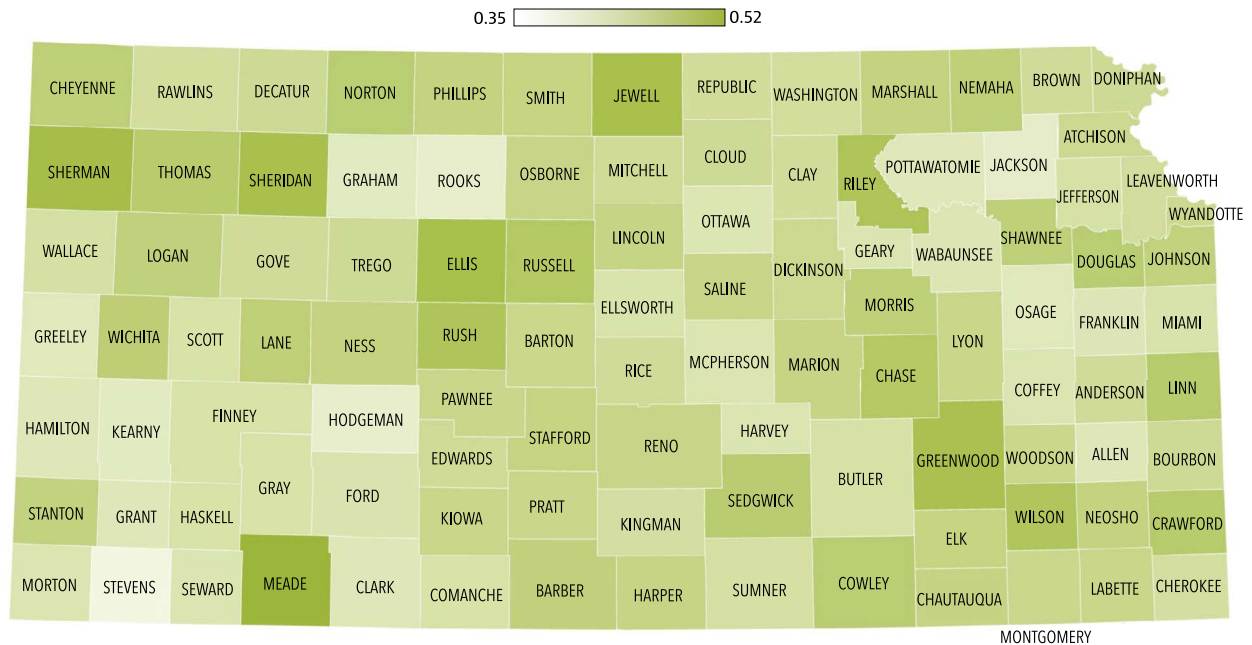
Figure 4.

### Gini Index of Income Inequality for Kansas by County.

Darker color and higher numbers indicate higher income inequality.

Most Kansas counties have low to moderate inequality indices.

Scale: 0 = complete equality, 1 = complete inequality



Source: US Census Bureau, 2023a

## Racial and Ethnic Income Disparities

Racial and ethnic income disparities are prevalent in Kansas, with median household incomes significantly differing among various racial and ethnic groups. According to US Census Bureau data, white households have a median income of \$70,867, while Black households average \$47,907, and multi-racial households average \$63,534 (Neilsberg Research, 2024). Furthermore, the percentage of individuals living in poverty is notably higher among Black (21%), Hispanic (21%), Native American/Alaska Native (18%), and multi-racial populations (16%) compared to the overall population rate of 12% (KFF, 2024b). These disparities reflect broader socioeconomic inequities and barriers faced by communities of color.

## Urban-Rural Distribution

Kansas, with a population of nearly 3 million, in terms of geography, is a predominantly rural state. While the majority of the population is concentrated in six urban counties and an additional 10 semi-urban counties—particularly in the Northeast (53%) and South Central (30%) regions—over a million Kansans live in rural and frontier areas (Steiner, 2021) ([Figure 5. Kansas County Population Density](#)). While Johnson and Wyandotte counties in Kansas have population densities of over 1,000 people per square mile (with Johnson County at 1,307 people per square mile and Wyandotte County at 1,093 people per square mile), other counties have significantly lower population densities, with many having less than 100 people per square mile. Urban counties are experiencing the most rapid growth, with over half of the state’s population residing in these areas. Rural and frontier counties, which make up a large part of the state’s geography, present significant barriers to essential services. Limited transportation options and distance from urban centers contribute to disparities in access to healthcare, education,

Figure 5.  
**Kansas County Population Density.**  
Johnson and Wyandotte counties are the most population-dense in Kansas.  
Over one-third are considered frontier with population densities of less than 6.0 people per square mile.

### Kansas County Population Density.

Over one-third are considered frontier with population densities of less than 6.0 people per square mile.

1.6  1,307.3



## Social and Economic Policies Impacting MCH

The policy environment in Kansas plays a significant role in shaping Maternal and Child Health (MCH) outcomes, particularly in relation to healthcare access and social support systems. Kansas has not expanded Medicaid under the Affordable Care Act, which leaves over 71,000 low-income residents, including women and children, without access to affordable healthcare coverage. As a result, 23% of low-income women in the state remain uninsured (Prenatal-to-3 Policy Impact Center, 2024a).

The conclusion of the continuous Medicaid coverage requirement implemented during the COVID-19 pandemic has further affected access to coverage. Between April and December 2023, Kansas experienced a net decline of nearly 57,000 children enrolled in CHIP/Medicaid, despite many remaining eligible for coverage (Alker et al., 2024; Kansas Health Institute, 2023a).

Figure 6. Uninsured rates are notably higher among certain populations in Kansas



*\*For counties with less than 40 persons per square mile compared to 10% in more densely populated counties.  
Source: Kansas Health Institute, 2023a*

Expanding access to healthcare coverage has the potential to reduce these disparities and improve maternal and child health outcomes by supporting preventive care and timely medical services.

Economic and social support programs also influence the health and well-being of families in Kansas. These policies can impact families' ability to achieve housing stability, food security, and economic well-being—factors that are known to influence health outcomes for women, infants, and children.

- ◆ **Temporary Assistance for Needy Families (TANF):** Kansas policies include a 24-month limit on cash assistance, which is below the federally allowable 60 months, and have relatively low maximum benefit levels (Pfeifer, 2023).
- ◆ **Supplemental Nutrition Assistance Program (SNAP):** Kansas ranks third lowest among states in access to SNAP benefits and fifth lowest in the percentage of eligible individuals receiving food assistance (Melton, 2023).
- ◆ **Medicaid/CHIP:** Kansas is one of ten remaining states who have not expanded Medicaid under the Affordable Care Act and has some of the strictest program eligibility requirements in the country. Since COVID-19 protections on disenrollment from Medicaid expired, substantial numbers of Kansas children, including some children believed to technically be eligible for coverage, have lost CHIP/Medicaid coverage.

Ultimately, low-income families may not be eligible for services vital to the health of their family members and not have the resources needed to access these services. Programs valuable to MCH families, such as the Supplemental Nutrition Assistance Program (SNAP) and the Women, Infants, and Children (WIC) program, have strict income eligibility thresholds. Families that earn even slightly more than the income for these programs' limits can lose access to essential services such as healthcare, nutritional support, and childcare subsidies, an abrupt loss commonly referred to as a benefits cliff (National Conference of State Legislatures, 2019). Additionally, some employed individuals may earn too much money to receive public assistance while also not being eligible for employee benefits.

An MCO representative noted...

*"We see a lot of the new moms are part-time workers so they're not eligible for benefits. They're not eligible for maternity leave. They're not eligible for anything like that. And so not having benefits available for part-time workers is one of the biggest detriments that I see."*

## System Capacity

Approximately one-third of Kansans reside in Health Professional Shortage Areas (HPSAs), which are designated by the National Health Service Corps (NHSC) to identify critical shortages of clinicians. Federally Qualified Health Centers (FQHCs) play a vital role in providing accessible care to underserved populations, but these facilities are unevenly distributed, leaving gaps in access, especially in rural and maternity care desert areas, where 8% of births occur. Preventive care, including vaccinations and regular check-ups, also lags, with only 68% of adults receiving flu vaccines and childhood immunization rates below recommendations. Telehealth services, which gained traction during the COVID-19 pandemic, presents a promising solution for bridging gaps in access, yet adoption is hindered by limited broadband access in rural areas, where 13% of households lack a subscription, compared to 9% in urban areas.

## Shortage Area Designations

The National Health Service Corps (NHSC) has developed the Health Professional Shortage Area (HPSA) score as a critical tool for identifying regions most in need of healthcare providers (Bureau of Health Workforce, 2023). The federal government recognizes three distinct types of HPSAs: those for primary care, oral/dental care, and mental health care. These scores range from 0 to 26, with higher values indicating a greater shortage of providers.

In Kansas, areas designated as HPSAs collectively impact a population exceeding 800,000—nearly one-third of the state's residents. According to the Health Resources and Services Administration (HRSA), the state currently requires an additional 113 primary care practitioners, 50 dental health practitioners, and 51 mental health practitioners to eliminate these designations and achieve sufficient healthcare coverage statewide (Bureau of Health Workforce, 2025). Among the counties in Kansas with elevated Primary Care HPSA scores, Crawford County stands out with the highest score of 21, followed closely by Lyon County at 20. Cowley, Reno, Sedgwick, and Wyandotte Counties each share a score of 19. A visual representation of the Primary Care HPSA map for Kansas can be found in [Figure 7](#).

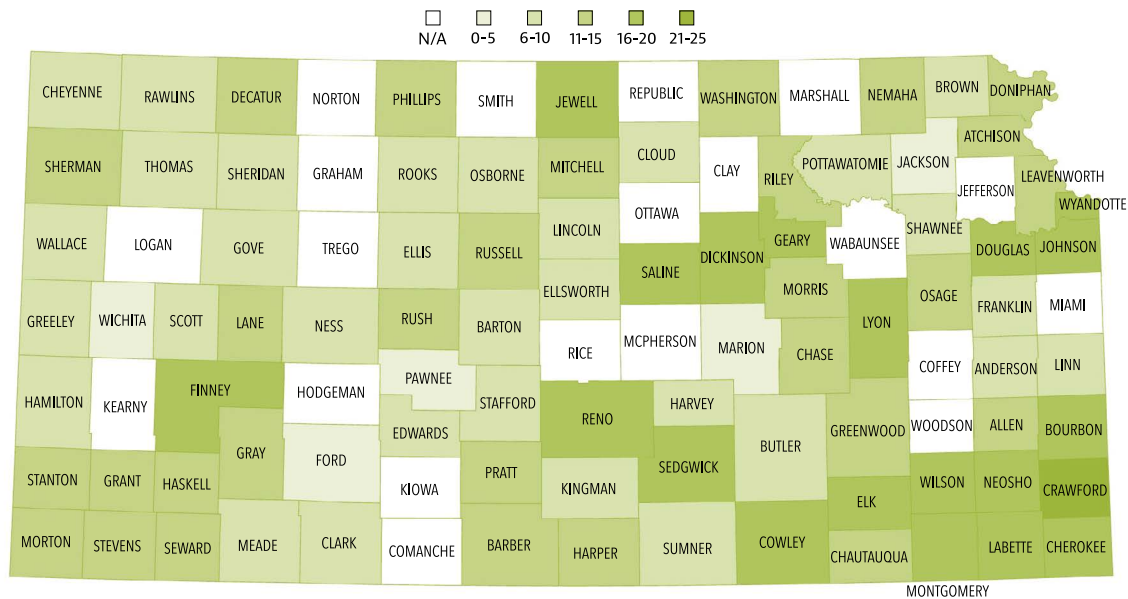
### SHORTAGE AREAS

One third of all Kansans live in health professional shortage areas.

Figure 7.

### Primary Care HPSA Scores in Kansas.

Scores are used to prioritize placements of National Health Service Corps clinicians and range from 0 to 25. Higher scores signify greater need and priority. Counties in white/grey indicate no available data to calculate the score. A majority of Kansas counties are designated as primary care shortage areas.



Data Source: [data.hrsa.gov](https://data.hrsa.gov)

## Access to Federally Qualified Health Centers (FQHCs)

FQHCs serve a critical role in providing primary care and preventive services to underserved populations in Kansas. These centers operate on a sliding fee scale, making them more accessible to low-income individuals and those who are un- or underinsured (Kansas Health Institute, 2023b). However, only 42 of the 105 Kansas counties have FQHCs, leaving many residents without local access to these vital services (Community Care Network of Kansas, 2024).

## Access to Behavioral Health Care

Using data from the National Survey on Drug Use and Health (NSDUH) and the Kansas Behavioral Sciences Regulatory Board, the behavioral health workforce rate across Kansas is 0.87 per 100 individuals needing services. This translates to fewer than one behavioral health worker per 100 people requiring care.

The distribution of behavioral health workers varies significantly by geographic area:

- ◆ **Urban areas:** Lead with a rate of 1.65 behavioral health workers per 100 individuals needing services.
- ◆ **Semi-urban areas:** Have a rate of 1.27 behavioral health workers per 100 individuals.
- ◆ **Rural areas:** Have a rate of 0.64 behavioral health workers per 100 individuals.
- ◆ **Frontier areas:** Face the most severe shortages with a rate of 0.38 behavioral health workers per 100 individuals.

These disparities are illustrated in [Figure 8. Behavioral Health Workforce by Estimated Need](#), which shows the behavioral health workforce per 100 individuals for each Kansas county.

### Behavioral Health Workforce by Estimated Need.

0 4.4

CHEYENNE RAWLINS DECATUR NORTON PHILLIPS SMITH JEWELL REPUBLIC WASHINGTON MARSHALL NEMAHA BROWN DONIPHAN

SHERMAN THOMAS SHERIDAN GRAHAM ROOKS OSBORNE MITCHELL CLOUD CLAY RILEY POTTAWATOMIE JACKSON ATCHISON

WALLACE LOGAN GOVE TREGO ELLIS RUSSELL LINCOLN OTTAWA CLAY RILEY POTTAWATOMIE JACKSON ATCHISON

GEARY WABAUNSEE SHAWNEE JEFFERSON LEAVENWORTH

WYANDOTTE

DOUGLAS JOHNSON

OSAGE MIAMI

FRANKLIN

CHASSE

LYON

COFFEY

ANDERSON LINN

ALLEN BOURBON

WILSON NEOSHO CRAWFORD

CHATAUQUA

LABETTE CHEROKEE

MONTGOMERY

STANTON GRANT HASKELL GRAY FORD KIOWA PRATT KINGMAN SEDGWICK BUTLER GREENWOOD WOODSON ALLEN BOURBON

MORTON STEVENS SEWARD MEADE CLARK COMANCHE BARBER HARPER SUMNER COWLEY CHATAUQUA

WICHITA SCOTT LANE NESS RUSH BARTON RICE MCPHERSON MARION CHASSE

HAMILTON KEARNY FINNEY HODGEMAN PAWNEE STAFFORD

EDWARDS

## Utilization of Telehealth Services

Kansas 2025 Title V Needs Assessment

## General Health and Chronic Disease

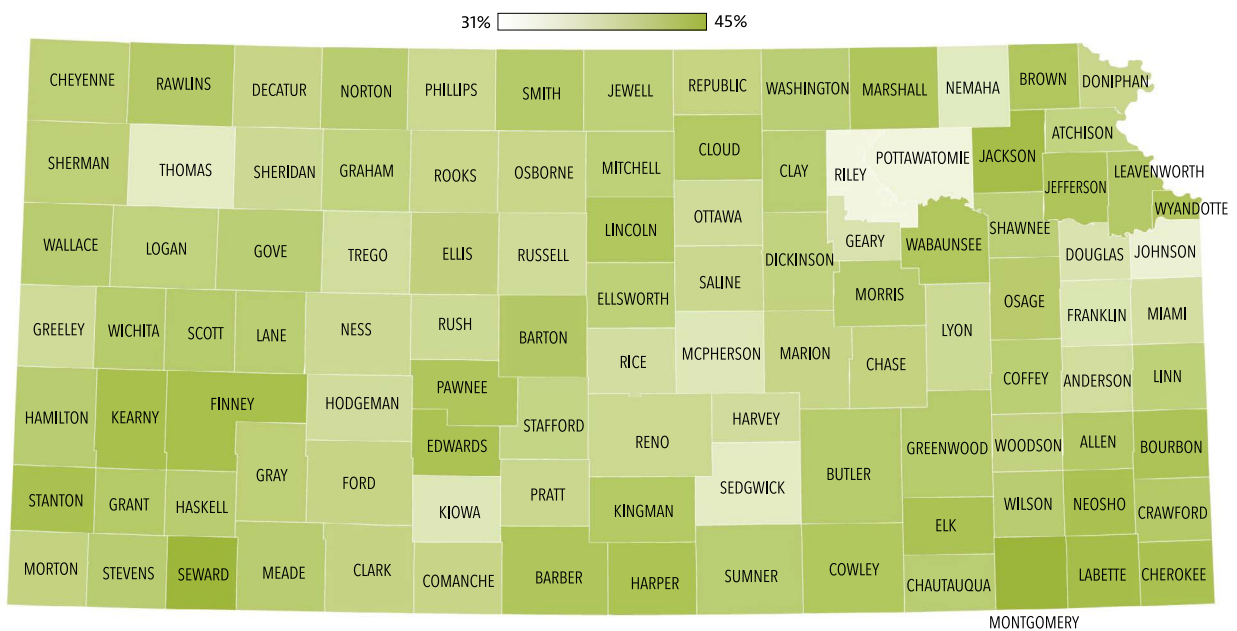
The general health of Kansans, encompassing adults, adolescents, and children, reveals a complex landscape marked by significant challenges and areas for improvement across various health metrics. Chronic diseases significantly impact the health of Kansans. Heart disease and cancer remain the leading causes of death in the state, with heart disease accounting for 20% of all deaths and cancer responsible for 17% in 2021-2022 (Kansas Department of Health and Environment, 2022b). An estimated 10% of adults in Kansas have a diabetes diagnosis (Centers for Disease Control and Prevention, n.d.). The prevalence of these chronic diseases in the state highlights the importance of healthy lifestyles (diet, physical activity, and tobacco use prevention and control) and preventive care across all age groups and suggests the need for a more active role of the public health community across all programs to address the risk factors of chronic disease.

### Obesity

A new report shows that 36% of adults in Kansas are classified as obese, one of 23 states the CDC highlights as having an obesity rate over 35%. There are counties, both urban and rural, with obesity rates exceeding 40%, while other counties have rates as low as 20% ([Figure 9. Obesity Among Adults by County](#)). Among Kansas adolescents in 9<sup>th</sup> through 12<sup>th</sup> grades, 18% are classified as overweight and another 17% are obese (Centers for Disease Control and Prevention, 2021) ([Appendix E.3: NOM: Child Obesity-Ages 6 through 17](#)). There are also disparities in obesity rates associated with educational attainment, income, health insurance status, and race ([Appendix E.3: NOM: Child Obesity-Ages 6 through 17](#)). These numbers underscore the need for comprehensive strategies to address weight management, including physical activity and nutrition initiatives, across all age groups.

Figure 9.  
**Obesity Among Adults by County.**

Percentages on map show the proportion of adults with a body mass index (BMI) greater than or equal to 30 ( $\geq 30$  kg/m<sup>2</sup>) based on self-reported weight and height.



Data source: Kansas Health Matters

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## Violence

Violent deaths in Kansas, including suicides, homicides, and other intentional incidents, disproportionately affect certain populations and create significant social and economic challenges. According to data from the Kansas Violent Death Reporting System (KSVDRS), males experience violent deaths at nearly three times the rate of females (Kansas Department of Health and Environment, 2024c). Non-Hispanic Black individuals had nearly double the mortality rate from violent deaths compared to White, non-Hispanic individuals. These deaths contributed to an estimated \$40.6 billion in societal losses and over 129,000 years of potential life lost before age 75 (Kansas Department of Health and Environment, 2024c). There are also notable disparities by race for adolescent firearm deaths, with death rates experienced by non-Hispanic black adolescents (37.4 per 100,000) far greater than those experienced by non-Hispanic whites (8.9 per 100,000) ([Appendix F.4 Adolescent Firearm Death](#)).

Among youth, suicide remains a leading cause of violent deaths, especially in rural and underserved areas of Kansas. Mental health challenges, family stress, and limited access to resources are critical factors that exacerbate these issues. The state has ongoing efforts to address these trends, with the KSVDRS collecting comprehensive data on the circumstances surrounding these deaths. This information helps inform violence prevention strategies, guiding efforts to reduce disparities and improve health outcomes across the state.

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## Health literacy

Rural communities face intertwined challenges of literacy and health literacy, which significantly contribute to disparities in healthcare access and outcomes (Miller Temple, 2022). General literacy—the ability to read, write, and understand basic information—is a foundational skill that underpins health literacy, or the ability to obtain, process, and understand healthcare information to make informed decisions. This issue is particularly acute in rural areas, where 1 in 9 Kansas counties reports that 25% or more of residents have below-basic literacy levels (Barbara Bush Foundation for Family Literacy, 2024). Limited literacy skills make it harder for individuals to comprehend medical instructions, navigate healthcare systems, or advocate for their needs, leading to delays or avoidance of care.

These challenges can be compounded by additional barriers common in rural settings, such as limited healthcare resources, social stigma, and privacy concerns. In smaller communities, residents may hesitate to seek care for sensitive issues like mental health, substance use, or chronic conditions due to fear of being noticed by acquaintances or the discomfort of knowing their healthcare provider personally. Addressing these interconnected issues requires targeted solutions, including improving health literacy through accessible education programs, integrating behavioral health services into primary care for more discreet access, and expanding telehealth options to provide confidential support. By tackling both literacy and health literacy simultaneously, these interventions can help reduce healthcare disparities and improve outcomes in rural communities (Graves et al., 2024).

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## Health Disparities

Health disparities are prevalent across different populations in Kansas. Rural residents often face higher rates of chronic diseases and lower access to healthcare compared to their urban counterparts (Ziller & Milkowski, 2020). Racial and ethnic minorities experience additional disparities in health outcomes and access to care, including lower rates of preventive services and higher rates of chronic diseases. For instance, Black/African American Kansans face higher rates of hospital admissions for chronic diseases and elevated mortality rates compared to White individuals. The need for targeted public health initiatives to ensure equitable health outcomes for all Kansans, regardless of age, rurality, or background.

## Domain-Specific Analysis

### Secondary Data, Qualitative Findings, and Recommendations

While there are encouraging outcomes, significant concerns remain regarding the health of MCH populations in Kansas. Several trends indicate that health outcomes have worsened since the previous Needs Assessment conducted five years ago. Persistent disparities tied to race/ethnicity, income, educational attainment, insurance coverage, and other socioeconomic factors remain evident. In some cases, these gaps have even widened over time. This report will highlight and explore these challenges in detail.

The data gathered and analyzed during the Needs Assessment process reveal both areas of progress and positive maternal and child health MCH outcomes in Kansas at this point in time.

#### About the data

Unless otherwise cited, the data points referenced in this section are sourced from the Population Domain tables in [Appendix E](#), where more details are available.



DOMAIN  
Women & Maternal

Maternal health outcomes in Kansas reflect both notable strengths and ongoing challenges. Expanding access to Title V services, telehealth, and community-based care can address disparities and improve maternal health across the state.

STRENGTHS

- + High rates of first-trimester prenatal care.
- + Cervical cancer screening rates meet HP2030 targets.
- + High rates of postpartum checkups.
- + Decreased tobacco use during pregnancy.
- + Increased postpartum contraceptive use.
- + Postpartum depression rates have improved.

CHALLENGES

- ✗ Maternal mortality rates have risen and exceed the HP2030 target.
- ✗ Gaps remain in preventive care and reproductive health services for women of reproductive age.
- ✗ Unintended pregnancies contribute to adverse outcomes, and disproportionately affect minorities.
- ✗ High prevalence of chronic disease (i.e., obesity, diabetes, and hypertension) contribute to long-term adverse health outcomes.
- ✗ Intimate partner violence compounds maternal health risks.
- ✗ Behavioral health issues (including substance use) compounds risks.
- ✗ Almost half of Kansas counties are considered maternity care deserts.



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## Women and Maternal Health Strengths

### *High cervical cancer screening rates*

Kansas has an age-adjusted cervical cancer incidence rate of 8.2 per 100,000 women, slightly higher than the national average (National Cancer Institute, 2025). Screening rates are high, with 84% of Kansas women up to date cervical cancer screening, meeting the HP2030 objective (Kansas Department of Health and Environment, 2024d).

### *High rates of prenatal care*

Access to prenatal care is crucial for healthy pregnancies. Kansas reports high rates of first-trimester prenatal care (81% in 2021-2023) compared to the national average of 77% (Kansas Health Matters, n.d.-a). Among most sub-population groups these numbers have remained stable or improved over the five-year period from 2018 to 2022.

### *High rates of postpartum care*

The percent of women who attended a postpartum checkup within 12 weeks of giving birth is 92%, and postpartum visit rates increased from 2018 to 2022 among women 20 to 24 years (89% in 2022) and less than 20 years (90%). The percent of women who attended a postpartum checkup and received the recommended components of care has been trending up as well; 79% of all women received all recommended components during their postpartum visit. There have been increases over time in the percent of women across ethnic/racial populations that have experienced improvements in receiving recommended care components during postpartum visits.

### *Decreased use of tobacco*

The percentage of women who smoke during pregnancy has fallen considerably from 2018 to 2022 (from 10% to 6%). Rates have been trending downward, positively, for nearly every sub-population of pregnant women.

### *Increased postpartum contraceptive use*

Among younger women postpartum contraceptive use has increased from 2018 to 2022. Among women 20 to 24 years the rate has trended up to 44% in 2022. The increase has been even more dramatic among women under 20 years of age, increasing from 61% in 2018 to 71% in 2022. Postpartum contraceptive use has also trended up among women with less than high school education (reaching a high of 62% in 2022), Hispanic women (56% in 2022), and uninsured women (39% in 2022). Women receiving WIC services have a higher prevalence of using contraceptive methods during the postpartum period (62%) compared to those not receiving WIC (55%).



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## Women and Maternal Health Challenges

### *Well-woman visits and preventive care*

Preventive care remains an area of concern for Kansas women aged 18 to 44 years, with only 74% reporting a preventive medical visit in the past year. Disparities exist, as only 62% of women with less than a high school education and just 45% of uninsured women reported such visits. Preventive dental care during pregnancy is also notably low, with fewer than half (49%) of women receiving a dental visit in 2022.

### *Chronic disease risks*

Chronic disease risk factors are high among Kansas women aged 14 to 44. Approximately 37% of women in this age group are obese (BMI over 30.0), placing Kansas 37th among states. Additionally, 13% of women have diagnosed diabetes, and 36% experience hypertension. These conditions significantly increase the risk of poor birth outcomes, including gestational hypertension, pre-eclampsia, and eclampsia, which occur in about 15% of Kansas births. Beyond pregnancy, they heighten the risk of premature death from chronic diseases such as heart disease, cancer, and stroke.

### *Breast cancer screening and mortality*

Breast cancer remains a significant health concern in Kansas. The breast cancer death rate aligns with national averages at approximately 19 per 100,000 women (Kansas Department of Health and Environment, 2019). About 75% of women aged 50 to 74 in Kansas report having a mammogram within the past two years (Economic Policy Institute, 2018). This rate is close to but slightly below the HP2030 target of 77% for women in this age group. Nationally, there are significant racial and ethnic disparities in breast cancer outcomes. Non-Hispanic Black women have higher breast cancer mortality rates compared to non-Hispanic White women, with a 39% higher likelihood of dying from breast cancer despite lower incidence rates (Primm, 2022). Black women are more likely to be diagnosed with breast cancer at a younger age and at a more advanced stage. Approximately 23% of African American patients with breast cancer are diagnosed before the age of 50, compared to 16% of White American patients (Stringer-Reasor, 2021). Hispanic women also experience disparities, including longer delays to confirmed diagnosis and higher rates of late-stage diagnosis (Molina, 2015). Similar disparities are observed in Kansas. The Kansas Early Detection Works (EDW) program has noted that Hispanic women initially showed improved breast cancer screening rates after 2016, but these disparities returned in 2020 (Ismail, 2022). Women living in rural communities in Kansas experience lower breast cancer screening rates than those living in urban areas (Brewer, 2023; Ismail, 2022).

### *Intimate partner violence*

Intimate partner violence remains a significant issue in Kansas. The current rate of domestic violence (as defined by the Kansas Bureau of Investigation as including verbal or physical abuse, threats, or crimes against a current or former partner, family, or household member) is 7.5 incidents per 1,000 residents, and there has been an upward trend of domestic violence-related homicides in recent decades, with over 30 deaths annually (ranging from 32 to 38) every year since 2017 (Kansas Bureau of Investigation, 2022). Women are disproportionately affected, being victims in 70% of Kansas reported incidents.



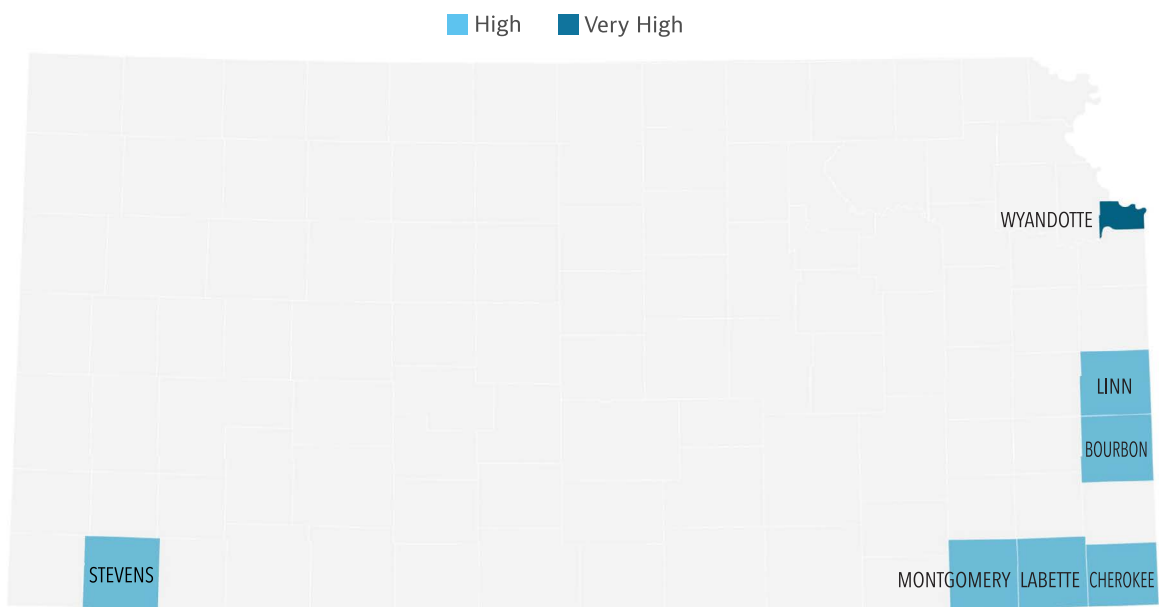
## Maternal Vulnerability Indices

The Kansas Maternal Vulnerability Index (MVI) assesses maternal health vulnerabilities across various domains, including reproductive healthcare, physical health, mental health and substance abuse, general healthcare, socioeconomic determinants, and the physical environment (MVI Surgo Ventures, 2024). The MVI uses 43 indicators to generate vulnerability scores for each Kansas county, ranging from 0 to 100. Scores of 60 to 79 indicate high vulnerability, while scores above 80 represent very high vulnerability. These insights provide a roadmap for addressing disparities and strengthening maternal health systems across Kansas.

Counties such as Wyandotte, Labette, Montgomery, and Linn rank among the most vulnerable across multiple domains. Key concerns include barriers to reproductive healthcare in rural areas, elevated rates of chronic health conditions, significant mental health and substance abuse challenges, and limited access to general healthcare in several counties. Socioeconomic challenges, such as poverty and housing instability, and environmental factors, such as pollution and violent crime, further exacerbate vulnerabilities ([Appendix F.4 The Kansas Maternal Vulnerability Index](#)).

The data highlights disparities across counties, with Wyandotte County scoring particularly high in physical health, socioeconomic determinants, and the physical environment. Rural counties face challenges in accessing reproductive and general healthcare. The MVI provides a valuable tool for identifying high-risk areas and targeting interventions to address maternal vulnerabilities. To improve outcomes, efforts must focus on increasing healthcare accessibility, addressing chronic conditions and mental health needs, and improving environmental and socioeconomic conditions in high-risk counties.

Figure 10.  
Kansas County Overall Maternal Vulnerability Score.



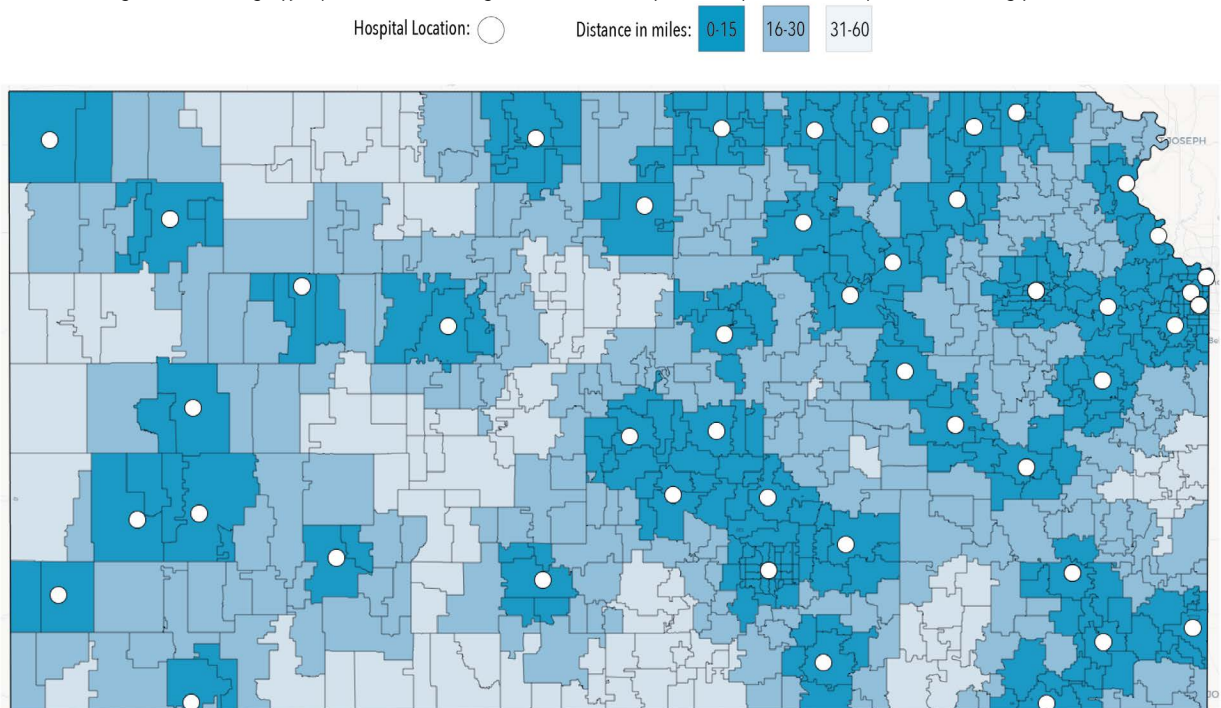
## Maternal morbidity and mortality

Kansas had a maternal mortality rate of 22.8 deaths per 100,000 live births in 2022. This figure has been trending up since 2018 and exceeds the HP2030 goal of 15.7. Since then, rates have been trending upward in a negative direction, reaching a high of 22.8 maternal deaths per 100,000 births in 2022. Factors contributing to maternal mortality include limited prenatal care, health complications, socioeconomic disparities, and inadequate postpartum support services (Dagher & Linares, 2022). Racial disparities are significant; Black and Indigenous women, along with other minority groups, experience higher rates of maternal mortality and severe maternal morbidity (SMM). The SMM rate for non-Hispanic Black women in Kansas during the period 2016 to 2020 was 103.5 per 10,000 delivery hospitalizations, substantially higher than that of non-Hispanic white women (56.4 per 10,000) (Kansas Department of Health and Environment, 2023d). Between 2018 to 2022 SMM rates worsened for all ethnic groups (Hispanic, non-Hispanic Black, non-Hispanic White, with persistent racial disparities). The overall 2022 maternal mortality rate experienced by Black women is many times that of Non-Hispanic White women: 100.3 maternal deaths per 100,000 live births among non-Hispanic Black women, compared to only 17.3 deaths among non-Hispanic White women.

## Access to Prenatal and Obstetrical Care

The report “Access to Obstetrical Care in Kansas” paints a concerning picture of the state of maternal healthcare in Kansas, particularly in rural areas. It uses various data sources to illustrate the growing problem of maternity care deserts and their impact on maternal and infant health outcomes. A key finding is that 46% of Kansas counties are considered maternity care deserts. An estimated 8% of all births in Kansas occurred in counties categorized as maternity care deserts. Many families, particularly in western Kansas, must drive considerable distances (some as far as 30 to 60 miles) to reach an inpatient obstetrical unit ([Figure 11. Distance to Inpatient Obstetrical Delivery Services](#)).

Figure 11.  
**Distance to inpatient obstetrical delivery services.**  
*Lighter areas signify zip codes that are greater distances from hospitals with inpatient birthing facilities.*



Source: University of Kansas School of Nursing, 2025.

One of the primary factors contributing to this crisis is the closure of obstetrical service lines in hospitals, leading to



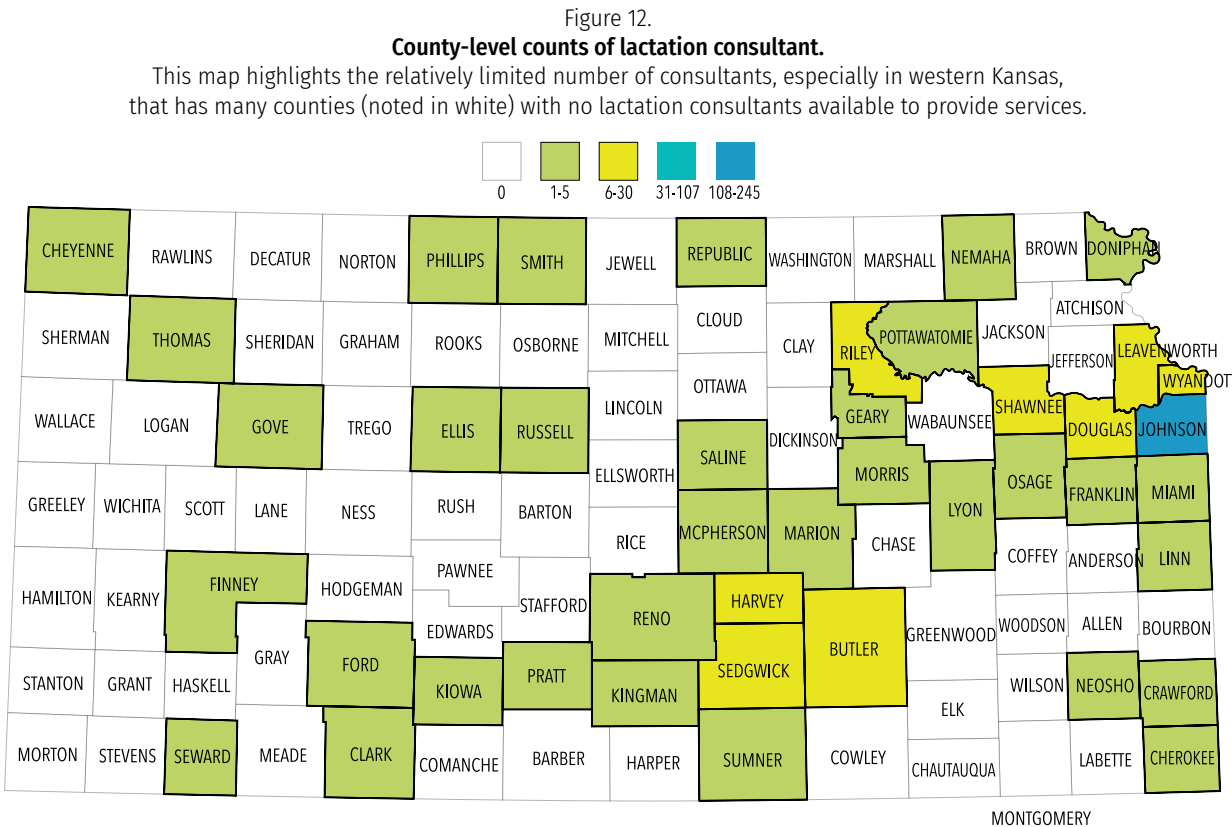
a shortage of qualified healthcare providers. The report reveals an existing scarcity of essential personnel, including nurses with obstetrical experience, anesthesiologists, and OB/GYNs, particularly in rural communities. Nearly as concerning as current scarcity is the potential closure of additional rural hospitals, further exacerbating a dire situation. Currently nearly one-third (32) of the rural hospitals in Kansas are considered at immediate risk of closing, which along with Texas (also with 32) is more than any other state in the country (Center for Healthcare Quality and Payment Reform, 2024).

*The role of community-based workers in prenatal and obstetrical care*

In Kansas, there has been increasing support for the expansion of the community-based workforce, including lactation consultants, doulas, home visitors, and Community Health Workers (CHWs), as vital resources to better help families navigate the system of prenatal and postpartum care. Doulas, for example, have been identified as a key solution to address the lack of obstetric care, especially in rural areas, not as clinical providers of obstetrical care, but to help women and families with navigating the system when services are fragmented and not always available in the community.

There have been barriers to progress, however, that have hampered system-wide utilization of a community-based workforce. The first barrier is the limited number of workers, particularly in more rural areas of Kansas.

The map below shows the distribution of lactation consultants in the state. As is true with many health professionals, the number of consultants is concentrated in the state’s urban areas in northeast and South Central Kansas. Many of the state’s rural counties have few or no lactation consultants, especially in the western half of the state.



Source: Weis & Alsop, University of Kansas School of Nursing, 2025.

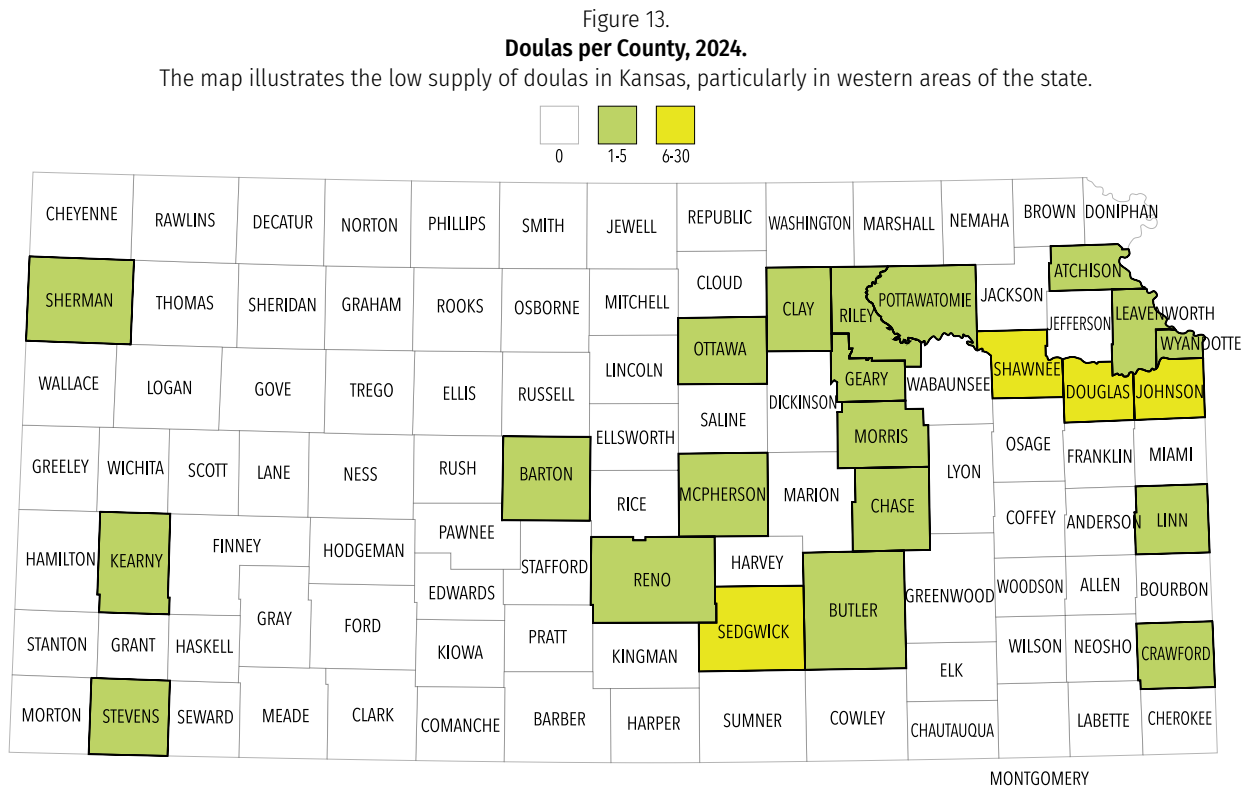


Kansas has taken steps to expand doula-based care, recently moving to provide coverage and reimbursement for community-based doula services under Medicaid. Kansas Medicaid will reimburse for up to 7 hours of prenatal care, 6.25 hours of postpartum care, and labor and delivery support. However, the total maximum Medicaid reimbursement rate for Kansas is \$1,295, less than most of the other 19 states that have Medicaid coverage of doulas (Prenatal-to-3 Policy Impact Center, 2024b). Eight states have also implemented policies to support doula training and workforce development through the creation of training funds meant to support educational offerings for maternal health workers, establishment of doula training scholarships, and technical assistance with things like Medicaid enrollment assistance (Prenatal-to-3 Policy Impact Center, 2024). In addition to policy change, there are still cultural and professional barriers to overcome as well. A provider, now working in one of the Medicaid MCOs in Kansas, noted her original response to doula care, and the amount of resistance that still exists in Kansas.

They explained...

*“I was like, ‘No.’ And then I learned how much doulas have changed. I think some of our offices are open to that. Some of them are very, very much not. Doula is still a dirty word to a lot of OB practices. And I think not only having the doulas but having the understanding of what they offer and that they’re part of the team versus an opposing force really needs to improve.”*

Given these challenges, it is not surprising to note, as seen in [Figure 13. Doulas per County, 2024](#), that the presence of doulas is limited to a relatively small number of counties. Doulas are also more likely to work in urban communities, and in the western half of Kansas they are found in only a handful of counties.



Source: Weis & Alsup, University of Kansas School of Nursing, 2025.



The integration of CHWs, who provide support through health education, resource coordination, and culturally competent care, also faces challenges such as limited workforce capacity and inconsistent reimbursement rates. Despite these obstacles, Kansas has made strides in formalizing and expanding the CHW workforce, supported by efforts like certification and training programs, and advocacy for better reimbursement policies. This ensures CHWs are equipped to address chronic diseases, public health emergencies, and other challenges, particularly among high-risk populations. Programs are supported by KDHE and the Kansas Community Health Worker Coalition, which emphasize integration into the broader healthcare system and sustainable funding strategies (Kansas Department of Health and Environment, n.d.-a; Wichita State University, 2024).

CHWs in Kansas also focus on building community resilience by increasing access to resources, conducting health education, and providing culturally competent services. Events like the annual Kansas Community Health Worker Symposium highlight leadership development and sustainable pathways for CHWs. Current initiatives include addressing social determinants of health, advocating for equitable care, and preparing for future public health emergencies. The field continues to grow as Kansas integrates CHWs into healthcare teams, with the ultimate goal of improving health outcomes statewide (Kansas Department of Health and Environment, n.d.-a).

Despite these advances, several challenges remain that impact efforts to expand the reach of CHWs:

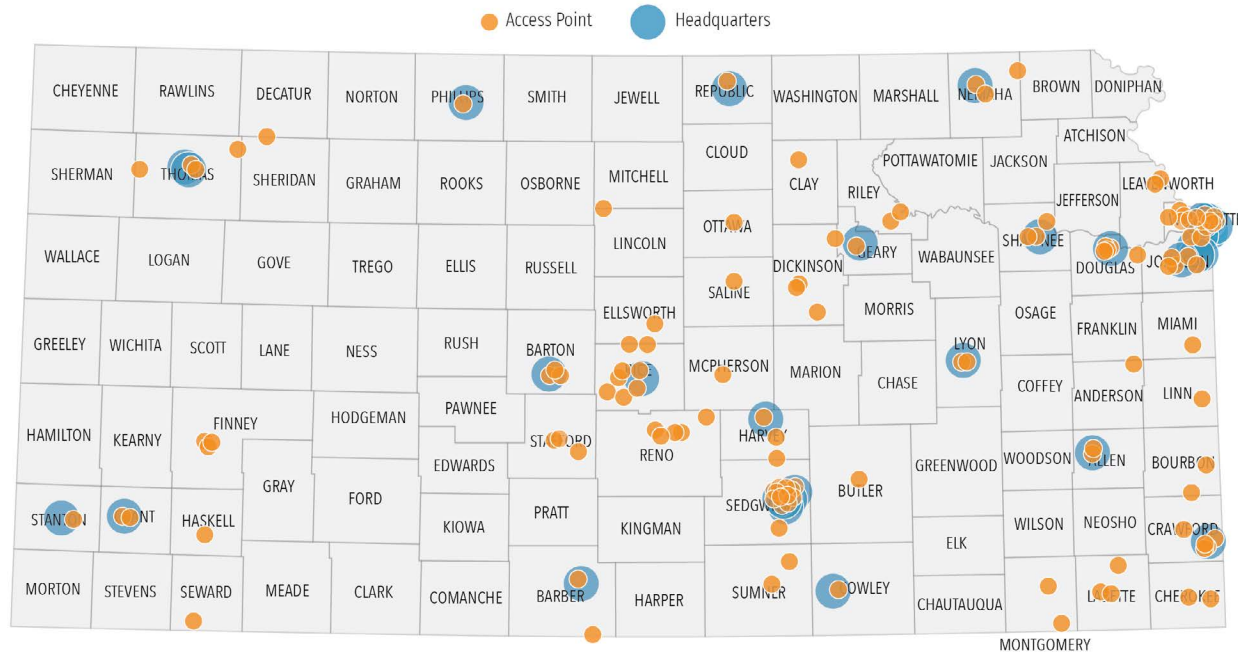
**Reimbursement Challenges:** Kansas Medicaid's initial reimbursement policy for CHWs was problematic. Early state plan amendments excluded key providers like Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Indian Health Clinics (IHCs), which serve many vulnerable populations. Additionally, the initial reimbursement rates were too low to support the sustainability of CHW services. However, advocacy efforts have led to a recent doubling of reimbursement rates, and these clinics are now included in the eligibility criteria, addressing some of these concerns (Mid-America Regional Council, nd; United Methodist Health Ministry Fund, 2024).

**Workforce Expansion and Training:** While there has been growth in the CHW workforce, with efforts to train and certify CHWs through programs supported by organizations like the Kansas CHW Coalition, gaps in capacity remain. There is also a wide array of training programs across the state with considerably different curricula, requirements, etc. There is also a need for more bilingual CHWs to meet the needs of diverse populations (Mid-America Regional Council, nd; United Methodist Health Ministry Fund, 2024).

**Integration into Healthcare Teams:** While CHWs play a critical role in linking patients to services, challenges remain in integrating CHWs into broader healthcare teams. Sustainable funding models and clear policies for CHW inclusion in managed care contracts have been slow to develop but are now gaining traction (United Methodist Health Ministry Fund, 2024).

Despite these hurdles, Kansas has made greater progress with expanding CHW statewide than has been the case with other community-based health workers. According to the Kansas Community Health Worker Coalition, there are approximately 45 community health worker organizations operating in Kansas, with over 120 access points distributed across the state ([Figure 14: Locations of Kansas Community Health Worker Headquarters and Access Points](#)). However, the majority of these CHWs are still concentrated in the eastern part of the state. While there are a growing number of western counties with CHWs, there are still significant portions of rural western Kansas that have not utilized CHWs within their health care delivery systems.

Figure 14.  
Locations of Kansas Community Health Work Headquarters and Access Points



Source: KS Community Health Workers Coalition.  
Note: Aetna's Better Health of Kansas serves all Kansas counties.

#### Access to Prenatal and Obstetrical Care—Kansas Voices

The lack of providers for maternal health and for birthing services was highlighted as a significant concern during interviews and focus groups performed as part of this Needs Assessment; particularly, members of the health care community themselves that have concerns about current and future system capacity. Many providers who were interviewed acknowledged and highlighted the limited capacity of birthing services and other maternal/perinatal services, with specific concerns shared about the state's more rural areas. When discussing access to health care in rural areas, participants frequently mention the lack of providers, the frequent necessity of traveling long distances for care, high rates of provider turnover, and insufficient continuity of care. Many rural residents struggle to access timely care, often relying on emergency services for routine needs, which exacerbates health disparities. One representative of the state's maternal mortality review committee observed...

*"I think just logistically there are programs where their catchment is like 16 counties. There's no way they can do that. I also know that there's OB clinics in western counties that have a provider shortage of OBGYNs, and they [patients] have to travel. Women are expected to travel two or three counties over to receive services, and that's just not realistic for a lot of women."*

An MCH nurse explained that one of their challenges was...

*"Just getting enough providers in to work. Our wait lists for our first prenatal appointment is about a month and a half out, which is not best practice. So, we're having to refer women to other safety net clinics."*



One medical student who participated in an interview and hopes to practice rural family medicine said,

*"The biggest downfall would be in rural communities where there aren't specific Gyn providers, so women aren't getting their annual wellness exams as much as they should. So, I've read a couple of papers about, in rural communities nationwide, higher incidences of cervical cancer due to not having an annual well-woman and stuff like that. And that's just, in general, due to there not being as many female providers or just not many GYN providers, and so then people just not seeking care. So that's a pretty serious downfall in my mind, which is part of the reason why I want to do rural medicine as well so that I can be a female provider that women in the community and surrounding communities feel comfortable seeing for those issues."*

There is a significant concern about the closing of birth units and the decreasing number of OB/GYN providers, leading to maternity deserts where expectant mothers have to travel long distances for care, contributing to adverse pregnancy outcomes. A physician working on a research project examining system capacity stated...

*"We surveyed all the rural hospitals in the state of Kansas and all the frontier hospitals. We surveyed them about how many providers they have that deliver babies, how many providers they anticipate retiring within the next five years, and if they anticipate being able to offer these services in the next five years. We are comparing it to data collected back in 2015 so we could get the general scope of how OB access has changed in the last nine years and also if the pandemic had any effect on that. Our results did show a significant decrease in providers, which has increased maternity deserts, in which patients are having to travel out of county and over an hour to see a provider, which increases adverse pregnancy outcomes, both for mom and baby."*

High turnover of obstetric providers and limited access to prenatal and postnatal care often results in patients being referred to multiple providers, affecting the continuity and quality of care.

A provider in a rural community without hospital-based delivery services had this to say...

*"Absolutely, our folks have to leave the community to go access those specialty services. Our local hospital does not have a labor and delivery unit. Of course, they could deliver in emergencies. And so typically, people, at a minimum, go to [nearby city] to deliver. But we see people going to other cities, really also accessing prenatal care in those areas where they plan to deliver. I don't know if it's quite severe enough to be considered a desert, but there are not a lot of those services available down here at this point."*



Another Kansas rural health researcher went further in explaining the “hub and spoke” model in Kansas, discussing its strengths but also limitations. They explained...

*“That model [hub and spoke] is alive here in Kansas. But the hub is affected by the same issues that the spoke is affected by . . . some of the supportive hospitals are not tertiary care facilities. So, they may say they have a NICU, but there may be limitations on that NICU. There may be limitations. There is no maternal fetal medicine. There’s no perinatologists. There’s OB/GYNs. And in a state like Kansas that’s so rural, the distance to that hub is a lot. And maintaining that hub is a lot. And then you’ve only got two really tertiary care facilities. I mean, you might say that Topeka has some, but really, it’s Wichita and Kansas City. The model idea is good. But [for example], a hub for network is Garden City, and Garden City has got a waiting list for maternal childcare access, and they’ve got one OB-GYN.”*

One area of discussion and multiple perspectives was that of midwifery. While viewed as an essential part of the delivery system for pregnant and delivering moms, there was a recognition of some of the challenges associated with integrating them in a meaningful way into the system. One of the most significant challenges is lack of availability, as currently there are only 81 licensed midwives in the entire state (Weis & Alsup, 2025). A number of clinicians and hospital executives in rural communities also expressed some reticence regarding hiring midwives, wanting to ensure their area is equipped with a provider with surgical capabilities if needed during delivery.

Said one physician, while acknowledging the need to integrate midwives into the rural health care delivery system...

*“With midwifery, we just don’t graduate enough in the state of Kansas, number one. And they’ll slowly trickle out as the need increases for this. But the challenge is what happens when the certified nurse midwife gets into trouble? I mean, if we’re looking at 90 miles to the nearest hospital capable of doing emergent C-section and hysterectomy, that’s a lot of distance between where they’re providing a service and where they need to get definitive care.”*

A nurse observed that...

*“They think, ‘Well, Kansas isn’t being a proponent of it.’ It isn’t that at all. If you’ve got a little tiny hospital, there’s this idea that midwives could be assisting women in the hospital. They can. But if you’ve only got so much money to hire a care provider, and you are now hiring a care provider that it’s only this much of your staff that can only see this little, tiny scope - and oh, by the way, when there’s a surgery that needs to be done, they can’t do that - then what are you going to hire? You’re going to hire a family medicine physician who can see all the spectrum of care, do C-sections, deliver babies, and meet the entire needs of that facility.”*



Others, however, felt the state is missing opportunities to better integrate midwives. One educator noted...

*"One of my personal goals is to train more home birth midwives. [They] can do all of the this in a home birth setting that have been disallowed in other states that are safe for the right provider. For example, twin births, breach birth. I've seen amazing outcomes with breach birth in the field as compared to how that's handled in a hospital system. But it takes the right provider. It takes somebody who's been trained and has breach skills. And that's a skill set of yesteryear. People are more inclined now to say, 'Well, why wouldn't we just do that with a C-section in the hospital?' Well, I could tell you why we shouldn't just do that with a C-section in the hospital, because you're seeing these high rates of complications."*

In addition to training, another provider noted the barrier caused by hospital privileging for midwives, saying...

*"We have multiple hospital systems; almost all of them that I know of, that will not give these APRNs privileges at their hospitals because of the political implications of pissing doctors off. . . . There was that bill two sessions ago that was passed that finally gave APRNs their full scope, but that's meaningless if you can't get hospital privileges. And so that's, in my mind, one of the big contributors to the maternal healthcare deserts."*

Utilizing doulas, home visitors, and Community Health Workers also was a frequent topic during interviews and focus groups, with a variety of perspectives offered on how they could help families navigate the care system and access needed resources. A Medicaid managed care representative noted...

*"Because of the lack of providers, one of the things, we've offered doulas across the state to kind of be that consistent person for them since their OBs are so inconsistent. But now there's this lack of doulas. We'd love to see more doulas trained too to kind of help bridge that gap of the lack of OB care."*

There was also significant recognition of the value of integrating community health workers into the health care system in a more meaningful way. As one rural physician noted...

*"We just need a systematic change. And you're talking to two family medicine physicians. It really comes back to an actual buy-in on value-based care and preventative measures and saying, 'Of course it would make sense to have health coaches and community health workers to cross these T's and dot these I's, and to make sure that the information is getting to the patients, and that the follow-up care is taking place so that we don't have that myocardial infarction six months down the road.' Someone who's watching the blood pressures, and we're making sure that we're tolerating the medication for high cholesterol well, and we're getting into follow-up on those things and making sure that everything is working like it should. So, I mean, really, in 2024, it's slow, but we are, I feel like, making progress on these types of things, but it's going to take-- it's going to take this last decade-plus worth of information on outcomes."*



## *Pregnancy*

The percentage of intended pregnancies in Kansas is 61%, slightly below the national average of 63% (Centers for Disease Control and Prevention, 2023b). Unintended pregnancies account for 25% of all live births, with higher rates among non-Hispanic Black (37%) and Hispanic (31%) populations compared to non-Hispanic White women (23%) (Kansas Department of Health and Environment, 2025).

## *Maternal Mental Health and Substance Use*

The medical and public health community increasingly acknowledges the crucial role of mental health in maternal health outcomes. During regional community engagement sessions around the state, when asked which of three issues were the most important to address in their community (the three being maternal mental health, adolescent suicide, and pregnancy-related death), 54% indicated maternal mental health was the most important to address in their community. The strong association between mental health conditions, such as maternal depression and anxiety, and adverse birth outcomes, highlights the need for targeted interventions and comprehensive support systems (Adane et al., 2021). In Kansas, behavioral health conditions are estimated to account for approximately one in five pregnancy-associated deaths (Kansas Department of Health and Environment, 2023d). In Kansas, the impact of behavioral health on pregnancy-associated deaths underscores the importance of integrated care approaches that prioritize mental well-being as part of maternal health. Efforts to reduce barriers, increase access to mental health services, and involve community-based support can help mitigate risks, ultimately contributing to healthier outcomes for MCH populations (Office of the Surgeon General, 2020).

Although depression during pregnancy has shown signs of decline among Kansas women, mental health concerns remain prevalent. According to 2018 data from the Pregnancy Risk Assessment Monitoring System (PRAMS), 13% of U.S. women with a recent live birth reported experiencing postpartum depressive symptoms. The prevalence of postpartum depression was higher among certain groups, including American Indian/Alaska Native women (22%), Asian/Pacific Islander women (19%), and Black women (18%), compared to White women (11%) (Bauman BL, 2020). In Kansas, 14% of postpartum women reported symptoms of depression within the first six months postpartum (Kansas Department of Health and Environment, 2025). The prevalence of postpartum depressive symptoms varied significantly across several demographic factors. Younger mothers had higher rates, with 27% of those under 20 years old, compared to 12% for those aged 25 to 34 and 9% for those 35 years old or older (Kansas Department of Health and Environment, 2025). Mothers who received WIC food during pregnancy also had a higher prevalence, at 21%, compared to non-WIC recipients at 11% (Kansas Department of Health and Environment, 2025).

Alarming, from 2016 to 2020, 11% of pregnancy-associated deaths involved suicide. The most common methods were hanging/strangulation/suffocation (64%), followed by poisoning/overdose (27%), and firearms (9%). The average age of women who died by suicide was 26.4 years, with most victims being non-Hispanic White and unmarried. Over half had a high school education or less (Kansas Department of Health and Environment, 2023d).



Substance use disorders, particularly involving non-prescription opioids, pose severe risks to maternal and child health. Pregnant women with these disorders face higher risks of adverse outcomes, and infants may develop neonatal abstinence syndrome (NAS). From 2017 to 2020, 16% of pregnancy-associated deaths nationally were linked to substance use (Board et al., 2023; Bruzelius & Martins, 2022). The monthly number of Emergency Department visits to Kansas hospitals for non-fatal overdoses was higher for females than for males every month from January 2021 to December 2022, and overdose death rates of Kansas females increased from 172 (a rate of 12.6 per 100,000 people) to 244, and a rate of 17.5 per 100,000 (Kansas Department of Health and Environment, 2024e). Among women enrolled in Medicaid, from July 1, 2022, to June 30, 2023, a total of 4,427 women who had a live birth did not access prenatal care, and of these women 823 of them almost one in five (19%) were diagnosed with a substance use disorder (Kansas Department of Health and Environment, unpublished data). During the same time period, 13% (1,153 of 8,710) of women with Medicaid coverage who did receive prenatal care had a diagnosis of substance abuse (Kansas Department of Health and Environment, unpublished data). This data highlights a significant overlap between substance use and the absence of prenatal care, raising concerns about both maternal and neonatal health outcomes.

Among women accessing care, data from clinics enrolled in the Kansas Connecting Communities (KCC) program initially showed a low screening rate for perinatal substance use disorders (34%), significantly lower than the rates for depression (82%) and anxiety (58%). By 2023 screening rates for all three conditions increased to over 70% among KCC providers (Kansas Department of Health and Environment, 2024a), but there are undoubtedly opportunities to continue improving screening rates statewide. Barriers to effective screening include time constraints, unsuitable screening tools, lack of familiarity with methods, concerns about mandated reporting, and insufficient referral resources (Kansas Department of Health and Environment, 2024a).

### *Access to Reproductive Health Services*

Access to reproductive health services and preventive care remains a critical need in Kansas, particularly for underserved populations. Approximately 173,000 women live in “contraceptive deserts,” lacking adequate access to contraceptive methods, while the rate of intended pregnancies (62%) is slightly below the national average, with disparities among racial and ethnic groups. Breast cancer screening rates in Kansas (75%) are also slightly below the HP2030 target of 77%, and racial disparities in breast cancer mortality highlight the need for more equitable access to screenings and timely diagnoses.

#### *Access to Title X Funded Services*

Title X is a federal program that supports family planning and reproductive health services, particularly for low-income populations. In Kansas, access to Title X-funded services has been essential for providing preventive health care, contraception, and reproductive health education to underserved communities. Title X-funded clinics offer vital services, especially for individuals without health insurance and those living in rural areas where healthcare options are limited. However, recent policy and funding changes have affected the reach of these services (Clochard et al., 2023). Political decisions, including funding restrictions and regulatory changes at both state and federal levels, have impacted clinic operations, limiting the number of Title X service providers in Kansas. According to the Center for Reproductive Rights and work by KU-CPPR, these challenges have strained the Kansas Title X infrastructure, making it harder for low-income families to access essential health services, which contributes to disparities in maternal and child health outcomes across the state (Center for Reproductive Rights, 2024; von Esenwein et al., 2024).

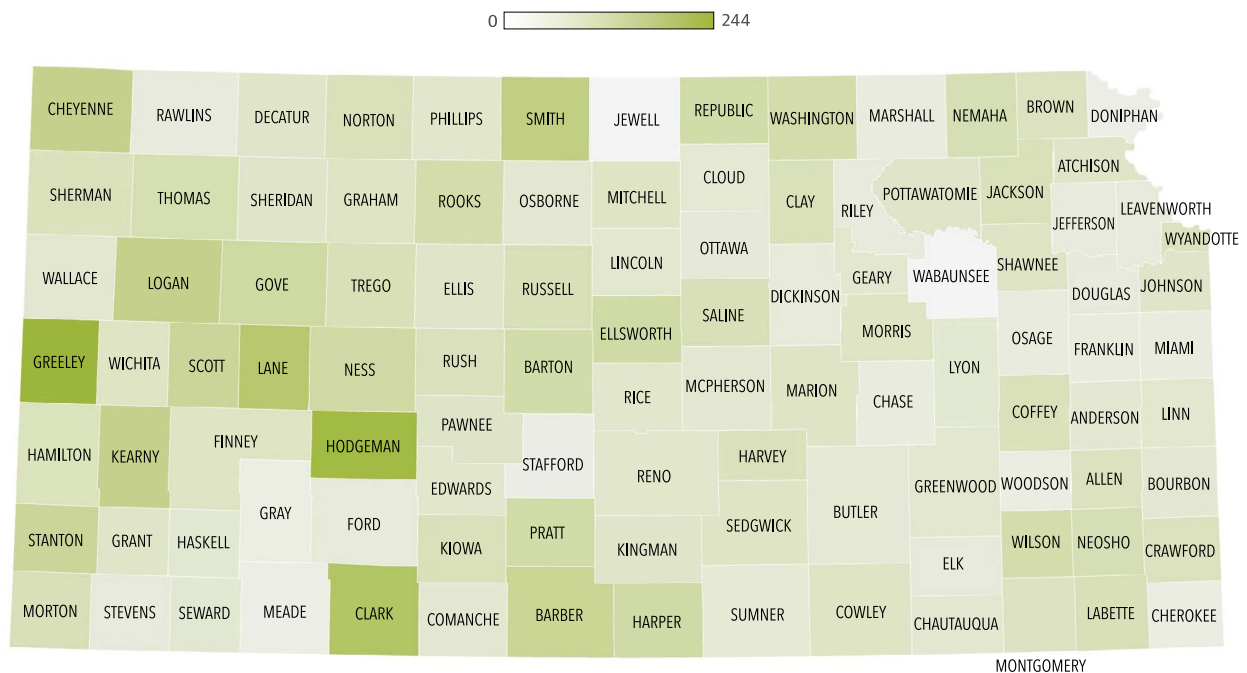


### Access to Contraception

While the statewide contraceptive provider-to-population ratio is reasonably high compared to other states across the country, approximately 173,000 women reside in “contraceptive deserts,” areas lacking adequate access to a full range of FDA-approved contraceptive methods. Nearly one-third of counties, including both semi-urban and urban regions like Butler, Franklin, Reno, Riley, Douglas, and Leavenworth, have provider coverage below the national median (Mullan Institute, 2023). This disparity in access creates considerable barriers for women in Kansas, particularly in rural and underserved urban areas, emphasizing the need for improved reproductive health services to ensure equitable access for all women.

Figure 15.

#### Ratio of contraception providers to women of reproductive age by County.



Data Source: Fitzhugh Mullan Institute for Health Workforce Equity. The prescriber-to-population ratio can be defined as the number of contraception prescribers per 10,000 females of reproductive age (15 to 44) within a given county or state. This ratio is calculated using data from the American Community Survey for population 2019 to 2022 estimates and IQVIA LRx datasets to determine the number of clinicians actively prescribing contraception. The resulting ratio is used to gauge the clinician density or accessibility of contraception prescribers in different regions, enabling comparisons across states and counties.

## Women & Maternal

### RECOMMENDATIONS

#### *Enhance Access to Prenatal and Postpartum Care*

- ◆ Expand provider availability in rural and underserved areas to reduce maternity care deserts.
- ◆ Strengthen support for safety net clinics to address delays in prenatal appointments.
- ◆ Promote integration of midwives and community-based doula services, including reimbursement and workforce development initiatives.

#### *Reduce Maternal Mortality and Address Disparities*

- ◆ Develop targeted interventions for racial/ethnic groups disproportionately affected by maternal mortality, especially Black and Indigenous women.
- ◆ Support hospitals and healthcare providers in addressing social determinants of health, such as transportation and continuity of care.
- ◆ Expand education and training for rural healthcare providers to manage obstetric emergencies and high-risk pregnancies.

#### *Expand Mental Health and Substance Use Screening*

- ◆ Increase screening rates for depression, anxiety, and substance use during pregnancy and postpartum through initiatives like Kansas Connecting Communities.
- ◆ Enhance community-based mental health services to address behavioral health conditions that contribute to pregnancy-associated deaths.
- ◆ Address stigma around mental health care and promote culturally sensitive services.

#### *Support Preventive and Reproductive Health Services*

- ◆ Strengthen Title X-funded services to improve access to contraception and family planning, focusing on contraceptive deserts.
- ◆ Increase educational outreach about cervical cancer screening and breast cancer prevention, especially in underserved populations.
- ◆ Promote telehealth services for preventive care, particularly in rural and semi-urban counties.

#### *Address Chronic Disease Risks and Intimate Partner Violence*

- ◆ Implement community-based programs to reduce obesity, hypertension, and diabetes among women of reproductive age.
- ◆ Expand initiatives to prevent intimate partner violence and provide support for survivors.
- ◆ Improve integration of chronic disease management into maternal healthcare services.

#### *Strengthen Workforce Capacity and System Integration*

- ◆ Develop incentives to attract and retain OB/GYNs, family medicine physicians, and other maternal health providers in rural areas.
- ◆ Address high turnover rates and workforce shortages through targeted recruitment and retention strategies.
- ◆ Explore policies to enable hospital privileges for midwives and advanced practice nurses.

#### *Improve Data Collection and System Coordination*

- ◆ Expand use of integrated data systems like DAISEY to inform program planning and evaluation.
- ◆ Use data to monitor maternal health outcomes and identify areas for intervention.
- ◆ Enhance communication and coordination between healthcare providers, community organizations, and state agencies.



## DOMAIN

### Infant & Perinatal

Infant and perinatal health in Kansas reflects both notable successes and significant challenges.

#### STRENGTHS

- + Comprehensive newborn screening programs are free and widely available.
- + Safe sleep education programs have shown positive outcomes.
- + Breastfeeding rates exceed national average.
- + Declining neonatal mortality rates.

#### CHALLENGES

- ✗ Preterm birth rates higher than HP2030 targets.
- ✗ Low screening rates for substance use disorders in healthcare settings is compounding risk.
- ✗ Gaps in care due to limited Level III+ NICU facilities.
- ✗ A number of populations experience disparities in Sleep-related Sudden Unexpected Infant Death rates.
- ✗ Low birth weight rates remain a significant public health issue.
- ✗ Persistent rates of low adherence to some safe sleep recommended practices.
- ✗ Persistent racial disparities adversely affects the rate of Cesarean deliveries.
- ✗ Infant mortality disparities persist.



## Strengths

### Newborn screening

The Kansas Newborn Screening (NBS) Program aims to identify at-risk infants through newborn screening and monitoring. Screening is free and available to all Kansas families. Screening is available for metabolic and genetic disorders (through the NBS blood spot program), hearing, critical congenital heart disease (CCHD), and birth defects. In all of these programs, 99% of Kansas infants are screened. All children who are identified with hearing loss, CCHD, or other conditions are referred to Early Intervention and the Special Health Care Needs Program.

It is estimated that 2.1 per 1,000 births in Kansas were diagnosed with hearing loss (deaf or hard of hearing), which is slightly higher than the national average of 1.7 per 1,000 births (Centers for Disease Control and Prevention, 2024a). Importantly, 56% of these children were enrolled in early intervention programs before 6 months of age; while this leaves room for improvement, the rate is higher than the national enrollment rate of 41% (Centers for Disease Control and Prevention, 2024b).

### Breastfeeding Duration

Kansas has a high percentage of infants exclusively breastfeeding at 3 months (58% compared to 47% nationally), and exclusively breastfeeding at 6 months, with a percentage of 36% compared to 27% nationally (Kansas Breastfeeding Coalition, 2024). Breastfeeding rates are also higher than national averages for rates of any breastfeeding at 6 months (65% vs. 60%) any breastfeeding at 12 months (44% vs. 40%) (Centers for Disease Control and Prevention, 2024f). While there are some disparities based on demographics and place of residence, the percentage of infants who were ever breastfed is close to 80% or above for all race/ethnicities ([Appendix E.2: Perinatal and Infant Health Population Domain](#)), and a strong majority of Kansas counties have breastfeeding initiation rates of 80% or higher (Kansas Breastfeeding Coalition, 2024).

### Safe Sleep-Positioning

A high proportion of Kansas infants (81% in 2022) were placed to sleep on their backs, a practice that has shown slight declines but remained relatively stable over the past five years. During regional community engagement sessions safe sleep education and clinics were frequently cited as bright spots for women and children's health in Kansas, particularly in South Central Kansas ([Appendix F.8 Community Engagement Session](#)).





## Challenges

### Infant Mortality

The infant mortality rate was reported at 5.8 per 1,000 live births in 2022. Disparities in infant mortality rates exist, with the highest rates observed among infants born to Black, non-Hispanic mothers. Infants born to non-Hispanic Black mothers have a mortality rate of 10.5 deaths per 1,000 live births, almost twice the state average.

Infant mortality was flagged as a significant concern by several participants that participated in community engagement sessions in Northeast and South Central Kansas in an open-ended exercise where participants were asked to describe challenges facing the state through open-ended responses. A participant in South Central Kansas noted that...

*"Sleep related death is the leading cause of infant death for 1 mo.-1yr children, higher than drowning and car accidents combined."*

### Neonatal Mortality

While the national neonatal mortality rate was 3.59 per 1,000 live births in 2022 (National Center for Health Statistics, 2024), Kansas reported a slightly higher rate of 3.7 per 1,000 live births in 2022. There has been positive trend downward since 2018 in the overall rate in Kansas and among most population subgroups. A health researcher in the state working on maternal and child health issues noted that,

*"Some of those racial disparities are related to maternal mortality and morbidity, the near deaths, the chronic conditions that women experience, especially those who are Black, Indigenous, and people of color, and also those who live in or experiencing under-resourced spaces, rural areas, and deep poverty, those kind of things. And honestly, it's those same families who are the parents of infants who are also, in many ways, more likely to be at risk of infant death and also to be exposed to different things in their environments that lead them to experiencing the developmental delays and disabilities . . ."*

### Preterm births

The rate of preterm births (births before 37 weeks of gestation) was 11% of births in 2022 (March of Dimes, 2024), which aligns closely with the national average of 10% (Centers for Disease Control and Prevention, 2023a) but is higher than the HP2030 target of 9%. There has been a slightly upward trend since 2013 (March of Dimes, 2024). Preterm birth rates in Kansas are highest among babies born to Black (15%) and Pacific Islander (20%) mothers (Muhe et al., 2021).





### Low birth weight infants

Approximately 8% of live births in Kansas are classified as low birth weight, which translates to about 7 out of the average 94 daily live births in the state (Kansas Annual Summary of Vital Statistics, 2022). Although this rate is slightly lower than the national average of 9% (Osterman, 2024), it still represents a substantial public health issue, as low birth weight infants face increased risks for various health complications and developmental delays. Notably, there are significant racial and ethnic disparities in birth outcomes. Black mothers experience a higher percentage of low-birth-weight babies (15%), compared to 7% for White mothers (Kansas Department of Health and Environment, 2023b).

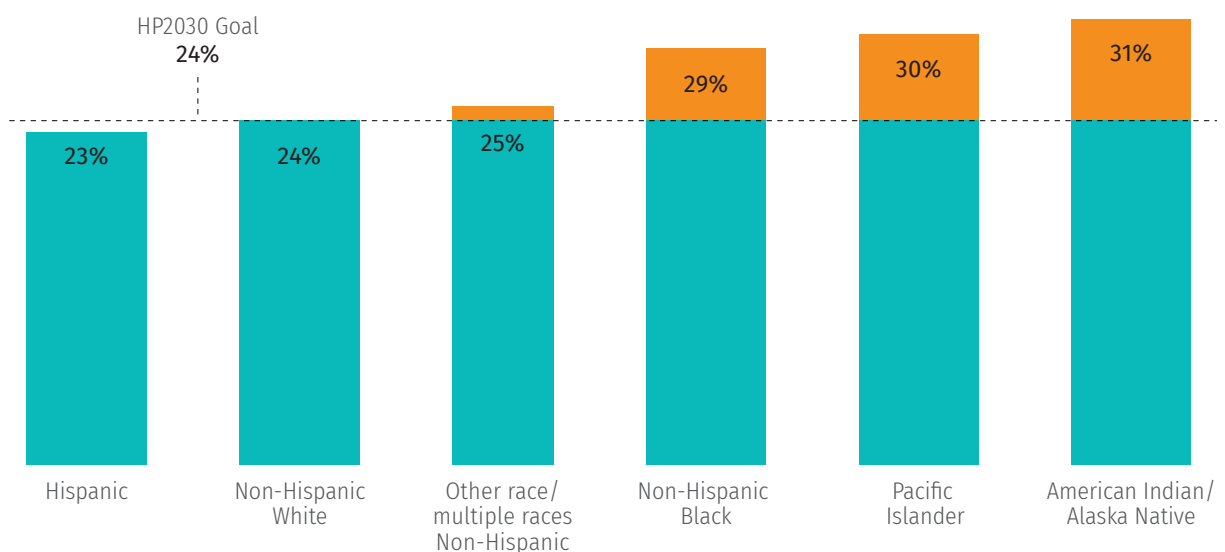
### Very low birth weight infants

In a state like Kansas where only a handful of urban communities have the highest level of Neonatal Intensive Care Unit (NICU) services, a relatively high percentage (88%) of very low birth weight infants are born in a facility with Level III+ NICU capabilities. However, there are disparities based on factors such as maternal educational attainment and source of payment for care, with lower rates among self-pay and Medicaid-insured mothers. Moreover, for most of the population, percentages of very low birth weight infants born in hospitals with Level III+ NICU capabilities have been decreasing, a worrying trend.

### Low-risk Cesarean deliveries

While the percentage of Cesarean deliveries among low-risk first births in Kansas is close to the HP2030 goal of 24%, rates are higher for mothers who are non-Hispanic Black, Pacific Islander, and American Indian/Alaska Native compared to those of non-Hispanic Whites ([Appendix E.2 Perinatal and Infant Health Population Domain](#)). The percentage has also been increasing among all racial/ethnic populations except for Hispanics and non-Hispanic Whites.

Figure 16.  
Low-Risk Cesarean Delivery Rate for Kansas





The high rate of C-sections among Indigenous women was something noted by a doula during an interview for the Needs Assessment. She noted...

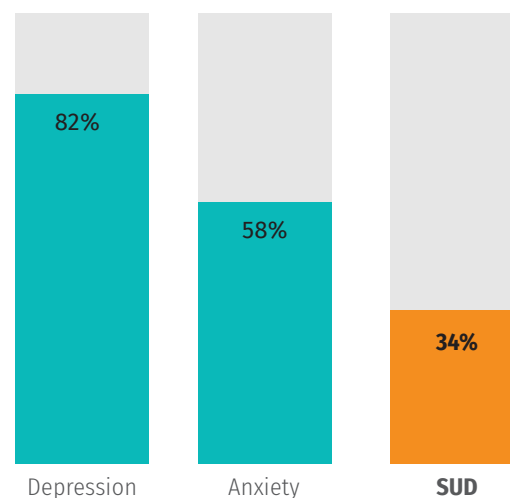
*"What I have been noticing is that - and I don't know yet if it's based on the fact that we're Native Americans - we have a higher rate of induction. Hands down, almost all of my Indigenous moms have been either induced or have been pushed to be induced compared to my non-Indigenous moms. And with increased inductions, that can cause increased emergency C-sections. This is something that I was speaking with my other colleagues that are throughout United States that are Indigenous as well. They're seeing the same thing."*

### Drug use during pregnancy

The percentage of infants who experience maternal use of marijuana or hash during pregnancy is 6% and has been increasing over the last five years. This is consistent with national figures, with most studies citing prenatal marijuana use of 2% to 6% during pregnancy (Thompson et al., 2019). Maternal use of prescription pain relievers (such as hydrocodone, oxycodone, or codeine) during pregnancy among Kansas women is also fairly consistent with national data (Ko et al., 2020); in 2019 the national estimate was 7% and Kansas was at 5%, a number that has been trending downward in the state).

Despite the risks associated with perinatal drug use, screening for perinatal substance use disorder in health care settings is low. When initially surveyed, clinics that had enrolled in the Kansas Connecting Communities (KCC) program had screening rates for perinatal substance use disorders of about one in three patients (34%), rates that were significantly lower than the screening rates for depression (82%) and anxiety (58%) (Kansas Department of Health and Environment, 2024a).

Figure 17.  
Screening rates for perinatal substance use disorder are low.



### Neonatal Abstinence Syndrome

The number of birth hospitalizations in Kansas with a diagnosis code of Neonatal Abstinence Syndrome (NAS) per 1,000 birth hospitalizations, which is withdrawal symptoms due to prenatal exposure to illicit drugs, has remained relatively steady since 2018, and is below the national average, with 3.4 NAS births per 1,000 birth hospitalizations in Kansas in 2021 compared to 5.9 in the U.S. (Agency for Healthcare Research and Quality, 2020; America's Health Rankings, 2024)



### Safe sleep-surfaces

The percent of infants placed to sleep on a separate approved sleep surface has remained below 50% (43% in 2022) over the five-year period from 2018 to 2022, and the percent of infants placed to sleep without soft objects of loose bedding, while increasing, is still well below two out of three (61%) in 2022.

### Sleep-related Sudden Unexpected Infant Death mortality

There were 110.5 sleep-related Sudden Unexpected Infant Deaths (SUID) per 100,000 live births in Kansas in 2022, and there are marked disparities based on insurance status (with a SUID rate of 185.4 deaths per 100,000 births among infants on Medicaid compared to a 51.6 rate among Non-Medicaid infants), educational attainment (a rate of 233.2 for birthing mothers with less than a high school degree and a rate of 24.5 among college graduates) and rates among non-Hispanic Black birth mothers of 238.1 compared to non-Hispanic White rates of 109.4 per 100,000 births. In many populations there were increasing negative trends over the last five years.

### Safe Sleep communications

Concerns were also raised about program approaches to safe sleep. While Kansas has made strides in these areas, opportunities for progress remain. A member of the state's Maternal Mortality Review Committee, reviewed for the Needs Assessment, had this to say about safe sleep communication efforts in the state:

*"We make these big generalities, without ever . . . talking to people about why it's important . . . or adjusting it in any way personally to them. . . . The ABCs of sleep . . . people can't leave the hospital at most places . . . without going through the ABCs of Safe Sleep . . . [W]hat ends up happening . . . is that parents just don't share that they're co-sleeping . . . so, then we don't have any opportunity to educate them at an individual level on . . . 'Okay, like a full-term, healthy baby, non-smoking, non-drinking parents with a tight sheet and no loose-fitting blankets,' that's probably pretty safe. But if your baby's 36 weeks, you smoke—there's no room for individualization. So, it's all or nothing."*



## Infant & Perinatal

### RECOMMENDATIONS

#### *Expand Access to Quality Prenatal and Newborn Care*

- ◆ Increase support for Level III+ NICU facilities and improve access for underinsured and uninsured populations.
- ◆ Enhance transportation and referral systems to ensure timely care for high-risk pregnancies and very low birth weight infants.
- ◆ Address the shortage of neonatal care providers in rural and underserved areas.

#### *Reduce Racial Disparities in Birth Outcomes*

- ◆ Implement targeted programs to reduce racial disparities in infant mortality, preterm births, and low birth weight.
- ◆ Develop culturally tailored safe sleep education and breastfeeding support initiatives for Black, Indigenous, and other marginalized populations.

#### *Promote Safe Sleep Practices*

- ◆ Expand individualized safe sleep education efforts, incorporating culturally competent messaging and addressing barriers to adherence.
- ◆ Strengthen data collection to better understand patterns and barriers to safe sleep compliance, focusing on populations at higher risk for SUID.

#### *Support Breastfeeding Initiatives*

- ◆ Increase funding and resources for breastfeeding education and lactation support services in underserved communities.
- ◆ Enhance workplace policies and community programs to sustain breastfeeding beyond three months.

#### *Enhance Screening and Support for Perinatal Substance Use Disorders (SUDs)*

- ◆ Improve screening rates for SUDs during pregnancy/postpartum through provider training and expanded use of tools in clinical settings.
- ◆ Increase access to treatment and support programs for pregnant and postpartum women with substance use disorders, prioritizing areas with low screening rates.

#### *Address High Rates of Low-Risk Cesarean Deliveries*

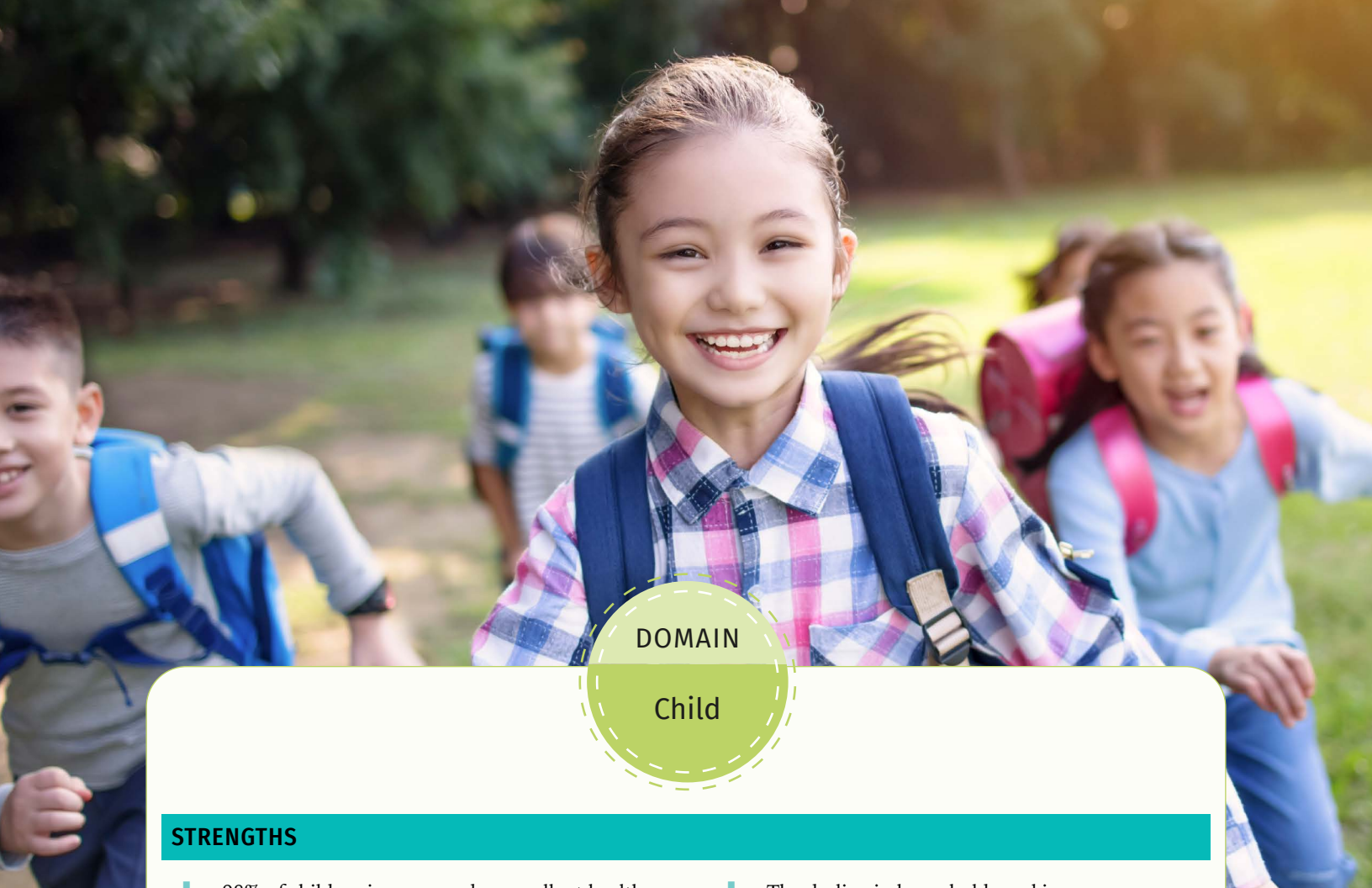
- ◆ Implement provider education and quality improvement initiatives to reduce unnecessary Cesarean sections, particularly among Indigenous and Black mothers.
- ◆ Promote patient-centered care approaches to ensure informed decision-making about birthing options.

#### *Expand Neonatal Abstinence Syndrome (NAS) Prevention and Care*

- ◆ Increase access to programs that address maternal substance use during pregnancy, including early intervention and treatment services.
- ◆ Enhance support for families and caregivers of infants diagnosed with NAS, including community-based resources.

#### *Focus on Neonatal and Infant Mortality Prevention*

- ◆ Develop and implement community-level interventions targeting factors contributing to neonatal and infant mortality.
- ◆ Collaborate with local organizations to address social determinants of health impacting infant health outcomes.



DOMAIN

Child

STRENGTHS

- + 98% of children in very good or excellent health.
- + Only 5% of children lack health insurance.
- + The decline in household smoking exposure represents significant progress in reducing long-term health risks.

CHALLENGES

- ✗ Less than one in three children receive adequate physical activity.
- ✗ Childcare capacity only meets 45% of demand.
- ✗ Food insecurity affects 27% of children.
- ✗ Unintentional injuries cause 32% of deaths.
- ✗ 22% of children are exposed to two or more Adverse Childhood Experiences (ACEs).
- ✗ Disparities in homicide and firearm-related deaths underscore systemic barriers impacting children's health and well-being.



## Strengths

### Health Status

The percentage of Kansas children ages 0 through 17 in excellent or very good health has been over 90% in each of the last five years and is currently 91%. However, although the overall percent of Kansas children ages 0 through 17 in excellent or “very good” health is high, there are some marked disparities. Excellent/good health status is almost ten percentage points lower among children with 2+ ACEs (84.3%) than those with no ACEs (93%). Only 78% of CYSHCN are in good/excellent health, compared to 95% of non-CYSHCN.

### Insurance

While having health insurance is not in-and-of-itself sufficient to ensure access to high quality health care, it is vitally important. Uninsured children and adults consistently experience disparities and poorer health outcomes than those with insurance. It is therefore an important indicator of success, that the overall percentage of children ages 0 through 17 years in Kansas who are without health insurance has remained relatively unchanged, and in 2022 was 5%, close to the national average. While relatively few Kansas children are uninsured, it is still worth noting that an estimated 57,000 Kansas children lost CHIP/Medicaid coverage between April and December 2023 as a result of the end of the federal continuous Medicaid coverage requirement enacted during the pandemic, despite many remaining eligible for coverage (Alker et al., 2024). This makes ongoing monitoring of insurance status, and assistance to families who would benefit from Medicaid coverage, an important priority.

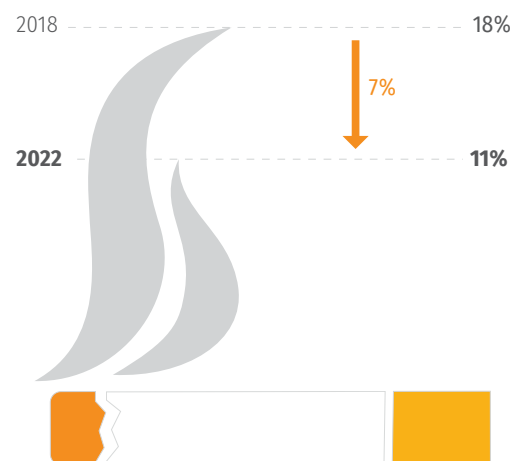
### Foregone health care

Relatively low rates of uninsured children in Kansas may contribute to the low percentage of children who must forego health care. In 2022, only 3% of Kansas children ages 0 through 17 were unable to obtain needed care in the past year. However, certain populations face higher barriers: 6% of children with two or more ACEs and 8% of CYSHCN reported unmet health care needs. Encouragingly, these percentages have shown improvement over the past five years, declining from 10% to 6% for children with two or more ACEs and from 9% to 8% for CYSHCN.

### Household smoking

Cancer remains one of the leading causes of disease among Kansas adults, with tobacco use being a significant contributing factor. Addressing tobacco use has been a long-standing public health priority in the state. Notably, the percentage of Kansas children ages 0 through 17 living in households where someone smokes has decreased significantly, from 18% in 2018 to 11% in 2022, reducing the potential long-term risk of chronic diseases associated with tobacco exposure (Figure 18). However, there are marked disparities. Children who are far more likely to experience dangerous second-hand tobacco at home include children with 2+ ACEs (18%) and children in households below the poverty line (19%).

Figure 18.  
The percentage of children (0 to 17) living in households where someone smokes has decreased.





## Challenges

### Developmental screening

Despite efforts in recent years through the collaborative work of the Kansas Early Childhood State Directors Team (with representation from the KDHE Bureau of Family Health) and financial investment in a coordinated statewide developmental screening effort, only about one-third (33%) of Kansas children ages 9 through 35 months received a developmental screening in the past year.

### School readiness

A child's physical and emotional development has a significant impact on their readiness to enter school, and adequate school readiness subsequently sets children up to do well across their entire academic career. As such, it is vital to recognize that less than two thirds (63%) of children meet the criteria for school readiness. Specific areas for improvement are self-regulation (67% of Kansas children prepared) and motor development (65%) (Health Resources and Services Administration, 2025). There may also be some population disparities, although at the subpopulation level most estimates are statistically unreliable. To address these gaps, efforts such as expanding funding for at-risk preschool students aim to enhance collaboration among early childhood providers, school districts, and communities. These initiatives are designed to improve outcomes for children from diverse backgrounds, including those from low-income families (Kansas State Department of Education, n.d.).

### Homicide

Homicide was the fifth leading cause of death for Kansas children ages 1 through 4 years and the third leading cause of death for children ages 5 through 14 in 2022 (Kansas Department of Health and Environment, 2023b). Between 2018 to 2022, an average of 24 children 0 through 17 years died by homicide in Kansas each year (Kansas State Child Death Review Board, 2024). Between 2018-2021, child death rates by homicide per 100,000 children varied greatly by race; the rate was 1.4 per 100,000 for non-Hispanic White children, 5.4 for Hispanic children, and 17.4 for non-Hispanic Black children (Kansas State Child Death Review Board, 2024). Males accounted for 70% of homicide victims in those five years, and males 15-17 years accounted for 39% of all child/youth homicide deaths (Kansas State Child Death Review Board, 2024).

### Firearm death

Fatal firearm injuries (including homicides, suicides, and unintentional injury accidents) accounted for 154 deaths of Kansas children ages 0 through 17 from 2018-2022, with a firearm death rate of 4.3 per 100,000 children, comparable to the national average (Kansas State Child Death Review Board, 2024). Of these, 82% were male. The five most populous counties in Kansas have a firearm death rate 22 times higher than all other Kansas counties combined (Kansas State Child Death Review Board, 2024).

A parent in a focus group spoke to concerns about increasing gun violence in the state, explaining...

*"We call it the 'look right, look left mentality.' Some people only want to look right and like, 'Look right over here. All these fancy, great things. Our main street's awesome. This is happening. Look right over here, right?' But if you look left, our homeless population has increased significantly since COVID. The number of kids in juvie has increased significantly. The number of drug users that are arrested, increasing. Gun violence in freaking Kansas, increasing, right?"*



## Unintentional injury

Unintentional injuries are a leading cause of death among children ages 0 through 17 years in Kansas and comprised 32% of deaths of children in this age range in 2022 (Kansas State Child Death Review Board, 2024). From 2018 to 2022, motor vehicle crashes and other transportation-related deaths claimed the lives of 103 children in this age range, 59% of all unintentional injury deaths (Kansas State Child Death Review Board, 2024). Rates of child injury hospitalization were comparable to national averages at 114.6 hospitalizations for non-fatal injury per 100,000 Kansas children ages 0 through 9 years in 2021 and 117.7 hospitalizations per 100,000 in 2022, compared to 116.0 nationally (Health Resources and Services Administration, 2024c). Injury hospitalization rates for non-Hispanic Black children were 50% higher (15.27 per 100,000 children) than rates for non-Hispanic White children (101.7 per 100,000).

## Medical home

The percentage of Kansas children ages 0 through 17 years who have a medical home is 53%. A higher percentage indicates they have a personal doctor or nurse (75%), but this still leaves one in four Kansas children without a designated primary care provider. The percent of children with a personal doctor or nurse is much lower for male children (49%), Hispanic children (61%) and non-Hispanic Black children (59%, although this rate is statistically unreliable), children not born in the U.S. (61%), and children with parental educational attainment of less than high school (54%) or high school education (60%), children in households below poverty (64%) and between 100% to 199% of the FPL (65%), on Medicaid (67%), or with a single mother (66%).

Family physicians, mid-level providers, and other practitioners provide most of the pediatric primary care in the state because of an extreme shortage of pediatricians. Statewide, in 2023 there were only 330 licensed pediatricians across the state of Kansas, and in 77 Kansas counties there is no pediatrician.

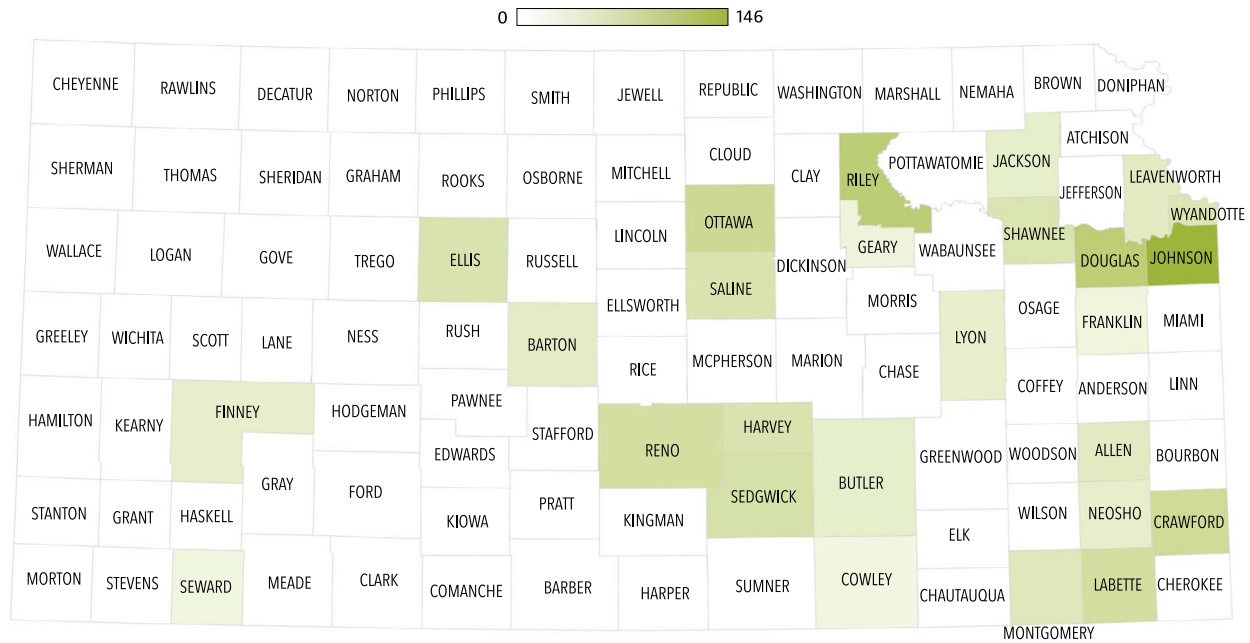
Kansas averaged 59.9 pediatricians per 100,000 population younger than 18, ranking 39th among all states (American Board of Pediatrics, 2024). This average, however, masks the stark variations in pediatrician availability across different counties. Johnson County has a significant number of pediatricians, with a ratio of 146.1 per 100,000 population. Douglas County and Riley County also stand out with high ratios of 95.3 and 95.7 pediatricians per 100,000 population, respectively. However, a substantial number of counties have zero pediatricians ([Figure 19. Pediatricians per 100,000 Children](#)).

### PRIMARY CARE

One in four children  
do not have a designated  
primary care doctor.



Figure 19.  
**Pediatricians per 100,000 by county.**



*Darker shades indicate a relatively greater supply of pediatricians. Seventy-seven counties have no pediatrician.*

The gap is even wider for pediatric specialists, with 40 per 100,000 patients in rural areas compared to 134 per 100,000 in nonrural areas.

A lack of pediatricians in rural Kansas means that family physicians and/or midlevel are often the only providers available to see children, which can limit specialized care and delay diagnoses. A physician, commenting on the lack of pediatricians in the state, said...

*"I will tell you this is why we need more family physicians in rural Kansas. I mean, we're trained to take care of patients from womb to tomb. That doesn't mean we have the same level of expertise as our colleagues who are trained solely as pediatricians. But then again, we do have a lot of exposure to them from looking at the assessment of the newborn and the growing child on childhood developmental milestones and whatnot. But we typically are the only providers that will see the adolescent patient in the role because most of them are participating in sport activities, so they have to have their yearly physical. And sometimes that's our only window of opportunity to get them in for general healthcare and preventive healthcare measures."*

A managed care representative shared...

*"I think especially in rural areas, ER is their choice. I mean, it's the only thing they have. That's their main doctor. And that's where the doctors also direct them to a lot more. I think that the family practitioners have to rely on the ER as their backup in rural areas because there is nowhere else. It's like, 'If my kid has a sniffle and they can't get me in for a week . . . ' They [providers] don't have the capacity to build in the sick visits because they don't have the numbers, so you go to the ER."*

### Dental health

Only about 4 out of 5 (81%) of Kansas children had a preventive dental visit in the previous year. Percentages were similar among most subpopulations, except among children 1 to 5 years, of whom only 62% had a preventive dental visit. The 2021 Kansas Oral Health Report Card gave Kansas a "C" rating based on the overall percentage of children with one or more dental visits in the last year (Kansas Department of Health and Environment, 2022e).



There are marked disparities in the percentage of children ages 0 through 17 experiencing tooth decay or cavities. Only 8% of children with no ACEs had decay/cavities, while 22% of children with 2+ ACEs had decay. The percentage of CYSHCN with decay (19%) was more than twice that (9%) of non-CYSHCN. Children with Medicaid insurance coverage had twice the percent (15%) of tooth decay compared to children with private insurance (8%). Hispanic children were almost twice as likely (18%) than non-Hispanic white children (11%) to experience decay. The 2021 Kansas Oral Health Report Card reported a higher percent of dental caries (48% among Kansas third graders), giving Kansas a "C" rating; Kansas also earned a "C" for having only 36% of third graders with dental sealants on their permanent molars (Kansas Department of Health and Environment, 2022e).

### Vaccinations

Under two-thirds (65%) of Kansas children completed the combined 7-vaccine series by 24 months (Immunize Kansas Coalition, 2024). This is similar to national vaccination rates and leaves considerable room for improvement. Kansas does even more poorly in annually vaccinating children against influenza, with 2023 to 2024 rates of 63% for children 6 months through 4 years and 51% among 5- to 12-year-olds, both below the HP2030 goal of 70% (Immunize Kansas Coalition, 2024).



## Accepting Medicaid

Finding providers who accept Medicaid is another barrier to care for some families. A provider observed...

*"Finding pediatricians in a lot of areas is a struggle. A lot of the offices are like, 'We're full to Medicaid. We're not accepting new members who have this or that.'"*

Another provider observed...

*"I think there's a gap with after-hours care when it comes to not just maternal but even just pediatric . . . they're walking into the ER, which is already overflowed, especially in Wichita. You will have at least a three-hour wait."*

## Coordination of care

In addition to concerns about provider availability and continuity, another concern was the complexity of navigating systems of care and the lack of resources to help families "connect the dots" in what is often seen as a fragmented system. This concern has been noted in many other state systems discussions, including the Kansas Early Childhood Systems Needs Assessment (Kansas Children's Cabinet and Trust Fund, 2024) and Healthy Kansans 2030 (Kansas Department of Health and Environment, 2022c). The Early Childhood Needs Assessment (which identifies Maternal and Child Health services as part of the "early childhood ecosystem") highlighted that...

*"Families [and professionals] experience barriers navigating the early childhood ecosystem, such as when families are trying to connect to services that they need . . ."*

Healthy Kansans noted that many Kansans, "feel overwhelmed by the complexity of navigating the health system and social service supports." One parent, part of a focus group of children and youth with special health care needs, said...

*"Parents are not hearing about these programs unless they just happen across somebody that knows . . . if you go into a pediatrician's or a special needs clinic or something, 9 times out of 10, they're not passing information out. So, unless a parent knows to ask questions, they're just struggling, not knowing that there's help."*

During an interview, a doula shared a similar concern. They observed...

*"Our healthcare providers are still not connected to the community enough to even know what's out there. If you don't even know what community organizations are out there, that's a problem. And so, I'm like, 'Well, who did you refer this client to?' And they're like, 'Well, I don't know. I gave her a pamphlet.' 'Oh, okay. But she just had a baby. She's not looking at your pamphlet. So how did you tell her about this program? Do you know about this program?'"*



## Adverse Childhood Experiences (ACEs)

Adverse Childhood Experiences (ACEs) are potentially traumatic events (which can include violence and abuse, economic hardship, exposure to family members with mental health or substance use problems, or racism/discrimination) that can have both short- and life-long consequences on health and well-being. ACEs are associated with many negative outcomes, and throughout this report it will be noted that children with 2 or more ACEs experience a considerable number of health disparities.

Statewide, 22% of Kansas children have experienced two or more ACEs. There are also marked disparities. The population of children with high percentages of children with 2+ ACEs include CYSHCN (36%), children with Medicaid insurance (41%), and children in single parent households (49%).

While the estimate is statistically unreliable and should be interpreted with caution, the data also suggest that the percent of children with 2+ ACEs (among children 6 through 11 years) who have a behavioral or conduct disorder is considerably greater (25%) than those with 1 ACE or no ACEs (6%).

## Food sufficiency and nutrition

A child's diet is critically important for overall development, such that food insufficiency among children should be considered a public health issue of utmost concern. Therefore, it is of great concern that less than three out of every four (73%) children ages 0 to 11 in Kansas live in households that were food sufficient in the past year. Populations of specific concern are CYSHCN (59%), children covered by Medicaid insurance (53%), children living in households below poverty (48%) and at 100% to 199% of the federal poverty level (56%), and two-parent unmarried (49%) and single parent (55%) household children. In all these groups, around half of all children had insufficient food in the past year.

There are relatively few indicators that speak to systemic efforts within states to ensure access to healthy food. However, a 2024 analysis of healthiest school lunches by state (based on publicly available data including the number of school lunches served per 10,000 students, estimated rates of fruit, vegetable, and sugary drink consumption among children, and farm to school program participation rate) ranked Kansas relatively low, 31<sup>st</sup> among all states (ProCare Therapy, 2024).

Participants in a youth focus group were asked about programs and resources in their community that helped kids stay healthy, and they immediately turned to the subject of food insecurity, as seen in the following passage (abridged for brevity):

Question: "So what about programs that keep you healthy . . . do you feel like there's a lot of those programs in your community?"

*"Our school does food drives."*

*"They do them every week."*

## FOOD INSUFFICIENCY

A quarter of all Kansas children go to bed hungry.

*“At our elementary school, we used to—because kids wouldn’t be able to have—when they got home, there’d be no one there, so we’d be able to pick up these bags that had a whole bunch of stuff in it. It had dinner stuff in it. It had little boxes of cereal, milk, and stuff, and snacks and that. And I used to get those all the time, but then they stopped.”*

*“I liked how when—during COVID, you could go to one of the schools, and they’d give you a breakfast and a lunch. I liked that.”*

### Childhood obesity

Children who are obese are likely to be obese as adults and at high risk for chronic diseases that are costly to society and often result in premature death. The percent of Kansas children from age 6 through 17 of 15% is better than the U.S. national average of 17%, but more than one in five children on Medicaid insurance (21%), living in households below the poverty line (24%), and of Hispanic ethnicity (26%) are obese. The obesity rate has been trending up slightly over the last five years for all Kansas children.

### Housing instability

Living in a stable household can have a dramatic effect on the health of children and adults. While there are universal concerns about housing affordability in our state and nation (Kansas Action for Children, 2022; Kansas Housing Resources Corporation, 2021), and having any children experience housing instability is of concern, the percent of Kansas children ages 0 through 11 who experienced housing instability in the last year, 14% in 2022, was better than the national average of 17%.

### Physical activity

Physical activity promotes good health among children and reduces the risk of chronic diseases which are the leading causes of death and disability of Kansans. Movement is a key pillar of good health, but few Kansas children are sufficiently active. Less than one in three (28%) of Kansas children ages 6 through 11 are physically active at least 60 minutes per day. There are no groups of children in the state where more than one-third of children meet this basic recommendation/guideline for physical activity.

A staff member of a local MCH Program noted a desire to do more to address physical activity, saying...

*“We would like to have a stepwise system where we can collaborate for care, optimize based on specialization. We would want to be able to do more work on nutrition, physical activity, mental health at the community level.”*

Several parents in our focus groups spoke to the lack of opportunities for physical activity for children. One explained...

*“There aren’t many cheap indoor activities suitable for young children. We play outside and at parks any time the weather is nice, but we have nothing to do for the majority of the year when it’s too hot or cold.”*



## Childcare and Parental Leave

Quality childcare is essential not only for promoting child development but also for enabling parents, particularly women, to participate in the workforce, which has a strong determining factor in both economic stability and family health. In Kansas, the state faces significant challenges related to access, availability, and affordability of childcare. Childcare deserts remain widespread, leaving many communities, especially rural areas, struggling to find suitable care options that align with the needs of working families. The supply of childcare slots in Kansas is estimated to meet only 45% of potential demand (Child Care of Aware of Kansas, 2024). The shortage of quality childcare options hampers workforce participation, and with limited affordable services available, it becomes difficult for families to find reliable care, which can undermine economic development efforts across the state (Kansas Children’s Cabinet and Trust Fund, 2024a). Moreover, the long-term sustainability of childcare programs is at risk due to a lack of stable funding infrastructure and an insufficient early childhood workforce. These factors contribute to a cycle of instability, further exacerbating the accessibility of childcare for Kansas families.

### CHILDCARE DESERTS

Communities struggle to find suitable care options to meet the needs of working families.

While state and federal measures during the COVID-19 pandemic aimed to support childcare providers, especially to mitigate workforce shortages, these solutions have proven insufficient for ensuring long-term stability. Without adequate resources and a more sustainable funding structure, the childcare system in Kansas will continue to face significant challenges, particularly in addressing workforce shortages. The inability to recruit and retain qualified childcare professionals exacerbates the lack of quality care, as low wages and insufficient benefits remain persistent barriers. As such, there is an urgent need for comprehensive policy and funding strategies to address these issues, ensure the sustainability of the early childhood workforce, and make high-quality childcare accessible and affordable for all families in Kansas (Kansas Children’s Cabinet and Trust Fund, 2024b).

The importance of addressing these challenges was underscored during six regional community engagement sessions held in Spring 2024, where participants identified childcare as a top priority. Through a budgeting exercise, childcare received nearly 20% of allocated funding statewide, and ranked as the top concern in Southeast Kansas. Open-ended comments from these sessions further highlighted the high cost and limited availability of childcare, along with gaps in afterschool and summer programs for school-aged children, emphasizing the need for targeted solutions to meet the diverse needs of Kansas families.

A consistent theme across discussions was the barrier to care caused by a lack of childcare and parental leave.

One MCH professional stated...

*“For the things that matter and directly impact the lives of women seeking care, there is no support . . . having quality, accessible childcare to access appointments, to access healthcare, to go to work, is just nonexistent.”*



One physician noted...

*"We've got this challenge in this particular population of accessible daycare and time off if they're employed in order to travel to obtain those services. And so, there's always not a lot of consideration of the out-of-pocket cost to the individual in order to seek access to these services. And that's obviously one of the downsides to Title V funding, is that you basically can't use the funding to give to the individual for those services. But I think we've got to figure out a way that we have good childcare services available."*

Another provider agreed, saying...

*"We don't have paid maternity leave, so having a baby or having kids is devastating if your kids are sick, so having some support when that happens [is needed]."*

A female participant in a focus group also noted...

*"There are only so many daycares that take the vouchers . . . I wager to say they're not always the highest quality of daycare centers, and so that's a challenge. Paying for daycare is an impossible dream if you don't qualify for one of those vouchers. It almost makes sense to not work than it does to pay a daycare to watch your newborn. So, I think there's a lot of factors kind of stacked against women trying to be a part of the workforce, take care of their family, and have a new baby."*

### **Access to Behavioral Health Services for Youth**

Access to behavioral health services for children was another area of concern. One physician emphasized...

*"Child psych services...are just rare. It's tough to get those services."*

Rural families may be required to travel great distances, sometimes up to an hour or more, just to access basic mental health services. As one Family Advisory Council member explained...

*"In rural areas, you have to drive an hour, hour and a half to get mental health care...maybe even Denver because we're a hole."*

Another parent shared this frustration, explaining they resorted to telehealth services for her child...

*"I had to pull my kid out of school to do a virtual session...I couldn't find availability even between two metro areas."*

Another theme was the development and staffing of school-based programs as a mechanism to promote accessibility of services among students and the opportunity to meet students' health needs where they are at most days, namely in school. Some participants shared:

*"One thing that's been nice is that the Community Mental Health Center is in our town. They have been putting case managers in the schools, and so everybody has access to those case managers, and it's really helped versus trying to find people that you have to go to . . . The schools are really focusing on the mental health piece."*

*"The schools are also starting to hire their own case managers and therapists to come in. In my kids' school district, each school they've been in has had their own case manager. They have two different case managers, and then a therapist."*

*"I know it's [Community in Schools] in different places in the state. And so, this is just an extra staff person in some of the buildings that builds a relationship. They work like a counselor, but they're not constrained to what teachers have to do. They go to homes. They transport whole families to doctor's appointments. They are kind of like that liaison between the school, the family, and community needs. It's making a huge difference, especially in our lowest-income schools."*



## Child

### RECOMMENDATIONS

#### *Enhance Access to Comprehensive Health Services*

- ◆ Increase the availability of pediatric care providers in rural and underserved areas through targeted recruitment and retention incentives, such as loan repayment programs and telehealth expansions.
- ◆ Promote the utilization of developmental screenings for children ages 9 to 35 months.
- ◆ Increase awareness among healthcare providers and families and integrate screenings into routine pediatric visits.
- ◆ Address barriers to Medicaid acceptance among providers, such as reimbursement rates, to expand access for low-income families.
- ◆ Collaborate with schools, healthcare providers, and community organizations to integrate services such as childcare, behavioral health, and nutrition support into a cohesive system.
- ◆ Develop centralized, user-friendly platforms to ensure families are aware of and can easily access available health and social services.
- ◆ Collaborate with local stakeholders, including parents and community leaders, to develop culturally appropriate programs and interventions.

#### *Support Vulnerable Populations to Reduce Disparities*

- ◆ Implement trauma-informed care training for providers and expand mental health services to support children experiencing ACEs. Partner with schools to integrate behavioral health services for children at risk.
- ◆ Address racial and socioeconomic disparities in health outcomes by prioritizing programs that target minority populations, low-income families, and rural communities.

#### *Promote Food Security*

- ◆ Collaborate with community organizations to improve food security for children in households below the poverty line. Expand access to programs like WIC and school meal initiatives.
- ◆ Partner with local businesses and nonprofits to regularly provide food resources, particularly in communities with high rates of food insufficiency.

#### *Encourage Physical Activity*

- ◆ Develop accessible and affordable physical activity opportunities, such as indoor play areas, parks, and youth sports programs. Focus on enhancing the built environment with sidewalks, playgrounds, and inclusive play equipment.
- ◆ Partner with schools to implement daily physical activity programs and after-school sports clubs, ensuring no-cost participation for low-income families.

#### *Reduce Exposure to Tobacco and Household Smoking*

- ◆ Increase outreach and accessibility of smoking cessation resources for families, particularly low-income and high-ACE households.
- ◆ Launch targeted campaigns highlighting the dangers of secondhand smoke exposure and the benefits of smoke-free households.

#### *Address Homicide and Firearm-Related Deaths*

- ◆ Implement community-based violence prevention initiatives, particularly in high-risk areas, and expand education on firearm safety and storage.
- ◆ Partner with law enforcement and community leaders to promote firearm safety programs, including the distribution of free gun locks.



## DOMAIN

### Adolescent

#### STRENGTHS

- + Vaccination rates are increasing.
- + Teen pregnancy and birth rates are decreasing.
- + Most Kansas teens identify at least one adult mentor, a known protective health factor.

#### CHALLENGES

- ✗ Firearm death rate far exceeds goal.
- ✗ Youth overdose deaths rising due to fentanyl.
- ✗ Teen birth rates higher for Black and Hispanic teens.
- ✗ More than one in four adolescents don't receive annual preventive care.
- ✗ Almost half of teens report being victims of bullying.
- ✗ Almost one in five adolescents experiences depression, and rates are higher in some populations.

As part of the Needs Assessment several initiatives were undertaken to understand the health of Kansas adolescents and their health and health care needs. These included a focus group of teen women and the collection of photos from two youth groups (using methods like Photovoice) to supplement quantitative data collection. The graphic below (Figure 20) is a digital record produced through the use of a recording and transcript of the focus group. It nicely highlights some of the bright spots and challenges young people in Kansas experience that impact their health and well-being.

Figure 20.  
Adolescent Focus Group Graphic Recording



Note: A summary of the content of this graphic can be found in [Appendix F.10 Insights of Kansas Adolescents](#).

Graphic recording created by Sara O'Keeffe. ©2024 The University of Kansas Center for Public Partnership and Research.

As the recording indicates, a key area of concern regarding adolescent health is behavioral health. The adolescent suicide rate for those aged 15 to 19 (18.7 per 100,000) is higher than the national average, highlighting the urgent need for expanded mental health services. Additionally, substance use disorder (SUD) among adolescents, at 9%, is similar to the national average, and there are rising concerns around vaping, alcohol use, and drug use, including fentanyl.

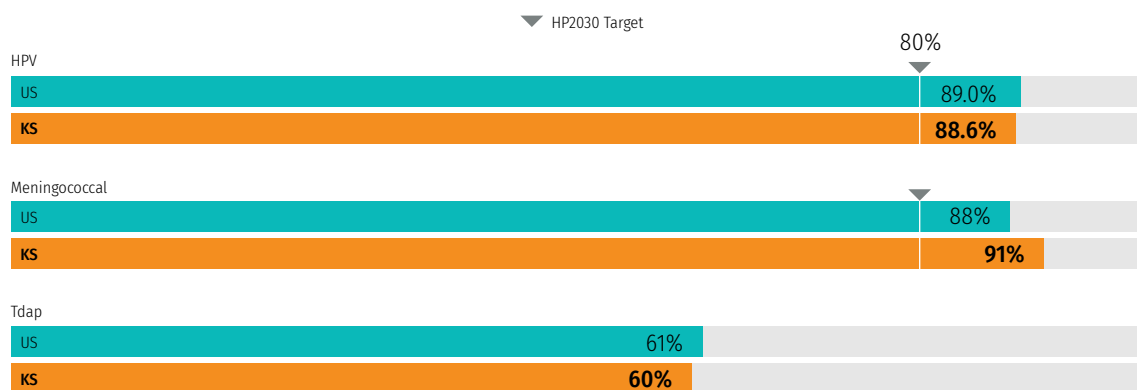
Preventive medical visits remain inconsistent, with lower rates among adolescents in low-income households and rural areas. Furthermore, the lack of comprehensive sexual health education and fragmented healthcare transitions underscores systemic gaps. Despite these challenges, strengths include a high percentage of adolescents with a reliable adult mentor (91%) and initiatives like KSKidsMAP, which address mental health needs in underserved areas.

## Strengths

### Vaccinations

Kansas has made strides in adolescent vaccinations, although still falling short in some areas (see Challenges below). Rates of up-to-date human papillomavirus (HPV) vaccination coverage for adolescents ages 13 to 17 years in Kansas has increased faster than the nation, and in 2023 Kansas (60%) and the U.S. (61%) had comparable vaccination rates (Immunize Kansas Coalition, 2024). Meningococcal vaccination coverage in Kansas (91% among those 13 to 17 years) is higher than the national average (88%) and exceeds the 80% HP2030 target; Kansas and the U.S. have nearly identical (88.6% and 89.0%) Tdap vaccination rates for adolescents (Immunize Kansas Coalition, 2024).

Figure 21.  
**Vaccination Rates for Adolescents Ages 13 to 17.**



### *Teen pregnancy and births*

Pregnancy rates continued to decline among Kansas females aged 10 to 19 to 11.1 per 1,000 individuals (Kansas Department of Health and Environment, 2022d). The 2020 teen pregnancy rate in Kansas for females aged 15 to 19 was 18.1 per 1,000 age-group population (Kansas Department of Health and Environment, 2022d). This rate continues to be favorable compared to the Healthy People 2030 (HP2030) national target, which aims to reduce pregnancies to 31.4 per 1,000 females in the same age group by 2030 (Kansas Department of Health and Environment, 2022d). However, significant disparities were observed among racial and ethnic groups for females aged 15 to 19. Black non-Hispanics and Hispanics had pregnancy rates of 32.6 and 37.1 per 1,000, respectively. In contrast, White non-Hispanics had a pregnancy rate of 15.9 per 1,000. These disparities highlight the need for comprehensive sexual education and improved access to contraceptive services to further reduce teen pregnancies and address demographic inequalities.

### *Adult mentoring*

The presence of an adult mentor is one of the MCH national performance measures because of the known value of mentorship as a protective factor associated with positive outcomes for youth health and well-being (Burns et al., 2024). The percentage of adolescents ages through 17 who have one or more adults outside the home they can rely on for guidance is 91%. Mentorship rates are high regardless of educational attainment, insurance status, or income level.

### *Suicide*

While the Kansas adolescent suicide rate of 10.6 per 100,000 meets the HP2030 goal of 12.8 and has remained relatively steady over the past five years, this figure still represents a deeply concerning issue. Moreover, the rate for non-Hispanic Black youth of 15.4 is also about 50% higher than that for non-Hispanic White (11.0) or Hispanic (10.1) youth.

Every instance of adolescent suicide is a tragic loss, highlighting the urgent need for continued and enhanced efforts to address the mental health needs of young people in Kansas. Preventive measures, access to mental health resources, and community-based support systems must remain a top priority to reduce this rate further and provide critical support to adolescents at risk.



### *Mental health treatment*

The percentage of adolescents ages 12 through 17 who received needed mental health treatment and counseling is high, 94%. Even adolescents who experience poor outcomes in many other domains appeared able to access needed treatment, as teens experiencing 2+ ACEs and teens living in single-parent households had rates as high or higher than the overall rate.

Ensuring access to pediatric mental health care has been a high priority in the state and was the impetus behind KSKidsMAP (Kansas Supporting Kids in Mind Access Program), a statewide initiative aimed at bridging gaps in pediatric mental health care, particularly in rural and underserved areas. The program has helped make significant advancements in pediatric mental health care across the state, driven by a commitment to empower primary care providers (PCPs) with essential resources and support. The network has expanded its reach to all 105 counties (Krogman, 2024).

However, qualitative data collected for this Needs Assessment highlights significant barriers to behavioral health services for youth, including long wait times, provider shortages exacerbated by retirements, and the need to travel great distances for care.

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## Challenges

### *Mortality Rate*

The mortality rate for Kansas adolescents, ages 10 through 19, is 47.3 deaths per 100,000 people, a rate well above than the HP2030 goal of 18.4. Rates are far higher for males (65.9) than females (28.6), and the rates experienced by non-Hispanic Black adolescents is more than two times that of non-Hispanic White (41.7).

### *Firearm deaths*

The rate of firearm death among Kansas youth ages 10 through 19 is 13.7 deaths per 100,000 people, which is far higher than the HP2030 goal of 3.7. The rate for males is 19.7; the rate for females 3.7. The death rate experience by non-Hispanic Black youth (37.4) is more than four times that for non-Hispanic White (8.9).

### *Well visits*

Only about three in four (74%) of Kansas adolescents (ages 12 to 17) had a preventive medical visit in the past year. Specific demographic groups experienced differing trends that warrant attention. Adolescents from households with parents with college degrees saw a decline in preventive visits, which is noteworthy given that higher education is often linked to greater health literacy and access to healthcare resources. Adolescents with private health insurance or Medicaid also showed a decline in well-visits, although the percentage of adolescents with Medicaid coverage was less (65%) than



that of adolescents with private insurance (80%). Rates were also lower for adolescents in households with lower incomes (70% for those in families below FPL and 60% for those in families between 100% to 199% FPL) compared to those with incomes above 400% FPL, of which 85% had preventive visits.

### *Immunizations*

While Kansas human papillomavirus (HPV) vaccination rates have greatly improved in recent years, they still lag behind many states (KFF, 2024a). Several factors could contribute to lower rates in Kansas, including limited public health funding, geographical barriers in rural areas, and cultural resistance to the vaccine due to misconceptions about safety. Low HPV vaccination rates are concerning because they contribute to higher future risks of cervical, throat, and other HPV-related cancers among Kansas residents. Public health officials and advocacy groups continue to push for increased vaccination efforts, especially in under-resourced and rural communities, where vaccination rates tend to be even lower (Vanderpool et al., 2019). This is true in Kansas, where only 46% of adolescents living in a non-metropolitan area are up to date on coverage compared to 61% of those living in a metropolitan statistical area principal city (Immunize Kansas Coalition, 2024).



### *Transition to adult healthcare*

Discussions with women and children across Kansas reveal a recurring challenge: navigating a complex and fragmented healthcare system to access necessary resources for achieving good health. This difficulty is highlighted by the transition indicator, which measures whether adolescents received services to prepare for the transition to adult healthcare. In 2022, only 20% of Kansas adolescents ages 12 to 17 received such services. Although subpopulation disparities were generally limited, two groups experienced significant gaps. Just 8% of adolescents whose first language is not English received transition preparation, compared to 21% of English speakers, and only 10% of adolescents not born in the U.S. received these services, compared to 22% of U.S.-born adolescents.

### *Comprehensive sexual health education*

Kansas mandates sex education in schools; however, local school boards have discretion in establishing curriculum requirements. There is no obligation for a comprehensive approach, and topics including sexual orientation, gender identity, healthy relationships, and affirmative consent are not mandated. Currently, Kansas employs an “opt-in” policy for comprehensive sexual health education, requiring parental consent for students to receive instruction. As a result, the quality and content of sexual health education differ widely across school districts. Some provide evidence-based, age-appropriate education on contraception, STI prevention, and healthy relationships, while others may adhere to abstinence-only education (SIECUS, 2024).



### *Food environment*

Rural Kansas teens who participated in a Photovoice-style data collection effort observed that their communities have an abundance of fast-food restaurants and convenience stores offering primarily unhealthy, highly processed foods. They also highlighted the limited availability of healthier options and the pervasive advertising of unhealthy snacks, energy drinks, and other less nutritious choices ([Appendix F.10 Insights of Kansas Adolescents](#)).

### *Health-promoting environmental factors*

As part of the Photovoice data collection effort, Kansas rural teens highlighted the significant influence of both the natural and built environments on health. They noted that, even in rural areas, industries and businesses contribute to environmental pollution, impacting people, animals, and ecosystems. However, they also appreciated the positive aspects of their environment, such as ample open spaces and the tree canopy, which provides shade and life-sustaining oxygen. Additionally, they emphasized the importance of a healthy built environment, particularly the role of parks and trails in supporting physical activity and play. For more details, see [Appendix F.10 Insights of Kansas Adolescents](#).

### *Flourishing*

“Flourishing” is a measure of well-being that reflects how individuals, particularly children, thrive across mental, emotional, physical, and social domains. The National Survey of Children’s Health (NSCH) measures flourishing through questions aimed at discovering children’s curiosity and discovery about learning, resilience, and self-regulation. In Kansas, fewer than two-thirds (63%) of children ages 6 to 17 are considered flourishing. Particularly concerning are children with 2+ ACEs, with only 52% flourishing, and CYSHCN, at just 40%.

### *Depression/anxiety*

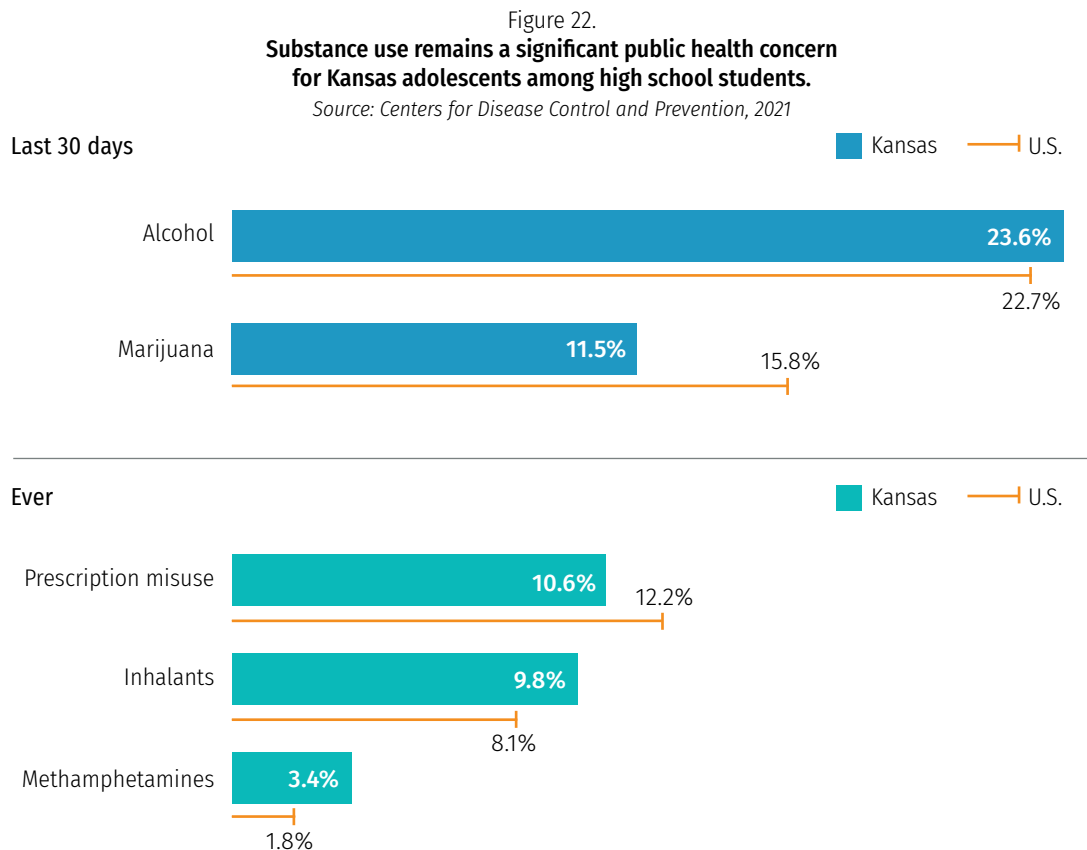
The percentage of adolescents ages 12 through 17 who have depression or anxiety is 17%. The statewide trend is moving in a positive direction, but overall, there is significant room for improvement. There are also marked disparities in certain populations. Adolescent females (22%), adolescents with 2+ ACEs (28%), and those covered by Medicaid insurance (23%) have notably high rates. While higher educational attainment and income is usually associated with more positive outcomes, a higher percent of adolescents with a parent with a college degree experienced depression or anxiety than those with parents who had graduated from high school (20% vs. 13%). Adolescents in households over 400% FPL had higher rates than adolescents living in households below FPL (18% vs. 15%).

### *Bullying*

Bullying can affect physical and emotional health and is measured both in terms of perpetration and victimization (National Institute of Child Health and Human Development, 2017). In both instances there are notable disparities and troubling trends in Kansas. The percent of adolescents ages 12 through 17 who are bullied or who bully others is 16% but is higher among those with 2+ ACEs (23% vs. 15% among those with none), CYSHCN (25%), adolescents with Medicaid coverage (24% vs. 13% with private insurance), and adolescents in households below the

poverty threshold (19% vs. 13% among those in households above 400% FPL). When looking at only those adolescents of high school age (9<sup>th</sup> through 12<sup>th</sup> grade), over 4 out of every 10 (43%) are victims of bullying. Bullying in this age cohort is higher among females than males (52% vs. 35%) and in rural (non-MSA) compared to metropolitan areas (52% vs. 35%). Particularly alarming are CYSHCN, of whom almost two of three (64%) are victims of bullying.

### Substance Use



The prevalence of substance use disorder (SUD) among Kansas youth aged 12 to 17 was 9% in 2021 to 2022 (Substance Abuse and Mental Health Services Administration, 2025), a rate that is comparable to the national average.

Overdose deaths among young people in Kansas have risen in recent years. Between 2020 and 2022, the overdose death rate for Kansas residents aged 15 to 24 increased to over 21 deaths per 100,000 (Kansas Department of Health and Environment, 2024e). In 2022 alone, 77 drug poisoning deaths were reported with opioids as a contributing cause, equating to a rate of 17.9 deaths per 100,000 for this age group (Kansas Department of Health and Environment, 2024e).

An increasing share of these opioid-related deaths is attributed to fentanyl, a synthetic opioid. In 2018 and 2019 there were no deaths attributable to fentanyl among children aged 0 to 17 years (Kansas State Child Death Review Board, 2024). In 2020, 11 fentanyl-related deaths occurred among children aged 0 to 17; in 2021, 9 such deaths were recorded, and in 2022, 13 deaths were attributed to fentanyl.

Note however, that fentanyl was not routinely included in post-mortem toxicology testing before 2020, which may have led to underreporting of its involvement in overdose deaths.

### Tobacco use and vaping

Tobacco use remains prevalent, with 16% of adolescents grades 9 through 12 using tobacco products. Vaping has emerged as a public health concern, with rates of e-cigarette use consistently outpacing traditional cigarette smoking. Data from the 2021 Youth Risk Behavior Survey indicate that over one-third of high school students have tried vaping, and 14% currently use e-cigarettes (Kansas Department of Health and Environment, 2023f). The health risks associated with vaping include respiratory issues, mental health issues, nicotine addiction, and potential cardiovascular effects (Jones & Salzman, 2020).



While the data highlights the scale of the issue, personal perspectives provide deeper insight into its broader effects. Teens who participated in the Photovoice project emphasized the social and environmental implications of vaping, noting its potential to disrupt social settings and advocating for respectful environments where such behaviors do not negatively impact the well-being of others ([Appendix F.10 Insights of Kansas Adolescents](#)). Young adults who participated in a focus group also emphasized the social aspects of vaping. Several young adults in a focus group who said they were regular vape users acknowledged potential health risks but noted that the acceptance they felt in their social circles while vaping, and the novelty associated with experimenting with different flavors, compelled them to continue the practice (von Esenwein & Tilden, 2024).

### Access to behavioral health

There is limited quantitative data on availability of behavioral health providers for youth, but only 10 Kansas counties have a child/adolescent psychiatrist (Fitzhugh Mullan Institute for Health Workforce Equity, 2024). A lack of mental and behavioral health services was a frequently cited concern during the interviews and focus groups conducted for this Needs Assessment and was also highlighted in the population survey. About one-third of Kansas parents indicated needing mental health support for their children. When discussing the availability of behavioral health providers, a survey respondent said...

*"More doctors/psychiatrists have retired recently due to the pandemic. It is difficult to find another provider accepting new patients . . ."*

Another survey respondent simply said...

*"Wait lists for mental health services are very long currently."*

One member of the Family Advisory Council said...

*"The rural areas, you have to drive how far to get mental health? I'm not in a super rural area. My town actually has a pretty good mental health facility, but outside of that, yeah, you'd be driving an hour, hour and a half. So going back to small towns talk. My town is small enough that they will talk, and if you then don't like [Mental Health Center], well, then now you're driving even further. Maybe even Denver because we're a hole."*

Another parent shared...

*“One thing specifically the child and adolescent workgroup has discussed in depth previously is what are the hoops you have to jump through to get mental healthcare in your area. And it’s either you’re driving hours, or you have to have the privilege to be able to, I don’t know, do virtual services . . . I don’t live in a rural area, and I had to pull my kid out of school to do a virtual session with the therapist out of Kansas City because there was no availability, and I am right in between two metro areas, and still couldn’t find what I was looking for.”*

## Kansas Youth Voices

Kansas adolescents provided sharp insights into factors that contribute to their health and well-being, and that of friends and families, through several means, including focus groups and Photovoice, where images (and accompanying descriptions) were collected and shared by participants. They highlight the importance of physical health through recreational spaces and activities like organized sports and play. They also emphasized the importance of food, including food sufficiency. Some adolescents address environmental concerns such as pollution and the importance of a healthy built environment. Mental and behavioral health, including substance use, was an overarching concern. Some spoke to the challenge of maintaining connectedness in a world increasingly dominated by digital distractions. In both Photovoice projects (conducted in two smaller, rural communities) and in a focus group of inner-city adolescent women vaping was brought up as a concern. Photovoice participants mentioned alcohol as an issue, and illicit drug use by teens was a topic in the focus group.



### Enhance Behavioral Health Care Services

- ◆ Strengthen initiatives like KSKidsMAP to address shortages in pediatric mental health providers, especially in rural and underserved areas, and reduce long wait times for services.
- ◆ Develop targeted suicide prevention programs

## Adolescent

### RECOMMENDATIONS

that includes school-based interventions, peer support initiatives, and expanded access to crisis counseling services.

- ◆ Train healthcare providers, educators, and community leaders in trauma-informed care to support adolescents experiencing mental health challenges resulting from ACEs.
- ◆ Increase the availability of adolescent-specific SUD treatment programs, with a focus on addressing rural access barriers and integrating screening into routine healthcare visits.
- ◆ Launch evidence-based awareness campaigns targeting adolescents and parents about the dangers of vaping, alcohol, and illicit drug use, including fentanyl, with culturally tailored messaging for diverse populations.
- ◆ Collaborate with schools to implement evidence-based substance abuse prevention programs and provide resources for early intervention.

#### *Promote Comprehensive Sexual Health Education*

- ◆ Advocate for comprehensive, evidence-based sexual health education in schools that includes information on contraception, STI prevention, healthy relationships, and affirmative consent.
- ◆ Transition from opt-in to opt-out policies for sexual health education to ensure more adolescents receive critical information.

#### *Target Disparities in Health Outcomes*

- ◆ Develop community-specific interventions to address disparities in health outcomes among Black and Hispanic adolescents, including culturally appropriate and peer-based teen pregnancy prevention programs and mental health resources.

#### *Improve Access to Preventive and Primary Care Services*

- ◆ Address barriers to adolescent well visits, particularly for low-income families and rural populations, through expanded mobile clinics, telehealth services, and community outreach.
- ◆ Develop incentives for providers to accept Medicaid

and offer flexible scheduling options to improve access for adolescents from low-income households.

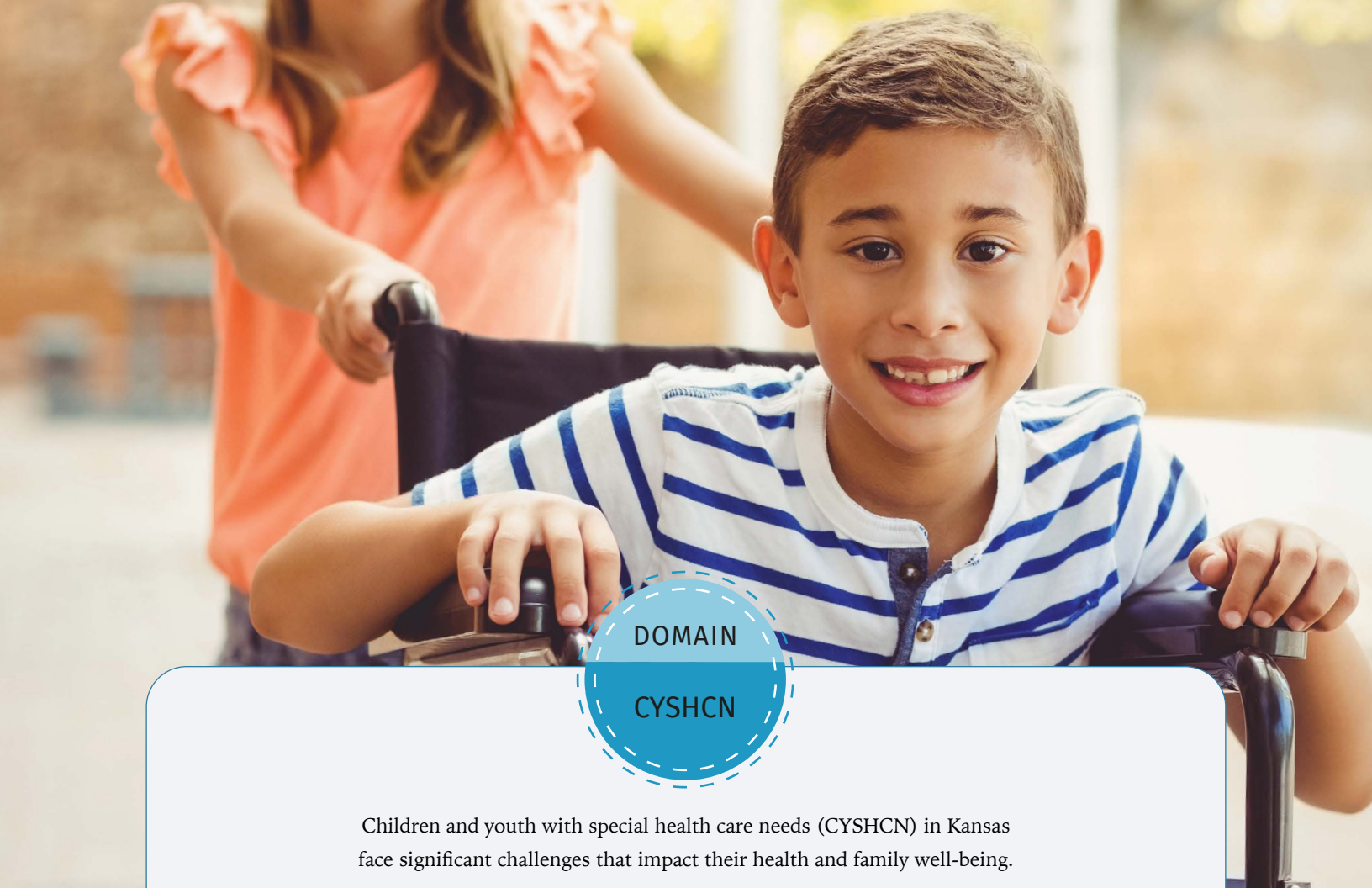
- ◆ Implement education campaigns to promote vaccination, particularly in rural areas and underserved communities.
- ◆ Provide HPV vaccines in schools, community health centers, and through mobile vaccination units to overcome logistical and geographic barriers.
- ◆ Simplify processes for families to access available services by creating centralized, user-friendly platforms and outreach programs.

#### *Support Youth Self-Sufficiency and Resilience*

- ◆ Expand initiatives that provide reliable adult mentors to underserved adolescents, reinforcing the protective benefits of mentorship.
- ◆ Increase efforts to prepare adolescents for the transition to adult healthcare, particularly for non-English speakers and non-native U.S. residents, by providing resources and education for both adolescents and their families.
- ◆ Work with schools and other community partners to promote and support development of adolescent leadership programs that focus on relationships and fostering resiliency.

#### *Support Healthy Environments (including the Built Environment)*

- ◆ Collaborate with industries and local governments to address pollution in rural areas and educate adolescents about environmental health impacts.
- ◆ Invest in parks, trails, and recreation areas to promote physical activity and overall well-being.



DOMAIN  
CYSHCN

Children and youth with special health care needs (CYSHCN) in Kansas face significant challenges that impact their health and family well-being.

STRENGTHS

- + Most adolescents with special health care needs receive preventive medical care.

CHALLENGES

- ✗ Few children with special health care needs have a primary care medical home to help manage and coordinate their health care needs.
- ✗ Specialty care for complex medical conditions is not available across most of the state, and families have to travel long distances for care.
- ✗ Nearly two-thirds of children with special health care needs experience bullying.
- ✗ Almost one of three Kansas children in the Early Intervention program are not assessed for ongoing needs when graduating from the program.

CYSHCN often require complex specialty care involving frequent medical appointments and therapies that are both time-consuming and costly. Accessing these services can be difficult, as many are only available in a few cities within Kansas or require families to seek care out of state. Additionally, navigating the complex healthcare system poses further barriers for families, highlighting the need for more accessible and coordinated care options (Ghandour et al., 2022).

Numerous challenges include limited access to specialty care, a complex healthcare system, and disparities in health outcomes. Many families must travel significant distances, often out of state, to access necessary therapies and care. However, some strengths have emerged, such as high rates of preventive medical visits among adolescents with special health care needs (92%) and higher developmental screening rates compared to non-CYSHCN peers (48% vs. 37%). Despite these positives, concerns remain, including declining access to medical homes, with just over half

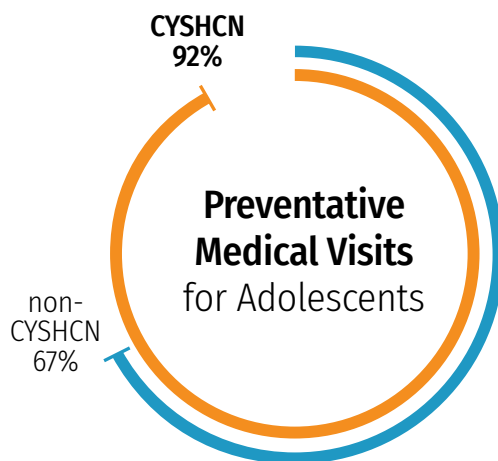
(50%) of CYSHCN having a medical home in 2022, and disparities in oral health and physical activity. Only 23% of CYSHCN meet daily physical activity recommendations, and they are more likely to experience bullying (64%) than any other population group. Transition services for CYSHCN youth are limited, with only 24% receiving support for the transition to adult healthcare. Families also report emotional and logistical burdens, such as workforce turnover in healthcare settings and challenges coordinating care for children exiting early intervention services.

## Strengths

### Well visits

More than 9 in 10 (92%) adolescents ages 12 through 17 with special health care needs had a preventive medical visit in the last year, which is far greater than that of their non-CYSHCN peers of 67%.

Figure 23.  
Preventative Medical Visits for Adolescents



### Transition to adult healthcare

Ensuring children are supported in their transition from pediatric to adult healthcare is critical, especially given the challenges families face navigating a complex

healthcare system. In 2022, 24% of CYSHCN received transitional services, compared to 19% of children without special health care needs. Children with adverse childhood experiences (ACEs) were more likely to receive these services, with 27% of children with one ACE and 30% of those with two or more ACEs receiving support, compared to 13% of children without ACEs. However, from 2020 to 2022, the overall percentage of CYSHCN receiving transitional services declined across most population groups, including those defined by income, educational attainment, gender, and household structure. Despite some progress for children with ACEs, these trends highlight significant room for improvement in ensuring continuity of care for CYSHCN.

### Developmental screening

Data suggest that Kansas CYSHCN aged 9 to 35 months may receive developmental screenings at higher rates than their non-CYSHCN peers. Specifically, 48% of CYSHCN were reported to have received appropriate developmental screenings, compared to 37% of non-CYSHCN children. However, it is important to note that the rate for CYSHCN is based on a small sample size and is therefore considered statistically unreliable.



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## Challenges

While some disparities affecting CYSHCN were discussed in the previous Child and Adolescent sections, it is important to emphasize the broad range of indicators where CYSHCN fare worse than their peers without special health care needs or where concerning trends have been identified.

### Health status

Only 78% of CYSHCN are in good/excellent health, compared to 95% of their non-CYSHCN peers.

### Medical home

While CYSHCN may routinely receive annual preventive visits, these may be conducted through school-based programs, health departments, and clinics (like urgent care clinics), while still not having a single, primary care provider to help manage and coordinate their health needs. In fact, the percent of CYSHCN with a medical home has been trending slightly down in the last five years. The percentage of CYSHCN with 2 or more ACEs with a medical home has also decreased from 2020 to 2022, when only 39% had a medical home. Poorer children were also less likely to report a usual source of sick care, with only 81% of CYSHCN living in households below the poverty line having a usual source of care, while 95% of CYSHCN in households exceeding 400% of the FPL reported having a usual source of sick care.

### Tooth decay

The percentage of CYSHCN with decay (19%) was more than twice that (9%) of their non-CYSHCN peers.

### Specialty Care

The downward trend in medical home access among CYSHCN, particularly those experiencing multiple ACEs or living in poverty, underscores significant disparities in access to consistent and comprehensive care. These challenges are further amplified for families seeking specialty care, with many parents expressing frustration and fear over the lack of nearby specialists and the long travel distances required to access necessary services.

This concern emerged as a clear theme in focus groups, particularly as it relates to specialty care. Explained one parent...

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*"[Our son] has seen specialists in Denver his whole life. Denver is a 3.5-to-4-hour drive. [Our son] has seen specialists in Denver his whole life. Denver is a 3.5-to-4-hour drive (one way) from our hometown. If he lost his private insurance, we would be forced to transfer his care to Wichita (a 5-hour drive) or Kansas City (7-to-8-hour drive ONE way). This terrifies me. There aren't any specialists closer to where we live."*

A provider shared their experience working with families who lived closer to specialty facilities outside of Kansas, but who were forced to seek services in-state to have services paid for by insurance. They noted...

*“Most people are either having to come to Wichita or Kansas City, at least from the Medicaid side, because they can’t cross that state line and go over there to Colorado if you’re out by that border. They’re going to have to stay in Kansas. And that’s really frustrating. For our high-risk kids, we have kids that go home from the NICU, and Denver Children’s is two hours, and Children’s Mercy is six, but they have to go to Children’s Mercy because it takes Kansas Medicaid where Denver Children’s, it’s a bunch of hoops to jump through and is really frustrating.”*

### Continuity of care

Workforce turnover was cited throughout the Needs Assessment as an area of concern, but a parent of a CYSHCN explained how this was particularly problematic for some CYSHCN children. They noted...

*“Another problem is you get kids that . . . need these services, but people aren’t staying on their jobs. So, my kids don’t like change. So, once they build a relationship with someone, they really start grounding. And then that person will leave the job, or something will happen or they’ll move to a different position, and then my son’s having to start over again with new people, and he’s inconsistent with it. He doesn’t like accepting new people. Then it gets hard, and then we have a backtrack of all the behaviors. But it’s supposed to be a service to help, but there’s no constant people. We had to cut out therapy because they lost all their therapists.”*

Another concern was CYSHCN and their families “slipping through the cracks” as they transitioned out of programs. Nearly one in five (18%) Kansas children with developmental delays are not evaluated for ongoing needs when they exit Part C early intervention services at age three, as required by law (Data.gov, n.d.). This highlights challenges in maintaining continuity of care for these children and their families, who often have substantial needs.

29% of children with developmental delays  
are not evaluated for ongoing needs after age 3.



### Physical activity

Just over one-fifth (23%) of CYSHCN ages 6 through 11 years of age are engaged in physical activity at least 60 minutes a day; this compares to 30% of their non-CYSHCN peers. This limited engagement in physical activity among CYSHCN highlights broader challenges related to accessibility and inclusivity in community resources. One key issue is the lack of adequate infrastructure to support children with mobility impairments, as illustrated by an MCH survey respondent who emphasized the need for improvements in the built environment, including sidewalks, accessible doors, and adaptive play equipment.

As a MCH survey respondent noted,

*“The built environment could use some work—sidewalks, door accesses/handicap buttons, play equipment. Our local parks were updated a few years ago with the intention of being handicap accessible, but the equipment is not easily accessed by those in wheelchairs.”*

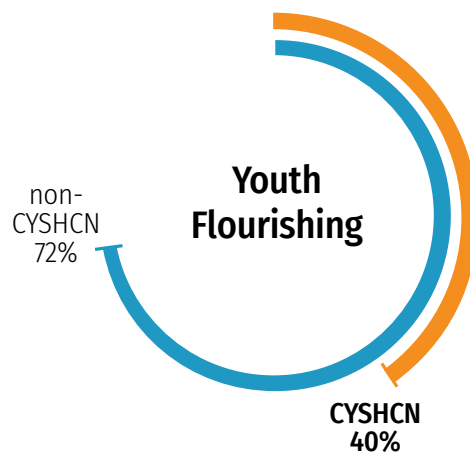
### Bullying

CYSHCN are disproportionately affected by bullying, with nearly two-thirds (64%) reporting being victims—making them more likely to experience bullying than any other population group.

### Flourishing

Less than half of CYSHCN ages 6 through 17 years (40%) are considered to be flourishing, compared to 72% of their non-CYSHCN peers.

Figure 24.  
Youth Flourishing



## CYSHCN

### RECOMMENDATIONS

#### *Expand Access to Comprehensive Medical Homes*

- ◆ Increase efforts to connect CYSHCN to medical homes, prioritizing those with multiple ACEs or from low-income households.
- ◆ Provide training and incentives for healthcare providers to expand medical home services in rural and underserved areas.

#### *Improve Access to Specialty Care*

- ◆ Collaborate with healthcare providers and policy-makers to address geographic barriers by increasing telehealth services and establishing regional specialty care hubs.
- ◆ Advocate for Medicaid policies that allow out-of-state coverage for families closer to neighboring state facilities, reducing travel burdens.
- ◆ Explore funding opportunities to support transportation and lodging assistance for families traveling long distances for specialty care.

#### *Enhance Developmental Screening and Early Intervention*

- ◆ Increase awareness and access to CYSHCN developmental screenings, especially in rural areas, by integrating these services into routine care.
- ◆ Strengthen transitions from early intervention (Part C) to ongoing developmental services to ensure continuity of care.

#### *Support Effective Transitions to Adult Healthcare*

- ◆ Expand transitional support services to prepare CYSHCN for adult healthcare, with a focus on those with ACEs and underserved populations.
- ◆ Develop standardized protocols and tools to help families/providers navigate the transition process.
- ◆ Promote partnerships between pediatric and adult healthcare providers to create a seamless transition of care.

#### *Address Disparities in Preventive Care and Physical Activity*

- ◆ Implement targeted outreach and education campaigns to increase preventive care and physical activity among CYSHCN.
- ◆ Work with communities to improve accessibility of recreational spaces, such as parks and playgrounds, with adaptive and inclusive designs.

#### *Combat Bullying and Promote Mental Health*

- ◆ Develop school-based programs and community initiatives to address bullying among CYSHCN, including anti-bullying policies and peer support programs.
- ◆ Increase access to mental health resources for families of CYSHCN, focusing on trauma-informed care and behavioral health interventions.

#### *Strengthen Workforce Stability*

- ◆ Implement strategies to reduce workforce turnover in healthcare and therapy services for CYSHCN, including competitive salaries, training, and professional development opportunities.
- ◆ Provide specialized training for providers to build consistent and trusting relationships with CYSHCN and their families.

#### *Support Families and Caregivers*

- ◆ Enhance peer support networks and counseling services for families of CYSHCN to alleviate emotional and logistical burdens.
- ◆ Develop community-based respite care programs to support caregivers and allow them time to focus on their own health and well-being.

#### *Update and Enhance Statewide Systems*

- ◆ Update the Kansas State Plan for Systems of Care for CYSHCN to reflect current needs, priorities, and best practices.
- ◆ Invest in data collection and monitoring to better understand trends, identify gaps, and guide program development for CYSHCN.

# Program Capacity Findings



## Summary

The Kansas Title V Maternal and Child Health (MCH) program has undergone significant transitions in recent years, with staff turnover and restructuring influencing its operations. Despite these changes, leadership vacancies have largely been filled by experienced professionals, maintaining the program's foundational capacity. Additionally, local program funding has shifted, with fewer funded agencies but stable staffing levels overall. The program has expanded home visiting services through state investments, reflecting a commitment to universal support for families. However, concerns were raised during assessments regarding local-level access to data and the limited ability of statewide initiatives to address specific community health disparities. To strengthen the Kansas MCH Program, there are five key recommendations for ongoing development of the Kansas MCH Program ([sidebar](#)).

## Organizational Structure

### State Agency Capacity

The Kansas state public health agency, the Kansas Department of Health and Environment (KDHE), is responsible for administering programs funded through the Title V MCH Services Block Grant. This grant is managed by the Bureau of Family Health (BFH), which has a mission to enhance the health of Kansas women and children through partnerships with families and communities.

Since the last Needs Assessment in 2020, BFH has experienced significant staffing changes. In early 2023, two co-Bureau Directors were appointed, with one co-director overseeing Title V Programs, Universal Home Visiting, the Maternal Infant and Early Childhood Visiting Program (MIECHV), Early Childhood Developmental Services (Part C), and other maternal health programs. However, the co-director in this role transitioned out in the summer of 2024, leading to an internal promotion to fill the position. Additionally, the Title V MCH Director, who also assumed her leadership role in 2023, undertook structural changes aimed at better aligning the efforts of BFH.

One of the key changes included creating separate full-time positions for the Child and Adolescent domains, which had previously been managed by one individual. This allowed for a more focused approach to serving both domains effectively. Furthermore, a Consultant Unit Manager role was established to oversee day-to-day operations, which freed up the MCH Director to focus on broader strategic initiatives. In line with this, a full-time position dedicated to behavioral health was also created, reflecting the growing emphasis on addressing behavioral health issues within the MCH framework.

### KEY PROGRAM RECOMMENDATIONS

#### Workforce development system

Develop a structured workforce development system for MCH staff at the state and local level.

#### Midwife workforce development

Facilitate the development of a midwife workforce that is well-integrated into the Kansas health care delivery system.

#### Doulas and community health workers

Promote greater health care coordination for MCH populations by helping build a stronger system of doulas and other community health workers.

#### MCH data access and use

Work on mechanisms to provide access to, and promote the use of, local MCH data to support efforts to address health disparities and promote health equity.

#### Fund community-based organizations

Alter funding structures to provide funding to community-based organizations who are working with traditionally underserved communities who experience health disparities.

To build a stronger foundation for Kansas families, the MCH Director now leads the System of Supports (SoS) team. This team is dedicated to creating partnerships and promoting family and consumer engagement initiatives that are central to the Title V block grant. Additionally, BFH has been working on expanding its staff to support emerging needs, including overseeing new programs like the HRSA Maternal Health Innovations (MHI) Grant. This grant led to the hiring of a program coordinator and a senior-level epidemiologist, who are focused on improving maternal health data management and establishing Medicaid data linkages. Through these structural changes and strategic realignments, the Kansas MCH Program aims to enhance its impact on maternal and child health outcomes across the state. The establishment of dedicated roles, like the behavioral health lead and the SoS team, highlights the increased focus on targeted, data-driven support systems for families by BFH.

## CORE TITLE V STAFF

### Senior Leadership (4)

- ◆ Co-Director, BFH
- ◆ Title V MCH Director
- ◆ Title V CSHCN Director
- ◆ Children & Families Section Director

### Administrative Assistant Support (2)

*Funded through other sources:*

- ◆ Screening & Surveillance  
Section Director

### Middle Management (4)

- ◆ Family and Consumer Partnership  
Unit Director
- ◆ Health Consultant Unit Manager

*Funded through other sources:*

- ◆ MCH Behavioral Health Director
- ◆ Maternal Mortality & Perinatal  
Quality Collaborative Consultant

### Special Health Care Needs (6)

- ◆ SHCN Program Manager

### SHCN Care Coordinators (4)

- ◆ SHCN Program Consultant &  
Financial Eligibility Specialist

### Consultants and MCH Program Leads (8)

- ◆ W/M Consultant
- ◆ P/I Clinical Consultant
- ◆ Adolescent Consultant
- ◆ Family Systems Consultant
- ◆ MCH Program Manager

*Funded through other sources:*

- ◆ Maternal Health Innovation Coordinator
- ◆ P/I Non-Clinical Consultant

### Data Supports (4)

- ◆ MCH Senior Epidemiologist
- ◆ MCH Advanced Epidemiologist
- ◆ MCH Data Analyst

*Funded through other sources:*

- ◆ MCH Senior Epidemiologist

The Title V MCH Program in Kansas faced significant supervisory shifts and numerous position vacancies (now mostly filled) in 2023 and 2024. In the last year alone, the MCH Program has filled 12 vacant positions fully or partially funded by Title V funds. Of specific note, several organizational changes have occurred in the Special Health Care Needs Program. The Special Health Care Needs Program was moved into the Screening and Surveillance Unit, which manages much of the day-to-day programming including Direct Assistance Programs (DAPs), while the Title V CSHCN Director reports to the Title V MCH Director and oversees the “systems level” efforts and family and community engagement work. In those efforts she is supported by the Family Systems Consultant. Both the Screening and Surveillance Unit Director and Title V CYSHCN Director are new to these roles, but both are experienced staff who have years of experience working in these areas of focus with BFH.

Despite staffing challenges, the program has maintained a focus on collaboration, innovation, and continuous quality improvement. The Title V Program places a high priority on supporting staff at all levels. To this end, Maternal and Child Health Block Grant funds provide salary support for approximately 26 BFH staff, including administration, MCH, CSHCN staff, and epidemiologists. In total, about 18% of the staffing within BFH is funded by the MCH Block Grant, reinforcing its role in sustaining the workforce and ensuring the continued delivery of essential maternal and child health services.

### *Kansas Special Health Care Needs Program*

One area of focus within the Title V Program is the Kansas Special Health Care Needs program, a program that has been, as noted above, moved into the Screening and Surveillance Unit. This program offers direct health services for individuals from birth to 21 years old who meet certain eligibility criteria and have conditions that hinder their physical growth and development. Financial assistance for families is provided through nine Direct Assistance Programs (DAPs), which cover a wide range of services from medication costs to orthodontic treatment and travel reimbursements.



However, gaps in capacity and challenges related to staffing turnover have delayed the full implementation of certain activities and policy discussions, such as the financing of care coordination services for CYSHCN.

The Kansas MCH Program also benefits from collaboration with local Title V grantees who work closely with CYSHCN families. Four grantees serve as Special Health Care Needs Satellite Offices, assisting families in navigating the healthcare system and providing care coordination. Despite positive feedback from families, there are still concerns about access, especially in rural areas where satellite offices are limited, with none serving the western third of the state.

In addition to core MCH services, the program tries to extend its reach through collaborations with other sections of the BFH, including coordination efforts with Family Planning, Kansas Early Childhood Development Services, and the Maternal Infant and Early Childhood Home Visiting Program. The MCH Program also supports workforce development and vital records analysis through partnerships with other bureaus like the Bureau of Epidemiology and Public Health Informatics. It is these collaborations and other systems development efforts that are the primary focus of the Title V CSHCN Director, who continues to report to the Title V MCH Director, while working closely with the program staff in the Screening and Surveillance Unit.

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## Local Title V-funded Agency Capacity

KDHE collaborates with local agencies, including public health departments and Federally Qualified Health Centers (FQHCs), to deliver MCH services. Funds are allocated to local providers through the agency's Aid-to-Local grant process. The annual process for engaging local agencies begins with the development of Grant Application Guidance and Reporting Materials, typically prepared in December.

### AID-TO-LOCAL GRANT PROCESS

#### December

Grant Application Guidance and Reporting Materials preparation.

#### Mid-January

Materials made available to local agencies seeking Title V funding.

#### March

Application submissions due.

By mid-January, these materials are made available to local agencies seeking Title V funding, with application submissions due by March. The review process for applications informs funding recommendations and involves internal and external reviewers, who apply specific criteria through the use of a scoring matrix. This matrix considers a funding formula based on poverty and population metrics for each county or target area, alongside the applicant's willingness and ability to meet grant requirements.

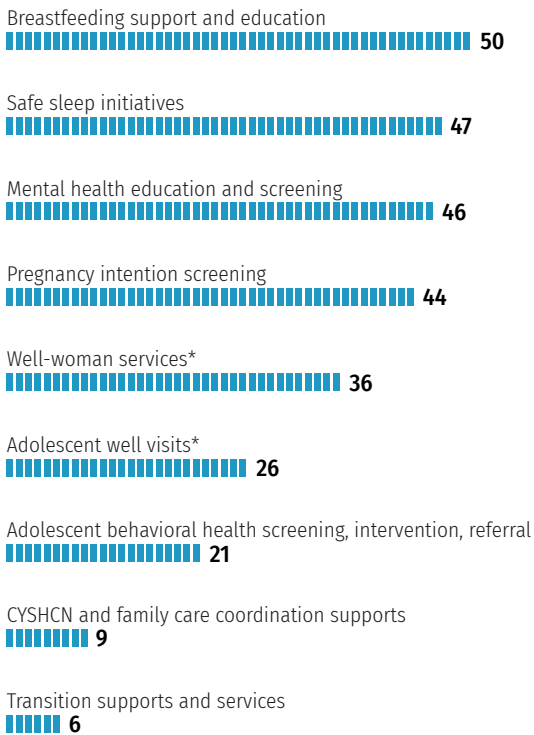
Notably, the funding structure is evolving. Changes are planned for State Fiscal Year (SFY) 2026, with SFY 2025 designated as a transition year to enhance the capacity of local programs before these changes take effect. Key planned adjustments include:

- ◆ Establishing a funding floor and ceiling for grant awards.
- ◆ Discontinuing the use of a funding formula to avoid penalizing sparsely populated counties.
- ◆ Promoting multi-county applications.
- ◆ Implementing multi-year grant periods.
- ◆ Enhancing outreach efforts for the Request for Applications to community-based organizations.

Local agencies are expected to tailor services towards needs identified in the *Kansas 2025 Title V Needs Assessment* and community health priorities highlighted in Community Health Needs Assessments. The reach of these services can fluctuate annually, influenced by local community needs and capacities.

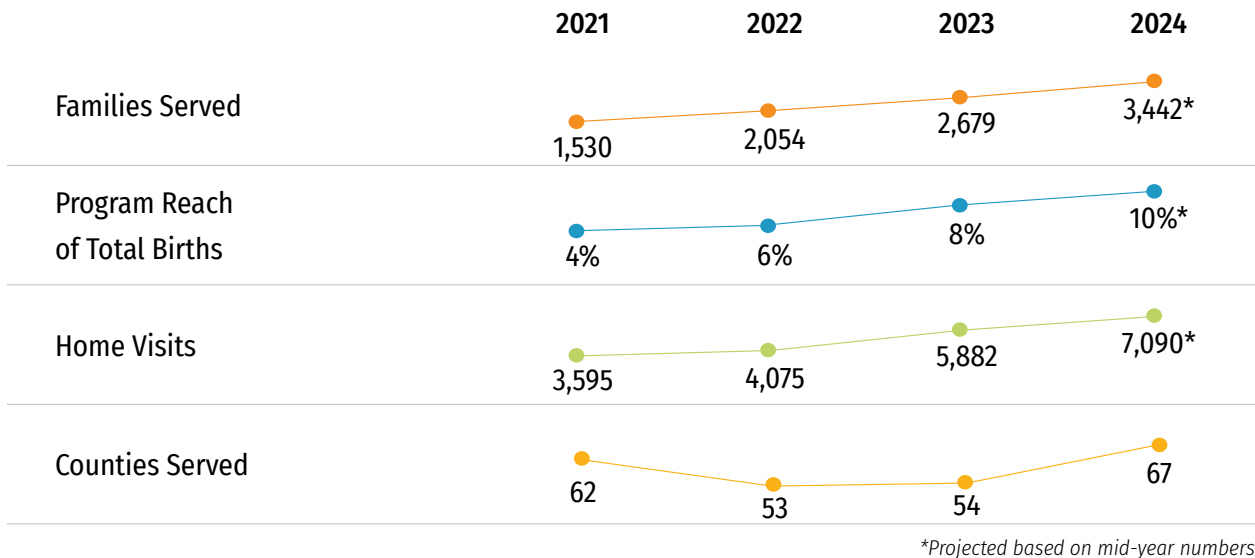
In SFY 2024, Title V contracted with 56 local agencies, with the same number of contracts awarded in SFY 2025, collectively serving 65 counties. This contrasts with the 68 local programs receiving Title V funds at the time of the last Five-Year Needs Assessment (Kansas Department of Health and Environment, 2020a). This drop can be attributed, at least in part, to a decrease in applicants in recent years, driven by competing priorities among community organizations at the local level. It is also important to note that local health programs do not have specific requirements around what services are offered, and few programs provide services across all MCH populations. In Aid-to-Local applications, applicants note programs that are continuing/expanding, discontinuing, or adding, which gives insight into how many programs serve different MCH populations. A high number of local programs provide care to women/maternal and perinatal/infant populations. [Figure 25](#) illustrates the number of local agencies providing services. Only 6 grantees indicated they provide transition supports and services, and 9 indicated they have efforts in place to provide care coordination supports to CYSHCN and their families.

Figure 25.  
The number of contracted local agencies  
(out of 56) providing these services.  
*\*annual comprehensive*



A notable area of growth in recent programming is universal home visiting. While the number of counties served by MCH-supported universal home visiting programs fell from 62 in 2020 to 54 in 2023, the number of visits and families served increased during this same period, likely due to state investment in the program. Historically, universal home visiting has been primarily funded through Title V and local resources. However, in 2022, an allocation of \$250,000 from the Kansas Children's Initiative Fund was introduced, increasing to \$1,652,876 in state fiscal years 2023 and 2024. By 2024, the program expanded to serve 67 counties, with the number of home visits rising to 7,090 and the number of families receiving services increasing to 3,442. Although the program's reach remains relatively limited, estimates suggest that the percentage of young families benefiting from the program (based on total births) has more than doubled, from 4% in 2021 to 10% of Kansas families with newborn children in 2024 (Figure 26).

Figure 26.  
Universal Home Visiting Change over Time by Fiscal Year



## Funding Distribution

During qualitative data collection, several partners indicate an interest in seeing the Kansas MCH Program explore different strategies for funding local MCH services. One participant spoke to the intended role of Title V funds for filling gaps, and suggested the current funding model hasn't developed a sustainable approach to efforts like home visiting and prenatal education. They noted that if these services could be funded "through Medicaid or other sources it would allow us to use those funds for other things."

Several other participants proposed the use of Title V funding to support local partner organizations that have not been previously funded and who are already involved in significant efforts serving the MCH population, often working with underserved populations.

One participant said...

*"I would love to see Aid-to-Local opportunities open up to not just health departments. I think there's no incentive for health departments to increase or innovate because it's just kind of pass-through funding . . . This is how we implement it."*

Others suggested the need to focus funding more specifically on populations experiencing health disparities, suggesting...

*"[They] would see increased capacity if they could be intentional . . . They could double up on the funding sources, potentially. I know there's some restrictions there, but at least they could double up on the population intended to benefit."*

Another partner suggested funding to...

*"Position more supports in spaces like early education and care spaces, in churches, in those neighborhood and community spaces where people trust the folks that are there, investing in things like community health workers, but community behavioral health workers that are well trained and well supported but they look like the community that they're serving. They speak the language. They're from the community. They understand the resources, and they are well supported with maybe even clinical or consultation services to process their cases and really be a support for them. And so, I struggle with saying like, 'Oh, yeah, just invest in this program.' What I would love to see is an investment in those kinds of programs and also a layering of programmatic consultation support around the mental health and substance use needs that are always there. They're always there in those programs, and there's never enough support to meet all those needs."*

One midwife working primarily with communities of color questioned...

*"Why does KDHE need to decide who's working within a program or mandate that it must be within a health department when the community is more than capable of deciding who should be trusted or not trusted within their community? These people are already out there doing these things. There are already aunties bringing people casseroles and all of those natural roles that you see within societies. Why are we not resourcing those people and paying those people? That community health worker model, I think we could say a lot for that at this juncture, that if we use that but actually use it with the people who are already in the community to serve other people in the community, that we would see larger changes in outcomes. Instead of expecting that we are going to train somebody, assimilate them into this health department culture, and then send them out once they've changed and they've assimilated. It's the assimilation that eats away at the effectiveness."*

Another provider offered...

*"I would say when you look at their funding . . . the funding allocation just does not align with the outcomes currently . . . They may be less aware of the people who are doing the work, or they may just be funding the same agencies that they funded for years, right? I can't honestly tell you what's happening or if there is resistance. I think that some of this could also be due to the high turnover within the organization. So, it usually seems like the last person that was leading the work was really into like, 'How can we do this differently,' right? But that was short-lived because the person moved on. And I think, to me, that is a greater sentiment of how we need to redistribute the hierarchy because community organizations are not going—if they've been doing this work for years without the support from the state, they're not going anywhere. So, if you had them leading some efforts, you wouldn't have to worry about your high turnover and how that impacts the work that's being done."*

## Workforce Capacity and Workforce Development

As previously mentioned, the MCH Program has undergone significant structural changes, including the introduction of several new positions aimed at ensuring dedicated staff coverage across all MCH domains at the state level. An additional epidemiologist has been integrated into the program to bolster data analytic capabilities. In an effort to strengthen recruitment and retention processes, the program has stated that it is committed to ensuring that newly hired staff possess the perspectives, skills, and attitudes necessary to foster the growth of the MCH system in Kansas. To this end, interview question sets have been revised to include inquiries about candidates' behaviors, lived experiences, health disparities and inequities, and MCH issues and priorities, ensuring alignment with program needs. Additionally, a *Core Title V MCH Block Grant Essential Duties and Expectations* training manual has been developed to guide the training of all staff responsible for Title V MCH Services Block Grant performance. Kansas is also in the process of developing a "Title V University," a comprehensive initiative designed to support state Title V staff, local grantees and partners, and family leaders in building the knowledge and skills necessary to meet the needs of MCH populations in Kansas. The MCH Navigator and MCH Self-Assessment tools have been fully integrated into the professional development planning and performance review processes for all MCH staff at the state level.

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## Local Title V-funded program staff capacity

As part of the *Title V Needs Assessment*, an estimate was made of the number of positions and their full-time equivalency of MCH positions among local Title V-funded programs. Currently, local MCH Programs collectively support approximately 439 positions, which translate to about 143 full-time equivalents (FTEs) ([Table 2](#) below and [Appendix F.5 Workforce](#)).

The MCH workforce is predominantly composed of home visitors and nurses, with 82 home visitors, 87 nurses, and 8 Nurse Practitioners/APRNs making up the largest number of staff. In terms of FTEs, there are 36.1 FTE home visitors, 28.9 FTE nurses, and 3.3 FTE Nurse Practitioners/APRNs. Additionally, the program supports 68 administrative, fiscal management, and support positions, accounting for 14.4 FTEs, along with 20 agency managers and supervisors, representing 5.5 FTEs. The state's MCH workforce also includes 12 care coordinators, the majority of whom are full-time, totaling nearly 11 FTEs (10.8 FTE).

The analysis reveals a noticeable decline in the overall number of positions since the previous Needs Assessment conducted in 2019-2020; however, the total number of FTEs remains relatively stable. This means there are more full-time positions or positions that involve more part-time hours. The most significant reductions in the absolute number of positions have occurred in administrative and managerial roles, although the FTE count for these positions has remained consistent over time. Additionally, there have been decreases in the number of social workers, counselors, and case managers/care coordinators. While the number of nurses has decreased, the overall FTEs for nurses have seen a slight increase. Conversely, there has been a substantial increase in the number of home visitor positions, with more than 20 additional staff and nearly double the number of FTEs compared to previous years.

Table 2.  
Statewide staffing of Title V-funded MCH Programs in Kansas

Position Type	Total Positions	Total FTEs
Administrative/Fiscal Management & Support	68	14.4
Agency Administration	34	6.1
Agency Managers/Supervisors	20	5.5
Breastfeeding Peer Counselor/Educator	4	1.4
Case Manager/Care Coordinator/Navigator	12	10.8
Dietitian/Nutritionist	2	0.1
Home Visitor	82	36.1
Interpreter/Translator	6	2.6
MCH Program Director/Supervisor	12	5.9
Nurse Clinician	87	28.9
Nurse Practitioner/APRN	8	3.3
Other/Unknown	79	21.4
Physician/Medical Director	3	0.2
Social Work/Counselor	9	3.5
Special Health Care Needs Staff	13	3.1
<b>TOTAL</b>	<b>439</b>	<b>143.3</b>

## Demographics of the Title V Workforce

With an increasing emphasis on health equity in the Title V Program, understanding the degree to which the workforce resembles the population they serve is an important consideration. As such, this analysis includes a comparison of the Title V workforce, Kansas Title V clients, and the Kansas female population.

Significant differences in gender, race, ethnicity, Spanish-speaking ability, economic status, and insurance coverage exist between the Title V workforce, Kansas Title V clients, and the Kansas female population ( $p < .001$  across all characteristics) ([Appendix F.5 Workforce](#)).

### Gender

Both the workforce (98%) and Kansas Title V clients (99%) are predominantly female, but the workforce has a slightly higher proportion of individuals preferring not to disclose their gender (1.1% vs. 0.1%).

### Racial Disparities

African Americans are underrepresented in the workforce (4%) compared to clients (9%). In contrast, white individuals are more prevalent in the workforce (87%) than among clients (80%). The workforce shows less representation of multiracial individuals (2%) compared to clients (9%).

### Ethnic Gaps

Hispanic individuals comprise 37% of clients but only 13% of the workforce, indicating a significant gap. Non-Hispanic individuals make up 88% of the workforce but only 63% of clients.

### Spanish-Speaking Needs

Only 12% of the workforce speaks Spanish, compared to 18% of clients.



## State Systems Development Initiative (SSDI)

The SSDI grant plays an important role in enhancing the capacity to analyze, link, and share data in order to assess needs, guide program activities, and evaluate program efficacy. The Kansas MCH Program and SSDI have developed substantial epidemiological capacity for timely data access and the integration of information from multiple sources, including data from vital records (birth and death), Medicaid, WIC, hospital discharges, newborn screening (bloodspot, hearing, heart), birth defects, the Behavioral Risk Factor Surveillance System (BRFSS), and the Youth Risk Behavior Survey (YRBS).

The annual linkage of data encompasses various datasets, including birth to infant death records, Medicaid (mother-infant dyads), WIC, and hospital discharge data for mothers, among others. Notably, the newborn screening information systems—including newborn metabolic screening, newborn hearing screening, and birth defects—are integrated into a single electronic system database system. This system connects with birth records and receives automated daily updates on selected variables, allowing for longitudinal research and the tracking of children across multiple programs over time.

The Kansas BRFSS is administered by the KDHE Bureau of Health Promotion in collaboration with the Centers for Disease Control and Prevention (CDC) and is funded by both the CDC and the Kansas Health Foundation. Meanwhile, the YRBS is conducted by the Kansas State Department of Education in partnership with the University of Kansas School of Medicine and the Bureau of Health Promotion.

As previously mentioned, the SSDI Project Director position has recently transitioned, with a new epidemiologist stepping into this role, following the long tenure of the previous Project Director, who had served since 2003. The former SSDI Project Director will primarily focus on supporting the new Maternal Health Initiative (MHI) grant while continuing to collaborate with MCH epidemiology staff on the statewide MCH Needs Assessment process and ongoing MCH efforts over the next five years.

The SSDI team supports the MCH Program through various initiatives, including:

- ◆ Examining quantifiable outputs for the MCH Program’s Evidence-Based or -Informed Strategy Measures (ESMs) to establish baseline values and monitor progress over time.
- ◆ Assessing MCH programmatic activities and accomplishments, as well as their impact on long-term outcomes using data collected through the MCH Community Checkbox, administered by the University of Kansas Center for Community Health and Development (this data is reviewed at quarterly program sensemaking sessions, allowing staff to understand the impact of their work and identify areas for collaboration and quality improvement).
- ◆ Supporting the publication of state data on maternal mortality and severe maternal morbidity.
- ◆ Evaluating outcomes from Kansas Perinatal Community Collaborative (KPCC) projects.
- ◆ Assisting in the development and continuous assessment of the Five-year State Action Plan, ESMs, State Performance Measures (SPMs), and annual objectives for each National Performance Measure (NPM) and SPM, along with conducting trend analyses and highlighting major statistical findings.
- ◆ Monitoring and reporting on the status and trends for National Outcome Measures (NOMs), NPMs, ESMs, and SPMs to inform ongoing Needs Assessment efforts, including the creation of the Five-Year MCH Needs Assessment.

## Other Data Capacity

As previously mentioned, the Kansas MCH Program has made significant investments in data capacity through Title V and other funding sources. This commitment allows for timely collection and reporting of data, which is essential for effective program planning, implementation, and quality improvement efforts. Both the existing staffing structure and partnerships within BFH and the broader state public health agency are dedicated to establishing priorities and objectives that address the needs of the MCH populations in Kansas while also monitoring progress toward these goals.

The current staff possesses robust epidemiological training, with two epidemiologists holding Master of Public Health (MPH) degrees and a third possessing a Master of Science degree in Epidemiology. Additionally, one of the MPH staff members has a Master of Applied Science degree in Spatial Analysis. Collectively, these three epidemiologists bring extensive experience from their tenure in state public health agencies, where they have worked in both the MCH Program and the KDHE Bureau of Epidemiology and Public Health Informatics. Their background includes managing the Pregnancy Risk Assessment Monitoring System and contributing to the Kansas Immunization Program.

To further enhance their capabilities, the three staff epidemiologists are supported by a full-time advanced data analyst. They also collaborate closely with the Screening and Surveillance Data Manager, who provides crucial data management, analysis, and reporting support for programs within the Screening and Surveillance Unit (including newborn screening and health defects surveillance). This collaborative approach is designed to ensure that MCH staff have access to high-quality data and analysis, enabling them to make informed decisions and continuously improve the services provided to Kansas families.

While there is recognition of significant data capacity within the program, there were some concerns, expressed about use of data to inform MCH decision-making in the state. A key concern highlighted by a nurse during an interview, emphasizes the need to balance state-level data with community-level insights:

*"The Kansas Perinatal Quality Collaborative . . . The way they're looking at data, saying the leading cause of death for pregnant women is MVAs, car accidents, and focusing education on seatbelt wearing for pregnant women. That's not going to touch my community. That's not going to make one iota of difference. I'm not saying that that's not the global reason for all of Kansas, and that there's no merit to their data, but that's not what's of social significance. And to focus on [expletive] when you really know what's what, when you really could be zoning into problem areas, looking county by county and examining where the real issues are and where the health disparities lie, but you insist on focusing on these other areas and calling that fidelity to the statistics, to me, that's just insane. That's just willfully letting mothers and babies die."*

A second provider expressed a similar opinion, saying Kansas needs to...

*"Disaggregate data by race, which Missouri has done a much better job of than Kansas. Do the bare minimum. You can't address a problem you don't know exists. And a lot of people don't want to know what exists, what really exists . . . so, know your own data. Disaggregate your own [expletive] data."*

Others also expressed difficulty accessing detailed, community-level data. One health department representative noted,

*"I know Kansas Information for Communities has all that data available for certain topics under maternal and child health. The problem is we can't see it at any smaller level than the county . . . it would be helpful for both us and community orgs that we work with to have that local level data disseminated by race, ethnicity, so on and so forth. I came from the Missouri side and all of that was available to us through their data systems. As a layperson, you could go on the computer and you could look that up. On the Kansas side, I've found difficulties actually being able to pull that data. Again, not having to submit a data request or anything like that, both for our ease for justifying programs and writing grants, but also for, again, our community orgs and our community members to understand and be able to not only navigate themselves, but even to ask us and pull data requests for them without having weeks or months at a time to have to turn around a data request."*

Another provider said they had a concern about KDHE "not freely releasing the raw data."



## Recommendations

### Title V Program Workforce Development

The Kansas Title V MCH Program has grappled with significant workforce challenges due to high staff turnover and a relatively inexperienced workforce, significantly influenced by the COVID-19 pandemic. These issues underscore the need for a robust workforce development strategy to address initial and ongoing training needs. Noting the high number of new and relatively inexperienced staff, one member of the MCH staff stated that there were *"significant training needs for our own staff and for community members."* Leveraging resources and technical assistance from organizations like the National MCH Workforce Development Center (<https://mchwdc.unc.edu/>) and the National Center for Education in Maternal and Child Health (<https://www.ncemch.org/>) could help design and implement comprehensive staff training initiatives. Such efforts would strengthen both state-level teams and local partners, ensuring the workforce is equipped to deliver high-quality services.

To address these challenges effectively, it is also recommended to conduct a retrospective assessment to identify factors contributing to turnover and vacancies. This could help develop systematic strategies to better support staff and improve retention. Moreover, fostering collaboration between the state Title V Program and locally funded entities is essential to ensure adequate resources and processes for staff development are in place. A coordinated, statewide approach would enhance the program's capacity to build a skilled and sustainable MCH workforce, ultimately improving outcomes for the populations it serves.

### *Integration of Midwives and Mid-Level Providers*

While there is recognition of the important role of midwifery in the system of maternal care and birthing services, the supply of providers is still not sufficient, and there are significant barriers to service utilization. Leaders of health systems, with resource limitations, are approaching these issues primarily within the context of recruitment and prioritizing hiring of physicians because of their broader scope of practice when it comes to deliveries. There is an opportunity for public health and the MCH Program to help facilitate statewide and regional systems level discussions to explore models that appropriately utilize, but are not overly reliant on, OB and Family Medicine care and are able to most efficiently and effectively meet the needs of women and children, most of whom will not need consistent physician-level care for pregnancy, delivery, and postpartum care. Specifically, Kansas could do more to promote the role of nurse midwives by recognizing the Certified Midwife (CM) credential, promoting midwifery training programs, and facilitating discussions to promote hospital and health system credentialing, something noted as a barrier in a number of health systems in the state (Niles & Zephyryn, 2023). Enhancing Medicaid reimbursement for obstetrics services could also encourage physician and non-physician providers to consider obstetrical practice (Mann et al., 2024).

### *Care Coordination*

Much in the same way that systems level discussions are needed to explore the development of systems of care that utilize non-physician options, so is there a significant need to explore ways to enhance care coordination. One important aspect of this discussion is to explore mechanisms to develop more capacity to train and utilize doulas and community health workers who can provide these care coordination services. A key aspect of this discussion is looking at mechanisms to adequately reimburse care coordination services provided by these community-based providers. While Kansas is one of 20 states that provides Medicaid reimbursement for community-based doula services, many states have much higher rates of reimbursement (Prenatal-to-3 Policy Impact Center, 2024). In Rhode Island, state law also requires doulas coverage by private insurers (National Health Law Program, 2022), and doulas receive “small business” training to ensure their financial success and sustainability of the program. Given the small number of practicing doulas, another area of opportunity is providing support for doula training and workforce development. Eight states have supported doulas training through direct funding of training programs and/or creation of doula training scholarship programs (Prenatal-to-3 Policy Impact Center, 2024).

### *Accessibility and Use of Data*

A number of participants in discussions noted barriers in being able to access data below the county level in order to inform policy and practice, and others suggested more granular analysis will be critical to meaningfully address health equity and make progress on entrenched disparities in health experienced by some Kansas populations. Specific suggestions involved examining supported public-facing data systems like Kansas Information for Communities and enabling immediate access to data below the county level for any end user. Others advocated for discussions involving those working in disparately impacted communities in a more meaningful way to ensure that policy and program decisions begin to focus more directly on community-level disparities.

## Title V Funding of Community Partners

The Title V MCH Program in Kansas has distributed considerable funding to many grantee organizations over the course of many years, and while those resources have enhanced access to important services for many Kansas women and children, there remain long-standing disparities in outcomes for MCH populations including low-income families, members of racial and ethnic minorities, and other underserved populations. Given the enhanced focus on health equity in the MCH Program at the federal and state level, consideration should be given to funding mechanisms that would offer resources to existing community-based organizations who are currently working with these populations. Discussions as part of this Needs Assessment process suggested that there are community-based organizations working with underserved populations in the state who are eager to have access to more funding in support of their work and see the MCH Program as an opportunity to help magnify their work in their communities.

# Program Partnerships, Collaboration, and Coordination Findings



## Overview

The Kansas MCH Program has a long history of successfully fostering public and private partnerships to promote access to care for MCH populations and to encourage access to quality health care services for Kansas women and children. The program has worked to align federal, state, and local initiatives supported by Title V funding and has sought active collaboration with a diverse array of partners, both internal and external to the agency, to share resources, leverage funding, and promote effective, efficient service delivery to MCH populations statewide. Staff and program partners have acknowledged that it has been challenging to meaningfully engage representatives of underserved populations to help inform and drive program and policy decision-making.



### Recommendations

The MCH Program is recognized for their willingness and success in building partnerships. The recommendations and considerations for ongoing development of the Kansas MCH Program included here primarily pertain to ways to more **meaningfully engage and collaborate with representatives of underserved populations who experience health disparities** including:

- ◆ Engaging directly with representatives of underserved populations to ensure their input into program planning efforts.
- ◆ Ensuring representation from diverse populations in formal advisory groups.
- ◆ Utilizing community-based organizations to manage some task force/work group efforts that contribute to program planning and decision-making.
- ◆ Promoting and/or offering leadership development to representatives of underserved populations to help develop capacity to engage in system-level decision-making.

## State health agency internal partnerships

Internally, the MCH Program works closely with many programs and bureaus within the agency to advance maternal and child health. These relationships include work supported by other MCHB investments. These, with others, include:

- ◆ **Maternal Health Innovation Grant**  
*In Kansas the Project Director of this grant is the Title V MCH Director.*
- ◆ **Maternal, Infant, and Early Childhood Home Visiting**
- ◆ **Pediatric Mental Health Care Access Program**  
*Managed by the MCH Behavioral Health Director*
- ◆ **Kansas Connecting Communities.**  
*Funded by the HRSA Maternal Mental and Substance Use Disorder Program.  
Directed by the MCH Behavioral Health Director.*

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## Key internal relationships

### *Bureau of Health Promotion (BHP)*

MCH Programs work closely with BHP on chronic disease risk reduction, tobacco cessation, injury prevention (e.g., Safe Kids Kansas), suicide prevention, and substance/opioid use prevention and response. MCH staff have been active in the development/implementation of the state's injury prevention plan; adolescent driving safety; physical activity in early care settings; and preventing and addressing Adverse Childhood Experiences. BHP also facilitates key activities for the agency around credentialing, training, and expansion of community health workers which Title V has been heavily involved in to align holistic care coordination activities.

### *Bureau of Epidemiology & Public Health Informatics (BEPHI)*

As described previously, Title V works with BEPHI related to core MCH epidemiological supports. This collaboration has resulted in implementing the PRAMS, launching maternal mortality review, and enhancing birth defects surveillance. Epidemiologists serve lead roles with the Perinatal Periods of Risk Analysis, Fetal and Infant Mortality Review processes, local public health system assessments, and developing/monitoring the State Health Assessment and Improvement Plan.

### *Bureau of Community Health Systems (BCHS)*

In partnership with BCHS, Title V supports development, training, capacity building, and systems development across the public health and MCH workforce (e.g., annual Governor's Public Health Conference, MCH pre-conference). The Special Health Care Needs Program program participates on the HRSA-funded Emergency Medical Services for Children (EMSC) Advisory Council to support partnership and collaboration across the EMSC and Title V grants. Monthly meetings have begun with the Bureau of Community Health Systems, which is funded with a number of HRSA grants including the Primary Care and State Office of Rural Health grants, to support coordinated efforts for MCH grantees.

### *Bureau of Oral Health (BOH)*

Title V partners with BOH and other state organizations (e.g., Oral Health Kansas) to promote and support good oral health and dental care across the life course. Title V continues to support integrating screening and sealant services into local programs and services, expanding school-based health services, and consistent messaging across all public health programming.

### *Bureau of Disease Control & Prevention (BDCP)*

Title V and BDCP are strong partners as it relates to women's health (e.g., immunizations; reproductive health/wellness; STI prevention and intervention during adolescence, preconception, pregnancy, and postpartum periods). There have been ongoing conversations between BDCP and Title V regarding the tracking, treatment of and education on congenital syphilis.

### *Title X Family Planning Program*

MCH has worked closely with the Title X program to promote reproductive health and ensure access to diagnostic and preventive services across the state. Collaborative efforts to advance preconception health through training to all local MCH Programs has been spotlighted by the [\*Reproductive Health National Training Center\*](#) funded by the Office of Population Affairs and the Office on Women's Health in the DHHS Office of the Assistant Secretary for Health.

### *Maternal , Infant, and Early Childhood Home Visiting (MIECHV) Program*

MCH works closely with MIECHV (which offers services in six Kansas counties with high rates of poverty, unemployment, child abuse, and intimate partner violence) to ensure families have access to trained family support professionals to provide in-home services to help families build skills and resilience and to connect them to appropriate resources in the community. Representatives across all home visiting models in the state are part of Home Visiting Leadership Group, which is co-led by representatives from KDHE and the state board of education, which is working to ensure a “no wrong door” approach that connects families with the home visiting service best able to help meet their needs and expand utilization of all home visiting programs statewide. This included supporting a MIECHV readiness assessment to identify additional Kansas communities that could benefit from the presence of a MIECHV program.

### *Newborn Screening Programs*

MCH works closely with screening programs that reside in the Screening and Surveillance Section of the Bureau of Family Health (BFH), including the Newborn Hearing Screening Program and the Newborn Metabolic Screening Program. MCH has worked with these programs to ensure Kansas infants are screened for all recommended conditions (Kansas currently screens for 34 of 36 core disorders recommended by the federal advisory committee) and to ensure Kansas newborns are screened and, when appropriate, referred to appropriate services, including referral to the Special Health Care Needs Program. This referral process is a formalized process developed and assessed for improvement by both the MCH and newborn screening programs.

### *Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)*

MCH partners with WIC (which also resides in BFH) including work on support of breastfeeding (done in partnership with the Kansas Breastfeeding Coalition, which also involves Child Care Licensing, home visiting programs, and other key partners), evaluation of WIC services, WIC enrollment (mothers in the MCH-supported Becoming a Mom program were more likely than other mothers to enroll in WIC), Count the Kicks, and others.

### *Kansas Early Childhood Developmental Services (KECDS)*

KECDS is the federally funded IDEA Part C Program for Infants and Toddlers with Disabilities in Kansas, and MCH and other program partners have worked closely with KECDS in recent years to develop a more robust state system of developmental screening and to support children and families transitioning out of Part C on the child's third birthday. MCH has partnered with KECDS to launch the Bridges care coordination pilot program, wherein local Bridges Care Coordinators (BCC) meet with families, conduct a holistic assessment looking at medical, education, social, financial, and legal aspects, to determine a child and family's strengths and needs and develop and action plan to navigate the transition. MCH is continuing efforts with KECDS to move the program beyond its pilot stage towards statewide implementation.

## Other HRSA Programs

The MCH Program coordinates efforts with a diverse number of HRSA-funded programs managed within BFH and other bureaus in the state health agency.

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### Primary Health Care

MCH works very closely with the state's HRSA-funded Primary Care Association, the Community Care Network of Kansas and their member health centers to promote access to quality women's health services among HRSA-funded safety net clinics in the state. Several Federally Qualified Health Centers receive direct funding support from MCH through the Aid-to-Local grant process and a pediatrician representing Community Health Center of Southeast Kansas (serving the poorest county in Kansas and surrounding areas) sits on the Kansas MCH Council.



## Local MCH Programs

The MCH Program views local MCH grantees as an integral part of the MCH Program and allocates a significant portion of MCHB funding to these local programs through an Aid-to-Local grant process which funds 56 local programs.

## Other governmental agencies

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### Medicaid

An interagency agreement between MCH and Medicaid in Kansas was established in 2016 and outlines the formal partnership. The agreement was reviewed in 2019 and amended to further define access to data needed to conduct maternal mortality case reviews. The amendment resulted in direct access to data needed to conduct case reviews. MCH continues to build on activities and progress that have provided a strong foundation for the partnership, although leadership turnover in the MCH Program, BFH, and in Medicaid in recent years has been a barrier to development of the relationships needed to forge a strong partnership. Turnover challenges have persisted into 2024 with turnover in BFH leadership (the co-Bureau Director with oversight left the agency in the summer of 2024) and at Medicaid (the Medical Director resigned in early 2024). Another important aspect of the interagency agreement is collaboration between Medicaid, the state's Medicaid Managed Care Organizations (MCOs), and the Special Health Care Needs Program to ensure dually enrolled clients receive appropriate services and care coordination. MCOs share data including authorized Medicaid services on a monthly basis with the Special Health Care Needs Program Care Coordinator to the Coordinator and MCO staff can work together to address gaps and/or barriers to services.

A primary focus in 2025 will be the convening of a workgroup of leaders from BFH, including the Title V MCH Director, and the Medicaid program to develop a strategic plan for investments by both Title V and Medicaid to advance maternal and infant health in the state.

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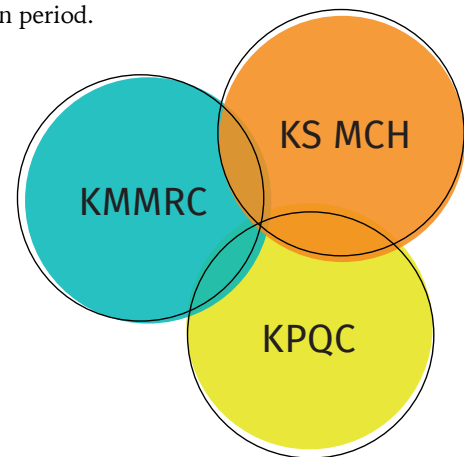
### Early Childhood Agencies

The MCH Program at KDHE is integrally involved in interagency efforts in Kansas who are committed to making Kansas the best place to raise a child. The MCH Program is housed in the Children and Families Section at KDHE, which is one of four state agencies represented on the the Kansas Children's Cabinet and State Directors Team, which also includes representation from the Kansas Department for Children and Families (the state child welfare agency), the Kansas State Department of Education, and the Kansas Children's Cabinet and Trust Fund. This Directors Team is formally recognized by the Kansas Governor and is funded with a Preschool Development Grant from the Administration for Children and Families. The Directors Team meets monthly to ensure coordinated efforts among agencies to enhance the lives of Kansas children. It supports efforts in the early childhood ecosystem of the state including prenatal and maternal support, child and maternal behavioral health, access to health care, home visiting, early intervention, and others. The 2024 All in For Kansas Kids Strategic Plan outlines a range of goals to enhance maternal and child health, including:

- ◆ Support of professional development opportunities to integrate evidence-based practices into services delivery with a focus on trauma-informed care, maternal and early childhood mental health, and special health care needs.
- ◆ Promotion of health development and screening within programs that serve expecting families and those with young children.
- ◆ Expand services for new parents during the postpartum transition period.

## Advisory Bodies

Several advisory groups/committees provide an opportunity for collaboration among a broad array of partners, representing public and private agencies to improve health among MCH populations in Kansas. The KMMRC, KPQC, and Kansas MCH program have worked in concert to improve maternal and perinatal health by leading efforts to invest in mothers' health to lead to better birth outcomes.




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### Kansas Maternal Mortality Review Committee (KMMRC)

Through the authority vested in KDHE through K.S.A. 65-177, KMMRC launched in 2018 as a result of an increasing trend of maternal and pregnancy-related deaths in Kansas. KMMRC gathers extensive information about individual cases of maternal death and synthesizes information to determine if the death was preventable, and what specific actions, if implemented, might have impacted the course of events. Supported by KDHE staff, including a number of MCH Program staff KMMRC has overseen the publication of a number of reports to identify statewide trends in maternal mortality and to provide recommendations to prevent mortality among mothers in Kansas. KMMRC conducts detailed Review of deaths to get complete and comprehensive data on pregnancy-associated deaths to prioritize efforts.

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### The Kansas Perinatal Quality Collaborative (KPQC)

KPQC was developed out of statewide recognition, in part due to MMRC reviews highlighting important mortality data, that the majority of deaths among Kansas mothers occurred between the time immediately after birth and the end of the child's first year. KPQC brought together a diverse group of partners, partnering with KDHE and the Kansas MCH Program, to establish and provide oversight for multiple maternal health quality initiatives. KPQC mobilizes state networks to implement evidence-based and data-drive quality improvement initiatives aimed at increasing safety and improving the health and well-being of mothers and infants.

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### Kansas Maternal and Child Health Council (KMCHC)

The KMCHC provides the vision and essential supports to monitor/assess and implement efforts to improve the health and well-being of mothers and infants.

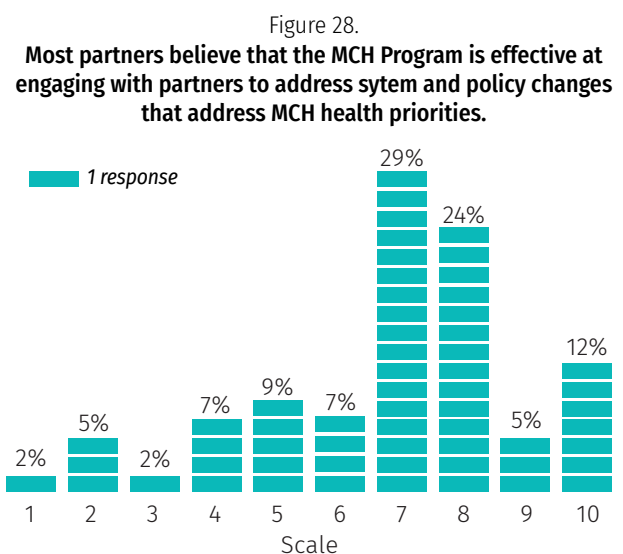
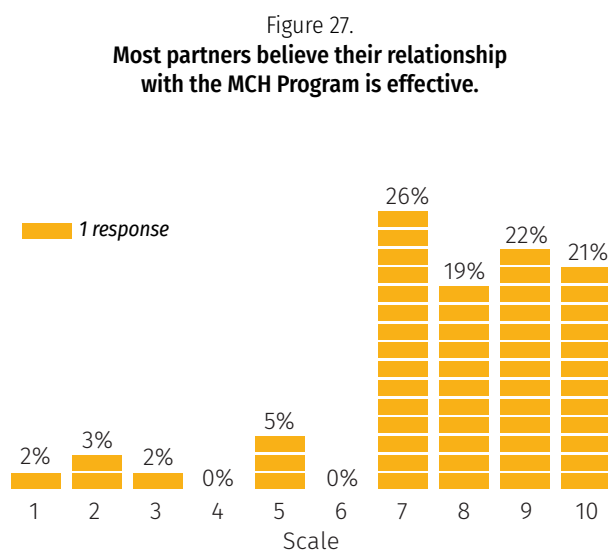
- ◆ Support KMMRC
- ◆ Fund Interventions
- ◆ Support KPQC
- ◆ Disseminate Messages

The KMCHC brings together many organizations in Kansas with a broad range of perspectives and expertise to advise the KDHE Secretary on ways to improve the health of Kansas families, focusing on the MCH population. Each year the Council submits an annual report summarizing their work and makes recommendations to the KDHE Secretary. Council members are appointed by the Title V MCH Director. In recent years, the Council has created a small group structure mirroring the primary MCH domains, with each group monitoring progress on the action plan for that domain, helping the MCH Program refine objectives and strategies, and providing the MCH Program and the KDHE Secretary recommendation to consider for implementation and improvements. The KMCHC has provide significant oversight in the development of the Five-Year MCH Needs Assessment, including a primary role in developing program priorities and outlining key strategic steps in the state action plan for the 2021-2015 Needs Assessment and State Action Plan.

## Effectiveness of Partnership Efforts

Turnover at KDHE, in the state MCH Program, and among local, Title-V funded MCH Programs in recent years has created challenges in developing and maintaining the partnerships that are a prerequisite for effective collaboration. Leadership at KDHE and the Kansas MCH Program have recognized that challenge and have worked to center their efforts around partnership. Those efforts have appeared to have had some success, as the MCH Partner Survey distributed to over 100 partners around the state (including members of the MCH Council and other councils, local MCH Program leadership, health departments, and other key partners identified by KDHE), provided positive feedback on MCH Program leadership.

When partners were asked to rate the effectiveness of their relationship with Kansas MCH Program, 88% of participants rated it 7 or higher on a 1 to 10 scale. Nearly half provided a score of 9 or 10 ([Figure 27](#)). When asked to rate the MCH Program's effectiveness in engaging partners to address system and policy changes related to MCH health priorities in Kansas, responses were also positive. Over two-thirds of respondents (70%) gave a rating of 7 or higher ([Figure 28](#)).



Effectiveness in collaboration and communication were also highlighted in open-ended responses in the Partner Survey. Some respondents noted that the program excels in collaboration and inclusion, effectively engaging various agencies—both large and small—in discussions about funding and program development, thereby fostering a collaborative environment. Respondents noted an increase in community partner engagement, particularly among those with lived experiences.

In terms of communication, respondents appreciated the program’s responsiveness to inquiries. Many highlighted the helpfulness and availability of MCH staff, who provide prompt replies to emails and calls, contributing to positive interactions. Effective communication channels, including regular updates via Govdelivery bulletins, have improved the flow of information regarding programs and initiatives, enhancing awareness among providers. The MCH Program is also praised for its problem-solving orientation, actively listening to concerns and collaborating to find solutions, which fosters a supportive atmosphere.

While these strengths were noted, increased engagement with community partners, particularly underrepresented communities, was advocated by survey respondents to better inform program development and practices. Respondents also called for clearer guidelines and consistency in messaging, alongside more transparency regarding funding and program changes. Navigating bureaucratic barriers was a common frustration, with recommendations for improved succession planning.

Survey findings suggesting the need for better engagement with underrepresented communities were also echoed in statements of some key informant interviews. One interviewee felt the structure and approach to advisory group itself was a problem, saying...

*“I think one of the major failures or issues right now is that they’ve developed a task force, and they’re bringing all of us to the table. And it seems useless. I don’t see any benefit in being at the table in this task force. It’s like you developed a task force. You’re leading it . . . And all you had to do was go to a community organization and say, ‘Hey, we want to develop a task force. And we want to truly address the maternal and child health issues, and we’d like for your organization to lead it because you’re already doing a lot of work in the community.’ And then the partnerships and collaborations that that grassroots organization has built, people are going to come to the table and they’re going to tell you the true problems, right? Not only that, you’re going to get your lived experience people, your community people that can tell you, ‘This is what our community needs, no matter what the data says. This is where the issue is. And if this issue is addressed, that will improve the data, right? That’ll improve our health.’ But they don’t do that. And so I don’t think that they’re trying to pivot. I think that it’s like, ‘We’re going to lead this work, and we want you at the table providing your expertise, and then we’re going to decide which direction the work goes in.’ A lot of that is like respecting the value of those that are truly on the ground doing the work and not having ownership of everything.”*

Effectively engaging representatives of underserved organizations is a core strategy for ensuring health equity lies at the heart of the MCH Program. In addition to recommendations below, other engagement strategies are available through the National MCH Workforce Development Center’s resource page on Equity and Engaging PWLE (National MCH Workforce Development Center, n.d.).



## Recommendations

### Outreach for Public Input

The MCH populations should develop proactive outreach efforts to populations who experience disparities to ensure they have the opportunity to provide input into guiding program documents such as the MCH Needs Assessment and State Action Plan and the MHC block grant application. The program should also consider mechanisms to involve those with lived experience in the decision-making processes that are used to create goals, objectives, and action plans that drive program and policy efforts.

### Council Representation

Mechanisms should be put in place to ensure representation of any councils, task forces, or other work groups closely represents that of the populations served by the program. Particular efforts should focus on minorities, youth, and non-traditional and grass roots organizations that work with underserved populations.

Efforts should be made to accommodate the needs of these representatives by developing meeting schedules that accommodate participants' schedules, providing adequate compensation for participation, and using technology to accommodate varying needs of participants. For example, a youth shared the following guidance for integrating special health care needs into group discussions: "Providing tablets for people so that they can read along by listening and having those audio screen reads or screen grabs for us, having Braille available, having a PCA who can help anybody that needs to be about to access things or may run into an issue what at a presentation."

### Task Force/Work Group Formation

The Title V MCH Program should seek opportunities to utilize community-based organizations for oversight and management of task forces or work groups, including responsibility for selection of participants, development and implementation of group processes, and development of recommendations. If management of the group must be under the purview of KDHE, an option would be to have subcommittee structures led by representatives of community-based groups.

### Leadership Development

Many representatives of marginalized populations will not be familiar with decision-making protocols and procedures of public health, and because of power balances may not be comfortable participating in policy and program discussions. The Title V MCH Program should consider developing or utilizing existing leadership programs to help better engage residents who may not have the skills and comfort to meaningfully engage and help representatives of underserved populations develop capacity as leaders.

# Family and Community Partnerships Findings



## Overview

The Kansas Title V Maternal and Child Health (MCH) Program prioritizes family and consumer engagement, using the National Family Support Network's Standards of Quality to guide efforts (National Family Support Network, 2016). These standards emphasize family-centered practices, diversity, equity, inclusion, community strengthening, and program evaluation. Key initiatives include the Family Advisory Council (FAC), which provides insights from lived experiences, supports resource development, and advises on strategic planning. FAC members receive advocacy training and leadership opportunities, though challenges remain in recruiting and retaining diverse members, particularly from minority racial and ethnic populations, rural areas, fathers, and youth/young adults. The Kansas Maternal and Child Health Council (KMCHC) also plays a role in advising the program and is aiming to increase family representation on its council of 49 members representing various organizations. A third group, the Family Leadership Team, was recently developed as part of the state's early childhood governance structure and involves families with lived experience as well as representatives of state agencies involved in early childhood education and care in the state. Kansas MCH is also pursuing the development of a Youth Advisory Council.



### Recommendations

Summary of Policy and Practice recommendations and considerations to further develop effective family and community partnerships to enhance MCH Program and policy efforts.

- ◆ Recruiting representatives from rural and ethnic minority populations, rural communities, and males and non-binary individuals to existing and future advisory bodies.
- ◆ Adequately and equitably compensating lived experience, treating these individuals in all respects like program consultants who bring valuable insight and information to the program.
- ◆ Promoting inclusion of diverse perspectives not only on MCH advisory bodies but also standing committees and task forces of other programs, bureaus, and agencies, whose work intersects and or impacts the MCH Program.
- ◆ Recruiting family leaders and other individuals with diverse backgrounds and perspectives to the MCH Program staff.
- ◆ Engage community representatives to play a meaningful and direct role in the development of public health messaging for the MCH Program.

# Advisory Committees

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## Family Advisory Council (FAC)

The primary body of family representatives that serves in an advisory capacity to the Kansas MCH Program is the FAC. The FAC serves to advise the Title V Program and the Secretary of KDHE on ways to improve the health of families, focusing on the MCH population. The FAC brings together family/consumer leaders with a broad range of lived experiences related to programming and supports. FAC members provide

- ◆ insight on personal and lived experiences
- ◆ advise on the best methods to reach and communicate with families
- ◆ inform engagement efforts across the MCH Program and the Bureau of Family Health (BFH)
- ◆ inform strategies and activities to address population needs
- ◆ consult with Title V Programs on the development of the annual MCH Block Grant Application Five-Year Needs Assessment.

The FAC and its workgroups support outreach efforts of the program and take on direct responsibility for program outreach, working to create a variety of resource maps, fact sheets, and resource documents to be used by Kansas families. FAC members are compensated for their time involved in council activities and for travel expenses associated with their involvement.

Professional development of family/consumer members is a core value of the Kansas MCH Program, and as part of FAC work members receive:

- ◆ a comprehensive new member orientation on the MCH Program and role of family/consumer members;
- ◆ advocacy training that includes education and training on legislative policy processes at the local, state, and national level;
- ◆ opportunities to serve in leadership roles in the FAC structure including work group leaders, FAC Executive Committee, and others;
- ◆ support to attend leadership conferences such as AMCHP, Family Voices, and the Family Support Network.



Until recently, the FAC was focused primarily on the efforts of the Special Health Care Needs program, but that has been expanded in recent years and now is comprised of five core work groups in each domain area (Women/Maternal, Early Childhood, Child, Adolescence, and CYSHCN) to represent the Title V populations served. Growth of the FAC is a positive development, but challenges remain in recruiting and retaining members to the FAC in its expanded capacity. The MCH Program seeks to maintain a diverse membership based on family experience, area of residence, age, racial/ethnic background, etc. both within workgroups and the council as a whole. This remains a challenge, with the majority of members representing the white majority, and a large percentage of members representing more eastern and more urban areas of the state. Representation from the state's more rural, western counties has been and remains a challenge. Other important populations not currently represented in the family advisory structure are youth/young adults and fathers. It is a program goal to recruit individuals representative of these populations in the next five-year cycle. Another goal is to reestablish a family liaison as one of the Kansas delegates to the Association of Maternal and Child Health Programs (AMCHP).

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## Kanas Maternal and Child Health Council

The Kansas Maternal and Child Health Council (KMCHC) also serves to advise the KDHE Secretary, BFH, and the MCH Program on ways to improve the health of families in Kansas, focusing on the MCH population. The Council brings together several organizations and groups in Kansas with a broad range of expertise, including many who have been working for years to address and improve health outcomes in Kansas and other states. KMCHC members are appointed by the Title V MCH Director. Its 49 members currently include representatives from:

- |   |  |
|---|--|
| ◆ Kansas Chapter American Academy of Pediatrics | ◆ Kansas SAFE KIDS                           |
| ◆ Kansas Department of Health and Environment   | ◆ Kansas School Nurse Organization           |
| ◆ Amerigroup Kansas, Inc.                       | ◆ KIDS Network of Kansas                     |
| ◆ Community Health Center of SE Kansas          | ◆ KU Medical Center                          |
| ◆ Family and parent representatives             | ◆ March of Dimes                             |
| ◆ Kansas Action for Children                    | ◆ MCH Coalition of Greater Kansas City       |
| ◆ Kansas Breastfeeding Coalition                | ◆ Mental Health Center - East Central Kansas |
| ◆ Kansas Child Death Review Board               | ◆ Private provider representatives           |
| ◆ Kansas Department for Aging and Disability    | ◆ Sedgwick County Health Department          |
| ◆ Kansas Head Start Association                 | ◆ University of Kansas                       |
| ◆ Kansas Health Institute                       | ◆ Wyandotte County Public Health Department  |

There are currently three representatives serving in the role of family/consumer member on KMCHC, but the goal is to have at least eight family member representatives.

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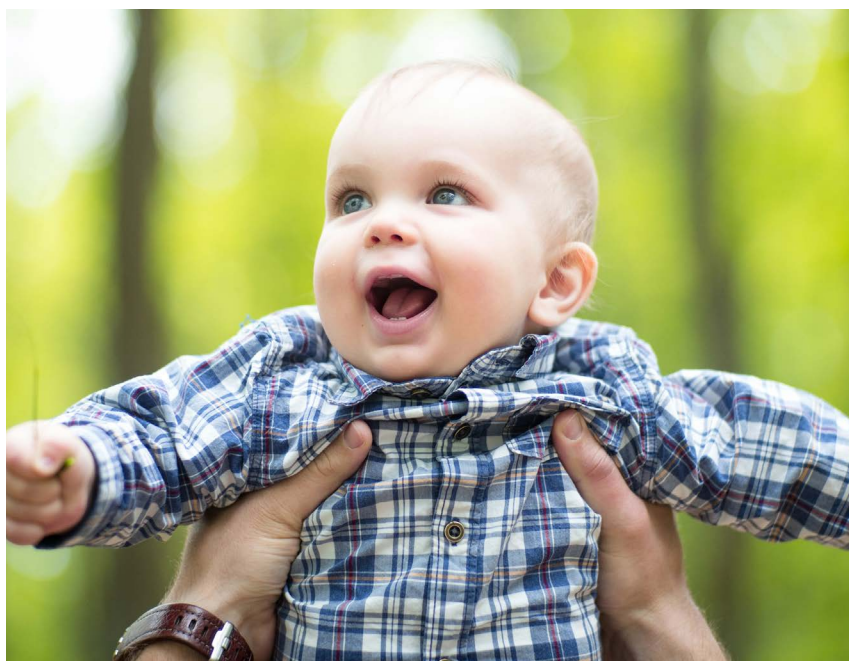
## Family Leadership Team

When Kansas was awarded Preschool Development Grant (PDG) funds in 2020 by the federal Administration for Children and Families, state leaders developed a formal early childhood governance structure. Recognizing the importance of maternal and child health in what Kansas calls the “early childhood ecosystem,” the FAC was formally recognized by state leaders as an advisory body in this governance structure, and a new Family Leadership Team, or FLT (with representation from families and the key state agencies involved in the early childhood system) was also created and included within the early childhood governance structure. The FLT was tasked to work in partnership with the FAC to establish a shared vision for family and consumer partnership across all involved agencies. In 2024, Kansas was one of 11 states awarded a PDG 3-Year Renewal Grant, so the FAC and FLT will continue to serve as key advisory bodies to state leaders as they work to strengthen early childhood education and care.

## Advisory Body Roles in Strategic and Program Planning

Both the FAC and KMCHC play an active role in strategic and program planning. At the initiation of the Five-Year Needs Assessment cycle, MCH staff and assessment coordinators from KU-CPPR met and consulted with both groups to discuss potential methodologies, gather input into key voices that should have input into assessment activities, and provide additional insight. Both groups have active working groups for all MCH population domains, and these workgroups routinely provide recommendations on programming to MCH staff and provide input into strategic direction.

The FAC is acknowledged across the state of Kansas for its active role in program planning, implementation and evaluation. As an example, the FAC were integrally engaged in development of the current MCH Needs Assessment published in 2021 and played a central role in the development of one of the Kansas MCH priorities highlighted in that assessment, “Strengths-based supports and services are available to promote healthy families and relationships.” It was FAC membership that led discussions to ensure families were recognized to be at the center of state priorities. The FAC played a central role in the recent development of the Engaging Families and Consumer in Program Planning, Implementation, and Evaluation Toolkit (Kansas Department of Health and Environment, 2022a). This toolkit has been recognized through the broader early childhood care and education system in Kansas and has been promoted through the state’s early childhood governance structure to help establish a shared vision for family and consumer partnership across all state agencies serving children and families.





## Recommendations

### Ensuring Diverse Representation on MCH Councils/Boards

It is critical that the Title V MCH Program recruit representation to family advisory groups that reflects the increasingly diverse demographics and experiences of the MCH population it serves. The MCH population in Kansas is far more diverse than the Kansas population at large, with about one in four clients identifying as Hispanic, so greater racial and ethnic diversity to existing advisory bodies should be a priority. There is little to no representation of males on the FAC and limited/no representation of individuals identifying as non-binary. During a focus group discussion with FAC members, current members noted the lack of diversity as an issue to be addressed.

The issue also came up during several interviews. Said one participant...

*"KDHE needs to recognize different types of knowledge and that knowledge is not always directly tied to a terminal degree . . . there should be acknowledgement that there are multiple types of valid knowledge because it makes it a lot more difficult to do this kind of work when you're constantly feeling like you have to prove yourself, like you have to prove why you are at the table in the first place."*

Another commented...

*"There is a shortcoming. And I think it is in the approach that KDHE has taken for years, which is funding only certain people, keeping the work in only certain pots, not freely releasing the raw data, and only inviting us to the table when they need information to get funding . . . . I think that the level of collaboration, the level of valuing those who are on the ground doing the work, is not there."*

Not only should recruiting efforts focus on this, but mechanisms must be put into place to break down barriers to both initial and ongoing participation, whether financial, geographic, or otherwise. Given significant differences in demographics of the MCH population around the state, the MCH Program may want to consider developing regional family advisory bodies. Such bodies would ensure diverse geographical perspective and could also be utilized to provide specific guidance to local programs that serve the areas that would be reflected in these bodies.

### Promoting Greater Family Representation on Councils/Boards that Influence MCH Program Decision-making

Greater family representation in key efforts that support MCH efforts such as the Maternal Mortality Review Committee, the development of standing advisory committees for Kansas PRAMS, and a task force or work group to guide the development of the Five-Year Needs Assessment would provide additional, meaningful opportunities for family representation in strategic and program planning. As is true with existing family advisory efforts, developing a mechanism to provide financial support through the MCH Program for family participation in these efforts is critical. The FAC has a formal reimbursement policy with ensures family/consumer participants receive consulting fees, travel reimbursement, and reimbursement of childcare cost for FAC meetings, but similar reimbursement is not available to support family/consumer involvement across other engagements.

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### Family Representation on the Title V MCH Program Staff

During the FAC focus group and in individual conversation with Kansas MCH Program staff, lack of diversity within the staff was noted. Efforts should be made to recruit individuals with diverse lived experience not only onto advisory groups, but within the ranks of Title V MCH Program staff as well.

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### Community Engagement and Co-Creation of Messaging

An area where community members and individuals with lived experience could play a valuable role is in the development of messaging and public information content. Content of public health messaging is often perceived as overly scientific, dense, and difficult to interpret by target audiences. Involving individuals with lived experience in the development of messages could increase their relevance and perceived trustworthiness. Engaging Kansas-specific community organizations and individuals with lived experience in message creation and dissemination efforts would help ensure that materials resonate with local values and address real-world challenges. Additional information on public health communication strategies can be found in [\*Appendix D. MCH Population Health and Well-Being Map Data.\*](#)

## Process and Methods



The approach to the *2025 Kansas Title V Needs Assessment* was designed to identify both strengths and needs of the program’s delivery system and the family health needs of Kansans. Overall direction for the *Kansas 2025 Title V Needs Assessment* was provided by the program staff at the Maternal and Child Health Bureau at KDHE, including input on the assessment process, identification of key populations for focus groups and individuals to participate in key informant interviews and group discussion, review of data, and the development of the final report and considerations. Coordination of the assessment was provided by the University of Kansas Center for Public Partnerships and Research (KU-CPPR), who was responsible for data collection, analysis, and synthesis.

A protocol outlining data collection processes for the Needs Assessment, and necessary supporting documentation, was submitted to the Human Research Protections Program at the University of Kansas for Institutional Review Board (IRB) approval. The study was approved by the IRB in April of 2024 (KU IRB ID STUDY00151350).

The Needs Assessment consisted of seven primary information gathering processes:

1. **Analysis of public health surveillance data**, including secondary quantitative data.
2. **Analysis of client records and services** provided by Title V-funded programs stored in DAISEY, an integrated data integration system used by KDHE.
3. **Surveys** with MCH Program staff, community partners, and individuals eligible for and/or receiving MCH services.
4. **Collection of qualitative data** through a series of key informant interviews and group discussions with Title V service providers, community partners, content experts, MCH clients, and other individuals with lived experience.
5. Two **Photovoice sessions** with youth groups.
6. Publicized **community engagement sessions** in each of the six KDHE public health regions.
7. **Review of MCH public health communication strategies** utilized in other states in order to gain insight into best and promising practices among those other jurisdictions.

In addition, Needs Assessment staff solicited input from MCH staff, other public health leaders, family leaders, and strategic advisors to the state MCH Program by participating in “listening sessions” at two statewide webinars hosted by KDHE (a “webinar Wednesday” and “KDHE fireside chat”), hosting a discussion about the MCH Needs Assessment process and conducting a focus group with the MCH Family Advisory Council, attending regional public health meetings in all six KDHE-recognized public health regions, presenting and gathering feedback at a quarterly meeting of the Kansas MCH Council meeting, and presenting and seeking feedback from participants at an All In For Kansas Kids Early Childhood System monthly seminar, a forum for discussion among providers and advocates working to develop a stronger system of early childhood education and care in the state facilitated on behalf of the Kansas Children’s Cabinet and Trust Fund.

## Family and Community Engagement

The Kansas MCH Program emphasized collaborative partnerships by engaging a diverse range of local and state participants in its Needs Assessment process. This included local public health agencies, healthcare providers, payors (including Medicaid Managed Care Organizations), statewide provider associations, clinicians, community-based advocacy and service organizations, representatives from other government agencies, and a diverse array of individuals and families, to ensure a comprehensive understanding of community health needs. Importantly, the inclusion of service providers working with underserved populations and with families and individuals with lived experiences—especially those from historically marginalized groups—captured insights on issues like food insecurity, housing instability, and the unique challenges faced by Indigenous communities, other people of color, and other underserved populations. This inclusive approach enabled the Kansas MCH Program to develop a Needs Assessment that reflected diverse perspectives from around the state, promote health equity, and gather valuable insight into desired program changes that participants envision would improve outcomes for, and address disparities among, women and children throughout the state. A list of data collection and engagement activities and the number of participants in each is provided in [Appendix B. Data Sources and Data Collection Instruments](#).



## Needs Assessment Framework

The collaboration between KU-CPPR and the MCH Program was essential for crafting a comprehensive Needs Assessment framework. This partnership aimed to ensure that the assessment would be reflective of community needs and aligned with the broader goals of the Bureau of Family Health (BFH) and KDHE.

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### Development of Guiding Questions

KU-CPPR lent expertise in public health research and community engagement to the process, working closely with MCH staff to identify the most pressing issues and gaps in service delivery. The process included reviewing existing data, engaging with diverse community stakeholders, and facilitating discussions to distill the core concerns and aspirations of the diverse array of MCH partners across the state. Through iterative consultations and feedback loops, the guiding questions were refined to ensure they were clear, actionable, and relevant.

#### The 5 Guiding Questions

1

*How will priorities be determined?*

This question focuses on establishing a transparent process for prioritizing health issues based on data and community input.

2

*How can we bring voices to the table that are usually not there?*

Emphasizing inclusivity, this question seeks strategies to ensure that marginalized and underrepresented communities are actively involved in the Needs Assessment process.

3

*How will gaps be filled, especially addressing health disparities?*

This question highlights the commitment to identify and address specific health disparities, ensuring equitable access to resources and services.

4

*How can the MCH Program aid local partners in fulfilling their mission?*

This reflects a collaborative approach, where the MCH Program can support local organizations in their efforts to improve health outcomes.

5

*How will planned efforts align with what is already offered by the BFH and KDHE?*

This question ensures that new initiatives are complementary to existing programs, fostering coherence and efficiency in public health strategies.

## Secondary Data Used

A wide array of secondary data sources were reviewed and integrated into the Needs Assessment when appropriate, including data from the Census, a diverse array of state and federal databases and reports, applications for Title V funding submitted to the state MCH Program by local agencies, a number of other studies and Needs Assessments performed for other public health programs, and an open-source “maternal vulnerability index” tool (Surgo Ventures) providing county-level scores based on 43 indicators associated with maternal health outcomes. Each of these sources is described in additional detail in the following paragraphs.

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### Population-Level Demographic Data

Demographic data were obtained from the U.S. Census and compiled by staff at KU-CPPR and the University of Kansas Institute for Policy and Social Research at to develop overall estimates of the current statewide MCH population. These data provided a foundational understanding of the population characteristics of MCH populations in Kansas and can be found later in the report and in [Appendix F.1. Population Demographics](#).

Many of these datasets provided data at the county level. For this report, county-level data were frequently aggregated by MCH region and by urban/rural classifications of counties. The MCH Program recognizes six regions across the state; [Appendix F.1. Population Demographics](#) provides a list of counties in each region. The urban/rural classification system used in this report is described in the state’s underserved areas report (Kansas Department of Health and Environment, 2023a). The data sources used for the population estimates include:

- ◆ Kansas Certified Population. Retrieved August 19, 2024 (Kansas Division of the Budget, 2024).
- ◆ County Population by Characteristics: 2020-2023 (Annual County and Puerto Rico Municipio Resident Population Estimates by Selected Age Groups and Sex: April 1, 2020, to July 1, 2023). Retrieved July 5, 2024 (US Census Bureau, 2024b).
- ◆ Demographic and Housing Estimates, ACS 5-Year Estimates Data Profile, Table DP05, 2022. Retrieved August 12, 2024 (US Census Bureau, 2024c).
- ◆ Selected Economic Characteristics. American Community Survey, ACS 5-Year Estimates Data Profiles, Table DP03, 2022. Retrieved August 12, 2024 (US Census Bureau, 2024e).
- ◆ Selected Social Characteristics in the United States, ACS 5-Year Estimates Data Profile, Table DP02, 2022. Retrieved August 12, 2024 (US Census Bureau, 2024f).

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## National Performance Measures, Outcome Measures, and Other Indicator Data

Extensive data on health indicators among MCH populations were compiled, analyzed, and aggregated by KDHE MCH epidemiologists and data analysts to assess the health status of these populations. Key health status data are highlighted in the section on MCH population health status, with additional detailed data tables located in [Appendix E. Performance and Outcome Measures](#). This population health data was compiled from multiple sources.

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## Maternal Vulnerability Index

The Maternal Vulnerability Index (MVI), developed by Surgo Ventures, is a data-driven tool designed to assess maternal health risks across U.S. counties. The MVI evaluates maternal vulnerability through six subscales that are summarized into an **Overall MVI score**. Each of these subscales captures critical factors affecting maternal health.

### MATERNAL VULNERABILITY SUBSCALES

#### Reproductive Healthcare Access

Measures proximity to and availability of maternal healthcare services.

#### Physical Health

Assesses overall maternal health and pre-existing conditions that may exacerbate pregnancy-related risks.

#### Mental Health

Examines the prevalence of conditions like postpartum depression and access to mental health care.

#### Socioeconomic Determinants

Evaluates factors like income, education, housing stability, and employment status.

#### Neighborhood Physical Environment

Considers environmental exposures, such as pollution, that can affect maternal and fetal health.

#### Health Behaviors

Focuses on lifestyle choices that may impact health outcomes, including substance use and smoking during pregnancy.

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## Reports

In addition to the secondary demographic data, a comprehensive review of data reports, recent evaluations, Needs Assessments, and strategic plans of relevant programs was conducted by KU-CPPR staff. Reviewed documents can be found in [Appendix B. Data Sources and Data Collection Instruments](#).

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## Local MCH Program Aid-to-Local Applications

Kansas utilizes an Aid-to-Local (ATL) grant process that allows community agencies and organizations, primarily local health departments and non-profit organizations such as Federally Qualified Health Centers (FQHCs), to apply for Title V funding for the provision of MCH services. Reviews of the State Fiscal Year (SFY) 2025 applications from Aid-to-Local applications provided insights into public health priorities in the areas served, identified disparities and gaps in services for specific local MCH populations, and highlighted current and proposed MCH Program priorities and activities. Information on organizational capacity, including staffing plans and budgets, was also reviewed in detail.

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## Primary Data Collection and Analysis

### Client-Level Data (DAISEY)

Kansas Title V-funded programs have been systematically archiving program and client data in the Data Application and Integration Solutions for the Early Years (DAISEY) system since 2015, with this study focused on data recorded from July 1, 2019, to June 30, 2024.

The DAISEY database includes comprehensive client demographic information such as birth date, gender, race, employment status, insurance, education, and income, alongside details of program visits. During each client visit, clinic staff document the services provided including direct services, education, screening, and referrals, allowing for detailed tracking of client interactions. The data from DAISEY enables the assessment of whether clients received specific services within a given year. By analyzing this data, service rates could be computed across various characteristics, including year, race, ethnicity, and county, providing valuable insights into service distribution and accessibility within the program.

Client demographics were analyzed both overall and by individual programs, including MCH, Pregnancy Maintenance Initiative (PMI), Becoming a Mom (BaM), and Teen Pregnancy Targeted Case Management (TPTCM). Service data was also examined separately for each program. Additionally, regional comparisons were conducted to identify any differences in the populations served and service rates across various regions.

### Client Demographics

After data cleaning, the assessment team examined changes in the number of unique clients served across counties, pinpointing those with the most notable increases or decreases. They also analyzed year-over-year percentage changes among various demographic segments, including race, gender, ethnicity, age group, education level, employment status, marital status, insurance coverage, English proficiency, and poverty level. This thorough analysis provided insights into the shifting demographics of clients within the Kansas Title V Program over time.



## Cluster Analysis

To identify distinct profiles within the Kansas Title V client population, a cluster analysis was conducted. Clustering is a method used to classify raw data and uncover hidden patterns within a dataset (Ikotun et al., 2023). The K-means algorithm, a partitioning technique that organizes clients into clusters based on the similarity of their characteristics, was employed. The attributes selected for this analysis included clients' age at enrollment, race, ethnicity, English proficiency, educational background, employment status, insurance coverage, and marital status. To ensure that each variable had an equal influence in the analysis, these characteristics were standardized into z-scores.

## Service Utilization

The assessment team calculated service rates by dividing the number of participants who received specific services by the total number of participants. These services included screening, testing, treatment, education, and referrals provided through the general MCH Program, the Pregnancy Maintenance Initiative (PMI), and Teen Pregnancy Targeted Case Management program. For the Becoming a Mom program, the assessment team evaluated participation rates for each session as well as overall completion rates. Additionally, the program conducted a completion survey to gather feedback from participants on the knowledge they gained from the classes and their overall experiences with the program. The assessment team analyzed survey responses related to program satisfaction, including participants' perceptions of support, whether the information was presented in an easily understandable way, and the value they attributed to the information.

## Title V Workforce Review

Data were collected on the size and composition of the MCH workforce funded through the Title V Program. In addition, a survey was developed and distributed to Title V-funded staff through MCH Programs across the state to collect demographic information as well as information on their knowledge of client needs, perceived challenges in meeting client needs, their perceived caseload and capacity, their level of engagement in their work, their sense of meaning in their work, their sense of accomplishment, their perceptions regarding agency turnover, and their personal job satisfaction.



## MCH Workforce Data

Data on staffing of MCH Programs (local and state) were collected through various means. For local programs, staffing information was initially retrieved from Aid-to-Local (ATL) applications for Title V funding for State Fiscal Year 2025 submitted by local programs to the state. This information (name, position, full-time equivalency (FTE) information, including the level of MCH grant funding covering the position salary) was included in a table for each program. This table was sent to MCH Program directors to verify currency and accuracy. Responses were received from 34 programs. For those programs not responding, information from ATL applications was reconciled with ATL information for SFY 2024 collected by KDHE.

For analysis, each position was characterized by a primary position type, including:

- ◆ Administrative Support
- ◆ Agency Administration
- ◆ Agency Manager/Supervisor
- ◆ Breastfeeding Educator/Peer Counselor
- ◆ Case Manager/Care Coordinator/Community Health Worker/Navigator
- ◆ Children and Youth with Special Health Care Needs Staff
- ◆ Dietitian/Nutritionist
- ◆ Home Visitor
- ◆ Interpreter/Translator
- ◆ MCH Program Director/Supervisor
- ◆ Nurse Clinician
- ◆ Other
- ◆ Physician/Medical Director
- ◆ Social Work/Counselor
- ◆ State MCH Program Staff

The total number of MCH positions and total FTEs were calculated, as well as the percentage of FTE funding from Title V funding and from other sources.

### *MCH Workforce Survey*

In 2022, CPPR developed a survey distributed to all local MCH Program coordinators to share with all Title V-funded staff. The purpose was to collect detailed demographic data and information on perceived challenges in meeting client needs, workload, level of engagement in their work, and their sense of meaning and accomplishment in their work. To incentive participation, CPPR made each respondent eligible for a drawing to receive one of 250 \$100 pre-paid gift cards. 187 MCH staff responded to the survey during November and December 2022. Survey results were initially included in an unpublished 2023 interim Needs Assessment for the Kansas MCH Program.

### Survey of MCH Clients/Populations

A survey was distributed statewide in October and November of 2022. A link to the online survey was shared on social media and was distributed through MCH Programs and MCH partner organizations. The survey's target populations included clients of Title V-funded programs and potential clients. 600 respondents completed the survey. The survey included Likert scale-based questions about accessibility, convenience, respectfulness, and value of MCH services received. There was also an opportunity to provide open-ended comments related to MCH services they had received.



### Survey of MCH Program Staff and Community Partners

An online survey was distributed to 85 MCH Programs and partnering community organizations between late June and early August 2024, resulting in 92 completed responses. Respondents were from a variety of organizations, including Title V MCH grantees (n=47), other local health departments (n=9), Kansas MCH Council members (n=5), and KDHE staff (n=6). There was also participation from a small number of higher education representatives (2), statewide associations (4), healthcare organizations (1), Managed Care Organization (1), and the Family Advisory Council (1). The survey asked questions related to the perceived effectiveness of the Kansas MCH Program's relationships and their ability



to effect system and policy change, perceived progress on the objectives in the Kansas MCH State Action Plan, and opportunities to impact the health of MCH populations in the state.

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## Interviews and Focus Groups

The maternal and child health Needs Assessment was designed to maximize community input and ensure that often-underrepresented voices were heard. Through focus groups and individual interviews, the process engaged marginalized communities, including those facing socioeconomic challenges, individuals of racial and ethnic minority identities, and residents of rural areas in Kansas. This inclusive approach revealed gaps in services and systemic barriers by centering the experiences of those most impacted by maternal and child health issues.

Focus groups allowed for group discussions where participants shared community-driven insights on issues affecting health, healthcare access, and health services. Participants in focus groups included the KDHE Family Advisory Council (N=18), Young Adults (N=3), and Youth (N=8). Individual interviews (N=27) complemented this by offering confidential spaces for community partners, policymakers, program staff, advocates, and service providers to share their experiences. The focus groups with the Family Advisory Council and youth were conducted in-person; all other interviews and the Young Adult focus group were conducted over Zoom.

All sessions were audio-recorded and/or video-recorded with participants' consent, to ensure accuracy during transcription. The recordings were transcribed verbatim, and were then anonymized, removing any identifying information to protect participants' privacy. After transcription, the data were imported into MAXQDA, a qualitative analysis software program (MAXQDA, 2024). A systematic coding process was employed, using both deductive and inductive approaches to categorize themes and patterns. The initial coding framework was developed based on key topics from the interview guide, while additional codes emerged from the data itself through iterative analysis. This coding process helped identify trends in community needs and highlighted gaps in maternal and child health services, forming the basis for actionable recommendations.

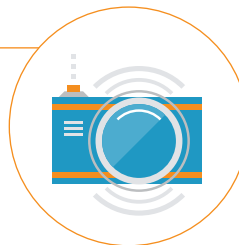


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## Photovoice

Photovoice is a participatory research method where individuals use photography to capture and express their experiences, perspectives, and challenges on specific social issues (Wang & Burris, 1997). For this Needs Assessment, two groups of high school students from rural Kansas engaged in a Photovoice activity during spring and summer 2024. The schools, located in Barton County (South Central public health region) and Wilson County (Southeast region), involved eleven students between 14 and 18 years old. With parental consent and student assent, the students worked under the guidance of KU-CPPR staff and a teacher at each school who helped facilitate the activity.

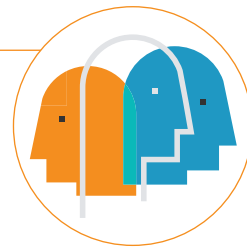
After an initial training session covering photography techniques and ethical considerations, the students set out to photograph elements of their communities that they felt impacted their health or the well-being of others. Once they collected their photos, the students met to share and discuss their work, leading to thoughtful conversations about shared concerns. Together, they identified themes that reflect their communities' challenges and strengths, aiming to use their insights to shape policy, increase awareness, and encourage local action.



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## Community Engagement Sessions

In May and June of 2024, CPPR held six community engagement sessions across the state, one session in each of the six designated public health regions, to gather input on health issues affecting women, infants, and children in Kansas. Sessions took place in Garden City, Hays, Kansas City, Pittsburg, Salina, and Wichita.



### *Event Format and Promotion*

Each session involved a two-hour “come and go” format and was held in a public library to take advantage of public “foot traffic.” Promotion for the events was conducted through local MCH Programs, CPPR communications (including social media and outreach to community partners), and host sites. MCH staff and partners from each region were invited to attend.

Upon arrival, participants were asked to review an Information Statement explaining the event’s purpose, confidentiality protocols, and voluntary participation. Attendees provided demographic details, including county of residence, gender, age, race/ethnicity, language, education level, and family income. They were also asked for consent to be photographed, with a written consent form required for those who agreed.

### *Interactive Stations*

Each session featured a series of interactive stations designed to engage participants and gather input. These included:

#### *Issue Prioritization*

This station displayed posters with current state-level statistics on various National Performance Measures (NPMs) and National Outcome Measures (NOMs). The focus was on measures where outcomes had worsened or where disparities existed in certain populations in the state.

Participants were asked two key questions:

- ◆ **Question 1:** Prioritize among adolescent suicide, disparities in pregnancy-related deaths, and maternal behavioral health.
- ◆ **Question 2:** Prioritize access to prenatal care, developmental screening in early childhood, and insurance coverage for youth.

Attendees were asked, for each question, to mark which issue they felt most needed to be prioritized to most effectively address MCH health needs. They also had the option to write an alternate response to those offered.

#### *Budget Allocation*

Participants were given ten “bills” (play money) to allocate across eight priority health topics. These topics had been highlighted by local MCH Programs and through discussions with state MCH staff, and included Child Care, Children’s Health, Addressing Health Equity, Healthy Food, Mental Health, Physical Activity, Substance Use, and Women’s Healthcare. Participants could allocate their funds as they saw fit—either spending all on one topic or distributing them across multiple topics.

### *Open-Ended Questions (Bright Spots, Barriers, Ideas)*

Participants were invited to share what they viewed as positive (“bright spots”) for women’s and children’s health in Kansas, as well as barriers to achieving optimal health outcomes. They were also encouraged to offer ideas on improving the health of women and children in the state. There were three boards for each “prompt” where participants were able to place sticky notes with their open-ended comments.

### *Sensemaking*

Sensemaking methods are approaches that emphasize understanding and interpreting complex social phenomena through qualitative data collection and analysis. These methods focus on how individuals and groups construct meaning from their experiences within specific contexts. In this exercise, participants were asked to reflect on and provide feedback regarding their perceptions of the need for social support services within their community, and comparatively in their community, if needs were greatest for:

- ◆ More services and programs
- ◆ Cheaper/free services and programs
- ◆ Accessible services and programs (hours, staffing, accommodations)

A second question asked about the degree to which services were provided compassionately in their community.

## **Public Health Communication Review**

The review employed an environmental scan to systematically gather, analyze, and interpret literature on public health communication and dissemination. Environmental scanning is especially relevant for informing decision-making and strategic planning in the healthcare sector (Charlton et al., 2019). The reviewers collected 12 sources from various venues, including academic databases and organizational websites, covering public health communication and dissemination activities that were impactful in the U.S. and abroad ([Appendix A. MCH Demographics Comparison](#)). Keyword searches included terms like “public health,” “dissemination,” “communication,” “strategies,” “frameworks,” “evidence-based,” and “best practices.” The review focused on literature from the past 10 years, chosen for relevance and currency.

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# Appendix A. MCH Demographics Comparison

## Comparison of MCH client population to state population and MCH workforce.

Table A1. Gender Comparison Between Kansas Title V Adult Clients, Kansas Population, and Title V Workforce\*

Gender (P value = <.001)	Kansas Title V clients N=33,122	Kansas population female 18 to 65 N=896,808	Title V workforce n=474
Female	98%	100%	98.30%
Male	1.4%	0%	0.60%
Prefer not to say	0.2%	0%	1.10%

Table A2. Race Comparison Between Kansas Title V Adult Clients, Kansas Population, and Title V Workforce

Race (P value = <.001)	Kansas Title V clients N=33,122	Kansas population female 18 to 65. N=896,808	Title V workforce n=474
Black or African American	9.1%	5.5%	4.0%
American Indian or Alaska Native	0.7%	0.7%	0.4%
Asian	1.5%	3.6%	1.1%
Multiracial	2.6%	6.9%	1.9%
Native Hawaiian or Other Pacific Islander	0.5%	0.1%	0.0%
Other	n/a	3.4%	5.9%
White	79%	79.7%	86.7%
Unknown/Not reported	6.4%	n/a	n/a

Table A3. Ethnicity Comparison Between Kansas Title V Adult Clients, Kansas Population, and Title V Workforce

Ethnicity (P value = <.001)	Kansas Title V clients N=33,122	Kansas population female 18 to 65. N=896,808	Title V workforce n=474
Hispanic	36%	13.4%	12.6%
Non-Hispanic	64%	86.6%	87.4%

Table A4. Language Comparison Between Kansas Title V Adult Clients, Kansas Population, and Title V Workforce

Language (P value = <.001)	Kansas Title V clients N=33,122	Kansas population female 18 to 65. N=896,808	Title V workforce n=474
Spanish as primary language or speaks Spanish	17% <sup>a</sup>	n/a	12.3% <sup>b</sup>

<sup>a</sup> Report Spanish as their primary language. <sup>b</sup> Report they speak Spanish

Table A5. Poverty Comparison Between Kansas Title V Adult Clients, Kansas Population, and Title V Workforce

Poverty (P value = <.001)	Kansas Title V clients N=33,122	Kansas population female 18 to 65 N=896,808	Title V workforce n=474
Below poverty line	69%	12.2%	n/a
Uninsured	37%	10.9%	n/a

\*Sources: Kansas Title V client data: DAISEY. Kansas population data: US Census Bureau ACS 5-year 2018-2022. Workforce data: ATL applications and local program communications.

# Appendix B.

## Data Sources and Data Collection Instruments

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A wide array of secondary data sources and reports were used to provide quantitative data used in this Needs Assessment. Listed below are population health data sources and other data reports and documentation reviewed as part of this effort.

- ◆ Health Resources and Services Administration (HRSA), National Survey of Children’s Health (Health Resources and Services Administration, 2024b)
- ◆ Kansas Department of Health and Environment (KDHE), Kansas birth data (resident)
- ◆ Centers for Disease Control and Prevention (CDC), National Immunization Surveys (Centers for Disease Control and Prevention, 2024d)
- ◆ Kansas Department of Health and Environment (KDHE), Kansas hospital discharge data (resident)
- ◆ US Census Bureau, American Community Survey (2024a)
- ◆ Kansas Department of Health and Environment, Youth Risk Behavior Surveillance System (Kansas Department of Health and Environment, 2023f)
- ◆ Kansas Department of Health and Environment (KDHE), Kansas Pregnancy Risk Assessment Monitoring System (Kansas Department of Health and Environment, n.d.-d)
- ◆ Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System (Centers for Disease Control and Prevention, 2024c)
- ◆ Kansas Department of Health and Environment (KDHE), Kansas death data (resident)
- ◆ Centers for Medicare & Medicaid Services (CMS) Hospital Compare
- ◆ Kansas Department of Health and Environment (KDHE), Kansas linked birth and infant death data (resident)
- ◆ National Vital Statistics System (Centers for Disease Control and Prevention, 2024e)
- ◆ American Public Health Laboratories
- ◆ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) (US Department of Agriculture, 2025)
- ◆ Kansas Department of Health and Environment (KDHE), Kansas fetal death data (resident)
- ◆ Kansas Department of Health and Environment (KDHE), Kansas Maternal & Child Health Sponsored Workforce Post-Event Surveys: Data available for 2022 Q4 onward only.
- ◆ Health Resources and Services Administration (HRSA). Federally Available Data (FAD). (Health Resources and Services Administration, 2025)
- ◆ Life Course Indicators Online Tool of the Association of Maternal and Child Health Programs (Association of Maternal & Child Health Programs, 2024)
- ◆ Healthy People 2030. Leading Health Indicators and Objectives. (DHHS Office of Disease Prevention and Health Promotion, n.d.-b)

## Other data reports and documentation reviewed

A comprehensive review of data reports, recent evaluations, Needs Assessments, and strategic plans of relevant programs was conducted by KU-CPPR staff which included:

- ◆ 2024 Kansas Early Childhood Needs Assessment (Kansas Children’s Cabinet and Trust Fund, 2024a)
- ◆ 2024 March of Dimes Report Card Kansas (March of Dimes, 2024)
- ◆ Access to Obstetrical Care in Kansas (Weis & Alsup, 2025)
- ◆ ALICE in Kansas: A Study of Financial Hardship in Kansas (United Way, 2023)
- ◆ All In for Kansas Kids 2024 Early Childhood Strategic Plan (Kansas Children’s Cabinet and Trust Fund, 2024b)
- ◆ Domestic Violence, Stalking, and Sexual Assault in Kansas (Kansas Bureau of Investigation, 2022)
- ◆ Kansas Annual Summary of Vital Statistics 2022 (Kansas Department of Health and Environment, 2023b)
- ◆ Kansas FY2025 Title V MCH Block Grant Program application (Kansas Department of Health and Environment, 2024b)
- ◆ Kansas Maternal Mortality Report 2016-2020 (Kansas Department of Health and Environment, 2023d)
- ◆ Kansas MIECHV Expansion Community Readiness Assessment Final Report (Biggs & Rowe, 2023)
- ◆ Kansas Primary Care Needs Assessment 2021 (Kansas Department of Health and Environment, 2021c)
- ◆ Kansas Home Visiting Alignment Progress Report (Rowe, 2023)
- ◆ Kansas 2024 Title X Needs Assessment (von Esenwein et al., 2024)
- ◆ Kansas Pregnancy Risk Assessment Monitoring System (PRAMS) 2021 Surveillance Report (Kansas Department of Health and Environment, 2021b)
- ◆ Youth Risk Behavior Survey Data Summary & Trends Report, 2013-2023 (Centers for Disease Control and Prevention, 2024h)
- ◆ 2024 Annual Report (Kansas State Child Death Review Board, 2024)
- ◆ Kansas State Plan for Systems of Care for Children and Youth with Special Health Care Needs (Kansas Department of Health and Environment, 2018)
- ◆ Kansas Infant-Toddler Services (Part C) Needs Assessment (Tilden et al., 2019)
- ◆ Kansas Oral Health Plan 2022-2027 (Kansas Department of Health and Environment, 2022e)
- ◆ Kansas Injury Prevention Program (Kansas Department of Health and Environment, n.d.-b)
- ◆ Kansas Tobacco Control Strategic Plan 2021-2025 (Tobacco Free Kansas Coalition, 2021)
- ◆ Mid-Course Review for the 2022-2027 Kansas Cancer Plan (Kansas Department of Health and Environment, 2024d)
- ◆ Kansas Cancer Partnership (Kansas Cancer Partnership, 2018)
- ◆ Governor’s Substance Use Disorders Task Force Report (2018)
- ◆ Kansas Blue Ribbon Task Force on Bullying Final Report 2020 (Kansas State Department of Education, 2019)

- ◆ KSKidsMap Annual Report 2023-2024. University of Kansas School of Medicine-Wichita (Krogman, 2024)
- ◆ United to Transform, Kansas Fights Addiction Needs Assessment (Hron et al., in preparation)
- ◆ Maternal & Child Health, III.B. Overview of the State - Kansas (Health Resources and Services Administration, 2024a)

A wide array of methods were used to engage a variety of audiences and to collect qualitative data essential for the Needs Assessment. These efforts are summarized in the table below.

Table B.1. MCH Needs Assessment Engagement

Event	Audience	Date	Format	Attending
KDHE Webinar Wednesday	LHD leaders and staff	4/24/24	Town Hall	72
KDHE Family Advisory Council	Family members	4/27/24	Focus Group	18
KDHE Fireside Chat Zoom call	LHD leaders and staff	4/30/24	Town Hall	72
KDHE South Central Meeting - Hutchinson	LHD leaders and staff	4/4/24	Presentation	15
KDHE Northeast Regional Meeting - Topeka	LHD leaders and staff	4/10/24	Presentation	14
Kansas MCH Council	Representatives of key organizations	4/10/24	Presentation	38
KDHE Southwest Regional Meeting - Garden City	LHD leaders and staff	5/8/24	Presentation	10
KDHE Northwest Regional Meeting - Colby	LHD leaders and staff	5/9/24	Presentation	11
All in For Kansas Kids Early Childhood System Monthly Webinar	Public	6/12/24	Presentation	40
KDHE North Central Regional Meeting - Beloit (7/10/24)	LHD leaders and staff	7/10/24	Presentation	19
KDHE Southeast Regional Meeting - Chanute (7/10/24)	LHD leaders and staff	7/25/24	Presentation	17
Southwest Regional Community Engagement Session (Finney County Library)	Community Members	5/8/24	Community Engagement	10
Northwest Regional Community Engagement Session (Hays Public Library)	Community Members	5/10/24	Community Engagement	9
North Central Regional Community Engagement Session (Salina Public Library)	Community Members	5/30/24	Community Engagement	15
South Central Regional Community Engagement Session (Wichita Advanced Learning Library)	Community Members	5/31/24	Community Engagement	30
Northeast Regional Community Engagement Session (Kansas City Public Library)	Community Members	6/27/24	Community Engagement	28
Southeast Regional Community Engagement Session (Pittsburg Public Library)	Community Members	6/28/24	Community Engagement	18
Young Adult Focus Group	Young Adults 18 to 25 years	6/21/24	Focus Group	3
Youth Focus Group (Young Women on the Move)	Adolescents 12 to 18 years	8/15/24	Focus Group	8
Photovoice Groups 1 and 2	Adolescents 14 to 18 years	April-August 2024	Photovoice	11
Interviews	Content experts, community partners, family members and other people with lived experience, providers etc.	March -September 2024	Interview	27

**Total 485**

The data collection instruments used in the assessment (focus group guides, interview protocols, surveys, community engagement session/open house methods, photo project guidance) are all included below.

## Community Member (Adolescent) Focus Group Guide

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### Purpose of the Focus Group

The University of Kansas Center for Public Partnerships and Research at is partnering with the Kansas Department of Health and Environment's Maternal and Child Health (MCH) Program to understand the needs for public health services for women, children, and young people in Kansas. The Maternal and Child Health program ensures that women get prenatal, delivery, and postpartum care, and that women, children and young people have access to preventive and primary health care services. We are interested in hearing about your health care needs and your experiences getting services, including barriers you've faced. We also want to hear what is working well in your community when it comes to health services delivery.

As was described on the consent form signed by your parent or guardian, your responses in this focus group will be treated confidentially, and you are free not to answer any questions you don't want to answer. While we cannot guarantee anonymity and confidentiality due to the nature of the focus group, we ask you to respect the confidentiality of everyone here and to not share what was discussed outside of this focus group. We are recording. Recordings from this session will be transcribed and any personal information removed. Results of our data collection will be combined and reported in a way that does not identify you. Your information will be used anonymously in our report to the state MCH Program and for possible future research projects.

Again, your participation is voluntary, and you can ask us to stop recording the session at any time and stop taking part in the focus group discussion.

**Incentive:** Participants who complete this focus group will receive a \$25 gift card. You have to be active in the discussion for us to consider you as a participant. You can participate by talking on or off camera and/or using the chat function.

**Consent:** Do we have your assent to participate in this recorded focus group? (Moderator: allow time for responses).

## Introduction/Warmup

First, let's briefly introduce ourselves, using a "one minute biography." In one minute or less, tell us important or interesting facts about yourself: your first name, what you do, or whatever you would like to share about yourself and/or your community.

## Needs for Services

1. How would you describe the overall health of adolescent youth in your community?

**Probes:** What are some health problems you believe affect adolescents and young adults in your community? How long has this problem/these issues been around for? How would you describe the change over time? What are your thoughts about this change? How urgent would you say these problems are for teens and young adults? How urgent do you think it is to address this need in the near future?

2. Can you share what services or programs exist in your community to address this issue?

What about medical services? Preventive services like immunizations? Services/programs to help keep you healthy, such as access to healthy food? Physical activity? Mental health services? Health departments (MCH Program)?

**Probes:** Can you describe who runs these services or programs? How would you describe what these programs or services do? What do you think is currently missing in your community to address healthcare needs of teens and young adults in your community?

**Probes:** What can you imagine could be there that addresses this need? What problems do you foresee if this gap is not addressed soon?

3. What are your thoughts about how these programs and services are working?

**Probes:** How well would you say these programs are working? What is working about them? What could be improved or changes? Who is benefiting from the program? Who are they not working for? What would it take to make them work better or for more people?

## Barriers

4. Tell me about what it's like to get healthcare for you?

**Prompts:** What are your options about where to go? What makes it difficult? What helps? What could be in place to make it easier or more comfortable for you? Transportation barriers, Language/Translation services, Shortage of providers, Childcare availability, Discrimination or lack of sensitivity to differences? Ethnic/racial? Income? Insurance? Religion? Knowledge about this health issue being important? Others?

## Mental health services

5. Tell me about your experiences with getting mental health services in your community? What about for substance use issues (tobacco, alcohol, drugs)?

**Prompts:** What are your options about where to go? What makes it difficult? What helps? What could be in place to make it easier? Transportation barriers, Language/Translation services, Shortage of providers, Childcare availability, Discrimination or lack of sensitivity to differences? Ethnic/racial? Income? Insurance? Religion? Knowledge about this health issue being important? Others?

6. Looking ten years into the future, what do you think the overall health of your community will look like?

**Prompts:** Why do you think that? What will change between now and then that will influence what the health of your community looks like?

Thanks so much for spending your time with me today and sharing all your ideas and experiences. This wraps up our discussion. Do you have any questions or anything extra you would like to share? [Note to Moderator: Allow sufficient time/pause for answers.] We appreciate your time and input. It has been extremely valuable. [Note to Moderator: Turn off audio recorder and provide information about incentives.]

# Community Member (Non-Provider) Focus Group Guide

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## Purpose of the Focus Group

The University of Kansas Center for Public Partnerships and Research is partnering with the Kansas Department of Health and Environment's Maternal and Child Health Program to understand the needs for public health services for women, children, and youth in Kansas. The Maternal and Child Health program helps ensure women have need prenatal, delivery, and postpartum care, and that women, children and youth have access to preventive and primary care services. We are interested in hearing about your health care needs and your experiences accessing services, including what it's like to get services.

As described in the consent form you signed prior to this focus group, your responses in this focus group are confidential, and you are free not to answer any questions you don't want to answer. Recordings from this session will be transcribed and any personal information removed. Results of our data collection will be combined and reported in a way that will not enable you to be identified. You can ask us to stop recording the session at any time and stop being part of the focus group discussion.

**Incentive:** Participants who participate in the entirety of the focus group will receive a \$25 gift card

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## Introduction/Warmup

First, let's briefly introduce ourselves, using a "one minute biography." In one minute or less, tell us the important or interesting facts about yourself: your first name, occupation, or whatever you would like to share about yourself and/or your community.

---

## Needs for Services

1. What are some health problems you believe affect children, mothers, and families in your community?
2. Are there any programs currently in place to address this need?

**Prompts:** Public health? Health care services like clinics? Programs to encourage healthy eating, active living? Health education?

3. Is this a need to improve existing program(s) or for entirely new program(s)?
  - a. If an improvement, what do you think needs to be changed/improved/enhanced about this program?
  - b. If not already existing, what do you envision a program looking like to address this need?
  - c. How urgent do you think it is to address this need in the near future?
  - d. What problems do you foresee if this gap is not addressed in the near future?
  - e. Are there particular groups that you believe have specifically significant barriers receiving the health care they need? What groups do you think experience barriers?

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## Barriers

4. What are some of the things that make it difficult for women, children, and families to get the health-care or services they need?

**Prompts:** Transportation barriers, Language/Translation services, Shortage of providers, Childcare availability, Discrimination or lack of sensitivity to differences? Ethnic/racial? Income? Insurance? Religion? Knowledge about this health issue being important? Others?

5. Tell me about a time when you had difficulties getting services you needed for yourself or your family.

**Prompts:** What made it difficult? What helped? What would you wish had happened instead? What could have been in place to make it easier?

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## Bright spots/facilitators

6. What are some of the things that help women, children, and families get the healthcare or services they need?

**Prompts:** Transportation barriers, Language/Translation services, Shortage of providers, Childcare availability, Discrimination or lack of sensitivity to differences? Ethnic/racial? Income? Insurance? Religion? Knowledge about this health issue being important? Others?

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## Mental health services

7. What are some of the things that make it difficult for women, children, and families to get mental health services they need in your community? What about for substance use issues (tobacco, alcohol, drugs)?

**Prompts:** Transportation barriers, Language/Translation services, Shortage of providers, Income/Insurance, Stigma?

8. What are some of the bright spots when it comes to mental health care?

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## Domain-specific questions

*[Note to moderator: What follows are sets of questions specific to the “domains” federally defined for the Title V Program. Please ask only those questions (9-10 for women’s health, 11-12 for infant health, 13-14 for child health, 15-16 for adolescent health, and 17-18 for children with special health care needs) that are applicable to the given focus group participant group.]*

9. For women’s health care, where do you see the biggest gaps in your community?

**Prompts:** Prenatal care, Delivery, Postpartum care, mental and behavioral health services?

10. For women’s care, what are the greatest bright spots? Things that are going well?

11. For infant health preventive and health care services, where do you see the biggest gaps?

**Prompts:** pediatric care? Safe sleep? Breastfeeding?

12. Infant: Greatest bright spots? Things that are going well?

13. For child preventive and health services, where do you see the biggest gaps?

**Prompts:** Pediatric care? Preventive care (immunizations)? Food programs? Physical activity?  
Mental health?

14. Child: Greatest bright spots?

15. For adolescent preventive and health services, where do you see the biggest gaps?

16. Adolescents: Greatest bright spots?

**Prompts/Follow-up:** Access to medical care? Mental Health? Substance abuse? Bullying?

17. For children with special health care needs, where do you see the biggest gaps?

18. Greatest bright spots?

**Prompts/Follow-up:** Care coordination? Specialty services?

19. Is there anything about health care services for women and children that you wanted to talk about that we didn’t cover in our discussion? What is it important for the state MCH Program to know as they implement policies and programs?

Thanks so much for spending your time with me today and sharing all your ideas and experiences. This wraps up our discussion. Do you have any questions or anything extra you would like to share? [Note to Moderator: Allow sufficient time/pause for answers.]

We appreciate your time and input. It has been extremely valuable. [Note to Moderator: Turn off audio recorder and provide information about incentives.]

# Title V/MCH Key Informant Interview Protocol

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## Purpose of the Interview

The University of Kansas Center for Public Partnerships and Research is partnering with the Kansas Department of Health and Environment's Maternal and Child Health Program to understand the needs for public health services for women, children, and youth in Kansas. The Maternal and Child Health program helps ensure women have need prenatal, delivery, and postpartum care, and that women, children and youth have access to preventive and primary care services. There is a special focus on low-income populations and children and youth with special health care needs and their families, but MCH services are available to any Kansan. We are interested in hearing about your perceptions of the greatest need of MCH populations, barriers to service provision to MCH populations, and what is working well in communities around the state to enhance the health of women, infants, children, and youth.

As was described in the consent form you signed prior to this interview, your responses are confidential, and you are free not to answer any questions you don't want to answer. We will record this session. Recordings from this session will be transcribed and any personal information removed. Results of our data collection will be synthesized and reported in a way that will not enable you to be identified. You can ask us to stop recording the session at any time and discontinue your participation in the focus group discussion.

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## Questions

1. Tell me about your professional role and how you interact with the system of care for MCH populations in the state.
2. In which of the MCH population domains does your organization have a focus area:

a. Women/Maternal Health	yes	no
b. Men's Health/Fatherhood	yes	no
c. Perinatal/Infant Health	yes	no
d. Child Health	yes	no
e. Adolescent Health	yes	no
f. Children with Special Health Care Needs	yes	no

*Note to moderator: adjust questions based on answers to a-e above. For example, skip questions #4-#5 if they don't work with women's/maternal health. Skip questions #6-#7 in they don't work with infant health, and so on.*

3. From your point of view as a (*moderator: insert self-identified role from Question #1*), how do you feel about the health status of women, infants, children, and youth in the state?
4. What do you see as the greatest health needs for women, infants, children, and youth in your service area or state as a whole?

**Prompts:** Mental health? Substance abuse? Tobacco? Obesity?

5. Across the spectrum of: [Moderator: choose categories consistent with the key informant's areas of expertise/experience based on Question #2 above]
  - a. Prenatal, delivery and postpartum care, what do you think is working well? What is not working well? What needs to change? What will happen if changes don't happen? Prompts: geographic availability of birthing services? Disparities in outcomes?
  - b. Maternal postpartum care, what do you think is working well? What is not working well? What needs to change? What will happen if changes don't happen? Prompts: primary care? Behavioral health? Disparities in outcomes?
  - c. Infant health services, where do you see the biggest gaps? Greatest bright spots? What needs to change? What will happen if changes don't happen? Prompts: breastfeeding? Safe sleep? Home visiting? Disparities in outcomes?
  - d. Pediatric health services, where do you see the biggest gaps? Greatest bright spots? What needs to change? What will happen if changes don't happen? Prompts: primary care access? Behavioral health? Disparities in outcomes?
  - e. Adolescent health services, where do you see the biggest gaps? Greatest bright spots? What needs to change? What will happen if changes don't happen?
  - f. Prompts: primary and preventive care? Behavioral health? School health? Disparities in outcomes?
  - g. Health services for children with specialty health care needs? Biggest gaps? Greatest bright spots? What needs to change? What will happen if changes don't happen?
  - h. Prompts: medical homes? Access to specialty services? Disparities in outcomes?
6. Specialized questions. Can you speak to barriers to care associated with:
  - a. Transportation barriers
  - b. Language barriers
  - c. Culturally sensitive care
  - d. Health care shortages
7. If there were no financial or other barriers, what changes would you make to address MCH health in Kansas?
 

**Probes:** What would MCH services look like in ten years? What services would be offered? How would staff or patients be treated?
8. Is there anything about health care services for women and children in our state that you wanted to talk about that we didn't cover in our discussion? What is it important for the state MCH Program to know as they implement policies and programs?

Thanks so much for spending your time with me today and sharing all your ideas and experiences. This wraps up our discussion. Do you have any questions or anything extra you would like to share? *[Note to Moderator: Allow sufficient time/pause for answers.]*

We appreciate your time and input. It has been extremely valuable. *[Note to Moderator: Turn off audio recorder and provide information about incentives.]*

# Title V/MCH Program (Provider) Town Hall Question Guide

This guide will be used at regional meetings of local MCH Programs hosted by the Kansas Department of Health and Environment. At those meetings we will be given time to ask questions of representatives of programs participating in the meeting. We will not gather any personal information about participants.

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## Purpose of the Focus Group

The University of Kansas Center for Public Partnerships and Research is partnering with the Kansas Department of Health and Environment's Maternal and Child Health Program to understand the needs for public health services for women, infants, children, and youth in Kansas. We are interested in hearing about your perceptions of the health care needs of MCH populations, and your experiences working to address the health care needs of these populations, as representatives of local programs providing care and services to the communities you serve. We are interested in understanding any barriers to service provision, and what is working well in your area when it comes to health services delivery.

During this town hall, we will treat your responses as confidential, and you are free not to answer any questions you don't want to answer. We will make a recording of the session. Recordings from this session will be transcribed and any personal information removed. Results of our data collection will be synthesized and reported in a way so that you will not enable you to be identified. You can ask us to stop recording the session at any time and discontinue your participation in this discussion.

**Consent:** Obtain verbal consent for participation and recording of the discussion.

---

## Questions

1. What do you feel are the greatest areas of need for women, infants, children, and adolescents in the communities you serve?
2. Across the spectrum of:
  - a. Women's/maternal care, what do you think is working well? What is not working well? What needs to change? What will happen if changes don't happen?  
**Prompts:** geographic availability of birthing services? Primary care? Behavioral health?
  - b. Infant health services, where do you see the biggest gaps? Greatest bright spots? What needs to change? What will happen if changes don't happen?  
**Prompts:** breastfeeding? Safe sleep? Home visiting?
  - c. Pediatric health services, where do you see the biggest gaps? Greatest bright spots? What needs to change? What will happen if changes don't happen? Prompts: primary care access? Behavioral health?
  - d. Adolescent health services, where do you see the biggest gaps? Greatest bright spots? What needs to change? What will happen if changes don't happen?

**Prompts:** primary and preventive care? Behavioral health? School health? Disparities in outcomes?

- e. Health services for children with specialty health care needs. Greatest bright spots? Biggest gaps? What needs to change? What will happen if changes don't happen? *Prompts: medical homes? Access to specialty services?*
  - 3. What disparities do you see/witness among the MCH populations you serve? Does anything need to change to address those disparities? If so, what?
  - 4. Specialized questions. Can you speak to barriers to care associated with:
    - a. Transportation
    - b. Language
    - c. Culturally sensitive care
    - d. Health care shortages
  - 5. If there were no financial or other barriers, what changes would you make to address MCH health in Kansas?
- Probes:** What would MCH services look like in ten years? What services would be offered? How would staff or patients be treated?
- 6. Can you please provide your perspective on the technical assistance and resources provided to local MCH Programs by the state health agency?
  - 7. Is there anything about health care services for women and children in our state that you wanted to talk about that we didn't cover in our discussion? What is it important for the state MCH Program to know as they implement policies and programs?

Thanks so much for spending your time with me today and sharing all your ideas and experiences. This wraps up our discussion. Do you have any questions or anything extra you would like to share? [Note to Moderator: Allow sufficient time/pause for answers.]

We appreciate your time and input. It has been extremely valuable. [Note to Moderator: Turn off audio recorder.]

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## Kansas Title V MCH Needs Assessment Survey

Q38 The Center for Public Partnerships and Research at the University of Kansas supports the practice of protection for human subjects participating in research. The following information is provided for you to decide whether you wish to participate in the present study. You may refuse to complete this survey and participate in this study. You should know even if you agree to participate, you are free to withdraw at any time. If you withdraw from this study, it will not affect your relationship with this unit, the services it may provide to you, or the University of Kansas.

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## Purpose of the Study

This study gathers information on provision of MCH services funded by Title V and services focused on MCH populations and the health needs of MCH populations around Kansas.

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## Procedures

You will be asked to complete a survey that should take no longer than 20 minutes to complete.

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## Risks

We do not anticipate any burdens, inconveniences, pain, discomforts, and risks associated with participation in the study.

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## Benefits

You may benefit by gaining satisfaction with sharing your perspectives and helping inform efforts of the Kansas Title V Program.

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## Payment to Participants

There is no payment for participation.

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## Participant Confidentiality

Your name and organization will not be associated with the research findings, although the survey asks for organizational affiliation to provide context related to your responses. Your identifiable information, including organizational affiliation, will not be shared unless you include any identifying information in any responses, you provide us with written permission, and/or it is required by law or university policy. The survey system will not retain any identifiable information including geolocation data, internet addresses or names. It is possible, however, with internet communications, that through intent or accident someone other than the intended recipient may see your response. If you would like additional information concerning this study before or after it is completed, please feel free to contact us by phone or mail.

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## Refusal to Consent and Authorization

You may refuse to complete this survey without affecting your right to any services you are receiving or may receive from the University of Kansas or to participate in any programs or events of the University of Kansas. However, if you refuse to sign, you cannot participate in this study.

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## Participation Certification

Completion of the survey indicates your willingness to take part in this study and that you are at least 18 years old. If you have any additional questions about your rights as a research participant, you may call (785) 864-7429 or write the Human Research Protection Program (HRPP), University of Kansas, 2385 Irving Hill Road, Lawrence, Kansas 66045-7563, email [irb@ku.edu](mailto:irb@ku.edu).

Q1 Please enter the name of your organization: \_\_\_\_\_

Q36 Please enter your position with the organization: \_\_\_\_\_

Q2 How many years have you been with the organization?

- ☐ Less than 1 year (1)
- ☐ 1 to 5 years (2)
- ☐ 6 to 10 years (3)
- ☐ More than 10 years (4)

## MCH Program Questions

Q3 On a scale of 1-10 (with 1 being not at all familiar and 10 being very familiar), how familiar are you with the Maternal and Child Health (MCH) Program at the Kansas Department of Health and Environment (KDHE)? \_\_\_\_\_

Q4 How frequently do you/your organization interact with Maternal and Child Health (MCH) Program staff at KDHE? (choose answer that best applies)

- ☐ Daily (1)
- ☐ Weekly (2)
- ☐ Monthly (3)
- ☐ Quarterly (4)
- ☐ Less frequent (than quarterly) (5)
- ☐ Never (6)

Q5 On a scale of 1-10 (with 1 being not at all effective and 10 being very effective), how effective is your relationship with Maternal and Child Health (MCH) Program staff at KDHE? You may indicate if this question is not applicable.

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Q6 On a scale of 1-10 (with 1 being not at all effective and 10 being very effective), how effective would you say the Maternal and Child Health (MCH) Program is at engaging partners to address system and policy changes that address MCH health priorities in Kansas? You may indicate if this question is not applicable. \_\_\_\_\_

Q7 Please share what you feel the MCH Program at KDHE is doing well. \_\_\_\_\_

\_\_\_\_\_

Q8 What are areas of improvement for the MCH Program you would like to see? \_\_\_\_\_

\_\_\_\_\_

### *MCH Program Objectives (2021-2025 State Action Plan)*

Q9 What follows are the objectives of the Kansas MCH 2021-2025 State Action Plan. For the last five years, please indicate how much progress (1 being very little, 5 being considerable) you believe Kansas has made on these objectives. You may indicate if this question is not applicable.

- ◆ Increase the proportion of women who receive an annual comprehensive medical visit/examination. \_\_\_\_\_
- ◆ Increase the proportion of women receiving education and screening about perinatal mood and anxiety disorders during pregnancy and the postpartum period. \_\_\_\_\_
- ◆ Increase the proportion of high-risk pregnant and postpartum women receiving prenatal education and support services through perinatal community collaboratives. \_\_\_\_\_

Q10 Please indicate level of progress (1 being very little, 5 being considerable).

You may indicate if this question is not applicable.

- ◆ Increase the proportion of women receiving pregnancy intention screening as part of preconception and inter-conception services. \_\_\_\_\_
- ◆ Increase the proportion of infants exclusively breastfed through 6 months of age. \_\_\_\_\_
- ◆ Reduce the rate of Sudden Unexpected Infant Death (SUID). \_\_\_\_\_

Q11 Please indicate level of progress (1 being very little, 5 being considerable).

You may indicate if this question is not applicable.

- ◆ Increase the proportion of pregnant and postpartum women receiving MCH Universal Home Visiting services. \_\_\_\_\_
- ◆ Increase the proportion of children from birth to kindergarten entry who receive a parent-completed developmental screening. \_\_\_\_\_
- ◆ Increase the proportion of children 1 through 11 years, who receive comprehensive annual wellness examinations. \_\_\_\_\_

Q12 Please indicate level of progress (1 being very little, 5 being considerable). You may indicate if this question is not applicable

- ◆ Increase the proportion of adolescents 12 through 17 years, who receive comprehensive annual wellness examinations. \_\_\_\_\_
- ◆ Increase the number of providers serving adolescents and young adults that screen, provide brief intervention, and refer to treatment for those at risk for behavioral health conditions. \_\_\_\_\_
- ◆ Increase the proportion of adolescents who actively participate, with their medical home provider, in developing a plan to transition into the adult health care system. \_\_\_\_\_
- ◆ Increase the proportion of families of children with special health care needs whose child receives care in a well-functioning system (a system where children are screened early and continuously for special needs; where parents are a true partner with clinicians in children's care; where children have a continuous, comprehensive, coordinated, compassionate, and culturally effective medical home, and where children's health care needs are adequately covered by health insurance). \_\_\_\_\_

### *Addressing Health Issues*

Q13 On a scale of 1-5, with 1 being not very well and 5 being extremely well, how well do you feel Kansas' public health and health care system are addressing these issues? You may indicate if this question is not applicable.

- ◆ Prenatal care in the first trimester \_\_\_\_\_
- ◆ Postpartum mental health \_\_\_\_\_
- ◆ Inductions or cesarean deliveries without justifying conditions prior to 39 weeks of pregnancy \_\_\_\_\_

Q14 Please indicate how well Kansas is addressing these issues (1 being not very well and 5 being extremely well). You may indicate if this question is not applicable.

- ◆ Alcohol use during pregnancy \_\_\_\_\_
- ◆ Drug use during pregnancy \_\_\_\_\_
- ◆ Timely follow-up and intervention for newborns with "out of range" screening results for heritable disorders \_\_\_\_\_

Q15 Please indicate how well Kansas is addressing these issues (1 being not very well and 5 being extremely well). You may indicate if this question is not applicable.

- ◆ Adolescent motor vehicle safety \_\_\_\_\_
- ◆ Adolescent suicide \_\_\_\_\_
- ◆ Treatment or counseling for children with mental/behavioral health conditions \_\_\_\_\_

Q16 Please indicate how well Kansas is addressing these issues (1 being not very well and 5 being extremely well). You may indicate if this question is not applicable.

- ◆ Childhood obesity \_\_\_\_\_
- ◆ Health insurance coverage for children \_\_\_\_\_
- ◆ Influenza vaccination of children \_\_\_\_\_

Q17 Please indicate how well Kansas is addressing these issues (1 being not very well and 5 being extremely well). You may indicate if this question is not applicable.

- ◆ Vaccination of adolescents (HPV, Tdap, meningococcal) \_\_\_\_\_
- ◆ Teen birth rate \_\_\_\_\_

Q18 Are there other health issues impacting MCH populations that are of concern to you/your organization?

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Q39 The following set of questions asks you to rank order interventions you feel would have substantial impact on health, by specific MCH domains. Check all domains that are pertinent to your work.

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## Q40 MCH Domains

- ☐ Women/Maternal (1)
- ☐ Infant/Perinatal (2)
- ☐ Children (3)
- ☐ Adolescents (4)
- ☐ Children with Special Health Care Needs (5)

### *Women/Maternal Domain*

**Display This Question: If MCH Domains = Women/Maternal**

Q19 Please move the blocks below in order to rank order interventions according to what you feel would have the greatest impact on maternal health (where 1 is the greatest impact, 2 is the second greatest impact, etc.).

- \_\_\_\_\_ Increasing the proportion of women of reproductive age who have an annual preventive medical visit (1)
- \_\_\_\_\_ Reducing the percent of cesarean deliveries for women with low-risk first births (2)
- \_\_\_\_\_ Ensuring high-risk mothers/newborns deliver at hospitals with appropriate services (i.e., neonatal intensive care units) (3)
- \_\_\_\_\_ Increasing the percent of women who have a preventive dental visit during pregnancy (4)
- \_\_\_\_\_ Decreasing the percent of women who smoke during pregnancy (5)

**Display This Question: If MCH Domains = Women/Maternal**

Q20 Please add and describe any intervention not listed in the previous question you feel would have a significant impact on maternal health in Kansas.

*Infant/Perinatal Domain*

**Display This Question: If MCH Domains = Infant/Perinatal**

Q1 Please rank order interventions below according to what you feel would have the greatest impact on infant/perinatal health (where 1 is the greatest impact, 2 is the second greatest impact, etc.).

\_\_\_\_\_ Increasing the percent of infants who are breastfed (1)

\_\_\_\_\_ Increasing the percent of infants who experience safe sleep practices (2)

**Display This Question: If MCH Domains = Infant/Perinatal**

Q2 Please add and describe any intervention not listed in the previous question you feel would have a significant impact on infant/perinatal health in Kansas.

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*Child Domain*

**Display This Question: If MCH Domains = Children**

Q1 Please rank order interventions below according to what you feel would have the greatest impact on child health (where 1 is the greatest impact, 2 is the second greatest impact, etc.).

\_\_\_\_\_ Increasing the percent of children who receive developmental screening (1)

\_\_\_\_\_ Decreasing the percent of children who live in households where someone smokes (2)

\_\_\_\_\_ Decreasing the percent of children experiencing unintentional injuries requiring hospitalization (3)

\_\_\_\_\_ Increasing the percent of children who are physically active, consistent with national guidelines (4)

\_\_\_\_\_ Increasing the percent of children who have a medical home (5)

\_\_\_\_\_ Increasing the percent of children who have annual preventive dental visits (6)

\_\_\_\_\_ Increasing the percent of children who are continuously and adequately insured (7)

**Display This Question: If MCH Domains = Children**

Q2 Please add and describe any intervention not listed in the previous question you feel would have a significant impact on child health in Kansas.

---

## Adolescent Domain

### Display This Question: If MCH Domains = Adolescents

Q1 Please rank order interventions below according to what you feel would have the greatest impact on adolescent health (where 1 is the greatest impact, 2 is the second greatest impact, etc.).

\_\_\_\_\_ Decreasing the percent of adolescents experiencing unintentional injuries (serious enough requiring hospitalization) (1)

\_\_\_\_\_ Increasing the percent of adolescents who are physically active (consistent with national guidelines) (2)

\_\_\_\_\_ Reducing the percent of adolescents who are bullied or bully others (3)

\_\_\_\_\_ Increasing the percent of adolescents who have an annual preventive medical visit (4)

\_\_\_\_\_ Increasing the percentage of adolescents who receive services to prepare them for transitions to adult health care (5)

### Display This Question: If MCH Domains = Adolescents

Q2 Please add and describe any intervention not listed in the previous question you feel would have a significant impact on adolescent health in Kansas.

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## CYSHCN Domain

### Display This Question: If MCH Domains = Children with Special Health Care Needs

Q1 Please rank order interventions below according to what you feel would have the greatest impact on the health of children and youth with special health care needs (where 1 is the greatest impact, 2 is the second greatest impact, etc.).

\_\_\_\_\_ Increasing the percent of children with special health care needs who have a medical home (1)

\_\_\_\_\_ Increasing the percent of adolescents with special health care needs who receive services to prepare them for transitions to adult health care (2)

**Display This Question: If MCH Domains = Children with Special Health Care Needs**

Q2 Please add and describe any intervention not listed in the previous question you feel would have a significant impact on the health of children and youth with special health care needs in Kansas.

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Q41 Does your organization currently have any program or initiatives that address opioid use disorders? This can include prevention, treatment, recovery, and harm reduction approaches.

- ☐ Yes (please describe) (1) \_\_\_\_\_
- ☐ No, but are planning one (please describe) (2) \_\_\_\_\_
- ☐ No, and not planning one (3)
- ☐ Other (please describe) (4) \_\_\_\_\_

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## MCH Participant Survey - English

T1 The University of Kansas's Center for Public Partnerships and Research (CPPR) is conducting this survey as part of a statewide Needs Assessment of the maternal and child health system. This survey is about your experience with your maternal and child health services provider.

The survey is voluntary and should take about 5 minutes to complete.

To continue, click the arrow at the bottom-right of this page.

Para realizar esta encuesta en español, haz clic aquí:

Encuesta de Participantes en MCH

This survey is modified (with permission) from a survey of The National Family Support Network (NFSN). All Rights Reserved. This project is supported by the Kansas Department of Health and Environment (KDHE) with funding through the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number #B04MC32543 and title Maternal and Child Health Services.

QA Please rate on a scale of 1 (strongly disagree) to 4 (strongly agree) how much you agree or disagree with the following statements about the Program:

- ◆ Services and activities are offered at a convenient location. (QA\_1) \_\_\_\_\_
- ◆ Services and activities are offered at convenient times. (QA\_2) \_\_\_\_\_
- ◆ Staff members are welcoming and respectful. (QA\_3) \_\_\_\_\_
- ◆ Staff members have asked me about my family's strengths, needs, and interests. (QA\_4) \_\_\_\_\_
- ◆ Staff members help me to understand healthy family development. (QA\_5) \_\_\_\_\_
- ◆ Staff members have invited other people in my family to participate in services and activities. (QA\_6) \_\_\_\_\_
- ◆ I have opportunities to meet and get to know other families through the Program. (QA\_7) \_\_\_\_\_

QB Please rate on a scale of 1 (strongly disagree) to 4 (strongly agree) how much you agree or disagree with the following statements about the Program:

- ◆ Staff members speak my language. (QB\_8) \_\_\_\_\_
- ◆ Staff members understand my identity and culture (traditions, values, religion, sexual orientation, special needs, etc.). (QB\_9) \_\_\_\_\_
- ◆ I have opportunities to learn about families that are different from mine. (QB\_10) \_\_\_\_\_
- ◆ Staff members have helped me to learn about services, resources, and opportunities that are available in the community. (QB\_11) \_\_\_\_\_
- ◆ I have opportunities to share my opinion and ideas about the program. (QB\_12) \_\_\_\_\_
- ◆ Overall, this program has provided valuable support for me and my family. (QB\_13) \_\_\_\_\_

Q14 Other comments about the Program: \_\_\_\_\_

### Demographics 1

Q15 What is the county of your primary address? \_\_\_\_\_

Q16 What is the name of the organization you receive maternal and child health services from?

\_\_\_\_\_

Q17 What is your sex?

- ☐ Male (1)
- ☐ Female (2)
- ☐ Other (3)
- ☐ Prefer not to answer (4)

Q18 Are you Hispanic and/or Latino or neither of these?

- ☐ Hispanic and/or Latino (1)
- ☐ Neither of these (2)
- ☐ Prefer not to answer (3)

Q19 Choose one or more races that you consider yourself to be:

- ☐ White (1)
- ☐ Black or African American (2)
- ☐ American Indian or Alaska Native (3)
- ☐ Asian (4)

Native Hawaiian or Pacific Islander (5)

- ☐ Other: (6) \_\_\_\_\_
- ☐ Prefer not to answer (7)

## Demographics 2

Q20 What is your year of birth?

- ☐ Enter year of birth here: (1) \_\_\_\_\_
- ☐ Prefer not to answer (2)

Q21 What is your household's total yearly income? It is fine to give your best guess.

- ☐ Less than \$10,000 (1)
- ☐ \$10,000 to \$14,999 (2)
- ☐ \$15,000 to \$19,999 (3)
- ☐ \$20,000 to \$24,999 (4)
- ☐ \$25,000 to \$34,999 (5)
- ☐ \$35,000 to \$49,999 (6)
- ☐ \$50,000 to \$79,999 (7)
- ☐ \$80,000 or more (8)
- ☐ Prefer not to answer (9)

Q22 What is the highest level of school you have completed or the highest degree you have received?

- ☐ Less than high school degree (1)
- ☐ High school graduate (high school diploma or equivalent including GED) (2)
- ☐ Some college but no degree (3)
- ☐ Associate degree in college (2-year) (4)
- ☐ Bachelor's degree in college (4-year) (5)
- ☐ Master's degree (6)
- ☐ Doctoral or Professional (JD, MD) degree (7)
- ☐ Prefer not to answer (8)

T2 Click the arrow to submit your survey. Thank you very much for participating!

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## MCH Workforce Survey

### Cover Letter

Consent: This survey, administered by the KU Center for Public Partnerships and Research on behalf of KDHE, is for staff of local Maternal and Child Health (MCH) programs in Kansas. Responses are welcomed from staff of any program, regardless of funding source.

Your participation in this survey is voluntary. It will take most participants around 10 minutes to complete. You may decline to answer any question(s) and have the right to withdraw from participation at any time. Your responses are anonymous.

Thank you! We appreciate your time and willingness to complete this survey.

Please move to the next page if you would like to continue.

### Identification Block

mchstaff I identify primarily as a:

- ☐ MCH Administrator/Coordinator (1)
- ☐ MCH Home Visitor (2)
- ☐ MCH Staff (not Home Visitor) (4)
- ☐ I don't work in an MCH Program and have any information about MCH Programs (5)

**Skip To: End of Survey If I identify primarily as a: = I don't work in an MCH Program and have any information about MCH Programs**

### Agency and Position

**agency\_name** What is the name of the agency where you provide MCH services? \_\_\_\_\_

**current\_position** What is the title of your current position? \_\_\_\_\_

**years\_in\_position** How many years have you been in your current position (enter as number)?

If less than one year, type 0. \_\_\_\_\_

**primary\_role** What is your primary role in your current position? \_\_\_\_\_

**sch\_hrs\_per\_week** In the last month, on average, how many hours per week were you scheduled to work (enter as number)? \_\_\_\_\_

**hrs\_per\_week** In the last month, on average, how many hours per week did you work (enter as number)? \_\_\_\_\_

**service\_counties** What is the primary county where you provide MCH services? \_\_\_\_\_

**Allen County (219) ... Wyandotte County (323)**

**service\_oth\_counties** Do you provide services in any other counties?

- ☐ Yes (1)
- ☐ No (2)

**Display This Question: If Do you provide services in any other counties? = Yes**

**oth\_counties\_name** Please name the other counties where you provide MCH services: \_\_\_\_\_

*MCH Workforce Wellbeing*

**accomplish\_goals** In general, a scale of 0 (Never) to 10 (Always)...

- ◆ How often do you feel you are making progress towards accomplishing your work-related goals? (PERMA\_A1) \_\_\_\_\_
- ◆ How often do you achieve the important work goals you have set for yourself? (PERMA\_A2) \_\_\_\_\_
- ◆ At work, how often do you become absorbed in what you are doing? (PERMA\_E1) \_\_\_\_\_

**On a scale of 0 (Never) to 10 (Always)...**

- ◆ How often do you feel you are making progress towards accomplishing your work-related goals? (PERMA\_A1) \_\_\_\_\_
- ◆ How often do you achieve the important work goals you have set for yourself? (PERMA\_A2) \_\_\_\_\_
- ◆ At work, how often do you become absorbed in what you are doing? (PERMA\_E1) \_\_\_\_\_

**emotional\_state** In general...

- ◆ At work, how often do you feel joyful? (PERMA\_P1) \_\_\_\_\_
- ◆ At work, how often do you feel anxious, depressed, or irritable? (PERMA\_N1) \_\_\_\_\_
- ◆ At work, how often have you felt burned out? (Q2\_10) \_\_\_\_\_

**peer\_support** On a scale of 0 (Not at all) to 10 (Completely)...

- ◆ To what extent do you receive help and support from coworkers when you need it? (Q5\_21) \_\_\_\_\_
- ◆ To what extent do you feel appreciated by your coworkers? (peer\_support\_26) \_\_\_\_\_
- ◆ How satisfied are you with your professional relationships? (peer\_support\_27) \_\_\_\_\_

**happy\_with\_work** On a scale of 0 (Not at all) to 10 (Completely)...

- ◆ Taking all things together, how happy would you say you are with your work? (PERMA\_hap) \_\_\_\_\_

**work\_life\_balance** On a scale of 1 (Strongly disagree) to 10 (Strongly agree)...

- ◆ My work schedule leaves me enough time for my personal/family life (eWBI\_9)

### *HV Workforce Case/Workload*

**wl\_manageable** How manageable is your current caseload? (1)

- ☐ Not at all manageable (1)
- ☐ A little manageable (2)
- ☐ Somewhat manageable (3)
- ☐ Mostly manageable (4)
- ☐ Completely manageable (5)

**wl\_struggle** How often do you struggle with staying on top of all of your cases? (1)

- ☐ Never (1)
- ☐ Sometimes (2)
- ☐ About half the time (3)
- ☐ Most of the time (4)
- ☐ Always (5)

**wl\_demands**

I feel my workload is higher than the ideal workload for my position (1)

- ☐ Strongly disagree (1)
- ☐ Somewhat disagree (2)
- ☐ Neither agree nor disagree (3)
- ☐ Somewhat agree (4)
- ☐ Strongly agree (5)

My workload is higher than colleagues in the same or similar positions as me (2)

- ☐ Strongly disagree (1)
- ☐ Somewhat disagree (2)
- ☐ Neither agree nor disagree (3)
- ☐ Somewhat agree (4)
- ☐ Strongly agree (5)

**My organization is staffed adequately to meet workload demands (3)**

- ☐ Strongly disagree (1)
- ☐ Somewhat disagree (2)
- ☐ Neither agree nor disagree (3)
- ☐ Somewhat agree (4)
- ☐ Strongly agree (5)

### *HV Workforce Workplace Supports*

workplace\_supports Please rate the following statements about your organization as “yes”, “sometimes”, or “no”. If you do not know, select “unknown”.

I feel I am paid in the salary range commensurate with my education, training, and experience. (1)

- ☐ Yes (1)
- ☐ Sometimes (2)
- ☐ No (3)
- ☐ Unknown (4)

There are opportunities for promotion and advancement in my workplace. (2)

- ☐ Yes (1)
- ☐ Sometimes (2)
- ☐ No (3)
- ☐ Unknown (4)

My organization offers flexibility in scheduling the work week (evening hours, 4-day work weeks, flex time). (3)

- ☐ Yes (1)
- ☐ Sometimes (2)
- ☐ No (3)
- ☐ Unknown (4)

The benefits at my job meet my needs and those of my family (if applicable). (4)

- ☐ Yes (1)
- ☐ Sometimes (2)
- ☐ No (3)
- ☐ Unknown (4)

**resource\_needed** What is the most important resource you need (if any) that would help you enhance the work you do? \_\_\_\_\_

### *HV Workforce Turnover - TIS-6*

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## Turnover Intention

Please read each question and indicate your response using the scale provided for each question.

DURING THE PAST 9 MONTHS...

On a scale of 1 (Never) to 5 (Always), how often have you considered leaving your job? (TIS6\_1)

**another\_job:** On a scale of 1 (Highly unlikely) to 5 (Highly likely), how likely are you to accept another job at the same compensation level should it be offered to you? (TIS6\_5)

**reasons\_turnover:** What do you feel are the common reasons (if any) for turnover in your organization?

Select up to 3 responses:

- ☐ Insufficient compensation (1)
- ☐ Insufficient benefits (2)
- ☐ Lack of promotional opportunities (3)
- ☐ Lack of feedback and recognition (4)
- ☐ Lack of professional development (5)
- ☐ Burnout (6)
- ☐ Poor work/life balance (7)
- ☐ Scheduling (8)
- ☐ Work-related stressors (9)
- ☐ Poor workplace culture (10)
- ☐ Life events (11)
- ☐ Discrimination (12)
- ☐ Health/well-being concerns (13)
- ☐ Other; Please explain: (14) \_\_\_\_\_

## Demographics

**demo\_intro** Please answer the questions below. Please note that all personal information will be kept completely confidential and none of the responses you provide will be connected to your identifying information.

**gender** What gender do you identify as?

- ☐ Male (1)
- ☐ Female (2)
- ☐ Non-binary / third gender (3)
- ☐ Prefer not to say (4)

**age** What is your age (in years)? Enter as a number. \_\_\_\_\_

**race** Which of the following best describes your racial/ethnic identity? (Select all that apply)

- ☐ African American or Black (1)
- ☐ American Indian or Alaskan Native (2)
- ☐ Asian or Pacific Islander (3)
- ☐ Hispanic or Latino (4)
- ☐ White or Caucasian (5)
- ☐ Other (specify) (6) \_\_\_\_\_

**multilingual** Are you fluent in more than one language?

- ☐ No, I am only fluent in one language (6)
- ☐ Yes, I am fluent in two languages (4)
- ☐ Yes, I am fluent in three or more languages (5)

**languages\_spoken** Which languages are you fluent in? Select all that apply:

- ☐ English (1)
- ☐ Spanish (2)
- ☐ Portuguese (3)
- ☐ French (4)
- ☐ Mandarin (5)
- ☐ Arabic (6)
- ☐ Other (7) \_\_\_\_\_

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## Open House

We will host 2-hour “open houses” held in public spaces (like libraries or community centers) around the state of Kansas (six locations) and invite community members to come provide input at a series of stations. We will explain that we are gathering information for the state health agency’s Maternal and Child Health program. They will be informed that the Maternal and Child Health program helps ensure women have need prenatal, delivery, and postpartum care, and that women, children and youth have access to preventive and primary care services. There is a special focus on low-income populations and children and youth with special health care needs and their families, but MCH services are available to any Kansan. The information we gather will be used as part of a statewide Needs Assessment for the program which will be used to develop a State Action Plan. The open houses will have a series of “stations” where different information will be sought.

There will be a sign-in sheet where we will gather demographic information about participants. No names will be collected, and individuals will be told they do not have to provide their demographic information in order to participate. They are free to provide responses at any station they choose and will be told they don’t have to answer anything they do not wish to answer. Participation in all activities is completely voluntary.

### Station 1

This station will have a series of Kansas’ statistics on the health of women and children (things like obesity rates, smoking rates, leading causes of injury and illness). Participants are given colored stickers to indicate which statistics they felt are most surprising, and which are the most important for the state to address to improve the health of women, infants, children, and youth.

### Station 2

At this station participants are given 10 fake \$10 bills and are asked to allocate their money by putting bills into boxes for previously selected MCH issues (mental health, nutrition and food security, physical activity, access to primary care, etc.). Participants are instructed that they can “budget” their money in any way they want, distributing their bills across as many categories (and as many bills in one category) as they want.

### Station 3

This station will have a poster with a large triangle where participants will be asked to place a dot within the triangle that best represents their response to the question: “What would make the biggest impact on your health?” with responses including “More money,” “Better information,” “Better access to care.”

### Station 4

This station features three large posters:

“What are bright spots in health for women, children, and youth in Kansas?”

“What are the biggest barriers to health for women, children, and youth in Kansas?”

“What are the most important actions the state could take to improve the health of women, children, and youth in Kansas?”

Participants are given sticky notes to write answers and stick them on the appropriate board.

### *Sign-in sheet for Open Houses*

Participants were asked to sign in with the following information:

Residence (city): \_\_\_\_\_

Gender: \_\_\_\_\_

Age:

- ☐ <18 years
- ☐ 18-44
- ☐ 45-65
- ☐ 65+ years

Race/ethnicity: \_\_\_\_\_

Primary Language: \_\_\_\_\_

Education:

- ☐ Less than high school
- ☐ High school/GED
- ☐ Some college
- ☐ College graduate
- ☐ Graduate degree

Yearly Family Income:

- ☐ < \$15,000
- ☐ \$15,000-\$49,999
- ☐ \$50,000-\$99,999
- ☐ > \$100,000

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## Photo Project Guide

Note: We will recruit existing youth groups (ages 12-17) to participate in the project. Normally these groups will be school-based or afterschool groups. We will gather consent forms from parents of participating youth, and assent of the youth participants. Parents and youth will be informed, through the consent process, that they can withdraw from participation at any time, but that any information collected before withdrawal of the project will be subject to use in the study.

### *Initial meeting protocol*

My name is [Name]. I am a researcher at KU and am working with the state health agency. They are interested in understanding what you think has the greatest impacts on your health, not just health care, but any factors in your lives or in your community that impact health, good or bad.

We want each of you to take 6-12 photos (more if you like) with your phones of things your community that impact the health of youth. We want to make sure, when you are taking photos, to protect the privacy of people. When taking someone's picture, ask them if it is okay. Even if they say it is okay, take a picture in a way that doesn't identify individuals, with their face or in front of their home, for example. We cannot accept pictures for the project that depict criminal behavior or involve nudity.

Between now and [date] we want you to take pictures. We will have you upload the pictures to a website (the youth and youth group leaders will be given a website address), along with a sentence or two that describes how the picture represents factors that you think impact health. We will print out the pictures and the things you write to use them in the next group session. There we'll have the printed photos along with their written descriptions. You will not have to identify which photographs are yours.

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### Second meeting protocol

On this table we have your printed photos and the descriptions you wrote. What we want you to do first is to work together to organize the pictures into groups that you think have a similar idea or theme. Try to put pictures into about 6 to 8 groups with different themes. When you are done grouping the pictures we want you to work together to come up with a few words that best describes the theme for each group of pictures. Once you've done that, we'll take a few minutes to ask you all how you think the community could address those themes to promote good health.

There are minimal risks for taking part in the study. Discussing photos could cause feelings of discomfort if any of the ideas share upset you in some way. That is okay. Your participation is voluntary. If at any point you don't want to participate any more, you can stop. Tell me if you want to stop, and you will be free to do so.

It is important to respect the privacy of others, so I am asking all of you not to repeat what is discussed in this group with others. We are going to do an audio recording of today's session so we can record the ideas you share to help us in putting together our report. We won't share the recording with anyone else, and when we write our final report, we will destroy that recording.

When we are done today, we will put all the photos and other information we gather into one collection. We are going to use the pictures and descriptions in a report to the state public health agency. They may post the report to a public website, but in that report, we will not use your names, so no one will know what information is yours, or that you contributed to the project.

We are going to begin, so if anyone does not want to be part of this, please tell [youth group instructor] you do not want to participate. It is voluntary so it is your choice. And if you change your mind, you can rejoin the activity at any time.

Do I have your permission to record the session? Are you ready to start?

# Appendix C.

## Public Health Communication Strategies to Improve Maternal and Child Health Outcomes: Evidence-Based Approaches and Best Practices

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In addition to traditional Needs Assessment efforts, the Kansas MCH Program requested KU-CPPR to prepare a report on effective dissemination strategies for public health messaging to enhance maternal and child health in the state. This report is included here as an addendum to the Needs Assessment report.

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### Goals and Process

The primary goal of this report is to enhance the effectiveness of public health messaging and dissemination strategies for maternal and child health across Kansas. The objective is to reach diverse populations with culturally relevant, accessible information that empowers individuals to make informed health decisions. This report was developed through a review of best practices in public health communication, analysis of existing Kansas-based initiatives, and consultation with local organizations to understand barriers and opportunities in message dissemination.

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### Detailed Findings and Recommendations on Public Health Dissemination for Maternal and Child Health in Kansas

#### *Audience Segmentation and Targeted Messaging*

Effective dissemination relies on tailoring messages for specific audience segments within maternal and child health. For Kansas, this involves identifying subgroups within both urban and rural populations, including those with unique social or cultural backgrounds, language needs, and literacy levels. Focusing on the needs and characteristics of these diverse populations increases the likelihood that public health messages are understood, accepted, and acted upon.

#### *Use of Digital and Traditional Channels*

Research underscores the value of a multi-channel approach, using both digital platforms and traditional media to maximize reach. Digital platforms—such as social media, email newsletters, and health apps—are effective for engaging younger audiences, including expecting parents and healthcare providers. Meanwhile, traditional channels (like print materials, radio, and community events) are essential for reaching populations with limited internet access, common in some rural Kansas communities.

### *Community Engagement and Co-Creation*

Involving community members and leaders in the development of messages increases their relevance and trustworthiness. Engaging Kansas-specific community organizations and local leaders in message creation and dissemination efforts ensures that materials resonate with local values and address real-world challenges.

### *Visual and Interactive Formats*

Studies emphasize that visual and interactive materials (such as infographics, videos, and interactive toolkits) are more effective than text-heavy content in improving health literacy and engagement, especially among younger audiences and those with lower health literacy levels. These formats facilitate quick understanding and retention of essential health information.

### *Addressing Social Determinants of Health*

Dissemination efforts are most impactful when they acknowledge and address social determinants of health, such as access to healthcare, transportation, and socioeconomic factors. For Kansas, effective strategies might highlight local resources, subsidies, or support programs that address these determinants, making health interventions more accessible.

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## **Recommendations**

These recommendations aim to strengthen the impact of public health initiatives related to maternal and child health in Kansas, fostering a more equitable, accessible, and community-centered approach to health communication.

### *Implement Audience-Specific Campaigns*

Develop separate, tailored campaigns for different demographic groups within Kansas, such as Spanish-speaking populations, low-income communities, and rural families. Each campaign should use culturally relevant language, symbols, and narratives to ensure resonance and improve health outcomes.

### *Leverage Partnerships with Local Organizations*

Collaborate with Kansas-based organizations, schools, and faith-based groups to distribute health messages. These trusted entities can help adapt messages to local needs and ensure they reach communities that might otherwise be disconnected from state-level public health initiatives.

### *Expand Digital Outreach, While Maintaining In-Person Support*

Increase the use of digital tools like social media and health-related apps to engage tech-savvy audiences. For rural and older populations, maintain or expand traditional outreach methods, such as in-person workshops and printed materials, ensuring no group is left out due to digital divides.

### *Utilize Data to Refine Dissemination Tactics*

Regularly collect and analyze data on message reach and impact (e.g., digital engagement metrics, surveys). This data-driven approach will help refine content and channels, ensuring that messages are both effective and responsive to changing needs and preferences.

### *Develop Culturally Competent, Visual Content*

Create more visual, language-accessible, and culturally relevant materials to communicate maternal and child health information effectively. Simple, visually engaging content is easier to understand and more likely to be shared, improving overall reach and comprehension across diverse communities.

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## Review Objectives

This review describes the characteristics and practical applications of public health dissemination strategies found within existing literature. Specifically, the review answers the following questions:

- ◆ What are key issues that impact the effectiveness of public health dissemination efforts?
- ◆ What are the emerging best practices in public health dissemination?
- ◆ What are the key features or characteristics of these practices?
- ◆ How can these practices be applied to maternal and child health initiatives in Kansas?
- ◆ What frameworks or examples can support strategic planning for the dissemination of maternal and child health in Kansas?

The findings from this review are intended to inform planning and program development, enabling the dissemination of public health research to a variety of audiences by leveraging promising practices. Furthermore, we discuss the implications for dissemination strategies that promote maternal and child health in Kansas.

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## Background

A persistent research-to-practice gap exists across public health, impacting the timely implementation of evidence-based practices and interventions (EBPIs) in real world situations (Shato et al., 2024). This research-to-practice gap is particularly significant when considering maternal and child health initiatives. The health of mothers and children is critical in public health, as early interventions can prevent complications, reduce infant mortality, improve long-term developmental outcomes, and reduce the risk of chronic disease and other negative health outcomes across the lifecourse. However, even when effective programs and interventions are identified, they are not always widely implemented, or they fail to reach the populations that need them most (Shelton et al., 2018). Public health researchers and agencies must develop and refine strategies for disseminating this research knowledge in ways that promote adoption and consistent use in health care practice, and in the real world.

Dissemination in the field of public health refers to the process of actively pushing knowledge of research discoveries and EBPIs to targeted populations, including partners, health practitioners, policymakers, and the public to enhance the audiences' ability to effectively pull that information and put it to use (Brownson et al., 2018) (Shato et al.,

2024). Research has shown that passive dissemination of public health research information is ineffective without intentional efforts, and that those efforts require sufficient capacity (i.e., knowledge, resources, and the workforce) to both put out evidence, and ensure its pull from targeted audiences (Brownson et al., 2018). The purpose of this literature review is to identify those efforts, so public health organizations can strategically plan for building the capacity needed to implement them.

There are numerous examples in public health where dissemination research has been utilized to bridge the research-to-practice gap (National Institutes of Health, 2024; The Public Good Projects, n.d.). These examples highlight both the potential and the challenges of implementing evidence-based interventions across different health domains. For instance, dissemination efforts in smoking cessation, HIV prevention, and chronic disease management have shown that well-planned strategies can reduce this gap, but they also underscore the complexities involved in changing behaviors, systems, and policies on a large scale (DHHS Office of Disease Prevention and Health Promotion, n.d.-a).

Our review findings suggest that state agencies can play a critical role in improving the dissemination of public health research and information. Emerging best practices in public health dissemination are shifting toward approaches that prioritize equity, community engagement, digital innovation, and cross-sector partnerships. Being mindful of these shifts, and key considerations related to them, state agencies can help ensure that evidence-based practices and interventions are more consistently integrated into community health programs, especially for vulnerable populations. In the following sections, we describe key findings from the literature and provide illustrative examples of efforts that state agencies can implement to enhance the dissemination process. These efforts offer a pathway to improve public health outcomes by more effectively translating research into practice.

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## Methods

The review used environmental scanning to collect information. Conducting an environmental scan of literature involves gathering, analyzing, and interpreting information systematically to understand the current state of knowledge on a specific topic. Scanning the environment is crucial for strategic planning and is connected to improved organizational performance. Environmental scanning is especially relevant for informing decision-making and strategic planning in the healthcare sector (Charlton et al., 2019).

The reviewers compiled 12 documents, listed in a table at the end of this report, from a variety of sources (e.g., academic databases, agency and organizational websites) to capture the wide range of public health dissemination activities occurring in the United States and abroad. Text used for the keyword search included “public health,” “dissemination,” “communication,” “strategies,” “frameworks,” “evidence-based,” and “best practices.” The reviewers also searched contextual and topical terms like “maternal and child health,” “health equity,” “prenatal,” and “postnatal.” The reviewers conducted searches of articles published before 2014 to identify newer studies that demonstrate how earlier research has been expanded upon. While the source documents do not represent all public health dissemination activities, they were selected based on their relevance to the review questions and their timeliness. The primary focus was on literature published within the past 10 years. However, some pre-2014 articles were included because they define essential terminology or provide historical context for the field of public health dissemination.

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## Key Findings

When developing public health dissemination efforts, four key issues should be considered based on literature analysis: access and audience, shift towards human and community-centered design, misinformation and trust, and third-party influence. This section discusses each theme and its implications for state agencies working to communicate public health initiatives effectively.

### *Access and Audience*

State public health agencies face significant challenges when target audiences, including health practitioners and the public, lack access to relevant, contextually tailored public health information. This disconnect often stems from a gap between researchers' methods of dissemination and the ways practitioners best absorb new evidence. For instance, researchers typically share findings through academic channels, while practitioners prefer more accessible formats such as webinars, workshops, and research summaries that clarify practical applications (Brownson et al., 2018). Additionally, factors like perceived relevance and applicability of evidence in specific settings can strongly influence its use in practice (Shato et al., 2024).

To improve the impact of public health interventions, state agencies should prioritize capacity-building efforts that go beyond simply tracking the adoption of evidence-based practices. This includes accounting for the complexities of public health decision-making and ensuring interventions are adapted to meet the unique needs of different populations and environments. Engaging partners and target adopters in the research process (e.g., practice-based research) not only makes findings more relevant but also strengthens dissemination and implementation across diverse communities (Brownson et al., 2018; Estabrooks et al., 2018; Mortillaro & Bonnevie, 2023; Shato et al., 2024).

### *A Shift Toward Human and Community-Centered Design*

For state public health agencies, shifting towards a more human-centered and community-centered approach is essential to developing interventions that resonate with diverse populations. Actively involving community members in intervention design makes content more relevant, acceptable, and tailored to the specific needs of various groups (Erika Bonnevie et al., 2021; Krawiec et al., 2021). Traditionally, public health models have separated medical research, discovery, and the implementation of evidence-based practices into distinct stages. Yet many preventive interventions require individuals to modify behaviors, an area where traditional, data-driven approaches often fall short by overlooking the nuances of human behavior and the importance of making changes desirable (Matheson et al., 2015).

Human-centered design (HCD) offers a solution by bridging the “knowing-doing” gap in disease prevention, emphasizing the needs, motivations, and contexts of individuals and communities. Through a participatory approach, HCD fosters empathy and collaboration by involving the target audience in all stages, from defining the problem to prototyping and refining (Krawiec et al., 2021; Matheson et al., 2015). Community-based participatory research (CBPR) similarly prioritizes empathy, co-creation, and responsiveness to community needs, enhancing intervention relevance and uptake (Alvarado-Torres et al., 2024; E. Bonnevie et al., 2021).

By combining principles from CBPR, HCD, and a nuanced understanding of social networks, public health practitioners can craft interventions that are not only more likely to be adopted and implemented but also sustained over time, resulting in greater health improvements at the population level (Bonnevie et al., 2021). This shift to human-centered, community-driven approaches represents a possible advancement for public health agencies striving to make a lasting impact.

## Campaign Spotlight

### Layla's Got You

The Layla's Got You campaign in Onondaga County, NY, is an exemplary public health dissemination initiative aimed at providing young women, especially Black and Hispanic teens, with easy access to sexual health information (Layla's Got You, n.d.) . In response to high rates of unplanned pregnancies, the campaign launched the Layla chatbot to offer a confidential, nonjudgmental space where young women can quickly find accurate information on pregnancy, contraception, and STDs. By June 2021, Layla received 4,390 messages and achieved a significant social media reach, with nearly 2.5 million impressions and 33,000 daily engagements.

Key features that set this campaign apart include:

- ◆ **Community-Driven Development:** Anonymous question boxes were placed in local spots, allowing young women to share their concerns, which informed Layla's responses. Approximately 100 questions were collected, thoroughly researched, and written in relatable language by a young woman of color.
- ◆ **Cultural and Visual Representation:** Focus groups with 31 young women helped design Layla's appearance, name, logo, and tagline, ensuring the chatbot resonated with the target audience and reflected their identities.
- ◆ **Innovative Technology:** The Layla chatbot represents the first of its kind—a sophisticated tool delivering personalized sexual health information to at-risk girls.
- ◆ **Comprehensive Campaign Elements:** Layla's website community page showcases Black and Hispanic women in promotional photos (#LaylaSquad) and offers free podcasts like *The Morning After Show* and *Layla @ Home*, spotlighting local women of color.
- ◆ **Targeted Outreach and Partnerships:** Advertising spanned social media (Instagram, Twitter, Facebook) with local influencers, and the campaign partnered with both traditional venues (e.g., clinics) and non-traditional ones (e.g., beauty stores). Monthly newsletters and a toolkit with free digital resources further amplified awareness.

The Layla's Got You campaign is a model for effectively using digital tools, community input, and culturally relevant messaging to increase access to critical sexual health information in underserved populations.

## *Trust and Misinformation*

Low public trust in health institutions, coupled with the rapid spread of misinformation, particularly on social media, poses a serious challenge for public health agencies. The COVID-19 pandemic highlighted this “infodemic,” as misinformation about the virus, prevention, treatments, and vaccines hindered public health efforts and worsened health outcomes (Ferreira Caceres et al., 2022; US Department of Health and Human Services, 2021). Misinformation often thrives in environments of social division and distrust, particularly among communities impacted by historical inequities, such as racial and socioeconomic injustices. This can further isolate these communities from reliable health information.

State public health agencies have a critical role in rebuilding public trust and mitigating misinformation. Actions include leveraging technology and social media to spread accurate health information, partnering with community groups to directly address misinformation, and providing training for clinicians to engage with patients’ diverse needs, backgrounds, and concerns. Engaging trusted messengers and rapidly disseminating accurate, accessible information—both online and in person—can help bridge the trust gap and improve the effectiveness of public health initiatives (Ferreira Caceres et al., 2022; US Department of Health and Human Services, 2021). Additional research into how various demographics interact with misinformation can further refine these efforts, enabling state agencies to tailor approaches to different community needs.

## *Third-party Influence*

Third-party entities, like social media influencers or trusted community leaders, can either support effective dissemination or contribute to misinformation, shaping public perception and behavior. For example, the success of the WhatMakesUs campaign, which is featured in a campaigns spotlight below, was largely driven by strategic partnerships with local influencers, selected for their ability to resonate with diverse demographic groups and address racial and ethnic disparities in mental health. Recruited through Instagram, these influencers collaborated closely with organizers to craft authentic messages based on personal experiences that highlighted key areas like shared experiences, susceptibility, stigma’s impacts, available treatments, and recovery potential. Their strong community presence made the campaign’s message both relatable and impactful, significantly expanding its reach and engagement among the target audience (Alvarado-Torres et al., 2024). State public health agencies can collaborate with local individuals and influencers to craft messaging ensuring that it reflects their own experiences while addressing key content areas critical to the intervention’s success.

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## Implications for Maternal and Child Health in Kansas

### *Addressing Misinformation and Building Trust*

Trust is essential for countering the harmful impacts of misinformation, particularly in maternal and child health, where expectant mothers, families, and young people are especially vulnerable to inaccurate or harmful information. Tailored campaigns using trusted messengers, such as healthcare providers and community leaders, can effectively address misinformation and build confidence in evidence-based guidance. Further research is needed to identify specific types of misinformation circulating in Kansas communities, especially those affecting pregnant women and new mothers (Moukarzel et al., 2020; US Department of Health and Human Services, 2021).

### *Promoting Adoption of Evidence-Based Interventions*

Equipping healthcare providers with the knowledge and skills to implement EBPIs related to maternal and child care is crucial. Training programs, webinars, and workshops can disseminate current research findings and best practices (Mahmood et al., 2019) (Alvarado-Torres et al., 2024; Brownson et al., 2018). Research findings and recommendations need to be communicated through channels favored by healthcare providers (Shato et al., 2024), and maternal and child health initiatives should be designed using human-centered design principles, considering the needs, preferences, and contexts of expectant mothers and families in Kansas (Matheson et al., 2015; NIH).

## Campaign Spotlight

### Hear Her

The Hear Her campaign, launched by the Centers for Disease Control and Prevention in 2020, aims to educate pregnant women, their support systems, and healthcare providers about urgent maternal warning signs (Connecticut State Department of Public Health, 2025). The campaign empowers women to speak up about any health concerns they experience during and after pregnancy.

An evaluation of the campaign found a statistically significant increase in patient-provider communications after the Hear Her campaign was promoted. This indicates that women felt more empowered to voice their concerns and engage in dialogue with their healthcare providers. The evaluation's findings highlight the potential for public health campaigns like Hear Her to improve communication between patients and providers, a crucial aspect of ensuring safe and effective maternity care.

While the sources do not explicitly state what factors contributed to the Hear Her campaign's success, it's possible that the campaign's clear messaging, focus on patient empowerment, and use of multiple channels to reach target audiences played a role (Greenberg et al., 2023)

## Leveraging Technology and Social Networks

Advanced technologies, like chatbots and Medical Health (mHealth) apps, and utilizing social networks offer potential for supporting maternal and child health but addressing the “digital divide” is essential to ensure equitable access (Erika Bonnevie et al., 2021; Moungui et al., 2024). Like the “Layla’s Got You” campaign, a tailored chatbot, blogs, and social media campaigns could be developed to provide confidential and accurate information on various aspects of maternal and child health, such as prenatal care, breastfeeding, postpartum depression, and infant safety. mHealth apps can empower individuals to manage their health and track their progress. For example, mHealth apps could be developed to track pregnancy milestones, monitor infant feeding schedules, or provide access to mental health resources (Mahmood et al., 2019). Furthermore, partnering with culturally relevant social media influencers with strong local followings, can significantly increase the reach and impact of campaigns within specific communities (Krawiec et al., 2021). Focusing on influencers with smaller, localized followings can be particularly effective in reaching specific communities within Kansas, as they are often seen as peers and trusted sources of information.

### Campaign Spotlight

#### WhatMakesUs

A study on the WhatMakesUs (WMU) campaign, which aimed to reduce mental health stigma in the Greater Omaha-Council Bluffs metropolitan area, showed that individuals aware of the campaign demonstrated lower social distance, fewer stigmatizing attitudes and beliefs, and more positive behaviors and self-efficacy toward people with mental health conditions compared to those unaware of the campaign (Alvarado-Torres et al., 2024)

Features of the WMU campaign that contributed to its success include:

- ◆ **Use of local voices:** Featuring local individuals and social media influencers sharing personal stories related to their mental health made the content relatable and recognizable.
- ◆ **Diversity and inclusion:** Influencers were selected to represent diverse demographic groups to address racial and ethnic disparities in mental health.
- ◆ **Digital and social media:** Leveraging these platforms allowed for wide dissemination of information, easy tracking of metrics, and the creation of supportive online communities.
- ◆ **Collective Impact Model:** Collaboration between researchers, The Public Good Projects (PGP), The Wellbeing Partners (TWP), and community-based organizations (CBOs) ensured that campaign messages were tailored to the community’s specific needs and cultural context.

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## Recommendations for Public Health Agencies in Kansas

State agencies can take several steps to improve the dissemination of public health research and information, ensuring it reaches diverse audiences effectively and influences policy and practice. The following recommendations are intended to guide public health agencies in Kansas as they strategically plan to build their organization's capacity to actively disseminate public health information:

### *Collaborate with Researchers and Community-based Organizations*

Successful health promotion interventions depend on strong partnerships between researchers, state public health agencies, and community-based organizations (CBOs). Kansas public health agencies can allocate resources specifically building reciprocal and ongoing collaborations with organizations like the Kansas Health Institute or the Kansas Center for Rural Health, whose research focuses on county and community-level needs, and community-based organizations like the Kansas Birth Equity Network, the Kansas Birth Justice Society, the Kansas City Association of Black Social Workers, the Topeka Doula Project, or the Kansas Youth Empowerment Academy who have or are affiliated with networks of local health educators who understand community needs and have established trust within those communities. These collaborations are most effective when all parties aim to reach the same target audience and are open to learning about each other's resources and goals. One way to initiate a collaborative relationship with researchers and CBOs is to identify and participate in shared training on the topic of public health dissemination strategies.

### *Use Technology to Access Social Networks and Increase Credibility*

Kansas public health agencies should increase their capacity to utilize technology, and the services of media and technology nonprofit organizations. Digital technologies, like chatbots, social media, and online platforms, can be powerful tools for disseminating information and engaging with communities. Partnering with social media influencers, who have established followings and credibility within specific communities can increase the reach and impact of campaigns (Krawiec et al., 2021). Campaigns can also leverage digital volunteers (DVs), who are willing to share information and promote health messages on their own social media platforms. This can be a cost-effective way to supplement influencer-driven campaigns and expand reach (Alvarado-Torres et al., 2024).

Incorporating entertainment, such as humor, music, or engaging visuals, can increase the memorability and shareability of health messages. However, it's also crucial to maintain credibility and trust. This can be achieved by (1) using government branding and logos when appropriate, (2) collaborating with trusted organizations and messengers, and (3) ensuring messages are accurate and evidence-based (Cover et al., 2024).

### *Tailor to Specific Audiences*

Public health agencies in Kansas should tailor health messages and interventions to resonate with specific communities by understanding their unique needs, cultural contexts, and preferences. Implementing a human-centered design approach—engaging community perspectives throughout the development process—can ensure interventions are relevant and address local concerns. Additionally, materials should be adapted to be culturally and linguistically inclusive, particularly for minority and non-English-speaking populations, to promote equitable access and engagement across the state. Establishing a collaborative relationship with researchers and CBOs, as described above can facilitate this work.

## Campaign Spotlight

### Pregnancy for Every Body

The Pregnancy for Every Body (NIH) initiative empowers plus-sized pregnant women and healthcare providers to partner for healthy pregnancies and safe deliveries. Recognizing the added health risks associated with obesity during pregnancy and the pervasive biases that can impact care, this initiative provides education to ensure open, judgment-free conversations about weight and pregnancy health.

Resources are organized into two key sections, directing critical information to two key target audiences—“Moms-to-Be” and “Information for Healthcare Providers.” For expecting mothers, the site offers guidance on BMI, lifestyle factors, and tips for finding a size-friendly provider, along with a planning tool for pregnancy. For providers, materials include best practices for plus-sized pregnancy care, from conception to postpartum, and strategies for overcoming implicit bias and fostering respectful communication. Free, downloadable resources in English and Spanish are available for sharing on social media, through healthcare portals, or in clinical settings, promoting a supportive, inclusive healthcare environment. The initiative promotes a shared goal to create a system where all pregnancies, regardless of size, are met with proactive, compassionate care for long-term health success (Eunice Kennedy Shriver National Institute of Child Health and Human Development, n.d.).

### *Partner with Influencers and Advocates*

Influencers and advocates, particularly those with strong local followings, can significantly expand the reach of public health campaigns and engage audiences who may not be reached through traditional channels (Alvarado-Torres et al., 2024; Cover et al., 2024). These individuals have built trust and credibility with their followers, who often perceive them as peers or friends. This can make health messages delivered by influencers more persuasive and impactful. Public health agencies in Kansas should identify local influencers and advocates across the state and explore a model for engaging them as promoters of EBPI health information.

One powerful advocate to consider is Clayton Williams, the husband of Kansas City Chiefs Cheerleader Krystal Anderson, who died shortly after giving birth to her daughter, Charlotte Willow, who was stillborn (ABCNews, 2024). There is a real opportunity to develop a human-centered campaign for maternal and infant health. This campaign should engage Mr. Williams and other members of Krystal Anderson’s family throughout the design and implementation process. Furthermore, members of the Kansas City Chief football team may volunteer to use their platforms to make the information more accessible to families throughout the state.

### *Evaluate the Impact of Dissemination Efforts and Adapt to the Findings*

Monitor campaign performance in real-time using digital metrics and traditional evaluation methods (e.g., surveys, interview, focus groups) to assess reach, engagement, and impact on knowledge, attitudes, and behaviors. Evaluating dissemination efforts and adapting them to reflect the findings is more feasible when state public health agencies cultivate long-term relationships with researchers, CBOs, and audiences with and for which the dissemination efforts were designed.

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## Conclusion

State public health agencies are essential in translating public health research into actionable information, especially to address the distinct challenges of maternal and child health in Kansas. This literature review examined dissemination strategies to close the research-to-practice gap, revealing a shift toward best practices that emphasize equity, community engagement, digital innovation, and cross-sector partnerships. Key issues, including audience access, misinformation, and external influence, were also explored. To address these issues, the authors recommend that public health agencies focus on building trust, using technology effectively, tailoring messages for specific communities, and collaborating with researchers, community organizations, and influencers. These strategies aim to support state agencies in building capacity and delivering interventions that reflect the unique needs of diverse populations.

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## Relevant literature

Table C.1 Literature Describing Theories, Frameworks, or Best Practices

Title	Citation	Brief Description
Designing for dissemination among public health and clinical practitioners in the USA	Shato, T., Kepper, M. M., McLoughlin, G. M., Tabak, R. G., Glasgow, R. E., & Brownson, R. C. (2023). Designing for dissemination among public health and clinical practitioners in the USA. <i>Journal of Clinical and Translational Science</i> , 8, e8, 1–10. <a href="https://doi.org/10.1017/cts.2023.695">https://doi.org/10.1017/cts.2023.695</a>	Existing studies examining designing for dissemination (D4D), a process that ensures interventions and implementation strategies consider adopters' contexts, have focused primarily on researchers, with limited perspectives of practitioners. To address these gaps, this study examined D4D practice among public health and clinical practitioners in the USA, and found that addressing both individual and modifiable barriers, including organizational capacity to access and use research evidence, may better align the efforts of researchers with priorities and resources of practitioners.
Dissemination and Implementation Science for Public Health Professionals: An Overview and Call to Action.	Estabrooks, P. A., Brownson, R. C., & Pronk, N. P. (2018). Dissemination and Implementation Science for Public Health Professionals: An Overview and Call to Action. <i>Preventing chronic disease</i> , 15, E162. <a href="https://doi.org/10.5888/pcd15.180525">https://doi.org/10.5888/pcd15.180525</a>	This commentary was written 1) to provide a brief DI description, 2) to demonstrate the shared systems-based focus of DI science and public health practice, and 3) to highlight pathways to move public health-focused DI science forward.
Implementation, dissemination, and diffusion of public health interventions.	Brownson, R. C., Tabak, R. G., Stamatakis, K. A., & Glanz, K. (2015). Implementation, dissemination, and diffusion of public health interventions. <i>Health Behavior: Theory, Research, and Practice</i> 5th ed. San Francisco, CA: John Wiley & Sons, 301-26.	This chapter provides an overview of key terminology and theoretical models for dissemination and implementation research.
Leveraging human-centered design in chronic disease prevention.	Matheson, G. O., Pacione, C., Shultz, R. K., & Klügl, M. (2015). Leveraging human-centered design in chronic disease prevention. <i>American Journal of Preventive Medicine</i> , 48(4), 472-479. <a href="https://doi.org/10.1016/j.amepre.2014.10.014">https://doi.org/10.1016/j.amepre.2014.10.014</a>	Bridging the knowing-doing gap in the prevention of chronic disease requires deep appreciation and understanding of the complexities inherent in behavioral change. The tools of human-centered design, used in conjunction with evidence-based data, hold much promise in providing an optimal approach for advancing disease prevention efforts.

Table C.2 Literature Describing Specific Topics, Strategies, or Tools

Title	Citation	Brief Description
Confronting health misinformation: The U.S. Surgeon General's advisory on building a healthy information environment.	US Department of Health and Human Services. (2021). <i>Confronting health misinformation: The U.S. Surgeon General's advisory on building a healthy information environment</i> . <a href="http://www.hhs.gov/sites/default/files/surgeon-general-misinformation-advisory.pdf">www.hhs.gov/sites/default/files/surgeon-general-misinformation-advisory.pdf</a>	The U.S. Surgeon General's Health Advisory on Confronting Health Misinformation emphasizes combatting health misinformation. It highlights that misinformation leads to mistrust, undermining public health efforts, particularly during the COVID-19 pandemic. Key recommendations include improving the public's ability to identify credible information, enhance medial and health literacy, and fostering community engagement to addresses misinformation. These advisory stresses that building a healthier information environment is essential for making informed health decisions.
Dissemination strategies for health apps: Systematic review	Moungui, H. C., Nana-Djeunga, H. C., Anyiang, C. F., Cano, M., Postigo, J. A. R., & Carrion, C. (2024). Dissemination strategies for mhealth apps: Systematic review. <i>JMIR mHealth and uHealth</i> , 12(1), e50293.	The aim of this study was to identify strategies and elements that ensure that end users adopt and remain engaged with mHealth apps. The literature reviewed suggests mHealth apps can be disseminated via paid and unpaid marketing strategies using various communication channels. The effects of these strategies are reflected in download numbers and user engagement with mHealth apps. The authors found that further research could provide guidance on a framework for disseminating mHealth apps and encouraging their routine use.
The future of public health campaigns: Digital strategies for amplifying influence and effectiveness	Krawiec, R. J., McGuire, K., McInerney, J., & Malik, N. (2021). <i>The future of public health campaigns: Digital strategies for amplifying influence and effectiveness</i> . Deloitte.	This report discusses how digital strategies can enhance public health campaigns. Emphasis on the importance of targeted communication to influence health behaviors, which significantly impact health outcomes.
The impact of misinformation on the COVID-19 pandemic.	Ferreira Caceres, M. M., Sosa, J. P., Lawrence, J. A., Sestacovski, C., Tidd-Johnson, A., Rasool, M. H. U., Gadamidi, V. K., Ozair, S., Pandav, K., Cuevas-Lou, C., Parrish, M., Rodriguez, I., & Fernandez, J. P. (2022). The impact of misinformation on the COVID-19 pandemic. <i>AIMS Public Health</i> , 9(2), 262–277.	COVID-19 related misinformation has played a role in defaulting control of the situation. This article provides an overview and summary regarding the role of media, other information outlets, and their impact on the pandemic. The goal of this article is to increase awareness of the negative impact of misinformation on the pandemic. In addition, the authors discussed a few recommendations that could aid in decreasing this burden.
Partnering for successful dissemination: How to improve public health with the National Cooperative Extension System.	Strayer, T. E. III, Balis, L. E., & Harden, S. M. (2020). Partnering for successful dissemination: How to improve public health with the National Cooperative Extension System. <i>Journal of Public Health Management and Practice</i> , 26(2), 184–186. <a href="https://doi.org/10.1097/PHH.0000000000001025">https://doi.org/10.1097/PHH.0000000000001025</a>	This article underscores the importance of partnering with county-based health educators through the Cooperative Extension System to identify community health needs and promote evidence-based public health interventions. The author exemplifying how the Cooperative Extension System partnered with university-based researchers identify community-based needs, and evaluate the impact of public health initiatives.
Social media in public health: Strategies to distill, package, and disseminate public health research.	Gatewood, J., Monks, S. L., Singletary, C. R., Vidrascu, E., & Moore, J. B. (2020). Social media in public health: Strategies to distill, package, and disseminate public health research. <i>Journal of Public Health Management and Practice</i> , 26(5), 489–492. <a href="https://doi.org/10.1097/PHH.0000000000001096">https://doi.org/10.1097/PHH.0000000000001096</a>	This article describes the process of developing a blog and using social media to disseminate public health information and potential applications in the day-to-day activities of other public health organizations.

Table C.3 Literature Describing Case Studies, Descriptive Examples, and Program Evaluation

Title	Citation	Brief Description
About the Pregnancy for Every Body Initiative	Eunice Kennedy Shriver National Institute of Child Health and Human Development. (National Institutes of Health, n.d.). <i>About the Pregnancy for Every Body initiative</i> . National Institutes of Health. <a href="https://www.nichd.nih.gov/ncmh/ep/initiatives/pregnancy-for-every-body/about">https://www.nichd.nih.gov/ncmh/ep/initiatives/pregnancy-for-every-body/about</a>	Obesity is associated with increased risks to the woman (during pregnancy, labor, and delivery), to the fetus (in the womb), and, in the long term, to the child. For these reasons, plus-size pregnancies require close monitoring and effective, respectful communication between women and healthcare providers, who treat them as partners. However, research shows that many healthcare providers may hold implicit bias against plus-size women. The Pregnancy for Every Body Initiative educates plus-size women and their healthcare providers about the importance of open and nonjudgmental conversations about weight when making plans for a healthy pregnancy.
Community-powered change in the Omaha metropolitan area: Examining a digital approach to mental health stigma reduction during the COVID-19 pandemic.	Bonnevie, E., Diouf, F., Goldbarg, J., Helgenberger, S., Wartella, E., Grimm, B., ... Smyser, J. (2024). Community-powered change in the Omaha metropolitan area: Examining a digital approach to mental health stigma reduction during the COVID-19 pandemic. <i>The Communication Review</i> , 27(2), 219–234. <a href="https://doi.org/10.1080/10714421.2024.2309853">https://doi.org/10.1080/10714421.2024.2309853</a>	This case study reviews the creation and implementation of a community-based participatory digital media campaign that uses a collective impact framework to address mental health stigma reduction in the Omaha metropolitan area. The campaign was delivered during the COVID-19 pandemic and consisted of various components, including two social media campaigns that delivered evidence-based messaging through user-generated content from local individuals.
Use of mobile health applications for health-promoting behavior among individuals with chronic medical conditions	Mahmood, A., Kedia, S., Wyant, D. K., Ahn, S., & Bhuyan, S. S. (2019). Use of mobile health applications for health-promoting behavior among individuals with chronic medical conditions. <i>Digital Health</i> , 5, 1–17. <a href="https://doi.org/10.1177/2055207619882181">https://doi.org/10.1177/2055207619882181</a>	This research paper examines the relationship between the use of mobile health (mHealth) applications and health-promoting behaviors among individuals with chronic medical conditions in the United States. Using data from the Health Information National Trends Survey, the researchers found a positive association between owning mHealth apps and engaging in health-promoting behaviors such as tracking health goals, making health-related decisions, and discussing health with a care provider. However, the study also identifies a digital divide, where older adults, despite owning smartphones, are less likely to own mHealth apps and benefit from these technologies. The paper calls for further research into the effectiveness of mHealth apps through randomized clinical trials, and emphasizes the need for healthcare providers to encourage the use of validated mHealth applications among patients with chronic conditions.
Diffusing science through social networks: The case of breastfeeding communication on Twitter.	Moukarzel S, Rehm M, del Fresno M, Daly AJ (2020) Diffusing science through social networks: The case of breastfeeding communication on Twitter. <i>PLoS ONE</i> 15(8): e0237471. <a href="https://doi.org/10.1371/journal.pone.0237471">https://doi.org/10.1371/journal.pone.0237471</a>	As recently highlighted by the National Academy of Sciences, there is a need for the scientific community (SC) to diffuse its findings to the public more effectively online, as means to counteract the spread of misinformation. In this article, researcher compare the efficacy of diffusing evidence based information about breastfeeding practices from the SC versus the interested citizens and companies. Their findings suggest SC influencers may possess latent potential to diffuse research and evidence- based practices. However, the research suggests specific ways to enhance diffusion.

Title	Citation	Brief Description
Entertaining information: Third-party influencers' role in COVID-safety health communication	Cover, R., Parker, L., Young, C., & Ostapets, K. (2024). Entertaining information: Third-party influencers' role in COVID-safety health communication. <i>Media International Australia</i> , 192(1), 150-164. <a href="https://doi.org/10.1177/1329878X231158880">https://doi.org/10.1177/1329878X231158880</a>	This paper discusses findings from a commissioned evaluation of an Australian government COVID-19 health campaign that utilized third-party influencers to increase the reach of health communication messages among culturally and linguistically diverse young people. Three themes emerged: (1) Entertaining health messages have a stronger fit with influencers who are known for their entertainment value; (2) Entertaining messages are more memorable and more likely to be shared; (3) A balance between entertainment and the signifiers of trust and credibility such as government health authority logos overcomes trust issues in the context of current health disinformation and misinformation.
Evaluation of a digital media campaign for reducing mental health stigma.	Alvarado-Torres, R., Dunn Silesky (Alvarado-Torres et al., 2024), M., Helgenberger, S., Anderson, A., Granillo, C., Nared, T., & Bonnevie, E. (2023). Evaluation of a digital media campaign for reducing mental health stigma. <i>Health Education Journal</i> . Advance online publication. <a href="https://doi.org/10.1177/00178969231215761">https://doi.org/10.1177/00178969231215761</a>	WhatMakesUs is a digital media campaign aimed at reducing mental health stigma in the Greater Omaha-Council Bluffs metropolitan area. This study evaluated the campaign's impact at the end of the second year of the campaign by examining different aspects of mental health stigma, including social distance, attitudes, behaviors and self-efficacy, among campaign-aware (CA) individuals and non-campaign-aware (NCA) individuals. : CA respondents exhibited lower social distance and stigmatizing attitudes and beliefs, and more positive behaviors and self-efficacy towards people with mental health conditions (MHCs) compared to NCA respondents.
Growing and glowing: A digital media campaign to increase access to pregnancy-related health information for Black women during the COVID-19 pandemic.	Bonnevie, E., Barth, C., May, J., Carey, T., Knell, S. B., Wartella, E., & Smyser, J. (2023). Growing and glowing: A digital media campaign to increase access to pregnancy-related health information for Black women during the COVID-19 pandemic. <i>Health Promotion Practice</i> , 24(3), 444-454. <a href="https://doi.org/10.1177/15248399221083844">https://doi.org/10.1177/15248399221083844</a>	In Hillsborough County, Florida, Black women experience higher rates of low birthweight compared to the rest of Florida. Content for the Growing and Glowing campaign was delivered on social media through a web series with local prenatal care providers and educational images. Two cross-sectional surveys examined changes in pregnancy-related knowledge, attitudes, and behaviors among Black women in Hillsborough. Results from the second study of this campaign approach suggest that using a highly targeted digital intervention can be a well-received and potentially effective way to deliver pregnancy-related health information to Black women, even during a global pandemic.
Implementation of the Hear Her Campaign	Greenberg, J., Apuzzio, J., Chaudhary, Z., Gittens-Williams, L., Martino, C., & Williams, S. (2023). Implementation of the Hear Her Campaign [ID: 1339546]. <i>Obstetrics and Gynecology (New York)</i> , 141(5S), 58-58S. <a href="https://doi.org/10.1097/01.AOG.0000930496.14331.53">https://doi.org/10.1097/01.AOG.0000930496.14331.53</a>	The Centers for Disease Control and Prevention 2020 Hear Her Campaign educates pregnant women, their support networks, and providers about urgent maternal warning signs, and empowers women to speak up. A 3-month period before and after promotion of the Hear Her campaign was studied and found that promotion of the Hear Her Campaign in this inner-city cohort correlated with an increase in maternal interaction with the health care system via patient-provider communication without increasing the use of emergency department services.

Title	Citation	Brief Description
Layla's Got You: Developing a tailored contraception chatbot for Black and Hispanic young women.	Bonnevie, E., Lloyd, T. D., Rosenberg, S. D., Williams, K., Goldbarg, J., & Smyser, J. (2021). Layla's Got You: Developing a tailored contraception chatbot for Black and Hispanic young women. <i>Health Education Journal</i> , 80(4), 413-424. <a href="https://doi.org/10.1177/0017896920981122">https://doi.org/10.1177/0017896920981122</a>	The Layla's Got You campaign consists of a chatbot, and social media campaign designed to increase contraception knowledge among 16- to 25-year-old Black and Hispanic women in Onondaga County. The campaign was co-created with local women in the target audience and employed digital and grassroots community building strategies. By merging innovative technology-driven strategies, participatory creation techniques and grassroots community building, the initiative delivers impactful, easily updated health information on a large scale. This strategy has promising implications for increasing knowledge and positive attitudes towards contraception among specific at-risk audiences.
Mental Health in the Digital Space: Key Lessons From a Cross-Sector Approach.	Mortillaro, G., & Bonnevie, E. (2023). Mental Health in the Digital Space: Key Lessons From a Cross-Sector Approach. <i>JAACAP Connect</i> .	In 2020, Kaiser Permanente (KP) partnered with the esports organization Cloud9 to create Presence of Mind, the first mental health initiative embedded into pre-existing professional esports networks. The initiative integrates each of the four pillars into its activities, with the goal of supporting the mental health of 14- to 25-year-old esports fans. This article summarizes the Presence of Mind's first year of implementation and comments on lessons learned toward optimizing health interventions that impact youth
NIH public health campaigns.	Office of Disease Prevention. (National Institutes of Health, 2023). <i>NIH public health campaigns</i> . Retrieved [October 1, 2024], from <a href="https://prevention.nih.gov/research-priorities/dissemination-implementation/nih-public-health-campaigns">https://prevention.nih.gov/research-priorities/dissemination-implementation/nih-public-health-campaigns</a>	These campaigns from across the U.S. Department of Health and Human Services promote behaviors that improve health or prevent disease. You can use these as models to help your community make informed decisions about disease prevention.

## Appendix D.

### MCH Population Health and Well-Being Map Data

Table D.1 Diversity Index by County

Kansas County	Diversity Index	Kansas County	Diversity Index	Kansas County	Diversity Index	Kansas County	Diversity Index
Allen	22.6	Finney	58.7	Logan	20.3	Rooks	13.9
Anderson	14	Ford	53.8	Lyon	47	Rush	13.5
Atchison	26.8	Franklin	22.5	Marion	17.1	Russell	18.2
Barber	18.3	Geary	64.5	Marshall	12	Saline	39.7
Barton	36.2	Gove	16.1	McPherson	22.5	Scott	38.7
Bourbon	24.3	Graham	18.3	Meade	39.3	Sedgwick	55
Brown	33.6	Grant	53.3	Miami	20.2	Seward	49.5
Butler	28.1	Gray	30.7	Mitchell	11.9	Shawnee	47.8
Chase	24.1	Greeley	32.4	Montgomery	42.3	Sheridan	17.9
Chautauqua	29.5	Greenwood	18.9	Morris	17	Sherman	32.6
Cherokee	28.7	Hamilton	52.2	Morton	43.5	Smith	10.8
Cheyenne	26.7	Harper	25.3	Nemaha	12.1	Stafford	30.1
Clark	28.6	Harvey	33.7	Neosho	24.4	Stanton	54.3
Clay	14.8	Haskell	44.7	Ness	25.1	Stevens	52.3
Cloud	16.6	Hodgeman	19.1	Norton	25.6	Sumner	24.7
Coffey	15.6	Jackson	35.3	Osage	15.1	Thomas	23.3
Comanche	18.6	Jefferson	18.5	Osborne	11.8	Trego	12.3
Cowley	40.6	Jewell	12.3	Ottawa	15.4	Wabaunsee	18.7
Crawford	31.9	Johnson	41.5	Pawnee	31	Wallace	20.4
Decatur	13.7	Kearny	51.9	Phillips	13.8	Washington	15.2
Dickinson	19.7	Kingman	16.2	Pottawatomie	23.7	Wichita	48
Doniphan	22.1	Kiowa	22.6	Pratt	25.3	Wilson	20.2
Douglas	41	Labette	35.4	Rawlins	22.8	Woodson	15.2
Edwards	40.2	Lane	22.8	Reno	32.7	Wyandotte	70.8
Elk	20.1	Leavenworth	40.2	Republic	11.2		
Ellis	24	Lincoln	15.9	Rice	34.3		
Ellsworth	26.2	Linn	15.9	Riley	46.2		

Table D.2 Gini Index of Income Inequality for Kansas by County

Kansas County	Gini Index of Income Inequality	Kansas County	Gini Index of Income Inequality	Kansas County	Gini Index of Income Inequality
Allen	0.388	Greeley	0.384	Osborne	0.436
Anderson	0.419	Greenwood	0.493	Ottawa	0.392
Atchison	0.429	Hamilton	0.388	Pawnee	0.434
Barber	0.447	Harper	0.439	Phillips	0.443
Barton	0.431	Harvey	0.394	Pottawatomie	0.386
Bourbon	0.423	Haskell	0.403	Pratt	0.435
Brown	0.419	Hodgeman	0.367	Rawlins	0.414
Butler	0.404	Jackson	0.372	Reno	0.437
Chase	0.473	Jefferson	0.405	Republic	0.417
Chautauqua	0.44	Jewell	0.497	Rice	0.42
Cherokee	0.411	Johnson	0.446	Riley	0.484
Cheyenne	0.454	Kearny	0.379	Rooks	0.369
Clark	0.388	Kingman	0.41	Rush	0.483
Clay	0.417	Kiowa	0.435	Russell	0.473
Cloud	0.423	Labette	0.435	Saline	0.437
Coffey	0.394	Lane	0.453	Scott	0.403
Comanche	0.403	Leavenworth	0.416	Sedgwick	0.461
Cowley	0.458	Lincoln	0.438	Seward	0.395
Crawford	0.466	Linn	0.465	Shawnee	0.451
Decatur	0.425	Logan	0.448	Sheridan	0.494
Dickinson	0.429	Lyon	0.434	Sherman	0.501
Doniphan	0.423	Marion	0.439	Smith	0.441
Douglas	0.459	Marshall	0.443	Stafford	0.441
Edwards	0.421	McPherson	0.394	Stanton	0.444
Elk	0.441	Meade	0.521	Stevens	0.348
Ellis	0.498	Miami	0.402	Sumner	0.408
Ellsworth	0.401	Mitchell	0.421	Thomas	0.464
Finney	0.403	Montgomery	0.431	Trego	0.423
Ford	0.397	Morris	0.451	Wabaunsee	0.393
Franklin	0.39	Morton	0.394	Wallace	0.408
Geary	0.395	Nemaha	0.45	Washington	0.414
Gove	0.419	Neosho	0.442	Wichita	0.455
Graham	0.38	Ness	0.442	Wilson	0.479
Grant	0.389	Norton	0.458	Woodson	0.432
Gray	0.403	Osage	0.384	Wyandotte	0.427

Table D.3 Kansas County Population Density

Kansas County	Density	Kansas County	Density	Kansas County	Density
Allen	25.1	Greeley	1.6	Osborne	3.9
Anderson	13.4	Greenwood	5.2	Ottawa	8
Atchison	37.4	Hamilton	2.4	Pawnee	8.2
Barber	3.6	Harper	6.6	Phillips	5.4
Barton	28	Harvey	62.6	Pottawatomie	31.2
Bourbon	22.8	Haskell	6.2	Pratt	12.3
Brown	16.4	Hodgeman	2	Rawlins	2.4
Butler	47.7	Jackson	20.2	Reno	49
Chase	3.3	Jefferson	34.4	Republic	6.5
Chautauqua	5.3	Jewell	3.2	Rice	13
Cherokee	32.5	Johnson	1,307.3	Riley	116.6
Cheyenne	2.5	Kearny	4.4	Rooks	5.4
Clark	2	Kingman	8.3	Rush	4.1
Clay	12.5	Kiowa	3.3	Russell	7.5
Cloud	12.5	Labette	30.6	Saline	74.4
Coffey	13.2	Lane	2.2	Scott	7
Comanche	2.1	Leavenworth	178.9	Sedgwick	527.1
Cowley	30.6	Lincoln	4	Seward	33.4
Crawford	66.3	Linn	16.5	Shawnee	326.2
Decatur	3	Logan	2.5	Sheridan	2.7
Dickinson	21.8	Lyon	37.6	Sherman	5.5
Doniphan	18.9	Marion	33.4	Smith	3.9
Douglas	263.2	Marshall	12.6	Stafford	5
Edwards	4.4	McPherson	11.1	Stanton	2.9
Elk	3.8	Meade	4	Stevens	7.1
Ellis	32.2	Miami	60.5	Sumner	19
Ellsworth	8.9	Mitchell	8.2	Thomas	7.3
Finney	28.9	Montgomery	48.2	Trego	3.1
Ford	30.8	Morris	7.7	Wabaunsee	8.8
Franklin	45.5	Morton	3.6	Wallace	1.6
Geary	92.8	Nemaha	14.1	Washington	6.1
Gove	2.5	Neosho	27.3	Wichita	2.9
Graham	2.7	Ness	2.5	Wilson	15.1
Grant	12.5	Norton	6	Woodson	6.2
Gray	6.6	Osage	22.2	Wyandotte	1,093

Table D.4 Primary Care HPSA Scores in Kansas

Kansas County	HPSA Primary Care Score	Kansas County	HPSA Primary Care Score	Kansas County	HPSA Primary Care Score
Allen	13	Greeley	9	Osborne	9
Anderson	8	Greenwood	15	Ottawa	100
Atchison	14	Hamilton	7	Pawnee	5
Barber	15	Harper	15	Phillips	13
Barton	8	Harvey	10	Pottawatomie	9
Bourbon	17	Haskell	14	Pratt	14
Brown	7	Hodgeman	100	Rawlins	7
Butler	6	Jackson	5	Reno	19
Chase	14	Jefferson	100	Republic	100
Chautauqua	15	Jewell	16	Rice	100
Cherokee	17	Johnson	17	Riley	15
Cheyenne	7	Kearny	100	Rooks	7
Clark	7	Kingman	8	Rush	12
Clay	100	Kiowa	100	Russell	15
Cloud	7	Labette	17	Saline	17
Coffey	100	Lane	13	Scott	9
Comanche	100	Leavenworth	12	Sedgwick	19
Cowley	19	Lincoln	7	Seward	14
Crawford	21	Linn	9	Shawnee	10
Decatur	14	Logan	100	Sheridan	7
Dickinson	16	Lyon	20	Sherman	13
Doniphan	14	Marion	4	Smith	100
Douglas	18	Marshall	100	Stafford	9
Edwards	9	McPherson	100	Stanton	13
Elk	16	Meade	7	Stevens	14
Ellis	9	Miami	100	Sumner	9
Ellsworth	7	Mitchell	15	Thomas	9
Finney	16	Montgomery	17	Trego	100
Ford	5	Morris	13	Wabaunsee	100
Franklin	10	Morton	13	Wallace	9
Geary	17	Nemaha	11	Washington	13
Gove	7	Neosho	17	Wichita	5
Graham	100	Ness	7	Wilson	17
Grant	14	Norton	100	Woodson	100
Gray	11	Osage	12	Wyandotte	19

Table D.5 Behavioral Health Workforce by Estimated Need

Kansas County	Prescriber to population ratio (Mullan Institute)	Kansas County	Prescriber to population ratio (Mullan Institute)	Kansas County	Prescriber to population ratio (Mullan Institute)
Allen	64	Greeley	244	Osborne	40
Anderson	40	Greenwood	46	Ottawa	35
Atchison	53	Hamilton	66	Pawnee	56
Barber	119	Harper	100	Phillips	49
Barton	93	Harvey	68	Pottawatomie	52
Bourbon	40	Haskell	42	Pratt	97
Brown	65	Hodgeman	226	Rawlins	29
Butler	39	Jackson	71	Reno	47
Chase	26	Jefferson	29	Republic	96
Chautauqua	43	Jewell	0	Rice	49
Cherokee	21	Johnson	52	Riley	29
Cheyenne	129	Kearny	129	Rooks	88
Clark	182	Kingman	51	Rush	71
Clay	71	Kiowa	71	Russell	77
Cloud	41	Labette	76	Saline	78
Coffey	68	Lane	169	Scott	114
Comanche	39	Leavenworth	29	Sedgwick	55
Cowley	58	Lincoln	47	Seward	42
Crawford	69	Linn	46	Shawnee	60
Decatur	51	Logan	132	Sheridan	51
Dickinson	33	Lyon	42	Sherman	68
Doniphan	15	Marion	57	Smith	143
Douglas	31	Marshall	26	Stafford	17
Edwards	47	McPherson	39	Stanton	114
Elk	31	Meade	15	Stevens	31
Ellis	52	Miami	24	Sumner	36
Ellsworth	100	Mitchell	55	Thomas	84
Finney	60	Montgomery	62	Trego	75
Ford	33	Morris	60	Wabaunsee	0
Franklin	24	Morton	79	Wallace	43
Geary	46	Nemaha	80	Washington	89
Gove	102	Neosho	80	Wichita	61
Graham	57	Ness	100	Wilson	89
Grant	53	Norton	72	Woodson	21
Gray	18	Osage	27	Wyandotte	64

Table D.6 Obesity Among Adults by County

Kansas County	Obesity Among Adults (2022)	Kansas County	Obesity Among Adults (2022)	Kansas County	Obesity Among Adults (2022)
Allen	40.5	Greeley	36.5	Osborne	37.8
Anderson	36.2	Greenwood	40.2	Ottawa	36.6
Atchison	38.5	Hamilton	40	Pawnee	41.5
Barber	41.4	Harper	42	Phillips	37.3
Barton	40.8	Harvey	36.4	Pottawatomie	31.2
Bourbon	41.9	Haskell	40	Pratt	37.4
Brown	41.3	Hodgeman	36.4	Rawlins	40.7
Butler	40.2	Jackson	43.3	Reno	37.3
Chase	38.4	Jefferson	41.7	Republic	38.3
Chautauqua	39.7	Jewell	39.1	Rice	35.9
Cherokee	42.3	Johnson	31.7	Riley	30.7
Cheyenne	39.2	Kearny	42.7	Rooks	37.6
Clark	38.2	Kingman	40.9	Rush	36.8
Clay	39.7	Kiowa	34.1	Russell	36.5
Cloud	40.9	Labette	43.1	Saline	37.4
Coffey	39.6	Lane	39.8	Scott	40.2
Comanche	37.9	Leavenworth	40.5	Sedgwick	33
Cowley	41.1	Lincoln	41.2	Seward	44.7
Crawford	40.7	Linn	38.9	Shawnee	39.4
Decatur	37.9	Logan	38.7	Sheridan	37
Dickinson	38.6	Lyon	36.8	Sherman	39.3
Doniphan	37.7	Marion	37.9	Smith	40.4
Douglas	34.8	Marshall	41.5	Stafford	38
Edwards	42.1	McPherson	34.1	Stanton	42.4
Elk	42.1	Meade	40	Stevens	39.9
Ellis	38.8	Miami	35.7	Sumner	39.7
Ellsworth	39.1	Mitchell	39.1	Thomas	33
Finney	42.9	Montgomery	44.8	Trego	36.2
Ford	38.1	Morris	40	Wabaunsee	41.3
Franklin	34.3	Morton	38.4	Wallace	39.9
Geary	35	Nemaha	33.3	Washington	39.5
Gove	39.5	Neosho	42.4	Wichita	40.3
Graham	38.5	Ness	37.1	Wilson	39.9
Grant	40.4	Norton	39.9	Woodson	38.6
Gray	39.2	Osage	40.1	Wyandotte	41.6

# Appendix E. Performance and Outcome Measures

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# Appendix E.1 Women and Maternal Health Population Domain

National Performance Measures / Outcome Measures / Life Course Indicators Linkage. 2026 Application/2024 Annual Report

## Key and Definitions

**NPM:** National Performance Measure

**NOM:** National Outcome Measure

**SM:** Standard Measure

**n/a** indicates the data were not available at the time of report

**HP2030:** Healthy People 2030 goal

**Bolded NPMs:** Selected National Performance Measures that are most closely aligned with Kansas priorities.

\* Statistically significant trend (p<0.05)

† Estimate is statistically unreliable; interpret with caution.

‡ Stratifiers for percentages use three-year rolling average (except for the 2018 PRAMS estimate, which includes only 2017-2018 data, as data were not collected in 2016). Stratifiers for rates use five-year rolling average

Two hyphens (i.e., --) indicate that the estimate has been suppressed due to statistical unreliability and/or low sample size.

## **NPM: Postpartum Contraceptive Use<sup>1</sup> (HP2030: 65.1%)**

Postpartum Visit	2018	2019	2020	2021	2022	Trend
Percent of women who are using a most or moderately effective contraceptive following a recent live birth	53.6%	56.0%	52.2%	51.7%	49.1%	Negative

## **NPM: Postpartum Contraceptive Use by Maternal Age**

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	61.0%	62.8%	61.1%	68.8%	71.1%	Positive*
20-24 Years	49.1%	52.6%	54.9%	56.1%	53.5%	Positive
25-29 Years	51.5%	53.6%	53.2%	53.2%	48.7%	Negative
30-34 Years	58.1%	56.6%	55.5%	53.4%	51.5%	Negative*
≥35 Years	55.3%	53.2%	48.9%	44.8%	45.6%	Negative*

## **NPM: Postpartum Contraceptive Use by Race/Ethnicity**

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	46.9%	50.3%	53.7%	56.7%	56.1%	Positive*
Non-Hispanic American Indian/Alaska Native	--	--	--	--	--	--
Non-Hispanic Asian/Native Hawaiian or Other Pacific Islander	24.5%	21.4%	19.9%	25.2%	26.5%	Positive
Non-Hispanic Black	52.9%	56.4%	54.6%	55.8%	47.7%	Negative
Non-Hispanic Other Race/Multiple Races	50.9%	55.1%	50.1%	54.8%	48.4%	Negative
Non-Hispanic White	56.6%	56.6%	55.3%	53.5%	51.3%	Negative*

*NPM: Postpartum Contraceptive Use by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than high school	54.9%	56.0%	57.2%	61.6%	62.0%	Positive*
High school graduate	56.9%	59.4%	57.6%	59.5%	56.9%	No change
Some college	55.9%	55.9%	55.8%	53.4%	52.5%	Negative
College graduate	50.5%	50.3%	49.5%	47.2%	43.5%	Negative

*NPM: Postpartum Contraceptive Use by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Medicaid	58.1%	59.2%	58.7%	60.1%	58.7%	No change
Private	54.2%	54.6%	53.6%	51.8%	48.7%	Negative*
None/Self-Pay	31.3%	34.2%	38.9%	39.8%	38.6%	Positive
Other	49.4%	51.0%	49.4%	49.5%	47.6%	Negative

*NPM: Postpartum Contraceptive Use by Marital Status*

Marital Status	2018	2019	2020	2021	2022	Trend
Married	50.5%	51.0%	49.0%	47.9%	45.1%	Negative*
Unmarried	60.4%	61.5%	62.8%	63.2%	61.9%	Positive

*NPM: Postpartum Contraceptive Use by WIC Participation*

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	60.5%	62.6%	61.1%	63.9%	61.5%	No change
No	51.1%	51.5%	51.4%	50.0%	47.9%	Positive

*NPM: Postpartum Contraceptive Use by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Metro	54.5%	54.8%	53.5%	52.6%	49.0%	Negative*
Non-Metro	52.9%	54.3%	55.0%	55.0%	55.0%	Positive

**NPM: Postpartum Visit – Attendance<sup>1</sup>**

Postpartum Visit – Attendance	2018	2019	2020	2021	2022	Trend
A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth	90.6%	92.5%	89.6%	91.7%	92.1%	No change

**NPM: Postpartum Visit – Attendance by Maternal Age**

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	84.6%	86.3%	83.5%	89.8%	90.2%	Positive*
20-24 Years	81.6%	84.4%	86.4%	88.2%	89.1%	Positive*
25-29 Years	92.4%	93.3%	92.8%	92.7%	91.3%	No change
30-34 Years	94.8%	93.9%	93.1%	92.6%	92.2%	Negative*
≥35 Years	90.6%	91.0%	91.9%	90.3%	91.8%	No change

**NPM: Postpartum Visit – Attendance by Race/Ethnicity**

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	82.4%	83.2%	83.7%	84.3%	85.9%	Positive*
Non-Hispanic American Indian/Alaska Native	--	--	--	--	--	--
Non-Hispanic Asian/Native Hawaiian or Other Pacific Islander	91.7%	91.2%	90.9%	90.6%	92.8%	No change
Non-Hispanic Black	88.5%	89.8%	87.7%	86.6%	81.8%	Negative*
Non-Hispanic Other Race/Multiple Races	79.3%	80.8%	89.8%	91.2%	93.0%	Positive*
Non-Hispanic White	91.8%	92.8%	92.7%	93.4%	93.0%	No change

**NPM: Postpartum Visit – Attendance by Educational Attainment**

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than high school	72.1%	74.2%	75.2%	80.4%	82.3%	Positive*
High school graduate	88.3%	89.2%	87.5%	87.3%	86.5%	Negative*
Some college	88.9%	90.6%	92.6%	92.5%	92.0%	Positive
College graduate	98.1%	97.6%	96.9%	96.6%	96.4%	Negative*

*NPM: Postpartum Visit – Attendance by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Medicaid	82.1%	84.6%	84.8%	86.2%	85.3%	Positive
Private	95.4%	95.5%	94.8%	94.5%	94.3%	Negative*
None/Self-Pay	76.8%	78.1%	83.6%	84.3%	85.5%	Positive*
Other	90.3%	90.0%	93.3%	94.1%	95.5%	Positive*

*NPM: Postpartum Visit – Attendance by Marital Status*

Marital Status	2018	2019	2020	2021	2022	Trend
Married	94.3%	94.8%	95.1%	94.5%	93.8%	No change
Unmarried	82.2%	83.7%	83.8%	85.6%	86.3%	Positive*

*NPM: Postpartum Visit – Attendance by WIC Participation*

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	81.3%	83.2%	84.0%	86.5%	86.5%	Positive*
No	93.7%	93.9%	93.4%	92.8%	92.5%	Negative*

*NPM: Postpartum Visit – Attendance by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Metro	89.8%	90.6%	90.7%	91.1%	91.1%	Positive*
Non-Metro	90.3%	91.2%	91.4%	91.6%	91.3%	No change

*NPM: Postpartum Visit – Recommended Care Components<sup>1</sup>*

Postpartum Visit – Recommended Care Components	2018	2019	2020	2021	2022	Trend
B) Percent of women who attended a postpartum checkup and received recommended care components	74.9%	76.1%	80.6%	77.7%	79.0%	Positive

*NPM: Postpartum Visit – Recommended Care Components by Maternal Age*

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	92.8%	91.1%	88.9%	85.3%	87.5%	Negative*
20-24 Years	80.7%	83.2%	85.7%	84.9%	81.7%	No change
25-29 Years	74.4%	74.0%	78.1%	78.6%	82.2%	Positive*
30-34 Years	68.1%	69.4%	72.4%	75.7%	77.1%	Positive*
≥35 Years	63.1%	65.8%	68.4%	69.4%	69.7%	Positive*

*NPM: Postpartum Visit – Recommended Care Components by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	71.9%	72.6%	75.9%	75.8%	76.6%	Positive*
Non-Hispanic American Indian/Alaska Native	--	--	--	--	--	--
Non-Hispanic Asian/Native Hawaiian or Other Pacific Islander	63.5%	65.9%	69.1%	70.2%	69.8%	Positive
Non-Hispanic Black	79.2%	79.9%	81.1%	81.9%	81.9%	Positive*
Non-Hispanic Other Race/Multiple Races	80.0%	77.8%	79.1%	66.2%	73.9%	Negative
Non-Hispanic White	71.9%	72.6%	75.9%	75.8%	76.6%	Positive*

*NPM: Postpartum Visit – Recommended Care Components by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than high school	73.6%	72.3%	76.6%	74.4%	76.4%	Positive
High school graduate	74.3%	75.2%	76.7%	78.1%	78.2%	Positive*
Some college	75.5%	76.2%	78.4%	78.0%	78.1%	Positive*
College graduate	70.6%	72.6%	76.7%	79.4%	81.2%	Positive*

*NPM: Postpartum Visit – Recommended Care Components by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Medicaid	76.2%	74.8%	75.0%	75.0%	76.9%	No change
Private	71.5%	73.6%	78.4%	79.9%	80.5%	Positive*
None/Self-Pay	77.3%	72.1%	67.4%	67.4%	68.3%	Negative
Other	75.4%	80.4%	82.7%	85.3%	86.0%	Positive*

*NPM: Postpartum Visit – Recommended Care Components by Marital Status*

Marital Status	2018	2019	2020	2021	2022	Trend
Married	71.7%	72.8%	76.4%	77.0%	78.6%	Positive*
Unmarried	76.7%	77.2%	78.7%	80.1%	80.1%	Positive*

*NPM: Postpartum Visit – Recommended Care Components by WIC Participation*

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	74.2%	75.8%	77.7%	80.0%	79.5%	Positive*
No	72.9%	73.6%	76.8%	77.5%	79.0%	Positive*

*NPM: Postpartum Visit – Recommended Care Components by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Metro	75.3%	75.8%	78.5%	80.0%	81.5%	Positive*
Non-Metro	68.9%	70.9%	74.3%	74.4%	74.3%	Positive*

*NPM: Preventive Dental Visit – Pregnancy<sup>1</sup>*

Preventive Dental Visit - Pregnancy	2018	2019	2020	2021	2022	Trend
Percent of women who had a preventive dental visit during pregnancy	46.5%	50.0%	45.9%	49.3%	48.9%	Positive

*NPM: Preventive Dental Visit - Pregnancy by Maternal Age*

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	36.6%	37.5%	33.7%	37.7%	35.0%	Negative
20-24 Years	30.2%	29.6%	30.1%	29.7%	31.8%	Positive
25-29 Years	46.8%	48.0%	48.1%	47.5%	46.9%	No change
30-34 Years	53.8%	56.6%	56.1%	58.0%	56.4%	Positive
≥35 Years	55.0%	56.8%	60.2%	62.1%	60.7%	Positive

*NPM: Preventive Dental Visit - Pregnancy by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	32.0%	35.8%	39.4%	36.6%	36.0%	Positive
Non-Hispanic American Indian/Alaska Native	--	--	--	--	--	--
Non-Hispanic Asian/Native Hawaiian or Other Pacific Islander	33.8%	34.3%	32.2%	45.5%	49.8%	Positive*
Non-Hispanic Black	38.4%	39.3%	39.9%	34.2%	30.4%	Negative
Non-Hispanic Other Race/Multiple Races	40.7%	36.3%	34.7%	38.6%	46.1%	Positive
Non-Hispanic White	49.4%	50.9%	50.8%	52.9%	52.4%	Positive*

*NPM: Preventive Dental Visit - Pregnancy by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	30.8%	30.5%	29.7%	27.8%	28.0%	Negative*
High School Graduate	31.2%	33.3%	33.4%	33.6%	30.6%	Negative
Some College	37.5%	40.4%	41.6%	42.3%	41.8%	Positive*
College Graduate	67.8%	67.5%	67.4%	69.4%	69.9%	Positive*

*NPM: Preventive Dental Visit - Pregnancy by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Medicaid	27.0%	28.6%	27.6%	28.1%	27.1%	No change
Private	56.5%	58.1%	60.0%	61.2%	61.1%	Positive*
None/Self-Pay	28.3%	31.9%	30.8%	33.8%	33.1%	Positive*
Other	54.9%	50.3%	48.2%	42.2%	43.6%	Negative*

*NPM: Preventive Dental Visit - Pregnancy by Marital Status*

Marital Status	2018	2019	2020	2021	2022	Trend
Married	55.1%	56.6%	57.4%	57.4%	56.9%	Positive
Unmarried	28.8%	29.8%	30.3%	32.4%	32.0%	Positive*

*NPM: Preventive Dental Visit - Pregnancy by WIC Participation*

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	28.5%	30.6%	30.2%	32.1%	32.3%	Positive*
No	52.9%	53.6%	53.7%	53.7%	52.8%	No change

*NPM: Preventive Dental Visit - Pregnancy by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Metro	49.6%	51.1%	50.4%	51.5%	50.3%	No change
Non-Metro	37.1%	38.4%	41.0%	42.2%	43.5%	Positive*

**SM: Early Prenatal Care<sup>2</sup>**

Percent of pregnant women who receive prenatal care beginning in the first trimester	2018	2019	2020	2021	2022	Trend
All	81.0%	80.9%	81.0%	81.9%	80.6%	No change
Medicaid	71.7%	71.4%	72.3%	75.1%	73.5%	Positive
Non-Medicaid	85.3%	85.0%	85.3%	85.4%	84.2%	No change

SM: Early Prenatal Care by Maternal Age

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	67.9%	67.6%	67.7%	67.4%	68.1%	No change
20-24 Years	76.0%	76.5%	76.7%	77.1%	77.3%	Positive*
25-29 Years	82.5%	82.3%	82.3%	82.8%	82.7%	No change
30-34 Years	85.1%	85.0%	84.8%	85.2%	84.8%	No change
≥35 Years	82.6%	82.4%	81.9%	81.3%	80.7%	Negative*

SM: Early Prenatal Care by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	70.7%	71.3%	71.6%	71.8%	71.1%	No change
Non-Hispanic American Indian/Alaska Native	66.9%	64.3%	64.7%	64.7%	67.1%	No change
Non-Hispanic Asian	82.0%	81.6%	80.8%	80.8%	81.1%	No change
Non-Hispanic Black	72.5%	71.3%	71.1%	71.3%	71.3%	No change
Non-Hispanic Native Hawaiian/Other Pacific Islander	47.3%	47.1%	50.5%	43.4%	44.7%	Negative
Non-Hispanic Other Race/Multiple Races	75.0%	75.1%	74.4%	76.0%	77.1%	Positive
Non-Hispanic White	84.6%	84.7%	84.7%	85.1%	85.1%	Positive*

SM: Early Prenatal Care by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	82.4%	82.5%	82.6%	83.1%	83.2%	Positive*
Not Born in U.S.	72.0%	71.4%	70.7%	69.8%	68.6%	Negative*

SM: Early Prenatal Care by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	62.3%	62.0%	61.2%	60.7%	59.7%	Negative*
High School Graduate	74.9%	75.4%	75.3%	76.3%	77.0%	Positive*
Some College	82.3%	82.0%	82.4%	82.7%	82.9%	No change
College Graduate	90.8%	90.7%	90.5%	90.3%	89.6%	Negative*

*SM: Early Prenatal Care by Marital Status*

Marital Status	2018	2019	2020	2021	2022	Trend
Married	85.9%	85.7%	85.7%	85.9%	85.6%	No change
Unmarried	72.3%	72.6%	72.7%	73.2%	73.4%	Positive*

*SM: Early Prenatal Care by WIC Participation*

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	72.9%	73.0%	73.2%	73.3%	73.0%	No change
No	84.5%	84.2%	83.8%	83.9%	83.7%	Negative*

*SM: Early Prenatal Care by Plural Birth*

Plural Birth	2018	2019	2020	2021	2022	Trend
Singleton	80.8%	80.9%	80.9%	81.2%	81.1%	Positive*
Multiple Birth	86.4%	85.3%	83.7%	83.5%	83.4%	Negative*

*SM: Early Prenatal Care by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Fringe Metro	84.1%	83.9%	83.3%	83.0%	81.9%	Negative*
Small/Medium Metro	82.1%	81.5%	81.3%	82.0%	83.0%	No change
Non-Metro	76.7%	77.6%	78.3%	78.8%	78.5%	Positive*

*SM: Low Risk Cesarean Deliveries: Percent of cesarean deliveries among low-risk first births (HP2030: 23.6%)<sup>2</sup>*

Low Risk Cesarean Deliveries	2018	2019	2020	2021	2022	Trend
All	24.2%	24.3%	24.6%	23.9%	24.6%	No change
Medicaid	23.8%	22.3%	22.9%	23.3%	24.0%	No change
Non-Medicaid	24.5%	25.0%	25.4%	24.3%	24.9%	No change

SM: Low Risk Cesarean Deliveries by Maternal Age

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	16.2%	16.1%	15.7%	15.3%	14.8%	Positive*
20-24 Years	21.6%	21.0%	21.2%	21.2%	21.6%	No change
25-29 Years	23.6%	23.9%	24.7%	24.8%	24.7%	Negative
30-34 Years	29.0%	30.1%	29.6%	29.0%	29.0%	No change
≥35 Years	41.8%	41.9%	42.4%	41.0%	41.3%	No change

SM: Low Risk Cesarean Deliveries by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	22.3%	22.5%	22.3%	21.8%	22.8%	No change
Non-Hispanic American Indian/Alaska Native	22.0%	22.1%	28.4%	29.0%	31.1%	Negative*
Non-Hispanic Asian	26.5%	29.0%	29.7%	29.6%	29.6%	Negative
Non-Hispanic Black	27.5%	26.2%	26.3%	27.3%	28.7%	Negative
Non-Hispanic Native Hawaiian/Other Pacific Islander	31.8%	34.8%	44.8%	46.2%	39.3%	Negative
Non-Hispanic Other Race/Multiple Races	21.1%	19.2%	22.5%	22.8%	25.1%	Negative
Non-Hispanic White	23.9%	24.2%	24.3%	24.3%	24.0%	No change

SM: Low Risk Cesarean Deliveries by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	23.9%	24.0%	24.1%	24.0%	24.1%	No change
Born outside U.S.	24.2%	24.8%	26.1%	26.2%	26.9%	Negative*

*SM: Low Risk Cesarean Deliveries by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than high school	20.5%	19.6%	18.7%	17.6%	17.5%	Positive*
High school graduate	22.2%	22.1%	23.7%	24.0%	24.7%	Negative*
Some college	25.4%	25.4%	25.5%	25.4%	25.9%	No change
College graduate	24.7%	25.4%	25.4%	25.2%	24.8%	No change

*SM: Low Risk Cesarean Deliveries by Marital Status*

Marital Status	2018	2019	2020	2021	2022	Trend
Married	24.4%	24.9%	25.3%	25.4%	25.4%	Negative
Unmarried	23.3%	23%	23.0	22.7	23.1	No change

*SM: Low Risk Cesarean Deliveries by WIC Participation*

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	23.2%	22.9%	23.1%	22.8%	23.1%	No change
No	24.2%	24.6%	24.8%	24.7%	24.7%	No change

*SM: Low Risk Cesarean Deliveries by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Fringe Metro	22.2%	23.1%	24.1%	24.2%	24.2%	Negative
Small/Medium Metro	25.0%	25.5%	25.1%	24.5%	24.5%	Positive
Non-Metro	24.5%	23.4%	23.8%	24.0%	24.4%	No change

*SM Smoking - Pregnancy: Smoking During Pregnancy<sup>2</sup>*

Percent of women who smoke during pregnancy	2018	2019	2020	2021	2022	Trend
All	9.5%	8.5%	8.2%	6.9%	5.5%	Positive *
Medicaid	22.2%	20.4%	19.1%	16.7%	12.9%	Positive *
Non-Medicaid	3.7%	3.4%	3.2%	2.6%	2.1%	Positive *

*SM: Smoking During Pregnancy by Maternal Age*

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	11.7%	11.0%	10.0%	8.2%	6.6%	Positive*
20-24 Years	14.2%	12.9%	11.7%	10.3%	8.8%	Positive*
25-29 Years	10.4%	9.8%	9.0%	8.0%	7.0%	Positive*
30-34 Years	7.2%	7.2%	7.0%	6.6%	5.8%	Positive*
≥35 Years	6.9%	6.8%	6.7%	6.4%	6.0%	Positive*

*SM: Smoking During Pregnancy by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	3.7%	3.7%	3.3%	3.0%	2.6%	Positive*
Non-Hispanic American Indian/Alaska Native	18.1%	18.5%	19.9%	18.0%	16.8%	Positive
Non-Hispanic Asian	0.8%	0.9%	1.0%	1.0%	0.8%	Negative
Non-Hispanic Black	11.4%	11.1%	10.0%	9.9%	8.9%	Positive*
Non-Hispanic Native Hawaiian/Other Pacific Islander	9.7%	9.2%	8.4%	7.5%	6.8%	Positive*
Non-Hispanic Other Race/Multiple Races	13.4%	13.1%	13.0%	11.0%	9.9%	Positive*
Non-Hispanic White	11.5%	10.8%	10.0%	9.0%	7.8%	Positive*

*SM: Smoking During Pregnancy by Nativity*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	11.4%	10.7%	10.0%	9.0%	7.8%	Positive*
Not Born in U.S.	1.1%	1.0%	0.9%	0.9%	0.8%	Positive*

*SM: Smoking During Pregnancy by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	19.4%	18.6%	17.7%	16.5%	15.2%	Positive*
High School Graduate	17.7%	16.7%	15.5%	14.0%	11.8%	Positive*
Some College	10.2%	9.5%	8.9%	8.1%	7.3%	Positive*
College Graduate	1.0%	0.9%	0.7%	0.6%	0.6%	Positive*

*SM: Smoking During Pregnancy by Marital Status*

Marital Status	2018	2019	2020	2021	2022	Trend
Married	4.2%	3.9%	3.6%	3.1%	2.7%	Positive*
Unmarried	20.1%	19.0%	17.7%	16.2%	14.2%	Positive*

*SM: Smoking During Pregnancy by WIC Participation*

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	18.6%	18%	17.2%	16.0%	14.2%	Positive*
No	6.2%	6.0%	5.6%	5.2%	4.7%	Positive*

*SM: Smoking During Pregnancy by Plural Birth*

Plural Birth	2018	2019	2020	2021	2022	Trend
Singleton	10.0%	9.4%	8.7%	7.8%	6.9%	Positive*
Multiple Birth	9.5%	10.0%	9.8%	8.5%	6.8%	Positive

*SM: Smoking During Pregnancy by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Fringe Metro	5.1%	4.7%	4.1%	3.4%	2.6%	Positive*
Small/Medium Metro	11.4%	10.7%	10.0%	9.2%	8.2%	Positive*
Non-Metro	12.9%	12.3%	11.7%	10.7%	9.4%	Positive*

*SM: Well-Women Visits<sup>3</sup>*

Well-Women Visits	2018	2019	2020	2021	2022	Trend
Percent of women, ages 18 - 44, with a preventive medical visit in the past year	71.4%	71.7%	72.2%	72.4%	74.0%	Positive*

*SM: Well-Women Visits by Maternal Age*

Maternal Age	2018	2019	2020	2021	2022	Trend
18-24 Years	69.3%	68.7%	70.5%	70.4%	70.4%	Positive
25-34 Years	67.6%	72.9%	71.3%	70.1%	73.4%	Positive
35-44 Years	76.9%	73.0%	74.4%	76.1%	77.5%	Positive

SM: Well-Women Visits by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	64.0%	73.8%	72.4%	69.8%	77.1%	Positive
Non-Hispanic American Indian/Alaska Native	--	--	--	--	--	--
Non-Hispanic Asian	81.7%	n/a	69.2%	60.9%	n/a	Negative
Non-Hispanic Black	78.8%	75.2%	78.0%	78.1%	76.0%	Negative
Non-Hispanic Multiple Race	57.2%	82.1%	56.6%	69.5%	65.4%	Positive
Non-Hispanic Native Hawaiian/Other Pacific Islander	--	--	--	--	--	--
Non-Hispanic White	72.2%	71.0%	72.3%	73.3%	74.4%	Positive*

SM: Well-Women Visits by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than high school	71.4%	74.2%	67.7%	65.2%	61.8%	Negative
High school graduate	52.6%	67.5%	71.3%	67.5%	71.4%	No change
Some college	70.6%	69.8%	70.6%	71.6%	73.4%	No change
College graduate	72.5%	76.1%	76.1%	78.9%	79.8%	Positive

SM: Well-Women Visits by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Insured	77.8%	76.7%	76.6%	76.3%	77.8%	No change
Uninsured	44.8%	49.5%	45.1%	41.2%	45.3%	Negative

SM: Well-Women Visits by Household Income/Poverty

Household Income/Poverty	2018	2019	2020	2021	2022	Trend
<\$25,000	66.2%	65.8%	70.5%	68.0%	65.8%	Positive
\$25,000-\$49,999	69.4%	69.7%	67.5%	68.6%	68.6%	No change
\$50,000-\$74,999	75.1%	76.1%	73.6%	74.7%	79.7%	Positive
≥\$75,000	80.7%	78.1%	77.6%	76.4%	79.3%	Negative

SM: Well-Women Visits by Language

Language	2018	2019	2020	2021	2022	Trend
English	71.3%	71.8%	72.2%	72.4%	73.9%	Positive*
Non-English	--	--	--	--	--	--

SM: Well-Women Visits by Marital Status

Marital Status	2018	2019	2020	2021	2022	Trend
Married	72.7%	74.1%	74.6%	76.0%	77.6%	Positive*
Unmarried	70.0%	69.6%	70.1%	69.1%	71.3%	No change

SM: Well-Women Visits by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Metro	73.9%	70.7%	72.3%	72.8%	73.7%	No change
Non-Metro	65.3%	74.2%	72.1%	71.3%	74.8%	Positive

NOM: Infant mortality rate per 1,000 live births (HP2030: 6.0)

Infant mortality rate per 1,000 live births	2018	2019	2020	2021	2022	Trend
All <sup>2,4</sup>	6.4	5.3	6.5	5.3	5.8	Positive
Medicaid <sup>2,5,†</sup>	7.9	7.2	8.7	7.0	6.7	Positive
Non-Medicaid <sup>2,5,†</sup>	5.5	4.3	4.3	3.5	4.0	Positive

NOM: Infant mortality rate per 1,000 live births by Gestational Age<sup>2,5,†</sup>

Gestational Age	2018	2019	2020	2021	2022	Trend
<34 Weeks	122.2	114.9	111.0	105.6	99.9	Positive*
34-36 Weeks	9.3	9.3	9.4	8.3	8.3	Positive
37-38 Weeks	3.9	3.8	3.9	3.7	3.6	Positive
39+ Weeks	1.8	1.8	1.8	1.8	1.8	Positive

NOM: Infant mortality rate per 1,000 live births by Birthweight

Birthweight	2018	2019	2020	2021	2022	Trend
<1,500 Grams	231.4	216.7	208.8	197.6	191.3	Positive*
1,500-2,499 Grams	15.2	14.7	16.0	14.2	13.7	Positive
2,500+ Grams	2.3	2.2	2.2	2.2	2.2	Positive*

NOM: Infant mortality rate per 1,000 live births by Maternal Age

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	8.2	7.7	8.3	8.7	8.8	Negative
20-24 Years	6.5	6.7	6.8	6.7	6.6	No change
25-29 Years	6.4	6.1	5.9	5.4	4.9	Positive*
30-34 Years	4.7	4.4	4.7	4.5	4.5	No change
≥35 Years	5.5	5.3	5.1	4.7	4.7	Positive*

NOM: Infant mortality rate per 1,000 live births by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	6.0	6.0	5.8	5.8	5.6	Positive*
Non-Hispanic American Indian/Alaska Native	--	--	--	--	--	--
Non-Hispanic Asian/Native Hawaiian or Other Pacific Islander	4.4	4.7	4.4	4.2	4.3	Positive
Non-Hispanic Black	11.3	11.0	12.2	11.5	10.5	Positive
Non-Hispanic Other Race/Multiple Races	7.1	7.4	6.8	6.3	5.8	Positive*
Non-Hispanic White	5.4	5.1	5.1	4.9	4.8	Positive*

NOM: Infant mortality rate per 1,000 live births by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	6.0	5.8	5.8	5.5	5.2	Positive*
Not Born in U.S.	5.4	5.3	5.2	5.5	5.8	Negative

NOM: Infant mortality rate per 1,000 live births by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	8.2	8.5	8.6	8.8	8.6	Negative
High School Graduate	7.8	7.6	7.4	7.3	7.1	Positive*
Some College	5.8	5.6	5.8	5.5	5.4	Positive
College Graduate	3.7	3.3	3.2	2.9	2.8	Positive*

NOM: Infant mortality rate per 1,000 live births by Marital Status

Marital Status	2018	2019	2020	2021	2022	Trend
Married	4.6	4.3	4.2	3.9	3.8	Positive*
Unmarried	8.3	8.3	8.5	8.3	7.9	Positive

NOM: Infant mortality rate per 1,000 live births by WIC Participation

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	6.5	6.2	6.5	6.7	6.7	Negative
No	5.7	5.5	5.5	5.1	4.8	Positive*

NOM: Infant mortality rate per 1,000 live births by Plural Birth

Plural Birth	2018	2019	2020	2021	2022	Trend
Singleton	5.4	5.2	5.2	5.0	4.8	Positive*
Multiple Birth	23.9	22.6	22.6	20.5	20.3	Positive*

NOM: Infant mortality rate per 1,000 live births by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Fringe Metro	4.7	4.7	4.5	4.3	4.1	Positive*
Small/Medium Metro	7.0	6.8	7.1	6.7	6.3	Positive
Non-Metro	5.9	5.5	5.4	5.2	5.3	Positive*

**NOM: Neonatal mortality rate per 1,000 live births (HP2030: 4.1)**

Neonatal mortality rate	2018	2019	2020	2021	2022	Trend
All <sup>2,4</sup>	4.5	3.3	4.3	3.1	3.7	Positive
Medicaid <sup>2,5,†</sup>	5.3	3.5	4.7	2.5	3.2	Positive
Non-Medicaid <sup>2,5,†</sup>	4.0	3.2	3.2	2.5	2.8	Positive*

**NOM: Neonatal mortality rate per 1,000 live births by Gestational Age<sup>2,5,†</sup>**

Gestational Age	2018	2019	2020	2021	2022	Trend
<34 Weeks	111.3	104.3	100.0	94.7	88.7	Positive*
34-36 Weeks	5.8	5.6	5.6	4.6	4.2	Positive*
37-38 Weeks	1.8	1.6	1.8	1.6	1.6	Positive
39+ Weeks	0.6	0.6	0.5	0.5	0.5	Positive*

**NOM: Neonatal mortality rate per 1,000 live births by Birthweight**

Birthweight	2018	2019	2020	2021	2022	Trend
<1,500 Grams	215.1	200.3	192.4	180.7	174.2	Positive*
1,500-2,499 Grams	9.9	9.7	10.5	9.3	8.1	Positive
2,500+ Grams	0.9	0.8	0.8	0.7	0.7	Positive*

**NOM: Neonatal mortality rate per 1,000 live births by Maternal Age**

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 years	5.6	5.2	5.1	5.1	4.6	Positive*
20-24 Years	4.3	4.1	4.2	4.0	3.8	Positive
25-29 Years	4.2	4.2	3.9	3.6	3.1	Positive*
30-34 Years	3.6	3.2	3.4	3.3	3.2	Positive
≥35 Years	4.2	3.8	3.7	3.2	3.3	Positive*

*NOM: Neonatal mortality rate per 1,000 live births by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	4.5	4.4	4.0	3.7	3.5	Positive*
Non-Hispanic American Indian/Alaska Native	--	--	--	--	--	--
Non-Hispanic Asian/Native Hawaiian or Other Pacific Islander	3.6	3.9	3.9	3.7	3.9	Negative
Non-Hispanic Black	7.9	7.6	8.2	7.6	6.8	Positive
Non-Hispanic Other Race/Multiple Races	4.4	4.3	4.3	3.8	3.9	Positive
Non-Hispanic White	3.7	3.4	3.4	3.2	3.0	Positive*

*NOM: Neonatal mortality rate per 1,000 live births by Nativity*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	4.1	3.9	3.8	3.5	3.2	Positive*
Not Born in U.S.	4.0	4.0	4.0	4.2	4.2	Negative

*NOM: Neonatal mortality rate per 1,000 live births by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	5.3	5.2	5.1	5.2	4.9	Positive
High School Graduate	5.1	4.8	4.6	4.4	4.1	Positive*
Some College	3.9	3.8	3.9	3.6	3.3	Positive
College Graduate	3.0	2.6	2.5	2.3	2.2	Positive*

*NOM: Neonatal mortality rate per 1,000 live births by Marital Status*

Marital Status	2018	2019	2020	2021	2022	Trend
Married	3.5	3.2	3.1	3.0	2.9	Positive*
Unmarried	5.3	5.1	5.2	4.7	4.3	Positive*

*NOM: Neonatal mortality rate per 1,000 live births by WIC Participation*

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	3.6	3.5	3.5	3.4	3.1	Positive*
No	4.3	4.1	4.0	3.7	3.4	Positive*

NOM: Neonatal mortality rate per 1,000 live births by Plural Birth

Plural Birth	2018	2019	2020	2021	2022	Trend
Singleton	3.6	3.4	3.4	3.2	3.0	Positive*
Multiple Birth	19.7	18.7	18.0	16.0	15.6	Positive*

NOM: Neonatal mortality rate per 1,000 live births by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Fringe Metro	3.2	3.1	2.9	2.7	2.7	Positive*
Small/Medium Metro	4.9	4.6	4.8	4.5	4.1	Positive
Non-Metro	4.1	3.9	3.7	3.4	3.1	Positive*

NOM: Percent of low birth weight deliveries<sup>2</sup> (<2,500 grams) (HP2030: 9.4%)

Percent of low birth weight	2018	2019	2020	2021	2022	Trend
All	7.4%	7.6%	7.3%	7.4%	7.9%	Negative
Medicaid	9.9%	9.7%	9.3%	9.5%	9.9%	No change
Non-Medicaid	6.4%	6.7%	6.4%	6.5%	6.9%	Negative
Very Low Birth Weight (<1,500 grams)	1.3%	1.4%	1.3%	1.2%	1.1%	Positive*
Moderately Low Birth Weight (1,500-2,499 grams)	6.1%	6.2%	6.0%	6.2%	6.7%	Negative

NOM: Percent of low birth weight deliveries by Maternal Age

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	9.3%	9.9%	9.6%	9.9%	10.2%	Negative*
20-24 Years	7.4%	7.6%	7.5%	7.6%	7.6%	No change
25-29 Years	6.9%	7.0%	7.1%	6.8%	6.9%	No change
30-34 Years	6.6%	6.8%	6.9%	6.9%	7.1%	Negative*
≥35 Years	8.4%	8.7%	8.3%	8.7%	8.6%	No change

*NOM: Percent of low birth weight deliveries by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	6.8%	7.2%	7.2%	7.2%	7.3%	Negative
Non-Hispanic American Indian/Alaska Native	6.7%	6.6%	6.8%	7.4%	6.5%	Negative
Non-Hispanic Asian	8.2%	8.1%	8.6%	8.5%	9.4%	Negative*
Non-Hispanic Black	13.9%	14.3%	14.3%	14.5%	14.4%	Negative
Non-Hispanic Native Hawaiian/Other Pacific Islander	5.9%	8.2%	9.3%	10.3%	9.9%	Negative*
Non-Hispanic Other Race/Multiple Races	8.9%	9.5%	9.0%	9.1%	8.8%	No change
Non-Hispanic White	6.6%	6.8%	6.7%	6.7%	6.8%	No change

*NOM: Percent of low birth weight deliveries by Nativity*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	7.3%	7.6%	7.5%	7.4%	7.4%	No change
Not Born in U.S.	6.9%	7.0%	7.3%	7.5%	8.0%	Negative*

*NOM: Percent of low birth weight deliveries by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	9.0%	9.2%	9.1%	8.8%	9.2%	No change
High School Graduate	8.5%	8.8%	8.9%	9.1%	9.3%	Negative*
Some College	7.2%	7.5%	7.5%	7.5%	7.5%	Negative
College Graduate	5.9%	5.9%	5.8%	5.7%	5.8%	Positive*

*NOM: Percent of low birth weight deliveries by Marital Status*

Marital Status	2018	2019	2020	2021	2022	Trend
Married	6.3%	6.4%	6.3%	6.3%	6.4%	No change
Unmarried	9.0%	9.4%	9.3%	9.4%	9.5%	Negative*

*NOM: Percent of low birth weight deliveries by WIC Participation*

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	8.5%	8.9%	9.1%	8.9%	8.7%	Negative
No	6.7%	6.9%	11.1%	11.5%	14.8%	Negative

NOM: Percent of low birth weight deliveries by Plural Birth

Plural Birth	2018	2019	2020	2021	2022	Trend
Singleton	5.7%	5.9%	5.9%	5.9%	6.0%	Negative
Multiple Birth	54.5%	55.8%	55.4%	54.6%	53.5%	Positive

NOM: Percent of low birth weight deliveries by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Fringe Metro	7.1%	7.4%	7.4%	7.4%	7.4%	Negative
Small/Medium Metro	7.6%	7.8%	7.7%	7.7%	7.9%	No change
Non-Metro	7.0%	7.1%	7.2%	7.2%	7.2%	Negative

NOM: Rate of Maternal Mortality (HP2030: 15.7) <sup>6</sup>

Maternal mortality	2018	2019	2020	2021	2022	Trend
Maternal mortality rate per 100,000 live births (5 year rolling average)	14.8	16.7	19.9	20.9	22.8	Negative*

NOM: Rate of Maternal Mortality by Maternal Age

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	--	--	--	--	--	--
20-24 Years	--	--	--	--	--	--
25-29 Years	--	--	--	--	--	--
30-34 Years	--	--	--	--	--	--
≥35 Years	45.3	56.2	75.6	70.1	72.6	Negative

*NOM: Rate of Maternal Mortality by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	--	--	--	--	--	--
Non-Hispanic American Indian/Alaska Native	--	--	--	--	--	--
Non-Hispanic Asian	--	--	--	--	--	--
Non-Hispanic Black	--	--	--	--	100.3	--
Non-Hispanic Other/Multiple Race	--	--	--	--	--	--
Non-Hispanic Native Hawaiian/Other Pacific Islander	--	--	--	--	--	--
Non-Hispanic White	10.3	11.4	--	--	17.3	Negative

*NOM: Rate of Maternal Mortality by Nativity*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	--	15.7	19.4	19.7	22.6	Negative*
Not Born in U.S.	--	--	--	--	--	--

*NOM: Rate of Maternal Mortality by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	--	--	--	--	--	--
High School Graduate	n/a	32.1	32.2	32.0	29.5	Positive
Some College	--	--	--	--	24.2	--
College Graduate	--	--	--	--	--	--

*NOM: Rate of Maternal Mortality by Marital Status*

Marital Status	2018	2019	2020	2021	2022	Trend
Married	--	13.5	13.0	14.2	13.4	Negative
Unmarried	--	20.9	30.6	31.1	37.8	Negative*

*NOM: Rate of Maternal Mortality by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Fringe Metro	--	--	--	--	--	--
Small/Medium Metro	--	--	--	--	20.2	--
Non-Metro	--	--	--	--	31.8	--

*NOM: Perinatal mortality rate per 1,000 live births plus fetal deaths (HP2030: 5.9)*

Perinatal mortality rate per 1,000 live births plus fetal deaths	2018	2019	2020	2021	2022	Trend
All <sup>2,4,7</sup>	6.2	5.3	6.1	5.8	6.1	Negative
Medicaid <sup>2,5,7,†</sup>	7.0	6.5	6.2	5.7	5.5	Positive*
Non-Medicaid <sup>2,5,7,†</sup>	5.6	4.5	5.1	4.8	5.3	Positive

*NOM: Perinatal mortality rate per 1,000 live births plus fetal deaths by Gestational Age<sup>2,5,7,†</sup>*

Gestational Age	2018	2019	2020	2021	2022	Trend
<34 Weeks	133.3	130.0	125.0	121.4	118.7	Positive*
34-36 Weeks	14.7	13.9	13.3	12.1	11.6	Positive*
37-38 Weeks	3.7	3.3	3.3	2.9	2.9	Positive*
39+ Weeks	1.0	1.0	1.1	1.1	1.1	Negative

*NOM: Perinatal mortality rate per 1,000 live births plus fetal deaths by Birthweight*

Birthweight	2018	2019	2020	2021	2022	Trend
<1,500 Grams	237.7	228.5	219.7	206.8	203.7	Positive*
1,500-2,499 Grams	21.3	20.9	21.3	22.1	21.1	No change
2,500+ Grams	1.8	1.7	1.7	1.5	1.6	Positive

*NOM: Perinatal mortality rate per 1,000 live births plus fetal deaths by Maternal Age*

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	8.2	7.6	6.5	6.3	6.5	Positive*
20-24 Years	6.0	6.3	6.6	6.2	6.1	No change
25-29 Years	6.1	5.9	5.6	5.5	5.1	Positive*
30-34 Years	5.1	5.1	5.3	5.2	5.3	Negative
≥35 Years	7.7	6.6	6.5	5.3	5.5	Positive*

*NOM: Perinatal mortality rate per 1,000 live births plus fetal deaths by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	7.1	7.0	6.9	6.5	6.5	Positive*
Non-Hispanic American Indian/Alaska Native	--	--	--	--	--	--
Non-Hispanic Asian/Native Hawaiian or Other Pacific Islander	5.2	5.3	5.7	5.3	6.0	Negative
Non-Hispanic Black	12.2	12.2	12.1	11.5	10.8	Positive*
Non-Hispanic Other Race/Multiple Races	7.1	5.9	5.5	5.0	5.6	Positive
Non-Hispanic White	5.3	5.1	5.1	4.9	4.8	Positive*

*NOM: Perinatal mortality rate per 1,000 live births plus fetal deaths by Plural Birth*

Plural Birth	2018	2019	2020	2021	2022	Trend
Singleton	5.6	5.5	5.4	5.2	5.2	Positive*
Multiple Birth	22.1	22.0	20.9	18.4	18.7	Positive*

*NOM: Perinatal mortality rate per 1,000 live births plus fetal deaths by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Fringe Metro	5.2%	4.8%	4.9%	4.5%	4.6	Positive*
Small/Medium Metro	6.2%	6.0%	6.2%	6.1	6.1	No change
Non-Metro	6.9%	7.0%	6.5%	6.1	5.8	Positive*

*NOM: Postpartum Depression<sup>1</sup>*

Postpartum Depression	2018	2019	2020	2021	2022	Trend
Percent of women who experience postpartum depressive symptoms	14.7%	13.5%	14.3%	15.1%	11.9%	Positive

*NOM: Postpartum Depression by Maternal Age*

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	27.1%	27.1%	25.8%	29.6%	26.1%	No change
20-24 Years	17.4%	18.8%	18.4%	21.0%	19.8%	Negative
25-29 Years	12.2%	11.6%	13.2%	12.4%	13.2%	Negative
30-34 Years	10.9%	11.0%	12.0%	11.6%	10.6%	Positive
35+ Years	9.5%	9.5%	9.8%	9.1%	9.0%	Positive

*NOM: Postpartum Depression by Race/Ethnicity by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	16.8%	15.5%	14.1%	14.2%	14.3%	Positive
Non-Hispanic American Indian/Alaska Native	--	--	--	--	--	--
Non-Hispanic Asian/Native Hawaiian or Other Pacific Islander	20.7%	19.6%	20.5%	22.5%	22.9%	Negative
Non-Hispanic Black	14.5%	17.1%	17.1%	20.8%	17.6%	Negative
Non-Hispanic Other Race/Multiple Races	11.6%	15.2%	17.5%	21.3%	13.5%	Negative
Non-Hispanic White	12.6%	12.5%	13.5%	13.2%	13.1%	Negative

*NOM: Postpartum Depression by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	17.1%	17.7%	15.1%	16.2%	13.2%	Positive*
High School Graduate	17.4%	19.7%	21.7%	22.1%	19.4%	Negative
Some College	17.4%	15.0%	16.2%	14.1%	15.6%	Positive
College Graduate	6.5%	6.6%	6.9%	8.3%	8.7%	Negative*

*NOM: Postpartum Depression by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Medicaid	24.3%	23.5%	23.0%	22.4%	21.2%	Positive*
Private	8.8%	9.1%	10.3%	10.8%	10.6%	Negative
None/Self-Pay	10.8%	11.2%	9.2%	9.3%	7.6%	Positive*
Other	6.4%	8.3%	12.3%	13.5%	13.0%	Negative*

*NOM: Postpartum Depression by Marital Status*

Marital Status	2018	2019	2020	2021	2022	Trend
Married	9.2%	9.4%	10.0%	10.8%	10.6%	Negative*
Unmarried	21.3%	21.0%	21.3%	20.6%	19.6%	Positive

*NOM: Postpartum Depression by WIC Participation*

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	21.4%	21.2%	21.9%	21.0%	19.9%	Positive
No	10.2%	10.5%	11.4%	12.2%	11.9%	Negative*

*NOM: Postpartum Depression by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Metro	13.2%	13.1%	12.9%	13.2%	12.4%	Positive
Non-Metro	14.3%	14.3%	16.7%	16.5%	16.3%	Negative

*NOM: Percent of preterm births (<37 weeks gestation)<sup>2</sup> (HP2030: 9.4%)*

Percent of preterm births (<37 weeks gestation)	2018	2019	2020	2021	2022	Trend
All	9.5%	10.1%	10.0%	9.8%	10.5%	Negative
Medicaid	11.4%	11.9%	11.9%	11.7%	12.0%	Negative
Non-Medicaid	8.6%	9.3%	9.1%	9.0%	9.8%	Negative
Early Preterm Birth (<34 weeks)	2.5%	2.7%	2.6%	2.5%	2.5%	Positive
Late Preterm Birth (34-36 weeks)	6.9%	7.4%	7.4%	7.3%	8.0%	Negative

NOM: Percent of preterm births (<37 weeks gestation) by Maternal Age

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	10.7%	10.9%	10.3%	10.5%	10.3%	Positive
20-24 Years	9.1%	9.5%	9.6%	9.7%	9.6%	Negative
25-29 Years	8.9%	9.1%	9.2%	9.2%	9.4%	Negative*
30-34 Years	8.8%	9.1%	9.6%	9.6%	9.9%	Negative*
≥35 Years	11.6%	12.0%	12.0%	12.3%	12.3%	Negative*

NOM: Percent of preterm births (<37 weeks gestation) by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	8.9%	9.5%	9.9%	10.0%	10.1%	Negative*
Non-Hispanic American Indian/Alaska Native	10.8%	11.2%	9.4%	8.8%	8.9%	Positive*
Non-Hispanic Asian	8.7%	8.9%	9.5%	9.8%	10.5%	Negative*
Non-Hispanic Black	13.7%	14.1%	13.8%	14.2%	14.1%	Negative
Non-Hispanic Other Race/Multiple Races	10.2%	10.7%	10.6%	10.7%	10.5%	Negative
Non-Hispanic Native Hawaiian/Other Pacific Islander	7.5%	8.7%	11.3%	14.7%	16.7%	Negative*
Non-Hispanic White	9.1%	9.3%	9.4%	9.5%	9.6%	Negative*

NOM: Percent of preterm births (<37 weeks gestation) by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	9.6%	9.9%	9.9%	10.0%	10.0%	Negative*
Not Born in U.S.	8.2%	8.8%	9.6%	9.9%	10.3%	Negative*

NOM: Percent of preterm births (<37 weeks gestation) by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	10.3%	10.8%	11.0%	11.1%	11.2%	Negative*
High School Graduate	10.4%	10.8%	11.3%	11.5%	11.7%	Negative*
Some College	9.6%	10.0%	10.1%	10.3%	10.3%	Negative*
College Graduate	8.1%	8.2%	8.2%	8.2%	8.3%	No change

NOM: Percent of preterm births (<37 weeks gestation) by Marital Status

Marital Status	2018	2019	2020	2021	2022	Trend
Married	8.6%	8.9%	9.0%	9.2%	9.3%	Negative*
Unmarried	10.8%	11.2%	11.3%	11.3%	11.5%	Negative

NOM: Percent of preterm births (<37 weeks gestation) by WIC Participation

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	10.4%	10.8%	11.1%	11.4%	11.2%	Negative*
No	8.9%	9.3%	9.4%	9.5%	9.7%	Negative*

NOM: Percent of preterm births (<37 weeks gestation) by Plural Birth

Plural Birth	2018	2019	2020	2021	2022	Trend
Singleton	7.7%	7.9%	8.1%	8.2%	8.4%	Negative*
Multiple Birth	61.5%	63.1%	63.7%	62.9%	61.5%	No change

NOM: Percent of preterm births (<37 weeks gestation) by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Fringe Metro	9.1%	9.4%	9.6%	9.7%	9.8%	Negative*
Small/Medium Metro	9.8%	10.2%	10.0%	10.1%	10.4%	Negative*
Non-Metro	9.1%	9.5%	9.9%	9.9%	10.0%	Negative

NOM: Preterm-Related Mortality: Preterm-related mortality rate per 100,000 live births (HP2030)

Preterm-related mortality rate per 100,000 live births	2018	2019	2020	2021	2022	Trend
All <sup>2,4</sup>	198.5	152.6	151.3	123.9	139.6	Positive
Medicaid <sup>4,5,†</sup>	229.5	143.0	168.4	114.2	120.5	Positive
Non-Medicaid <sup>4,5,†</sup>	181.7	153.6	145.2	126.6	150.4	Positive

NOM: Preterm-related mortality rate per 100,000 live births by Maternal Age

Maternal Age <sup>4,5,†</sup>	2018	2019	2020	2021	2022	Trend
<20 Years	317.3	285.0	234.7	226.3	203.4†	Positive*
20-24 Years	197.1	193.4	197.6	190.7	196.1	No change
25-29 Years	200.5	199.8	173.9	159.2	130.6	Positive*
30-34 Years	186.1	164.5	168.7	158.5	144.9	Positive*
≥35 Years	185.7	168.6	163.2	140.3	141.4	Positive*

NOM: Preterm-related mortality rate per 100,000 live births by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	235.0	225.6	191.7	172.9	157.8	Positive*
Non-Hispanic American Indian/Alaska Native	--	--	--	--	--	--
Non-Hispanic Asian/Native Hawaiian or Other Pacific Islander	180.0†	242.4†	277.5†	250.6†	256.2†	Negative
Non-Hispanic Black	560.4	537.7	498.2	448.9	399.7	Positive*
Non-Hispanic Other Race/Multiple Races	--	--	177.9†	--	--	--
Non-Hispanic White	160.7	145.1	138.8	133.9	123.5	Positive*

NOM: Preterm-related mortality rate per 100,000 live births by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	204.7	187.7	174.5	158.4	143.6	Positive*
Not Born in U.S.	166.7	188.9	198.3	213.8	217.3	Negative*

NOM: Preterm-related mortality rate per 100,000 live births by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	234.5	232.7	236.6	224.8	191.8	Positive
High School Graduate	274.2	272.9	234.7	219.2	195.2	Positive*
Some College	198.0	186.4	183.4	172.5	165.2	Positive*
College Graduate	130.4	107.4	104.5	96.7	98.1	Positive*

*NOM: Preterm-related mortality rate per 100,000 live births by Marital Status*

Marital Status	2018	2019	2020	2021	2022	Trend
Married	156.5	147.0	141.7	130.1	122.8	Positive*
Unmarried	279.8	264.7	246.1	230.7	207.8	Positive*

*NOM: Preterm-related mortality rate per 100,000 live births by WIC Participation*

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	148.0	138.5	146.7	139.3	118.0	Positive
No	224.7	209.7	190.8	176.2	165.1	Positive*

*NOM: Preterm-related mortality rate per 100,000 live births by Plural Birth*

Plural Birth	2018	2019	2020	2021	2022	Trend
Singleton	167.2	157.7	152.7	141.7	130.3	Positive*
Multiple Birth	1,227.6	1,155.7	996.5	916.8	868.8	Positive*

*NOM: Preterm-related mortality rate per 100,000 live births by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Fringe Metro	163.9	153.9	137.1	124.5	122.0	Positive*
Small/Medium Metro	252.8	234.3	232.2	220.8	194.2	Positive*
Non-Metro	176.6	171.6	159.4	144.8	137.6	Positive*

*NOM: Rate of Severe Maternal Morbidity<sup>8</sup> (Stratifiers for rates use a three-year rolling average, reflecting the ICD-10-CM transition effective 10/1/2015.)*

Severe Maternal Morbidity	2018	2019	2020	2021	2022	Trend
Rate of severe maternal morbidity per 10,000 delivery hospitalizations	61.8	65.9	71.0	70.0	69.4	Negative

*NOM: Rate of Severe Maternal Morbidity by Maternal Age*

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	74.4	68.9	82.2	81.8	82.1	Negative
20-24 Years	49.2	53.5	62.2	64.8	64.5	Negative*
25-29 Years	46.8	48.0	49.1	52.6	56.7	Negative*
30-34 Years	57.5	60.2	64.0	61.6	65.2	Negative*
≥35 Years	93.3	103.0	107.5	117.8	109.9	Negative

*NOM: Rate of Severe Maternal Morbidity by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	63.4	73.4	85.4	78.8	77.6	Negative
Non-Hispanic American Indian/Alaska Native	--	--	--	--	--	--
Non-Hispanic Asian	--	--	--	--	--	--
Non-Hispanic Black	101.1	99.3	100.2	113.2	110.6	Negative
Non-Hispanic Native Hawaiian/Other Pacific Islander	--	--	--	--	--	--
Non-Hispanic Other Race/Multiple Races	--	--	--	--	--	--
Non-Hispanic White	54.1	56.3	58.1	61.8	62.4	Negative*

*NOM: Rate of Severe Maternal Morbidity by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Medicaid	68.3	72.5	74.9	79.7	78.5	Negative*
Private	49.5	51.1	56.7	59.8	61.8	Negative*
Uninsured	--	--	69.0	84.1	95.5	Negative*
Other	91.4	112.5	113.5	93.3	91.9	Positive

*NOM: Rate of Severe Maternal Morbidity by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Metro	55.5	58.6	64.8	69.1	73.0	Negative*
Small/Medium Metro	68.2	71.5	77.5	73.5	73.0	Negative
Non-Metro	48.3	51.8	53.8	63.3	63.6	Negative*

*NOM: Stillbirth*

Stillbirth rate per 1,000 live births plus fetal deaths	2018	2019	2020	2021	2022	Trend
All <sup>2,4</sup>	5.4	5.4	4.8	5.5	5.8	Negative
Medicaid <sup>2,5</sup> †	4.7	6.6	6.1	5.8	6.0	Positive
Non-Medicaid <sup>2,5</sup> †	6.5	4.8	4.7	4.4	4.5	Positive*

*NOM: Stillbirth by Gestational Age<sup>2,5</sup> †*

Gestational Age	2018	2019	2020	2021	2022	Trend
<34 Weeks	133.4	136.8	128.3	124.4	129.0	Positive
34-36 Weeks	10.6	9.9	9.7	9.1	9.0	Positive*
37-38 Weeks	2.4	2.1	1.9	1.8	1.7	Positive*
39+ Weeks	0.6	0.6	0.7	0.7	0.8	Negative

*NOM: Stillbirth by Birthweight*

Birthweight	2018	2019	2020	2021	2022	Trend
<1,500 Grams	221.0	225.5	213.3	200.5	207.7	Positive
1,500-2,499 Grams	14.0	13.8	13.6	15.2	15.0	Negative
2,500+ Grams	1.2	1.1	1.2	1.1	1.2	Positive

*NOM: Stillbirth by Maternal Age*

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	6.7	6.1	6.7	6.0	6.5	Positive
20-24 Years	5.0	5.4	5.2	4.8	5.1	No change
25-29 Years	5.2	5.0	4.7	4.6	4.5	Positive*
30-34 Years	4.8	5.1	4.9	4.9	5.2	Negative
≥35 Years	8.4	8.2	7.6	6.5	6.3	Positive*

*NOM: Stillbirth by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	6.5	6.7	6.9	6.9	7.3	Negative*
Non-Hispanic American Indian/Alaska Native	--	--	--	--	--	--
Non-Hispanic Asian	4.6	3.9	4.0	3.4	3.8	Positive
Non-Hispanic Black	10.8	11.3	9.9	9.4	9.4	Positive*
Non-Hispanic Native Hawaiian/Other Pacific Islander	--	--	--	--	--	--
Non-Hispanic Other Race/Multiple Races	7.0	6.2	6.0	5.4	6.2	Positive
Non-Hispanic White	4.8	4.8	4.6	4.3	4.4	Positive

*NOM: Stillbirth by Nativity*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	5.5	5.6	5.4	5.2	5.3	Positive
Not Born in U.S.	6.2	5.9	5.5	5.2	5.5	Positive

*NOM: Stillbirth by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	6.4	6.5	6.6	6.4	7.5	Negative
High School Graduate	6.8	7.0	6.7	6.3	6.7	Positive
Some College	5.2	5.2	5.2	5.1	4.9	Positive
College Graduate	4.1	4.0	3.5	3.4	3.4	Positive*

*NOM: Stillbirth by Marital Status*

Marital Status	2018	2019	2020	2021	2022	Trend
Married	4.7	4.8	4.5	4.3	4.4	Positive
Unmarried	6.6	6.8	6.7	6.3	6.5	Positive

*NOM: Stillbirth by WIC Participation*

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	4.1	4.1	3.6	3.5	3.8	Positive
No	5.5	5.4	5.2	4.9	5.0	Positive*

*NOM: Stillbirth by Plural Birth*

Plural Birth	2018	2019	2020	2021	2022	Trend
Singleton	5.4	5.4	5.3	5.1	5.2	Positive
Multiple Birth	10.8	11.9	11.2	9.9	10.7	Positive

*NOM: Stillbirth by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Fringe Metro	5.3	5.1	5.0	4.7	4.7	Positive*
Small/Medium Metro	5.1	5.4	5.2	5.1	5.5	Negative
Non-Metro	6.2	6.5	6.0	5.7	5.8	Positive

*NOM: SUID Mortality Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (R95, R99, W75)*

Sleep-related SUID rate	2018	2019	2020	2021	2022	Trend
All <sup>2,4</sup>	118.6	101.7	148.4	138.3	110.5	Negative
Medicaid <sup>2,5</sup> †	158.9†	200.2	299.3	314.0	185.4	Negative
Non-Medicaid <sup>2,5</sup> †	96.9	48.5†	72.6†	59.1†	51.6†	Positive

*NOM: Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (R95, R99, W75) by Gestational Age<sup>2,5</sup> †*

Gestational Age	2018	2019	2020	2021	2022	Trend
<34 Weeks	336.0†	338.5†	364.2†	327.3†	291.2†	Positive
34-36 Weeks	168.6	150.2†	188.9	180.7	193.1	Negative
37-38 Weeks	148.7	139.9	150.6	148.3	139.6	Positive
39+ Weeks	77.8	82.9	87.2	93.0	91.9	Negative*

*NOM: Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (R95, R99, W75) by Birthweight*

Birthweight	2018	2019	2020	2021	2022	Trend
<1,500 Grams	--	--	--	--	--	--
1,500-2,499 Grams	234.1	226.4	302.3	258.2	237.5	Negative
2,500+ Grams	96.3	97.8	102.8	107.9	105.0	Negative*

NOM: Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (R95, R99, W75) by Maternal Age

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	158.7†	180.5†	255.1	323.2	373.0	Negative*
20-24 Years	155.3	166.8	162.2	158.9	166.1	Negative
25-29 Years	119.7	112.0	126.0	130.2	112.2	No change
30-34 Years	64.7	65.4	76.3	71.1	75.5	Negative
≥35 Years	61.9†	60.2†	55.7†	58.5†	57.3†	Positive

NOM: Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (R95, R99, W75) by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	75.1	81.8	99.2	106.4	105.2	Negative*
Non-Hispanic American Indian/Alaska Native	--	--	--	--	--	--
Non-Hispanic Asian/Native Hawaiian or Other Pacific Islander	--	--	--	--	--	--
Non-Hispanic Black	221.0	224.7	277.7	257.7	238.1	Negative
Non-Hispanic Other Race/Multiple Races	218.4†	251.1†	266.9†	252.1†	206.5†	Positive
Non-Hispanic White	102.1	98.0	102.1	107.7	109.4	Negative

NOM: Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (R95, R99, W75) by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	118.0	119.3	129.5	130.9	126.4	Negative
Not Born in U.S.	45.5†	42.4†	43.6†	49.3†	62.7†	Negative

NOM: Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (R95, R99, W75) by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	204.6	237.1	255.5	249.8	233.2	Negative
High School Graduate	151.8	155.9	165.7	187.2	190.7	Negative*
Some College	113.6	103.0	118.5	120.2	122.9	Negative
College Graduate	35.0	32.1	32.7	27.9†	24.5†	Positive*

NOM: Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (R95, R99, W75) by Marital Status

Marital Status	2018	2019	2020	2021	2022	Trend
Married	53.8	45.6	51.3	50.5	50.2	Positive
Unmarried	202.1	218.3	233.9	241.6	237.7	Negative*

NOM: Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (R95, R99, W75) by WIC Participation

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	167.9	176.3	187.8	207.8	224.5	Negative*
No	79.3	78.9	90.0	88.5	83.0	Negative

NOM: Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (R95, R99, W75) by Plural Birth

Plural Birth	2018	2019	2020	2021	2022	Trend
Singleton	106.0	106.5	114.4	116.6	115.0	Negative*
Multiple Birth	165.9†	170.0†	227.3†	229.2†	235.3†	Negative*

NOM: Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (R95, R99, W75) by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Fringe Metro	83.7	88.4	86.6	87.9	75.8	Positive
Small/Medium Metro	138.5	139.7	155.8	151.8	144.5	Negative
Non-Metro	94.0	88.3	102.8	111.6	127.1	Negative*

NOM - Women's Health Status<sup>3</sup>

Health	2018	2019	2020	2021	2022	Trend
Percent of women, ages 18 through 44, in excellent or very good health	56.2%	52.6%	59.7%	58.8%	51.9%	No change

NOM: Women's Health Status by Maternal Age

Maternal Age	2018	2019	2020	2021	2022	Trend
18-24 Years	58.5%	50.5%	62.4%	62.3%	53.7%	Positive
25-34 Years	58.1%	51.9%	59.7%	59.1%	51.6%	No change
35-44 Years	52.4%	54.9%	57.5%	55.7%	50.6%	No change

NOM: Women's Health Status by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	42.8%	43.4%	45.7%	54.0%	55.9%	Positive *
Non-Hispanic American Indian/Alaska Native	--	--	--	--	--	--
Non-Hispanic Asian/Native Hawaiian or Other Pacific Islander	--	--	69.5%	70.7%	--	--
Non-Hispanic Black	55.1%	41.7%	55.7%	40.2%	33.6%	Negative
Non-Hispanic Other Race/Multiple Races	--	--	48.3%	45.1%	41.8%	Positive
Non-Hispanic White	59.2%	57.2%	64.0%	61.9%	53.0%	No change

NOM: Women's Health Status by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	49.3%	37.4%	40.2%	48.0%	27.1%	Negative
High School Graduate	44.8%	45.9%	55.0%	52.1%	41.2%	Positive
Some College	54.7%	52.3%	55.9%	57.7%	52.9%	Positive
College Graduate	69.8%	63.7%	74.1%	68.3%	65.8%	No change

NOM: Women's Health Status by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Insured	58.8%	55.6%	62.4%	60.6%	52.6%	No change
Uninsured	45.1%	39.9%	43.0%	46.8%	36.7%	No change

NOM: Women's Health Status by Household Income/Poverty

Household Income/Poverty	2018	2019	2020	2021	2022	Trend
<\$25,000	38.6%	42.7%	45.5%	44.9%	34.2%	Positive
\$25,000-\$49,999	57.0%	48.1%	56.2%	51.3%	50.3%	Negative
\$50,000-\$74,999	60.0%	59.0%	61.4%	62.0%	43.9%	Negative
≥\$75,000	73.1%	69.0%	74.4%	62.9%	65.4%	Negative

NOM: Women's Health Status by Language

Language	2018	2019	2020	2021	2022	Trend
English	56.1%	52.5%	59.7%	58.8%	51.6%	No change
Non-English	--	--	--	--	--	--

*NOM: Women's Health Status by Marital Status*

Marital Status	2018	2019	2020	2021	2022	Trend
Married	62.0%	58.2%	64.2%	63.9%	59.0%	No change
Unmarried	50.8%	47.8%	55.7%	54.4%	45.7%	No change

*NOM: Women's Health Status by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Metro	58.2%	52.1%	59.9%	59.2%	52.7%	Positive
Non-Metro	51.4%	53.6%	59.3%	57.8%	50.0%	No change

**Sources:**

<sup>1</sup> Kansas Pregnancy Risk Assessment Monitoring System (PRAMS)

<sup>2</sup> Kansas Department of Health and Environment (KDHE), Bureau of Epidemiology and Public Health Informatics. Kansas birth data (resident)

<sup>3</sup> Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System (BRFSS)

<sup>4</sup> Kansas Department of Health and Environment (KDHE), Bureau of Epidemiology and Public Health Informatics. Kansas death data (resident)

<sup>5</sup> Kansas Department of Health and Environment (KDHE), Bureau of Epidemiology and Public Health Informatics. Kansas linked birth and infant death data (resident)

<sup>6</sup> National Vital Statistics System (NVSS)

<sup>7</sup> Kansas Department of Health and Environment (KDHE), Bureau of Epidemiology and Public Health Informatics. Kansas fetal death data (resident)

<sup>8</sup> Kansas Department of Health and Environment (KDHE), Bureau of Epidemiology and Public Health Informatics. Kansas hospital discharge data (resident)

## Appendix E.2 Perinatal and Infant Health Population Domain

National Performance Measures / Outcome Measures / Life Course Indicators Linkage. 2026 Application/2024 Annual Report

### Key and Definitions

**NPM:** National Performance Measure

**NOM:** National Outcome Measure

**SM:** Standard Measure

**n/a** indicates the data were not available at the time of report

**HP2030:** Healthy People 2030 goal

**Bolded NPMs:** Selected National Performance Measures that are most closely aligned with Kansas priorities.

\* Statistically significant trend (p<0.05)

† Estimate is statistically unreliable; interpret with caution.

‡ Stratifiers for percentages use three-year rolling average (except for the 2018 PRAMS estimate, which includes only 2017-2018 data, as data were not collected in 2016). Stratifiers for rates use five-year rolling average

Two hyphens (i.e., --) indicate that the estimate has been suppressed due to statistical unreliability and/or low sample size.

### NPM: Breastfeeding (Exclusivity through 6 Months)<sup>1</sup>

Breastfeeding Exclusivity	2018	2019	2020	2021	2022	Trend
Percent of children, ages 6 months through 2 years, who were breastfed exclusively for 6 months (Birth year: 2021, 2022, 2018, 2019, 2020)	31.4%	31.6%	32.0%	29.2%	22.2%	Negative

### NPM: Breastfeeding: Percent of infants who are ever breastfed<sup>2</sup>

Breastfeeding	2018	2019	2020	2021	2022	Trend
All	88.7%	88.9%	89.3%	89.4%	90.5%	Positive*
Medicaid	79.9%	80.7%	81.4%	81.7%	84.8%	Positive*
Non-Medicaid	92.8%	92.5%	93.0%	93.1%	93.4%	No change

### NPM: Breastfeeding: Percent of infants who are ever breastfed by Maternal Age<sup>2 ‡</sup>

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	81.8%	81.6%	81.6%	81.6%	82.8%	No change
20-24 Years	85.3%	85.6%	86.1%	86.1%	86.7%	Positive*
25-29 Years	88.8%	89.1%	89.4%	89.6%	90.3%	Positive*
30-34 Years	91.1%	91.2%	91.3%	91.6%	91.8%	Positive*
≥35 Years	90.1%	90.5%	90.5%	90.8%	91.2%	Positive*

### NPM: Breastfeeding: Percent of infants who are ever breastfed by Maternal Race/Ethnicity<sup>2 ‡</sup>

Maternal Race/Ethnicity	2018	2019	2020	2021	2022	Trend
American Indian/Alaska Native, Non-Hispanic	81.6%	81.5%	80.7%	78.3%	78.1%	Negative*
Asian/Native Hawaiian or Other Pacific Islander, Non-Hispanic	93.4%	92.8%	93.2%	92.4%	92.9%	No change
Black, Non-Hispanic	79.2%	80.1%	81.4%	82.6%	84.3%	Positive*
Hispanic	87.5%	87.5%	87.4%	86.8%	86.9%	No change
Other Race/Multiple Races, Non-Hispanic	85.8%	85.8%	86.2%	87.2%	87.7%	Positive*
White, Non-Hispanic	89.5%	89.8%	90.1%	90.5%	91.0%	Positive*

NPM: Breastfeeding: Percent of infants who are ever breastfed by Maternal Educational Attainment<sup>2+</sup>

Maternal Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	77.6%	77.4%	77.6%	77.1%	78.0%	No change
High School Graduate	81.9%	82.8%	83.5%	84.2%	85.3%	Positive*
Some College	89.5%	89.8%	89.9%	90.1%	90.8%	Positive*
College Graduate	96.0%	96.1%	96.0%	96.1%	95.9%	No change

NPM: Breastfeeding: Percent of infants who are ever breastfed by Delivery Payment Source<sup>2+</sup>

Source of Payment for Delivery	2018	2019	2020	2021	2022	Trend
Medicaid	79.2%	79.9%	80.6%	81.3%	82.7%	Positive*
Private	93.5%	93.6%	93.6%	93.7%	94.0%	Positive*
None/Self-Pay	87.3%	86.6%	86.7%	86.7%	87.6%	No change
Other	92.0%	92.3%	91.9%	91.9%	91.8%	No change

NPM: Breastfeeding: Percent of infants who are ever breastfed by Maternal Marital Status<sup>2+</sup>

Marital Status	2018	2019	2020	2021	2022	Trend
Unmarried	80.3%	80.9%	81.6%	82.1%	83.2%	Positive*
Married	93.0%	93.2%	93.2%	93.3%	93.5%	Positive*

NPM: Breastfeeding: Percent of infants who are ever breastfed by Birth Plurality<sup>2 †</sup>

Birth Plurality	2018	2019	2020	2021	2022	Trend
Singleton	88.5%	88.8%	89.1%	89.3%	89.9%	Positive*
Multiple Birth	86.1%	86.4%	86.2%	86.2%	86.1%	No change

NPM: Breastfeeding: Percent of infants who are ever breastfed by WIC Participation<sup>2 †</sup>

WIC Participation	2018	2019	2020	2021	2022	Trend
No	91.5%	91.6%	91.7%	91.8%	92.1%	Positive*
Yes	81.3%	81.4%	81.4%	81.1%	81.9%	No change

NPM: Breastfeeding: Percent of infants who are ever breastfed by Urban-Rural Residence<sup>2 †</sup>

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Fringe Metro	92.2%	92.5%	93.3%	93.6%	94.2%	Positive*
Small/Medium Metro	88.5%	88.8%	89.2%	89.8%	90.5%	Positive*
Non-Metro	84.8%	85.0%	84.6%	84.4%	84.7%	No change

NPM: Breastfeeding: Percent of infants who are ever breastfed by Maternal Nativity<sup>2 †</sup>

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	88.0%	88.4%	88.8%	89.2%	89.8%	Positive*
Not Born in U.S.	91.1%	90.7%	90.2%	89.4%	89.3%	Negative*

NPM: Breastfeeding: Percent of infants who are ever breastfed by Infant's Sex<sup>2 †</sup>

Sex	2018	2019	2020	2021	2022	Trend
Female	88.6%	88.9%	89.2%	89.4%	90.0%	Positive*
Male	88.3%	88.5%	88.8%	89.0%	89.5%	Positive*

NPM: Breastfeeding: Percent of infants who are ever breastfed by Birth Order<sup>2 †</sup>

Birth Order	2018	2019	2020	2021	2022	Trend
First born	88.5%	88.8%	89.0%	89.3%	89.8%	Positive*
Not first born	85.9%	85.9%	85.6%	85.9%	86.2%	No change

NPM: Low-Risk Cesarean Delivery: Percent of Cesarean deliveries among low-risk first births<sup>2</sup> (HP 2030: 23.6%)

Low-Risk Cesarean Delivery	2018	2019	2020	2021	2022	Trend
All	24.2%	24.3%	24.6%	23.9%	24.6%	No change
Medicaid	23.8%	22.3%	22.9%	23.3%	24.0%	No change
Non-Medicaid	24.5%	25.0%	25.4%	24.3%	24.9%	Positive

NPM: Low-Risk Cesarean Delivery: Percent of Cesarean deliveries among low-risk first births by Maternal Age<sup>2+</sup>

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	16.2%	16.1%	15.7%	15.3%	14.8%	Positive*
20-24 Years	21.6%	21.0%	21.2%	21.2%	21.6%	No change
25-29 Years	23.6%	23.9%	24.7%	24.8%	24.7%	Negative*
30-34 Years	29.0%	30.1%	29.6%	29.0%	29.0%	No change
≥35 Years	41.8%	41.9%	42.4%	41.0%	41.3%	No change

NPM: Low-Risk Cesarean Delivery: Percent of Cesarean deliveries among low-risk first births by Maternal Race/Ethnicity<sup>2+</sup>

Maternal Race/Ethnicity	2018	2019	2020	2021	2022	Trend
American Indian/Alaska Native, Non-Hispanic	22.0%	22.1%	28.4%	29.0%	31.1%	Negative*
Asian/Native Hawaiian or Other Pacific Islander, Non-Hispanic	26.6%	29.2%	30.3%	30.3%	30.0%	Negative
Black, Non-Hispanic	27.5%	26.2%	26.3%	27.3%	28.7%	Negative
Hispanic	22.3%	22.5%	22.3%	21.8%	22.8%	No change
Other Race/Multiple Races, Non-Hispanic	21.1%	19.2%	22.5%	22.8%	25.1%	Negative
White, Non-Hispanic	23.9%	24.2%	24.3%	24.3%	24.0%	No change

NPM: Low-Risk Cesarean Delivery: Percent of Cesarean deliveries among low-risk first births by Maternal Educational Attainment<sup>2+</sup>

Maternal Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	20.5%	19.6%	18.7%	17.6%	17.5%	Positive*
High School Graduate	22.2%	22.1%	23.7%	24.0%	24.7%	Negative*
Some College	25.4%	25.4%	25.5%	25.4%	25.9%	No change
College Graduate	24.7%	25.4%	25.4%	25.2%	24.8%	No change

NPM: Low-Risk Cesarean Delivery: Percent of Cesarean deliveries among low-risk first births by Delivery Payment Source<sup>2 †</sup>

Source of Payment for Delivery	2018	2019	2020	2021	2022	Trend
Medicaid	23.4%	23.0%	23.0%	22.8%	23.4%	No change
Private	25.3%	25.9%	26.2%	25.9%	25.6%	No change
None/Self-Pay	17.7%	17.1%	17.2%	16.0%	16.4%	Positive
Other	18.1%	17.6%	19.4%	22.3%	24.2%	Negative*

NPM: Low-Risk Cesarean Delivery: Percent of Cesarean deliveries among low-risk first births by Maternal Marital Status<sup>2 †</sup>

Marital Status	2018	2019	2020	2021	2022	Trend
Unmarried	23.3%	23.0%	23.0%	22.7%	23.1%	No change
Married	24.4%	24.9%	25.3%	25.4%	25.4%	Negative*

NPM: Low-Risk Cesarean Delivery: Percent of Cesarean deliveries among low-risk first births by Birth Plurality<sup>2 †</sup>

Birth Plurality	2018	2019	2020	2021	2022	Trend
Singleton	23.9%	24.1%	24.4%	24.3%	24.4%	Negative*
Multiple Birth	N/A	N/A	N/A	N/A	N/A	N/A

NPM: Low-Risk Cesarean Delivery: Percent of Cesarean deliveries among low-risk first births by WIC Participation<sup>2 †</sup>

WIC Participation	2018	2019	2020	2021	2022	Trend
No	24.2%	24.6%	24.8%	24.7%	24.7%	No change
Yes	23.2%	22.9%	23.1%	22.8%	23.1%	No change

NPM: Low-Risk Cesarean Delivery: Percent of Cesarean deliveries among low-risk first births by Urban-Rural Residence<sup>2 †</sup>

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large/Fringe Metro	22.2%	23.1%	24.1%	24.2%	24.2%	Negative*
Small/Medium Metro	25.0%	25.5%	25.1%	24.5%	24.5%	Positive
Non-Metro	24.5%	23.4%	23.8%	24.0%	24.4%	No change

*NPM: Low-Risk Cesarean Delivery: Percent of Cesarean deliveries among low-risk first births by Maternal Nativity<sup>2 †</sup>*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	23.9%	24.0%	24.1%	24.0%	24.1%	No change
Not Born in U.S.	24.2%	24.8%	26.1%	26.2%	26.9%	Negative*

*NPM: Risk-Appropriate Perinatal Care: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)<sup>2</sup>*

Risk-Appropriate Perinatal Care	2018	2019	2020	2021	2022	Trend
All	88.7%	87.9%	88.4%	86.8%	88.4%	No change

*NPM: Risk-Appropriate Perinatal Care: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ NICU by Maternal Age<sup>2 †</sup>*

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	88.0% <sup>†</sup>	86.4% <sup>†</sup>	85.1% <sup>†</sup>	80.0% <sup>†</sup>	81.9% <sup>†</sup>	Negative*
20-24 Years	85.7% <sup>†</sup>	85.7% <sup>†</sup>	84.5% <sup>†</sup>	84.7% <sup>†</sup>	84.0% <sup>†</sup>	Negative*
25-29 Years	89.5% <sup>†</sup>	88.8% <sup>†</sup>	88.5% <sup>†</sup>	88.0% <sup>†</sup>	88.8% <sup>†</sup>	No change
30-34 Years	89.3% <sup>†</sup>	91.4% <sup>†</sup>	91.3% <sup>†</sup>	90.2% <sup>†</sup>	90.9% <sup>†</sup>	No change
≥35 Years	93.3% <sup>†</sup>	91.9% <sup>†</sup>	90.1% <sup>†</sup>	90.9% <sup>†</sup>	89.0% <sup>†</sup>	Negative*

*NPM: Risk-Appropriate Perinatal Care: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ NICU by Maternal Race/Ethnicity<sup>2 †</sup>*

Maternal Race/Ethnicity	2018	2019	2020	2021	2022	Trend
American Indian/Alaska Native, Non-Hispanic	--	--	--	--	--	--
Asian/Native Hawaiian or Other Pacific Islander, Non-Hispanic	82.4% <sup>†</sup>	80.5% <sup>†</sup>	86.3% <sup>†</sup>	89.4% <sup>†</sup>	93.3% <sup>†</sup>	Negative*
Black, Non-Hispanic	94.8% <sup>†</sup>	95.9% <sup>†</sup>	94.0% <sup>†</sup>	91.7% <sup>†</sup>	92.3% <sup>†</sup>	Negative
Hispanic	83.4% <sup>†</sup>	83.0% <sup>†</sup>	82.0% <sup>†</sup>	81.3% <sup>†</sup>	79.9% <sup>†</sup>	Negative*
Other Race/Multiple Races, Non-Hispanic	89.8% <sup>†</sup>	87.5% <sup>†</sup>	82.4% <sup>†</sup>	85.7% <sup>†</sup>	78.3% <sup>†</sup>	Negative
White, Non-Hispanic	89.1% <sup>†</sup>	89.5% <sup>†</sup>	89.3% <sup>†</sup>	88.9% <sup>†</sup>	89.2% <sup>†</sup>	No change

*NPM: Risk-Appropriate Perinatal Care: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ NICU by Maternal Nativity<sup>2 †</sup>*

Maternal Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	89.2% <sup>†</sup>	89.2% <sup>†</sup>	88.8% <sup>†</sup>	88.3% <sup>†</sup>	83.6% <sup>†</sup>	Negative
Not Born in U.S.	88.0% <sup>†</sup>	88.1% <sup>†</sup>	85.5% <sup>†</sup>	84.1% <sup>†</sup>	81.7% <sup>†</sup>	Negative*

NPM: Risk-Appropriate Perinatal Care: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ NICU by Maternal Educational Attainment<sup>2 †</sup>

Maternal Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	81.9% <sup>†</sup>	82.9% <sup>†</sup>	79.5% <sup>†</sup>	76.4% <sup>†</sup>	74.8% <sup>†</sup>	Negative*
High School Graduate	91.2% <sup>†</sup>	89.6% <sup>†</sup>	87.2% <sup>†</sup>	87.5% <sup>†</sup>	88.1% <sup>†</sup>	Negative
Some College	87.7% <sup>†</sup>	89.7% <sup>†</sup>	88.9% <sup>†</sup>	90.6% <sup>†</sup>	90.4% <sup>†</sup>	Positive
College Graduate	92.9% <sup>†</sup>	92.3% <sup>†</sup>	95.0% <sup>†</sup>	92.4% <sup>†</sup>	93.2% <sup>†</sup>	No change

NPM: Risk-Appropriate Perinatal Care: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ NICU by Delivery Payment Source<sup>2 †</sup>

Delivery Payment Source	2018	2019	2020	2021	2022	Trend
Private	89.4% <sup>†</sup>	89.5% <sup>†</sup>	90.5% <sup>†</sup>	91.1% <sup>†</sup>	92.0% <sup>†</sup>	Positive*
Medicaid	87.9% <sup>†</sup>	88.4% <sup>†</sup>	86.4% <sup>†</sup>	85.5% <sup>†</sup>	84.6% <sup>†</sup>	Negative*
Other Public	94.2% <sup>†</sup>	96.9% <sup>†</sup>	96.8% <sup>†</sup>	92.3% <sup>†</sup>	93.8% <sup>†</sup>	Negative
None/Self-Pay	91.4% <sup>†</sup>	85.4% <sup>†</sup>	81.6% <sup>†</sup>	77.7% <sup>†</sup>	79.8% <sup>†</sup>	Negative*

NPM: Risk-Appropriate Perinatal Care: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ NICU by Plural Birth<sup>2 †</sup>

Plural Birth	2018	2019	2020	2021	2022	Trend
Singleton	88.0% <sup>†</sup>	88.3% <sup>†</sup>	86.5% <sup>†</sup>	86.3% <sup>†</sup>	86.5% <sup>†</sup>	Negative
Multiple Birth	N/A	N/A	N/A	N/A	N/A	N/A

NPM: Risk-Appropriate Perinatal Care: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ NICU by WIC Participation<sup>2 †</sup>

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	86.8% <sup>†</sup>	86.4% <sup>†</sup>	83.7% <sup>†</sup>	83.3% <sup>†</sup>	83.7% <sup>†</sup>	Negative*
No	90.1% <sup>†</sup>	90.5% <sup>†</sup>	90.5% <sup>†</sup>	89.6% <sup>†</sup>	89.4% <sup>†</sup>	No change

NPM: Risk-Appropriate Perinatal Care: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ NICU by Urban-Rural Residence<sup>2 †</sup>

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Fringe Metro	96.0% <sup>†</sup>	96.8% <sup>†</sup>	96.3% <sup>†</sup>	96.6% <sup>†</sup>	97.6% <sup>†</sup>	No change
Small/Medium Metro	95.3% <sup>†</sup>	95.9% <sup>†</sup>	95.5% <sup>†</sup>	93.7% <sup>†</sup>	93.8% <sup>†</sup>	Negative
Non-Metro	74.3% <sup>†</sup>	72.5% <sup>†</sup>	71.2% <sup>†</sup>	70.7% <sup>†</sup>	70.0% <sup>†</sup>	Negative*

*NPM: Safe Sleep: Percent of infants placed to sleep on their backs<sup>3</sup>*

Safe Sleep (A)	2018	2019	2020	2021	2022	Trend
Percent of infants placed to sleep on their backs	84.8%	84.4%	82.3%	82.2%	81.1%	Negative*

*NPM: Safe Sleep: Percent of infants placed to sleep on their backs by Maternal Age<sup>3+</sup>*

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	67.0% <sup>+</sup>	69.3% <sup>+</sup>	69.5%	70.9%	67.9%	No change
20-24 Years	81.0%	80.3%	79.3%	77.6%	77.1%	Negative*
25-29 Years	84.8%	84.8%	85.2%	85.3%	83.8%	No change
30-34 Years	85.1%	86.2%	88.5%	85.9%	84.7%	No change
≥35 Years	81.3%	82.9%	83.7%	83.2%	82.6%	No change

*NPM: Safe Sleep: Percent of infants placed to sleep on their backs by Maternal Race/Ethnicity<sup>3+</sup>*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
American Indian/Alaska Native, Non-Hispanic	--	--	--	--	--	--
Asian/Native Hawaiian or Other Pacific Islander, Non-Hispanic	82.3% <sup>+</sup>	82.8% <sup>+</sup>	82.4% <sup>+</sup>	72.4% <sup>+</sup>	69.5% <sup>+</sup>	Negative
Black, Non-Hispanic	80.4%	77.0%	72.6%	67.6%	68.7%	Negative*
Hispanic	81.1%	82.9%	84.2%	80.6%	75.4%	Negative
Other Race/Multiple Races, Non-Hispanic	84.3% <sup>+</sup>	82.9% <sup>+</sup>	78.1% <sup>+</sup>	80.0% <sup>+</sup>	84.5%	No change
White, Non-Hispanic	82.7%	83.6%	85.2%	85.7%	85.1%	Positive

*NPM: Safe Sleep: Percent of infants placed to sleep on their backs by Maternal Educational Attainment<sup>3+</sup>*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	72.9%	74.3%	75.8%	68.2%	64.1%	Negative
High School Graduate	77.6%	77.5%	79.6%	79.0%	77.5%	No change
Some College	82.6%	83.5%	83.2%	83.7%	83.1%	No change
College Graduate	88.8%	89.4%	89.7%	89.4%	88.7%	No change

*NPM: Safe Sleep: Percent of infants placed to sleep on their backs by Payment Source for Delivery<sup>3+</sup>*

Payment Source for Delivery	2018	2019	2020	2021	2022	Trend
Medicaid	79.5%	79.8%	81.0%	77.5%	76.2%	Negative
Private	84.9%	85.7%	86.4%	86.9%	86.4%	No change
None/Self-Pay	76.4%	75.4%	77.3%	73.6%	69.9%	Negative
Other	80.0% <sup>†</sup>	84.0%	84.1%	83.8%	80.7%	No change

*NPM: Safe Sleep: Percent of infants placed to sleep on their backs by Maternal Marital Status<sup>3+</sup>*

Marital Status	2018	2019	2020	2021	2022	Trend
Married	82.3%	84.2%	86.1%	86.3%	84.7%	Positive
Unmarried	82.9%	81.2%	79.9%	76.9%	76.6%	Negative*

*NPM: Safe Sleep: Percent of infants placed to sleep on their backs by WIC Participation<sup>3+</sup>*

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	80.3%	79.5%	80.6%	78.4%	77.1%	No change
No	83.4%	84.5%	85.0%	84.4%	83.2%	Negative

*NPM: Safe Sleep: Percent of infants placed to sleep on a separate approved sleep surface<sup>3+</sup>*

Safe Sleep (B)	2018	2019	2020	2021	2022	Trend
Percent of infants placed to sleep on a separate approved sleep surface	37.0%	41.2%	46.1%	47.7%	43.0%	Positive

*NPM: Safe Sleep: Percent of infants placed to sleep on a separate approved sleep surface by Maternal Age<sup>3+</sup>*

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	29.3% <sup>†</sup>	25.7% <sup>†</sup>	33.1% <sup>†</sup>	36.6% <sup>†</sup>	45.3% <sup>†</sup>	Positive*
20-24 Years	27.9%	32.0%	32.3%	36.7%	37.0%	Positive*
25-29 Years	39.2%	39.2%	42.9%	46.0%	45.7%	Positive*
30-34 Years	42.1%	42.7%	46.5%	48.2%	49.5%	Positive*
≥35 Years	40.0%	43.2%	44.2%	50.7%	49.1%	Positive*

NPM: Safe Sleep: Percent of infants placed to sleep on a separate approved sleep surface by Maternal Race/Ethnicity<sup>3+</sup>

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
American Indian/Alaska Native, Non-Hispanic	--	--	--	--	--	--
Asian/Native Hawaiian or Other Pacific Islander, Non-Hispanic	20.2% <sup>+</sup>	20.5% <sup>+</sup>	24.1% <sup>+</sup>	30.5% <sup>+</sup>	32.9% <sup>+</sup>	Positive*
Black, Non-Hispanic	29.2% <sup>+</sup>	29.6%	28.9%	30.9%	35.0%	Positive
Hispanic	25.3%	30.4%	35.8%	39.4%	41.0%	Positive*
Other Race/Multiple Races, Non-Hispanic	26.7% <sup>+</sup>	28.7% <sup>+</sup>	27.0% <sup>+</sup>	27.4% <sup>+</sup>	34.8% <sup>+</sup>	Positive
White, Non-Hispanic	40.8%	41.8%	44.7%	48.7%	48.6%	Positive*

NPM: Safe Sleep: Percent of infants placed to sleep on a separate approved sleep surface by Maternal Educational Attainment<sup>3+</sup>

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	29.6%	32.7%	33.4%	39.9%	37.8%	Positive
High School Graduate	33.0%	31.8%	33.2%	35.7%	38.4%	Positive*
Some College	33.2%	35.5%	37.7%	40.9%	41.8%	Positive*
College Graduate	44.9%	46.6%	51.6%	56.0%	55.3%	Positive*

NPM: Safe Sleep: Percent of infants placed to sleep on a separate approved sleep surface by Payment Source for Delivery<sup>3+</sup>

Health Insurance	2018	2019	2020	2021	2022	Trend
Medicaid	28.7%	29.2%	32.3%	37.0%	41.4%	Positive*
Private	41.2%	43.1%	47.2%	49.9%	49.4%	Positive*
None/Self-Pay	37.3% <sup>+</sup>	38.9% <sup>+</sup>	36.3%	38.2%	30.6%	Negative
Other	38.1% <sup>+</sup>	38.7%	36.4%	43.1%	44.9%	Positive

NPM: Safe Sleep: Percent of infants placed to sleep on a separate approved sleep surface by Maternal Marital Status<sup>3+</sup>

Marital Status	2018	2019	2020	2021	2022	Trend
Married	41.2%	43.0%	46.1%	49.9%	48.3%	Positive*
Unmarried	29.3%	29.9%	33.0%	35.9%	40.6%	Positive*

NPM: Safe Sleep: Percent of infants placed to sleep on a separate approved sleep surface by WIC Participation<sup>3+</sup>

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	28.9%	29.1%	32.5%	49.9%	43.1%	Positive*
No	40.3%	42.1%	44.5%	35.9%	46.4%	Positive*

NPM: Safe Sleep: Percent of infants placed to sleep without soft objects or loose bedding<sup>3</sup>

Safe Sleep (C)	2018	2019	2020	2021	2022	Trend
Percent of infants placed to sleep without soft objects or loose bedding	49.1%	54.1%	54.8%	61.1%	60.8%	Positive*

NPM: Safe Sleep: Percent of infants placed to sleep without soft objects or loose bedding by Maternal Age<sup>3+</sup>

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	35.1% <sup>†</sup>	33.4% <sup>†</sup>	37.0% <sup>†</sup>	39.8% <sup>†</sup>	43.2% <sup>†</sup>	Positive*
20-24 Years	42.8%	44.1%	44.2%	45.2%	47.3%	Positive*
25-29 Years	48.4%	50.8%	53.3%	57.1%	58.9%	Positive*
30-34 Years	49.7%	52.7%	59.3%	65.3%	68.6%	Positive*
≥35 Years	47.7%	51.9%	56.3%	59.9%	59.8%	Positive*

NPM: Safe Sleep: Percent of infants placed to sleep without soft objects or loose bedding by Maternal Race/Ethnicity<sup>3+</sup>

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
American Indian/Alaska Native, Non-Hispanic	--	--	--	--	--	--
Asian/Native Hawaiian or Other Pacific Islander, Non-Hispanic	32.4% <sup>†</sup>	32.3% <sup>†</sup>	38.4% <sup>†</sup>	49.6% <sup>†</sup>	49.0% <sup>†</sup>	Positive*
Black, Non-Hispanic	35.5% <sup>†</sup>	39.1%	37.9%	37.8%	32.7%	Negative
Hispanic	40.2%	44.3%	48.4%	46.4%	47.3%	Positive
Other Race/Multiple Races, Non-Hispanic	38.2% <sup>†</sup>	44.2% <sup>†</sup>	47.9% <sup>†</sup>	53.9% <sup>†</sup>	54.1% <sup>†</sup>	Positive*
White, Non-Hispanic	49.5%	51.7%	55.6%	61.2%	64.6%	Positive*

NPM: Safe Sleep: Percent of infants placed to sleep without soft objects or loose bedding by Educational Attainment<sup>3+</sup>

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	43.3%	45.7%	47.9%	42.6%	42.1%	Negative
High School Graduate	38.6%	39.9%	42.5%	45.3%	45.6%	Positive*
Some College	37.5%	40.8%	44.6%	50.0%	53.6%	Positive*
College Graduate	60.4%	62.7%	67.0%	73.5%	76.3%	Positive*

NPM: Safe Sleep: Percent of infants placed to sleep without soft objects or loose bedding by Payment Source for Delivery<sup>3+</sup>

Health Insurance	2018	2019	2020	2021	2022	Trend
Medicaid	37.6%	39.5%	39.6%	42.3%	44.1%	Positive*
Private	52.0%	54.6%	60.5%	65.3%	68.1%	Positive*
None/Self-Pay	37.8% <sup>†</sup>	44.6% <sup>†</sup>	47.3% <sup>†</sup>	49.2%	47.8%	Positive
Other	49.6% <sup>†</sup>	50.1% <sup>†</sup>	49.5%	48.8%	53.5%	Positive

NPM: Safe Sleep: Percent of infants placed to sleep without soft objects or loose bedding by Maternal Marital Status<sup>3+</sup>

Marital Status	2018	2019	2020	2021	2022	Trend
Married	51.6%	55.1%	60.4%	64.8%	65.9%	Positive*
Unmarried	37.5%	37.9%	39.0%	41.9%	46.0%	Positive*

NPM: Safe Sleep: Percent of infants placed to sleep without soft objects or loose bedding by WIC Participation<sup>3+</sup>

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	37.8%	40.0%	43.0%	45.9%	46.5%	Positive*
No	50.3%	52.6%	56.0%	60.1%	62.6%	Positive*

NPM: Drinking During Pregnancy: Percent of birthing persons who drink alcohol in the last 3 months of pregnancy<sup>3</sup>

Drinking During Pregnancy	2018	2019	2020	2021	2022	Trend
Percent of birthing persons who drink alcohol in the last 3 months of pregnancy	n/a	n/a	n/a	n/a	n/a	n/a

*NPM: Drinking During Pregnancy: Percent of birthing persons who drink alcohol in the last 3 months of pregnancy by Maternal Age<sup>3+</sup>*

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	n/a	n/a	n/a	n/a	n/a	n/a
20-24 Years	n/a	n/a	n/a	n/a	n/a	n/a
25-29 Years	n/a	n/a	n/a	n/a	n/a	n/a
30-34 Years	n/a	n/a	n/a	n/a	n/a	n/a
≥35 Years	n/a	n/a	n/a	n/a	n/a	n/a

*NPM: Drinking During Pregnancy: Percent of birthing persons who drink alcohol in the last 3 months of pregnancy by Maternal Race/Ethnicity<sup>3+</sup>*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
American Indian/Alaska Native, Non-Hispanic	n/a	n/a	n/a	n/a	n/a	n/a
Asian/Native Hawaiian or Other Pacific Islander, Non-Hispanic	n/a	n/a	n/a	n/a	n/a	n/a
Black, Non-Hispanic	n/a	n/a	n/a	n/a	n/a	n/a
Hispanic	n/a	n/a	n/a	n/a	n/a	n/a
Other Race/Multiple Races, Non-Hispanic	n/a	n/a	n/a	n/a	n/a	n/a
White, Non-Hispanic	n/a	n/a	n/a	n/a	n/a	n/a

*NPM: Drinking During Pregnancy: Percent of birthing persons who drink alcohol in the last 3 months of pregnancy by Maternal Educational Attainment<sup>3+</sup>*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	n/a	n/a	n/a	n/a	n/a	n/a
High School Graduate	n/a	n/a	n/a	n/a	n/a	n/a
Some College	n/a	n/a	n/a	n/a	n/a	n/a
College Graduate	n/a	n/a	n/a	n/a	n/a	n/a

*NPM: Drinking During Pregnancy: Percent of birthing persons who drink alcohol in the last 3 months of pregnancy by Payment Source for Delivery<sup>3+</sup>*

Health Insurance	2018	2019	2020	2021	2022	Trend
Medicaid	n/a	n/a	n/a	n/a	n/a	n/a
Private	n/a	n/a	n/a	n/a	n/a	n/a
None/Self-Pay	n/a	n/a	n/a	n/a	n/a	n/a
Other	n/a	n/a	n/a	n/a	n/a	n/a

NPM: Drinking During Pregnancy: Percent of birthing persons who drink alcohol in the last 3 months of pregnancy by Maternal Marital Status<sup>3 \*</sup>

Marital Status	2018	2019	2020	2021	2022	Trend
Married	n/a	n/a	n/a	n/a	n/a	n/a
Unmarried	n/a	n/a	n/a	n/a	n/a	n/a

NPM: Drinking During Pregnancy: Percent of birthing persons who drink alcohol in the last 3 months of pregnancy by WIC Participation<sup>3 \*</sup>

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	n/a	n/a	n/a	n/a	n/a	n/a
No	n/a	n/a	n/a	n/a	n/a	n/a

NOM: Infant Mortality: Infant mortality rate per 1,000 live births<sup>1,4,5</sup> (Healthy People 2030: 5.0)

Infant mortality rate per 1,000 live births	2018	2019	2020	2021	2022	Trend
All <sup>1,4</sup>	6.4	5.3	6.5	5.3	5.8	Positive
Medicaid <sup>2,5</sup>	7.9	7.2	8.7	7.0	6.7	Positive
Non-Medicaid <sup>2,5</sup>	5.5	4.3	4.3	3.5	4.0	Positive

NOM: Infant Mortality: Infant mortality rate per 1,000 live births by Gestational Age<sup>2,5 \*</sup>

Gestational Age	2018	2019	2020	2021	2022	Trend
<34 Weeks	122.2	114.9	111.0	105.6	99.9	Positive*
34-36 Weeks	9.3	9.3	9.4	8.3	8.3	Positive
37-38 Weeks	3.9	3.8	3.9	3.7	3.6	Positive
39+ Weeks	1.8	1.8	1.8	1.8	1.8	Positive

NOM: Infant Mortality: Infant mortality rate per 1,000 live births by Birthweight<sup>2,5 \*</sup>

Birthweight	2018	2019	2020	2021	2022	Trend
<1,500 Grams	231.4	216.7	208.8	197.6	191.3	Positive*
1,500-2,499 Grams	15.2	14.7	16.0	14.2	13.7	Positive
2,500+ Grams	2.3	2.2	2.2	2.2	2.2	Positive*

NOM: Infant Mortality: Infant mortality rate per 1,000 live births by Maternal Age<sup>2,5</sup> †

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	8.2	7.7	8.3	8.7	8.8	Negative
20-24 Years	6.5	6.7	6.8	6.7	6.6	No change
25-29 Years	6.4	6.1	5.9	5.4	4.9	Positive*
30-34 Years	4.7	4.4	4.7	4.5	4.5	No change
≥35 Years	5.5	5.3	5.1	4.7	4.7	Positive*

NOM: Infant Mortality: Infant mortality rate per 1,000 live births by Maternal Race/Ethnicity<sup>2,5</sup> †

Maternal Race/Ethnicity	2018	2019	2020	2021	2022	Trend
American Indian/Alaska Native, Non-Hispanic	--	--	--	--	--	--
Asian/Native Hawaiian or Other Pacific Islander, Non-Hispanic	4.4	4.7	4.4	4.2	4.3	Positive
Black, Non-Hispanic	11.3	11.0	12.2	11.5	10.5	Positive
Hispanic	6.0	6.0	5.8	5.8	5.6	Positive*
Other Race/Multiple Races, Non-Hispanic	7.1	7.4	6.8	6.3	5.8	Positive*
White, Non-Hispanic	5.4	5.1	5.1	4.9	4.8	Positive*

NOM: Infant Mortality: Infant mortality rate per 1,000 live births by Maternal Nativity<sup>2,5</sup> †

Maternal Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	6.0	5.8	5.8	5.5	5.2	Positive*
Not Born in U.S.	5.4	5.3	5.2	5.5	5.8	Negative

NOM: Infant Mortality: Infant mortality rate per 1,000 live births by Maternal Educational Attainment<sup>2,5</sup> †

Maternal Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	8.2	8.5	8.6	8.8	8.6	Negative
High School Graduate	7.8	7.6	7.4	7.3	7.1	Positive*
Some College	5.8	5.6	5.8	5.5	5.4	Positive
College Graduate	3.7	3.3	3.2	2.9	2.8	Positive*

NOM: Infant Mortality: Infant mortality rate per 1,000 live births by Maternal Marital Status<sup>2,5</sup> †

Maternal Marital Status	2018	2019	2020	2021	2022	Trend
Married	4.6	4.3	4.2	3.9	3.8	Positive*
Unmarried	8.3	8.3	8.5	8.3	7.9	Positive

NOM: Infant Mortality: Infant mortality rate per 1,000 live births by WIC Participation<sup>2,5</sup> †

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	6.5	6.2	6.5	6.7	6.7	Negative
No	5.7	5.5	5.5	5.1	4.8	Positive*

NOM: Infant Mortality: Infant mortality rate per 1,000 live births by Plural Birth<sup>2,5</sup> †

Plural Birth	2018	2019	2020	2021	2022	Trend
Singleton	5.4	5.2	5.2	5.0	4.8	Positive*
Multiple Birth	23.9	22.6	22.6	20.5	20.3	Positive*

NOM: Infant Mortality: Infant mortality rate per 1,000 live births by Urban-Rural Residence<sup>2,5</sup> †

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Fringe Metro	4.7	4.7	4.5	4.3	4.1	Positive*
Small/Medium Metro	7.0	6.8	7.1	6.7	6.3	Positive
Non-Metro	5.9	5.5	5.4	5.2	5.3	Positive*

NOM: Neonatal Mortality: Neonatal mortality rate per 1,000 live births<sup>2,5,6</sup>

Neonatal mortality rate per 1,000 live births	2018	2019	2020	2021	2022	Trend
All <sup>1,4</sup>	4.5	3.3	4.3	3.1	3.7	Positive
Medicaid <sup>2,5</sup>	5.3	3.5	4.7	2.5	3.2	Positive
Non-Medicaid <sup>2,5</sup>	4.0	3.2	3.2	2.5	2.8	Positive*

NOM: Neonatal Mortality: Neonatal mortality rate per 1,000 live births by Gestational Age<sup>2,5</sup> †

Gestational Age	2018	2019	2020	2021	2022	Trend
<34 Weeks	111.3	104.3	100.0	94.7	88.7	Positive*
34-36 Weeks	5.8	5.6	5.6	4.6	4.2	Positive*
37-38 Weeks	1.8	1.6	1.8	1.6	1.6	Positive
39+ Weeks	0.6	0.6	0.5	0.5	0.5	Positive*

NOM #9.2: Neonatal mortality rate per 1,000 live births by Birthweight<sup>2,5</sup> †

Birthweight	2018	2019	2020	2021	2022	Trend
<1,500 Grams	215.1	200.3	192.4	180.7	174.2	Positive*
1,500-2,499 Grams	9.9	9.7	10.5	9.3	8.1	Positive
2,500+ Grams	0.9	0.8	0.8	0.7	0.7	Positive*

NOM: Neonatal Mortality: Neonatal mortality rate per 1,000 live births by Maternal Age<sup>2,5</sup> †

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	5.6	5.2	5.1	5.1	4.6	Positive*
20-24 Years	4.3	4.1	4.2	4.0	3.8	Positive
25-29 Years	4.2	4.2	3.9	3.6	3.1	Positive*
30-34 Years	3.6	3.2	3.4	3.3	3.2	Positive
≥35 Years	4.2	3.8	3.7	3.2	3.3	Positive*

NOM: Neonatal Mortality: Neonatal mortality rate per 1,000 live births by Maternal Race/Ethnicity<sup>2,5</sup> †

Maternal Race/Ethnicity	2018	2019	2020	2021	2022	Trend
American Indian/Alaska Native, Non-Hispanic	--	--	--	--	--	--
Asian/Native Hawaiian or Other Pacific Islander, Non-Hispanic	3.6	3.9	3.9	3.7	3.9	Negative
Black, Non-Hispanic	7.9	7.6	8.2	7.6	6.8	Positive
Hispanic	4.5	4.4	4.0	3.7	3.5	Positive*
Other Race/Multiple Races, Non-Hispanic	4.4	4.3	4.3	3.8	3.9	Positive
White, Non-Hispanic	3.7	3.4	3.4	3.2	3.0	Positive*

NOM: Neonatal Mortality: Neonatal mortality rate per 1,000 live births by Maternal Nativity<sup>2,5</sup> †

Maternal Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	4.1	3.9	3.8	3.5	3.2	Positive*
Not Born in U.S.	4.0	4.0	4.0	4.2	4.2	Negative

NOM: Neonatal Mortality: Neonatal mortality rate per 1,000 live births by Maternal Educational Attainment<sup>2,5</sup> †

Maternal Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	5.3	5.2	5.1	5.2	4.9	Positive
High School Graduate	5.1	4.8	4.6	4.4	4.1	Positive*
Some College	3.9	3.8	3.9	3.6	3.3	Positive
College Graduate	3.0	2.6	2.5	2.3	2.2	Positive*

NOM: Neonatal Mortality: Neonatal mortality rate per 1,000 live births by Maternal Marital Status<sup>2,5</sup> †

Maternal Marital Status	2018	2019	2020	2021	2022	Trend
Married	3.5	3.2	3.1	3.0	2.9	Positive*
Unmarried	5.3	5.1	5.2	4.7	4.3	Positive*

NOM: Neonatal Mortality: Neonatal mortality rate per 1,000 live births by WIC Participation<sup>2,5</sup> †

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	3.6	3.5	3.5	3.4	3.1	Positive*
No	4.3	4.1	4.0	3.7	3.4	Positive*

NOM: Neonatal Mortality: Neonatal mortality rate per 1,000 live births by Plural Birth<sup>2,5</sup> †

Plural Birth	2018	2019	2020	2021	2022	Trend
Singleton	3.6	3.4	3.4	3.2	3.0	Positive*
Multiple Birth	19.7	18.7	18.0	16.0	15.6	Positive*

NOM: Neonatal Mortality: Neonatal mortality rate per 1,000 live births by Urban-Rural Residence<sup>2,5</sup> †

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Fringe Metro	3.2	3.1	2.9	2.7	2.7	Positive*
Small/Medium Metro	4.9	4.6	4.8	4.5	4.1	Positive
Non-Metro	4.1	3.9	3.7	3.4	3.1	Positive*

NOM: Postneonatal Mortality: Postneonatal mortality rate per 1,000 live births<sup>1,4,5</sup>

Postneonatal mortality rate per 1,000 live births	2018	2019	2020	2021	2022	Trend
All <sup>1,4</sup>	1.9	2.0	2.2	2.2	2.1	Negative
Medicaid <sup>2,5</sup>	2.6	3.6	4.0	4.6	3.4	Negative
Non-Medicaid <sup>2,5</sup>	1.6	1.1	1.1	1.0	1.2	Positive

NOM: Postneonatal Mortality: Postneonatal mortality rate per 1,000 live births by Gestational Age<sup>2,5</sup> †

Gestational Age	2018	2019	2020	2021	2022	Trend
<34 Weeks	10.9	10.6	10.9	10.9	11.2	Negative
34-36 Weeks	3.5	3.6	3.9	3.7	4.1	Negative
37-38 Weeks	2.1	2.1	2.1	2.1	2.0	Positive
39+ Weeks	1.2	1.2	1.2	1.3	1.3	Negative*

NOM: Postneonatal Mortality: Postneonatal mortality rate per 1,000 live births by Birthweight<sup>2,5</sup> †

Birthweight	2018	2019	2020	2021	2022	Trend
<1,500 Grams	16.3	16.4	16.4	16.9	17.1	Negative*
1,500-2,499 Grams	5.3	5.0	5.5	4.9	5.6	Negative
2,500+ Grams	1.4	1.4	1.5	1.5	1.5	Negative*

NOM: Postneonatal Mortality: Postneonatal mortality rate per 1,000 live births by Maternal Age<sup>2,5</sup> †

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	2.6	2.5	3.2	3.7	4.2	Negative*
20-24 Years	2.2	2.5	2.5	2.6	2.8	Negative*
25-29 Years	2.2	2.0	2.0	1.9	1.8	Positive*
30-34 Years	1.1	1.1	1.3	1.2	1.4	Negative*
≥35 Years	1.3	1.5	1.4	1.5	1.4	Negative

NOM: Postneonatal Mortality: Postneonatal mortality rate per 1,000 live births by Maternal Race/Ethnicity<sup>2,5</sup> †

Maternal Race/Ethnicity	2018	2019	2020	2021	2022	Trend
American Indian/Alaska Native, Non-Hispanic	--	--	--	--	--	--
Asian/Native Hawaiian or Other Pacific Islander, Non-Hispanic	--	--	--	--	--	--
Black, Non-Hispanic	3.4	3.4	3.9	3.8	3.7	Negative
Hispanic	1.5	1.6	1.8	2.0	2.1	Negative*
Other Race/Multiple Races, Non-Hispanic	2.7 <sup>+</sup>	3.0 <sup>+</sup>	2.5 <sup>+</sup>	2.5 <sup>+</sup>	1.9 <sup>+</sup>	Positive
White, Non-Hispanic	1.7	1.7	1.7	1.7	1.8	Negative

NOM: Postneonatal Mortality: Postneonatal mortality rate per 1,000 live births by Maternal Nativity<sup>2,5</sup> †

Maternal Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	1.9	1.9	2.0	2.0	2.0	Negative*
Not Born in U.S.	1.4	1.3	1.2	1.4	1.5	Negative

NOM: Postneonatal Mortality: Postneonatal mortality rate per 1,000 live births by Maternal Educational Attainment<sup>2,5</sup> †

Maternal Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	2.9	3.3	3.5	3.6	3.7	Negative*
High School Graduate	2.8	2.8	2.8	2.9	3.0	Negative*
Some College	1.8	1.8	1.9	1.9	2.1	Negative*
College Graduate	0.7	0.7	0.7	0.6	0.6	Positive

NOM: Postneonatal Mortality: Postneonatal mortality rate per 1,000 live births by Maternal Marital Status<sup>2,5</sup> †

Maternal Marital Status	2018	2019	2020	2021	2022	Trend
Married	1.1	1.1	1.1	1.0	1.0	Positive*
Unmarried	3.0	3.2	3.3	3.5	3.7	Negative*

NOM #9.3: Postneonatal mortality rate per 1,000 live births by WIC Participation<sup>2,5</sup> †

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	2.9	2.7	2.9	3.3	3.7	Negative*
No	1.3	1.4	1.5	1.4	1.4	Negative

NOM: Postneonatal Mortality: Postneonatal mortality rate per 1,000 live births by Plural Birth<sup>2,5</sup> †

Plural Birth	2018	2019	2020	2021	2022	Trend
Singleton	1.7	1.8	1.8	1.8	1.9	Negative*
Multiple Birth	4.1	3.9	4.5	4.4	4.7	Negative

NOM: Postneonatal Mortality: Postneonatal mortality rate per 1,000 live births by Urban-Rural Residence<sup>2,5</sup> †

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Fringe Metro	1.5	1.6	1.6	1.6	1.4	No change
Small/Medium Metro	2.1	2.2	2.3	2.2	2.2	Negative
Non-Metro	1.8	1.7	1.7	1.8	2.2	Negative

NOM: Preterm-Related Mortality: Preterm-related mortality rate per 100,000 live births<sup>2,5</sup>

Preterm-related mortality rate per 100,000 live births	2018	2019	2020	2021	2022	Trend
All	198.5	152.6	151.3	123.9	139.6	Positive
Medicaid	229.5	143.0	168.4	114.2	120.5	Positive
Non-Medicaid	181.7	153.6	145.2	126.6	150.4	Positive

NOM: Preterm-Related Mortality: Preterm-related mortality rate per 100,000 live births by Maternal Age<sup>2,5</sup> †

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	317.3	285.0	234.7	226.3	203.4 <sup>†</sup>	Positive*
20-24 Years	197.1	193.4	197.6	190.7	196.1	No change
25-29 Years	200.5	199.8	173.9	159.2	130.6	Positive*
30-34 Years	186.1	164.5	168.7	158.5	144.9	Positive*
≥35 Years	185.7	168.6	163.2	140.3	141.4	Positive*

NOM: Preterm-Related Mortality: Preterm-related mortality rate per 100,000 live births by Maternal Race/Ethnicity<sup>2,5</sup> †

Maternal Race/Ethnicity	2018	2019	2020	2021	2022	Trend
American Indian/Alaska Native, Non-Hispanic	--	--	--	--	--	--
Asian/Native Hawaiian or Other Pacific Islander, Non-Hispanic	180.0 <sup>†</sup>	242.4 <sup>†</sup>	277.5 <sup>†</sup>	250.6 <sup>†</sup>	256.2 <sup>†</sup>	Negative
Black, Non-Hispanic	560.4	537.7	498.2	448.9	399.7	Positive*
Hispanic	235.0	225.6	191.7	172.9	157.8	Positive*
Other Race/Multiple Races, Non-Hispanic	--	--	177.9 <sup>†</sup>	--	--	--
White, Non-Hispanic	160.7	145.1	138.8	133.9	123.5	Positive*

NOM: Preterm-Related Mortality: Preterm-related mortality rate per 100,000 live births by Maternal Nativity<sup>2,5</sup> †

Maternal Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	204.7	187.7	174.5	158.4	143.6	Positive*
Not Born in U.S.	166.7	188.9	198.3	213.8	217.3	Negative*

NOM: Preterm-Related Mortality: Preterm-related mortality rate per 100,000 live births by Maternal Educational Attainment<sup>2,5</sup> †

Maternal Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	234.5	232.7	236.6	224.8	191.8	Positive
High School Graduate	274.2	272.9	234.7	219.2	195.2	Positive*
Some College	198.0	186.4	183.4	172.5	165.2	Positive*
College Graduate	130.4	107.4	104.5	96.7	98.1	Positive*

NOM: Preterm-Related Mortality: Preterm-related mortality rate per 100,000 live births by Maternal Marital Status<sup>2,5</sup> †

Maternal Marital Status	2018	2019	2020	2021	2022	Trend
Married	156.5	147.0	141.7	130.1	122.8	Positive*
Unmarried	279.8	264.7	246.1	230.7	207.8	Positive*

NOM: Preterm-Related Mortality: Preterm-related mortality rate per 100,000 live births by WIC Participation<sup>2,5</sup> †

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	148.0	138.5	146.7	139.3	118.0	Positive
No	224.7	209.7	190.8	176.2	165.1	Positive*

NOM: Preterm-Related Mortality: Preterm-related mortality rate per 100,000 live births by Plural Birth<sup>2,5</sup> †

Plural Birth	2018	2019	2020	2021	2022	Trend
Singleton	167.2	157.7	152.7	141.7	130.3	Positive*
Multiple Birth	1,227.6	1,155.7	996.5	916.8	868.8	Positive*

NOM: Preterm-Related Mortality: Preterm-related mortality rate per 100,000 live births by Urban-Rural Residence<sup>2,5</sup> †

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Fringe Metro	163.9	153.9	137.1	124.5	122.0	Positive*
Small/Medium Metro	252.8	234.3	232.2	220.8	194.2	Positive*
Non-Metro	176.6	171.6	159.4	144.8	137.6	Positive*

NOM: Sleep-related Sudden Unexpected Infant Death (SUID) Mortality: SUID rate per 100,000 live births (R95, R99, W75)<sup>2,5</sup>

SUID rate per 100,000 live births (R95, R99, W75)	2018	2019	2020	2021	2022	Trend
All	118.6	101.7	148.4	138.3	110.5	Negative
Medicaid	158.9 <sup>†</sup>	200.2	299.3	314.0	185.4	Negative
Non-Medicaid	96.9	48.5 <sup>†</sup>	72.6 <sup>†</sup>	59.1 <sup>†</sup>	51.6 <sup>†</sup>	Positive

NOM: SUID Mortality: SUID rate per 100,000 live births (R95, R99, W75) by Gestational Age<sup>2,5</sup> †

Gestational Age	2018	2019	2020	2021	2022	Trend
<34 Weeks	336.0 <sup>†</sup>	338.5 <sup>†</sup>	364.2 <sup>†</sup>	327.3 <sup>†</sup>	291.2 <sup>†</sup>	Positive
34-36 Weeks	168.6	150.2 <sup>†</sup>	188.9	180.7	193.1	Negative
37-38 Weeks	148.7	139.9	150.6	148.3	139.6	Positive
39+ Weeks	77.8	82.9	87.2	93.0	91.9	Negative*

NOM: SUID Mortality: SUID rate per 100,000 live births (R95, R99, W75) by Birthweight<sup>2,5</sup> †

Birthweight	2018	2019	2020	2021	2022	Trend
<1,500 Grams	--	--	--	--	--	--
1,500-2,499 Grams	234.1	226.4	302.3	258.2	237.5	Negative
2,500+ Grams	96.3	97.8	102.8	107.9	105.0	Negative*

NOM: SUID Mortality: SUID rate per 100,000 live births (R95, R99, W75) by Maternal Age<sup>2,5</sup> †

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	158.7 <sup>†</sup>	180.5 <sup>†</sup>	255.1	323.2	373.0	Negative*
20-24 Years	155.3	166.8	162.2	158.9	166.1	Negative
25-29 Years	119.7	112.0	126.0	130.2	112.2	No change
30-34 Years	64.7	65.4	76.3	71.1	75.5	Negative
≥35 Years	61.9 <sup>†</sup>	60.2 <sup>†</sup>	55.7 <sup>†</sup>	58.5 <sup>†</sup>	57.3 <sup>†</sup>	Positive

NOM: SUID Mortality: SUID rate per 100,000 live births (R95, R99, W75) by Maternal Race/Ethnicity<sup>2,5</sup> †

Maternal Race/Ethnicity	2018	2019	2020	2021	2022	Trend
American Indian/Alaska Native, Non-Hispanic	--	--	--	--	--	--
Asian/Native Hawaiian or Other Pacific Islander, Non-Hispanic	--	--	--	--	--	--
Black, Non-Hispanic	221.0	224.7	277.7	257.7	238.1	Negative
Hispanic	75.1	81.8	99.2	106.4	105.2	Negative*
Other Race/Multiple Races, Non-Hispanic	218.4 <sup>†</sup>	251.1 <sup>†</sup>	266.9 <sup>†</sup>	252.1 <sup>†</sup>	206.5 <sup>†</sup>	Positive
White, Non-Hispanic	102.1	98.0	102.1	107.7	109.4	Negative

NOM: SUID Mortality: SUID rate per 100,000 live births (R95, R99, W75) by Maternal Nativity<sup>2,5</sup> †

Maternal Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	118.0	119.3	129.5	130.9	126.4	Negative
Not Born in U.S.	45.5 <sup>†</sup>	42.4 <sup>†</sup>	43.6 <sup>†</sup>	49.3 <sup>†</sup>	62.7 <sup>†</sup>	Negative

NOM: SUID Mortality: SUID rate per 100,000 live births (R95, R99, W75) by Maternal Educational Attainment<sup>2,5</sup> †

Maternal Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	204.6	237.1	255.5	249.8	233.2	Negative
High School Graduate	151.8	155.9	165.7	187.2	190.7	Negative*
Some College	113.6	103.0	118.5	120.2	122.9	Negative
College Graduate	35.0	32.1	32.7	27.9 <sup>†</sup>	24.5 <sup>†</sup>	Positive*

NOM: SUID Mortality: SUID rate per 100,000 live births (R95, R99, W75) by Maternal Marital Status<sup>2,5</sup> †

Maternal Marital Status	2018	2019	2020	2021	2022	Trend
Married	53.8	45.6	51.3	50.5	50.2	Positive
Unmarried	202.1	218.3	233.9	241.6	237.7	Negative*

NOM: SUID Mortality: SUID rate per 100,000 live births (R95, R99, W75) by WIC Participation<sup>2,5</sup> †

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	167.9	176.3	187.8	207.8	224.5	Negative*
No	79.3	78.9	90.0	88.5	83.0	Negative

NOM: SUID Mortality: SUID rate per 100,000 live births (R95, R99, W75) by Plural Birth<sup>2,5</sup> †

Plural Birth	2018	2019	2020	2021	2022	Trend
Singleton	106.0	106.5	114.4	116.6	115.0	Negative*
Multiple Birth	165.9 <sup>†</sup>	170.0 <sup>†</sup>	227.3 <sup>†</sup>	229.2 <sup>†</sup>	235.3 <sup>†</sup>	Negative*

NOM: SUID Mortality: SUID rate per 100,000 live births (R95, R99, W75) by Urban-Rural Residence<sup>2,5</sup> †

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Fringe Metro	83.7	88.4	86.6	87.9	75.8	Positive
Small/Medium Metro	138.5	139.7	155.8	151.8	144.5	Negative
Non-Metro	94.0	88.3	102.8	111.6	127.1	Negative*

NOM: Perinatal Mortality: Perinatal mortality rate per 1,000 live births plus fetal deaths<sup>2,4,5,6</sup>

Perinatal mortality rate	2018	2019	2020	2021	2022	Trend
All <sup>2,4,6</sup>	6.2	5.3	6.1	5.8	6.1	Negative
Medicaid <sup>2,5,6</sup>	7.0	6.5	6.2	5.7	5.5	Positive*
Non-Medicaid <sup>2,5,6</sup>	5.6	4.5	5.1	4.8	5.3	Positive

NOM: Perinatal Mortality: Perinatal mortality rate per 1,000 live births plus fetal deaths by Gestational Age<sup>2,5,6</sup> †

Gestational Age	2018	2019	2020	2021	2022	Trend
<34 Weeks	133.3	130.0	125.0	121.4	118.7	Positive*
34-36 Weeks	14.7	13.9	13.3	12.1	11.6	Positive*
37-38 Weeks	3.7	3.3	3.3	2.9	2.9	Positive*
39+ Weeks	1.0	1.0	1.1	1.1	1.1	Negative

NOM: Perinatal Mortality: Perinatal mortality rate per 1,000 live births plus fetal deaths by Birthweight<sup>2,5,6</sup> †

Birthweight	2018	2019	2020	2021	2022	Trend
<1,500 Grams	237.7	228.5	219.7	206.8	203.7	Positive*
1,500-2,499 Grams	21.3	20.9	21.3	22.1	21.1	No change
2,500+ Grams	1.8	1.7	1.7	1.5	1.6	Positive

NOM: Perinatal Mortality: Perinatal mortality rate per 1,000 live births plus fetal deaths by Maternal Age<sup>2,5,6</sup> †

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	8.2	7.6	6.5	6.3	6.5	Positive*
20-24 Years	6.0	6.3	6.6	6.2	6.1	No change
25-29 Years	6.1	5.9	5.6	5.5	5.1	Positive*
30-34 Years	5.1	5.1	5.3	5.2	5.3	Negative
≥35 Years	7.7	6.6	6.5	5.3	5.5	Positive*

NOM: Perinatal Mortality: Perinatal mortality rate per 1,000 live births plus fetal deaths by Race/Ethnicity<sup>2,5,6</sup> †

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
American Indian/Alaska Native, Non-Hispanic	--	--	--	--	--	--
Asian/Native Hawaiian or Other Pacific Islander, Non-Hispanic	5.2	5.3	5.7	5.3	6.0	Negative
Black, Non-Hispanic	12.2	12.2	12.1	11.5	10.8	Positive*
Hispanic	7.1	7.0	6.9	6.5	6.5	Positive*
Other Race/Multiple Races, Non-Hispanic	7.1	5.9	5.5	5.0	5.6	Positive
White, Non-Hispanic	5.3	5.1	5.1	4.9	4.8	Positive*

NOM: Perinatal Mortality: Perinatal mortality rate per 1,000 live births plus fetal deaths by Plural Birth<sup>2,5,6</sup> †

Plural Birth	2018	2019	2020	2021	2022	Trend
Singleton	5.6	5.5	5.4	5.2	5.2	Positive*
Multiple Birth	22.1	22.0	20.9	18.4	18.7	Positive*

NOM: Perinatal Mortality: Perinatal mortality rate per 1,000 live births plus fetal deaths by Urban-Rural Residence<sup>2,5,6</sup> †

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Fringe Metro	5.2	4.8	4.9	4.5	4.6	Positive*
Small/Medium Metro	6.2	6.0	6.2	6.1	6.1	No change
Non-Metro	6.9	7.0	6.5	6.1	5.8	Positive*

NOM: Percent of preterm births (<37 weeks gestation) (HP2030: 9.4%)<sup>2</sup>

Percent of preterm births (<37 weeks gestation)	2018	2019	2020	2021	2022	Trend
All <sup>4</sup>	9.5%	10.1%	10.0%	9.8%	10.5%	Negative
Medicaid	11.4%	11.9%	11.9%	11.7%	12.0%	Negative
Non-Medicaid	8.6%	9.3%	9.1%	9.0%	9.8%	Negative
Early Preterm Birth (<34 weeks)	2.5%	2.7%	2.6%	2.5%	2.5%	Positive
Late Preterm Birth (34-36 weeks)	6.9%	7.4%	7.4%	7.3%	8.0%	Negative

NOM: Percent of preterm births (<37 weeks gestation) by Maternal Age<sup>2‡</sup>

Maternal Age	2018	2019	2020	2021	2022	Trend
<20 Years	10.7%	10.9%	10.3%	10.5%	10.3%	Positive
20-24 Years	9.1%	9.5%	9.6%	9.7%	9.6%	Negative
25-29 Years	8.9%	9.1%	9.2%	9.2%	9.4%	Negative*
30-34 Years	8.8%	9.1%	9.6%	9.6%	9.9%	Negative*
≥35 Years	11.6%	12.0%	12.0%	12.3%	12.3%	Negative*

NOM: Percent of preterm births (<37 weeks gestation) by Race/Ethnicity<sup>2‡</sup>

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	9.1%	9.3%	9.4%	9.5%	9.6%	Negative*
Non-Hispanic Black	13.7%	14.1%	13.8%	14.2%	14.1%	Negative
Hispanic	8.9%	9.5%	9.9%	10.0%	10.1%	Negative*
Non-Hispanic American Indian/Alaska Native	10.8%	11.2%	9.4%	8.8%	8.9%	Positive*
Non-Hispanic Asian	8.7%	8.9%	9.5%	9.8%	10.5%	Negative*
Non-Hispanic Native Hawaiian/Other Pacific Islander	7.5%	8.7%	11.3%	14.7%	16.7%	Negative*
Non-Hispanic Multiple Race	10.2%	10.7%	10.6%	10.7%	10.5%	Negative

NOM: Percent of preterm births (<37 weeks gestation) by Nativity<sup>2+</sup>

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	9.6%	9.9%	9.9%	10.0%	10.0%	Negative*
Not Born in U.S.	8.2%	8.8%	9.6%	9.9%	10.3%	Negative*

NOM: Percent of preterm births (<37 weeks gestation) by Educational Attainment<sup>2+</sup>

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	10.3%	10.8%	11.0%	11.1%	11.2%	Negative*
High School Graduate	10.4%	10.8%	11.3%	11.5%	11.7%	Negative*
Some College	9.6%	10.0%	10.1%	10.3%	10.3%	Negative*
College Graduate	8.1%	8.2%	8.2%	8.2%	8.3%	No change

NOM: Percent of preterm births (<37 weeks gestation) by Marital Status<sup>2+</sup>

Marital Status	2018	2019	2020	2021	2022	Trend
Married	8.6%	8.9%	9.0%	9.2%	9.3%	Negative*
Unmarried	10.8%	11.2%	11.3%	11.3%	11.5%	Negative

NOM: Percent of preterm births (<37 weeks gestation) by WIC Participation<sup>2+</sup>

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	10.4%	10.8%	11.1%	11.4%	11.2%	Negative*
No	8.9%	9.3%	9.4%	9.5%	9.7%	Negative*

NOM: Percent of preterm births (<37 weeks gestation) by Plural Birth<sup>2+</sup>

Plural Birth	2018	2019	2020	2021	2022	Trend
Singleton	7.7%	7.9%	8.1%	8.2%	8.4%	Negative*
Multiple Birth	61.5%	63.1%	63.7%	62.9%	61.5%	No change

NOM: Percent of preterm births (<37 weeks gestation) by Urban-Rural Residence<sup>2†</sup>

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Fringe Metro	9.1%	9.4%	9.6%	9.7%	9.8%	Negative*
Small/Medium Metro	9.8%	10.2%	10.0%	10.1%	10.4%	Negative*
Non-Metro	9.1%	9.5%	9.9%	9.9%	10.0%	Negative

Life Course Indicator 27 (LC-27): Family Wellbeing - Infants who are exclusively breastfed at 3 months<sup>1</sup>

LC-27: Family Wellbeing	2017	2018	2019	2020	2021	Trend
Infants who are exclusively breastfed at 3 months (Birth year: 2017, 2018, 2019, 2020, 2021)	51.6%	53.6%	47.0%	46.3%	57.5%	Trend not available

Additional Data

Indicators	2018	2019	2020	2021	2022	Trend	HP2030
Stillbirth (rate per 1,000 live births plus fetal deaths) <sup>2,6</sup>	5.4	5.4	4.8	5.5	5.8	Negative	N/A
Congenital abnormality mortality (rate per 100,000 live births) <sup>2,4</sup>	159.9	132.8	130.9	109.5	151.2	Positive	N/A
Non-Hispanic Black/Non-Hispanic White infant mortality (rate per 1,000 live births, in five-year rolling averages from 2014-2018 to 2018-2022) <sup>2,4</sup>	2.1	2.1	2.4	2.3	2.2	N/A	N/A
Hispanic/Non-Hispanic White infant mortality rate per 1,000 live births, in five-year rolling averages from 2014-2018 to 2018-2022) <sup>2,4</sup>	1.1	1.2	1.1	1.2	1.2	N/A	N/A
Live births at a baby-friendly facility <sup>7</sup>	41.1%	N/A	N/A	52.9%	N/A	N/A	N/A
Well-baby checkups <sup>3</sup>	98.0%	98.5%	99.2%	99.1%	98.8%	No change	N/A
Maternal heavy drinking (8 or more drinks a week) during the 3 months before pregnancy <sup>3</sup>	3.4%	3.7%	3.8%	2.5%	2.8%	Positive	N/A
Maternal use of any e-cigarettes during the last 3 months of pregnancy <sup>3</sup>	1.1% <sup>†</sup>	2.1%	1.7%	2.5%	2.7%	Negative	N/A
Maternal marijuana or hash use during pregnancy <sup>3</sup>	5.0%	4.9%	4.9%	4.3%	5.8%	Negative	N/A
Maternal use of prescription pain relievers such as hydrocodone (Vicodin®), oxycodone (Percocet®), or codeine during pregnancy <sup>3</sup>	6.4%	5.2%	4.7%	5.9%	4.8%	Positive	N/A

**Sources**

- Centers for Disease Control and Prevention (CDC). National Immunization Survey (NIS)
- Kansas Department of Health and Environment (KDHE), Bureau of Epidemiology and Public Health Informatics. Kansas birth data (resident)
- Kansas Department of Health and Environment (KDHE), Bureau of Epidemiology and Public Health Informatics, Kansas Pregnancy Risk Assessment Monitoring System
- Kansas Department of Health and Environment (KDHE), Bureau of Epidemiology and Public Health Informatics. Kansas death data (resident)
- Kansas Department of Health and Environment (KDHE), Bureau of Epidemiology and Public Health Informatics. Kansas linked birth and infant death data (resident)
- Kansas Department of Health and Environment (KDHE), Bureau of Epidemiology and Public Health Informatics, Kansas fetal death data (resident)
- Baby-Friendly USA and National Center for Health Statistics

## Appendix E.3. Child Health Population Domain

National Performance Measures / Standardized Measures/Outcome Measures / Life Course Indicators Linkage. 2026 Application/2024 Annual Report

### Key and Definitions

**NPM:** National Performance Measure (Blue)

**SM:** National Standardized Measure (Orange)

**NOM:** National Outcome Measure (Green)

**n/a** indicates the data were not available at the time of report

**HP2030:** Healthy People 2030 goal

**Bolded NPMs:** Selected National Performance Measures that are most closely aligned with Kansas priorities.

**\*\*** Statistically significant trend ( $p < 0.05$ ): – for measures with 4 years of data, assessed by Joinpoint Regression software version 5.2.0, using Annual Percent Change (APC) method. All others with less than 4 years of data were assessed by the direction of the change between the first and last data point and was not measured for significance.

† Estimate is statistically unreliable; interpret with caution

§Stratifies use five-year rolling average

Two hyphens (i.e., --) indicate that the estimate has been suppressed due to statistical unreliability and/or low sample size.

*NPM: Child Vaccination LC-35 Health Care Access and Quality: Children Receiving Age Appropriate Immunizations<sup>1</sup>*

Combine 7-Vaccine Series	2018	2019	2020	2021	2022	Trend
Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months (Birth year 2015, 2016, 2017, 2019)	73.2%	67.9%	73.7%	68.0%	65.4%	Negative

*NPM: Child Vaccination by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	n/a	73.1%	72.6%	72.4%	Negative
Non-Hispanic Black	n/a	n/a	60.3%†	49.9%†	60.7%†	No Change
Hispanic	n/a	n/a	65.3%†	60.5%	63.1%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	72.3%†	n/a
Non-Hispanic, Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	85.3%†	79.5%†	66.2%†	Negative

NPM: Child Vaccination by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	66.6%	60.1%	60.1%	Negative
100%-199%	n/a	n/a	60.9%†	63.1%	67.3%	Positive
200%-399%	n/a	n/a	74.5%	71.3%	70.4%	Negative
>400%	n/a	n/a	82.8%	84.1%	77.7%	Negative

NPM: Child Vaccination by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	n/a	78.6%	78.5%	74.0%	Negative
Medicaid	n/a	n/a	66.5%	61.2%	60.6%	Negative
Other Public	n/a	n/a	n/a	65.7%	73.8%	Positive
Uninsured	n/a	n/a	65.8%	33.4%†	n/a	Negative

NPM: Child Vaccination by WIC Participation

WIC Participation	2018	2019	2020	2021	2022	Trend
Yes	n/a	n/a	66.4%	61.6%	64.1%	Positive
No	n/a	n/a	75.2%	75.6%	72.6%	Negative

NPM: Child Vaccination by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	74.2%	68.8%	68.2%	Negative
MSA, Non-Central City	n/a	n/a	68.6%	70.4%	71.0%	Positive
Non-MSA	n/a	n/a	71.9%	70.4%	68.3%	Negative

NPM: Developmental Screening (HP2030:35.8%) Life Course Indicators LC-19\*\* Early Life Service: Early Childhood Health Screening-EPST,²

Developmental Screening	2018	2019	2020	2021	2022	Trend
Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	35.5%†	37.6%†	44.6%†	40.9%	33.4%	Negative

*NPM: Developmental Screening by Sex*

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	38.9%	41.6%†	29.7%†	30%†	Negative
Male	n/a	35.9%	48.2%†	50.3%†	37.3%†	Positive

*NPM: Developmental Screening by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	34.4%†	37.6%†	37.1%	35.3%	Positive
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Hispanic	n/a	n/a	n/a	n/a	53.9%†	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multi-Race	n/a	n/a	n/a	n/a	n/a	n/a

*NPM: Developmental Screening by Child Health Care Needs Status*

Child Health Care Needs Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	n/a	n/a	n/a	47.6%†	n/a
Non-CSHCN	n/a	32.0%†	39.2%†	39.9%†	31.9%	Negative

*NPM: Developmental Screening by Language*

Language	2018	2019	2020	2021	2022	Trend
English	n/a	33.6%†	40%	36.2%	32.1%	Negative
Non-English	n/a	n/a	n/a	n/a	n/a	n/a

*NPM: Developmental Screening by Nativity*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	34.2%†	39%	39.8%	34.4%	No Change
Not Born in U.S.	n/a	n/a	n/a	n/a	41.4%	n/a

*NPM: Developmental Screening by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	n/a	n/a	n/a	n/a	n/a	n/a
High School Graduate	n/a	n/a	n/a	n/a	21.5%†	n/a
Some College	n/a	n/a	n/a	48%†	29.6%†	Negative
College Graduate	n/a	38.2†	34.4%†	38.1%†	37.8%	Positive

*NPM: Developmental Screening by Household Income-Poverty Ratio*

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	n/a	n/a	22%†	n/a
100%-199%	n/a	n/a	n/a	40.5%†	39.1%†	Negative
200%-399%	n/a	28.8%†	26.3%†	30.0%†	32.8%†	Positive
>400%	n/a	40.4%†	49.5%†	53.2%†	38.6%†	Negative

*NPM: Developmental Screening by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	34.3%†	35.8%†	40.6%†	33.7%	Positive
Medicaid	n/a	n/a	n/a	45.2%†	32.6%†	Negative
Uninsured	n/a	n/a	n/a	n/a	n/a	n/a

*NPM: Developmental Screening by Household Structure*

Household Structure	2018	2019	2020	2021	2022	Trend
Two-parent married	n/a	42.7%†	43.0%†	41.3%†	35.9%	Negative
Two-parent unmarried	n/a	n/a	n/a	n/a	n/a	n/a
Single Mother	n/a	n/a	n/a	n/a	n/a	n/a
Other	n/a	n/a	n/a	n/a	n/a	n/a

*NPM: Developmental Screening by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	50.7%†	48.8%†	29.4%†	Negative
MSA, Non-Central City	n/a	n/a	33.5%†	36.9%†	34%†	Positive
Non-MSA	n/a	n/a	49.5%†	34.5%†	38.1%†	Negative

*NPM: Food Sufficiency Life Course Indicators LC-9\*\* Community Wellbeing: Household Food Insecurity,<sup>2</sup>*

Food Sufficiency	2018	2019	2020	2021	2022	Trend
Percent of children, ages 0 through 11, whose households were food sufficient in the past year	66.6%	65.0%	67.8%	71.7%	72.6%	Positive

*NPM: Food Sufficiency by Adverse Childhood Experiences*

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	78.8%	80.5%	82.6%	82.6%	Positive*
1 ACE	n/a	52.2%†	51.8%†	54.0%†	59.0%†	Positive
2+ ACEs	n/a	23.7%	32.5%†	44.6%†	40.1%†	Positive

*NPM: Food Sufficiency by Child Age*

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	64.7%	69.2%	74.7%	72.7%	Positive
6-11 Years	n/a	65.4%	66.4%	69.0%	72.5%	Positive*

*NPM: Food Sufficiency by CSHCN Status*

CSHCN Status	2018	2019	2020	2021	2022	Trend
CSHCN Status	n/a	51.9%†	55.5%†	55.0%	59.1%	Positive*
Non-CSHCN	n/a	67.3%	70.1%	75.4%	75.9%	Positive*

*NPM: Food Sufficiency by Educational Attainment*

CSHCN Status	2018	2019	2020	2021	2022	Trend
Less than high school	n/a	n/a	n/a	52.7%†	n/a	n/a
High school graduate	n/a	44.3%†	43.5%†	42.3%†	47.2%	Positive
Some college	n/a	46.2%†	54.2%†	61.5%	54.5%	Positive
College graduate	n/a	77.9%†	80.3%	85.3%	86.4%	Positive*

*NPM: Food Sufficiency by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	80.6%	82.2%†	80.9%	82.3%	No Change
Medicaid	n/a	40.4%†	42.6%	50.9%	52.9%	Positive*
Uninsured	n/a	54.6%†	49.7%†	75.8%†	76.2%†	Positive

*NPM: Food Sufficiency by Household Income-Poverty Ratio*

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	46.8%†	38.4%†	42.6%†	47.5%†	Positive
100%-199%	n/a	43.8%†	50.6%†	54.9%	56.3%	Positive*
200%-399%	n/a	70.4%	77.2%	80.0%	75.5%	Positive
≥400%	n/a	88.3%	89.5%	92.2%	94.4%	Positive*

*NPM: Food Sufficiency by Household Structure*

Household Structured	2018	2019	2020	2021	2022	Trend
Two-parent married	n/a	73.1%	73.4%	77.2%	78.7%	Positive*
Two-parent unmarried	n/a	55.6%†	54.6%†	52.0%†	49.2%†	Negative
Single parent	n/a	45.5%†	48.9%†	53.1%†	55.3%†	Positive
Other	n/a	n/a	n/a	n/a	72.3%†	n/a

*NPM: Food Sufficiency by Language*

Language	2018	2019	2020	2021	2022	Trend
English	n/a	63.7%	67.3%	72.7%	72.8%	Positive*
Non-English	n/a	73.2%†	74.7%†	68.8%†	74.7%†	No Change

*NPM: Food Sufficiency by Nativity*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	63.2%	67.0%	73.0%	74.0%	Positive*
Born outside U.S.	n/a	72.6%†	67.0%†	67.0%†	70.5%†	Negative

*NPM: Food Sufficiency by Race/Ethnicity*

Nativity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	54.6%†	63.2%†	67.0%†	65.0%	Positive
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	64.8%†	n/a
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	68.5%†	60.5%†	71.8%†	Positive
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	68.2%	69.9%	75.5%	77.2%	Positive*

*NPM: Food Sufficiency by Sex*

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	68.2%	65.9%	74.7%	75.8%	Positive
Male	n/a	62.3%	70.0%	68.9%	69.6%	Positive

*NPM: Food Sufficiency by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	59.6%	63.1%	68.9%	Positive
MSA, Non-Central City	n/a	n/a	77.4%	78.6%	76.8%	Negative
Non-MSA	n/a	n/a	66.4%	73.7%	71.8%	Positive

*NPM: Housing Instability Life Course Indicator LC-7B\*\* Community Wellbeing: Homelessness,<sup>2</sup>*

Housing Instability	2018	2019	2020	2021	2022	Trend
Percent of children, ages 0 through 11, who experienced housing instability in the past year	n/a	n/a	n/a	n/a	13.7%	n/a

*NPM: Housing Instability by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	n/a	n/a	n/a	9.8%	n/a
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Hispanic	n/a	n/a	n/a	n/a	21.2%†	n/a
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic , Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic, Multiple Race	n/a	n/a	n/a	n/a	22.2%†	n/a

*NPM: Housing Instability by Household Income-Poverty Ratio*

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	n/a	n/a	35.9%†	n/a
100%-199%	n/a	n/a	n/a	n/a	15.2%†	n/a
200%-399%	n/a	n/a	n/a	n/a	8.9%†	n/a
>400%	n/a	n/a	n/a	n/a	6.4%†	n/a

*NPM: Housing Instability by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	n/a	n/a	n/a	6.9%	n/a
Medicaid	n/a	n/a	n/a	n/a	28.3%†	n/a
Other Public	n/a	n/a	n/a	n/a	n/a	n/a
Uninsured	n/a	n/a	n/a	n/a	n/a	n/a

*NPM: Housing Instability by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	n/a	n/a	20.8%	n/a
MSA, Non-Central City	n/a	n/a	n/a	n/a	5.1%†	n/a
Non-MSA	n/a	n/a	n/a	n/a	16.9%	n/a

*NPM: Housing Instability by Adverse Childhood Experiences*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
1 ACE	n/a	n/a	n/a	n/a	18.9%†	n/a
2+ ACEs	n/a	n/a	n/a	n/a	50.0%†	n/a
None	n/a	n/a	n/a	n/a	5.6%	n/a

*NPM: Housing Instability by Child Age*

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	n/a	n/a	n/a	16.2%	n/a
6-11 Years	n/a	n/a	n/a	n/a	11.5%	n/a

*NPM: Housing Instability by CSHCN Status*

CSHCN Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	n/a	n/a	n/a	17.5%	n/a
Non-CSHCN	n/a	n/a	n/a	n/a	12.8%	n/a

*NPM: Housing Instability by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than high school	n/a	n/a	n/a	n/a	n/a	n/a
High school graduate	n/a	n/a	n/a	n/a	21.1%†	n/a
Some college	n/a	n/a	n/a	n/a	23.1%†	n/a
Collage graduate	n/a	n/a	n/a	n/a	8.7%	n/a

*NPM: Housing Instability by Household Structure*

Household Structure	2018	2019	2020	2021	2022	Trend
Two-parent married	n/a	n/a	n/a	n/a	7.8%	n/a
Two-parent unmarried	n/a	n/a	n/a	n/a	17.3%†	n/a
Single parent	n/a	n/a	n/a	n/a	40.5%†	n/a
Other	n/a	n/a	n/a	n/a	n/a	n/a

*NPM: Housing Instability by Language*

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	n/a	n/a	14.2%	n/a
Non-English	n/a	n/a	n/a	n/a	n/a	n/a

*NPM: Housing Instability by Nativity*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	n/a	n/a	13.1%	n/a
Born outside U.S.	n/a	n/a	n/a	n/a	16.2%†	n/a

*NPM: Housing Instability by Sex*

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	n/a	n/a	10.4%	n/a
Male	n/a	n/a	n/a	n/a	17.2%	n/a

NPM: Medical Home: All Children (HP 2030: 53.6%) Life Course Indicator LC-37 Health Care Access and Quality: Medical Home for Children,<sup>2</sup>

Child Health Care Needs Status	2018	2019	2020	2021	2022	Trend
Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	52.4%	53.7%	53.5%	52.9%	52.7%	Negative

NPM: Medical Home: All Children by Child

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	57.3%	58.8%	54.5%	51.0%	Negative
6-11 Years	n/a	54.5%	50.3%	50.6%	53.4%	Negative
12-17 Years	n/a	49.4%	51.9%	53.5%	53.6%	Positive

NPM: Medical Home: All Children by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	50.9%	55.4%	52.5%	50.8%	Negative
Male	n/a	56.3%	51.6%	53.2%	54.4%	Negative

NPM: Medical Home: All Children by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	57.0%	58.2%	58.5%	58.6%	Positive
Non-Hispanic Black	n/a	40.4%†	32.0%†	30.1%†	29.1%†	Negative
Hispanic	n/a	43.3%†	41.5%†	37.4%	37.9%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	49.1%†	47.9%†	33.5%†	31.1%†	Negative
Non-Hispanic Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	74.0%†	65.1%†	61.8%†	63.4%†	Negative

*NPM: Medical Home: All Children by Language*

Language	2018	2019	2020	2021	2022	Trend
English	n/a	55.6%	57.0%	55.9%	55.5%	Negative
Non-English	n/a	38.0%	26.5%†	26.3%†	26.0%†	Negative

*NPM: Medical Home: All Children by Nativity*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	55.7%	57.6%	56.6%	57.2%	Positive
Not Born in U.S.	n/a	45.0%†	38.3%†	40.2%	36.9%	Negative

*NPM: Medical Home: All Children by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	n/a	n/a	25.0%†	31.1%†	37.1%†	Positive
High School Graduate	n/a	44.8%	34.0%	30.6%	34.9%	Negative
Some College	n/a	48.9%	56.6%	52.9%	53.4%	Positive
College Graduate	n/a	61.0%	63.7%	62.1%	60.2%	Negative

*NPM: Medical Home: All Children by Household Income-Poverty Ratio*

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	45.7%†	35.6%†	38.4%	41.1%	Positive
100%-199%	n/a	43.8%	50.1%	42.0%	42.1%	Negative
200%-399%	n/a	53.6%	55.3%	54.0%	54.8%	Positive
>400%	n/a	65.9%	64.7%	66.7%	63.7%	Negative

*NPM: Medical Home: All Children by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	60.6%	61.0%	61.4%	59.9%	Negative
Medicaid	n/a	46.1%	41.0%	36.5%	40.7%	Negative
Uninsured	n/a	38.0%†	41.4%†	39.3%†	33.8%†	Negative

*NPM: Medical Home: All Children by Household Structure*

Household Structure	2018	2019	2020	2021	2022	Trend
Two-parent married	n/a	59.9%	58.7%	58.5%	57.6%	Negative
Two-parent unmarried	n/a	53.7%†	51.6%†	50.8%†	51.5%†	Negative
Single Mother	n/a	36.2%	40.3%	36.6%	39.8%	Positive
Other	n/a	n/a	46.9%†	45%†	43.9%†	Negative

*NPM: Medical Home: All Children by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	49.9%	47%	50.5%	Positive
MSA, Non-Central City	n/a	n/a	57.5%	58.8%	55.8%	Negative
Non-MSA	n/a	n/a	53.8%	53.1%	51.5%	Negative

*NPM: Medical Home: All Children by Child Health Care Needs Status (HP 2020: 63.3%)*

Child Health Care Needs Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	55.9%	56.9%	49.0%	50.2%	Negative
Non-CSHCN	n/a	53.2%	52.8%	53.9%	53.4%	Positive

*NPM: Medical Home: All Children by Adverse Childhood Experiences (HP 2020: 63.3%)*

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	60.0%	57.6%	57.2%	58.3%	Negative
1 ACE	n/a	50.5%	49.0%	46.8%	43.4%	Negative*
2+ ACEs	n/a	38.6%	46.0%	44.7%	45.3%	Positive

*NPM: Medical Home: CSHCN <sup>2</sup>*

Child Health Care Needs Status	2018	2019	2020	2021	2022	Trend
Percent of children with special health care needs, ages 0 through 17, who have a medical home	53.2%	55.9%	56.9%	49.0%	50.2%	Positive

*NPM: Medical Home: CSHCN by Child*

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	55.8%†	63.9%	35.1%	36.4%	Negative
6-11 Years	n/a	55.8%†	50.4%	50.6%	51.0%	Negative
12-17 Years	n/a	56.1%	60.0%	52.3%	55.7%	Negative

*NPM: Medical Home: CSHCN by Sex*

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	56.1%†	53.5%	44.7%	48.2%	Negative*
Male	n/a	55.8%†	60.5%	52.2%	51.7%	Negative

*NPM: Medical Home: CSHCN by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	54.2%	52.7%	47.9%	51.3%	Negative
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Hispanic	n/a	n/a	n/a	43.3%	35.5%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	66.0%	68.4%	Positive

*NPM: Medical Home: CSHCN by Language*

Language	2018	2019	2020	2021	2022	Trend
English	n/a	55.7%	57.7%	48.9%	50.4%	Negative
Non-English	n/a	n/a	n/a	n/a	n/a	n/a

*NPM: Medical Home: CSHCN by Nativity*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	55.9%	54.3%	48.4%	51.7%	Negative
Not Born in U.S.	n/a	n/a	n/a	61.4%	47.8%	Negative

*NPM: Medical Home: CSHCN by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	n/a	n/a	n/a	n/a	n/a	n/a
High School Graduate	n/a	65.1%†	50.2%	24.2%	36.6%	Negative
Some College	n/a	44.3%†	55.3%	46.8%	43.8%	Negative
College Graduate	n/a	54.9%	58.5%	54.7%	55.9%	No Change

*NPM: Medical Home: CSHCN by Household Income-Poverty Ratio*

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	59.2%	43.6%	44.0%	Negative
100%-199%	n/a	53.4%†	46.9%	33.4%	38.8%	Negative*
200%-399%	n/a	47.8%†	63.5%	55.6%	54.9%	Positive
>400%	n/a	61.1%†	55.7%	56.3%	56.4%	Negative

*NPM: Medical Home: CSHCN by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	59.1%	64.9%	60.6%	60.0%	No Change
Medicaid	n/a	61.7%†	51.7%	35.3%	35.5%	Negative*
Uninsured	n/a	n/a	n/a	n/a	n/a	n/a

*NPM: Medical Home: CSHCN by Household Structure*

Household Structure	2018	2019	2020	2021	2022	Trend
Two-parent married	n/a	64.6%	59.6%	51.6%	56.1%	Negative
Two-parent unmarried	n/a	n/a	n/a	n/a	n/a	n/a
Single Mother	n/a	37.6%†	46.6%	43.5%	41.2%	Positive
Other	n/a	n/a	n/a	n/a	n/a	n/a

*NPM: Medical Home: CSHCN by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	49.9%	41.2%	45.5%	Negative
MSA, Non-Central City	n/a	n/a	63.8%	55.8%	53.3%	Negative
Non-MSA	n/a	n/a	57.1%	51.1%	52.3%	Negative

*NPM: Medical Home: CSHCN by Adverse Childhood Experiences*

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	68.5%	66.4%	56.0%	54.9%	Negative*
1 ACE	n/a	64.2%†	43.1%	44.4%	58.7%	Negative
2+ ACEs	n/a	38.3%†	55.5%	44.7%	39.4%	Negative

*NPM: Medical Home: All Children-Care Coordination,<sup>2</sup>*

Child Health Care Needs Status	2018	2019	2020	2021	2022	Trend
Percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination	74.5%	70.9%	73.4%	72.3%	70.8%	Negative

*NPM: Medical Home: All Children-Care Coordination by Child*

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	79.6%	78.3%	72.4%	70.5%	Negative*
6-11 Years	n/a	68.5%	74.2%	72.8%	70.1%	Positive
12-17 Years	n/a	65.7%	68.1%	71.7%	71.7%	Positive*

*NPM: Medical Home: All Children-Care Coordination by Sex*

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	69.1%	74.7%	70.1%	67.7%	Negative
Male	n/a	72.6%	71.9%	74.2%	73.4%	Positive

*NPM: Medical Home: All Children-Care Coordination by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	73.4%	72.8%	73.3%	71.1%	Negative
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Hispanic	n/a	60.0%†	70.9%†	68.9%†	67.5%	Positive
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic, Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic, Multiple Race	n/a	73.4%†	80.2%†	76.6%†	78.6%†	Positive

*NPM: Medical Home: All Children-Care Coordination by Language*

Language	2018	2019	2020	2021	2022	Trend
English	n/a	72.3%	74.9%	72.9%	70.7%	Negative
Non-English	n/a	n/a	71.8%†	72.5%†	72.8%†	Positive

*NPM: Medical Home: All Children-Care Coordination by Nativity*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	71.8%	74.9%	72.9%	69.7%	Negative
Not Born in U.S.	n/a	67.2%†	68.1%†	69.7%†	72.0%†	Positive*

*NPM: Medical Home: All Children-Care Coordination by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	n/a	n/a	n/a	n/a	n/a	n/a
High School Graduate	n/a	71.3%†	80.5%†	68.5%†	62.4%†	Negative
Some College	n/a	72.9%†	74.8%†	69.7%	70.8%	Negative
College Graduate	n/a	71.7%	72.6%	73.1%	72.1%	No Change

*NPM: Medical Home: All Children-Care Coordination by Household Income-Poverty Ratio*

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	76.7%†	74.6%†	67.1%†	65.0%†	Negative
100%-199%	n/a	57.8%†	69.0%†	69.2%†	70.2%	Positive
200%-399%	n/a	70.7%	74.3%	71.9%	69.2%	Negative
>400%	n/a	77.6%	74.2%	76.7%	75.5%	Negative

*NPM: Medical Home: All Children-Care Coordination by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	76.3%	75.5%	74.8%	73.5%	Negative*
Medicaid	n/a	66.2%†	70.3%	66.6%	67.0%	No Change
Uninsured	n/a	51.0%†	n/a	n/a	n/a	n/a

*NPM: Medical Home: All Children-Care Coordination by Household Structure*

Household Structure	2018	2019	2020	2021	2022	Trend
Two-parent married	n/a	73.1%	73.5%	74.7%	72.9%	No Change
Two-parent unmarried	n/a	67.6%†	78.9%†	74.2%†	56.3%†	Negative
Single Parent	n/a	64.4%†	73.2%†	65.4%	65.9%	No Change
Other	n/a	n/a	n/a	n/a	n/a	n/a

*NPM: Medical Home: All Children-Care Coordination by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	72.7%	70.3%	70.8%	Negative
MSA, Non-Central City	n/a	n/a	73.2%	79.8%	73.4%	No Change
Non-MSA	n/a	n/a	74.7%	65.8%	67.5%	Negative

*NPM: Medical Home: All Children-Care Coordination by Child Health Care Needs Status*

Child Health Care Needs Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	65.7%	74.7%	70.1%	67.7%	No Change
Non-CSHCN	n/a	73.0%	71.9%	74.2%	73.4%	No Change

*NPM: Medical Home: All Children-Care Coordination by Adverse Childhood Experiences*

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	75.9%	76.0%	77.7%	76.9%	Positive
1 ACE	n/a	80.5%	79.1%	67.8%	66.9%	Negative*
2+ ACEs	n/a	50.5%†	61.7%†	60.5%	59.5%	Positive

*NPM: Medical Home: All Children-Family Centered Care,<sup>2</sup>*

Child Health Care Needs Status	2018	2019	2020	2021	2022	Trend
Percent of children with and without special health care needs, ages 0 through 17, who have family centered care	89.5%	88.2%	89.6%	90.7%	88.4%	Positive

*NPM: Medical Home: All Children-Family Centered Care by Child*

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	86.4%	87.2%	90.0%	86.4%	No Change
6-11 Years	n/a	85.3%	87.7%	90.4%	88.7%	Positive
12-17 Years	n/a	92.8%	94.2%	91.6%	90.0%	Negative

*NPM: Medical Home: All Children-Family Centered Care by Sex*

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	87.8%	88.7%	90.3%	87.6%	No Change
Male	n/a	88.6%	90.7%	91.0%	89.0%	No Change

*NPM: Medical Home: All Children-Family Centered Care by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	91.6%	92.0%	93.0%	92.2%	No Change
Non-Hispanic Black	n/a	n/a	n/a	88.3%†	91.8%†	Positive
Hispanic	n/a	79.3%†	87.5%	83.3%	75.9%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	86.5%†	82.6%†	89.0%†	Positive
Non-Hispanic Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	89.8%	88.3%†	88.8%	86.4%	Negative*

*NPM: Medical Home: All Children-Family Centered Care by Language*

Language	2018	2019	2020	2021	2022	Trend
English	n/a	89.4%	90.6%	92.0%	89.8%	No Change
Non-English	n/a	73.8%†	82.5%†	80.3%†	69.7%†	Negative

*NPM: Medical Home: All Children-Family Centered Care by Nativity*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	89.8%	90.9%	92.0%	90.5%	No Change
Not Born in U.S.	n/a	84.6%†	83.6%	81.6%	75.1%	Negative

*NPM: Medical Home: All Children-Family Centered Care by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	n/a	n/a	n/a	75.6%†	n/a	n/a
High School Graduate	n/a	84.1%	81.9%	88.9%	81.5%	No Change
Some College	n/a	88.5%	92.8%	88.1%	88.1%	Negative
College Graduate	n/a	89.7%	91.8%	93.3%	91.6%	Positive

*NPM: Medical Home: All Children-Family Centered Care by Household Income-Poverty Ratio*

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	85.5%†	83.4%†	85.7%	81.4%	Negative
100%-199%	n/a	80.5%	89.3%	86.5%	82.1%	No Change
200%-399%	n/a	89.4%	89.6%	91.5%	90.1%	No Change
>400%	n/a	92.7%	93.4%	94.6%	93.0%	No Change

*NPM: Medical Home: All Children-Family Centered Care by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	90.1%	91.7%	93.7%	91.0%	Positive
Medicaid	n/a	87.0%	85.9%	83.6%	82.7%	Negative*
Uninsured	n/a	76.9%†	83.1%†	87.4%	79.5%†	Positive

*NPM: Medical Home: All Children-Family Centered Care by Household Structure*

Household Structure	2018	2019	2020	2021	2022	Trend
Two-parent married	n/a	91.0%	90.9%	92.0%	90.3%	No Change
Two-parent unmarried	n/a	88.9%†	92.7%	88.0%	89.4%	No Change
Single Mother	n/a	80.6%	83.5%	83.4%	80.7%	No Change
Other	n/a	n/a	87.3%†	96.2%	88.9%†	Positive

*NPM: Medical Home: All Children-Family Centered Care by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	90.3%	88.8%	87.8%	Negative
MSA, Non-Central City	n/a	n/a	89.0%	92.2%	90.9%	Positive
Non-MSA	n/a	n/a	89.5%	91.1%	85.4%	Negative

*NPM: Medical Home: All Children-Family Centered Care by Child Health Care Needs Status*

Child Health Care Needs Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	88.3%	91.7%	89.7%	88.2%	No Change
Non-CSHCN	n/a	88.2%	89.1%	90.9%	88.4%	No Change

*NPM: Medical Home: All Children-Family Centered Care by Adverse Childhood*

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	90.5%	90.5%	92.0%	90.8%	No Change
1 ACE	n/a	89.5%	91.4%	91.1%	89.9%	No Change
2+ ACEs	n/a	79.0%	85.2%	85.8%	81.2%	Positive

*NPM: Medical Home: All Children-Personal Doctor,<sup>2</sup>*

Child Health Care Needs Status	2018	2019	2020	2021	2022	Trend
Percent of children with and without special health care needs, ages 0 through 17, who have a personal doctor or nurse	73.5%	75.9%	74.5%	73.6%	74.9%	Positive

*NPM: Medical Home: All Children-Personal Doctor by Child*

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	75.7%	76.5%	76.9%	77.1%	Positive*
6-11 Years	n/a	76.4%	73.1%	70.8%	74.3%	Positive
12-17 Years	n/a	75.5%	74.0%	73.2%	73.6%	Negative

*NPM: Medical Home: All Children-Personal Doctor by Sex*

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	76.3%	77.8%	76.3%	77.8%	No Change
Male	n/a	75.4%	42.9%	48.1%	48.7%	Negative

*NPM: Medical Home: All Children-Personal Doctor by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	77.0%	78.6%	78.3%	80.3%	Positive*
Non-Hispanic Black	n/a	68.3%†	51.8%†	50.6%†	59.4%†	Negative
Hispanic	n/a	72.6%†	64.3%†	59.4%	61.2%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	68.6%†	70.8%†	61.3%†	53.7%†	Negative*
Non-Hispanic Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	95.7%	91.8%	87.4%	84.8%	Negative*

*NPM: Medical Home: All Children-Personal Doctor by Language*

Language	2018	2019	2020	2021	2022	Trend
English	n/a	77.5%	77.8%	76.3%	77.8%	No Change
Non-English	n/a	59.8%†	42.9%†	48.1%†	48.7%†	Negative

*NPM: Medical Home: All Children-Personal Doctor by Nativity*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	78.0%	79.0%	76.7%	79.0%	No Change
Not Born in U.S.	n/a	68.4%†	60.7%†	64.5%	61.2%	Negative

*NPM: Medical Home: All Children-Personal Doctor by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	n/a	n/a	47.9%†	54.0%†	53.6%†	Positive
High School Graduate	n/a	70.9%	61.2%	55.4%	60.4%	Negative
Some College	n/a	73.7%	75.5%	71.0%	74.1%	No Change
College Graduate	n/a	81.7%	82.9%	82.3%	82.6%	No Change

*NPM: Medical Home: All Children-Personal Doctor by Household Income-Poverty Ratio*

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	67.0%†	63.9%†	60.7%	64.0%	Negative
100%-199%	n/a	73.3%	69.9%	62.6%	65.3%	Negative*
200%-399%	n/a	73.4%	74.1%	76.7%	77.8%	Positive*
>400%	n/a	85.7%	84.8%	84.6%	84.2%	Negative*

*NPM: Medical Home: All Children-Personal Doctor by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	80.8%	81.5%	81.4%	81.2%	No Change
Medicaid	n/a	74.3%	65.6%	61.1%	66.6%	Negative
Uninsured	n/a	55.3%†	55.5%†	51.1%†	45.2%†	Negative

*NPM: Medical Home: All Children-Personal Doctor by Household Structure*

Household Structure	2018	2019	2020	2021	2022	Trend
Two-parent married	n/a	81.0%	78.8%	77.4%	77.8%	Negative
Two-parent unmarried	n/a	70.1%†	65.8%†	65.0%†	76.2%†	Positive
Single Mother	n/a	64.7%	68.9%	66.0%	66.1%	No Change
Other	n/a	n/a	60.5%†	72.9%†	74.6%†	Positive

*NPM: Medical Home: All Children-Personal Doctor by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	73.3%	71.1%	72.3%	Negative
MSA, Non-Central City	n/a	n/a	79.3%	77.4%	77.6%	Negative
Non-MSA	n/a	n/a	70.2%	72.0%	74.7%	Positive

*NPM: Medical Home: All Children-Personal Doctor by Child Health Care Needs Status*

Child Health Care Needs Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	84.1%	83.1%	79.8%	85.9%	No Change
Non-CSHCN	n/a	74.0%	72.5%	71.9%	71.8%	Positive

*NPM: Medical Home: All Children-Personal Doctor by Adverse Childhood Experiences*

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	79.5%	76.1%	75.2%	78.7%	No Change
1 ACE	n/a	74.2%	71.6%	66.7%	64.6%	Negative*
2+ ACEs	n/a	67.9%	72.7%	74.2%	72.6%	Positive

*NPM: Medical Home: All Children-Referrals,<sup>2</sup>*

Child Health Care Needs Status	2018	2019	2020	2021	2022	Trend
Percent of children with and without special health care needs, ages 0 through 17, who received needed referrals	n/a	86.4%	90.1%	84.9%	77.8%	Negative

*NPM: Medical Home: All Children-Referrals by Child*

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	88.4%	90.3%	91.5%	84.2%	Negative
6-11 Years	n/a	88.1%†	89.0%	78.7%†	70.0%†	Negative*
12-17 Years	n/a	83.8%†	90.8%	83.6%	78.4%†	Negative

*NPM: Medical Home: All Children-Referrals by Sex*

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	85.1%†	91.8%	86.3%	77.1%	Negative
Male	n/a	88.0%	88.3%	83.6%	78.4%	Negative*

*NPM: Medical Home: All Children-Referrals by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	85.8%	87.7%	87.0%	81.6%	Negative
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Hispanic	n/a	n/a	n/a	71.2%†	61.7%†	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	n/a	n/a	n/a

*NPM: Medical Home: All Children-Referrals by Language*

Language	2018	2019	2020	2021	2022	Trend
English	n/a	86.1%	89.7%	86.9%	80.3%	Negative
Non-English	n/a	n/a	n/a	n/a	n/a	n/a

*NPM: Medical Home: All Children-Referrals by Nativity*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	86.3%	88.3%	84.8%	77.9%	Negative
Not Born in U.S.	n/a	n/a	n/a	82.2%†	69.6%†	Negative

*NPM: Medical Home: All Children-Referrals by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	n/a	n/a	n/a	n/a	n/a	n/a
High School Graduate	n/a	n/a	n/a	78.3%†	64.7%†	Negative
Some College	n/a	70.0%†	83.6%†	85.8%	86.5%	Positive
College Graduate	n/a	88.3%	89.5%	87.1%	79.3%	Negative

*NPM: Medical Home: All Children-Referrals by Household Income-Poverty Ratio*

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	n/a	n/a	65.2%†	n/a
100%-199%	n/a	n/a	78.8%†	79.8%†	74.6%†	Negative
200%-399%	n/a	88.8%†	93.5%	87.8%	83.2%	Negative
>400%	n/a	88.1%	88.1%	91.0%	80.1%†	Negative

*NPM: Medical Home All Children-Referrals by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	86.9%	89.6%	89.0%	81.3%	Negative
Medicaid	n/a	86.3%†	91.3%	77.9%†	74.3%†	Negative*
Uninsured	n/a	n/a	n/a	n/a	n/a	n/a

*NPM: Medical Home: All Children-Referrals by Household Structure*

Household Structure	2018	2019	2020	2021	2022	Trend
Two-parent married	n/a	87.4%	90.3%	86.2%	78.5%	Negative
Two-parent unmarried	n/a	n/a	n/a	n/a	n/a	n/a
Single Mother	n/a	85.4%†	88.7%	84.3%†	73.0%†	Negative
Other	n/a	n/a	n/a	n/a	n/a	n/a

*NPM: Medical Home: All Children-Referrals by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	93.4%	93.8%	85.8%	Negative
MSA, Non-Central City	n/a	n/a	88.4%	79.3%	70.3%†	Negative
Non-MSA	n/a	n/a	88.6%†	81.4%†	79.6%†	Negative

*NPM: Medical Home: All Children-Referrals by Child Health Care Needs Status*

Child Health Care Needs Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	84.7%	83.1%	75.7%	69.3%	Negative*
Non-CSHCN	n/a	87.6%	94.7%	91.5%	85.4%	Negative

*NPM: Medical Home: All Children-Referrals by Adverse Childhood Experiences*

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	89.3%	93.4%	90.3%	80.5%	Negative
1 ACE	n/a	81.8%†	86.4%†	76.7%†	79.8%†	Negative
2+ ACEs	n/a	84.3%†	85.2%†	77.3%†	69.9%†	Negative*

*NPM: Medical Home: All Children-Usual Source of Sick Care,<sup>2</sup>*

Child Health Care Needs Status	2018	2019	2020	2021	2022	Trend
Percent of children with and without special health care needs, ages 0 through 17, who have a usual source of sick care	80.5%	80.6%	79.7%	80.8%	80.8%	Positive

*NPM: Medical Home: All Children-Usual Source of Sick Care by Child*

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	82.7%	84.6%	81.6%	79.4%	Negative
6-11 Years	n/a	80.8%	76.9%	80.1%	81.1%	Positive
12-17 Years	n/a	78.3%	78.0%	80.6%	81.8%	Positive*

*NPM: Medical Home: All Children-Usual Source of Sick Care by Sex*

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	80.4%	78.6%	79.4%	80.7%	No Change
Male	n/a	80.8%	80.9%	82.1%	81.0%	No Change

*NPM: Medical Home: All Children-Usual Source of Sick Care by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	84.4%	84.2%	85.0%	85.0%	No Change
Non-Hispanic Black	n/a	81.2%†	73.3%†	68.4%†	63.4%†	Negative*
Hispanic	n/a	65.7%†	65.2%†	70.3%	69.9%	Positive
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	67.5%†	69.3%†	66.9%†	59.9%†	Negative
Non-Hispanic Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	88.7%	81.7%†	82.7%†	91.3%	Positive

*NPM: Medical Home: All Children-Usual Source of Sick Care by Language*

Language	2018	2019	2020	2021	2022	Trend
English	n/a	83.1%	82.5%	82.9%	83.8%	No Change
Non-English	n/a	59.0%†	53.4%†	61.4%†	53.2%†	Negative

*NPM: Medical Home: All Children-Usual Source of Sick Care by Nativity*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	84.9%	84.2%	84.7%	86.1%	No Change
Not Born in U.S.	n/a	62.0%†	63.5%†	68.4%	64.8%	Positive

*NPM: Medical Home: All Children-Usual Source of Sick Care by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	n/a	n/a	52.4%†	74.2%†	66.0%†	Positive
High School Graduate	n/a	72.2%	65.0%	60.9%	64.9%	Negative
Some College	n/a	77.6%	80.3%	81.6%	82.2%	Positive*
College Graduate	n/a	87.8%	88.9%	87.3%	87.3%	No Change

*NPM: Medical Home: All Children-Usual Source of Sick Care by Household Income-Poverty Ratio*

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	74.7%†	67.7%†	68.1%	68.2%	Negative
100%-199%	n/a	75.4%	76.1%	74.9%	75.2%	No Change
200%-399%	n/a	79.6%	80.9%	82.2%	82.9%	Positive*
>400%	n/a	88.9%	88.2%	90.3%	88.9%	No Change

*NPM: Medical Home: All Children-Usual Source of Sick Care by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	86.1%	85.8%	86.5%	86.4%	No Change
Medicaid	n/a	75.4%	70.8%	71.7%	74.3%	No Change
Uninsured	n/a	72.3%†	70.5%†	67.3%†	54.0%†	Negative

*NPM: Medical Home All Children-Usual Source of Sick Care by Household Structure*

Household Structure	2018	2019	2020	2021	2022	Trend
Two-parent married	n/a	85.0%	83.3%	83.7%	85.2%	No Change
Two-parent unmarried	n/a	78.8%†	77.2%†	83.5%†	79.0%†	Positive
Single Mother	n/a	69.6%	71.7%	72.1%	69.7%	No Change
Other	n/a	n/a	69.2%†	70.2%†	68.6%†	Negative

*NPM: Medical Home: All Children-Usual Source of Sick Care by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	77.2%	76.3%	76.7%	Negative
MSA, Non-Central City	n/a	n/a	86.1%	86.1%	86.6%	No Change
Non-MSA	n/a	n/a	75.3%	80.1%	78.7%	Positive

*NPM: Medical Home: All Children-Usual Source of Sick Care by Child Health Care Needs Status*

Child Health Care Needs Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	85.2%	84.7%	87.7%	91.4%	Positive*
Non-CSHCN	n/a	79.5%	78.5%	79.0%	77.8%	Negative

*NPM: Medical Home: All Children-Usual Source of Sick Care by Adverse Childhood Experiences*

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	84.2%	82.4%	82.3%	83.7%	Negative
1 ACE	n/a	72.9%	73.8%	78.4%	72.1%	Negative
2+ ACEs	n/a	78.2%	78.4%	79.4%	80.4%	Positive

*NPM: Child Physical Activity (NSCH), Family Wellbeing: LC 33<sup>2</sup>*

Physical Activity	2018	2019	2020	2021	2022	Trend
Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day (NSCH)	25.6%	32.3%	31.1%	30.7%	28.0%	Positive

*NPM: Child Physical Activity by Sex*

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	38.8%	31.4%	28.1%	23.9%	Negative*
Male	n/a	24.8%	30.7%	33.0%	32.0%	Positive

*NPM: Child Physical Activity by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	37.6%	34.5%	31.3%	32.5%	Negative*
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Hispanic	n/a	24.9%†	23.0%†	34.6%†	23.5%†	Positive
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	40.7%†	33.7%†	24.0%†	Negative

*NPM: Child Physical Activity by Child Health Care Needs Status*

Child Health Care Needs Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	32.0%†	32.7%†	29.0%†	22.5%	Negative
Non-CSHCN	n/a	32.3%	30.6%	31.2%	30.0%	Negative

*NPM: Child Physical Activity by Language*

Language	2018	2019	2020	2021	2022	Trend
English	n/a	31.1%	31.7%	32.2%	29.4%	Negative
Non-English	n/a	n/a	n/a	19.5%†	18.2%†	Negative

*NPM: Child Physical Activity by Nativity*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	32.1%	30.9%	31.2%	31.1%	Negative
Not Born in U.S.	n/a	25.4%†	21.0%†	26.8%†	15.3%†	Negative

*NPM: Child Physical Activity by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	n/a	n/a	n/a	n/a	n/a	n/a
High School Graduate	n/a	35.2%†	29.6%†	34.2%†	28.9%†	Negative
Some College	n/a	19.1%†	30.4%†	37.6%†	33.3%†	Positive
College Graduate	n/a	33.7%	30.6%	27.1%	25.6%	Negative*

*NPM: Child Physical Activity by Household Income-Poverty Ratio*

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	38.0%†	25.1%†	24.0%†	26.3%†	Negative
100%-199%	n/a	34.1%†	33.8%†	35.1%†	32.3%†	Negative
200%-399%	n/a	25.0%	29.8%	34.2%	30.9%	Positive
>400%	n/a	35.2%	34.0%†	27.0%	23.4%	Negative*

*NPM: Child Physical Activity by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	33.2%	32.2%	31.7%	29.9%	Negative*
Medicaid	n/a	34.8%†	28.8%†	29.1%†	24.9%	Negative*
Uninsured	n/a	n/a	n/a	n/a	n/a	n/a

*NPM: Child Physical Activity by Household Structure*

Household Structure	2018	2019	2020	2021	2022	Trend
Two-parent married	n/a	36.1%	31.3%	27.3%	27.3%	Negative*
Two-parent unmarried	n/a	n/a	n/a	n/a	n/a	n/a
Single Mother	n/a	16.7%†	20.1%†	32.4%†	24.2%†	Positive
Other	n/a	n/a	31.3%	27.3%	27.3%	Negative

*NPM: Child Physical Activity by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	22.7%	19.8%	17.3%	Negative
MSA, Non-Central City	n/a	n/a	33.3%	31.2%	25.1%	Negative
Non-MSA	n/a	n/a	39.1%†	44.4%†	44.2%†	Positive

*NPM: Child Physical Adverse Childhood Experiences*

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	39.2%	32.4%	28.8%	29.0%	Negative
1 ACE	n/a	18.2%†	20.7%†	22.2%†	21.9%†	Positive
2+ ACEs	n/a	23.7%†	34.3%†	41.2%†	31.0%†	Positive

*NPM: Child Dental Visit,<sup>2</sup>*

Children Dental Visit	2018	2019	2020	2021	2022	Trend
Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	79.8%	78.9%	78.7%	77.3%	81.1%	Positive

*NPM: Child Dental Visit by Child Age*

Child Age	2018	2019	2020	2021	2022	Trend
1-5 Years	n/a	56.7%	57.7%	55%	61.6%	Positive
6-11 Years	n/a	87.3%	84.0%	84.5%	86.8%	No Change
12-17 Years	n/a	87.7%	89.1%	87.8%	90.1%	Positive

*NPM: Child Dental Visit by Sex*

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	81.0%	78.9%	76.2%	79.6%	Negative
Male	n/a	76.5%	78.4%	78.4%	82.6%	Positive*

*NPM: Child Dental Visit by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	78.7%	79.7%	79.2%	81.6%	Positive*
Non-Hispanic Black	n/a	n/a	76.4%†	67.2%†	72.4%†	Negative
Hispanic	n/a	78.9%	77.6%	75.2%	80.9%	No Change
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	81.0%†	76.4%†	85.3%	87.8%	Positive
Non-Hispanic Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	78.3%†	76.1%†	68.9%†	80.1%†	No Change

*NPM: Child Dental Visit by Child Health Care Needs Status*

Child Health Care Needs Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	88.6%	80.0%	78.4%	85.9%	Negative
Non-CSHCN	n/a	76.6%	78.3%	77.1%	79.7%	Positive

*NPM: Child Dental Visit by Language*

Language	2018	2019	2020	2021	2022	Trend
English	n/a	78.6%	78.6%	77.8%	81.7%	Positive
Non-English	n/a	79.5%†	77.9%†	72.2%†	75.5%	Negative

*NPM: Child Dental Visit by Nativity*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	84.6%	78.6%	78.0%	81.9%	Negative
Not Born in U.S.	n/a	78.2%	82.2%	77.0%	78.2%	Negative

*NPM: Child Dental Visit by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	n/a	n/a	85.2%†	77.1%†	88.0%†	Positive
High School Graduate	n/a	70.2%	61%†	62.3%	71.6%	Positive
Some College	n/a	70.7%	75.9%	76.8%	78.3%	Positive*
College Graduate	n/a	84.2%	84.8%	82.2%	84.5%	No Change

*NPM: Child Dental Visit by Household Income-Poverty Ratio*

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	65.4%†	60.0%†	60.6%	71.2%	Positive
100%-199%	n/a	78.4%	79.2%	76.5%	79.8%	No Change
200%-399%	n/a	79.5%	82.2%	81.3%	82.9%	Positive
>400%	n/a	85.9%	85.3%	82.9%	85.3%	No Change

*NPM: Child Dental Visit by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	83.3%	84.6%	83.2%	85.5%	Positive
Medicaid	n/a	73.7%	71.5%	68.2%	73.5%	Negative
Uninsured	n/a	62.6%†	58.0%†	57.9%†	70.1%†	Positive

*NPM: Child Dental Visit by Household Structure*

Household Structure	2018	2019	2020	2021	2022	Trend
Two-parent married	n/a	82.7%	81.4%	79.8%	82.6%	No Change
Two-parent unmarried	n/a	67.4%†	66.5%†	61.8%†	65.6%†	Negative
Single Mother	n/a	74.1%	77.2%	75.5%	79.8%	Positive
Other	n/a	n/a	67.8%†	74.1%†	92.4%	Positive

*NPM: Child Dental Visit by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	78.5%	77.6%	82.5%	Positive
MSA, Non-Central City	n/a	n/a	82.3%	81.0%	83.6%	Positive
Non-MSA	n/a	n/a	74.4%	72.5%	76.0%	Positive

*SM: Adequate Insurance,<sup>2</sup>*

Adequate Insurance	2018	2019	2020	2021	2022	Trend
Percent of adolescents, ages 12 through 17, who are continuously and adequately insured	64.9%	65.3%	65.0%	66.7%	65.7%	Positive

*SM: Adequate Insurance by Adverse Childhood Experiences*

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	64.6%	64.5%	68.9%	68.1%	Positive
1 ACE	n/a	66.8%	67.7%	63.0%	62.8%	Negative
2+ ACEs	n/a	64.8%	64.1%	64.3%	61.7%	Negative

*SM: Adequate Insurance by Child Age*

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	68.1%	66.3%	68.8%	68.2%	No Change
6-11 Years	n/a	63.1%	64.0%	67.2%	64.8%	Positive
12-17 Years	n/a	64.8%	64.7%	64.3%	64.2%	No Change*

*SM: Adequate Insurance by CSHCN Status*

CSHCN Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	62.1%	59.4%	59.6%	55.7%	Negative*
Non-CSHCN	n/a	66.0%	66.3%	68.6%	68.5%	Positive*

*SM: Adequate Insurance by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than high school	n/a	n/a	79.2%†	76.4%†	59.8%†	Negative
High school graduate	n/a	75.4%	76.2%	72.3%	71.7%	Negative*
Some college	n/a	61.3%	67.9%	67.9%	68.9%	Positive
College graduate	n/a	62.8%	58.0%	63.4%	63.2%	Positive

SM: Adequate Insurance by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	76.8%†	77.0%†	74.4%	69.4%	Negative
100%-199%	n/a	69.9%	68.9%	71.2%	72.6%	Positive*
200%-399%	n/a	61.5%	62.8%	61.1%	59.8%	Negative
≥400%	n/a	59.8%	57.8%	65.4%	64.9%	Positive

SM: Adequate Insurance by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Two-parent married	n/a	64.3%	62.9%	64.8%	64.1%	No Change
Two-parent unmarried	n/a	67.9%†	73.6%†	67.8%†	64.6%†	Negative
Single parent	n/a	64.5%	66.2%	71.3%	68.6%	Positive
Other	n/a	n/a	75.5%†	80.6%†	80.6%†	Positive

SM: Adequate Insurance by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	64.9%	65.2%	66.7%	66.5%	Positive*
Non-English	n/a	65.5%†	60.1%†	65.0%†	57.9%†	Negative

SM: Adequate Insurance by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	64.4%	64.2%	67.0%	66.2%	Positive
Born outside U.S.	n/a	67.1%†	63.6%†	62.1%	60.8%	Negative*

SM: Adequate Insurance by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	69.1%†	67.2%	70.0%	66.4%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	70.6%†	60.7%†	53.0%†	50.8%†	Negative*
Non-Hispanic Black	n/a	72.4%†	82.5%†	75.3%†	65.3%†	Negative
Non-Hispanic Multiple Race	n/a	78.3%†	66.4%†	67.3%†	64.1%†	Negative*
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	62.8%	63.0%	65.3%	66.0%	Positive*

SM: Adequate Insurance by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	65.0%	63.8%	65.6%	67.3%	Positive
Male	n/a	65.6%	66.3%	67.7%	64.1%	No Change

SM: Adequate Insurance by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Non-MSA	n/a	n/a	64.5%	66.4%	70.6%	Positive
MSA, Central City	n/a	n/a	69.3%	69.7%	64.7%	Negative
MSA, Non-Central City	n/a	n/a	60.6%	63.8%	62.9%	Positive

SM: Flu Vaccination,<sup>1</sup>

Adequate Insurance	2018	2019	2020	2021	2022	Trend
Percent of Children, 6 months through 17 years, who are vaccinated annually against seasonal influenza	53.2%	63.3%	66.1%	56.7%	55.8%	Negative

SM: Flu Vaccination Insurance by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
6-23 Months	n/a	n/a	n/a	76.7%	79.0%	Positive
2-4 Years	n/a	n/a	n/a	60.4%	65.7%	Positive
5-12 Years	n/a	n/a	n/a	59.2%	56.9%	Negative
13-17 Years	n/a	n/a	n/a	45.7%	42.5%	Negative

SM: Flu Vaccination by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
Below Poverty	n/a	n/a	n/a	48.1%	51.0%†	Positive
<75k, Above Poverty	n/a	n/a	n/a	53.1%	50.3%	Negative
>75k	n/a	n/a	n/a	66.3%	62.4%	Negative

SM: Flu Vaccination by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	n/a	n/a	56.5%	53.8%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	75.8%	82.6%	Positive
Non-Hispanic Black	n/a	n/a	n/a	51.7%†	48.3%†	Negative
Non-Hispanic Multiple Race	n/a	n/a	n/a	62.4%†	52.9%†	Negative
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	n/a	n/a	56.9%†	56.4%†	Negative

SM: Flu Vaccination by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	n/a	55.7%	56.1%	Positive
Male	n/a	n/a	n/a	57.7%	55.4%	Negative

SM: Flu Vaccination by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Non-MSA	n/a	n/a	n/a	44.5%	47.3%	Positive
MSA, Central City	n/a	n/a	n/a	59.1%	57.2%	Negative
MSA, Non-Central City	n/a	n/a	n/a	61.9%	59.9%	Negative

SM: Forgone Health Care,<sup>2</sup>

Forgone Health Care	2018	2019	2020	2021	2022	Trend
Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	2.1%	2.7%	3.4%	3.1%	2.5%	Negative

SM: Forgone Health Care by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	0.5%†	0.7%†	1.1%†	0.8%†	Negative
1 ACE	n/a	2.6%†	3.2%†	4.8%†	3.8%†	Negative
2+ ACEs	n/a	10.1%†	12.1%†	7.2%	6.1%	Positive*

SM: Forgone Health Care by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	1.7%†	2.4%†	1.7%†	1.4%†	Positive
6-11 Years	n/a	4.2%†	5.3%†	4.1%	2.7%†	Negative
12-17 Years	n/a	2.2%†	2.3%†	3.3%†	3.3%†	Negative*

SM: Forgone Health Care by CSHCN Status

CSHCN Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	9.2%†	10.7%	8.8%	7.8%	Positive
Non-CSHCN	n/a	1.2%†	1.6%†	1.6%†	1.0%†	Positive

SM: Forgone Health Care by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than high school	n/a	n/a	0.0%†	0.0%†	0.0%†	No Change
High school graduate	n/a	5.7%†	4.7%†	3.7%†	4.8%†	Positive
Some college	n/a	4.1%†	5.7%†	4.5%†	3.4%†	Positive
College graduate	n/a	1.3%†	2.6%	2.8%	1.7%	Negative

SM: Forgone Health Care by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	1.0%†	1.5%	2.1%	1.6%	Negative
Medicaid	n/a	5.4%†	5.8%†	3.7%	3.8%†	Positive
Uninsured	n/a	7.4%†	9.0%†	9.7%†	7.4%†	No Change

SM: Forgone Health Care by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	5.2%†	5.8%†	5.0%†	5.1%†	Positive
100%-199%	n/a	4.9%†	5.1%†	3.8%†	3.2%†	Positive
200%-399%	n/a	1.6%†	2.0%†	2.5%†	2.2%†	Negative
≥400%	n/a	1.0%†	2.3%†	2.1%†	0.9%†	Positive

SM: Forgone Health Care by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Two-parent married	n/a	1.8%†	1.9%†	2.3%	1.9%	Negative
Two-parent unmarried	n/a	1.1%†	0.8%†	4.0%†	5.6%†	Negative*
Single parent	n/a	3.3%†	5.6%†	4.8%	4.4%†	Negative
Other	n/a	n/a	19.9%†	7.9%†	0.0%†	Positive

SM: Forgone Health Care by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	2.8%†	3.7%	2.9%	2.1%	Positive
Non-English	n/a	2.6%†	0.8%†	4.8%†	5.9%†	Negative

SM: Forgone Health Care by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	2.1%†	3.0%	2.9%	2.4%	Negative
Born outside U.S.	n/a	2.2%†	0.7%†	3.3%†	3.6%†	Negative

SM: Forgone Health Care by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	2.4%†	0.6%†	3.7%†	4.8%†	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	2.9%†	3.2%†	0.0%†	Positive
Non-Hispanic Black	n/a	1.6%†	3.2%†	5.1%†	3.8%†	Negative
Non-Hispanic Multiple Race	n/a	0.9%†	2.8%†	2.3%†	1.4%†	Negative
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	2.5%†	3.6%	2.8%	2.0%	Positive

SM: Forgone Health Care by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	2.8%†	3.8%†	2.6%†	2.7%	Positive
Male	n/a	2.6%†	2.8%†	3.5%	2.3%	Positive

SM: Forgone Health Care by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Non-MSA	n/a	n/a	2.5%†	3.5%†	3.6%†	Negative
MSA, Central City	n/a	n/a	3.5%†	2.8%†	2.3%†	Positive
MSA, Non-Central City	n/a	n/a	4.0%†	3.0%	1.9%†	Positive

SM: MMR Vaccination<sup>1</sup>

MMR Vaccination	2018	2019	2020	2021	2022	Trend
Percent of children in kindergarten who have received at least two doses of the MMR vaccine	89.1%	90.8%	90.0%	92.6%	91.0%	Positive

SM: Smoking – Household,<sup>2</sup>

Smoking – Household	2018	2019	2020	2021	2022	Trend
Percent of children, ages 0 through 17, who live in households where someone smokes	18.0%	19.5%	16.2%	12.6%	10.5%	Positive

SM: Smoking – Household by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	10.4%	9.9%	8.5%	6.8%	Positive*
1 ACE	n/a	28.3%	19.5%	15.7%	14.3%	Positive*
2+ ACEs	n/a	39.8%	33.8%	22.3%	18.0%	Positive*

SM: Smoking – Household by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	15.6%	13.5%	11.2%	8.5%	Positive*
6-11 Years	n/a	22.0%	17.5%	12.7%	10.6%	Positive*
12-17 Years	n/a	20.6%	17.5%	13.8%	12.2%	Positive*

SM: Smoking – Household by CSHCN Status

CSHCN Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	23.6%	20.4%	14.5%	9.8%	Positive*
Non-CSHCN	n/a	18.5%	15.2%	12.2%	10.8%	Positive*

SM: Smoking – Household by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than high school	n/a	n/a	26.5%†	13.8%†	12.0%†	Positive
High school graduate	n/a	30.8%	31.6%	25.9%	21.6%	Positive*
Some college	n/a	31.1%	25.3%	19.2%	16.4%	Positive*
College graduate	n/a	8.7%	6.5%	6.4%	4.8%	Positive*

SM: Smoking – Household by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
Private	n/a	n/a	10.4%	8.0%	6.8%	Positive
Medicaid	n/a	n/a	29.1%	23.6%	17.5%	Positive
Uninsured	n/a	n/a	14.7%†	10.8%†	18.2%†	Negative

SM: Smoking – Household by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	29.2%†	26.3%†	22.8%	19.2%	Positive*
100%-199%	n/a	27.5%	24.0%	14.1%	13.8%	Positive*
200%-399%	n/a	19.3%	15.4%	12.4%	9.0%	Positive*
≥400%	n/a	8.1%	5.7%	6.3%	5.5%	Positive*

SM: Smoking – Household by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Two-parent married	n/a	16.0%	13.0%	9.1%	7.5%	Positive*
Two-parent unmarried	n/a	29.2%†	36.5%†	36.9%†	25.5%†	Positive
Single parent	n/a	23.1%	19.3%	18.2%	14.6%	Positive*
Other	n/a	n/a	22.7%†	9.1%†	18.6%†	Positive

SM: Smoking – Household by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	20.2%	16.6%	12.9%	10.6%	Positive*
Non-English	n/a	13.9%†	11.0%†	6.7%†	9.0%†	Positive

SM: Smoking – Household by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	19.9%	17.1%	13.7%	11.0%	Positive*
Born outside U.S.	n/a	13.5%†	12.0%†	8.8%†	5.9%†	Positive*

SM: Smoking – Household by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	21.4%†	19.5%	15.6%	9.1%	Positive*
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	11.2%†	5.4%†	8.4%†	14.9%†	Negative
Non-Hispanic Black	n/a	10.8%†	11.0%†	17.4%†	4.8%†	Positive
Non-Hispanic Multiple Race	n/a	29.7%†	19.5%†	19.2%	16.0%	Positive*
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	18.9%	15.6%	11.1%	10.4%	Positive*

SM: Smoking – Household by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	18.6%	16.1%	10.3%	9.9%	Positive*
Male	n/a	20.4%	16.4%	14.8%	11.1%	Positive*

SM: Smoking – Household by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Non-MSA	n/a	n/a	22.4%	14.6%	12.1%	Positive
MSA, Central City	n/a	n/a	12.9%	11.0%	10.9%	Positive
MSA, Non-Central City	n/a	n/a	15.2%	12.7%	9.0%	Positive

SM: Uninsured, <sup>8</sup>

Uninsured	2018	2019	2020	2021	2022	Trend
Percent of children, ages 0 through 17, without health insurance	5.0%	4.9%	n/a	4.9%	4.9%	No Change

SM: Uninsured by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	3.8%	n/a	5.1%	4.5%	Negative
6-11 Years	n/a	5.7%	n/a	4.4%	4.5%	Positive
12-17 Years	n/a	7.7%	n/a	5.4%	5.5%	Positive

SM: Uninsured by Disability

Disability	2018	2019	2020	2021	2022	Trend
Activity Limitations	n/a	6.8%†	n/a	2.6%†	6.5%†	No Change
No Activity Limitations	n/a	5.8%	n/a	5.1%	4.8%	Positive

SM: Uninsured by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than high school	n/a	17.7%	n/a	10.6%	11.8%	Positive
High school graduate	n/a	9.4%	n/a	8.8%	7.5%	Positive
Some college	n/a	5.7%	n/a	3.6%	4.9%	Positive
College graduate	n/a	2.5%	n/a	3.9%	2.6%	No Change

SM: Uninsured by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	8.7%	n/a	9.5%	6.7%	Positive
100%-199%	n/a	9.4%	n/a	5.6%	6.6%	Positive
200%-399%	n/a	4.4%	n/a	3.9%	4.4%	No Change
≥400%	n/a	2.9%	n/a	3.1%	3.3%	No Change

SM: Uninsured by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	3.7%	n/a	4.0%	4.0%	No Change
Non-English	n/a	13.5%	n/a	8.9%	8.1%	Positive

SM: Uninsured by Marital Status

Marital Status	2018	2019	2020	2021	2022	Trend
Married	n/a	4.5%	n/a	4.2%	3.9%	Positive
Unmarried	n/a	8.5%	n/a	6.7%	7.3%	Positive

SM: Uninsured by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	4.0%	n/a	3.6%	3.8%	No Change
Born outside U.S.	n/a	13.4%	n/a	9.8%	9.8%	Positive

SM: Uninsured by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	11.8%	n/a	8.4%	7.9%	Positive
Non-Hispanic American Indian/Alaska Native	n/a	3.1%†	n/a	27.6%†	14.9%†	Negative
Non-Hispanic Asian	n/a	1.6%†	n/a	4.7%†	5.7%†	Negative
Non-Hispanic Black	n/a	14.3%†	n/a	10.1%†	5.6%†	Positive
Non-Hispanic Multiple Race	n/a	9.2%†	n/a	6.2%†	2.4%†	Positive
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	3.2%	n/a	3.2%	3.8%	Negative

SM: Uninsured by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	5.9%	n/a	4.6%	4.7%	Positive
Male	n/a	5.7%	n/a	5.3%	5.0%	Positive

NOM: Adverse Childhood Experiences,<sup>2</sup>

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
Percent of children, ages 0 through 17, who have experienced 2 or more Adverse Childhood Experiences	20.8%	19.3%	19.1%	20.4%	21.9%	Negative

NOM: Adverse Childhood Experiences by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	n/a	10.1%	11.0%	13.2%	Negative
6-11 Years	n/a	n/a	22.6%	21.6%	16.9%	Positive
12-17 Years	n/a	n/a	23.9%	27.8%	34.3%	Negative

NOM: Adverse Childhood Experiences by CSHCN Status

CSHCN Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	n/a	37.9%	36.5%	35.9%	Positive
Non-CSHCN	n/a	n/a	14.6%	16.2%	17.9%	Negative

NOM: Adverse Childhood Experiences by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than high school	n/a	n/a	12.8%†	29.0%†	18.5%†	Negative
High school graduate	n/a	n/a	28.6%	27.2%	31.4%	Negative
Some college	n/a	n/a	31.2%	31.3%	33.4%	Negative
College graduate	n/a	n/a	12.7%	13.8%	15.3%	Negative

NOM: Adverse Childhood Experiences by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	n/a	12.2%	13.6%	14.3%	Negative
Medicaid	n/a	n/a	32.7%	37.8%	41.0%	Negative
Uninsured	n/a	n/a	27.9%†	13.8%†	10.1%†	Positive

NOM: Adverse Childhood Experiences by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	32.6%†	33.7%	36.8%	Negative
100%-199%	n/a	n/a	24.9%	27.4%	28.4%	Negative
200%-399%	n/a	n/a	16.6%	17.9%	19.8%	Negative
≥400%	n/a	n/a	9.8%	11.1%	12.2%	Negative

NOM: Adverse Childhood Experiences by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Two-parent married	n/a	n/a	7.9%	8.6%	10.3%	Negative
Two-parent unmarried	n/a	n/a	34.8%†	41.4%†	43.9%†	Negative
Single parent	n/a	n/a	42.3%	45.6%	49.4%	Negative
Other	n/a	n/a	60.8%†	79.0%†	53.2%†	Positive

NOM: Adverse Childhood Experiences by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	20.5%	21.4%	22.2%	Negative
Non-English	n/a	n/a	7.5%†	12.0%†	18.7%	Negative

NOM: Adverse Childhood Experiences by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	18.7%	19.0%	21.3%	Negative
Born outside U.S.	n/a	n/a	10.6%†	16.4%	18.7%	Negative

NOM: Adverse Childhood Experiences by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	n/a	16.9%	24.4%	29.6%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	7.2%†	8.6%†	11.3%†	Negative
Non-Hispanic Black	n/a	n/a	25.8%†	35.7%†	35.4%†	Negative
Non-Hispanic Multiple Race	n/a	n/a	40.9%†	37.8%†	27.1%	Positive
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	n/a	17.5%	16.8%	18.1%	Negative

NOM: Adverse Childhood Experiences by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	21.8%	20.1%	20.3%	Positive
Male	n/a	n/a	16.1%	20.7%	23.4%	Negative

NOM: Adverse Childhood Experiences by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Non-MSA	n/a	n/a	18.1%	25.6%	26.6%	Negative
MSA, Central City	n/a	n/a	20.3%	18.9%	23.3%	Negative
MSA, Non-Central City	n/a	n/a	18.5%	17.8%	17.0%	Positive

NOM: Behavioral/Conduct Disorders,<sup>2</sup>

Behavioral/Conduct Disorders	2018	2019	2020	2021	2022	Trend
Percent of children, ages 6 through 11, who have a behavioral or conduct disorder	6.4%	8.6%	8.6%	9.0%	9.3%	Negative*

NOM: Behavioral/Conduct Disorders by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	3.8%†	5.4%	5.9%	6.1%	Negative
1 ACE	n/a	4.4%†	7.3%†	7.6%†	6.1%†	Negative
2+ ACEs	n/a	25.6%†	18.5%†	19.3%	24.7%†	Positive

NOM: Behavioral/Conduct Disorders by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than high school	n/a	n/a	n/a	n/a	n/a	n/a
High school graduate	n/a	12.7%†	8.6%†	8.1%†	5.6%†	Positive*
Some college	n/a	10.5%†	13.5%†	16.7%	15.3%	Negative
College graduate	n/a	6.1%†	7.4%	7.2%	8.8%	Negative*

NOM: Behavioral/Conduct Disorders by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	5.4%	6.1%	6.3%	6.8%	Negative*
Medicaid	n/a	10.9%†	10.4%†	13.6%	13.5%	Negative
Uninsured	n/a	n/a	n/a	n/a	n/a	n/a

NOM: Behavioral/Conduct Disorders by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	5.2%†	9.0%†	9.6%†	7.9%†	Negative
100%-199%	n/a	18.7%†	13.8%†	11.5%†	11.0%†	Positive*
200%-399%	n/a	5.6%†	7.3%†	9.9%	11.6%	Negative*
≥400%	n/a	4.3%†	4.9%†	5.7%†	6.7%	Negative*

NOM: Behavioral/Conduct Disorders by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Two-parent married	n/a	8.6%	9.6%	9.3%	9.4%	Negative
Two-parent unmarried	n/a	n/a	n/a	n/a	n/a	n/a
Single parent	n/a	13.0%†	9.3%†	7.0%†	8.8%†	Positive
Other	n/a	n/a	n/a	n/a	n/a	n/a

NOM: Behavioral/Conduct Disorders by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	9.6%	9.4%	10.1%	9.9%	Negative
Non-English	n/a	n/a	n/a	0.0%†	4.9%†	Negative

NOM: Behavioral/Conduct Disorders by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	10.4%	10.3%	10.9%	11.2%	Negative*
Born outside U.S.	n/a	1.8%†	2.3%†	3.1%†	3.9%†	Negative*

NOM: Behavioral/Conduct Disorders by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	7.1%†	1.8%†	6.9%†	10.1%†	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	10.0%†	17.1%†	11.7%†	Negative
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	10.4%	11.0%	9.3%	9.2%	Positive

NOM: Behavioral/Conduct Disorders by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	6.4%†	7.3%†	5.5%†	4.7%†	Positive
Male	n/a	11.1%†	10.1%	12.3%	13.7%	Negative*

NOM: Behavioral/Conduct Disorders by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Non-MSA	n/a	n/a	10.1%†	12.5%	11.1%†	Negative
MSA, Central City	n/a	n/a	11.2%†	8.5%	8.2%	Positive
MSA, Non-Central City	n/a	n/a	4.7%†	7.1%	8.8%	Negative

NOM: Child Injury Hospitalization,<sup>6,7</sup>

Child Injury Hospitalization	2018	2019	2020	2021	2022	Trend
Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9	109.1	119.5	110.0	114.6	117.7	Negative

NOM: Child Injury Hospitalization by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
<1 Year	247.0	268.9	223.9	263.1	258.8	Negative
1-4 Years	123.6	142.7	132.6	134.8	138.6	Negative
5-9 Years	72.4	74.9	72.1	74.0	76.5	Negative

NOM: Child Injury Hospitalization by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	n/a	n/a	n/a	n/a	n/a
Medicaid	n/a	n/a	n/a	n/a	n/a	n/a
Other Public	n/a	n/a	n/a	n/a	n/a	n/a
Uninsured	n/a	n/a	n/a	n/a	n/a	n/a

NOM: Child Injury Hospitalization by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	81.1	90.1	73.1	101.1	95.3	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian/Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Black	203.5	207.3	206.4	140.2	152.7	Positive
Non-Hispanic White	107.7	108.3	108.2	111.3	101.7	Positive
Other	n/a	n/a	n/a	n/a	n/a	n/a

NOM: Child Injury Hospitalization by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	85.6	113.1	99.8	109.8	108.4	Negative
Male	131.5	125.6	119.6	119.1	126.0	Positive

NOM: Child Injury Hospitalization by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Metro	68.0	96.2	88.4	83.6	82.9	Negative
Small/Medium Metro	136.2	154.3	143.2	144.8	157.5	Negative
Non-Metro	117.5	101.4	92.1	110.0	106.4	Positive

NOM: Child Mortality,<sup>5,6</sup>

Child Mortality	2018	2019	2020	2021	2022	Trend
Child mortality rate, ages 1 through 9, per 100,000	16.3	17.3	14.0	18.3	19.0	Negative

NOM: Child Mortality by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
1-4 Years	23.1	23.1	20.4	22.6	23.5	No Change
5-9 Years	14.0	13.5	12.4	12.0	12.2	Positive*

NOM: Child Mortality by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	17.9	19.7	17.9	17.6	15.0	Positive
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Black	25.2	25.7	29.0	40.2	42.3	Negative*
Non-Hispanic Multiple Race	n/a	n/a	n/a	n/a	21.0	n/a
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	16.9	15.4	14.1	14.4	15.1	Positive

NOM: Child Mortality by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	17.9	15.7	14.2	14.7	17.4	Positive
Male	18.0	19.5	17.5	18.3	16.8	Positive

NOM: Child Mortality by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Fringe Metro	13.1	13.1	11.4	12.1	11.9	Positive
Small/Medium Metro	14.9	15.8	15.8	19.2	21.2	Negative*
Non-Metro	26.3	24.3	20.5	17.9	17.5	Positive*

NOM: Child Obesity – ages 2 through 4,<sup>3</sup>

Child Obesity	2018	2019	2020	2021	2022	Trend
Percent of children, ages 2 through 4, who are obese (BMI above the 95 <sup>th</sup> percentile)	13.7%	n/a	12.2%	n/a	n/a	Positive

NOM: Child Obesity – ages 2 through 4 by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
2 Years	12.2%	n/a	10.7%	n/a	n/a	Positive
3 Years	14.0%	n/a	12.6%	n/a	n/a	Positive
4 Years	15.8%	n/a	14.3%	n/a	n/a	Positive

NOM: Child Obesity – ages 2 through 4 by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	16.4%	n/a	15.1%	n/a	n/a	Positive
Non-Hispanic American Indian/Alaska Native	18.6%	n/a	15.6%	n/a	n/a	Positive
Non-Hispanic Asian/Pacific Islander	9.9%	n/a	9.5%	n/a	n/a	No Change
Non-Hispanic Black	11.1%	n/a	9.5%	n/a	n/a	Positive
Non-Hispanic White	12.5%	n/a	11.0%	n/a	n/a	Positive

NOM: Child Obesity – ages 2 through 4 by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	13.3%	n/a	11.9%	n/a	n/a	Positive
Male	14.1%	n/a	12.4%	n/a	n/a	Positive

NOM: Child Obesity – Ages 6 through 17,<sup>2</sup>

Child Obesity – Ages 6 through 17	2018	2019	2020	2021	2022	Trend
Percent of children, ages 6 through 17, who are obese (BMI above the 95 <sup>th</sup> percentile)	13.1%	14.0%	14.6%	14.5%	14.9%	Negative*

NOM: Child Obesity – Ages 6 through 17 by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	11.0%	13.3%	11.4%	12.5%	Negative
1 ACE	n/a	12.5%†	14.3%	16.7%	19.0%	Negative*
2+ ACEs	n/a	21.9%	18.8%	20.3%	16.7%	Positive

NOM: Child Obesity – Ages 6 through 17 by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
6-11 Years	n/a	16.8%	16.6%	15.4%	16.9%	Positive
12-17 Years	n/a	11.3%	12.8%	13.7%	13.0%	Negative

NOM: Child Obesity – Ages 6 through 17 by CSHCN Status

CSHCN Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	13.2%	16.3%	18.4%	16.7%	Negative
Non-CSHCN	n/a	14.2%	14.1%	13.1%	14.2%	Negative

NOM: Child Obesity – Ages 6 through 17 by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than high school	n/a	n/a	n/a	n/a	n/a	n/a
High school graduate	n/a	25.8%†	20.5%	18.1%	23.9%	Positive
Some college	n/a	17.0%	18.0%	15.7%	11.7%	Positive
College graduate	n/a	8.0%	9.9%	9.7%	10.4%	Negative*

NOM: Child Obesity – Ages 6 through 17 by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	11.1%	12.0%	10.7%	11.4%	No Change
Medicaid	n/a	20.9%	16.6%	22.1%	20.6%	Negative
Uninsured	n/a	15.6%†	28.2%†	21.6%†	28.7%†	Negative

NOM: Child Obesity – Ages 6 through 17 by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	35.4%†	22.1%†	24.5%	23.8%	Positive
100%-199%	n/a	13.8%	14.5%†	13.2%	18.7%†	Negative
200%-399%	n/a	12.4%	14.6%	13.8%	13.7%	Negative
≥400%	n/a	7.0%	10.8%	11.0%	9.6%	Negative

NOM: Child Obesity – Ages 6 through 17 by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Two-parent married	n/a	9.7%	10.6%	11.0%	12.8%	Negative*
Two-parent unmarried	n/a	17.0%†	22.9%†	24.1%†	27.6%†	Negative*
Single parent	n/a	22.3%†	20.1%	22.5%	20.0%	Positive
Other	n/a	n/a	31.6%†	19.1%†	12.1%†	Positive

NOM: Child Obesity – Ages 6 through 17 by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	14.0%	14.2%	13.0%	13.3%	Positive
Non-English	n/a	15.9%†	20.6%†	28.2%†	26.7%†	Negative*

NOM: Child Obesity – Ages 6 through 17 by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	14.3%	13.8%	13.2%	12.9%	Positive*
Born outside U.S.	n/a	7.9%†	13.3%	19.0%	23.2%	Negative*

*NOM: Child Obesity – Ages 6 through 17 by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	13.8%†	12.7%	23.9%	25.8%	Negative*
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	10.9%†	11.4%†	14.7%†	Negative
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	20.3%†	18.2%†	10.9%†	14.3%†	Positive
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	12.6%	13.3%	12.1%	10.8%	Positive

*NOM: Child Obesity – Ages 6 through 17 by Sex*

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	11.9%	13.0%	12.1%	13.2%	Negative
Male	n/a	16.1%	16.3%	16.8%	16.4%	Negative

*NOM: Child Obesity – Ages 6 through 17 by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Non-MSA	n/a	n/a	16.3%	17.7%	15.3%	Positive
MSA, Central City	n/a	n/a	15.6%	16.8%	15.1%	Positive
MSA, Non-Central City	n/a	n/a	12.4%	9.7%	14.3%	Negative

*NOM: Children's Health Status,<sup>2</sup>*

Children's Health Status	2018	2019	2020	2021	2022	Trend
Percent of children, ages 0 through 17, in excellent or very good health	93.0%	93.4%	91.0%	90.9%	90.8%	Negative

*NOM: Children's Health Status by Adverse Childhood Experiences*

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	94.4%	94.6%	95.4%	93.3%	No Change
1 ACE	n/a	94.2%	89.9%	89.6%	89.5%	Negative
2+ ACEs	n/a	89.2%	80.4%	78.4%	84.3%	Negative

*NOM: Children's Health Status by Child Age*

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	94.1%	91.7%	92.9%	92.5%	No Change
6-11 Years	n/a	97.3%	94.5%	92.5%	91.6%	Negative*
12-17 Years	n/a	89.0%	87.1%	87.6%	88.5%	No Change

NOM: Children's Health Status by CSHCN Status

CSHCN Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	81.3%	77.8%	77.8%	77.6%	Negative
Non-CSHCN	n/a	96.2%	94.2%	94.3%	94.5%	Negative

NOM: Children's Health Status by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than high school	n/a	n/a	72.7%†	73.8%†	78.4%†	Positive
High school graduate	n/a	91.4%	86.9%	86.3%	90.1%	Negative
Some college	n/a	91.9%	91.2%	91.1%	88.0%	Negative
College graduate	n/a	96.5%	95.3%	94.3%	93.4%	Negative*

NOM: Children's Health Status by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	96.0%	95.3%	95.6%	94.4%	No Change
Medicaid	n/a	86.9%	81.1%	80.0%	83.5%	Negative
Uninsured	n/a	95.6%	93.2%	92.1%	85.6%†	Negative*

NOM: Children's Health Status by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	89.5%	76.4%†	77.7%	86.5%	Negative
100%-199%	n/a	88.7%	89.5%	89.8%	86.9%	Negative
200%-399%	n/a	95.5%	94.9%	93.6%	92.2%	Negative*
≥400%	n/a	97.0%	96.3%	96.0%	94.0%	Negative*

NOM: Children's Health Status by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Two-parent married	n/a	92.9%	92.0%	93.7%	92.6%	No Change
Two-parent unmarried	n/a	96.4%	94.3%	90.6%	87.4%†	Negative*
Single parent	n/a	95.8%	92.6%	86.0%	88.1%	Negative*
Other	n/a	n/a	69.7%†	68.9%†	80.3%†	Positive

NOM: Children's Health Status by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	94.1%	92.4%	92.4%	91.9%	Negative*
Non-English	n/a	90.8%†	85.3%†	81.9%	82.1%	Negative

NOM: Children's Health Status by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	94.7%	93.2%	92.8%	92.2%	Negative*
Born outside U.S.	n/a	89.5%	87.4%	86.9%	84.9%	Negative*

NOM: Children's Health Status by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	91.9%	88.8%	85.5%	83.3%	Negative*
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	76.2%†	77.2%†	88.7%†	91.8%	Positive*
Non-Hispanic Black	n/a	96.9%	87.7%†	82.6%†	94.4%	Negative
Non-Hispanic Multiple Race	n/a	97.4%	91.2%†	91.1%	91.5%	Negative
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	94.4%	93.0%	93.0%	92.7%	Negative*

NOM: Children's Health Status by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	91.4%	90.2%	92.3%	91.7%	No Change
Male	n/a	95.7%	91.9%	89.7%	89.9%	Negative

NOM: Children's Health Status by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Non-MSA	n/a	n/a	89.0%	87.9%	89.7%	Positive
MSA, Central City	n/a	n/a	90.2%	89.9%	90.8%	Positive
MSA, Non-Central City	n/a	n/a	93.7%	94.4%	91.5%	Negative

NOM: CSHCN Systems of Care,<sup>2</sup>

CSHCN Systems of Care	2018	2019	2020	2021	2022	Trend
Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	19.5%	20.9%	18.7%	14.2%	14.7%	Negative*

NOM: CSHCN Systems of Care by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	34.8%†	24.9%†	14.1%	16.9%	Negative*
1 ACE	n/a	24.1%†	14.3%†	12.5%†	16.1%†	Negative
2+ ACEs	n/a	4.6%†	15.1%†	15.3%	11.3%†	Positive

NOM: CSHCN Systems of Care by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	31.3%†	35.1%†	9.4%†	14.7%†	Negative
6-11 Years	n/a	29.6%†	20.6%†	23.4%	24.7%	Negative
12-17 Years	n/a	10.9%	12.3%	7.5%†	5.6%†	Negative*

NOM: CSHCN Systems of Care by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than high school	n/a	n/a	n/a	n/a	n/a	n/a
High school graduate	n/a	18.3%†	10.8%†	5.3%†	18.0%†	Negative
Some college	n/a	10.1%†	16.1%†	20.6%†	13.9%	Positive
College graduate	n/a	22.9%	16.2%	11.0%	12.1%	Negative*

NOM: CSHCN Systems of Care by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	26.8%†	11.6%†	19.6%†	Negative
100%-199%	n/a	9.4%†	18.0%†	15.8%†	10.3%†	Positive
200%-399%	n/a	18.2%	19.4%†	16.2%	14.6%	Negative*
≥400%	n/a	27.0%	13.2%	12.1%	14.9%	Negative

NOM: CSHCN Systems of Care by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Two-parent married	n/a	24.6%	17.5%	11.8%	15.8%	Negative
Two-parent unmarried	n/a	n/a	n/a	n/a	n/a	n/a
Single parent	n/a	16.3%†	19.7%†	18.0%†	14.4%†	Negative
Other	n/a	n/a	n/a	n/a	n/a	n/a

NOM: CSHCN Systems of Care by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	19.7%	17.4%	13.1%	14.1%	Negative*
Non-English	n/a	n/a	n/a	n/a	n/a	n/a

NOM: CSHCN Systems of Care by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	17.7%	14.9%	14.2%	14.5%	Negative
Born outside U.S.	n/a	n/a	n/a	15.2%†	19.6%†	Positive

NOM: CSHCN Systems of Care by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	n/a	n/a	21.8%†	17.6%†	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	17.7%†	19.9%†	Positive
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	18.0%	16.3%	12.5%	12.5%	Negative*

NOM: CSHCN Systems of Care by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	23.6%†	21.2%†	11.1%	8.6%	Negative*
Male	n/a	17.9%	16.1%	16.5%	19.2%	Positive

NOM: CSHCN Systems of Care by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Non-MSA	n/a	n/a	13.7%†	12.9%	15.4%	Positive
MSA, Central City	n/a	n/a	18.4%†	15.9%	14.4%	Negative
MSA, Non-Central City	n/a	n/a	23.1%†	13.3%	14.5%	Negative

NOM: Flourishing – Child Adolescent,<sup>2</sup>

Flourishing – Child Adolescent	2018	2019	2020	2021	2022	Trend
Percent of children with and without special health care needs, ages 6 through 17, who are flourishing	n/a	72.5%	66.9%	61.4%	63.4%	Negative*

NOM: Flourishing – Child Adolescent by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	77.0%	71.1%	65.2%	69.8%	Negative
1 ACE	n/a	76.0%	65.0%	59.1%	61.0%	Negative
2+ ACEs	n/a	57.6%	57.6%	54.4%	52.1%	Negative*

NOM: Flourishing – Child Adolescent by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
6-11 Years	n/a	70.7%	64.2%	62.5%	67.0%	Negative
12-17 Years	n/a	74.4%	69.5%	60.3%	60.0%	Negative*

NOM: Flourishing – Child Adolescent by CSHCN Status

CSHCN Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	51.2%	41.9%	37.8%	40.3%	Negative
Non-CSHCN	n/a	78.8%	74.9%	69.7%	71.5%	Negative*

NOM: Flourishing – Child Adolescent by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than high school	n/a	n/a	n/a	n/a	n/a	n/a
High school graduate	n/a	73.1%	62.8%†	56.8%	63.0%	Negative
Some college	n/a	59.9%	67.6%	63.5%	59.5%	Negative
College graduate	n/a	75.9%	67.1%	62.4%	63.6%	Negative

NOM: Flourishing – Child Adolescent by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	73.2%	68.0%	62.2%	63.0%	Negative*
Medicaid	n/a	73.4%	67.1%	57.2%	62.1%	Negative*
Uninsured	n/a	63.8%†	55.2%†	69.4%†	73.8%†	Positive

NOM: Flourishing – Child Adolescent by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	76.5%†	64.8%†	59.6%†	67.5%†	Negative
100%-199%	n/a	64.9%	65.4%†	58.4%	62.1%	Negative
200%-399%	n/a	70.9%	66.3%	62.9%	61.7%	Negative*
≥400%	n/a	78.7%	69.7%	62.7%	64.0%	Negative*

NOM: Flourishing – Child Adolescent by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Two-parent married	n/a	74.9%	67.3%	62.5%	64.3%	Negative
Two-parent unmarried	n/a	69.1%†	73.4%†	77.1%†	77.9%†	Positive*
Single parent	n/a	71.7%	65.3%	53.6%	58.2%	Negative*
Other	n/a	n/a	62.8%†	68.8%†	68.0%†	Positive

NOM: Flourishing – Child Adolescent by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	71.3%	66.7%	61.4%	63.0%	Negative
Non-English	n/a	82.7%†	66.4%†	63.5%†	67.8%†	Negative

NOM: Flourishing – Child Adolescent by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	71.2%	65.4%	60.0%	61.7%	Negative
Born outside U.S.	n/a	87.5%	76.8%	67.5%	70.1%	Negative*

*NOM: Flourishing – Child Adolescent by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	87.7%	80.0%	71.0%	68.2%	Negative*
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	81.7%†	65.5%†	47.1%†	54.3%†	Negative*
Non-Hispanic Black	n/a	n/a	n/a	71.0%†	n/a	n/a
Non-Hispanic Multiple Race	n/a	67.1%†	54.4%†	51.6%†	64.7%†	Negative
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	69.8%	64.9%	59.3%	61.3%	Negative*

*NOM: Flourishing – Child Adolescent by Sex*

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	73.4%	69.3%	64.9%	65.7%	Negative*
Male	n/a	71.7%	64.4%	58.2%	61.4%	Negative

*NOM: Flourishing – Child Adolescent by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Non-MSA	n/a	n/a	69.7%	64.8%	67.7%	Negative
MSA, Central City	n/a	n/a	66.6%	59.4%	64.3%	Negative
MSA, Non-Central City	n/a	n/a	65.0%	60.8%	59.4%	Negative

*NOM: Flourishing – Young Child*

Flourishing – Young Child	2018	2019	2020	2021	2022	Trend
Percent of children, ages 6 months through 5 years, who are flourishing	n/a	89.9%	87.9%	85.3%	83.9%	Negative*

*NOM: Flourishing – Young Child by Adverse Childhood Experiences*

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	92.0%	89.2%	87.7%	88.5%	Negative
1 ACE	n/a	93.0%	87.6%†	74.8%†	69.4%†	Negative*
2+ ACEs	n/a	n/a	n/a	81.0%†	72.0%†	Negative

*NOM: Flourishing – Young Child by CSHCN Status*

CSHCN Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	78.9%†	79.7%†	55.6%†	57.3%†	Negative
Non-CSHCN	n/a	90.9%	88.7%	88.6%	88.2%	Negative*

*NOM: Flourishing – Young Child by Educational Attainment*

<b>Educational Attainment</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>Trend</b>
Less than high school	n/a	n/a	n/a	n/a	n/a	n/a
High school graduate	n/a	n/a	n/a	86.0%†	78.6%†	Negative
Some college	n/a	89.2%†	88.0%	86.2%	83.5%	Negative*
College graduate	n/a	93.3%	91.1%	86.0%	84.8%	Negative*

*NOM: Flourishing – Young Child by Health Insurance*

<b>Health Insurance</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>Trend</b>
Private	n/a	94.3%	92.4%	88.5%	87.7%	Negative*
Medicaid	n/a	79.3%†	74.9%†	75.4%†	76.8%	Negative
Uninsured	n/a	n/a	n/a	n/a	n/a	n/a

*NOM: Flourishing – Young Child by Household Income-Poverty Ratio*

<b>Household Income-Poverty Ratio</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>Trend</b>
<100%	n/a	n/a	77.4%†	76.9%†	79.7%†	Positive
100%-199%	n/a	74.6%†	83.7%†	89.3%	86.3%	Positive
200%-399%	n/a	95.6%	92.1%	82.1%	79.0%	Negative*
≥400%	n/a	93.8%	93.7%	91.6%	89.9%	Negative*

*NOM: Flourishing – Young Child by Household Structure*

<b>Household Structure</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>Trend</b>
Two-parent married	n/a	92.7%	90.4%	87.5%	86.5%	Negative*
Two-parent unmarried	n/a	n/a	n/a	77.0%†	76.4%†	Negative
Single parent	n/a	85.6%†	86.7%	78.9%†	72.7%†	Negative*
Other	n/a	n/a	n/a	n/a	n/a	n/a

*NOM: Flourishing – Young Child by Language*

<b>Language</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>Trend</b>
English	n/a	89.9%	89.1%	85.7%	83.9%	Negative*
Non-English	n/a	n/a	n/a	89.3%†	87.4%†	Negative

*NOM: Flourishing – Young Child by Nativity*

<b>Nativity</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>Trend</b>
Born in U.S.	n/a	92.2%	92.4%	86.5%	82.5%	Negative*
Born outside U.S.	n/a	87.2%†	79.5%†	76.6%†	85.1%†	Negative

NOM: Flourishing – Young Child by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	85.0%†	81.9%†	81.5%†	78.6%†	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	65.0%†	73.4%†	Positive
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	92.5%	92.4%	88.9%	86.6%	Negative*

NOM: Flourishing – Young Child by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	87.1%	87.5%	88.4%	88.2%	No Change*
Male	n/a	93.4%	88.4%	82.3%	79.6%	Negative*

NOM: Flourishing – Young Child by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Non-MSA	n/a	n/a	91.3%	85.2%	83.9%	Negative
MSA, Central City	n/a	n/a	85.5%	83.5%	81.5%	Negative
MSA, Non-Central City	n/a	n/a	87.9%	87.2%	86.6%	Negative

NOM: School Readiness,<sup>2</sup>

School Readiness	2018	2019	2020	2021	2022	Trend
Percent of children meeting the criteria developed for school readiness	n/a	n/a	n/a	n/a	62.7%†	n/a
Early Learning Skills	n/a	n/a	n/a	n/a	76.0%	n/a
Social-Emotional Development	n/a	n/a	n/a	n/a	87.4%	n/a
Health	n/a	n/a	n/a	n/a	87.4%	n/a
Motor Development	n/a	n/a	n/a	n/a	65.1%†	n/a
Self-Regulation	n/a	n/a	n/a	n/a	67.1%†	n/a

NOM: School Readiness by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	n/a	n/a	n/a	71.0%†	n/a
1 ACE	n/a	n/a	n/a	n/a	n/a	n/a
2+ ACEs	n/a	n/a	n/a	n/a	n/a	n/a

NOM: School Readiness by CSHCN Status

CSHCN Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	n/a	n/a	n/a	32.4%†	n/a
Non-CSHCN	n/a	n/a	n/a	n/a	68.8%†	n/a

NOM: School Readiness by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than high school	n/a	n/a	n/a	n/a	n/a	n/a
High school graduate	n/a	n/a	n/a	n/a	n/a	n/a
Some college	n/a	n/a	n/a	n/a	35.7%†	n/a
College graduate	n/a	n/a	n/a	n/a	80.3%†	n/a

NOM: School Readiness by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	n/a	n/a	n/a	69.7%†	n/a
Medicaid	n/a	n/a	n/a	n/a	44.4%†	n/a
Uninsured	n/a	n/a	n/a	n/a	n/a	n/a

NOM: School Readiness by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	n/a	n/a	n/a	n/a
100%-199%	n/a	n/a	n/a	n/a	n/a	n/a
200%-399%	n/a	n/a	n/a	n/a	56.7%†	n/a
≥400%	n/a	n/a	n/a	n/a	82.9%†	n/a

NOM: School Readiness by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Two-parent married	n/a	n/a	n/a	n/a	68.3%†	n/a
Two-parent unmarried	n/a	n/a	n/a	n/a	n/a	n/a
Single parent	n/a	n/a	n/a	n/a	n/a	n/a
Other	n/a	n/a	n/a	n/a	n/a	n/a

NOM: School Readiness by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	n/a	n/a	65.6%†	n/a
Non-English	n/a	n/a	n/a	n/a	n/a	n/a

NOM: School Readiness by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	n/a	n/a	62.6%†	n/a
Born outside U.S.	n/a	n/a	n/a	n/a	n/a	n/a

NOM: School Readiness by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	n/a	n/a	n/a	72.0%†	n/a

NOM: School Readiness by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	n/a	n/a	65.8%†	n/a
Male	n/a	n/a	n/a	n/a	60.1%†	n/a

NOM: School Readiness by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Non-MSA	n/a	n/a	n/a	n/a	58.2%†	n/a
MSA, Central City	n/a	n/a	n/a	n/a	63.9%†	n/a
MSA, Non-Central City	n/a	n/a	n/a	n/a	63.8%†	n/a

NOM: Tooth Decay/Cavities,<sup>2</sup>

Uninsured	2018	2019	2020	2021	2022	Trend
Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	10.2%	11.5%	11.0%	12.1%	11.4%	Negative

NOM: Tooth Decay/Cavities by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	9.5%	10.4%	9.2%	7.9%	Positive
1 ACE	n/a	15.3%	12.7%	13.1%	10.7%	Positive*
2+ ACEs	n/a	14.2%	11.3%	20.0%	21.5%	Negative*

NOM: Tooth Decay/Cavities by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
1-5 Years	n/a	9.8%	8.3%	6.0%	7.6%	Positive
6-11 Years	n/a	16.3%	14.5%	17.1%	14.9%	Positive
12-17 Years	n/a	8.1%	9.6%	12.0%	10.9%	Negative

NOM: Tooth Decay/Cavities by CSHCN Status

CSHCN Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	15.2%	14.7%	18.2%	19.4%	Negative*
Non-CSHCN	n/a	10.6%	10.1%	10.4%	9.0%	Positive*

NOM: Tooth Decay/Cavities by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than high school	n/a	n/a	17.0%†	22.4%†	18.6%†	Negative
High school graduate	n/a	11.2%	11.8%	15.0%	14.4%	Negative*
Some college	n/a	15.4%	9.9%	13.5%	14.2%	Negative
College graduate	n/a	8.9%	10.1%	9.4%	8.6%	Positive

NOM: Tooth Decay/Cavities by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	10.3%	8.3%	6.0%	7.6%	Positive
Medicaid	n/a	15.0%	14.5%	17.1%	14.9%	Negative
Uninsured	n/a	16.5%†	9.6%†	12.0%†	10.9%†	Positive

NOM: Tooth Decay/Cavities by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	11.7%†	11.8%†	14.5%	16.6%	Negative*
100%-199%	n/a	17.1%	10.9%†	13.8%	14.4%	Positive
200%-399%	n/a	9.7%	11.5%	12.1%	9.3%	Positive
≥400%	n/a	9.2%	10.0%	9.6%	9.1%	Positive

NOM: Tooth Decay/Cavities by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Two-parent married	n/a	10.9%	10.4%	10.7%	10.2%	Positive
Two-parent unmarried	n/a	8.0%†	2.4%†	6.7%†	7.5%†	Negative
Single parent	n/a	14.8%	13.1%	15.3%	17.1%	Negative
Other	n/a	n/a	15.4%†	25.4%†	14.3%†	Positive

NOM: Tooth Decay/Cavities by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	10.7%	10.3%	11.5%	11.0%	Negative
Non-English	n/a	19.9%†	18.2%†	16.8%	14.4%†	Positive*

NOM: Tooth Decay/Cavities by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	9.9%	9.7%	11.1%	11.3%	Negative*
Born outside U.S.	n/a	17.2%	11.8%†	11.2%	12.8%	Positive

*NOM: Tooth Decay/Cavities by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	14.8%	9.6%†	13.3%	18.4%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	28.1%†	25.7%†	10.3%†	5.1%†	Positive*
Non-Hispanic Black	n/a	n/a	19.7%†	9.7%†	6.4%†	Positive
Non-Hispanic Multiple Race	n/a	5.5%†	15.7%†	17.7%†	6.3%†	Negative
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	10.0%	9.9%	11.6%	10.7%	Negative

*NOM: Tooth Decay/Cavities by Sex*

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	11.4%	11.8%	10.0%	10.2%	Positive
Male	n/a	11.6%	10.1%	14.0%	12.6%	Negative

*NOM: Tooth Decay/Cavities by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Non-MSA	n/a	n/a	7.8%	12.3%	11.7%	NPM
MSA, Central City	n/a	n/a	13.8%	13.4%	12.6%	Positive
MSA, Non-Central City	n/a	n/a	10.4%	10.6%	10.1%	No Change

*Sources:*

- Centers for Disease Control and Prevention (CDC). National Immunization Survey (NIS)
- Health Resources and Services Administration (HRSA). National Survey of Children's Health (NSCH)
- U.S. Department of Agriculture, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Centers for Disease Control and Prevention (CDC). Youth Risk Behavior Surveillance System (YRBSS)
- Kansas Department of Health and Environment (KDHE), Bureau of Epidemiology and Public Health Informatics. Kansas death data (resident)
- U.S. Census Bureau, Population Estimate, Single-Race Vintage data set
- Kansas Department of Health and Environment (KDHE), Bureau of Epidemiology and Public Health Informatics. Kansas hospital discharge data (resident)
- United States Census Bureau. American Community Survey (ACS).

## Appendix E.4 Adolescent Health Population Domain

National Performance Measures (blue tables) / National Outcome Measures (green tables). 2026 Application/2024 Annual Report

### Key and Definitions

**NPM:** National Performance Measure (blue tables)

**NOM:** National Outcome Measure (green tables)

**n/a:** Indicates the data were not available at the time of report.

**HP2030:** Healthy People 2030 goal.

**LC-##:** Life Course Indicators

\* Statistically significant trend is indicated by a “\*” ( $p < 0.05$ ) – for measures with 5 years of data, assessed by Joinpoint Regression software version 5.2.0, using Annual Percent Change (APC) method. All others with less than 5 years of data were assessed by the direction of the change between the first and last data point and was not measured for significance. For measures where the latest year was not provided, a trend was not assessed on prior year values where there was less than 3 years of prior data. Trends were indicated as 'no change' when the difference between data points were within plus or minus 0.5 difference. N/A was listed for any trend that was not able to be assessed or where there was missing data.

\*\*FAD estimates are collated by HRSA from several different federal agencies. The tables in this report are the attempt to organize these for easier understanding. Some estimates by stratifiers are calculated with three-year data, while others may use five-year data to improve precision and reportability. Further details about a specific measure(s)' originating agency and additional data notes can be found in the NPM and NOM Data Notes tab of the FAD data Excel files<sup>1</sup>. Measures with an associated HP2030 goal or LC Indicator were indicated for those with similar health objectives. Not all FAD measures had HP2030 goals or LC indicators that could be associated to them.

\*\*\* All data should be interpreted with caution for any use in programmatic decision making.

### Adolescent Well-Visit (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year)

Adolescent Well-Visit	2018	2019	2020	2021	2022	Trend
Total	n/a	n/a	75.7%	72.2%	73.7%	Negative

### Adolescent Well-Visit by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	n/a	80.0%	72.7%	73.9%	Negative
1 ACE	n/a	n/a	57.3%	68.6%	71.4%	Positive
2+ ACEs	n/a	n/a	83.0%	74.6%	74.9%	Negative

### Adolescent Well-Visit by CSHCN Status

CSHCN Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	n/a	88.6%	85.6%	91.9%	Positive
Non-CSHCN	n/a	n/a	71.2%	67.3%	67.2%	Negative

#### Adolescent Well-Visit by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	n/a	n/a	n/a	n/a	n/a	n/a
High School Graduate	n/a	n/a	64.9%	57.1%	57.2%	Negative
Some College	n/a	n/a	81.3%	66.9%	75.1%	Negative
College Graduate	n/a	n/a	83.6%	81.1%	81.9%	Negative

#### Adolescent Well-Visit by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	n/a	80.8%	78.2%	79.5%	Negative
Medicaid	n/a	n/a	67.8%	64.9%	64.6%	Negative
Uninsured	n/a	n/a	59.1%	49.5%	n/a	n/a

#### Adolescent Well-Visit by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	76.3%	65.3%	69.8%	Negative
100%-199%	n/a	n/a	66.9%	67.4%	60.0%	Negative
200%-399%	n/a	n/a	72.5%	67.6%	72.5%	No change
>400%	n/a	n/a	83.7%	82.1%	85.0%	Positive

#### Adolescent Well-Visit by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Two-parent married	n/a	n/a	78.2%	74.4%	75.5%	Negative
Two-parent unmarried	n/a	n/a	n/a	n/a	n/a	n/a
Single parent	n/a	n/a	65.2%	62.4%	69.7%	Positive
Other	n/a	n/a	n/a	n/a	n/a	n/a

#### Adolescent Well-Visit by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	77.1%	74.6%	76.9%	No change
Non-English	n/a	n/a	57.0%	44.8%	47.9%	Negative

#### Adolescent Well-Visit by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	77.5%	75.6%	77.6%	No change
Not Born in U.S.	n/a	n/a	63.4%	53.2%	57.3%	Negative

#### Adolescent Well-Visit by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	n/a	77.0%	74.3%	75.6%	Negative
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Hispanic	n/a	n/a	76.0%	64.5%	70.4%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic, Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	80.3%	86.3%	Positive

#### Adolescent Well-Visit by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	69.6%	72.7%	72.5%	Positive
MSA, Non-Central City	n/a	n/a	83.1%	74.7%	76.6%	Negative
Non-MSA	n/a	n/a	76.0%	68.8%	71.6%	Negative

#### Adult Mentor (Percent of adolescents, ages 12 through 17, who have one or more adults outside the home who they can rely on for advice or guidance)

Adult Mentor	2018	2019	2020	2021	2022	Trend
Total	93.5%	92.7%	91.2%	91.2%	90.8%	Negative*

#### Adult Mentor by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	n/a	89.4%	93.2%	92.7%	Positive
1 ACE	n/a	n/a	93.2%	88.9%	87.7%	Negative
2+ ACEs	n/a	n/a	93.6%	93.6%	93.6%	No change

#### Adult Mentor by CSHCN Status

CSHCN Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	n/a	91.9%	89.8%	95.3%	Positive
Non-CSHCN	n/a	n/a	91.0%	91.8%	89.1%	Negative

#### Adult Mentor by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	n/a	n/a	n/a	n/a	n/a	n/a
High School Graduate	n/a	n/a	94.3%	86.5%	90.9%	Negative
Some College	n/a	n/a	84.1%	84.1%	84.1%	No change
College Graduate	n/a	n/a	95.7%	95.7%	95.7%	No change

#### Adult Mentor by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Medicaid	n/a	n/a	84.6%	88.1%	86.5%	Positive
Private	n/a	n/a	93.9%	94.1%	95.2%	Positive
Uninsured	n/a	n/a	89.2%	89.2%	89.2%	No change

#### Adult Mentor by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	81.4%	82.3%	86.9%	Positive
100%-199%	n/a	n/a	86.1%	85.8%	80.1%	Negative
200%-399%	n/a	n/a	93.5%	93.6%	91.6%	Negative
>400%	n/a	n/a	96.2%	95.6%	97.8%	Positive

#### Adult Mentor by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Single parent	n/a	n/a	95.6%	88.1%	86.2%	Negative
Two-parent married	n/a	n/a	89.6%	93.0%	93.0%	Positive
Two-parent unmarried	n/a	n/a	n/a	n/a	n/a	n/a
Other	n/a	n/a	n/a	n/a	n/a	n/a

#### Adult Mentor by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	94.4%	94.1%	94.8%	No change
Non-English	n/a	n/a	n/a	60.4%	60.6%	No change

#### Adult Mentor by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	95.2%	94.8%	96.3%	Positive
Not Born in U.S.	n/a	n/a	73.0%	72.2%	69.3%	Negative

#### Adult Mentor by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	n/a	96.1%	95.2%	96.0%	No change
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Hispanic	n/a	n/a	74.2%	77.9%	78.0%	Positive
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	92.9%	81.3%	Negative

#### Adult Mentor by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	93.8%	92.0%	88.5%	Negative
Male	n/a	n/a	88.9%	90.6%	92.7%	Positive

#### Adult Mentor by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	83.8%	89.0%	89.6%	Positive
MSA, Non-Central City	n/a	n/a	95.8%	93.8%	93.7%	Negative
Non-MSA	n/a	n/a	96.8%	91.2%	88.6%	Negative

Bullying-Perpetration (Percent of adolescents, ages 12 through 17, who are bullied or who bully others) (LC-12: Discrimination and Segregation: Bullying) (HP2030: LGBT-DO1, LGBT-05: 20.7%, AH-10: 199.2/100k)

Bullying-Perpetration	2018	2019	2020	2021	2022	Trend
Total	n/a	19.0%	16.7%	16.4%	16.6%	Positive

#### Bullying-Perpetration by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	n/a	12.0%	12.5%	15.1%	Negative
1 ACE	n/a	n/a	16.5%	12.3%	10.0%	Positive
2+ ACEs	n/a	n/a	27.7%	26.9%	22.8%	Positive

#### Bullying-Perpetration by CSHCN Status

CSHCN Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	n/a	27.1%	26.1%	24.9%	Positive
Non-CSHCN	n/a	n/a	13.0%	12.8%	13.5%	No change

#### *Bullying-Perpetration by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	n/a	n/a	n/a	n/a	n/a	n/a
High School Graduate	n/a	n/a	10.1%	8.2%	20.2%	Negative
Some College	n/a	n/a	19.2%	17.5%	17.9%	Positive
College Graduate	n/a	n/a	21.4%	19.5%	16.1%	Positive

#### *Bullying-Perpetration by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Medicaid	n/a	n/a	15.4%	20.1%	24.3%	Negative
Private	n/a	n/a	19.4%	15.2%	13.1%	Positive
Uninsured	n/a	n/a	0.7%	15.5%	n/a	n/a

#### *Bullying-Perpetration by Household Income-Poverty Ratio*

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	7.5%	12.3%	18.6%	Negative
100%-199%	n/a	n/a	17.6%	22.8%	18.0%	No change
200%-399%	n/a	n/a	16.9%	18.2%	18.2%	Negative
>400%	n/a	n/a	20.3%	13.4%	12.9%	Positive

#### *Bullying-Perpetration by Household Structure*

Household Structure	2018	2019	2020	2021	2022	Trend
Single parent	n/a	n/a	13.1%	17.5%	18.4%	Negative
Two-parent married	n/a	n/a	15.8%	14.7%	15.4%	No change
Two-parent unmarried	n/a	n/a	n/a	n/a	n/a	n/a
Other	n/a	n/a	n/a	n/a	n/a	n/a

#### *Bullying-Perpetration by Language*

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	18.3%	18.3%	18.3%	No change
Non-English	n/a	n/a	1.6%	1.6%	1.6%	No change

#### *Bullying-Perpetration by Nativity*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	19.8%	19.0%	18.8%	Positive
Not Born in U.S.	n/a	n/a	3.2%	3.8%	5.4%	Negative

#### *Bullying-Perpetration by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	n/a	19.0%	17.8%	19.7%	Negative
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Hispanic	n/a	n/a	10.3%	17.4%	15.3%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	23.6%	9.8%	Positive

#### *Bullying-Perpetration by Sex*

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	15.6%	15.1%	16.6%	Negative
Male	n/a	n/a	17.7%	17.6%	16.5%	Positive

#### *Bullying-Perpetration by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	11.8%	13.6%	13.2%	Negative
MSA, Non-Central City	n/a	n/a	19.0%	16.5%	17.3%	Positive
Non-MSA	n/a	n/a	21.5%	20.2%	20.2%	Positive

#### *Bullying- Victimization (Percent of adolescents, grades 9 through 12, who are bullied) (LC-12: Discrimination and Segregation: Bullying) (HP2030: LGBT-DO1, LGBT-05: 20.7%)*

Bullying- Victimization	2018	2019	2020	2021	2022	Trend
Total	n/a	42.6%	35.8%	34.6%	42.5%	No change

#### *Bullying-Victimization by Adverse Childhood Experiences*

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	n/a	30.3%	32.0%	35.2%	Negative
1 ACE	n/a	n/a	35.1%	39.0%	55.3%	Negative
2+ ACEs	n/a	n/a	48.1%	36.0%	43.7%	Positive

#### *Bullying-Victimization by CSHCN Status*

CSHCN Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	n/a	54.2%	54.7%	64.2%	Negative
Non-CSHCN	n/a	n/a	29.3%	27.1%	34.7%	Negative

#### *Bullying- Victimization by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	n/a	n/a	n/a	n/a	n/a	n/a
High School Graduate	n/a	n/a	31.1%	25.6%	40.2%	Negative
Some College	n/a	n/a	38.4%	33.2%	38.0%	No change
College Graduate	n/a	n/a	42.4%	39.9%	46.4%	Negative

#### *Bullying- Victimization by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Medicaid	n/a	n/a	27.1%	21.6%	33.7%	Negative
Private	n/a	n/a	39.0%	37.0%	44.0%	Negative
Uninsured	n/a	n/a	47.8%	53.6%	n/a	n/a

#### *Bullying-Victimization by Household Income-Poverty Ratio*

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	21.9%	26.6%	33.6%	Negative
100%-199%	n/a	n/a	30.7%	26.4%	35.0%	Negative
200%-399%	n/a	n/a	35.8%	39.2%	50.2%	Negative
>400%	n/a	n/a	45.1%	38.4%	42.9%	Positive

#### *Bullying- Victimization by Household Structure*

Household Structure	2018	2019	2020	2021	2022	Trend
Single parent	n/a	n/a	22.5%	29.4%	42.8%	Negative
Two-parent married	n/a	n/a	37.9%	35.4%	41.3%	Negative
Two-parent unmarried	n/a	n/a	n/a	n/a	n/a	n/a
Other	n/a	n/a	n/a	n/a	n/a	n/a

#### *Bullying- Victimization by Language*

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	38.4%	35.8%	42.3%	Negative
Non-English	n/a	n/a	11.8%	18.6%	42.4%	Negative

#### *Bullying- Victimization by Nativity*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	40.6%	37.8%	44.2%	Negative
Not Born in U.S.	n/a	n/a	12.1%	20.5%	35.1%	Negative

Bullying- Victimization by Race/Ethnicity from NSCH-ALL ADOLESCENTS

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	n/a	41.7%	39.9%	46.6%	Negative
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Hispanic	n/a	n/a	16.7%	24.6%	39.9%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	45.0%	41.1%	Positive

*Bullying- Victimization by Sex*

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	38.5%	37.1%	51.7%	Negative
Male	n/a	n/a	33.3%	32.5%	35.1%	Negative

*Bullying- Victimization by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	38.0%	35.7%	34.9%	Positive
MSA, Non-Central City	n/a	n/a	36.7%	34.8%	43.8%	Negative
Non-MSA	n/a	n/a	31.0%	33.0%	51.6%	Negative

Medical Home (Percent of children with and without special health care needs, ages 0 through 17, who have a medical home) (LC-37: Health Care Access and Quality: Medical Home for Children) (HP2030: MICH-19: 53.6%)

Medical Home	2018	2019	2020	2021	2022	Trend
Total	52.4%	53.7%	53.5%	52.9%	52.7%	Negative
Component: Usual Source of Care	n/a	n/a	79.7%	80.8%	80.8%	Positive
Component: Referrals if needed	n/a	n/a	90.1%	84.9%	77.8%	Negative
Component: Personal Doctor or Nurse	n/a	n/a	74.5%	73.6%	74.9%	No change
Component: Family-Centered Care	n/a	n/a	89.6%	90.7%	88.4%	Negative
Component: Care Coordination if needed	n/a	n/a	73.4%	72.3%	70.8%	Negative

#### Medical Home by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	n/a	57.6%	57.2%	58.3%	Positive
1 ACE	n/a	n/a	49.0%	46.8%	43.4%	Negative
2+ ACEs	n/a	n/a	46.0%	44.7%	45.3%	Negative

#### Medical Home by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	n/a	58.8%	54.5%	51.0%	Negative
6-11 Years	n/a	n/a	50.3%	50.6%	53.4%	Positive
12-17 Years	n/a	n/a	51.9%	53.5%	53.6%	Positive

#### Medical Home by CSHCN Status

CSHCN Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	n/a	56.9%	49.0%	50.2%	Negative
Non-CSHCN	n/a	n/a	52.8%	53.9%	53.4%	Positive

#### Medical Home by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	n/a	n/a	25.0%	31.1%	37.1%	Positive
High School Graduate	n/a	n/a	34.0%	30.6%	34.9%	Positive
Some College	n/a	n/a	56.6%	52.9%	53.4%	Negative
College Graduate	n/a	n/a	63.7%	62.1%	60.2%	Negative

#### Medical Home by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Medicaid	n/a	n/a	41.0%	36.5%	40.7%	No change
Private	n/a	n/a	61.0%	61.4%	59.9%	Negative
Uninsured	n/a	n/a	41.4%	39.3%	33.8%	Negative

#### Medical Home by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	35.6%	38.4%	41.1%	Positive
100%-199%	n/a	n/a	50.1%	42.0%	42.1%	Negative
200%-399%	n/a	n/a	55.3%	54.0%	54.8%	No change
>400%	n/a	n/a	64.7%	66.7%	63.7%	Negative

#### Medical Home by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Single parent	n/a	n/a	40.3%	36.6%	39.8%	No change
Two-parent married	n/a	n/a	58.7%	58.5%	57.6%	Negative
Two-parent unmarried	n/a	n/a	51.6%	50.8%	51.5%	No change
Other	n/a	n/a	46.9%	45.0%	43.9%	Negative

#### Medical Home by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	57.0%	55.9%	55.5%	Negative
Non-English	n/a	n/a	26.5%	26.3%	26.0%	No change

#### Medical Home by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	57.6%	56.6%	57.2%	No change
Not Born in U.S.	n/a	n/a	38.3%	40.2%	36.9%	Negative

#### Medical Home by Race/Ethnicity from NSCH-ALL ADOLESCENTS

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	n/a	58.2%	58.5%	58.6%	No change
Non-Hispanic Black	n/a	n/a	32.0%	30.1%	29.1%	Negative
Hispanic	n/a	n/a	41.5%	37.4%	37.9%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	47.9%	33.5%	31.1%	Negative
Non-Hispanic Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	65.1%	61.8%	63.4%	Negative

#### Medical Home by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	55.4%	52.5%	50.8%	Negative
Male	n/a	n/a	51.6%	53.2%	54.4%	Positive

#### Medical Home by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	49.9%	47.0%	50.5%	Positive
MSA, Non-Central City	n/a	n/a	57.5%	58.8%	55.8%	Negative
Non-MSA	n/a	n/a	53.8%	53.1%	51.5%	Negative

Mental Health Treatment (Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling) (HP2030: MHMD-06: 44.9%, MHMD-08: 13.5%)

Mental Health Treatment	2018	2019	2020	2021	2022	Trend
Total	79.3%	78.6%	82.3%	93.2%	93.6%	Positive*

#### Mental Health Treatment by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	n/a	75.0%	87.3%	n/a	n/a
1 ACE	n/a	n/a	n/a	n/a	93.1%	n/a
2+ ACEs	n/a	n/a	87.5%	93.4%	93.8%	Positive

#### Mental Health Treatment by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	n/a	n/a	n/a	n/a	n/a	n/a
High School Graduate	n/a	n/a	n/a	n/a	n/a	n/a
Some College	n/a	n/a	n/a	n/a	n/a	n/a
College Graduate	n/a	n/a	85.7%	91.1%	94.1%	Positive

#### Mental Health Treatment by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Medicaid	n/a	n/a	86.8%	96.6%	n/a	n/a
Private	n/a	n/a	86.8%	90.9%	93.2%	Positive
Uninsured	n/a	n/a	n/a	n/a	n/a	n/a

#### *Mental Health Treatment by Household Income-Poverty Ratio*

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	n/a	n/a	n/a	n/a
100%-199%	n/a	n/a	n/a	n/a	n/a	n/a
200%-399%	n/a	n/a	n/a	92.3%	92.1%	No change
>400%	n/a	n/a	79.2%	90.8%	96.2%	Positive

#### *Mental Health Treatment by Household Structure*

Household Structure	2018	2019	2020	2021	2022	Trend
Single parent	n/a	n/a	n/a	92.1%	95.1%	Positive
Two-parent married	n/a	n/a	84.9%	93.0%	96.3%	Positive
Two-parent unmarried	n/a	n/a	n/a	n/a	n/a	n/a
Other	n/a	n/a	n/a	n/a	n/a	n/a

#### *Mental Health Treatment by Language*

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	82.8%	93.0%	94.5%	Positive
Non-English	n/a	n/a	n/a	n/a	n/a	n/a

#### *Mental Health Treatment by Nativity*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	79.2%	93.2%	95.1%	Positive
Not Born in U.S.	n/a	n/a	n/a	n/a	n/a	n/a

#### *Mental Health Treatment by Sex*

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	81.4%	92.1%	91.2%	Positive
Male	n/a	n/a	83.9%	94.4%	96.3%	Positive

#### Mental Health Treatment by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	n/a	83.8%	93.4%	94.0%	Positive
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Hispanic	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	n/a	n/a	n/a

#### Mental Health Treatment by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	76.6%	95.1%	97.7%	Positive
MSA, Non-Central City	n/a	n/a	88.3%	90.1%	89.1%	Positive
Non-MSA	n/a	n/a	n/a	n/a	n/a	n/a

*Preventive Dental Visit – Child (Percent of children, ages 1 through 17, who had a preventive dental visit in the past year) (LC-41: Health Care Access and Quality: Oral Health Preventive Visit for Children) (HP2030: OH-09: 79.7%, OH-02: 10.2%)*

Preventive Dental Visit – Child	2018	2019	2020	2021	2022	Trend
Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	79.8%	78.9%	78.7%	77.3%	81.1%	Positive

#### Preventive Dental Visit – Child by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	n/a	81.3%	79.1%	81.1%	No change
2+ ACEs	n/a	n/a	71.3%	74.0%	80.8%	Positive

*Preventive Dental Visit – Child by Child Age*

Child Age	2018	2019	2020	2021	2022	Trend
1-5 Years	n/a	n/a	57.7%	55.0%	61.6%	Positive
6-11 Years	n/a	n/a	84.0%	84.5%	86.8%	Positive
12-17 Years	n/a	n/a	89.1%	87.8%	90.1%	Positive

*Preventive Dental Visit – Child by CSHCN Status*

CSHCN Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	n/a	80.0%	78.4%	85.9%	Positive
Non-CSHCN	n/a	n/a	78.3%	77.1%	79.7%	Positive

*Preventive Dental Visit – Child by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than high school	n/a	n/a	85.2%	77.1%	88.0%	Positive
High school graduate	n/a	n/a	61.0%	62.3%	71.6%	Positive
Some college	n/a	n/a	75.9%	76.8%	78.3%	Positive
College graduate	n/a	n/a	84.8%	82.2%	84.5%	No change

*Preventive Dental Visit – Child by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Medicaid	n/a	n/a	71.5%	68.2%	73.5%	Positive
Private	n/a	n/a	84.6%	83.2%	85.5%	Positive
Uninsured	n/a	n/a	58.0%	57.9%	70.1%	Positive

*Preventive Dental Visit – Child by Household Income-Poverty Ratio*

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	60.0%	60.6%	71.2%	Positive
100%-199%	n/a	n/a	79.2%	76.5%	79.8%	Positive
200%-399%	n/a	n/a	82.2%	81.3%	82.9%	Positive
≥400%	n/a	n/a	85.3%	82.9%	85.3%	No change

*Preventive Dental Visit – Child by Household Structure*

Household Structure	2018	2019	2020	2021	2022	Trend
Single parent	n/a	n/a	77.2%	75.5%	79.8%	Positive
Two-parent married	n/a	n/a	81.4%	79.8%	82.6%	Positive
Two-parent unmarried	n/a	n/a	66.5%	61.8%	65.6%	Negative
Other	n/a	n/a	67.8%	74.1%	92.4%	Positive

*Preventive Dental Visit – Child by Language*

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	78.6%	77.8%	81.7%	Positive
Non-English	n/a	n/a	77.9%	72.2%	75.5%	Negative

*Preventive Dental Visit – Child by Nativity*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	78.6%	78.0%	81.9%	Positive
Not Born in U.S.	n/a	n/a	82.2%	77.0%	78.2%	Negative

*Preventive Dental Visit – Child by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	n/a	79.7%	79.2%	81.6%	Positive
Non-Hispanic Black	n/a	n/a	76.4%	67.2%	72.4%	Negative
Hispanic	n/a	n/a	77.6%	75.2%	80.9%	Positive
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	76.4%	85.3%	87.8%	Positive
Non-Hispanic Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	76.1%	68.9%	80.1%	Positive

*Preventive Dental Visit – Child by Sex*

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	78.9%	76.2%	79.6%	Positive
Male	n/a	n/a	78.4%	78.4%	78.4%	No change

*Preventive Dental Visit – Child by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	78.5%	77.6%	82.5%	Positive
MSA, Non-Central City	n/a	n/a	82.3%	81.0%	83.6%	Positive
Non-MSA	n/a	n/a	74.4%	72.5%	76.0%	Positive

*Tobacco Use (Percent of adolescents, grades 9 through 12, who currently use tobacco products) (LC-23: Family Wellbeing: Adolescent Smoking) (HP2030: TU-04: 11.3%)*

Tobacco Use	2011	2013	2017	2019	2021	Trend
Total	18.8%	15.1%	15.6%	21.3%	15.1%	Negative

*Tobacco Use by Sexual Orientation*

Sexual Orientation	2011	2013	2017	2019	2021	Trend
Heterosexual	n/a	n/a	n/a	n/a	11.6%	n/a
Lesbian, Gay, Bisexual	n/a	n/a	n/a	n/a	25.1%	n/a
Other, Questioning	n/a	n/a	n/a	n/a	23.8%	n/a

*Tobacco Use by Sex*

Sex	2011	2013	2017	2019	2021	Trend
Female	n/a	n/a	n/a	n/a	15.0%	n/a
Male	n/a	n/a	n/a	n/a	13.7%	n/a

#### Tobacco Use by Race/Ethnicity

Race/Ethnicity	2011	2013	2017	2019	2021	Trend
Non-Hispanic White	n/a	n/a	n/a	n/a	14.0%	n/a
Non-Hispanic Black	n/a	n/a	n/a	n/a	16.9%	n/a
Hispanic	n/a	n/a	n/a	n/a	13.6%	n/a
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	14.5%	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	16.2%	n/a
Non-Hispanic Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	n/a	17.8%	n/a

#### Tobacco Use by Grade

Grade	2011	2013	2017	2019	2021	Trend
9th grade	n/a	n/a	n/a	n/a	13.4%	n/a
10th grade	n/a	n/a	n/a	n/a	10.1%	n/a
11th grade	n/a	n/a	n/a	n/a	15.9%	n/a
12th grade	n/a	n/a	n/a	n/a	19.8%	n/a

#### Transition Total (Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transitions to adult health care)

Total	2018	2019	2020	2021	2022	Trend
Total	22.3%	23.7%	23.9%	19.4%	20.1%	Negative
Component: Time Alone with Provider	n/a	n/a	43.5%	41.9%	42.1%	Negative
Component: Anticipatory Guidance if needed	n/a	n/a	29.4%	26.9%	23.5%	Negative
Component: Active Work with Child	n/a	n/a	63.7%	62.2%	65.7%	Positive

#### Transition by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	n/a	19.2%	13.6%	14.1%	Negative
1 ACE	n/a	n/a	22.7%	20.2%	23.3%	Positive
2+ ACEs	n/a	n/a	35.2%	29.5%	24.8%	Negative

#### Transition by CSHCN Status

CSHCN Status	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	n/a	32.9%	25.2%	24.3%	Negative
Non-CSHCN	n/a	n/a	20.8%	17.2%	18.5%	Negative

#### Transition by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	n/a	n/a	n/a	n/a	n/a	n/a
High School Graduate	n/a	n/a	25.6%	17.3%	22.5%	Negative
Some College	n/a	n/a	33.7%	19.6%	22.9%	Negative
College Graduate	n/a	n/a	24.1%	21.8%	20.8%	Negative

#### Transition by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Medicaid	n/a	n/a	21.4%	24.7%	21.4%	No change
Private	n/a	n/a	24.0%	17.6%	20.8%	Negative
Uninsured	n/a	n/a	38.9%	21.5%	n/a	n/a

#### Transition by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	32.4%	17.7%	20.3%	Negative
100%-199%	n/a	n/a	20.6%	19.4%	15.3%	Negative
200%-399%	n/a	n/a	20.2%	16.4%	20.0%	No change
>400%	n/a	n/a	25.8%	22.8%	22.9%	Negative

#### Transition by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Single parent	n/a	n/a	24.6%	20.0%	22.2%	Negative
Two-parent married	n/a	n/a	22.6%	15.8%	18.4%	Negative
Two-parent unmarried	n/a	n/a	n/a	n/a	n/a	n/a
Other	n/a	n/a	n/a	n/a	n/a	n/a

#### Transition by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	26.4%	20.8%	21.3%	Negative
Non-English	n/a	n/a	0.0%	2.0%	8.2%	Positive

#### Transition by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	25.8%	18.6%	21.9%	Negative
Not Born in U.S.	n/a	n/a	12.1%	11.3%	10.5%	Negative

#### Transition by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	n/a	26.6%	18.8%	19.9%	Negative
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Hispanic	n/a	n/a	16.4%	16.5%	19.3%	Positive
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	24.2%	32.9%	Positive

#### Transition by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	25.4%	18.5%	17.6%	Negative
Male	n/a	n/a	22.5%	20.1%	22.0%	No change

#### Transition by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	17.7%	15.7%	19.6%	Positive
MSA, Non-Central City	n/a	n/a	28.4%	20.4%	18.9%	Negative
Non-MSA	n/a	n/a	28.1%	23.0%	22.2%	Negative

Adolescent Depression/Anxiety Total (Percent of adolescents, ages 12 through 17, who have depression or anxiety) (LC-2: Mental Health: Depression Among Youth) (HP2030: MHMD-06: 44.9%, MHMD-08: 13.5%)

Total	2018	2019	2020	2021	2022	Trend
Total	18.2%	15.4%	15.0%	14.9%	17.4%	Positive

#### Adolescent Depression/Anxiety by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
None	n/a	n/a	10.8%	11.0%	8.0%	Positive
1 ACE	n/a	n/a	12.3%	16.8%	19.9%	Negative
2+ ACEs	n/a	n/a	27.6%	21.0%	27.9%	No change

#### Adolescent Depression/Anxiety by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	n/a	n/a	n/a	n/a	n/a	n/a
High School Graduate	n/a	n/a	14.2%	9.9%	12.6%	Positive
Some College	n/a	n/a	15.7%	12.0%	17.0%	Negative
College Graduate	n/a	n/a	17.8%	17.4%	19.8%	Negative

#### Adolescent Depression/Anxiety by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Medicaid	n/a	n/a	20.3%	21.3%	22.6%	Negative
Private	n/a	n/a	14.3%	13.8%	16.3%	Negative
Uninsured	n/a	n/a	7.4%	5.8%	n/a	n/a

#### Adolescent Depression/Anxiety by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	16.5%	14.2%	14.8%	Positive
100%-199%	n/a	n/a	17.6%	17.0%	15.7%	Positive
200%-399%	n/a	n/a	11.1%	14.4%	19.4%	Negative
>400%	n/a	n/a	17.1%	14.7%	17.6%	No change

#### Adolescent Depression/Anxiety by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Single parent	n/a	n/a	11.1%	14.6%	20.0%	Negative
Two-parent married	n/a	n/a	14.6%	13.6%	15.1%	No change
Two-parent unmarried	n/a	n/a	n/a	n/a	n/a	n/a
Other	n/a	n/a	n/a	n/a	n/a	n/a

#### Adolescent Depression/Anxiety by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	16.1%	15.6%	18.2%	Negative
Non-English	n/a	n/a	5.3%	8.0%	12.2%	Negative

#### Adolescent Depression/Anxiety by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	15.8%	15.4%	19.6%	Negative
Not Born in U.S.	n/a	n/a	6.3%	10.6%	9.4%	Negative

#### Adolescent Depression/Anxiety by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	n/a	17.9%	17.9%	20.2%	Negative
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Hispanic	n/a	n/a	4.9%	9.6%	15.5%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	7.0%	16.9%	Negative

#### Adolescent Depression/Anxiety by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	21.5%	18.4%	21.9%	No change
Male	n/a	n/a	9.0%	11.8%	13.8%	Negative

#### Adolescent Depression/Anxiety by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	11.1%	13.5%	18.9%	Negative
MSA, Non-Central City	n/a	n/a	19.2%	17.4%	18.9%	No change
Non-MSA	n/a	n/a	15.8%	14.0%	13.4%	Positive

#### Adolescent Firearm Death Total (Adolescent firearm death rate, ages 10 through 19, per 100,000) (HP2030: IVP-12: 3.7%)

Total	2018	2019	2020	2021	2022	Trend
Total	8.9	9.9	11.8	14.0	13.7	Positive*

#### Adolescent Firearm Death by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
10-14 Years	n/a	n/a	2.6	3.2	3.7	Negative
15-19 Years	n/a	n/a	19.0	21.5	20.1	Negative

#### Adolescent Firearm Death by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	n/a	n/a	n/a	8.9	n/a
Non-Hispanic Black	n/a	n/a	n/a	n/a	37.4	n/a
Hispanic	n/a	n/a	n/a	n/a	14.3	n/a
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	n/a	9.8	n/a

#### Adolescent Firearm Death by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	2.8	3.5	3.7	Negative
Male	n/a	n/a	18.4	20.7	19.7	Negative

#### Adolescent Firearm Death by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Non-Metro	n/a	n/a	8.4	11.5	10.6	Negative
Small/Medium Metro	n/a	n/a	11.4	12.9	13.2	Negative
Large Fringe Metro	n/a	n/a	12.5	12.4	11.7	Positive

#### Adolescent Mortality Total (Adolescent mortality rate ages 10 through 19 per 100,000) (HP2030: MICH-03: 18.4%)

Total	2018	2019	2020	2021	2022	Trend
Total	39.9	37.7	46.3	49.7	47.3	Negative

#### Adolescent Mortality by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
10-14 Years	n/a	n/a	17.8	18.1	19.7	Negative
15-19 Years	n/a	n/a	64.8	71.2	75.7	Negative

#### Adolescent Mortality by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	n/a	37.7	39.3	41.7	Negative
Non-Hispanic Black	n/a	n/a	80.3	97.3	108.1	Negative
Hispanic	n/a	n/a	44.3	51.4	54.7	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	28.9	n/a	n/a	n/a
Non-Hispanic Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	26.9	27.8	22.4	Positive

#### Adolescent Mortality by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	27.4	28.0	28.6	Negative
Male	n/a	n/a	54.4	60.3	65.9	Negative

#### Adolescent Mortality by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Non-Metro	n/a	n/a	42.0	46.9	47.1	Negative
Small/Medium Metro	n/a	n/a	40.7	46.0	50.2	Negative
Large Fringe Metro	n/a	n/a	41.5	40.5	45.5	Negative

#### Adolescent Motor Vehicle Death Total (Adolescent motor vehicle mortality rate ages 15 through 19 per 100,000) (HP2030: IVP-06: 10.1 per 100,000)

Total	2018	2019	2020	2021	2022	Trend
Total	14.3	14.8	12.5	12.4	12.4	Positive

#### Adolescent Motor Vehicle Death by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	n/a	n/a	n/a	14.4	n/a
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Hispanic	n/a	n/a	n/a	n/a	14.7	n/a
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	n/a	n/a	n/a

#### Adolescent Motor Vehicle Death by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	9.9	10.5	10.4	No change
Male	n/a	n/a	16.0	16.3	15.8	No change

#### Adolescent Motor Vehicle Death by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Non-Metro	n/a	n/a	17.6	18.9	18.2	Negative
Small/Medium Metro	n/a	n/a	11.3	11.0	11.9	Negative
Large Fringe Metro	n/a	n/a	10.5	11.1	9.6	Positive

#### Adolescent Suicide Total (Adolescent suicide rate ages 10 through 19 per 100,000) (LC-45: Mental Health: Suicide) (HP2030: MHMD-01: 12.8 per 100,000)

Total	2018	2019	2020	2021	2022	Trend
Total	10.7	11.6	11.6	11.2	10.6	Positive

#### Adolescent Suicide by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
10-14 Years	n/a	n/a	3.6	3.9	3.5	No change
15-19 Years	n/a	n/a	18.1	19.1	18.7	Negative

#### Adolescent Suicide by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	n/a	n/a	n/a	11.0	n/a
Non-Hispanic Black	n/a	n/a	n/a	n/a	15.4	n/a
Hispanic	n/a	n/a	n/a	n/a	10.1	n/a
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	n/a	n/a	n/a

#### Adolescent Suicide by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	5.9	5.8	5.4	No change
Male	n/a	n/a	15.6	16.8	16.4	Negative

#### Adolescent Suicide by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Non-Metro	n/a	n/a	11.9	14.1	13.2	Negative
Small/Medium Metro	n/a	n/a	10.9	10.8	10.7	No change
Large Fringe Metro	n/a	n/a	9.7	9.6	9.4	No change

#### Adverse Childhood Experiences Total (Percent of children, ages 0 through 17, who have experienced 2 or more Adverse Childhood Experiences) (LC-2: Childhood Experiences: Prevalence of Adverse Childhood Experiences Among Children) (HP2030: IVP-D03)

Total	2018	2019	2020	2021	2022	Trend
Total	20.8%	19.3%	19.1%	20.4%	21.9%	Negative

#### Adverse Childhood Experiences by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	n/a	10.1%	11.0%	13.2%	Negative
6-11 Years	n/a	n/a	22.6%	21.6%	16.9%	Positive
12-17 Years	n/a	n/a	23.9%	27.8%	34.3%	Negative

#### Adverse Childhood Experiences by CSHCN Status

Child Age	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	n/a	37.9%	36.5%	35.9%	Positive
Non-CSHCN	n/a	n/a	14.6%	16.2%	17.9%	Negative

#### Adverse Childhood Experiences by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
Less than High School	n/a	n/a	12.8%	29.0%	18.5%	Negative
High School Graduate	n/a	n/a	28.6%	27.2%	31.4%	Negative
Some College	n/a	n/a	31.2%	31.3%	33.4%	Negative
College Graduate	n/a	n/a	12.7%	13.8%	15.3%	Negative

#### Adverse Childhood Experiences by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Medicaid	n/a	n/a	32.7%	37.8%	41.0%	Negative
Private	n/a	n/a	12.2%	13.6%	14.3%	Negative
Uninsured	n/a	n/a	27.9%	13.8%	10.1%	Positive

#### Adverse Childhood Experiences by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	32.6%	33.7%	36.8%	Negative
100%-199%	n/a	n/a	24.9%	27.4%	28.4%	Negative
200%-399%	n/a	n/a	16.6%	17.9%	19.8%	Negative
>400%	n/a	n/a	9.8%	11.1%	12.2%	Negative

#### Adverse Childhood Experiences by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Single parent	n/a	n/a	42.3%	45.6%	49.4%	Negative
Two-parent married	n/a	n/a	7.9%	8.6%	10.3%	Negative
Two-parent unmarried	n/a	n/a	34.8%	41.4%	43.9%	Negative
Other	n/a	n/a	60.8%	79.0%	53.2%	Positive

#### Adverse Childhood Experiences by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	20.5%	21.4%	22.2%	Negative
Non-English	n/a	n/a	7.5%	12.0%	18.7%	Negative

#### Adverse Childhood Experiences by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	18.7%	19.0%	21.3%	Negative
Not Born in U.S.	n/a	n/a	10.6%	16.4%	18.7%	Negative

#### Adverse Childhood Experiences by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	n/a	17.5%	16.8%	18.1%	Negative
Non-Hispanic Black	n/a	n/a	25.8%	35.7%	35.4%	Negative
Hispanic	n/a	n/a	16.9%	24.4%	29.6%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	7.2%	8.6%	11.3%	Negative
Non-Hispanic Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	40.9%	37.8%	27.1%	Positive

#### Adverse Childhood Experiences by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	21.8%	20.1%	20.3%	Positive
Male	n/a	n/a	16.1%	20.7%	23.4%	Negative

#### Adverse Childhood Experiences by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	20.3%	18.9%	23.3%	Negative
MSA, Non-Central City	n/a	n/a	18.5%	17.8%	17.0%	Positive
Non-MSA	n/a	n/a	18.1%	25.6%	26.6%	Negative

#### CSHCN Systems of Care by Component (Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system) (HP2030: MICH-20: 19.5%)

Component	2018	2019	2020	2021	2022	Trend
Component: Continuous and Adequate Insurance	n/a	n/a	59.4%	59.6%	55.7%	Negative
Component: Ease of Access	n/a	n/a	88.0%	88.9%	88.8%	Positive
Component: Medical Home	n/a	n/a	56.9%	49.0%	50.2%	Negative
Component: Preventive Medical and Dental Care	n/a	n/a	72.0%	71.9%	78.7%	Positive
Component: Shared Decision-Making if needed	n/a	n/a	85.0%	85.5%	86.4%	Positive
Component: Transition among Adolescents	n/a	n/a	32.9%	25.2%	24.3%	Negative
Total	19.5%	20.9%	18.7%	14.2%	14.7%	Negative*

#### CSHCN Systems of Care by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
1 ACE	n/a	n/a	14.3%	12.5%	16.1%	Positive
2+ ACEs	n/a	n/a	15.1%	15.3%	11.3%	Negative
None	n/a	n/a	24.9%	14.1%	16.9%	Negative

#### CSHCN Systems of Care by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	n/a	35.1%	9.4%	14.7%	Negative
6-11 Years	n/a	n/a	20.6%	23.4%	24.7%	Positive
12-17 Years	n/a	n/a	12.3%	7.5%	5.6%	Negative

#### CSHCN Systems of Care by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
College graduate	n/a	n/a	16.2%	11.0%	12.1%	Negative
High school graduate	n/a	n/a	10.8%	5.3%	18.0%	Positive
Less than high school	n/a	n/a	n/a	n/a	n/a	n/a
Some college	n/a	n/a	16.1%	20.6%	13.9%	Negative

#### CSHCN Systems of Care by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	26.8%	11.6%	19.6%	Negative
100%-199%	n/a	n/a	18.0%	15.8%	10.3%	Negative
200%-399%	n/a	n/a	19.4%	16.2%	14.6%	Negative
>400%	n/a	n/a	13.2%	12.1%	14.9%	Positive

#### CSHCN Systems of Care by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Single parent	n/a	n/a	19.7%	18.0%	14.4%	Negative
Two-parent married	n/a	n/a	17.5%	11.8%	15.8%	Negative
Two-parent unmarried	n/a	n/a	n/a	n/a	n/a	n/a
Other	n/a	n/a	n/a	n/a	n/a	n/a

*CSHCN Systems of Care by Language*

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	17.4%	13.1%	14.1%	Negative
Non-English	n/a	n/a	n/a	n/a	n/a	n/a

*CSHCN Systems of Care by Nativity*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	14.9%	14.2%	14.5%	No change
Not Born in U.S.	n/a	n/a	n/a	15.2%	19.6%	Positive

*CSHCN Systems of Care by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Non-Hispanic White	n/a	n/a	16.3%	12.5%	12.5%	Negative
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Hispanic	n/a	n/a	n/a	21.8%	17.6%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	7.2%	8.6%	11.3%	Positive
Non-Hispanic Native Hawaiian/ Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	17.7%	19.9%	Positive

*CSHCN Systems of Care by Sex*

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	21.2%	11.1%	8.6%	Negative
Male	n/a	n/a	16.1%	16.5%	19.2%	Positive

*CSHCN Systems of Care by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	18.4%	15.9%	14.4%	Negative
MSA, Non-Central City	n/a	n/a	23.1%	13.3%	14.5%	Negative
Non-MSA	n/a	n/a	13.7%	12.9%	15.4%	Positive

*Flourishing - Child Adolescent – All Total (Percent of children with and without special health care needs, ages 6 through 17 years, who are flourishing)*

Total	2018	2019	2020	2021	2022	Trend
Total	n/a	72.5%	66.9%	61.4%	63.4%	Negative

*Flourishing - Child Adolescent – All by Adverse Childhood Experiences*

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
1 ACE	n/a	n/a	65.0%	59.1%	61.0%	Negative
2+ ACEs	n/a	n/a	57.6%	54.4%	52.1%	Negative
None	n/a	n/a	71.1%	65.2%	69.8%	Negative

*Flourishing - Child Adolescent – All by Child Age*

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	n/a	n/a	n/a	n/a	n/a
6-11 Years	n/a	n/a	64.2%	62.5%	67.0%	Positive
12-17 Years	n/a	n/a	69.5%	60.3%	60.0%	Negative

*Flourishing - Child Adolescent – All by CSHCN Status*

Child Age	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	n/a	41.9%	37.8%	40.3%	Negative
Non-CSHCN	n/a	n/a	74.9%	69.7%	71.5%	Negative

*Flourishing - Child Adolescent – All by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
College graduate	n/a	n/a	67.1%	62.4%	63.6%	Negative
High school graduate	n/a	n/a	62.8%	56.8%	63.0%	No change
Less than high school	n/a	n/a	n/a	n/a	n/a	n/a
Some college	n/a	n/a	67.6%	63.5%	59.5%	Negative

*Flourishing - Child Adolescent – All by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Medicaid	n/a	n/a	67.1%	57.2%	62.1%	Negative
Private	n/a	n/a	68.0%	62.2%	63.0%	Negative
Uninsured	n/a	n/a	55.2%	69.4%	73.8%	Positive

*Flourishing - Child Adolescent – All by Household Income-Poverty Ratio*

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	64.8%	59.6%	67.5%	Positive
100%-199%	n/a	n/a	65.4%	58.4%	62.1%	Negative
200%-399%	n/a	n/a	66.3%	62.9%	61.7%	Negative
>400%	n/a	n/a	69.7%	62.7%	64.0%	Negative

*Flourishing - Child Adolescent – All by Household Structure*

Household Structure	2018	2019	2020	2021	2022	Trend
Single parent	n/a	n/a	65.3%	53.6%	58.2%	Negative
Two-parent married	n/a	n/a	67.3%	62.5%	64.3%	Negative
Two-parent unmarried	n/a	n/a	73.4%	77.1%	77.9%	Positive
Other	n/a	n/a	62.8%	68.8%	68.0%	Positive

*Flourishing - Child Adolescent – All by Language*

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	66.7%	61.4%	63.0%	Negative
Non-English	n/a	n/a	66.4%	63.5%	67.8%	Positive

*Flourishing - Child Adolescent – All by Nativity*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	65.4%	60.0%	61.7%	Negative
Not Born in U.S.	n/a	n/a	76.8%	67.5%	70.1%	Negative

*Flourishing - Child Adolescent – All by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	n/a	80.0%	71.0%	68.2%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	65.5%	47.1%	54.3%	Negative
Non-Hispanic Black	n/a	n/a	n/a	71.0%	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	54.4%	51.6%	64.7%	Positive
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	n/a	64.9%	59.3%	61.3%	Negative

*Flourishing - Child Adolescent – All by Sex*

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	69.3%	64.9%	65.7%	Negative
Male	n/a	n/a	64.4%	58.2%	61.4%	Negative

*Flourishing - Child Adolescent – All by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	66.6%	59.4%	64.3%	Negative
MSA, Non-Central City	n/a	n/a	65.0%	60.8%	59.4%	Negative
Non-MSA	n/a	n/a	69.7%	64.8%	67.7%	Negative

*Flourishing - Child Adolescent – CSHCN Total*

Total	2018	2019	2020	2021	2022	Trend
Total	n/a	51.2%	41.9%	37.8%	40.3%	Negative

*Flourishing - Child Adolescent – CSHCN by Adverse Childhood Experiences*

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
1 ACE	n/a	n/a	41.2%	38.0%	39.1%	Negative
2+ ACEs	n/a	n/a	40.3%	39.2%	33.6%	Negative
None	n/a	n/a	44.5%	36.4%	47.2%	Positive

*Flourishing - Child Adolescent – CSHCN by Child Age*

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	n/a	n/a	n/a	n/a	n/a
6-11 Years	n/a	n/a	38.4%	36.4%	45.8%	Positive
12-17 Years	n/a	n/a	44.9%	39.1%	35.4%	Negative

*Flourishing - Child Adolescent – CSHCN by Education Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
College graduate	n/a	n/a	44.6%	39.5%	39.5%	Negative
High school graduate	n/a	n/a	26.5%	32.1%	41.7%	Positive
Less than high school	n/a	n/a	n/a	n/a	n/a	n/a
Some college	n/a	n/a	42.7%	38.1%	38.7%	Negative

*Flourishing - Child Adolescent – CSHCN by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Medicaid	n/a	n/a	37.0%	34.6%	36.5%	No change
Private	n/a	n/a	47.3%	39.3%	41.9%	Negative
Uninsured	n/a	n/a	n/a	n/a	n/a	n/a

*Flourishing - Child Adolescent – CSHCN by Household Income-Poverty Ratio*

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	n/a	39.0%	47.9%	Positive
100%-199%	n/a	n/a	43.3%	33.8%	40.1%	Negative
200%-399%	n/a	n/a	40.2%	42.8%	42.1%	Positive
>400%	n/a	n/a	49.4%	33.7%	35.4%	Negative

*Flourishing - Child Adolescent – CSHCN by Household Structure*

Household Structure	2018	2019	2020	2021	2022	Trend
Single parent	n/a	n/a	37.8%	26.2%	39.5%	Positive
Two-parent married	n/a	n/a	37.3%	34.0%	38.8%	Positive
Two-parent unmarried	n/a	n/a	n/a	n/a	n/a	n/a
Other	n/a	n/a	n/a	n/a	n/a	n/a

*Flourishing - Child Adolescent – CSHCN by Language*

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	40.9%	37.3%	38.5%	Negative
Non-English	n/a	n/a	n/a	n/a	n/a	n/a

*Flourishing - Child Adolescent – CSHCN by Nativity*

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	36.3%	32.5%	36.6%	No change
Not Born in U.S.	n/a	n/a	n/a	53.3%	63.0%	Positive

*Flourishing - Child Adolescent – CSHCN by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	n/a	n/a	57.5%	47.9%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Black	n/a	n/a	n/a	71.0%	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	59.5%	51.5%	
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	n/a	36.6%	32.3%	35.9%	Negative

*Flourishing - Child Adolescent – CSHCN by Sex*

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	44.2%	43.4%	42.3%	Negative
Male	n/a	n/a	39.6%	33.4%	38.8%	Negative

*Flourishing - Child Adolescent – CSHCN by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	29.9%	30.2%	37.5%	Positive
MSA, Non-Central City	n/a	n/a	47.9%	46.5%	43.3%	Negative
Non-MSA	n/a	n/a	49.8%	38.1%	39.4%	Negative

*Injury Hospitalization – Adolescent Total (Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19)*

Total	2018	2019	2020	2021	2022	Trend
Total	n/a	278.2	271.0	270.9	n/a	Positive

*Injury Hospitalization - Adolescent*

Child Age	2018	2019	2020	2021	2022	Trend
10-14 Years	n/a	156.1	158.5	163.5	n/a	Negative
15-19 Years	n/a	400.0	383.8	378.7	n/a	Positive

#### Injury Hospitalization – Adolescent by Injury Intent

Injury Intent	2018	2019	2020	2021	2022	Trend
Intentional, assault	n/a	15.0	14.0	12.1	n/a	Positive
Intentional, self-harm	n/a	109.1	106.4	102.1	n/a	Positive
Other/Unknown	n/a	3.2	4.5	5.3	n/a	Negative
Unintentional	n/a	150.6	147.7	152.5	n/a	Negative

#### Injury Hospitalization – Adolescent by Mechanism of Injury

Injury Intent	2018	2019	2020	2021	2022	Trend
Cut or pierce	n/a	8.0	10.3	5.8	n/a	Positive
Drowning or submersion	n/a	n/a	n/a	n/a	n/a	n/a
Fall	n/a	25.7	23.8	24.0	n/a	Positive
Fire, flame, hot object, or hot substance	n/a	n/a	4.5	5.1	n/a	n/a
Firearm	n/a	19.2	19.0	14.8	n/a	Positive
Machinery	n/a	n/a	n/a	n/a	n/a	n/a
Motor Vehicle Traffic (MVT)	n/a	45.0	48.1	48.5	n/a	Negative
Natural or environment, including bites	n/a	4.5	3.5	6.5	n/a	Negative
Other/Unknown	n/a	26.2	18.8	25.5	n/a	Positive
Overexertion	n/a	n/a	n/a	n/a	n/a	n/a
Poisoning	n/a	118.6	120.6	119.6	n/a	Negative
Struck by or against	n/a	14.0	8.0	12.6	n/a	Positive
Suffocation	n/a	2.7	n/a	n/a	n/a	n/a
Transportation (not MVT)	n/a	21.5	23.0	16.7	n/a	Positive

#### *Injury Hospitalization – Adolescent by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	200.4	180.0	199.8	n/a	Positive
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian/Pacific Islander	n/a	164.9	109.4	132.4	n/a	Positive
Non-Hispanic Black	n/a	452.2	516.8	483.4	n/a	Negative
Non-Hispanic White	n/a	265.4	264.3	255.5	n/a	Positive
Other	n/a	343.8	291.2	270.0	n/a	Positive

#### *Injury Hospitalization – Adolescent by Sex*

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	274.4	282.8	292.6	n/a	Negative
Male	n/a	281.8	260.0	250.4	n/a	Positive

#### *Injury Hospitalization – Adolescent by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Metro	n/a	282.0	258.9	240.9	n/a	Positive
Non-Metro	n/a	261.0	246.9	239.4	n/a	Positive
Small/Medium Metro	n/a	289.3	300.0	315.6	n/a	Negative

*Obesity - Ages 6 thru 17 years Total (Percent of children, ages 6 through 17, who are obese (BMI at or above the 95th percentile)) (LC-32A: Family Wellbeing: Obesity) (HP2030: NWS-04: 15.5%)*

Total	2018	2019	2020	2021	2022	Trend
Total	n/a	n/a	14.6%	14.5%	14.9%	No change

#### *Obesity - Ages 6 thru 17 years by Adverse Childhood Experiences*

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
1 ACE	n/a	n/a	14.3%	16.7%	19.0%	Negative
2+ ACEs	n/a	n/a	18.8%	20.3%	16.7%	Positive
None	n/a	n/a	13.3%	11.4%	12.5%	Positive

*Obesity - Ages 6 thru 17 years by Child Age*

Child Age	2018	2019	2020	2021	2022	Trend
6-11 Years	n/a	n/a	16.6%	15.4%	16.9%	No change
12-17 Years	n/a	n/a	12.8%	13.7%	13.0%	No change

*Obesity - Ages 6 thru 17 years by CSHCN Status*

Child Age	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	n/a	16.3%	18.4%	16.7%	No change
Non-CSHCN	n/a	n/a	14.1%	13.1%	14.2%	No change

*Obesity - Ages 6 thru 17 years by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
College graduate	n/a	n/a	9.9%	9.7%	10.4%	No change
High school graduate	n/a	n/a	20.5%	18.1%	23.9%	Negative
Less than high school	n/a	n/a	n/a	n/a	n/a	n/a
Some college	n/a	n/a	18.0%	15.7%	11.7%	Positive

*Obesity - Ages 6 thru 17 years by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Medicaid	n/a	n/a	16.6%	22.1%	20.6%	Negative
Private	n/a	n/a	12.0%	10.7%	11.4%	Positive
Uninsured	n/a	n/a	28.2%	21.6%	28.7%	Negative

*Obesity - Ages 6 thru 17 years by Household Income-Poverty Ratio*

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	22.1%	24.5%	23.8%	Negative
100%-199%	n/a	n/a	14.5%	13.2%	18.7%	Negative
200%-399%	n/a	n/a	14.6%	13.8%	13.7%	Positive
>400%	n/a	n/a	10.8%	11.0%	9.6%	Positive

Obesity - Ages 6 thru 17 years by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Other	n/a	n/a	31.6%	19.1%	12.1%	Positive
Single parent	n/a	n/a	20.1%	22.5%	20.0%	No change
Two-parent married	n/a	n/a	10.6%	11.0%	12.8%	Negative
Two-parent unmarried	n/a	n/a	22.9%	24.1%	27.6%	Negative

Obesity - Ages 6 thru 17 years by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	14.2%	13.0%	13.3%	Positive
Non-English	n/a	n/a	20.6%	28.2%	26.7%	Negative

Obesity - Ages 6 thru 17 years by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	13.8%	13.2%	12.9%	Positive
Not Born in U.S.	n/a	n/a	13.3%	19.0%	23.2%	Negative

Obesity - Ages 6 thru 17 years by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	n/a	12.7%	23.9%	25.8%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	10.9%	11.4%	14.7%	Negative
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	18.2%	10.9%	14.3%	Positive
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	n/a	13.3%	12.1%	10.8%	Positive

*Obesity - Ages 6 thru 17 years by Sex*

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	13.0%	12.1%	13.2%	No change
Male	n/a	n/a	16.3%	16.8%	16.4%	No change

*Obesity - Ages 6 thru 17 years by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	15.6%	16.8%	15.1%	No change
MSA, Non-Central City	n/a	n/a	12.4%	9.7%	14.3%	Negative
Non-MSA	n/a	n/a	16.3%	17.7%	15.3%	Positive

*Overall Health Status Total (Percent of children, ages 0 through 17, in excellent or very good health)*

Total	2018	2019	2020	2021	2022	Trend
Total	n/a	n/a	91.0%	90.9%	90.8%	No change

*Overall Health Status by Adverse Childhood Experiences*

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
1 ACE	n/a	n/a	89.9%	89.6%	89.5%	No change
2+ ACEs	n/a	n/a	80.4%	78.4%	84.3%	Positive
None	n/a	n/a	94.6%	95.4%	93.3%	Negative

*Overall Health Status by Child Age*

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	n/a	91.7%	92.9%	92.5%	Positive
6-11 Years	n/a	n/a	94.5%	92.5%	91.6%	Negative
12-17 Years	n/a	n/a	87.1%	87.6%	88.5%	Positive

*Overall Health Status by CSHCN Status*

Child Age	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	n/a	77.8%	77.8%	77.6%	No change
Non-CSHCN	n/a	n/a	94.2%	94.3%	94.5%	No change

*Overall Health Status by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
College graduate	n/a	n/a	95.3%	94.3%	93.4%	Negative
High school graduate	n/a	n/a	86.9%	86.3%	90.1%	Positive
Less than high school	n/a	n/a	72.7%	73.8%	78.4%	Positive
Some college	n/a	n/a	91.2%	91.1%	88.0%	Negative

*Overall Health Status by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Medicaid	n/a	n/a	81.1%	80.0%	83.5%	Positive
Private	n/a	n/a	95.3%	95.6%	94.4%	Negative
Uninsured	n/a	n/a	93.2%	92.1%	85.6%	Negative

*Overall Health Status by Household Income-Poverty Ratio*

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	76.4%	77.7%	86.5%	Positive
100%-199%	n/a	n/a	89.5%	89.8%	86.9%	Negative
200%-399%	n/a	n/a	94.9%	93.6%	92.2%	Negative
>400%	n/a	n/a	96.3%	96.0%	94.0%	Negative

*Overall Health Status by Household Structure*

Household Structure	2018	2019	2020	2021	2022	Trend
Other	n/a	n/a	69.7%	68.9%	80.3%	Positive
Single parent	n/a	n/a	92.6%	86.0%	88.1%	Negative
Two-parent married	n/a	n/a	92.0%	93.7%	92.6%	Positive
Two-parent unmarried	n/a	n/a	94.3%	90.6%	87.4%	Negative

#### Overall Health Status by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	92.4%	92.4%	91.9%	No change
Non-English	n/a	n/a	85.3%	81.9%	82.1%	Negative

#### Overall Health Status by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	93.2%	92.8%	92.2%	Negative
Not Born in U.S.	n/a	n/a	87.4%	86.9%	84.9%	Negative

#### Overall Health Status by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	n/a	88.8%	85.5%	83.3%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	77.2%	88.7%	91.8%	Positive
Non-Hispanic Black	n/a	n/a	87.7%	82.6%	94.4%	Positive
Non-Hispanic Multiple Race	n/a	n/a	91.2%	91.1%	91.5%	No change
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	n/a	93.0%	93.0%	92.7%	No change

#### Overall Health Status by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	90.2%	92.3%	91.7%	Positive
Male	n/a	n/a	91.9%	89.7%	89.9%	Negative

#### Overall Health Status by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	90.2%	89.9%	90.8%	Positive
MSA, Non-Central City	n/a	n/a	93.7%	94.4%	91.5%	Negative
Non-MSA	n/a	n/a	89.0%	87.9%	89.7%	Positive

*Teen Births Total (Teen birth rate, ages 15 through 19, per 1,000 females) (LC-54: Reproductive Life Experiences: Teen Births) (HP2030: FP-01: 36.5%)*

Total	2018	2019	2020	2021	2022	Trend
Total	n/a	n/a	18.1%	16.3%	16.2%	Positive

*Teen Births by Maternal Age*

Maternal Age	2018	2019	2020	2021	2022	Trend
15-17 Years	n/a	n/a	6.7%	5.8%	6.5%	No change
18-19 Years	n/a	n/a	35.3%	32.2%	31.0%	Positive

*Teen Births by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	n/a	31.9%	28.9%	29.8%	Positive
Non-Hispanic American Indian/Alaska Native	n/a	n/a	15.4%	15.0%	n/a	n/a
Non-Hispanic Asian	n/a	n/a	5.4%	n/a	4.2%	n/a
Non-Hispanic Black	n/a	n/a	30.7%	32.0%	28.1%	Positive
Non-Hispanic Multiple Race	n/a	n/a	20.6%	15.3%	12.8%	Positive
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	n/a	13.7%	12.0%	12.1%	Positive

*Teen Births by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Large Fringe Metro	n/a	n/a	14.5%	11.7%	11.3%	Positive
Non-Metro	n/a	n/a	22.8%	21.3%	20.7%	Positive
Small/Medium Metro	n/a	n/a	17.2%	15.7%	16.2%	Positive

*Tooth Decay/Cavities Total (Percent of children, age 1-17 years, who had decayed teeth or cavities in the past year) (HP2030: OH-02: 10.2%, OH-01: 42.9%)*

Total	2018	2019	2020	2021	2022	Trend
Total	n/a	n/a	11.0%	12.1%	11.4%	No change

#### *Tooth Decay/Cavities by Adverse Childhood Experiences*

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
1 ACE	n/a	n/a	12.7%	13.1%	10.7%	Positive
2+ ACEs	n/a	n/a	11.3%	20.0%	21.5%	Negative
None	n/a	n/a	10.4%	9.2%	7.9%	Positive

#### *Tooth Decay/Cavities by Child Age*

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	n/a	8.3%	6.0%	7.6%	Positive
6-11 Years	n/a	n/a	14.5%	17.1%	14.9%	No change
12-17 Years	n/a	n/a	9.6%	12.0%	10.9%	Negative

#### *Tooth Decay/Cavities by CSHCN Status*

Child Age	2018	2019	2020	2021	2022	Trend
CSHCN	n/a	n/a	14.7%	18.2%	19.4%	Negative
Non-CSHCN	n/a	n/a	10.1%	10.4%	9.0%	Positive

#### *Tooth Decay/Cavities by Educational Attainment*

Educational Attainment	2018	2019	2020	2021	2022	Trend
College graduate	n/a	n/a	10.1%	9.4%	8.6%	Positive
High school graduate	n/a	n/a	11.8%	15.0%	14.4%	Negative
Less than high school	n/a	n/a	17.0%	22.4%	18.6%	Negative
Some college	n/a	n/a	9.9%	13.5%	14.2%	Negative

#### *Tooth Decay/Cavities by Health Insurance*

Health Insurance	2018	2019	2020	2021	2022	Trend
Medicaid	n/a	n/a	11.1%	18.0%	17.3%	Negative
Private	n/a	n/a	10.3%	9.7%	9.2%	Positive
Uninsured	n/a	n/a	18.5%	13.2%	7.8%	Positive

Tooth Decay/Cavities by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	11.8%	14.5%	16.6%	Negative
100%-199%	n/a	n/a	10.9%	13.8%	14.4%	Negative
200%-399%	n/a	n/a	11.5%	12.1%	9.3%	Positive
>400%	n/a	n/a	10.0%	9.6%	9.1%	Positive

Tooth Decay/Cavities by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Other	n/a	n/a	15.4%	25.4%	14.3%	Positive
Single parent	n/a	n/a	13.1%	15.3%	17.1%	Negative
Two-parent married	n/a	n/a	10.4%	10.7%	10.2%	No change
Two-parent unmarried	n/a	n/a	2.4%	6.7%	7.5%	Negative

Tooth Decay/Cavities by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	10.3%	11.5%	11.0%	Negative
Non-English	n/a	n/a	18.2%	16.8%	14.4%	Positive

Tooth Decay/Cavities by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	9.7%	11.1%	11.3%	Negative
Not Born in U.S.	n/a	n/a	11.8%	11.2%	12.8%	Negative

*Tooth Decay/Cavities by Race/Ethnicity*

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	n/a	9.6%	13.3%	18.4%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	25.7%	10.3%	5.1%	Positive
Non-Hispanic Black	n/a	n/a	19.7%	9.7%	6.4%	Positive
Non-Hispanic Multiple Race	n/a	n/a	15.7%	17.7%	6.3%	Positive
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	n/a	9.9%	11.6%	10.7%	Negative

*Tooth Decay/Cavities by Sex*

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	11.8%	10.0%	10.2%	Positive
Male	n/a	n/a	10.1%	14.0%	12.6%	Negative

*Tooth Decay/Cavities by Urban-Rural Residence*

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	13.8%	13.4%	12.6%	Positive
MSA, Non-Central City	n/a	n/a	10.4%	10.6%	10.1%	No change
Non-MSA	n/a	n/a	7.8%	12.3%	11.7%	Negative

*Women's Health Status Total (Percent of women, ages 18 through 44, in excellent or very good health)*

Total	2018	2019	2020	2021	2022	Trend
Total	n/a	n/a	59.7%	58.8%	51.9%	Negative

#### Women's Health Status by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
College graduate	n/a	n/a	74.1%	68.3%	65.8%	Negative
High school graduate	n/a	n/a	55.0%	52.1%	41.2%	Negative
Less than high school	n/a	n/a	40.2%	48.0%	27.1%	Negative
Some college	n/a	n/a	55.9%	57.7%	52.9%	Negative

#### Women's Health Status by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Insured	n/a	n/a	62.4%	60.6%	52.6%	Negative
Uninsured	n/a	n/a	43.0%	46.8%	36.7%	Negative

#### Women's Health Status by Household Income/Poverty

Household Income/Poverty	2018	2019	2020	2021	2022	Trend
<\$25,000	n/a	n/a	45.5%	44.9%	34.2%	Negative
≥\$75,000	n/a	n/a	74.4%	62.9%	65.4%	Negative
\$25,000-\$49,999	n/a	n/a	56.2%	51.3%	50.3%	Negative
\$50,000-\$74,999	n/a	n/a	61.4%	62.0%	43.9%	Negative

#### Women's Health Status by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	59.7%	58.8%	51.6%	Negative
Non-English	n/a	n/a	n/a	n/a	n/a	n/a

#### Women's Health Status by Marital Status

Marital Status	2018	2019	2020	2021	2022	Trend
Married	n/a	n/a	64.2%	63.9%	59.0%	Negative
Unmarried	n/a	n/a	55.7%	54.4%	45.7%	Negative

### Women's Health Status by Maternal Age

Maternal Age	2018	2019	2020	2021	2022	Trend
18-24 Years	n/a	n/a	62.4%	62.3%	53.7%	Negative
25-34 Years	n/a	n/a	59.7%	59.1%	51.6%	Negative
35-44 Years	n/a	n/a	57.5%	55.7%	50.6%	Negative

### Women's Health Status by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	n/a	45.7%	54.0%	55.9%	Positive
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	69.5%	70.7%	n/a	n/a
Non-Hispanic Black	n/a	n/a	55.7%	40.2%	33.6%	Negative
Non-Hispanic Multiple Race	n/a	n/a	48.3%	45.1%	41.8%	Negative
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	n/a	64.0%	61.9%	53.0%	Negative

### Women's Health Status by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
Metro	n/a	n/a	59.9%	59.2%	52.7%	Negative
Non-Metro	n/a	n/a	59.3%	57.8%	50.0%	Negative

#### Sources:

1. Health Resources and Services Administration (HRSA). Federally Available Data (FAD) 2025/2023. <https://mchb.tvisdata.hrsa.gov/Home/FADDdocuments>.
2. National Survey of Children's Health (NSCH), 2018-2022. <https://www.childhealthdata.org/learn-about-the-nsch/NSCH/data>
3. Kansas Maternal and Child Health Services Title V Block Grant. <https://www.kdhe.ks.gov/626/Maternal-Child-Health-Block-Grant>
4. Life Course Indicators Online Tool at The Association of Maternal and Child Health Programs (AMCHP). <https://amchp.org/resources/life-course-indicators-online-tool/>
5. Healthy People 2030. Leading Health Indicators and objectives. <https://odphp.health.gov/healthypeople/objectives-and-data/find-objectives>

## Appendix E.5 Children and Youth With Special Health Care Needs Health Population Domain

National Performance Measures (blue tables) / National Outcome Measures (green tables). 2026 Application/2024 Annual Report

### Key and Definitions

**NPM:** National Performance Measure (blue tables)

**NOM:** National Outcome Measure (green tables)

**n/a:** Indicates the data were not available at the time of report.

**HP2030:** Healthy People 2030 goal

**LC-##:** Life Course Indicators

\* Statistically significant trend is indicated by a “\*” (p<0.05) – for measures with 5 years of data, assessed by Joinpoint Regression software version 5.2.0, using Annual Percent Change (APC) method. All others with less than 5 years of data were assessed by the direction of the change between the first and last data point and was not measured for significance. For measures where the latest year was not provided, a trend was not assessed on prior year values where there was less than 3 years of prior data. Trends were indicated as 'no change' when the difference between data points were within plus or minus 0.5 difference. N/A was listed for any trend that was not able to be assessed or where there was missing data.

\*\*FAD estimates are collated by HRSA from several different federal agencies. The tables in this report are the attempt to organize these for easier understanding. Some estimates by stratifiers are calculated with three-year data, while others may use five-year data to improve precision and reportability. Further details about a specific measure(s)' originating agency and additional data notes can be found in the NPM and NOM Data Notes tab of the FAD data Excel files<sup>1</sup>. Measures with an associated HP2030 goal or LC Indicator were indicated for those with similar health objectives. Not all FAD measures had HP2030 goals or LC indicators that could be associated to them.

\*\*\* All data should be interpreted with caution for any use in programmatic decision making.

Medical Home (Percent of children with special health care needs, ages 0 through 17, who have a medical home) (LC-37: Health Care Access and Quality: Medical Home for Children) (HP2030: MICH-20: 19.5%)

Total	2018	2019	2020	2021	2022	Trend
Total	53.2%	55.9%	56.9%	49.0%	50.2%	Negative

Medical Home by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
1 ACE	n/a	n/a	43.1%	44.4%	58.7%	Positive
2+ ACEs	n/a	n/a	55.5%	44.7%	39.4%	Negative
None	n/a	n/a	66.4%	56.0%	54.9%	Negative

Medical Home by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	n/a	63.9%	35.1%	36.4%	Negative
6-11 Years	n/a	n/a	50.4%	50.6%	51.0%	Positive
12-17 Years	n/a	n/a	60.0%	52.3%	55.7%	Negative

Medical Home by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
College graduate	n/a	n/a	58.5%	54.7%	55.9%	Negative
High school graduate	n/a	n/a	50.2%	24.2%	36.6%	Negative
Less than high school	n/a	n/a	n/a	n/a	n/a	n/a
Some college	n/a	n/a	55.3%	46.8%	43.8%	Negative

Medical Home by Health Insurance

CSHCN Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	n/a	51.7%	35.3%	35.5%	Negative
Medicaid	n/a	n/a	64.9%	60.6%	60.0%	Negative
Uninsured	n/a	n/a	n/a	n/a	n/a	n/a

Medical Home by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	59.2%	43.6%	44.0%	Negative
100%-199%	n/a	n/a	46.9%	33.4%	38.8%	Negative
200%-399%	n/a	n/a	63.5%	55.6%	54.9%	Negative
≥400%	n/a	n/a	55.7%	56.3%	56.4%	Positive

Medical Home by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Other	n/a	n/a	n/a	n/a	n/a	n/a
Single parent	n/a	n/a	46.6%	43.5%	41.2%	Negative
Two-parent married	n/a	n/a	59.6%	51.6%	56.1%	Negative
Two-parent unmarried	n/a	n/a	n/a	n/a	n/a	n/a

Medical Home by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	57.7%	48.9%	50.4%	Negative
Non-English	n/a	n/a	n/a	n/a	n/a	n/a

Medical Home by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	54.3%	48.4%	51.7%	Negative
Born outside U.S.	n/a	n/a	n/a	61.4%	47.8%	Negative

Medical Home by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	n/a	n/a	43.3%	35.5%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	66.0%	68.4%	Positive
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	n/a	52.7%	47.9%	51.3%	Negative

Medical Home by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	53.5%	44.7%	48.2%	Negative
Male	n/a	n/a	60.5%	52.2%	51.7%	Negative

Medical Home by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	49.9%	41.2%	45.5%	Negative
MSA, Non-Central City	n/a	n/a	63.8%	55.8%	53.3%	Negative
Non-MSA	n/a	n/a	57.1%	51.1%	52.3%	Negative

Medical Home - Care Coordination Total (Percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination) (LC-37: Health Care Access and Quality: Medical Home for Children) (HP2030: MICH-19: 53.6%)

Total	2018	2019	2020	2021	2022	Trend
Total	66.1%	65.7%	66.2%	59.6%	60.4%	Negative

Medical Home - Care Coordination by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
1 ACE	n/a	n/a	67.9%	62.7%	67.0%	Negative
2+ ACEs	n/a	n/a	53.9%	47.2%	50.1%	Negative
None	n/a	n/a	76.8%	68.5%	66.4%	Negative

Medical Home - Care Coordination by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	n/a	n/a	44.8%	47.0%	Positive
6-11 Years	n/a	n/a	58.4%	67.8%	64.2%	Positive
12-17 Years	n/a	n/a	70.9%	57.5%	63.1%	Negative

Medical Home - Care Coordination by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
College graduate	n/a	n/a	62.7%	59.4%	63.1%	No change
High school graduate	n/a	n/a	n/a	57.7%	57.2%	No change
Less than high school	n/a	n/a	n/a	n/a	n/a	n/a
Some college	n/a	n/a	64.4%	61.9%	56.9%	Negative

Medical Home - Care Coordination by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	n/a	67.3%	52.4%	53.9%	Negative
Medicaid	n/a	n/a	68.8%	63.8%	65.2%	Negative
Uninsured	n/a	n/a	n/a	n/a	n/a	n/a

Medical Home - Care Coordination by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	n/a	57.0%	57.1%	No Change
100%-199%	n/a	n/a	55.6%	52.9%	59.2%	Positive
200%-399%	n/a	n/a	67.7%	62.0%	57.4%	Negative
≥400%	n/a	n/a	67.1%	63.2%	66.3%	Negative

Medical Home - Care Coordination by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Other	n/a	n/a	n/a	n/a	n/a	n/a
Single parent	n/a	n/a	56.0%	47.7%	54.8%	Negative
Two-parent married	n/a	n/a	70.8%	63.4%	62.9%	Negative
Two-parent unmarried	n/a	n/a	n/a	n/a	n/a	n/a

Medical Home - Care Coordination by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	64.7%	59.7%	60.0%	Negative
Non-English	n/a	n/a	n/a	n/a	n/a	n/a

Medical Home - Care Coordination by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	60.9%	59.0%	60.3%	Negative
Born outside U.S.	n/a	n/a	n/a	70.6%	60.7%	Negative

Medical Home - Care Coordination by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	n/a	n/a	47.0%	42.7%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	71.6%	80.1%	Positive
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	n/a	59.6%	60.7%	62.2%	Positive

Medical Home - Care Coordination by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	68.3%	58.8%	57.4%	Negative
Male	n/a	n/a	63.6%	60.3%	62.5%	Negative

Medical Home - Care Coordination by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	65.2%	56.4%	55.6%	Negative
MSA, Non-Central City	n/a	n/a	67.5%	69.2%	67.8%	No change
Non-MSA	n/a	n/a	65.5%	52.7%	55.7%	Negative

Medical Home - Family Centered Care Total (Percent of children with and without special health care needs, ages 0 through 17, who have family centered care) (LC-37: Health Care Access and Quality: Medical Home for Children) (HP2030: MICH-19: 53.6%)

Total	2018	2019	2020	2021	2022	Trend
Total	84.4%	88.3%	91.7%	89.7%	88.2%	Positive

Medical Home - Family Centered Care by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
1 ACE	n/a	n/a	96.1%	95.4%	96.4%	No change
2+ ACEs	n/a	n/a	88.3%	82.6%	78.4%	Negative
None	n/a	n/a	93.3%	92.8%	91.9%	Negative

Medical Home - Family Centered Care by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	n/a	83.5%	87.9%	83.8%	No change
6-11 Years	n/a	n/a	89.3%	88.5%	87.8%	Negative
12-17 Years	n/a	n/a	96.1%	91.5%	90.5%	Negative

Medical Home - Family Centered Care by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
College graduate	n/a	n/a	87.8%	91.5%	90.3%	Positive
High school graduate	n/a	n/a	95.9%	88.8%	85.4%	Negative
Less than high school	n/a	n/a	n/a	n/a	n/a	n/a
Some college	n/a	n/a	96.3%	82.5%	83.7%	Negative

Medical Home - Family Centered Care by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	n/a	95.0%	87.7%	87.4%	Negative
Medicaid	n/a	n/a	92.7%	91.6%	88.9%	Negative
Uninsured	n/a	n/a	n/a	n/a	n/a	n/a

Medical Home - Family Centered Care by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	n/a	86.3%	84.4%	Negative
100%-199%	n/a	n/a	84.5%	88.4%	89.4%	Positive
200%-399%	n/a	n/a	93.1%	92.1%	86.5%	Negative
≥400%	n/a	n/a	91.7%	90.0%	91.3%	No change

Medical Home - Family Centered Care by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Other	n/a	n/a	n/a	n/a	n/a	n/a
Single parent	n/a	n/a	86.9%	83.3%	80.2%	Negative
Two-parent married	n/a	n/a	92.4%	91.2%	90.9%	Negative
Two-parent unmarried	n/a	n/a	n/a	n/a	n/a	n/a

Medical Home - Family Centered Care by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	91.5%	89.8%	88.2%	Negative
Non-English	n/a	n/a	n/a	n/a	n/a	n/a

Medical Home - Family Centered Care by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	91.0%	89.7%	88.0%	Negative
Born outside U.S.	n/a	n/a	n/a	90.6%	89.7%	Negative

Medical Home - Family Centered Care by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	n/a	n/a	77.5%	78.2%	Positive
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	95.6%	90.2%	Negative
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	n/a	89.6%	90.7%	89.5%	No change

Medical Home - Family Centered Care by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	88.5%	87.9%	90.7%	Positive
Male	n/a	n/a	95.2%	91.0%	86.4%	Negative

Medical Home - Family Centered Care by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	91.6%	89.0%	87.0%	Negative
MSA, Non-Central City	n/a	n/a	93.0%	91.3%	90.2%	Negative
Non-MSA	n/a	n/a	90.1%	89.0%	86.8%	Negative

Medical Home - Personal Doctor Total (Percent of children with and without special health care needs, ages 0 through 17, who have a personal doctor or nurse) (LC-37: Health Care Access and Quality: Medical Home for Children) (HP2030: MICH-19: 53.6%)

Total	2018	2019	2020	2021	2022	Trend
Total	78.0%	84.1%	83.1%	79.8%	85.9%	Positive

Medical Home – Personal Doctor by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
1 ACE	n/a	n/a	68.9%	73.3%	86.7%	Positive
2+ ACEs	n/a	n/a	86.5%	79.6%	81.9%	Negative
None	n/a	n/a	88.4%	84.2%	88.8%	No change

Medical Home - Personal Doctor by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	n/a	88.1%	81.1%	88.3%	No change
6-11 Years	n/a	n/a	78.8%	73.4%	80.7%	Positive
12-17 Years	n/a	n/a	85.2%	85.1%	89.5%	Positive

Medical Home - Personal Doctor by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
College graduate	n/a	n/a	87.5%	87.6%	91.1%	Positive
High school graduate	n/a	n/a	73.9%	55.9%	78.1%	Positive
Less than high school	n/a	n/a	n/a	n/a	n/a	n/a
Some college	n/a	n/a	88.1%	75.4%	77.4%	Negative

Medical Home - Personal Doctor by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	n/a	75.2%	68.1%	78.4%	Positive
Medicaid	n/a	n/a	90.5%	90.0%	91.4%	Positive
Uninsured	n/a	n/a	n/a	n/a	n/a	n/a

Medical Home - Personal Doctor by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	77.8%	66.7%	82.6%	Positive
100%-199%	n/a	n/a	80.4%	70.9%	77.8%	Negative
200%-399%	n/a	n/a	86.8%	83.8%	86.9%	No Change
≥400%	n/a	n/a	85.0%	91.2%	92.2%	Positive

Medical Home - Personal Doctor by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Other	n/a	n/a	n/a	n/a	n/a	n/a
Single parent	n/a	n/a	76.5%	81.0%	84.1%	Positive
Two-parent married	n/a	n/a	86.5%	80.9%	87.9%	Positive
Two-parent unmarried	n/a	n/a	n/a	n/a	n/a	n/a

Medical Home - Personal Doctor by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	85.3%	80.1%	85.8%	No change
Non-English	n/a	n/a	n/a	n/a	n/a	n/a

Medical Home - Personal Doctor by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	85.6%	80.2%	85.8%	No Change
Born outside U.S.	n/a	n/a	n/a	87.7%	88.9%	Positive

Medical Home - Personal Doctor by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	n/a	n/a	78.1%	84.9%	Positive
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	94.1%	92.9%	Negative
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	n/a	85.0%	78.7%	84.6%	No Change

Medical Home - Personal Doctor by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	78.3%	76.9%	85.2%	Positive
Male	n/a	n/a	88.2%	82.0%	86.4%	Negative

Medical Home - Personal Doctor by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	80.2%	75.4%	87.4%	Positive
MSA, Non-Central City	n/a	n/a	90.9%	85.3%	86.4%	Negative
Non-MSA	n/a	n/a	77.1%	79.1%	82.7%	Positive

Medical Home - Referrals Total (Percent of children with and without special health care needs, ages 0 through 17, who have no problem getting needed referrals) (LC-37: Health Care Access and Quality: Medical Home for Children) (HP2030: MICH-19: 53.6%)

Total	2018	2019	2020	2021	2022	Trend
Total	n/a	84.7%	83.1%	75.7%	69.3%	Negative*

Medical Home – Referrals by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
1 ACE	n/a	n/a	n/a	69.5%	83.3%	Positive
2+ ACEs	n/a	n/a	72.8%	67.4%	56.7%	Negative
None	n/a	n/a	94.0%	85.2%	72.5%	Negative

Medical Home - Referrals by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	n/a	n/a	83.0%	79.7%	Negative
6-11 Years	n/a	n/a	83.4%	71.4%	59.5%	Negative
12-17 Years	n/a	n/a	80.2%	75.3%	70.5%	Negative

Medical Home - Referrals by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
College graduate	n/a	n/a	83.8%	75.9%	69.3%	Negative
High school graduate	n/a	n/a	n/a	n/a	n/a	n/a
Less than high school	n/a	n/a	n/a	n/a	n/a	n/a
Some college	n/a	n/a	n/a	n/a	76.4%	n/a

Medical Home - Referrals by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	n/a	n/a	65.9%	68.6%	Positive
Medicaid	n/a	n/a	83.7%	80.6%	70.4%	Negative
Uninsured	n/a	n/a	n/a	n/a	n/a	n/a

Medical Home - Referrals by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	n/a	n/a	n/a	n/a
100%-199%	n/a	n/a	n/a	70.8	n/a	n/a
200%-399%	n/a	n/a	91.0%	82.7%	76.8%	Negative
≥400%	n/a	n/a	74.2%	76.3%	71.7%	Negative

Medical Home - Referrals by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Other	n/a	n/a	n/a	n/a	n/a	n/a
Single parent	n/a	n/a	n/a	n/a	n/a	n/a
Two-parent married	n/a	n/a	83.7%	74.5%	69.2%	Negative
Two-parent unmarried	n/a	n/a	n/a	n/a	n/a	n/a

Medical Home - Referrals by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	81.8%	76.4%	72.0%	Negative
Non-English	n/a	n/a	n/a	n/a	n/a	n/a

Medical Home - Referrals by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	80.5%	74.1%	67.5%	Negative
Born outside U.S.	n/a	n/a	n/a	n/a	n/a	n/a

Medical Home - Referrals by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	n/a	77.9%	77.9%	76.3%	Negative

Medical Home - Referrals by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	84.8%	76.5%	69.6%	Negative
Male	n/a	n/a	81.1%	75.1%	69.1%	Negative

Medical Home - Referrals by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	n/a	88.6%	76.8%	Negative
MSA, Non-Central City	n/a	n/a	77.1%	62.3%	60.1%	Negative
Non-MSA	n/a	n/a	n/a	76.0%	71.6%	Negative

Medical Home - Usual Source of Sick Care Total (Percent of children with and without special health care needs, ages 0 through 17, who have a usual source of sick care)  
(LC-37: Health Care Access and Quality: Medical Home for Children) (HP2030: MICH-19: 53.6%)

Total	2018	2019	2020	2021	2022	Trend
Total	84.0%	85.2%	84.7%	87.7%	91.4%	Positive*

Medical Home – Usual Source of Sick Care by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
1 ACE	n/a	n/a	71.6%	81.1%	86.9%	Positive
2+ ACEs	n/a	n/a	83.7%	87.6%	91.4%	Positive
None	n/a	n/a	93.0%	92.1%	93.9%	Positive

Medical Home - Usual Source of Sick Care by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
0-5 Years	n/a	n/a	94.2%	88.9%	80.7%	Negative
6-11 Years	n/a	n/a	81.4%	87.8%	94.9%	Positive
12-17 Years	n/a	n/a	84.6%	87.3%	93.1%	Positive

Medical Home - Usual Source of Sick Care by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
College graduate	n/a	n/a	90.9%	92.1%	96.2%	Positive
High school graduate	n/a	n/a	65.8%	63.9%	75.7%	Positive
Less than high school	n/a	n/a	n/a	n/a	n/a	n/a
Some college	n/a	n/a	90.8%	92.1%	90.7%	No Change

Medical Home - Usual Source of Sick Care by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	n/a	72.6%	78.1%	85.9%	Positive
Medicaid	n/a	n/a	94.8%	96.7%	96.6%	Positive
Uninsured	n/a	n/a	n/a	n/a	n/a	n/a

Medical Home - Usual Source of Sick Care by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	63.3%	64.9%	80.9%	Positive
100%-199%	n/a	n/a	93.0%	88.1%	86.4%	Negative
200%-399%	n/a	n/a	94.8%	95.4%	96.7%	Positive
≥400%	n/a	n/a	83.0%	94.2%	95.2%	Positive

Medical Home - Usual Source of Sick Care by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Other	n/a	n/a	n/a	n/a	n/a	n/a
Single parent	n/a	n/a	81.6%	85.6%	85.0%	Positive
Two-parent married	n/a	n/a	88.9%	89.4%	96.0%	Positive
Two-parent unmarried	n/a	n/a	n/a	n/a	n/a	n/a

Medical Home - Usual Source of Sick Care by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	86.5%	87.8%	91.5%	Positive
Non-English	n/a	n/a	n/a	n/a	n/a	n/a

Medical Home - Usual Source of Sick Care by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	87.8%	89.4%	92.5%	Positive
Born outside U.S.	n/a	n/a	n/a	87.8%	91.9%	Positive

Medical Home - Usual Source of Sick Care by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	n/a	n/a	89.6%	88.9%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	95.1%	97.1%	Positive
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	n/a	87.1%	87.9%	91.0%	Positive

Medical Home - Usual Source of Sick Care by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	79.1%	86.9%	92.2%	Positive
Male	n/a	n/a	90.6%	88.4%	90.9%	No Change

Medical Home - Usual Source of Sick Care by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	82.2%	84.1%	92.0%	Positive
MSA, Non-Central City	n/a	n/a	90.7%	90.2%	91.0%	No Change
Non-MSA	n/a	n/a	80.3%	89.6%	91.2%	Positive

Transition Total (Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transitions to adult health care) (LC-37: Health Care Access and Quality: Medical Home for Children) (HP2030: MICH-19: 53.6%)

Transition	2018	2019	2020	2021	2022	Trend
Component: Active Work with Child	n/a	n/a	75.4%	68.7%	70.6%	Negative
Component: Anticipatory Guidance if needed	n/a	n/a	28.8%	29.5%	26.8%	Negative
Component: Time Alone with Provider	n/a	n/a	52.1%	48.3%	51.8%	No change
Total	22.0%	30.5%	32.9%	25.2%	24.3%	Negative

Transition by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
1 ACE	n/a	n/a	25.5%	18.7%	26.6%	Positive
2+ ACEs	n/a	n/a	45.4%	43.4%	29.2%	Negative
None	n/a	n/a	23.5%	11.1%	13.9%	Negative

Transition by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
College graduate	n/a	n/a	28.6%	20.1%	20.2%	Negative
High school graduate	n/a	n/a	n/a	n/a	n/a	n/a
Less than high school	n/a	n/a	n/a	n/a	n/a	n/a
Some college	n/a	n/a	43.2%	41.7%	32.1%	Negative

Transition by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	n/a	41.7%	44.9%	25.1%	Negative
Medicaid	n/a	n/a	29.3%	17.2%	24.4%	Negative
Uninsured	n/a	n/a	n/a	n/a	n/a	n/a

Transition by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	n/a	n/a	n/a	n/a
100%-199%	n/a	n/a	32.1%	n/a	n/a	n/a
200%-399%	n/a	n/a	35.2%	26.4%	27.5%	Negative
≥400%	n/a	n/a	21.8%	13.0%	24.5%	Positive

Transition by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Other	n/a	n/a	n/a	n/a	n/a	n/a
Single parent	n/a	n/a	42.7%	34.5%	26.2%	Negative
Two-parent married	n/a	n/a	29.1%	15.8%	24.5%	Negative
Two-parent unmarried	n/a	n/a	n/a	n/a	n/a	n/a

Transition by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	34.2%	25.6%	22.1%	Negative
Non-English	n/a	n/a	n/a	n/a	n/a	n/a

Transition by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	35.1%	24.2%	24.1%	Negative
Born outside U.S.	n/a	n/a	n/a	n/a	n/a	n/a

Transition by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	n/a	30.9%	21.7%	23.9%	Negative

Transition by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	37.1%	28.7%	25.0%	Negative
Male	n/a	n/a	28.9%	21.5%	23.4%	Negative

Transition by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	19.5%	8.9%	22.2%	Positive
MSA, Non-Central City	n/a	n/a	33.1%	23.8%	23.3%	Negative
Non-MSA	n/a	n/a	46.0%	44.3%	28.9%	Negative

Flourishing - Child Adolescent – CSHCN Total (Percent of children with and without special health care needs, ages 6 through 17 years, who are flourishing)

Total	2018	2019	2020	2021	2022	Trend
Total	n/a	51.2%	41.9%	37.8%	40.3%	Negative

Flourishing - Child Adolescent – CSHCN by Adverse Childhood Experiences

Adverse Childhood Experiences	2018	2019	2020	2021	2022	Trend
1 ACE	n/a	n/a	41.2%	38.0%	39.1%	Negative
2+ ACEs	n/a	n/a	40.3%	39.2%	33.6%	Negative
None	n/a	n/a	44.5%	36.4%	47.2%	Positive

Flourishing - Child Adolescent – CSHCN by Child Age

Child Age	2018	2019	2020	2021	2022	Trend
6-11 Years	n/a	n/a	38.4%	36.4%	45.8%	Positive
12-17 Years	n/a	n/a	44.9%	39.1%	35.4%	Negative

Flourishing - Child Adolescent – CSHCN by Educational Attainment

Educational Attainment	2018	2019	2020	2021	2022	Trend
College graduate	n/a	n/a	44.6%	39.5%	39.5%	Negative
High school graduate	n/a	n/a	26.5%	32.1%	41.7%	Positive
Less than high school	n/a	n/a	n/a	n/a	n/a	n/a
Some college	n/a	n/a	42.7%	38.1%	38.7%	Negative

Flourishing - Child Adolescent – CSHCN by Health Insurance

Health Insurance	2018	2019	2020	2021	2022	Trend
Private	n/a	n/a	37.0%	34.6%	36.5%	No change
Medicaid	n/a	n/a	47.3%	39.3%	41.9%	Negative
Uninsured	n/a	n/a	n/a	n/a	n/a	n/a

Flourishing - Child Adolescent – CSHCN by Household Income-Poverty Ratio

Household Income-Poverty Ratio	2018	2019	2020	2021	2022	Trend
<100%	n/a	n/a	n/a	39.0%	47.9%	Positive
100%-199%	n/a	n/a	43.3%	33.8%	40.1%	Negative
200%-399%	n/a	n/a	40.2%	42.8%	42.1%	Positive
≥400%	n/a	n/a	49.4%	33.7%	35.4%	Negative

Flourishing - Child Adolescent – CSHCN by Household Structure

Household Structure	2018	2019	2020	2021	2022	Trend
Other	n/a	n/a	n/a	n/a	n/a	n/a
Single parent	n/a	n/a	37.8%	26.2%	39.5%	Positive
Two-parent married	n/a	n/a	37.3%	34.0%	38.8%	Positive
Two-parent unmarried	n/a	n/a	n/a	n/a	n/a	n/a

Flourishing - Child Adolescent – CSHCN by Language

Language	2018	2019	2020	2021	2022	Trend
English	n/a	n/a	40.9%	37.3%	38.5%	Negative
Non-English	n/a	n/a	n/a	n/a	n/a	n/a

Flourishing - Child Adolescent – CSHCN by Nativity

Nativity	2018	2019	2020	2021	2022	Trend
Born in U.S.	n/a	n/a	36.3%	32.5%	36.6%	No Change
Born outside U.S.	n/a	n/a	n/a	53.3%	63.0%	Positive

Flourishing - Child Adolescent – CSHCN by Race/Ethnicity

Race/Ethnicity	2018	2019	2020	2021	2022	Trend
Hispanic	n/a	n/a	n/a	57.5%	47.9%	Negative
Non-Hispanic American Indian/Alaska Native	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Asian	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Black	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic Multiple Race	n/a	n/a	n/a	59.5%	51.5%	Negative
Non-Hispanic Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a	n/a
Non-Hispanic White	n/a	n/a	36.6%	32.3%	35.9%	Negative

Flourishing - Child Adolescent – CSHCN by Sex

Sex	2018	2019	2020	2021	2022	Trend
Female	n/a	n/a	44.2%	43.4%	42.3%	Negative
Male	n/a	n/a	39.6%	33.4%	38.8%	Negative

Flourishing - Child Adolescent – CSHCN by Urban-Rural Residence

Urban-Rural Residence	2018	2019	2020	2021	2022	Trend
MSA, Central City	n/a	n/a	29.9%	30.2%	37.5%	Positive
MSA, Non-Central City	n/a	n/a	47.9%	46.5%	43.3%	Negative
Non-MSA	n/a	n/a	49.8%	38.1%	39.4%	Negative

Sources:

Health Resources and Services Administration (HRSA). Federally Available Data (FAD) 2025/2023. <https://mchb.tvisdata.hrsa.gov/Home/FADDocuments>.

National Survey of Children's Health (NSCH), 2018-2022. <https://www.childhealthdata.org/learn-about-the-nsch/NSCH/data>

Kansas Maternal and Child Health Services Title V Block Grant. <https://www.kdhe.ks.gov/626/Maternal-Child-Health-Block-Grant>

Life Course Indicators Online Tool at The Association of Maternal and Child Health Programs (AMCHP). <https://amchp.org/resources/life-course-indicators-online-tool/>

Healthy People 2030. Leading Health Indicators and objectives. <https://odphp.health.gov/healthypeople/objectives-and-data/find-objectives>

## Appendix F. Other Primary and Secondary Data

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## Appendix F.1 Population Demographics

Of Kansas' 2,940,546 residents (Division of Budget, 2024), 694,337 (23.6%) are young people under the age of 18, a slightly decrease from 24.2% when the last Five-Year Title V Needs Assessment was completed (U.S. Census Bureau, 2024a). Another 511,007 are females 18 to 44 years of age, 17.4% of the total population, comparable to 17.3% in 2018 (U.S. Census Bureau, 2024a). The total target population of Title V in Kansas remains virtually unchanged since the previous Needs Assessment, at approximately 1.2 million (1,205,344) Kansas residents.

The table below shows the percentage of age cohorts within the MCH population relative to the total population by MCH region. The percentage of total population comprised of youth under the age of 18 ranges from 21.8% to 24.0% among all regions except for Southwest Kansas, where 29.2% of residents are under 18 years of age. The percentage of the population comprised of females 18-44 is somewhat higher in the Northeast region than other regions.

Table F1.1: Percentage of individuals in age categories by MCH region, and their percentage (of the total population)

Region	Pop. Estimate	Pop. Under Age 1	Percent Under Age 1	Pop. Age 1-5	Percent Age 1-5	Pop. Age 6-11	Percent Age 6-11	Pop. Age 12-17	Percent Age 12-17	Total Pop. Under 18	Percent Under 18	Pop. Females Age 18-44	Percent Females Age 18-44
<b>North Central</b>	135,936	1,498	1.1%	7,697	5.7%	10,307	7.6%	11,175	8.2%	30,677	22.6%	19,631	14.4%
<b>Northeast</b>	1,511,078	17,517	1.2%	89,910	6.0%	117,579	7.8%	123,634	8.2%	348,640	23.1%	275,173	18.2%
<b>Northwest</b>	79,638	893	1.1%	4,482	5.8%	5,785	7.3%	6,128	7.7%	17,388	21.8%	13,272	16.7%
<b>South Central</b>	869,814	10,320	1.2%	52,099	6.0%	69,982	8.0%	76,700	8.8%	209,101	24.0%	148,362	17.1%
<b>Southeast</b>	199,484	2,076	1.0%	11,692	5.9%	15,749	7.9%	16,808	8.4%	46,325	23.2%	31,116	15.6%
<b>Southwest</b>	144,596	2,286	1.6%	11,117	7.7%	14,002	9.7%	14,801	10.2%	42,206	29.2%	23,453	16.2%
<b>Kansas</b>	2,940,546	34,590	1.2%	177,097	6.0%	233,404	7.9%	249,246	8.5%	694,337	23.6%	511,007	17.4%

Source: U.S. Census Bureau, Annual County and Puerto Rico Municipio Resident Population Estimates by Single Year of Age and Sex: April 1, 2020 to July 1, 2023 (CC-EST2023-SYASEX), <https://www.census.gov/data/tables/time-series/demo/popest/2020s-counties-detail.html> (accessed July 5, 2024).

NOTE: This data is found in SYA Custom Age Groups file

Table F.1.2: Percentage of individuals in age categories by urban/rural designation

Urban/Rural Designation	Pop. Estimate	Pop. Under Age 1	Percent Under Age 1	Pop. Age 1-5	Percent Age 1-5	Pop. Age 6-11	Percent Age 6-11	Pop. Age 12-17	Percent Age 12-17	Total Pop. Under 18	Percent Under 18	Pop. Females Age 18-44	Percent Females Age 18-44
Urban	1,697,804	19,780	1.1%	101,765	6.0%	135,127	8.0%	143,710	8.5%	400,382	23.6%	306,994	18.1%
Semi-Urban	453,957	5,402	1.2%	26,567	5.9%	34,291	7.6%	36,444	8.0%	102,704	22.6%	81,879	18.0%
Densely-Settled Rural	432,026	5,330	1.1%	27,560	6.4%	35,666	8.3%	38,673	9.0%	107,229	24.8%	71,885	16.6%
Rural	248,943	2,820	1.1%	14,787	5.9%	19,807	8.0%	21,327	8.6%	58,741	23.6%	35,624	14.3%
Frontier	107,816	1,258	1.2%	6,418	6.0%	8,513	7.9%	9,092	7.4%	25,281	23.4%	14,625	13.6%
Kansas	2,940,546	34,590	1.2%	177,097	6.0%	233,404	7.9%	249,246	8.5%	694,337	23.6%	511,007	17.4%

Over four-fifths (81.5%) of Kansas' MCH target population resides in the Northeast and South Central regions, the regions that are home to Kansas' largest urban centers (see Table x.x below). The smallest percentage of the target MCH population lives in the North Central region.

Source: U.S. Census Bureau, Annual County and Puerto Rico Municipio Resident Population Estimates by Single Year of Age and Sex: April 1, 2020 to July 1, 2023 (CC-EST2023-SYASEX), <https://www.census.gov/data/tables/time-series/demo/popest/2020s-counties-detail.html> (accessed July 5, 2024).

NOTE: This data is found in SYA Custom Age Groups file

Table F.1.3. Distribution of MCH age cohort populations across the state MCH regions

Region	Percent of State Population	Percent of State Under Age 1	Percent of State Age 1-5	Percent of State Age 6-11	Percent of State Age 12-17	Percent Under 18	Percent Females in State Age 18-44	Percent of MCH Population in State
North Central	4.6%	4.3%	4.3%	4.4%	4.5%	4.4%	3.8%	4.2%
Northeast	51.4%	50.6%	50.8%	50.4%	8.0%	50.2%	53.8%	51.8%
Northwest	2.7%	2.6%	2.6%	2.5%	9.0%	2.5%	2.6%	2.5%
South Central	29.6%	29.8%	29.4%	30.0%	8.6%	30.1%	29.0%	29.7%
Southeast	6.8%	6.0%	6.6%	6.7%	7.4%	6.7%	6.1%	6.4%
Southwest	4.9%	6.6%	6.3%	6.0%	8.4%	6.1%	4.6%	5.4%

Table F.1.4. Distribution of MCH age cohort populations across urban and rural areas

Urban/Rural Designation	Percent of State Population	Percent of State Under Age 1	Percent of State Age 1-5	Percent of State Age 6-11	Percent of State Age 12-17	Percent Under 18	Percent Females in State Age 18-44	Percent of MCH Population in State
<b>Urban</b>	57.7%	57.2%	57.5%	57.9%	57.7%	57.7%	60.1%	58.7%
<b>Semi-Urban</b>	15.4%	15.6%	15.0%	14.7%	14.6%	14.8%	16.0%	15.3%
<b>Densely-Settled Rural</b>	14.7%	15.4%	15.6%	15.3%	15.5%	15.4%	14.1%	14.9%
<b>Rural</b>	8.5%	8.2%	8.3%	8.5%	8.6%	8.5%	7.0%	7.8%
<b>Frontier</b>	3.7%	3.6%	3.6%	3.6%	3.6%	3.6%	2.9%	3.3%

Approximately three out of four (74.0%) residents in Kansas in the MCH target population reside in urban and semi-urban counties. However, nearly as many MCH-aged individuals reside in densely-settled rural areas as in semi-urban counties. Just over one in ten (11.1%) of the target MCH population resides in rural and frontier counties.

Other demographics (race/ethnicity, education, disability status, insurance status, poverty) also differ somewhat from region to region as seen below in Table F.1.5..

Table F.1.5. Additional demographics by MCH region.

Region	North Central	Northeast	Northwest	South Central	Southeast	Southwest	Kansas
Percent of total population who are non-white <sup>1</sup>	9.2%	21.7%	8.0%	20.9%	10.8%	31.9%	20.2%
Percent total population (over 25 years) high school or higher <sup>2</sup>	94.0%	93.6%	93.5%	90.6%	91.3%	77.1%	91.8%
Percent total population (over 25 years) college graduate <sup>2</sup>	25.3%	42.3%	28.4%	29.3%	22.3%	18.3%	34.7%
Percent of children under 18 years with disability <sup>2</sup>	5.2%	4.2%	6.7%	5.6%	6.1%	3.3%	4.8%
Percent uninsured <sup>3</sup>	8.5%	7.8%	7.9%	10.0%	10.6%	13.0%	8.9%
Percent children (under 19 years old) who are uninsured <sup>3</sup>	6.1%	4.7%	5.2%	5.2%	6.2%	6.7%	5.2%
Percent families in below 100% FPL <sup>3</sup>	7.5%	6.6%	7.5%	8.6%	11.0%	8.8%	7.6%
Percent of individuals below 100% FPL <sup>3</sup>	11.6%	10.4%	11.7%	12.7%	15.9%	11.5%	11.6%
Percent of children under 18 below 100% FPL <sup>3</sup>	14.1%	11.7%	11.9%	16.2%	19.1%	15.5%	13.9%

Sources: Demographic summary by county and region file (for race, education, disability, insurance coverage); Poverty ACS 2022 5 Year Estimates file (for poverty)

<sup>1</sup> Source: U.S. Census Bureau, Demographic and Housing Estimates, ACS 5-Year Estimates Data Profile, Table DP05, 2022, [https://data.census.gov/table/ACSDP5Y2022.DP05?q=DP05&g=040XX00US20,20\\$0500000](https://data.census.gov/table/ACSDP5Y2022.DP05?q=DP05&g=040XX00US20,20$0500000), accessed August 12, 2024 (US Census Bureau, 2024c). *Demographic and Housing Estimates, ACS 5-Year Estimates Data Profile, Table DP05, 2022.*

<sup>2</sup> U.S. Census Bureau. Selected Social Characteristics in the United States, American Community Survey, ACS 5-Year Estimates Data Profiles, Table DP02, 2022, [https://data.census.gov/table/ACSDP5Y2022.DP02?q=DP02&g=040XX00US20,20\\$0500000](https://data.census.gov/table/ACSDP5Y2022.DP02?q=DP02&g=040XX00US20,20$0500000), accessed August 12, 2024 (US Census Bureau, 2024f).

<sup>3</sup> Source: US Census Bureau. Selected Economic Characteristics. American Community Survey, ACS 5-Year Estimates Data Profiles, Table DP03, 2022, [https://data.census.gov/table/ACSDP5Y2022.DP03?q=DP03&g=040XX00US20,20\\$0500000](https://data.census.gov/table/ACSDP5Y2022.DP03?q=DP03&g=040XX00US20,20$0500000), accessed on August 12, 2024 (US Census Bureau, 2024e).

Table F.1.6.: Additional demographics by Urban/Rural Designation.

Demographic	Urban	Semi-Urban	Densely-Settled Rural	Rural	Frontier	Kansas
Percent of total population who are non-white <sup>1</sup>	24.7%	15.3%	17.9%	8.9%	9.8%	20.2%
Percent total population (over 25 years) high school or higher <sup>2</sup>	92.3%	93.4%	88.3%	91.4%	91.1%	91.8%
Percent total population (over 25 years) college graduate <sup>2</sup>	41.4%	29.5%	23.5%	23.6%	21.9%	34.7%
Percent of children under 18 years with disability <sup>2</sup>	4.8%	5.3%	4.5%	4.7%	5.3%	4.8%
Percent uninsured <sup>2</sup>	8.9%	8.2%	9.8%	8.8%	9.5%	8.9%
Percent children (under 19 years old) who are uninsured <sup>3</sup>	5.1%	4.2%	5.9%	5.7%	6.4%	5.2%
Percent families in below 100% FPL <sup>3</sup>	7.0%	9.2%	8.6%	7.6%	8.1%	7.7%
Percent individuals below 100% FPL <sup>3</sup>	10.8%	13.9%	12.7%	11.0%	11.2%	11.6%
Percent of children under 18 below 100% FPL <sup>3</sup>	13.2%	16.1%	15.2%	12.2%	14.7%	13.9%

Sources: Demographic summary by county and region file (for race, education, disability, insurance coverage); Poverty ACS 2022 5 Year Estimates file (for poverty)

<sup>1</sup> Source: US Census Bureau, Demographic and Housing Estimates, ACS 5-Year Estimates Data Profile, Table DP05, 2022, [https://data.census.gov/table/ACSDP5Y2022.DP05?q=DP05&g=040XX00US20,20\\$0500000](https://data.census.gov/table/ACSDP5Y2022.DP05?q=DP05&g=040XX00US20,20$0500000), accessed August 12, 2024 (US Census Bureau, 2024c)

<sup>2</sup> US Census Bureau. Selected Social Characteristics in the United States, American Community Survey, ACS 5-Year Estimates Data Profiles, Table DP02, 2022, [https://data.census.gov/table/ACSDP5Y2022.DP02?q=DP02&g=040XX00US20,20\\$0500000](https://data.census.gov/table/ACSDP5Y2022.DP02?q=DP02&g=040XX00US20,20$0500000), accessed August 12, 2024 (US Census Bureau, 2024f).

<sup>3</sup> Source: US Census Bureau. Selected Economic Characteristics. American Community Survey, ACS 5-Year Estimates Data Profiles, Table DP03, 2022, [https://data.census.gov/table/ACSDP5Y2022.DP03?q=DP03&g=040XX00US20,20\\$0500000](https://data.census.gov/table/ACSDP5Y2022.DP03?q=DP03&g=040XX00US20,20$0500000), accessed on August 12, 2024 (US Census Bureau, 2024e).

Notable differences in Kansas' population since the last MCH Needs Assessment include:

- A statewide increase in non-white residents. Each region saw an increase in the percent of non-white residents, and statewide the percentage grew from 15.4% to 20.2%.
- A decrease in poverty rates of children under the age of 18.

There are also a few differences among regions worth noting:

- The Northeast region has a much higher percentage of residents with a college degree or higher. Educational attainment (both for high school and college graduates) is lowest in the Southwest region.
- Poverty rates are higher in Southeast region compared to other regions.
- The highest percentages of uninsured residents are found in the Southwest region of the state.
- The percentage of non-white residents is about one in five in three regions (North Central, Northwest, Southeast), is higher in the Northeast and South Central regions (approximately 20%), and is nearly one-third (31.9%) of residents in the Southwest region.

Kansas Division of Budget (2024). *Kansas Certified Population*. Retrieved August 19, 2024 from [https://budget.kansas.gov/wp-content/uploads/2023\\_Kansas\\_Certified\\_Population-07.01.2024.pdf](https://budget.kansas.gov/wp-content/uploads/2023_Kansas_Certified_Population-07.01.2024.pdf)

US Census Bureau. (2024b). *County Population by Characteristics: 2020-2023 (Annual County and Puerto Rico Municipio Resident Population Estimates by Selected Age Groups and Sex: April 1, 2020 to July 1, 2023)*. Retrieved July 5, 2024 from <https://www.census.gov/data/tables/time-series/demo/popest/2020s-counties-detail.html>

US Census Bureau. (2024c). *Demographic and Housing Estimates, ACS 5-Year Estimates Data Profile, Table DP05, 2022*. Retrieved August 12, 2024 from [https://data.census.gov/table/ACSDP5Y2022.DP05?q=DP05&g=040XX00US20,20\\$0500000](https://data.census.gov/table/ACSDP5Y2022.DP05?q=DP05&g=040XX00US20,20$0500000)

US Census Bureau. (2024e). *Selected Economic Characteristics. American Community Survey, ACS 5-Year Estimates Data Profiles, Table DP03, 2022*. Retrieved August 12, 2024 from [https://data.census.gov/table/ACSDP5Y2022.DP03?q=DP03&g=040XX00US20,20\\$0500000](https://data.census.gov/table/ACSDP5Y2022.DP03?q=DP03&g=040XX00US20,20$0500000)

US Census Bureau. (2024f). *Selected Social Characteristics in the United States, ACS 5-Year Estimates Data Profile, Table DP02, 2022*. Retrieved August 12, 2024 from [https://data.census.gov/table/ACSDP5Y2022.DP02?q=DP02&g=040XX00US20,20\\$0500000](https://data.census.gov/table/ACSDP5Y2022.DP02?q=DP02&g=040XX00US20,20$0500000)

## Appendix F.2 MCH Program Demographics (DAISEY)

### Kansas Title V Adult Client Demographics by Fiscal Year (Tables F.2.1-F.2.11)

Source: Kansas Title V DAISEY Data System

Table F.2.1. Client Programs

Program	Overall N = 33,122	2020 N = 9,115	2021 N = 7,275	2022 N = 8,409	2023 N = 8,377	2024 N = 9,994
Becoming a Mom	4,033 (12%)	1,121 (12%)	779 (11%)	730 (8.7%)	863 (10%)	1,203 (12%)
Maternal Child Health (MCH/M&I)	25,267 (76%)	7,170 (79%)	5,468 (75%)	6,565 (78%)	6,402 (76%)	7,633 (76%)
Pregnancy Maintenance (PMI)	2,686 (8.1%)	495 (5.4%)	682 (9.4%)	777 (9.2%)	738 (8.8%)	866 (8.7%)
Teen Pregnancy (TPTCM)	1,136 (3.4%)	329 (3.6%)	346 (4.8%)	337 (4.0%)	374 (4.5%)	292 (2.9%)

Table F.2.2. Client Age at Visit

Age at Visit	Overall N = 33,122	2020 N = 9,115	2021 N = 7,275	2022 N = 8,409	2023 N = 8,377	2024 N = 9,994
<15	243 (0.7%)	83 (0.9%)	46 (0.6%)	53 (0.6%)	51 (0.6%)	74 (0.7%)
15-17	653 (2.0%)	190 (2.1%)	154 (2.1%)	158 (1.9%)	149 (1.8%)	156 (1.6%)
17-19	1,843 (5.6%)	552 (6.1%)	443 (6.1%)	448 (5.4%)	468 (5.6%)	435 (4.4%)
19-25	10,697 (33%)	3,084 (34%)	2,342 (32%)	2,552 (31%)	2,703 (33%)	3,239 (33%)
25-35	14,697 (45%)	3,949 (44%)	3,137 (43%)	3,698 (44%)	3,801 (46%)	4,619 (47%)
35-45	4,582 (14%)	1,191 (13%)	1,092 (15%)	1,399 (17%)	1,101 (13%)	1,341 (14%)
>45	176 (0.5%)	27 (0.3%)	23 (0.3%)	44 (0.5%)	42 (0.5%)	66 (0.7%)
Missing	231	39	38	57	62	64

Table F.2.3. Client Race

Race	Overall N = 33,122	2020 N = 9,115	2021 N = 7,275	2022 N = 8,409	2023 N = 8,377	2024 N = 9,994
White	26,222 (79%)	7,420 (81%)	5,907 (81%)	6,786 (81%)	6,540 (78%)	7,677 (77%)
Black or African American	3,012 (9.1%)	888 (9.7%)	771 (11%)	831 (9.9%)	675 (8.1%)	759 (7.6%)
Asian	512 (1.5%)	142 (1.6%)	134 (1.8%)	127 (1.5%)	121 (1.4%)	142 (1.4%)
American Indian or Alaska Native	248 (0.7%)	92 (1.0%)	35 (0.5%)	46 (0.5%)	61 (0.7%)	73 (0.7%)
Native Hawaiian or Other Pacific Islander	162 (0.5%)	39 (0.4%)	37 (0.5%)	41 (0.5%)	68 (0.8%)	32 (0.3%)
Multiracial	852 (2.6%)	219 (2.4%)	138 (1.9%)	172 (2.0%)	218 (2.6%)	303 (3.0%)
Unknown/Not Reported	2,114 (6.4%)	315 (3.5%)	253 (3.5%)	406 (4.8%)	694 (8.3%)	1,008 (10%)

Table F.2.4. Client Ethnicity

Ethnicity	Overall N = 33,122	2020 N = 9,115	2021 N = 7,275	2022 N = 8,409	2023 N = 8,377	2024 N = 9,994
Hispanic or Latino	11,464 (36%)	2,996 (34%)	2,672 (38%)	3,077 (38%)	3,006 (38%)	3,721 (39%)
Not Hispanic or Latino	20,226 (64%)	5,745 (66%)	4,369 (62%)	4,998 (62%)	4,972 (62%)	5,838 (61%)
Missing	1,432	374	234	334	399	435

Table F.2.5. Client Primary Language

Primary Language	Overall N = 33,122	2020 N = 9,115	2021 N = 7,275	2022 N = 8,409	2023 N = 8,377	2024 N = 9,994
English	26,565 (80%)	7,458 (82%)	5,824 (80%)	6,776 (81%)	6,547 (78%)	7,643 (77%)
Spanish	5,726 (17%)	1,418 (16%)	1,264 (17%)	1,461 (17%)	1,584 (19%)	2,063 (21%)
Other language	825 (2.5%)	239 (2.6%)	187 (2.6%)	169 (2.0%)	244 (2.9%)	284 (2.8%)
Missing	6	0	0	3	2	4
LEP	5,912 (18%)	1,475 (16%)	1,409 (20%)	1,514 (18%)	1,628 (20%)	2,046 (21%)
Missing	792	161	142	144	187	355

Table F.2.6. Client Gender

Gender	Overall N = 33,122	2020 N = 9,115	2021 N = 7,275	2022 N = 8,409	2023 N = 8,377	2024 N = 9,994
Choose not to disclose	56 (0.2%)	0 (0%)	0 (0%)	1 (<0.1%)	16 (0.2%)	45 (0.5%)
Female	32,586 (98%)	8,957 (98%)	7,195 (99%)	8,332 (99%)	8,255 (99%)	9,846 (99%)
Male	474 (1.4%)	158 (1.7%)	80 (1.1%)	73 (0.9%)	104 (1.2%)	99 (1.0%)
Missing	6	0	0	3	2	4

Table F.2.7. Client Education Attainment

Education Attainment	Overall N = 33,122	2020 N = 9,115	2021 N = 7,275	2022 N = 8,409	2023 N = 8,377	2024 N = 9,994
<12 Years	6,818 (23%)	1,876 (23%)	1,746 (25%)	1,802 (23%)	1,698 (23%)	1,958 (22%)
High School Diploma or GED	13,011 (43%)	3,694 (44%)	2,921 (43%)	3,400 (43%)	3,244 (44%)	3,982 (45%)
Associates Degree or Vocational Certification/License	2,901 (9.7%)	716 (8.6%)	624 (9.1%)	755 (9.6%)	711 (9.6%)	884 (10.0%)
College-No Degree	3,685 (12%)	1,167 (14%)	847 (12%)	970 (12%)	795 (11%)	889 (10%)
Bachelor Degree or higher	3,600 (12%)	849 (10%)	717 (10%)	924 (12%)	937 (13%)	1,133 (13%)
Missing	3,107	813	420	558	992	1,148

Table F.2.8. Client Employment Status

Employment Status	Overall N = 33,122	2020 N = 9,115	2021 N = 7,275	2022 N = 8,409	2023 N = 8,377	2024 N = 9,994
Unemployed	14,164 (46%)	3,948 (46%)	3,390 (48%)	3,639 (46%)	3,422 (45%)	4,261 (46%)
Part-time or occasional	4,816 (16%)	1,465 (17%)	1,273 (18%)	1,301 (16%)	1,089 (14%)	1,240 (14%)
Full-time	11,795 (38%)	3,126 (37%)	2,349 (33%)	3,053 (38%)	3,028 (40%)	3,664 (40%)
Missing	2,347	576	263	416	838	829

Table F.2.9. Client Marital Status

Marital Status	Overall N = 33,122	2020 N = 9,115	2021 N = 7,275	2022 N = 8,409	2023 N = 8,377	2024 N = 9,994
Single	18,025 (59%)	5,069 (58%)	4,070 (59%)	4,683 (59%)	4,387 (59%)	5,320 (58%)
Married	11,581 (38%)	3,185 (37%)	2,597 (37%)	2,856 (36%)	2,852 (38%)	3,638 (39%)
Separated/Divorced/Widowed	1,182 (3.8%)	415 (4.8%)	290 (4.2%)	347 (4.4%)	193 (2.6%)	278 (3.0%)
Missing	2,334	446	318	523	945	758

Table F.2.10. Client Insurance Status

Insurance Coverage	Overall N = 33,122	2020 N = 9,115	2021 N = 7,275	2022 N = 8,409	2023 N = 8,377	2024 N = 9,994
None/Self pay	10,955 (34%)	3,454 (39%)	3,001 (42%)	3,102 (38%)	2,254 (28%)	2,849 (30%)
private insurance	8,275 (26%)	2,199 (25%)	1,646 (23%)	2,046 (25%)	2,079 (26%)	2,480 (26%)
public insurance	12,691 (40%)	3,213 (36%)	2,546 (35%)	3,058 (37%)	3,615 (45%)	4,190 (44%)
Missing	1,201	249	82	203	429	475
Under federal poverty line	14,701 (69%)	4,733 (75%)	3,774 (72%)	4,087 (70%)	3,072 (62%)	4,016 (69%)
Missing	11,831	2,803	2,051	2,600	3,425	4,152
Rural	5,158 (16%)	1,399 (16%)	1,023 (14%)	1,125 (13%)	1,351 (16%)	1,663 (17%)
Missing	391	97	16	44	115	169

Table F.2.11. Client Urban/Rural Status

Urban/Rural Status	Overall N = 33,122	2020 N = 9,115	2021 N = 7,275	2022 N = 8,409	2023 N = 8,377	2024 N = 9,994
Densely-settled Rural	8,242 (25%)	2,123 (24%)	1,606 (22%)	2,046 (24%)	2,278 (28%)	2,680 (27%)
Frontier	1,352 (4.1%)	381 (4.2%)	307 (4.2%)	350 (4.2%)	358 (4.3%)	391 (4.0%)
Rural	2,949 (9.0%)	832 (9.2%)	485 (6.7%)	498 (6.0%)	777 (9.4%)	1,020 (10%)
Semi-Urban	7,408 (23%)	2,166 (24%)	1,421 (20%)	1,815 (22%)	2,068 (25%)	2,285 (23%)
Urban	12,780 (39%)	3,516 (39%)	3,440 (47%)	3,656 (44%)	2,781 (34%)	3,449 (35%)
Missing	391	97	16	44	115	169

# Kansas Title V Child Client Demographics by Fiscal Year (Tables F.2.12-F.2.17)

Source: Kansas Title V DAISEY Data System

Table F.2.12. Child Client Age at Enrollment

Age at enrollment	Overall N = 26,725	2020 N = 7,567	2021 N = 5,227	2022 N = 6,010	2023 N = 7,199	2024 N = 8,443
<1	7,259 (28%)	1,592 (21%)	1,114 (22%)	1,442 (24%)	1,805 (25%)	2,120 (25%)
1-3	2,977 (11%)	1,042 (14%)	661 (13%)	740 (12%)	895 (13%)	1,099 (13%)
3-5	3,453 (13%)	1,189 (16%)	681 (13%)	786 (13%)	984 (14%)	1,026 (12%)
5-14	8,155 (31%)	2,441 (33%)	1,655 (32%)	1,831 (31%)	2,109 (30%)	2,636 (32%)
14-18	3,725 (14%)	1,062 (14%)	873 (17%)	916 (15%)	1,058 (15%)	1,205 (14%)
>18	772 (2.9%)	161 (2.2%)	183 (3.5%)	219 (3.7%)	268 (3.8%)	268 (3.2%)
Missing	384	80	60	76	80	89

Table F.2.13. Child Client Race

Race	Overall N = 26,725	2020 N = 7,567	2021 N = 5,227	2022 N = 6,010	2023 N = 7,199	2024 N = 8,443
White	22,475 (89%)	6,679 (90%)	4,591 (91%)	5,198 (91%)	5,895 (89%)	6,684 (88%)
Black or African American	1,209 (4.8%)	300 (4.0%)	200 (4.0%)	244 (4.3%)	359 (5.4%)	472 (6.2%)
Asian	350 (1.4%)	134 (1.8%)	90 (1.8%)	92 (1.6%)	88 (1.3%)	86 (1.1%)
American Indian or Alaska Native	123 (0.5%)	39 (0.5%)	21 (0.4%)	20 (0.3%)	40 (0.6%)	40 (0.5%)
Native Hawaiian or Other Pacific Islander	99 (0.4%)	16 (0.2%)	17 (0.3%)	25 (0.4%)	34 (0.5%)	24 (0.3%)
Multiracial	872 (3.5%)	284 (3.8%)	115 (2.3%)	150 (2.6%)	213 (3.2%)	297 (3.9%)
Missing	1,597	115	193	281	570	840

Table F.2.14. Child Client Ethnicity

Ethnicity	Overall N = 26,725	2020 N = 7,567	2021 N = 5,227	2022 N = 6,010	2023 N = 7,199	2024 N = 8,443
Hispanic or Latino	9,378 (37%)	2,855 (39%)	2,051 (41%)	2,466 (43%)	2,502 (38%)	2,833 (37%)
Not Hispanic or Latino	15,637 (63%)	4,533 (61%)	2,978 (59%)	3,220 (57%)	4,076 (62%)	4,837 (63%)
Missing	1,710	179	198	324	621	773

Table F.2.15. Child Client Primary Language

Primary Language	Overall N = 26,725	2020 N = 7,567	2021 N = 5,227	2022 N = 6,010	2023 N = 7,199	2024 N = 8,443
English	23,337 (88%)	6,793 (90%)	4,699 (90%)	5,179 (87%)	6,104 (87%)	7,025 (85%)
Spanish	2,653 (10%)	680 (9.0%)	468 (9.0%)	669 (11%)	751 (11%)	1,052 (13%)
Other language	472 (1.8%)	93 (1.2%)	60 (1.1%)	86 (1.4%)	170 (2.4%)	227 (2.7%)
Missing	263	1	0	76	174	139
LEP	2,797 (11%)	682 (9.2%)	460 (9.0%)	698 (12%)	869 (13%)	1,129 (14%)
Missing	698	131	105	205	273	255

Table F.2.16. Child Client Gender

Gender	Overall N = 26,725	2020 N = 7,567	2021 N = 5,227	2022 N = 6,010	2023 N = 7,199	2024 N = 8,443
Choose not to disclose	70 (0.3%)	0 (0%)	0 (0%)	0 (0%)	4 (<0.1%)	69 (0.8%)
Female	13,704 (51%)	3,925 (52%)	2,709 (52%)	3,145 (52%)	3,673 (51%)	4,283 (51%)
Male	12,950 (48%)	3,641 (48%)	2,518 (48%)	2,864 (48%)	3,522 (49%)	4,091 (48%)
Missing	1	1	0	1	0	0
Special Needs	671 (2.5%)	176 (2.3%)	116 (2.2%)	113 (1.9%)	250 (3.5%)	220 (2.6%)
Missing	1	0	1	0	1	0

Table F.2.17. Child Client Insurance coverage

Insurance coverage	Overall N = 26,725	2020 N = 7,567	2021 N = 5,227	2022 N = 6,010	2023 N = 7,199	2024 N = 8,443
None/Self pay	6,172 (24%)	1,734 (23%)	1,016 (20%)	1,324 (22%)	1,664 (24%)	2,105 (28%)
Private insurance	6,160 (24%)	2,022 (27%)	1,374 (27%)	1,406 (24%)	1,400 (20%)	1,508 (20%)
Public insurance	13,199 (52%)	3,782 (50%)	2,692 (53%)	3,171 (54%)	3,800 (55%)	3,975 (52%)
Missing	1,194	29	145	109	335	855
Living under federal poverty line	9,238 (55%)	3,313 (61%)	1,877 (54%)	2,008 (52%)	2,231 (50%)	3,062 (64%)
Missing	9,976	2,163	1,768	2,112	2,764	3,630

## The Representative Kansas Title V Child Client

Cluster analysis is a statistical technique used to group objects that are like each other within the same cluster (Wade, 2023). This method is instrumental in identifying patterns or groupings within a dataset without prior knowledge of group definitions. It is important to note that not all individuals included in a cluster will have all of the identifying characteristics for that cluster.

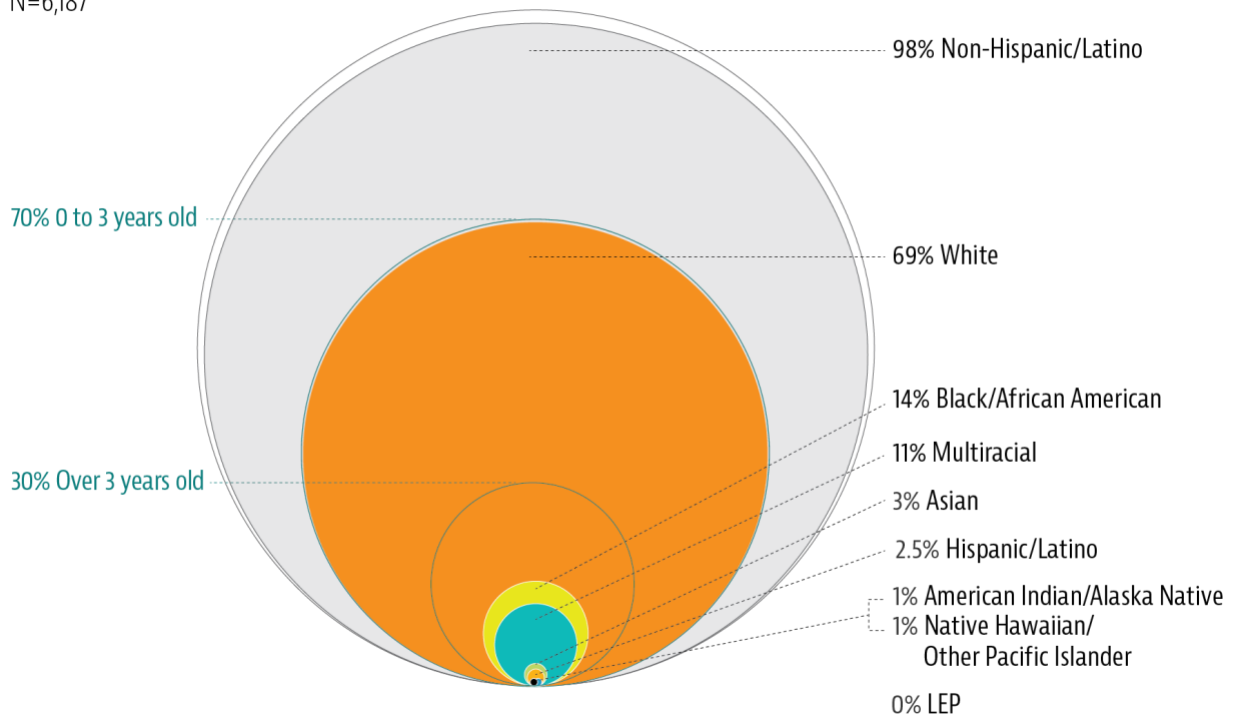
The demographic data from Kansas Title V child clients reveals distinct profiles among the population served. Cluster analysis identified four main child groups as described below :

### Group 1. Non-Hispanic Child Clients

Group 1 consists of 6,187 clients, predominantly younger children. 70% of the clients in this group are infants under the age of 3. Older children make up 30%. This group is primarily White (69%), with 14% identifying as Black or African American and 11% as Multiracial. Only 2.5% of this group is Hispanic or Latino, with the vast majority (98%) identifying as Not Hispanic or Latino. Among those identifying as White, none are White-Hispanic, and all are White, Non-Hispanic.

#### Non-Hispanic Child Clients

N=6,187

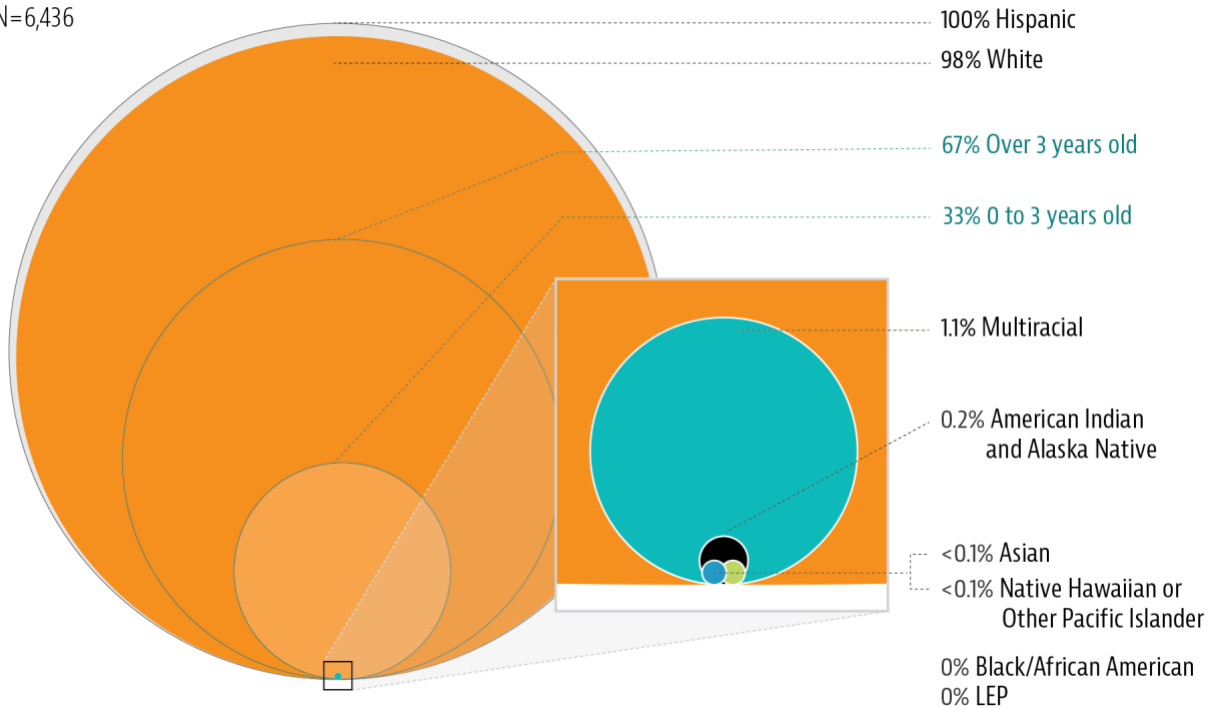


## Group 2. Diverse Age, White Hispanic Children

Group 2 consists of 6,436 clients, all of whom are Hispanic or Latino and predominantly White (98%). This group has fewer infants and young children compared to Group 1, with 33% of clients under 3 years old. All of the White clients in this group are classified as White-Hispanic, and 100% of the group is Hispanic.

### Diverse Age White Hispanic Child Clients

N=6,436

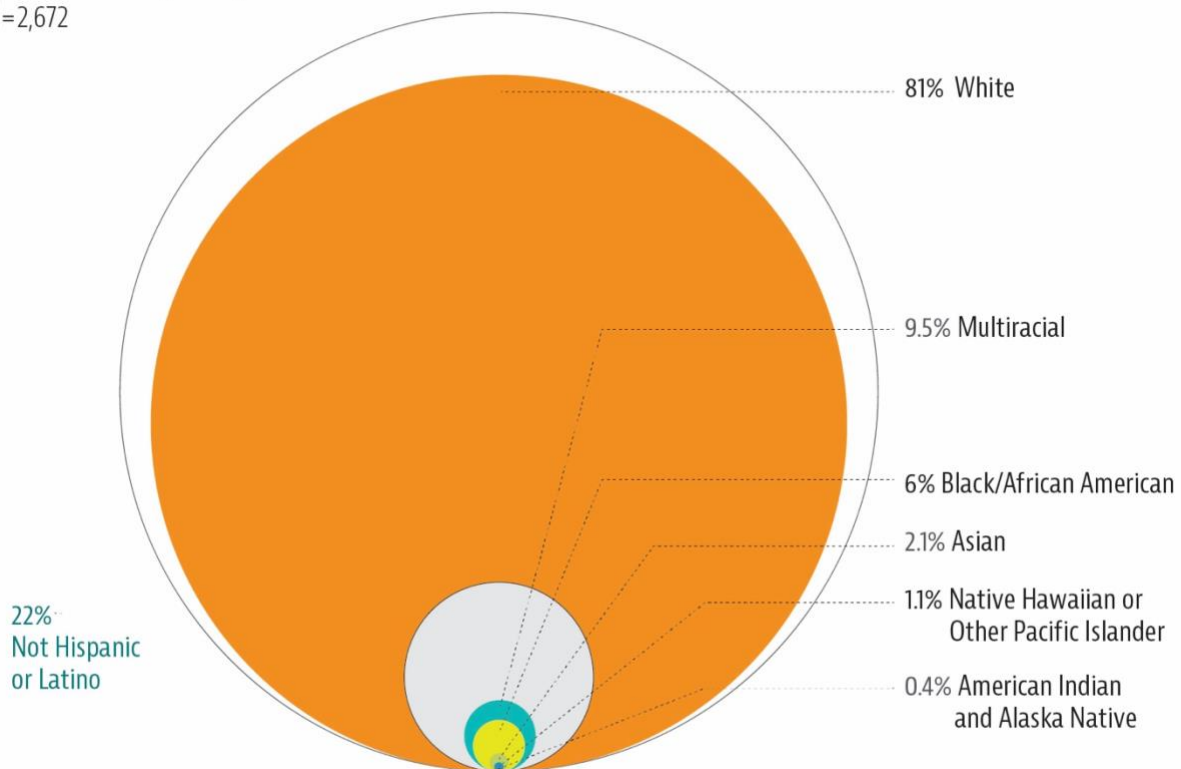


### Group 3. LEP Primarily Hispanic Children

Group 3 has 2,672 clients and is characterized by a high proportion of clients with Limited English Proficiency (LEP)—100% of the group falls under this category. This group is diverse in age, including younger children, with 32% being under 1 year old, 11% aged 1 to 3 years, and 14% aged 3 to 5 years. Clients aged 5 to 14 years make up 34% of the group, and 9.6% are adolescents aged 14 to 18 years. Most of the clients in this group are Hispanic or Latino (78%), and 85% of the White clients are White-Hispanic, while 15% are White-Non-Hispanic.

#### LEP Primarily Hispanic Children

N=2,672

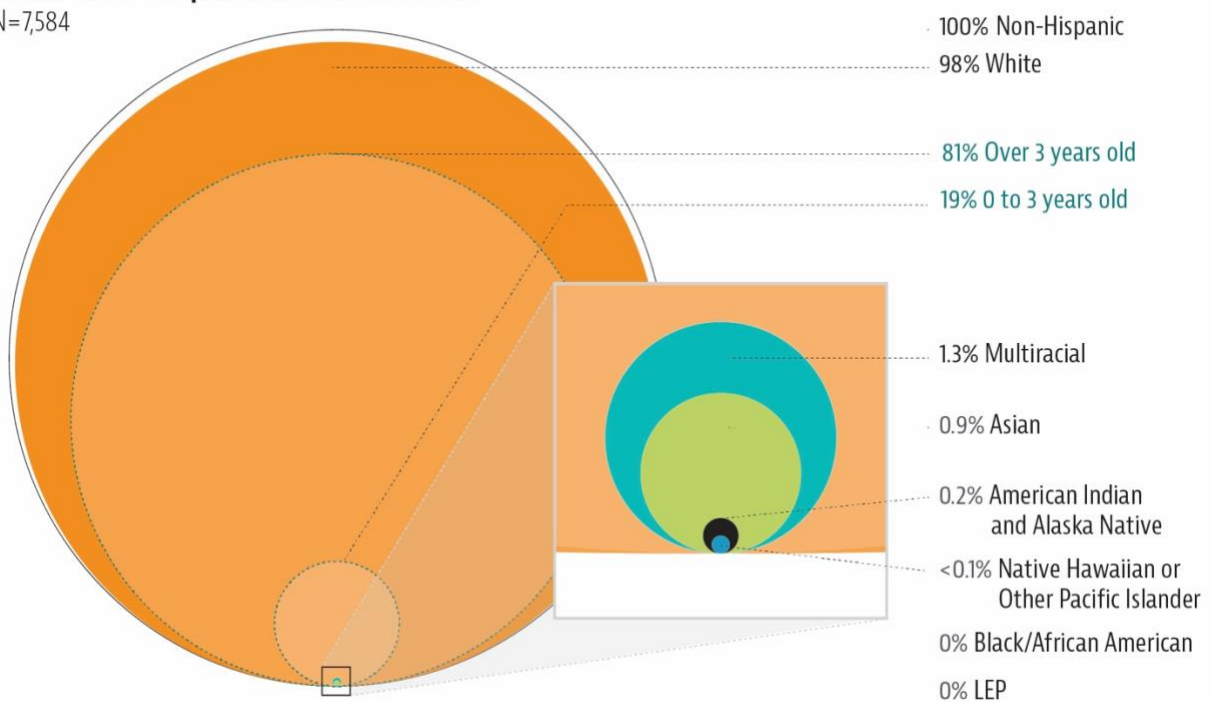


#### Group 4. Older Non-Hispanic White Children

Group 4 consists of 7,584 clients, most of whom are older children with 81% being older than 3 years old. There are fewer younger children in this group, with only 19% aged 0 to 3 years. This group is overwhelmingly White (98%) and non-Hispanic (100%).

#### Older Non-Hispanic White Children

N=7,584



# The Representative Kansas Title V Adult Client

The demographic data from Kansas Title V adult clients reveals distinct profiles among the population served. Cluster analysis identified three main adult groups for each of the following programs:

- **Maternal and Child Health:** clinical services
- **Becoming a Mom:** A prenatal education program that has been widely adopted by local MCH agencies in Kansas
- **Pregnancy Maintenance (PMI):** A program funded through the state general fund that uses a team-based, case management approach to enable pregnant women to carry their pregnancies to term
- **Teen Pregnancy Targeted Case Management (TPTCM):** A program that provides comprehensive case management services to pregnant and/or parenting (up to one year postpartum) adolescents up to the age of 21 who are eligible for Medicaid services

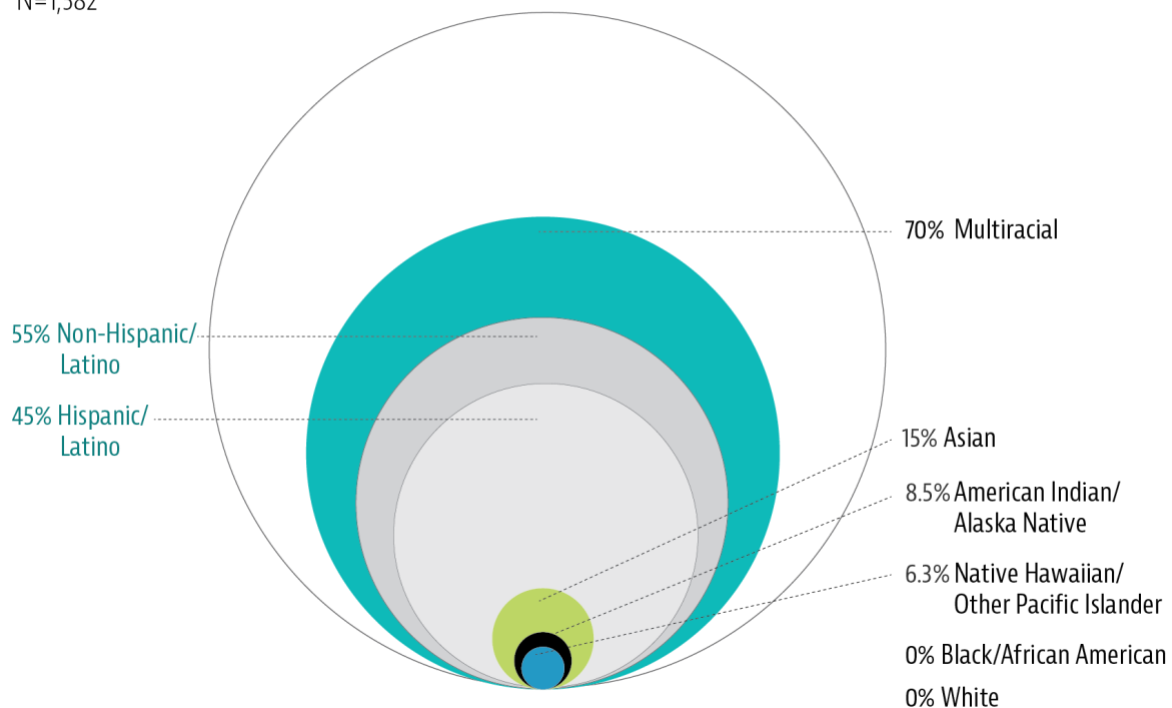
## Maternal and Child Health Clinical Services

Group 1: Racially Diverse (non-White, non-Black)

Group 1 consists of 1,582 clients, all of whom are non-White and non-Black. This group is highly racially diverse, with 15% Asian, 8.5% American Indian or Alaska Native, 6.3% Native Hawaiian or Other Pacific Islander, and a significant 70% Multiracial population. In terms of ethnicity, 45% are Hispanic or Latino, while 55% identify as Not Hispanic or Latino. 64% of clients speak English as their primary language, while 29% primarily speak Spanish, and 7.1% primarily speak another language.

### Racially Diverse Group

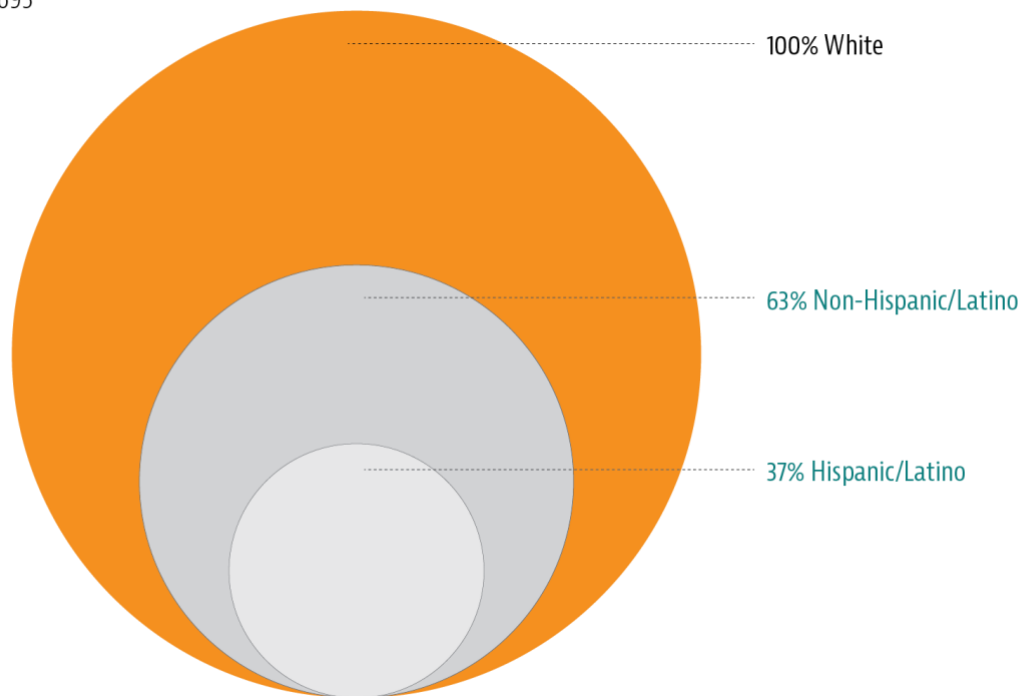
N=1,582



*Group 2: White*

Group 2 is the largest group, with 17,695 clients, all of whom are White. In terms of ethnicity, 37% of this group is White-Hispanic, while 63% are White-Non-Hispanic. Most clients (81%) speak English as their primary language, while 18% primarily speak Spanish.

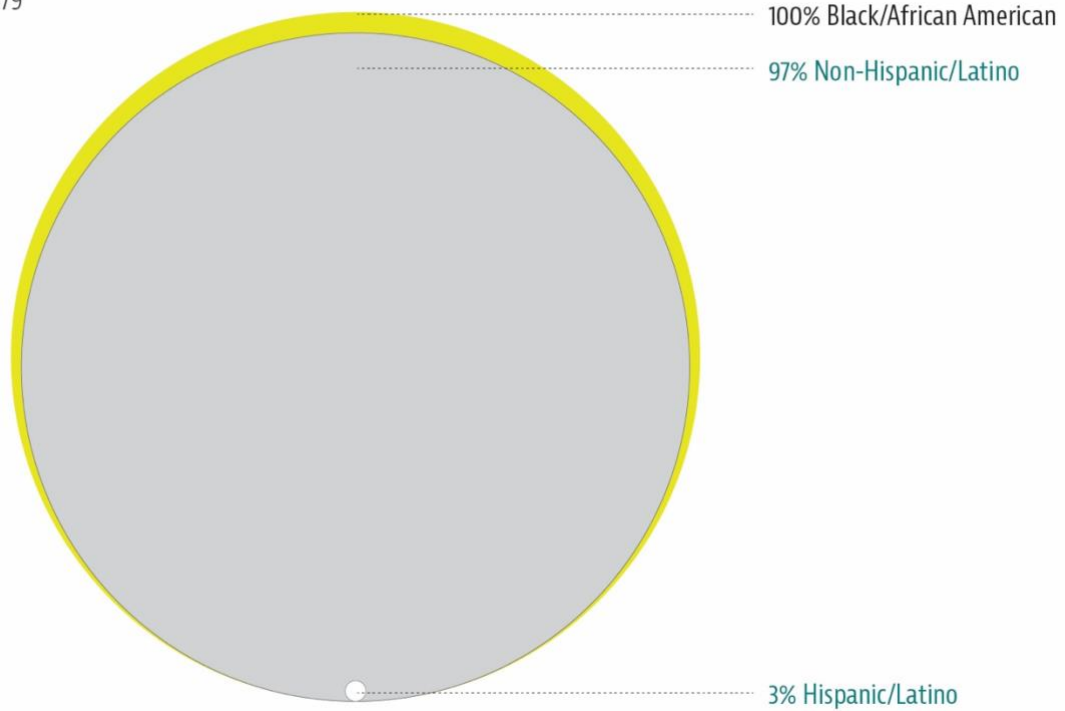
**White**  
N=17,695



*Group 3: Black Americans.*

Group 3 consists of 1,679 clients, all of whom are Black or African American. Most clients (97%) identify as Not Hispanic or Latino, while 2.5% identify as Hispanic or Latino. 96% of clients in this group speak English as their primary language, with a small percentage primarily speaking other languages.

**Black**  
N=1,679



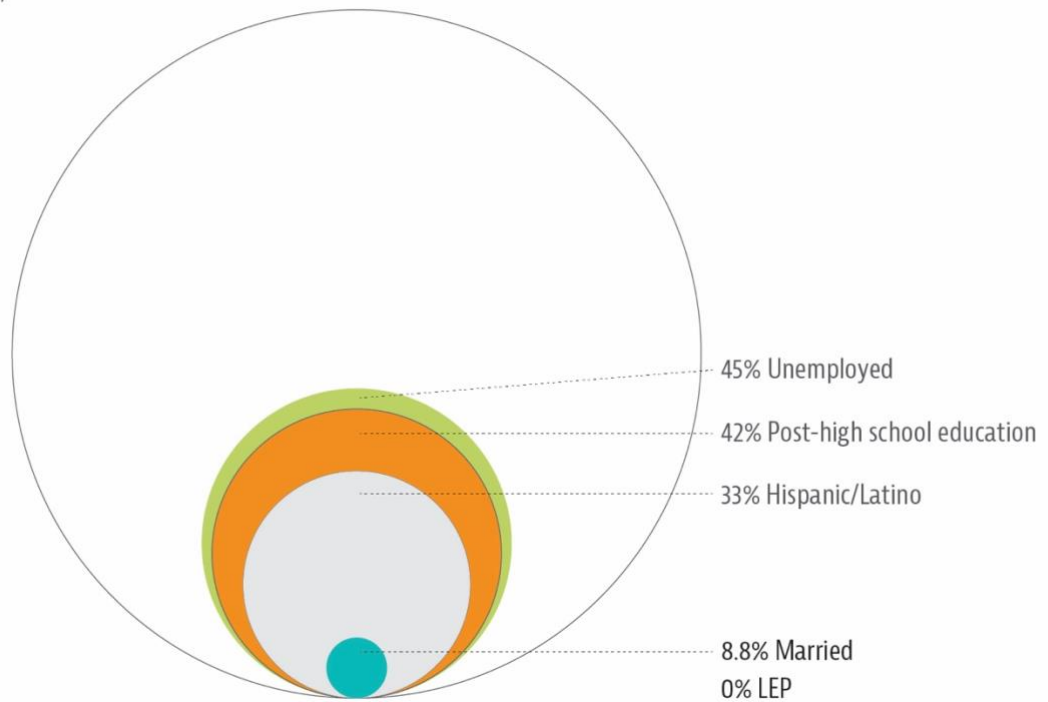
## Becoming a Mom Program

### Group 1: Single Women

Group 1 consists of 1,499 clients, predominantly younger women. The majority of clients in this group are aged 19 to 25 years (41%) and 25 to 35 years (39%), with smaller portions in the 35- to 45-year age range (8.8%) and very few clients under 19 or over 45. Most clients (84%) are single, with a small percentage (8.8%) being married. In terms of education, 15% of the clients have less than 12 years of education, and 43% have a High School Diploma or GED. Only 11% of the clients hold a bachelor's degree or higher. Employment data shows that 45% are unemployed, and 19% work part-time, while 37% are employed full-time.

### Becoming a Mom *Single Women*

N=1,499

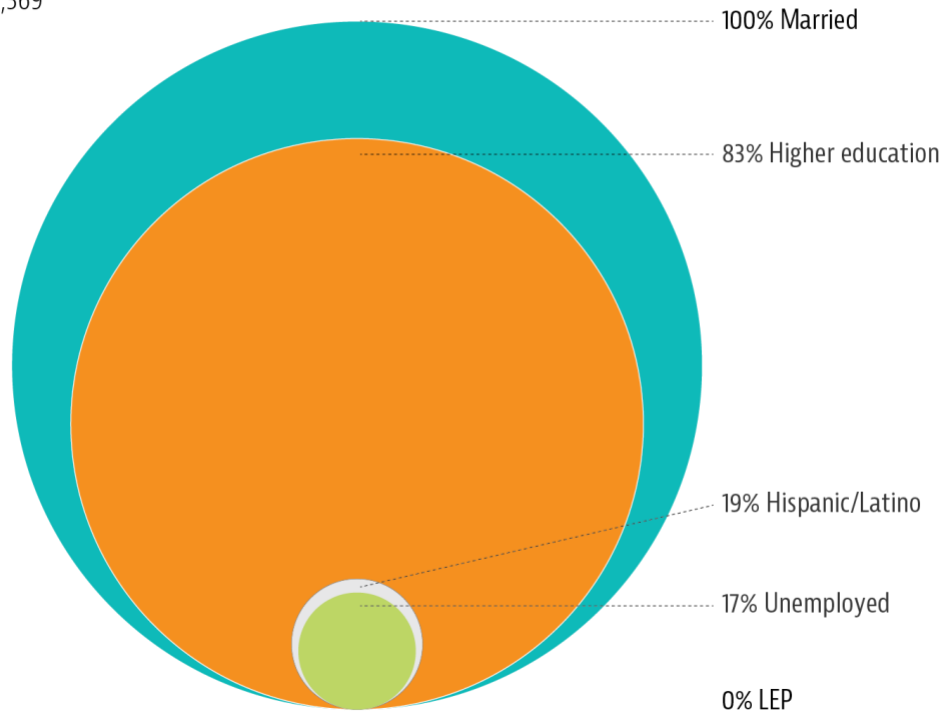


### Group 2: Married Women

Group 2 consists of 1,369 clients, predominantly White (89%), married, and English-speaking. This group is older compared to Group 1, with many clients aged 25 to 35 years (68%). All clients in this group are married. In terms of race, 89% of clients are White, with small proportions identifying as Black or African American, Asian, or Multiracial. 19% of clients are Hispanic or Latino, while the remaining 81% are Not Hispanic or Latino. Most clients in this group (97%) primarily speak English, with only 2.3% primarily speaking Spanish. There are no clients in this group classified as having Limited English Proficiency (LEP).

### Becoming a Mom Married Women

N=1,369

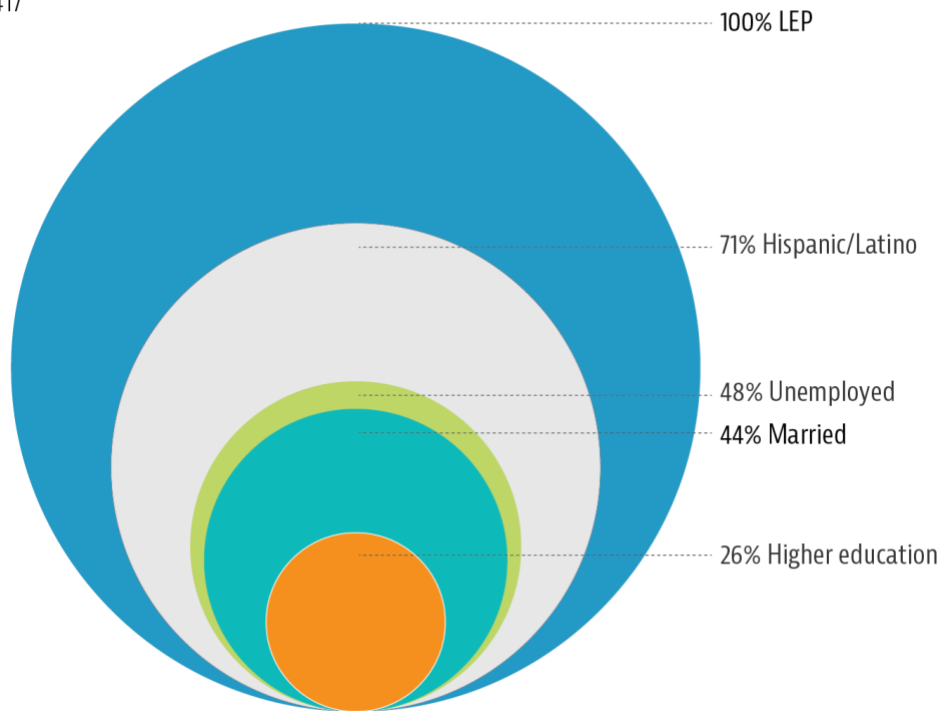


### Group 3: Women with Limited English Proficiency

Group 3 consists of 417 clients, predominantly Hispanic or Latino (71%) and characterized by Limited English Proficiency (LEP). A large proportion of clients in this group primarily speak Spanish (56%), and 100% are classified as having Limited English Proficiency (LEP). Only 39% of clients primarily speak English, while 5% reported another language as their primary language.

#### Becoming a Mom *Women with LEP*

N=417

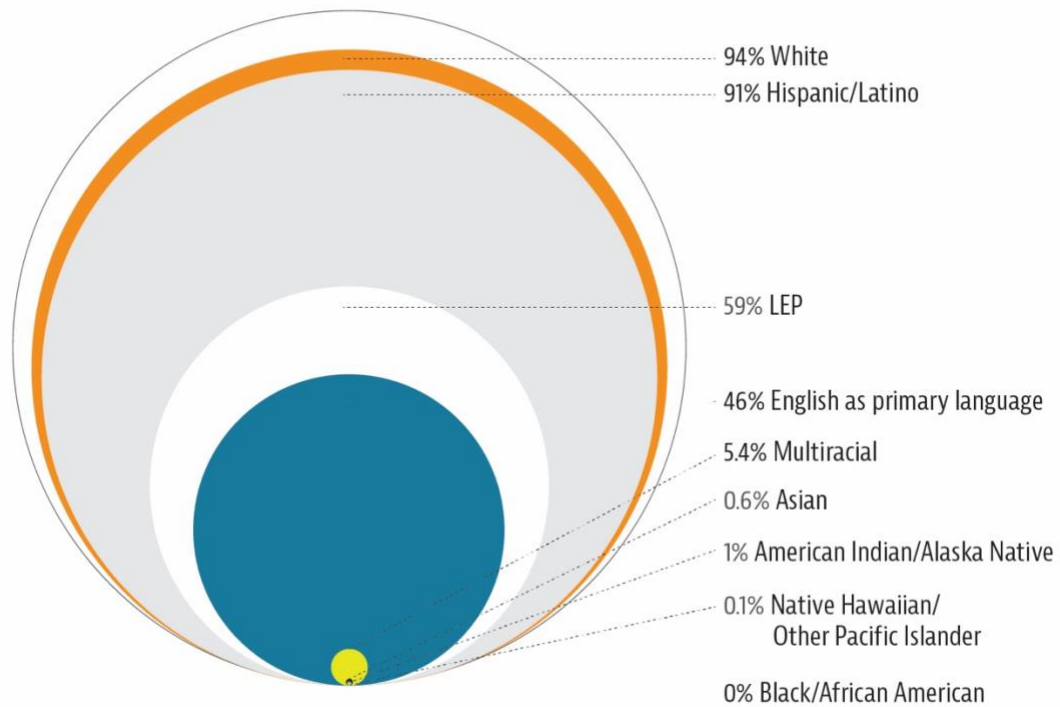


## PMI Program

### Group 1: White Hispanic or Latino

Group 1 consists of 680 clients, overwhelmingly Hispanic or Latino (91%), with only 8.8% identifying as Not Hispanic or Latino.

**PMI White, Hispanic or Latino**  
N=680

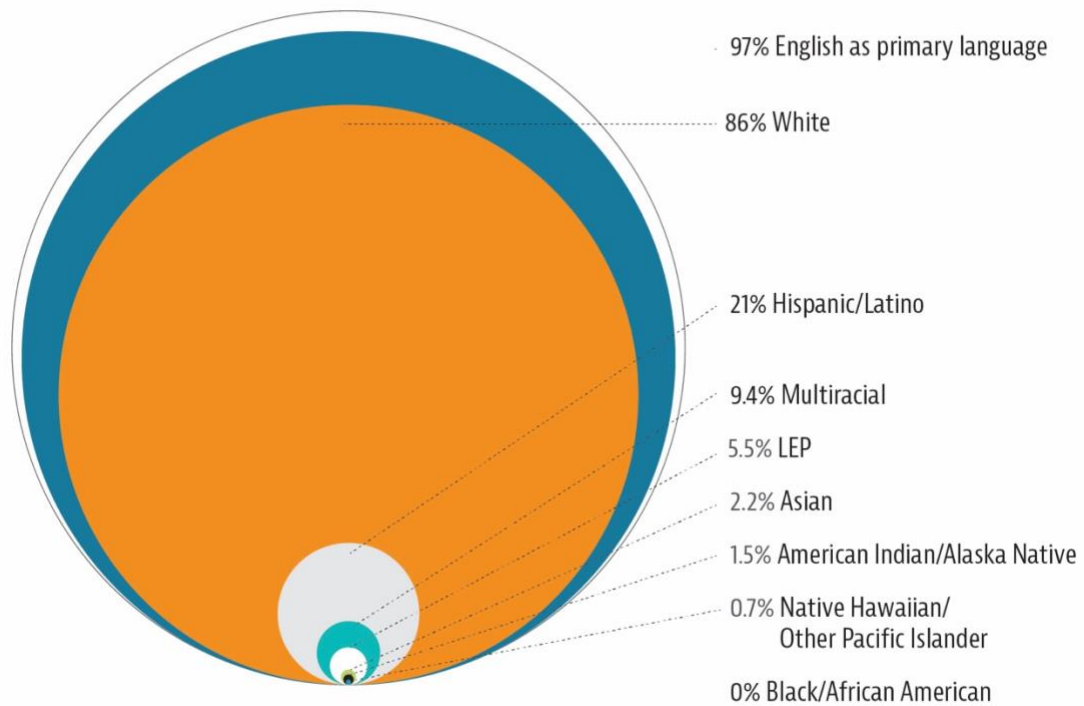


### Group 2: White, English as Primary Language

Group 2 consists of 1,426 clients, predominantly White (86%) and Not Hispanic or Latino (79%). Most clients (97%) primarily speak English, and only 1.3% primarily speak Spanish. Only 5.5% of clients in this group are classified as having Limited English Proficiency (LEP).

#### PMI White, English as primary language

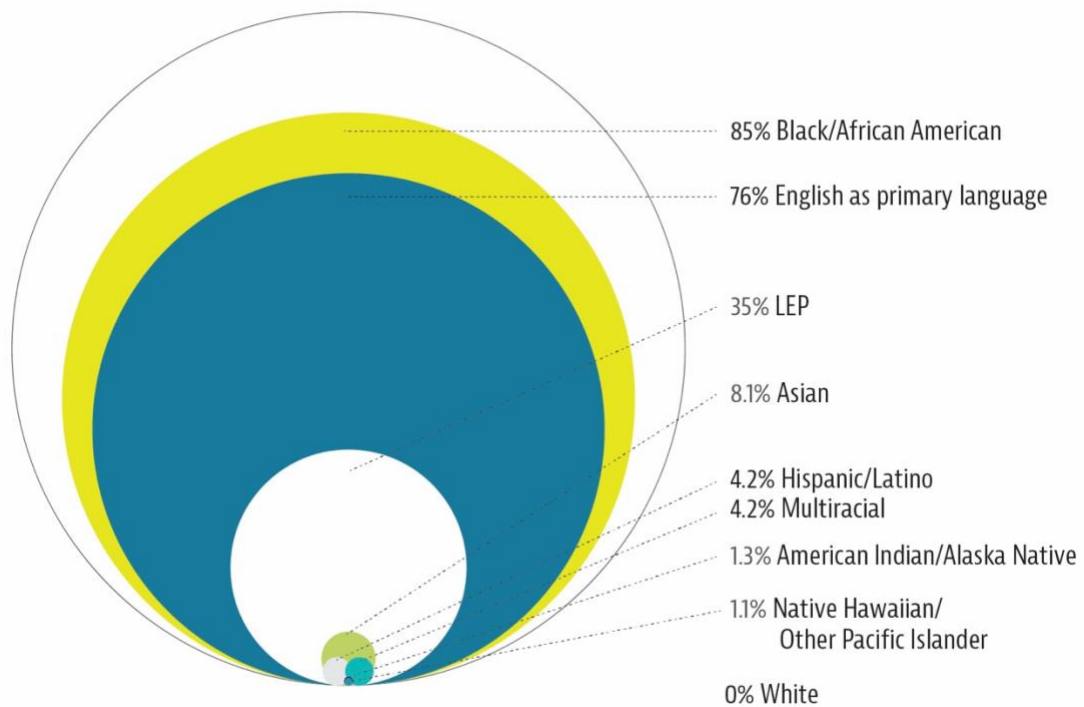
N=1,426



### Group 3: Racially diverse (Black, Asian, Multiracial)

Group 3 consists of 457 clients, all of whom are Black or African American (85%), with 8.1% identifying as Asian and smaller proportions identifying as American Indian or Alaska Native. This group is slightly younger, with 35% of clients aged 19 to 25 years and 44% aged 25 to 35 years. There are fewer clients aged 35 to 45 years (11%). Only 4.2% of clients identify as Hispanic or Latino, and the majority (96%) are Not Hispanic or Latino.

**PMI Racially Diverse (Black, Asian, Multiracial)**  
N=457



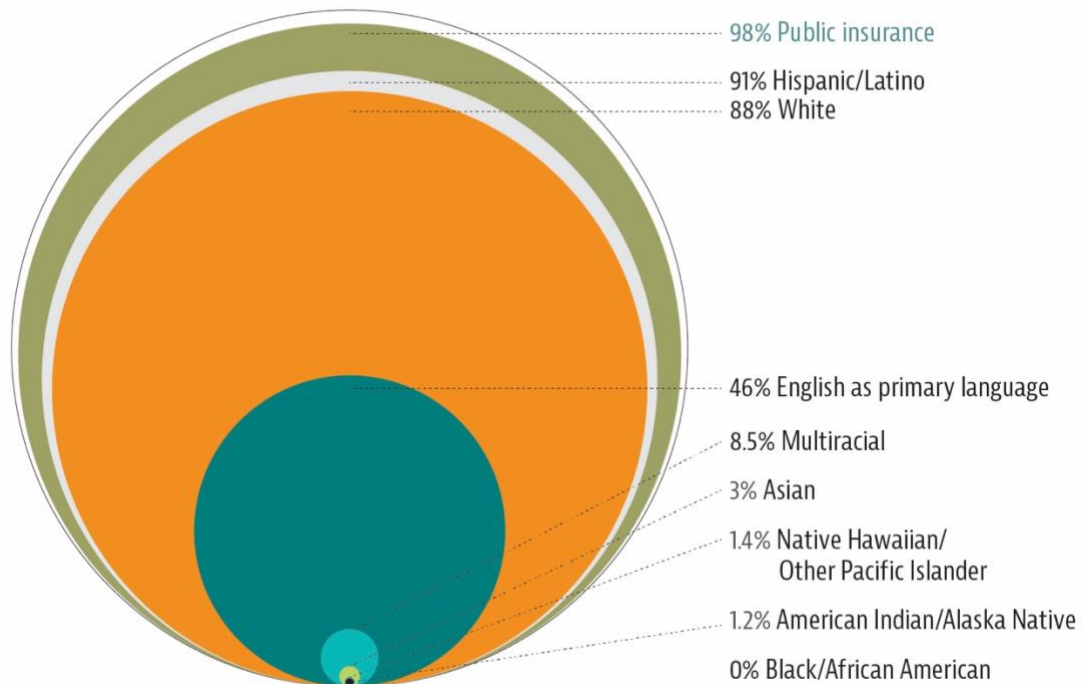
## TPTCM Program

### Group 1: White with Public Insurance

Group 1 consists of 772 clients, predominantly White (88%). Almost all clients in this group (98%) are covered by public insurance (including Medicaid), and only 2.3% are self-paid or uninsured.

### TPTCM White with public insurance

N=772



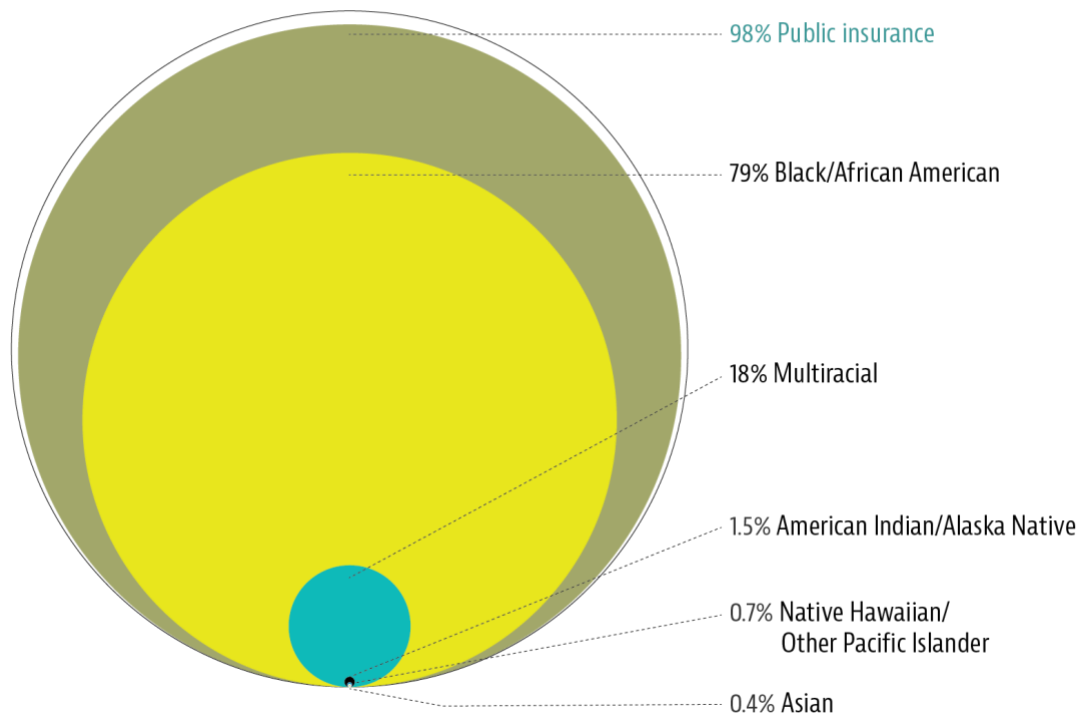
**Group 2: Black Americans, Covered by Public Insurance.**

Group 2 consists of 271 clients, all of whom are Black or African American (79%) or Multiracial (18%).

Similar to Group 1, almost all clients (98%) are covered by public insurance, including Medicaid, with 2.2% being self-paid or uninsured.

**PMI Black and multiracial Americans with public insurance**

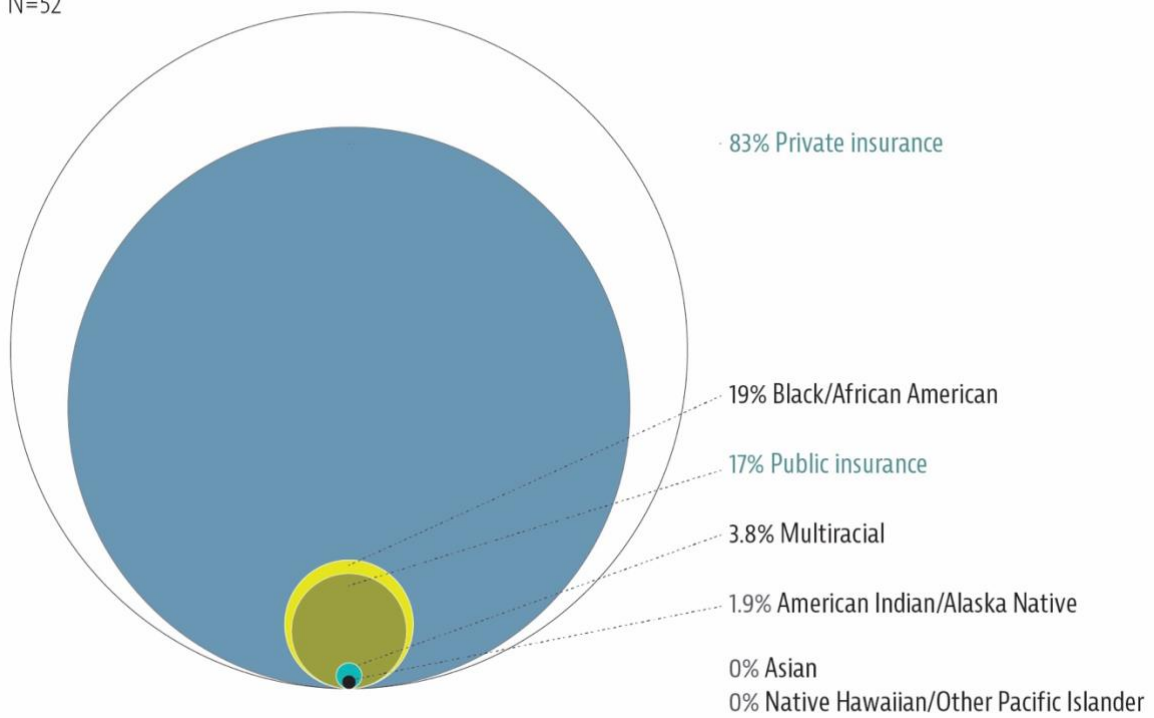
N=271



Group 3: White, mostly private insurance.

Group 3 is the smallest group, with 52 clients, primarily White (75%), and covered by private insurance (83%).

**PMI White, mostly private insurance**  
N=52



## Appendix F.3 MCH Services (DAISEY)

Table F.3.1. MCH Adult Direct Service Rates by Fiscal Year

Service Type	Overall N = 32,043	2020 N = 6,751	2021 N = 5,081	2022 N = 6,751	2023 N = 6,139	2024 N = 7,321
Education	17,661 (55%)	3,552 (53%)	2,870 (56%)	3,552 (53%)	3,653 (60%)	4,034 (55%)
Maternal Depression Screening	9,188 (29%)	2,035 (30%)	1,378 (27%)	2,035 (30%)	1,674 (27%)	2,066 (28%)
MCH Home Visit Education	8,679 (27%)	1,599 (24%)	925 (18%)	1,599 (24%)	1,877 (31%)	2,679 (37%)
Blood/Lab Work	6,314 (20%)	1,008 (15%)	1,140 (22%)	1,008 (15%)	1,452 (24%)	1,706 (23%)
Other Service/Screening	6,115 (19%)	1,219 (18%)	864 (17%)	1,219 (18%)	1,325 (22%)	1,488 (20%)
Well Woman Care/Annual Visit	4,978 (16%)	1,393 (21%)	1,463 (29%)	1,393 (21%)	225 (3.7%)	504 (6.9%)
Prenatal/ Post-Partum Nursing Assessment	4,888 (15%)	1,030 (15%)	724 (14%)	1,030 (15%)	895 (15%)	1,209 (17%)
BP/WT/Hgb	4,771 (15%)	802 (12%)	648 (13%)	802 (12%)	1,165 (19%)	1,354 (18%)
Contraception	4,119 (13%)	564 (8.4%)	926 (18%)	564 (8.4%)	941 (15%)	1,124 (15%)
Immunization	3,913 (12%)	626 (9.3%)	777 (15%)	626 (9.3%)	1,010 (16%)	874 (12%)
Chlamydia Test	3,882 (12%)	779 (12%)	1,023 (20%)	779 (12%)	606 (9.9%)	695 (9.5%)
Gonorrhea Test	3,809 (12%)	772 (11%)	990 (19%)	772 (11%)	591 (9.6%)	684 (9.3%)
Syphilis Test	3,618 (11%)	745 (11%)	815 (16%)	745 (11%)	637 (10%)	676 (9.2%)
Breastfeeding Assistance/Counseling	3,419 (11%)	614 (9.1%)	582 (11%)	614 (9.1%)	699 (11%)	910 (12%)
HIV Test	3,315 (10%)	636 (9.4%)	788 (16%)	636 (9.4%)	599 (9.8%)	656 (9.0%)
Other Nursing Assessment	3,090 (9.6%)	666 (9.9%)	471 (9.3%)	666 (9.9%)	574 (9.4%)	713 (9.7%)
Perinatal Mood and Anxiety Disorders	2,493 (7.8%)	0 (0%)	0 (0%)	0 (0%)	936 (15%)	1,557 (21%)
MCH Breast Exam	2,368 (7.4%)	505 (7.5%)	421 (8.3%)	505 (7.5%)	435 (7.1%)	502 (6.9%)
Injury Prevention	2,353 (7.3%)	3 (<0.1%)	283 (5.6%)	3 (<0.1%)	982 (16%)	1,082 (15%)
Breastfeeding Assessment	2,181 (6.8%)	364 (5.4%)	420 (8.3%)	364 (5.4%)	437 (7.1%)	596 (8.1%)
Fetal Heart Tones (FHT)	2,053 (6.4%)	3 (<0.1%)	275 (5.4%)	3 (<0.1%)	821 (13%)	951 (13%)
Maternal Depression Counseling	2,005 (6.3%)	303 (4.5%)	193 (3.8%)	303 (4.5%)	574 (9.4%)	632 (8.6%)
Glucose Tolerance Test	1,934 (6.0%)	1 (<0.1%)	440 (8.7%)	1 (<0.1%)	791 (13%)	701 (9.6%)
MCH Pap Smear	1,722 (5.4%)	347 (5.1%)	280 (5.5%)	347 (5.1%)	325 (5.3%)	423 (5.8%)
Car Seat Installation/Check	1,713 (5.3%)	357 (5.3%)	320 (6.3%)	357 (5.3%)	248 (4.0%)	431 (5.9%)

Service Type	Overall N = 32,043	2020 N = 6,751	2021 N = 5,081	2022 N = 6,751	2023 N = 6,139	2024 N = 7,321
Dental	1,671 (5.2%)	116 (1.7%)	274 (5.4%)	116 (1.7%)	527 (8.6%)	638 (8.7%)
Pregnancy Test	1,513 (4.7%)	191 (2.8%)	339 (6.7%)	191 (2.8%)	352 (5.7%)	440 (6.0%)
PHQ-9	1,440 (4.5%)	235 (3.5%)	160 (3.1%)	235 (3.5%)	159 (2.6%)	651 (8.9%)
Social Determinants of Health Screen	1,377 (4.3%)	0 (0%)	0 (0%)	0 (0%)	90 (1.5%)	1,287 (18%)
High-risk Case Management	837 (2.6%)	158 (2.3%)	216 (4.3%)	158 (2.3%)	173 (2.8%)	132 (1.8%)
Lead Screening	831 (2.6%)	177 (2.6%)	111 (2.2%)	177 (2.6%)	153 (2.5%)	213 (2.9%)
Developmental Screening	718 (2.2%)	77 (1.1%)	93 (1.8%)	77 (1.1%)	140 (2.3%)	331 (4.5%)
Sick Visit	579 (1.8%)	16 (0.2%)	14 (0.3%)	16 (0.2%)	225 (3.7%)	308 (4.2%)
Ages & Stages Questionnaire (ASQ)	456 (1.4%)	67 (1.0%)	51 (1.0%)	67 (1.0%)	114 (1.9%)	157 (2.1%)
Smoking Cessation Counseling	439 (1.4%)	106 (1.6%)	88 (1.7%)	106 (1.6%)	42 (0.7%)	97 (1.3%)
Smoking Cessation Baby & Me Tobacco Free	368 (1.1%)	111 (1.6%)	70 (1.4%)	111 (1.6%)	27 (0.4%)	49 (0.7%)
Smoking Cessation Other	362 (1.1%)	43 (0.6%)	83 (1.6%)	43 (0.6%)	111 (1.8%)	82 (1.1%)
Well Infant Visit	349 (1.1%)	59 (0.9%)	68 (1.3%)	59 (0.9%)	66 (1.1%)	97 (1.3%)

Source: Kansas Title V DAISEY Data System. Note. Services with a rate under 1% are not included in this table.

Table F.3.2. MCH Adult Education Service Rates by Fiscal Year

Service Type	Overall N = 32,043	2020 N = 6,751	2021 N = 5,081	2022 N = 6,751	2023 N = 6,139	2024 N = 7,321
Breastfeeding	14,681 (46%)	2,764 (41%)	2,056 (40%)	2,764 (41%)	3,131 (51%)	3,966 (54%)
Safe Sleep	13,937 (43%)	2,773 (41%)	1,836 (36%)	2,773 (41%)	2,890 (47%)	3,665 (50%)
Nutrition	13,845 (43%)	2,396 (35%)	1,853 (36%)	2,396 (35%)	3,273 (53%)	3,927 (54%)
Immunizations	13,294 (41%)	2,558 (38%)	1,932 (38%)	2,558 (38%)	2,878 (47%)	3,368 (46%)
State/local resources	12,689 (40%)	2,294 (34%)	1,967 (39%)	2,294 (34%)	2,885 (47%)	3,249 (44%)
Oral Health	10,747 (34%)	1,988 (29%)	1,377 (27%)	1,988 (29%)	2,534 (41%)	2,860 (39%)
Father Involvement	10,462 (33%)	1,704 (25%)	1,407 (28%)	1,704 (25%)	2,516 (41%)	3,131 (43%)
Infant Care	10,434 (33%)	1,898 (28%)	1,332 (26%)	1,898 (28%)	2,383 (39%)	2,923 (40%)
Prenatal Care	10,167 (32%)	1,852 (27%)	1,521 (30%)	1,852 (27%)	2,211 (36%)	2,731 (37%)
Car seat safety/installation	9,853 (31%)	1,936 (29%)	1,435 (28%)	1,936 (29%)	2,018 (33%)	2,528 (35%)
Injury prevention/safety	9,770 (30%)	1,739 (26%)	1,405 (28%)	1,739 (26%)	2,192 (36%)	2,695 (37%)
Health Care Coverage / Medicaid Eligibility	9,769 (30%)	1,666 (25%)	1,367 (27%)	1,666 (25%)	2,256 (37%)	2,814 (38%)
Reproductive Health/Family Planning	9,012 (28%)	1,637 (24%)	1,362 (27%)	1,637 (24%)	1,951 (32%)	2,425 (33%)
Postpartum care	8,960 (28%)	1,585 (23%)	1,149 (23%)	1,585 (23%)	2,024 (33%)	2,617 (36%)
Medical Home	8,349 (26%)	1,474 (22%)	1,229 (24%)	1,474 (22%)	1,864 (30%)	2,308 (32%)
Parenting	8,291 (26%)	1,354 (20%)	1,026 (20%)	1,354 (20%)	2,094 (34%)	2,463 (34%)
WIC	7,338 (23%)	19 (0.3%)	1,290 (25%)	19 (0.3%)	2,677 (44%)	3,333 (46%)
Lifestyle risk factors/prenatal exposures	7,139 (22%)	1,248 (18%)	1,217 (24%)	1,248 (18%)	1,517 (25%)	1,909 (26%)
Child development/Developmental Screening	6,250 (20%)	1,398 (21%)	815 (16%)	1,398 (21%)	1,112 (18%)	1,527 (21%)
Postpartum depression	6,071 (19%)	2,311 (34%)	1,448 (28%)	2,311 (34%)	1 (<0.1%)	0 (0%)
Labor/Childbirth	6,025 (19%)	997 (15%)	1,018 (20%)	997 (15%)	1,390 (23%)	1,623 (22%)
Smoking Cessation/Second-hand exposure	5,938 (19%)	1,350 (20%)	851 (17%)	1,350 (20%)	915 (15%)	1,472 (20%)
Maternal Warning Signs	5,574 (17%)	0 (0%)	24 (0.5%)	0 (0%)	2,318 (38%)	3,232 (44%)
Perinatal Mood and Anxiety Disorders	5,290 (17%)	0 (0%)	22 (0.4%)	0 (0%)	2,365 (39%)	2,903 (40%)
Well Woman	5,139 (16%)	805 (12%)	943 (19%)	805 (12%)	1,150 (19%)	1,436 (20%)
Preterm Labor	5,056 (16%)	878 (13%)	745 (15%)	878 (13%)	1,061 (17%)	1,494 (20%)
Alcohol/Substance Abuse	4,224 (13%)	716 (11%)	538 (11%)	716 (11%)	981 (16%)	1,273 (17%)

Service Type	Overall N = 32,043	2020 N = 6,751	2021 N = 5,081	2022 N = 6,751	2023 N = 6,139	2024 N = 7,321
Count the Kicks	4,161 (13%)	10 (0.1%)	674 (13%)	10 (0.1%)	1,541 (25%)	1,926 (26%)
Family Violence	3,649 (11%)	719 (11%)	450 (8.9%)	719 (11%)	770 (13%)	991 (14%)
Preconception/Interconception	3,028 (9.4%)	575 (8.5%)	510 (10%)	575 (8.5%)	524 (8.5%)	844 (12%)
Behavioral Health (Other than Post-partum depression)	2,956 (9.2%)	1,029 (15%)	898 (18%)	1,029 (15%)	0 (0%)	0 (0%)
Continuation of Education	2,914 (9.1%)	0 (0%)	0 (0%)	0 (0%)	1,175 (19%)	1,739 (24%)
Weight Management	2,910 (9.1%)	362 (5.4%)	561 (11%)	362 (5.4%)	837 (14%)	788 (11%)
Other	2,841 (8.9%)	633 (9.4%)	323 (6.4%)	633 (9.4%)	573 (9.3%)	679 (9.3%)
Food Assistance	2,436 (7.6%)	0 (0%)	0 (0%)	0 (0%)	961 (16%)	1,475 (20%)
Lead Prevention	2,260 (7.1%)	7 (0.1%)	300 (5.9%)	7 (0.1%)	798 (13%)	1,148 (16%)
Child Care Resources	1,855 (5.8%)	0 (0%)	0 (0%)	0 (0%)	731 (12%)	1,124 (15%)
Behavioral Health (Other than Perinatal Mood and Anxiety Disorders)	1,777 (5.5%)	0 (0%)	12 (0.2%)	0 (0%)	994 (16%)	771 (11%)
Suicide Prevention	1,000 (3.1%)	231 (3.4%)	121 (2.4%)	231 (3.4%)	169 (2.8%)	248 (3.4%)
Child Protection Information	729 (2.3%)	0 (0%)	0 (0%)	0 (0%)	287 (4.7%)	442 (6.0%)
Teen Pregnancy Prevention	685 (2.1%)	201 (3.0%)	99 (1.9%)	201 (3.0%)	61 (1.0%)	123 (1.7%)
Utilities Assistance	652 (2.0%)	0 (0%)	0 (0%)	0 (0%)	196 (3.2%)	456 (6.2%)
Well Adolescent	632 (2.0%)	185 (2.7%)	93 (1.8%)	185 (2.7%)	42 (0.7%)	127 (1.7%)
Transition	620 (1.9%)	0 (0%)	92 (1.8%)	0 (0%)	204 (3.3%)	324 (4.4%)
Transportation Assistance	557 (1.7%)	0 (0%)	0 (0%)	0 (0%)	163 (2.7%)	394 (5.4%)
Bullying	518 (1.6%)	79 (1.2%)	96 (1.9%)	79 (1.2%)	79 (1.3%)	185 (2.5%)

Source: Kansas Title V DAISEY Data System.

Table F.3.3. MCH Adult Screening Service Rates by Fiscal Year

Service Type	Overall N = 32,043	2020 N = 6,751	2021 N = 5,081	2022 N = 6,751	2023 N = 6,139	2024 N = 7,321
Missing	25,899 (81%)	6,751 (100%)	5,047 (99%)	6,751 (100%)	3,699 (60%)	3,651 (50%)
No Screening tool Administered	4,075 (13%)	1 (<0.1%)	61 (1.2%)	1 (<0.1%)	1,775 (29%)	2,237 (31%)
PHQ-9	731 (2.3%)	0 (0%)	0 (0%)	0 (0%)	169 (2.8%)	562 (7.7%)
EPDS	4,469 (14%)	0 (0%)	26 (0.5%)	0 (0%)	1,838 (30%)	2,605 (36%)
Other	800 (2.5%)	0 (0%)	0 (0%)	0 (0%)	279 (4.5%)	521 (7.1%)
AUDIT	66 (0.2%)	0 (0%)	0 (0%)	0 (0%)	51 (0.8%)	15 (0.2%)
DAST	73 (0.2%)	0 (0%)	0 (0%)	0 (0%)	13 (0.2%)	60 (0.8%)
ASSIST	41 (0.1%)	0 (0%)	0 (0%)	0 (0%)	4 (<0.1%)	37 (0.5%)
GAD-7	168 (0.5%)	0 (0%)	0 (0%)	0 (0%)	25 (0.4%)	143 (2.0%)
PHQ-A	19 (<0.1%)	0 (0%)	0 (0%)	0 (0%)	4 (<0.1%)	15 (0.2%)

Source: Kansas Title V DAISEY Data System.

Table F.3.4. MCH Child Direct Service Rates by Fiscal Year

Service Type	Overall N = 28,536	2020 N = 6,215	2021 N = 4,212	2022 N = 6,215	2023 N = 5,466	2024 N = 6,428
Immunization	15,736 (55%)	3,626 (58%)	2,572 (61%)	3,626 (58%)	2,852 (52%)	3,060 (48%)
Education	13,255 (46%)	3,163 (51%)	2,146 (51%)	3,163 (51%)	2,467 (45%)	2,316 (36%)
Vision Screening	4,892 (17%)	1,194 (19%)	735 (17%)	1,194 (19%)	898 (16%)	871 (14%)
Hearing Screening	4,602 (16%)	1,157 (19%)	645 (15%)	1,157 (19%)	888 (16%)	755 (12%)
Kan Be Healthy	4,442 (16%)	1,007 (16%)	708 (17%)	1,007 (16%)	881 (16%)	839 (13%)
Dental	3,593 (13%)	675 (11%)	415 (9.9%)	675 (11%)	814 (15%)	1,014 (16%)
Developmental Screening	3,523 (12%)	909 (15%)	490 (12%)	909 (15%)	561 (10%)	654 (10%)
BP/WT/Hgb	3,396 (12%)	406 (6.5%)	404 (9.6%)	406 (6.5%)	1,140 (21%)	1,040 (16%)
Lead Screening	3,255 (11%)	637 (10%)	336 (8.0%)	637 (10%)	781 (14%)	864 (13%)
Ages & Stages Questionnaire (ASQ)	3,155 (11%)	765 (12%)	434 (10%)	765 (12%)	565 (10%)	626 (9.7%)
Well Child Visit	3,032 (11%)	710 (11%)	404 (9.6%)	710 (11%)	544 (10.0%)	664 (10%)
Blood/Lab Work	1,711 (6.0%)	338 (5.4%)	196 (4.7%)	338 (5.4%)	448 (8.2%)	391 (6.1%)
Sick Visit	1,297 (4.5%)	230 (3.7%)	164 (3.9%)	230 (3.7%)	342 (6.3%)	331 (5.1%)

Other Service/Screening	1,238 (4.3%)	302 (4.9%)	195 (4.6%)	302 (4.9%)	217 (4.0%)	222 (3.5%)
Sports Physical	988 (3.5%)	147 (2.4%)	237 (5.6%)	147 (2.4%)	221 (4.0%)	236 (3.7%)
Other Nursing Assessment	976 (3.4%)	188 (3.0%)	153 (3.6%)	188 (3.0%)	177 (3.2%)	270 (4.2%)
Well Adolescent Visit	778 (2.7%)	227 (3.7%)	142 (3.4%)	227 (3.7%)	78 (1.4%)	104 (1.6%)
Injury Prevention	614 (2.2%)	16 (0.3%)	79 (1.9%)	16 (0.3%)	252 (4.6%)	251 (3.9%)
MCH Home Visit Education	304 (1.1%)	22 (0.4%)	30 (0.7%)	22 (0.4%)	21 (0.4%)	209 (3.3%)
Car Seat Installation/Check	274 (1.0%)	65 (1.0%)	21 (0.5%)	65 (1.0%)	55 (1.0%)	68 (1.1%)

Source: Kansas Title V DAISEY Data System. Note. Services with a rate under 1% are not included in this table.

Table F.3.5. MCH Child Education Service Rates by Fiscal Year

Service Type	Overall N = 28,536	2020 N = 6,215	2021 N = 4,212	2022 N = 6,215	2023 N = 5,466	2024 N = 6,428
Immunizations	18,205 (64%)	4,208 (68%)	2,844 (68%)	4,208 (68%)	3,226 (59%)	3,719 (58%)
Oral Health	9,409 (33%)	1,757 (28%)	1,400 (33%)	1,757 (28%)	1,898 (35%)	2,597 (40%)
Nutrition	7,309 (26%)	1,431 (23%)	971 (23%)	1,431 (23%)	1,442 (26%)	2,034 (32%)
Well Child	4,496 (16%)	988 (16%)	584 (14%)	988 (16%)	755 (14%)	1,181 (18%)
Medical Home	3,686 (13%)	560 (9.0%)	409 (9.7%)	560 (9.0%)	920 (17%)	1,237 (19%)
Child development/Developmental Screening	3,641 (13%)	954 (15%)	478 (11%)	954 (15%)	555 (10%)	700 (11%)
Injury prevention/safety	3,516 (12%)	687 (11%)	567 (13%)	687 (11%)	629 (12%)	946 (15%)
Well Adolescent	1,670 (5.9%)	358 (5.8%)	410 (9.7%)	358 (5.8%)	197 (3.6%)	347 (5.4%)
Other	1,606 (5.6%)	151 (2.4%)	117 (2.8%)	151 (2.4%)	496 (9.1%)	691 (11%)
Lead Prevention	1,381 (4.8%)	9 (0.1%)	166 (3.9%)	9 (0.1%)	549 (10%)	648 (10%)
Parenting	1,271 (4.5%)	196 (3.2%)	116 (2.8%)	196 (3.2%)	346 (6.3%)	417 (6.5%)
Car seat safety/installation	844 (3.0%)	197 (3.2%)	97 (2.3%)	197 (3.2%)	160 (2.9%)	193 (3.0%)
Health Care Coverage / Medicaid Eligibility	817 (2.9%)	191 (3.1%)	56 (1.3%)	191 (3.1%)	157 (2.9%)	222 (3.5%)
State/local resources	757 (2.7%)	204 (3.3%)	68 (1.6%)	204 (3.3%)	101 (1.8%)	180 (2.8%)
Smoking Cessation/Second-hand exposure	738 (2.6%)	112 (1.8%)	84 (2.0%)	112 (1.8%)	145 (2.7%)	285 (4.4%)
WIC	660 (2.3%)	3 (<0.1%)	65 (1.5%)	3 (<0.1%)	265 (4.8%)	324 (5.0%)
Father Involvement	430 (1.5%)	83 (1.3%)	37 (0.9%)	83 (1.3%)	108 (2.0%)	119 (1.9%)
Bullying	359 (1.3%)	84 (1.4%)	11 (0.3%)	84 (1.4%)	76 (1.4%)	104 (1.6%)

Source: Kansas Title V DAISEY Data System. Note. Services with a rate under 1% are not included in this table.

Table F.3.6. Becoming a Mom Session Attendance Rates by Fiscal Year

	Overall N = 5,379	2020 N = 1,191	2021 N = 724	2022 N = 821	2023 N = 1,061	2024 N = 1,582
Session 1	4,356 (81%)	987 (83%)	636 (88%)	685 (83%)	810 (76%)	1,238 (78%)
Session 3	4,272 (79%)	974 (82%)	632 (87%)	688 (84%)	789 (74%)	1,189 (75%)
Session 4	4,205 (78%)	931 (78%)	630 (87%)	677 (82%)	780 (74%)	1,187 (75%)
Session 2	4,188 (78%)	934 (78%)	621 (86%)	670 (82%)	787 (74%)	1,176 (74%)
Session 5	4,084 (76%)	905 (76%)	614 (85%)	669 (81%)	760 (72%)	1,136 (72%)
Session 6	4,012 (75%)	877 (74%)	614 (85%)	654 (80%)	740 (70%)	1,127 (71%)
Session 7	255 (4.7%)	0 (0%)	0 (0%)	0 (0%)	111 (10%)	144 (9.1%)

Source: Kansas Title V DAISEY Data System.

Table F.3.7. PMI Direct Service Rates by Fiscal Year

Service Type	Overall N = 3,913	2020 N = 558	2021 N = 761	2022 N = 844	2023 N = 784	2024 N = 966
Material Goods	2,608 (67%)	436 (78%)	445 (58%)	484 (57%)	558 (71%)	685 (71%)
Prenatal Support	2,581 (66%)	358 (64%)	587 (77%)	592 (70%)	496 (63%)	548 (57%)
Education	2,454 (63%)	393 (70%)	404 (53%)	431 (51%)	521 (66%)	705 (73%)
Parenting Support	2,435 (62%)	383 (69%)	452 (59%)	486 (58%)	528 (67%)	586 (61%)
Healthcare Coverage Information	1,330 (34%)	152 (27%)	213 (28%)	263 (31%)	286 (36%)	416 (43%)
Counselingother type not specified	908 (23%)	108 (19%)	166 (22%)	183 (22%)	204 (26%)	247 (26%)
Maternal Depression Screening	882 (23%)	129 (23%)	236 (31%)	163 (19%)	121 (15%)	233 (24%)
Behavioral Health Services	835 (21%)	58 (10%)	242 (32%)	297 (35%)	153 (20%)	85 (8.8%)
Food Assistance	750 (19%)	117 (21%)	124 (16%)	113 (13%)	168 (21%)	228 (24%)
Other	603 (15%)	67 (12%)	98 (13%)	152 (18%)	106 (14%)	180 (19%)
Employment Assistance	603 (15%)	119 (21%)	129 (17%)	110 (13%)	112 (14%)	133 (14%)
Reproductive Health/Family Planning information	585 (15%)	83 (15%)	101 (13%)	139 (16%)	131 (17%)	131 (14%)
Housing Assistance	577 (15%)	100 (18%)	123 (16%)	111 (13%)	118 (15%)	125 (13%)
Transportation Assistance	487 (12%)	62 (11%)	65 (8.5%)	56 (6.6%)	87 (11%)	217 (22%)
Information about Continuation of Education	485 (12%)	88 (16%)	101 (13%)	106 (13%)	110 (14%)	80 (8.3%)
Adoption Counseling/Services	385 (9.8%)	57 (10%)	67 (8.8%)	62 (7.3%)	74 (9.4%)	125 (13%)

Budgeting	304 (7.8%)	36 (6.5%)	38 (5.0%)	74 (8.8%)	73 (9.3%)	83 (8.6%)
Smoking Cessation Counseling	225 (5.8%)	51 (9.1%)	56 (7.4%)	58 (6.9%)	25 (3.2%)	35 (3.6%)
Social Determinants of Health Screen	218 (5.6%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	218 (23%)
Child Care Assistance	164 (4.2%)	21 (3.8%)	41 (5.4%)	45 (5.3%)	21 (2.7%)	36 (3.7%)
Alcohol/Substance Abuse Services	130 (3.3%)	18 (3.2%)	32 (4.2%)	49 (5.8%)	19 (2.4%)	12 (1.2%)
Domestic Violence Information/Services	127 (3.2%)	17 (3.0%)	25 (3.3%)	43 (5.1%)	19 (2.4%)	23 (2.4%)
Utilities Assistance	124 (3.2%)	20 (3.6%)	27 (3.5%)	22 (2.6%)	19 (2.4%)	36 (3.7%)
Child Protection Information/Services	61 (1.6%)	14 (2.5%)	15 (2.0%)	17 (2.0%)	7 (0.9%)	8 (0.8%)

Source: Kansas Title V DAISEY Data System. Note. Services with a rate under 1% are not included in this table.

Table F.3.8 PMI Education Service Rates by Fiscal Year

Service Type	Overall N = 3,913	2020 N = 558	2021 N = 761	2022 N = 844	2023 N = 784	2024 N = 966
State/local resources	2,017 (52%)	225 (40%)	368 (48%)	450 (53%)	410 (52%)	564 (58%)
Prenatal Care	1,838 (47%)	235 (42%)	421 (55%)	450 (53%)	353 (45%)	379 (39%)
Safe Sleep	1,502 (38%)	244 (44%)	303 (40%)	346 (41%)	274 (35%)	335 (35%)
Breastfeeding	1,475 (38%)	224 (40%)	297 (39%)	377 (45%)	275 (35%)	302 (31%)
WIC	1,420 (36%)	0 (0%)	266 (35%)	415 (49%)	353 (45%)	386 (40%)
Parenting	1,417 (36%)	219 (39%)	299 (39%)	360 (43%)	289 (37%)	250 (26%)
Nutrition	1,400 (36%)	192 (34%)	274 (36%)	344 (41%)	274 (35%)	316 (33%)
Health Care Coverage / Medicaid Eligibility	1,385 (35%)	163 (29%)	253 (33%)	292 (35%)	293 (37%)	384 (40%)
Infant Care	1,315 (34%)	207 (37%)	260 (34%)	337 (40%)	265 (34%)	246 (25%)
Labor/Childbirth	1,293 (33%)	177 (32%)	278 (37%)	340 (40%)	250 (32%)	248 (26%)
Oral Health	1,057 (27%)	136 (24%)	207 (27%)	274 (32%)	208 (27%)	232 (24%)
Car seat safety/installation	973 (25%)	145 (26%)	164 (22%)	186 (22%)	199 (25%)	279 (29%)
Perinatal Mood and Anxiety Disorders	965 (25%)	0 (0%)	2 (0.3%)	261 (31%)	272 (35%)	430 (45%)
Child development/Developmental Screening	866 (22%)	99 (18%)	142 (19%)	200 (24%)	179 (23%)	246 (25%)
Immunizations	825 (21%)	119 (21%)	148 (19%)	227 (27%)	164 (21%)	167 (17%)
Lifestyle risk factors/prenatal exposures	823 (21%)	60 (11%)	148 (19%)	241 (29%)	151 (19%)	223 (23%)
Reproductive Health/Family Planning	809 (21%)	111 (20%)	147 (19%)	185 (22%)	162 (21%)	204 (21%)
Count the Kicks	691 (18%)	0 (0%)	126 (17%)	190 (23%)	148 (19%)	227 (23%)

Father Involvement	681 (17%)	77 (14%)	102 (13%)	151 (18%)	147 (19%)	204 (21%)
Postpartum care	660 (17%)	99 (18%)	87 (11%)	172 (20%)	151 (19%)	151 (16%)
Medical Home	637 (16%)	57 (10%)	140 (18%)	180 (21%)	101 (13%)	159 (16%)
Smoking Cessation/Second-hand exposure	585 (15%)	114 (20%)	101 (13%)	121 (14%)	105 (13%)	144 (15%)
Injury prevention/safety	563 (14%)	75 (13%)	113 (15%)	113 (13%)	95 (12%)	167 (17%)
Maternal Warning Signs	548 (14%)	0 (0%)	2 (0.3%)	242 (29%)	113 (14%)	191 (20%)
Postpartum depression	529 (14%)	159 (28%)	160 (21%)	210 (25%)	0 (0%)	0 (0%)
Well Woman	515 (13%)	36 (6.5%)	95 (12%)	106 (13%)	145 (18%)	133 (14%)
Behavioral Health (Other than Post-partum depression)	512 (13%)	109 (20%)	226 (30%)	177 (21%)	0 (0%)	0 (0%)
Preterm Labor	412 (11%)	61 (11%)	53 (7.0%)	100 (12%)	50 (6.4%)	148 (15%)
Behavioral Health (Other than Perinatal Mood and Anxiety Disorders)	409 (10%)	0 (0%)	1 (0.1%)	158 (19%)	137 (17%)	113 (12%)
Weight Management	339 (8.7%)	54 (9.7%)	62 (8.1%)	78 (9.2%)	80 (10%)	65 (6.7%)
Alcohol/Substance Abuse	277 (7.1%)	68 (12%)	54 (7.1%)	59 (7.0%)	50 (6.4%)	46 (4.8%)
Other	276 (7.1%)	46 (8.2%)	42 (5.5%)	49 (5.8%)	30 (3.8%)	109 (11%)
Food Assistance	270 (6.9%)	0 (0%)	0 (0%)	5 (0.6%)	89 (11%)	176 (18%)
Well Child	267 (6.8%)	20 (3.6%)	23 (3.0%)	56 (6.6%)	73 (9.3%)	95 (9.8%)
Family Violence	251 (6.4%)	20 (3.6%)	37 (4.9%)	58 (6.9%)	33 (4.2%)	103 (11%)
Transition	187 (4.8%)	0 (0%)	6 (0.8%)	35 (4.1%)	52 (6.6%)	94 (9.7%)
Child Care Resources	138 (3.5%)	0 (0%)	0 (0%)	2 (0.2%)	62 (7.9%)	74 (7.7%)
Preconception/Interconception	114 (2.9%)	7 (1.3%)	15 (2.0%)	31 (3.7%)	16 (2.0%)	45 (4.7%)
Continuation of Education	107 (2.7%)	0 (0%)	0 (0%)	6 (0.7%)	71 (9.1%)	30 (3.1%)
Transportation Assistance	101 (2.6%)	0 (0%)	0 (0%)	5 (0.6%)	33 (4.2%)	63 (6.5%)
Utilities Assistance	85 (2.2%)	0 (0%)	0 (0%)	0 (0%)	17 (2.2%)	68 (7.0%)
Lead Prevention	39 (1.0%)	0 (0%)	5 (0.7%)	14 (1.7%)	11 (1.4%)	9 (0.9%)
Bullying	38 (1.0%)	5 (0.9%)	0 (0%)	16 (1.9%)	10 (1.3%)	7 (0.7%)
Teen Pregnancy Prevention	38 (1.0%)	8 (1.4%)	3 (0.4%)	12 (1.4%)	7 (0.9%)	8 (0.8%)
Suicide Prevention	22 (0.6%)	6 (1.1%)	6 (0.8%)	5 (0.6%)	2 (0.3%)	3 (0.3%)
Child Protection Information	18 (0.5%)	0 (0%)	0 (0%)	1 (0.1%)	9 (1.1%)	8 (0.8%)
Well Adolescent	18 (0.5%)	7 (1.3%)	6 (0.8%)	3 (0.4%)	2 (0.3%)	0 (0%)

Source: Kansas Title V DAISEY Data System. Note. Services with a rate under 1% are not included in this table.

Table F.3.9 TPTCM Direct Service Rates by Fiscal Year

Service Type	Overall N = 1,893	2020 N = 363	2021 N = 384	2022 N = 380	2023 N = 416	2024 N = 350
Education	1,472 (78%)	298 (82%)	312 (81%)	304 (80%)	301 (72%)	257 (73%)
Parenting Support	1,268 (67%)	250 (69%)	290 (76%)	236 (62%)	276 (66%)	216 (62%)
Prenatal Support	1,226 (65%)	247 (68%)	275 (72%)	248 (65%)	248 (60%)	208 (59%)
Material Goods	1,049 (55%)	191 (53%)	221 (58%)	198 (52%)	242 (58%)	197 (56%)
Maternal Depression Screening	745 (39%)	122 (34%)	146 (38%)	164 (43%)	171 (41%)	142 (41%)
Healthcare Coverage Information	611 (32%)	147 (40%)	119 (31%)	118 (31%)	91 (22%)	136 (39%)
Counseling other type not specified	521 (28%)	137 (38%)	122 (32%)	118 (31%)	71 (17%)	73 (21%)
Reproductive Health/Family Planning information	516 (27%)	116 (32%)	147 (38%)	114 (30%)	86 (21%)	53 (15%)
Budgeting	455 (24%)	87 (24%)	94 (24%)	103 (27%)	97 (23%)	74 (21%)
Food Assistance	425 (22%)	104 (29%)	102 (27%)	86 (23%)	53 (13%)	80 (23%)
Information about Continuation of Education	400 (21%)	103 (28%)	87 (23%)	93 (24%)	55 (13%)	62 (18%)
Other	369 (19%)	93 (26%)	87 (23%)	76 (20%)	63 (15%)	50 (14%)
Behavioral Health Services	369 (19%)	74 (20%)	65 (17%)	96 (25%)	75 (18%)	59 (17%)
Housing Assistance	367 (19%)	74 (20%)	95 (25%)	74 (19%)	68 (16%)	56 (16%)
Employment Assistance	336 (18%)	82 (23%)	73 (19%)	75 (20%)	57 (14%)	49 (14%)
Child Care Assistance	229 (12%)	50 (14%)	44 (11%)	52 (14%)	37 (8.9%)	46 (13%)
Transportation Assistance	226 (12%)	52 (14%)	45 (12%)	45 (12%)	38 (9.1%)	46 (13%)
Smoking Cessation Counseling	196 (10%)	56 (15%)	48 (13%)	39 (10%)	30 (7.2%)	23 (6.6%)
Domestic Violence Information/Services	142 (7.5%)	39 (11%)	41 (11%)	36 (9.5%)	17 (4.1%)	9 (2.6%)
Alcohol/Substance Abuse Services	132 (7.0%)	35 (9.6%)	24 (6.3%)	33 (8.7%)	19 (4.6%)	21 (6.0%)
Child Protection Information/Services	123 (6.5%)	40 (11%)	28 (7.3%)	30 (7.9%)	13 (3.1%)	12 (3.4%)
Utilities Assistance	111 (5.9%)	31 (8.5%)	29 (7.6%)	34 (8.9%)	12 (2.9%)	5 (1.4%)
Adoption Counseling/Services	102 (5.4%)	31 (8.5%)	26 (6.8%)	29 (7.6%)	13 (3.1%)	3 (0.9%)
Social Determinants of Health Screen	53 (2.8%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	53 (15%)

Source: Kansas Title V DAISEY Data System. Note. Services with a rate under 1% are not included in this table.

Table F.3.10 TPTCM Education Service Rates by Fiscal Year

Service Type	Overall N = 1,893	2020 N = 363	2021 N = 384	2022 N = 380	2023 N = 416	2024 N = 350
Parenting	1,196 (63%)	209 (58%)	235 (61%)	220 (58%)	305 (73%)	227 (65%)
State/local resources	1,173 (62%)	194 (53%)	238 (62%)	249 (66%)	258 (62%)	234 (67%)
Infant Care	1,096 (58%)	204 (56%)	238 (62%)	211 (56%)	251 (60%)	192 (55%)
Prenatal Care	1,070 (57%)	206 (57%)	228 (59%)	221 (58%)	228 (55%)	187 (53%)
Father Involvement	1,005 (53%)	184 (51%)	198 (52%)	199 (52%)	229 (55%)	195 (56%)
Nutrition	977 (52%)	145 (40%)	198 (52%)	204 (54%)	249 (60%)	181 (52%)
Safe Sleep	912 (48%)	157 (43%)	190 (49%)	175 (46%)	227 (55%)	163 (47%)
Health Care Coverage / Medicaid Eligibility	860 (45%)	182 (50%)	173 (45%)	157 (41%)	174 (42%)	174 (50%)
Breastfeeding	855 (45%)	146 (40%)	169 (44%)	160 (42%)	217 (52%)	163 (47%)
WIC	720 (38%)	7 (1.9%)	161 (42%)	165 (43%)	199 (48%)	188 (54%)
Reproductive Health/Family Planning	685 (36%)	131 (36%)	164 (43%)	122 (32%)	156 (38%)	112 (32%)
Labor/Childbirth	626 (33%)	119 (33%)	137 (36%)	124 (33%)	139 (33%)	107 (31%)
Postpartum care	624 (33%)	113 (31%)	131 (34%)	125 (33%)	155 (37%)	100 (29%)
Immunizations	618 (33%)	112 (31%)	131 (34%)	129 (34%)	130 (31%)	116 (33%)
Child development/Developmental Screening	557 (29%)	95 (26%)	99 (26%)	104 (27%)	137 (33%)	122 (35%)
Medical Home	546 (29%)	105 (29%)	112 (29%)	130 (34%)	112 (27%)	87 (25%)
Oral Health	527 (28%)	82 (23%)	68 (18%)	112 (29%)	143 (34%)	122 (35%)
Car seat safety/installation	448 (24%)	107 (29%)	78 (20%)	95 (25%)	94 (23%)	74 (21%)
Lifestyle risk factors/prenatal exposures	426 (23%)	104 (29%)	93 (24%)	98 (26%)	72 (17%)	59 (17%)
Perinatal Mood and Anxiety Disorders	396 (21%)	0 (0%)	6 (1.6%)	128 (34%)	150 (36%)	112 (32%)
Well Woman	378 (20%)	46 (13%)	73 (19%)	64 (17%)	118 (28%)	77 (22%)
Injury prevention/safety	368 (19%)	62 (17%)	80 (21%)	85 (22%)	65 (16%)	76 (22%)
Behavioral Health (Other than Perinatal Mood and Anxiety Disorders)	360 (19%)	0 (0%)	3 (0.8%)	115 (30%)	126 (30%)	116 (33%)
Maternal Warning Signs	349 (18%)	0 (0%)	1 (0.3%)	110 (29%)	140 (34%)	98 (28%)
Smoking Cessation/Second-hand exposure	343 (18%)	70 (19%)	64 (17%)	79 (21%)	80 (19%)	50 (14%)
Postpartum depression	326 (17%)	89 (25%)	121 (32%)	116 (31%)	0 (0%)	0 (0%)
Behavioral Health (Other than Post-partum depression)	312 (16%)	85 (23%)	111 (29%)	116 (31%)	0 (0%)	0 (0%)

Service Type	Overall N = 1,893	2020 N = 363	2021 N = 384	2022 N = 380	2023 N = 416	2024 N = 350
Preterm Labor	298 (16%)	42 (12%)	51 (13%)	57 (15%)	77 (19%)	71 (20%)
Count the Kicks	291 (15%)	0 (0%)	55 (14%)	86 (23%)	87 (21%)	63 (18%)
Well Child	277 (15%)	15 (4.1%)	40 (10%)	53 (14%)	100 (24%)	69 (20%)
Other	274 (14%)	61 (17%)	71 (18%)	46 (12%)	50 (12%)	46 (13%)
Family Violence	227 (12%)	28 (7.7%)	53 (14%)	53 (14%)	53 (13%)	40 (11%)
Continuation of Education	198 (10%)	0 (0%)	0 (0%)	2 (0.5%)	99 (24%)	97 (28%)
Teen Pregnancy Prevention	161 (8.5%)	26 (7.2%)	23 (6.0%)	35 (9.2%)	49 (12%)	28 (8.0%)
Child Care Resources	140 (7.4%)	0 (0%)	0 (0%)	2 (0.5%)	66 (16%)	72 (21%)
Food Assistance	139 (7.3%)	0 (0%)	0 (0%)	1 (0.3%)	60 (14%)	78 (22%)
Alcohol/Substance Abuse	126 (6.7%)	13 (3.6%)	21 (5.5%)	26 (6.8%)	32 (7.7%)	34 (9.7%)
Preconception/Interconception	94 (5.0%)	1 (0.3%)	4 (1.0%)	11 (2.9%)	31 (7.5%)	47 (13%)
Transition	74 (3.9%)	4 (1.1%)	3 (0.8%)	4 (1.1%)	40 (9.6%)	23 (6.6%)
Transportation Assistance	67 (3.5%)	0 (0%)	0 (0%)	3 (0.8%)	34 (8.2%)	30 (8.6%)
Weight Management	43 (2.3%)	5 (1.4%)	4 (1.0%)	12 (3.2%)	16 (3.8%)	6 (1.7%)
Lead Prevention	40 (2.1%)	0 (0%)	3 (0.8%)	18 (4.7%)	15 (3.6%)	4 (1.1%)
Suicide Prevention	35 (1.8%)	5 (1.4%)	5 (1.3%)	5 (1.3%)	18 (4.3%)	2 (0.6%)
Bullying	27 (1.4%)	1 (0.3%)	3 (0.8%)	11 (2.9%)	8 (1.9%)	4 (1.1%)
Child Protection Information	23 (1.2%)	0 (0%)	0 (0%)	1 (0.3%)	11 (2.6%)	11 (3.1%)
Utilities Assistance	23 (1.2%)	0 (0%)	0 (0%)	1 (0.3%)	17 (4.1%)	5 (1.4%)
Well Adolescent	19 (1.0%)	1 (0.3%)	5 (1.3%)	3 (0.8%)	7 (1.7%)	3 (0.9%)

Source: Kansas Title V DAISEY Data System. Note. Services with a rate under 1% are not included in this table.

Table F.3.11. Title V Adult Referrals by Fiscal Year

Referral Type	Overall N = 12,872	2020 N = 3,226	2021 N = 2,337	2022 N = 2,379	2023 N = 2,357	2024 N = 2,573
WIC referral	4,496 (35%)	952 (30%)	1,005 (43%)	899 (38%)	816 (35%)	824 (32%)
Breastfeeding referral	3,268 (25%)	852 (26%)	572 (24%)	696 (29%)	498 (21%)	650 (25%)
Pregnancy Education referral	3,068 (24%)	550 (17%)	602 (26%)	664 (28%)	559 (24%)	693 (27%)
Parenting Education/Support referral	2,996 (23%)	748 (23%)	561 (24%)	674 (28%)	428 (18%)	585 (23%)
Other referral	2,743 (21%)	752 (23%)	617 (26%)	595 (25%)	331 (14%)	448 (17%)
Prenatal Care or Education referral	2,539 (20%)	551 (17%)	426 (18%)	537 (23%)	492 (21%)	533 (21%)
MCH/HSV referral	2,401 (19%)	550 (17%)	282 (12%)	528 (22%)	430 (18%)	611 (24%)
Postpartum Care or Education referral	2,359 (18%)	524 (16%)	216 (9.2%)	417 (18%)	535 (23%)	667 (26%)
Reproductive Health/Family Planning referral	1,989 (15%)	339 (11%)	217 (9.3%)	466 (20%)	435 (18%)	532 (21%)
Immunizations referral	1,278 (9.9%)	349 (11%)	197 (8.4%)	215 (9.0%)	230 (9.8%)	287 (11%)
Early Childhood Services (HeadStartPAT) referral	1,255 (9.7%)	409 (13%)	231 (9.9%)	266 (11%)	186 (7.9%)	163 (6.3%)
Health Care Coverage referral	1,172 (9.1%)	305 (9.5%)	219 (9.4%)	196 (8.2%)	188 (8.0%)	264 (10%)
Smoking Cessation: Kansas Tobacco Quitline referral	1,137 (8.8%)	303 (9.4%)	246 (11%)	194 (8.2%)	193 (8.2%)	201 (7.8%)
Food/Food Stamps (not WIC) referral	1,018 (7.9%)	172 (5.3%)	178 (7.6%)	183 (7.7%)	223 (9.5%)	262 (10%)
Dental Services referral	808 (6.3%)	182 (5.6%)	206 (8.8%)	236 (9.9%)	114 (4.8%)	70 (2.7%)
Other Medical referral	592 (4.6%)	154 (4.8%)	91 (3.9%)	114 (4.8%)	126 (5.3%)	107 (4.2%)
Housing referral	450 (3.5%)	120 (3.7%)	78 (3.3%)	81 (3.4%)	94 (4.0%)	77 (3.0%)
Cash Assistance referral	434 (3.4%)	88 (2.7%)	101 (4.3%)	87 (3.7%)	74 (3.1%)	84 (3.3%)
Employment Resources referral	393 (3.1%)	113 (3.5%)	107 (4.6%)	73 (3.1%)	49 (2.1%)	51 (2.0%)
Clothing referral	391 (3.0%)	98 (3.0%)	37 (1.6%)	40 (1.7%)	45 (1.9%)	171 (6.6%)
Child Care referral	389 (3.0%)	111 (3.4%)	66 (2.8%)	73 (3.1%)	58 (2.5%)	81 (3.1%)
Vision referral	346 (2.7%)	34 (1.1%)	87 (3.7%)	161 (6.8%)	57 (2.4%)	7 (0.3%)
Utilities Assistance referral	323 (2.5%)	57 (1.8%)	74 (3.2%)	66 (2.8%)	52 (2.2%)	74 (2.9%)
Well Woman Visit referral	281 (2.2%)	2 (<0.1%)	24 (1.0%)	91 (3.8%)	64 (2.7%)	100 (3.9%)
GED/High School Completion referral	276 (2.1%)	49 (1.5%)	43 (1.8%)	71 (3.0%)	60 (2.5%)	53 (2.1%)
Out of County MCH/HSV referral	268 (2.1%)	84 (2.6%)	20 (0.9%)	70 (2.9%)	47 (2.0%)	47 (1.8%)
Smoking Cessation: Baby & Me Tobacco Free referral	252 (2.0%)	112 (3.5%)	58 (2.5%)	23 (1.0%)	25 (1.1%)	34 (1.3%)

Referral Type	Overall N = 12,872	2020 N = 3,226	2021 N = 2,337	2022 N = 2,379	2023 N = 2,357	2024 N = 2,573
Child Care Subsidy referral	252 (2.0%)	60 (1.9%)	70 (3.0%)	48 (2.0%)	33 (1.4%)	41 (1.6%)
Transportation referral	215 (1.7%)	51 (1.6%)	32 (1.4%)	47 (2.0%)	38 (1.6%)	47 (1.8%)
Alcohol/Substance Abuse referral	175 (1.4%)	21 (0.7%)	34 (1.5%)	30 (1.3%)	62 (2.6%)	28 (1.1%)
Developmental Assessment/Screening referral	166 (1.3%)	83 (2.6%)	20 (0.9%)	34 (1.4%)	14 (0.6%)	15 (0.6%)
Fatherhood Initiative Referral	137 (1.1%)	15 (0.5%)	25 (1.1%)	33 (1.4%)	47 (2.0%)	17 (0.7%)
Domestic Violence referral	109 (0.8%)	26 (0.8%)	26 (1.1%)	22 (0.9%)	10 (0.4%)	25 (1.0%)

Source: Kansas Title V DAISEY Data System. Note. Services with a rate under 1% are not included in this table.

Table F.3.12. Title V Child Referrals by Fiscal Year

Referral Type	Overall N = 4,461	2020 N = 1,260	2021 N = 673	2022 N = 677	2023 N = 902	2024 N = 949
Immunizations referral	2,155 (48%)	442 (35%)	333 (49%)	407 (60%)	473 (52%)	500 (53%)
Dental Services referral	765 (17%)	233 (18%)	91 (14%)	92 (14%)	187 (21%)	162 (17%)
Other Medical referral	711 (16%)	176 (14%)	94 (14%)	97 (14%)	171 (19%)	173 (18%)
Vision referral	589 (13%)	162 (13%)	81 (12%)	99 (15%)	142 (16%)	105 (11%)
Hearing referral	246 (5.5%)	82 (6.5%)	24 (3.6%)	31 (4.6%)	74 (8.2%)	35 (3.7%)
Early Childhood Services (HeadStartPAT) referral	245 (5.5%)	70 (5.6%)	22 (3.3%)	27 (4.0%)	46 (5.1%)	80 (8.4%)
Developmental Assessment/Screening referral	216 (4.8%)	35 (2.8%)	26 (3.9%)	41 (6.1%)	54 (6.0%)	60 (6.3%)
Early Childhood Intervention (Part C Tiny-K) referral	143 (3.2%)	33 (2.6%)	17 (2.5%)	20 (3.0%)	41 (4.5%)	32 (3.4%)
Speech/Language referral	129 (2.9%)	42 (3.3%)	15 (2.2%)	21 (3.1%)	27 (3.0%)	24 (2.5%)
Other referral	116 (2.6%)	36 (2.9%)	15 (2.2%)	13 (1.9%)	19 (2.1%)	33 (3.5%)
Health Care Coverage referral	94 (2.1%)	33 (2.6%)	6 (0.9%)	8 (1.2%)	19 (2.1%)	28 (3.0%)
Smoking Cessation: Kansas Tobacco Quitline referral	79 (1.8%)	9 (0.7%)	56 (8.3%)	3 (0.4%)	4 (0.4%)	7 (0.7%)
Food/Food Stamps (not WIC) referral	76 (1.7%)	9 (0.7%)	3 (0.4%)	6 (0.9%)	25 (2.8%)	33 (3.5%)
Weight Management referral	74 (1.7%)	51 (4.0%)	8 (1.2%)	4 (0.6%)	6 (0.7%)	5 (0.5%)
MCH/HSV referral	48 (1.1%)	5 (0.4%)	1 (0.1%)	2 (0.3%)	16 (1.8%)	24 (2.5%)
Breastfeeding referral	44 (1.0%)	12 (1.0%)	1 (0.1%)	2 (0.3%)	15 (1.7%)	14 (1.5%)

Source: Kansas Title V DAISEY Data System. Note. Services with a rate under 1% are not included in this table.

Table F.3.13. MCH Service Delivery by Region

Service Type	North Central N = 1,952	Northeast N = 10,886	Northwest N = 568	South Central N = 8,523	Southeast N = 4,928	Southwest N = 4,582
Education	1,364 (70%)	8,025 (74%)	390 (69%)	3,005 (35%)	2,293 (47%)	2,425 (53%)
Maternal Depression Screening	448 (23%)	4,660 (43%)	23 (4.0%)	2,215 (26%)	635 (13%)	1,156 (25%)
MCH Home Visit Education	711 (36%)	2,037 (19%)	199 (35%)	2,177 (26%)	1,768 (36%)	1,417 (31%)
Blood/Lab Work	22 (1.1%)	3,119 (29%)	8 (1.4%)	567 (6.7%)	654 (13%)	1,881 (41%)
Other Service/Screening	26 (1.3%)	4,102 (38%)	11 (1.9%)	1,057 (12%)	188 (3.8%)	701 (15%)
Well Woman Care/Annual Visit	9 (0.5%)	542 (5.0%)	1 (0.2%)	3,995 (47%)	109 (2.2%)	286 (6.2%)
Prenatal/Post-Partum Nursing Assessment	127 (6.5%)	2,325 (21%)	22 (3.9%)	1,079 (13%)	632 (13%)	675 (15%)
BP/WT/Hgb	36 (1.8%)	2,981 (27%)	3 (0.5%)	614 (7.2%)	783 (16%)	324 (7.1%)
Contraception	18 (0.9%)	2,573 (24%)	4 (0.7%)	663 (7.8%)	158 (3.2%)	655 (14%)
Chlamydia Test	2 (0.1%)	2,339 (21%)	1 (0.2%)	652 (7.6%)	322 (6.5%)	542 (12%)
Immunization	74 (3.8%)	1,137 (10%)	21 (3.7%)	246 (2.9%)	864 (18%)	1,498 (33%)
Gonorrhea Test	2 (0.1%)	2,339 (21%)	1 (0.2%)	637 (7.5%)	312 (6.3%)	495 (11%)
Syphilis Test	3 (0.2%)	2,455 (23%)	0 (0%)	285 (3.3%)	302 (6.1%)	556 (12%)
Breastfeeding Assistance/Counseling	295 (15%)	1,337 (12%)	38 (6.7%)	373 (4.4%)	378 (7.7%)	970 (21%)
HIV Test	3 (0.2%)	2,256 (21%)	0 (0%)	248 (2.9%)	281 (5.7%)	515 (11%)
Other Nursing Assessment	13 (0.7%)	2,433 (22%)	10 (1.8%)	350 (4.1%)	77 (1.6%)	189 (4.1%)
Perinatal Mood and Anxiety Disorders	85 (4.4%)	789 (7.2%)	5 (0.9%)	768 (9.0%)	33 (0.7%)	784 (17%)
MCH Breast Exam	5 (0.3%)	1,612 (15%)	1 (0.2%)	225 (2.6%)	209 (4.2%)	303 (6.6%)
Injury Prevention	39 (2.0%)	493 (4.5%)	10 (1.8%)	305 (3.6%)	133 (2.7%)	1,321 (29%)
Breastfeeding Assessment	179 (9.2%)	933 (8.6%)	12 (2.1%)	252 (3.0%)	198 (4.0%)	581 (13%)
Fetal Heart Tones (FHT)	0 (0%)	367 (3.4%)	7 (1.2%)	156 (1.8%)	285 (5.8%)	1,197 (26%)
Maternal Depression Counseling	189 (9.7%)	1,068 (9.8%)	15 (2.6%)	422 (5.0%)	81 (1.6%)	227 (5.0%)
Glucose Tolerance Test	0 (0%)	938 (8.6%)	3 (0.5%)	73 (0.9%)	137 (2.8%)	757 (17%)
MCH Pap Smear	0 (0%)	1,188 (11%)	1 (0.2%)	137 (1.6%)	193 (3.9%)	192 (4.2%)
Car Seat Installation/Check	25 (1.3%)	348 (3.2%)	8 (1.4%)	117 (1.4%)	164 (3.3%)	1,024 (22%)
Dental	2 (0.1%)	70 (0.6%)	6 (1.1%)	339 (4.0%)	262 (5.3%)	951 (21%)
Pregnancy Test	12 (0.6%)	796 (7.3%)	3 (0.5%)	214 (2.5%)	124 (2.5%)	343 (7.5%)

Service Type	North Central N = 1,952	Northeast N = 10,886	Northwest N = 568	South Central N = 8,523	Southeast N = 4,928	Southwest N = 4,582
PHQ-9	3 (0.2%)	1,194 (11%)	3 (0.5%)	29 (0.3%)	187 (3.8%)	19 (0.4%)
Social Determinants of Health Screen	56 (2.9%)	848 (7.8%)	1 (0.2%)	396 (4.6%)	65 (1.3%)	9 (0.2%)
High-risk Case Management	18 (0.9%)	305 (2.8%)	0 (0%)	17 (0.2%)	474 (9.6%)	20 (0.4%)
Lead Screening	24 (1.2%)	193 (1.8%)	1 (0.2%)	545 (6.4%)	62 (1.3%)	3 (<0.1%)
Developmental Screening	0 (0%)	189 (1.7%)	5 (0.9%)	335 (3.9%)	121 (2.5%)	59 (1.3%)
Sick Visit	1 (<0.1%)	510 (4.7%)	1 (0.2%)	9 (0.1%)	50 (1.0%)	3 (<0.1%)
Ages & Stages Questionnaire (ASQ)	0 (0%)	181 (1.7%)	0 (0%)	133 (1.6%)	128 (2.6%)	0 (0%)
Smoking Cessation Counseling	23 (1.2%)	105 (1.0%)	3 (0.5%)	99 (1.2%)	188 (3.8%)	19 (0.4%)
Smoking Cessation Baby & Me Tobacco Free	2 (0.1%)	67 (0.6%)	2 (0.4%)	86 (1.0%)	199 (4.0%)	6 (0.1%)
Smoking Cessation Other	12 (0.6%)	177 (1.6%)	6 (1.1%)	106 (1.2%)	56 (1.1%)	4 (<0.1%)
Well Infant Visit	6 (0.3%)	142 (1.3%)	2 (0.4%)	18 (0.2%)	69 (1.4%)	108 (2.4%)

Source: Kansas Title V DAISEY Data System. Note. Services with a rate under 1% are not included in this table.

Table F.3.14. PMI Service Delivery by Region

Service Type	Overall N = 3,909	North Central N = 248	Northeast N = 1,764	Northwest N = 181	South Central N = 1,653	Southeast N = 3	Southwest N = 60
Material Goods	2,605 (67%)	231 (93%)	954 (54%)	167 (92%)	1,200 (73%)	2 (67%)	51 (85%)
Prenatal Support	2,579 (66%)	201 (81%)	1,277 (72%)	123 (68%)	944 (57%)	2 (67%)	32 (53%)
Education	2,452 (63%)	57 (23%)	990 (56%)	141 (78%)	1,204 (73%)	2 (67%)	58 (97%)
Parenting Support	2,434 (62%)	177 (71%)	885 (50%)	133 (73%)	1,183 (72%)	2 (67%)	54 (90%)
Healthcare Coverage Information	1,328 (34%)	51 (21%)	430 (24%)	2 (1.1%)	834 (50%)	0 (0%)	11 (18%)
Counseling other type not specified	908 (23%)	5 (2.0%)	307 (17%)	4 (2.2%)	576 (35%)	1 (33%)	15 (25%)
Maternal Depression Screening	882 (23%)	49 (20%)	418 (24%)	25 (14%)	366 (22%)	0 (0%)	24 (40%)
Behavioral Health Services	835 (21%)	4 (1.6%)	603 (34%)	0 (0%)	225 (14%)	0 (0%)	3 (5.0%)
Food Assistance	750 (19%)	49 (20%)	435 (25%)	38 (21%)	223 (13%)	0 (0%)	5 (8.3%)
Employment Assistance	603 (15%)	46 (19%)	306 (17%)	3 (1.7%)	248 (15%)	0 (0%)	0 (0%)
Other	601 (15%)	5 (2.0%)	240 (14%)	4 (2.2%)	335 (20%)	3 (100%)	14 (23%)
Reproductive Health/Family Planning information	585 (15%)	88 (35%)	274 (16%)	2 (1.1%)	195 (12%)	1 (33%)	25 (42%)
Housing Assistance	577 (15%)	49 (20%)	305 (17%)	5 (2.8%)	212 (13%)	0 (0%)	6 (10%)
Transportation Assistance	486 (12%)	43 (17%)	80 (4.5%)	0 (0%)	355 (21%)	0 (0%)	8 (13%)
Information about Continuation of Education	485 (12%)	26 (10%)	286 (16%)	2 (1.1%)	161 (9.7%)	0 (0%)	10 (17%)
Adoption Counseling/Services	385 (9.8%)	54 (22%)	263 (15%)	38 (21%)	30 (1.8%)	0 (0%)	0 (0%)
Budgeting	304 (7.8%)	17 (6.9%)	48 (2.7%)	0 (0%)	229 (14%)	0 (0%)	10 (17%)
Smoking Cessation Counseling	225 (5.8%)	15 (6.0%)	111 (6.3%)	1 (0.6%)	94 (5.7%)	0 (0%)	4 (6.7%)
Social Determinants of Health Screen	218 (5.6%)	18 (7.3%)	82 (4.6%)	22 (12%)	96 (5.8%)	0 (0%)	0 (0%)
Child Care Assistance	164 (4.2%)	18 (7.3%)	40 (2.3%)	2 (1.1%)	94 (5.7%)	0 (0%)	10 (17%)
Alcohol/Substance Abuse Services	130 (3.3%)	4 (1.6%)	67 (3.8%)	0 (0%)	56 (3.4%)	0 (0%)	3 (5.0%)
Domestic Violence Information/Services	127 (3.2%)	5 (2.0%)	35 (2.0%)	3 (1.7%)	80 (4.8%)	0 (0%)	4 (6.7%)
Utilities Assistance	124 (3.2%)	11 (4.4%)	50 (2.8%)	1 (0.6%)	60 (3.6%)	0 (0%)	2 (3.3%)
Child Protection Information/Services	61 (1.6%)	2 (0.8%)	12 (0.7%)	1 (0.6%)	46 (2.8%)	0 (0%)	0 (0%)

Source: Kansas Title V DAISEY Data System. Note. Services with a rate under 1% are not included in this table.

Table F.3.15. TPTCM Service Delivery by Region

Service Type	North Central N = 21	Northeast N = 756	Northwest N = 1	South Central N = 529	Southeast N = 583
Education	16 (76%)	671 (89%)	1 (100%)	360 (68%)	423 (73%)
Parenting Support	12 (57%)	430 (57%)	1 (100%)	413 (78%)	411 (70%)
Prenatal Support	17 (81%)	503 (67%)	1 (100%)	323 (61%)	381 (65%)
Material Goods	7 (33%)	383 (51%)	1 (100%)	273 (52%)	385 (66%)
Maternal Depression Screening	12 (57%)	357 (47%)	0 (0%)	170 (32%)	206 (35%)
Healthcare Coverage Information	14 (67%)	340 (45%)	1 (100%)	81 (15%)	175 (30%)
Counseling other type not specified	13 (62%)	272 (36%)	1 (100%)	85 (16%)	150 (26%)
Reproductive Health/Family Planning information	10 (48%)	185 (24%)	1 (100%)	168 (32%)	152 (26%)
Budgeting	3 (14%)	45 (6.0%)	1 (100%)	261 (49%)	145 (25%)
Food Assistance	13 (62%)	209 (28%)	1 (100%)	54 (10%)	148 (25%)
Information about Continuation of Education	4 (19%)	119 (16%)	0 (0%)	115 (22%)	162 (28%)
Other	2 (9.5%)	109 (14%)	0 (0%)	48 (9.1%)	210 (36%)
Behavioral Health Services	11 (52%)	125 (17%)	0 (0%)	115 (22%)	118 (20%)
Housing Assistance	4 (19%)	86 (11%)	1 (100%)	135 (26%)	140 (24%)
Employment Assistance	5 (24%)	127 (17%)	1 (100%)	69 (13%)	134 (23%)
Child Care Assistance	0 (0%)	23 (3.0%)	0 (0%)	90 (17%)	116 (20%)
Transportation Assistance	2 (9.5%)	71 (9.4%)	0 (0%)	36 (6.8%)	117 (20%)
Smoking Cessation Counseling	2 (9.5%)	21 (2.8%)	1 (100%)	23 (4.3%)	149 (26%)
Domestic Violence Information/Services	4 (19%)	20 (2.6%)	0 (0%)	28 (5.3%)	90 (15%)
Alcohol/Substance Abuse Services	1 (4.8%)	15 (2.0%)	0 (0%)	26 (4.9%)	89 (15%)
Child Protection Information/Services	3 (14%)	10 (1.3%)	0 (0%)	15 (2.8%)	95 (16%)
Utilities Assistance	0 (0%)	3 (0.4%)	0 (0%)	20 (3.8%)	88 (15%)
Adoption Counseling/Services	0 (0%)	13 (1.7%)	0 (0%)	5 (0.9%)	83 (14%)
Social Determinants of Health Screen	0 (0%)	15 (2.0%)	0 (0%)	13 (2.5%)	25 (4.3%)

Source: Kansas Title V DAISEY Data System. Note. Services with a rate under 1% are not included in this table.

Table F.3.16. Title V Adult Referrals by Region

Referral Type	North Central N = 1,087	Northeast N = 4,514	Northwest N = 265	South Central N = 3,316	Southeast N = 1,262	Southwest N = 2,072
WIC referral	340 (31%)	2,165 (48%)	41 (15%)	728 (22%)	303 (24%)	825 (40%)
Breastfeeding referral	191 (18%)	1,231 (27%)	56 (21%)	603 (18%)	304 (24%)	856 (41%)
Pregnancy Education referral	174 (16%)	1,887 (42%)	20 (7.5%)	590 (18%)	330 (26%)	54 (2.6%)
Parenting Education/Support referral	126 (12%)	1,556 (34%)	32 (12%)	942 (28%)	300 (24%)	22 (1.1%)
Other referral	59 (5.4%)	619 (14%)	94 (35%)	704 (21%)	418 (33%)	826 (40%)
Prenatal Care or Education referral	40 (3.7%)	1,521 (34%)	17 (6.4%)	395 (12%)	174 (14%)	363 (18%)
MCH/HSV referral	33 (3.0%)	908 (20%)	3 (1.1%)	726 (22%)	377 (30%)	335 (16%)
Postpartum Care or Education referral	556 (51%)	1,065 (24%)	4 (1.5%)	155 (4.7%)	82 (6.5%)	374 (18%)
Reproductive Health/Family Planning referral	70 (6.4%)	1,228 (27%)	2 (0.8%)	400 (12%)	80 (6.3%)	198 (9.6%)
Early Childhood Services (HeadStartPAT) referral	147 (14%)	517 (11%)	58 (22%)	105 (3.2%)	409 (32%)	8 (0.4%)
Health Care Coverage referral	37 (3.4%)	555 (12%)	11 (4.2%)	382 (12%)	101 (8.0%)	74 (3.6%)
Immunizations referral	37 (3.4%)	102 (2.3%)	3 (1.1%)	81 (2.4%)	288 (23%)	635 (31%)
Smoking Cessation: Kansas Tobacco Quitline referral	45 (4.1%)	318 (7.0%)	14 (5.3%)	574 (17%)	160 (13%)	13 (0.6%)
Food/Food Stamps (not WIC) referral	27 (2.5%)	510 (11%)	7 (2.6%)	238 (7.2%)	217 (17%)	11 (0.5%)
Dental Services referral	2 (0.2%)	440 (9.7%)	2 (0.8%)	188 (5.7%)	169 (13%)	3 (0.1%)
Other Medical referral	12 (1.1%)	289 (6.4%)	7 (2.6%)	149 (4.5%)	41 (3.2%)	83 (4.0%)
Housing referral	17 (1.6%)	218 (4.8%)	5 (1.9%)	158 (4.8%)	47 (3.7%)	2 (<0.1%)
Cash Assistance referral	9 (0.8%)	109 (2.4%)	22 (8.3%)	144 (4.3%)	142 (11%)	4 (0.2%)
Employment Resources referral	5 (0.5%)	94 (2.1%)	5 (1.9%)	125 (3.8%)	163 (13%)	0 (0%)
Clothing referral	5 (0.5%)	140 (3.1%)	7 (2.6%)	201 (6.1%)	29 (2.3%)	7 (0.3%)
Child Care referral	15 (1.4%)	259 (5.7%)	15 (5.7%)	60 (1.8%)	33 (2.6%)	3 (0.1%)
Vision referral	0 (0%)	266 (5.9%)	0 (0%)	73 (2.2%)	3 (0.2%)	1 (<0.1%)
Utilities Assistance referral	16 (1.5%)	155 (3.4%)	8 (3.0%)	101 (3.0%)	40 (3.2%)	2 (<0.1%)
GED/High School Completion referral	12 (1.1%)	106 (2.3%)	0 (0%)	118 (3.6%)	39 (3.1%)	0 (0%)

Source: Kansas Title V DAISEY Data System. Note. Services with a rate under 1% are not included in this table.

Table F.3.17 Title V Child Referrals by Region

Referral Type	North Central N = 193	Northeast N = 842	Northwest N = 124	South Central N = 1,115	Southeast N = 153	Southwest N = 1,942
Immunizations referral	26 (13%)	82 (9.7%)	20 (16%)	175 (16%)	10 (6.5%)	1,790 (92%)
Dental Services referral	30 (16%)	219 (26%)	39 (31%)	411 (37%)	23 (15%)	36 (1.9%)
Other Medical referral	37 (19%)	236 (28%)	22 (18%)	271 (24%)	24 (16%)	112 (5.8%)
Vision referral	17 (8.8%)	241 (29%)	34 (27%)	255 (23%)	16 (10%)	19 (1.0%)
WIC referral	28 (15%)	70 (8.3%)	16 (13%)	141 (13%)	2 (1.3%)	65 (3.3%)
Hearing referral	9 (4.7%)	51 (6.1%)	26 (21%)	106 (9.5%)	38 (25%)	13 (0.7%)
Early Childhood Services (HeadStartPAT) referral	22 (11%)	59 (7.0%)	19 (15%)	81 (7.3%)	43 (28%)	16 (0.8%)
Developmental Assessment/Screening referral	7 (3.6%)	35 (4.2%)	11 (8.9%)	108 (9.7%)	8 (5.2%)	47 (2.4%)
Early Childhood Intervention (Part CTiny-K) referral	3 (1.6%)	39 (4.6%)	8 (6.5%)	80 (7.2%)	4 (2.6%)	9 (0.5%)
Speech/Language referral	5 (2.6%)	44 (5.2%)	7 (5.6%)	59 (5.3%)	5 (3.3%)	8 (0.4%)
Other referral	7 (3.6%)	51 (6.1%)	4 (3.2%)	19 (1.7%)	13 (8.5%)	21 (1.1%)
Health Care Coverage referral	6 (3.1%)	35 (4.2%)	2 (1.6%)	23 (2.1%)	9 (5.9%)	16 (0.8%)
Smoking Cessation: Kansas Tobacco Quitline referral	51 (26%)	14 (1.7%)	1 (0.8%)	10 (0.9%)	1 (0.7%)	2 (0.1%)
Food/Food Stamps (not WIC) referral	1 (0.5%)	31 (3.7%)	5 (4.0%)	32 (2.9%)	4 (2.6%)	3 (0.2%)
Weight Management referral	0 (0%)	25 (3.0%)	2 (1.6%)	44 (3.9%)	0 (0%)	3 (0.2%)
MCH/HSVH referral	1 (0.5%)	1 (0.1%)	1 (0.8%)	40 (3.6%)	3 (2.0%)	1 (<0.1%)

Source: Kansas Title V DAISEY Data System. Note. Services with a rate under 1% are not included in this table.

## Appendix F.4

# The Kansas Maternal Vulnerability Index

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The Maternal Vulnerability Index (MVI) is an index designed to quantify area-level indicators of maternal vulnerability to adverse maternal health outcomes (MVI Surgo Ventures, n.d.). Surgo Ventures developed the MVI by aggregating 43 indicators from 2000 through 2020 into one overall vulnerability score and six thematic scores in reproductive healthcare, physical health, mental health & substance abuse, general healthcare, socioeconomic determinants, and the physical environment. Using methods such as percentile-ranking, iterative aggregation, and re-percentile ranking—like the CDC’s Social Vulnerability Index—the MVI assigns each county a score from 0 (lowest vulnerability) to 100 (highest vulnerability). Scores of 60-79 indicate high vulnerability, while scores of 80-100 represent very high vulnerability to adverse maternal outcomes (Valerio et al., 2023).

**Overall:** Several counties in eastern Kansas, specifically Wyandotte, Linn, Montgomery, Cherokee, Bourbon, and Labette, exhibit high or very high overall maternal vulnerability scores. Wyandotte, Labette, Linn, and Cherokee counties stand out due to their elevated scores across multiple domains.

**Reproductive Healthcare:** Counties such as Clark, Hodgeman, Greeley, and Stevens demonstrate very high vulnerability in reproductive healthcare, which assesses access to and quality of reproductive services. This sub-score considers factors like the availability of family planning services, access to skilled birth attendants, and the presence of comprehensive reproductive health services.

**Physical Health:** Wyandotte County has the highest MVI sub-score for physical health. Cherokee, Labette, and Montgomery counties also face high vulnerability in this area. The physical health sub-score considers the prevalence of conditions like diabetes, hypertension, obesity, and sexually transmitted infections.

**Mental Health and Substance Abuse:** Greenwood, Anderson, and Linn counties exhibit high vulnerability in maternal mental health and substance abuse. This sub-score accounts for factors related to the prevalence of mental health conditions such as depression and anxiety, as well as substance use disorders.

**General Healthcare:** Fifteen counties have very high general healthcare vulnerability sub-scores, with Haskell, Morton, Gray, and Gove counties facing particularly significant barriers to accessing basic healthcare. The general healthcare sub-score measures healthcare accessibility, affordability, and utilization, as well as insurance coverage.

**Socioeconomic Determinants of Health:** Seward, Kearny, and Wyandotte counties face substantial socioeconomic challenges. This sub-score considers factors like educational attainment, poverty levels, food insecurity, employment status, housing stability, and the availability of social support networks.

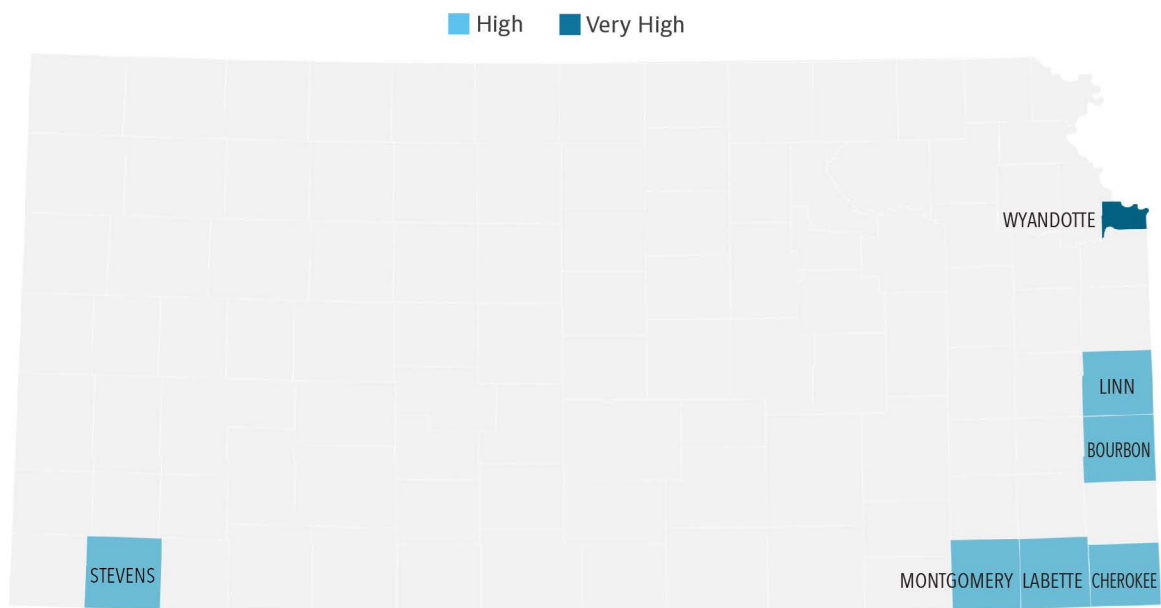
**Physical Environment:** Counties including Crawford, Geary, Montgomery, Riley, and Wyandotte show high vulnerability in their physical environments. This sub-score assesses environmental factors such as exposure to pollution, access to transportation, and the prevalence of violent crime.

[Table D.4 Maternal Vulnerability Index by County](#) provides a detailed breakdown of MVI scores by county, encompassing the overall score and sub-scores across various domains.

## Overall Score

Several counties in Kansas are identified as having very high or high overall maternal vulnerability scores ([Figure F4.1. Kansas County Overall Maternal Vulnerability Score](#)). These counties are Wyandotte, an urban county encompassing Kansas City, Kansas, with an overall score of 81, Stevens County (60) in the rural southwest corner of the state, and a cluster of counties in the southeast corner of Kansas: Linn (73), Montgomery (72), Cherokee (71), Bourbon (68), and Labette (63). Of these, Wyandotte, Labette, Linn, and Cherokee counties demonstrate particularly high scores across multiple domains, indicating significant vulnerabilities. For MVI scores for all counties, see [Table F.4. Maternal Vulnerability Index by County](#) at the end of this section.

Figure F4.1.  
**Kansas County Overall Maternal Vulnerability Score.**

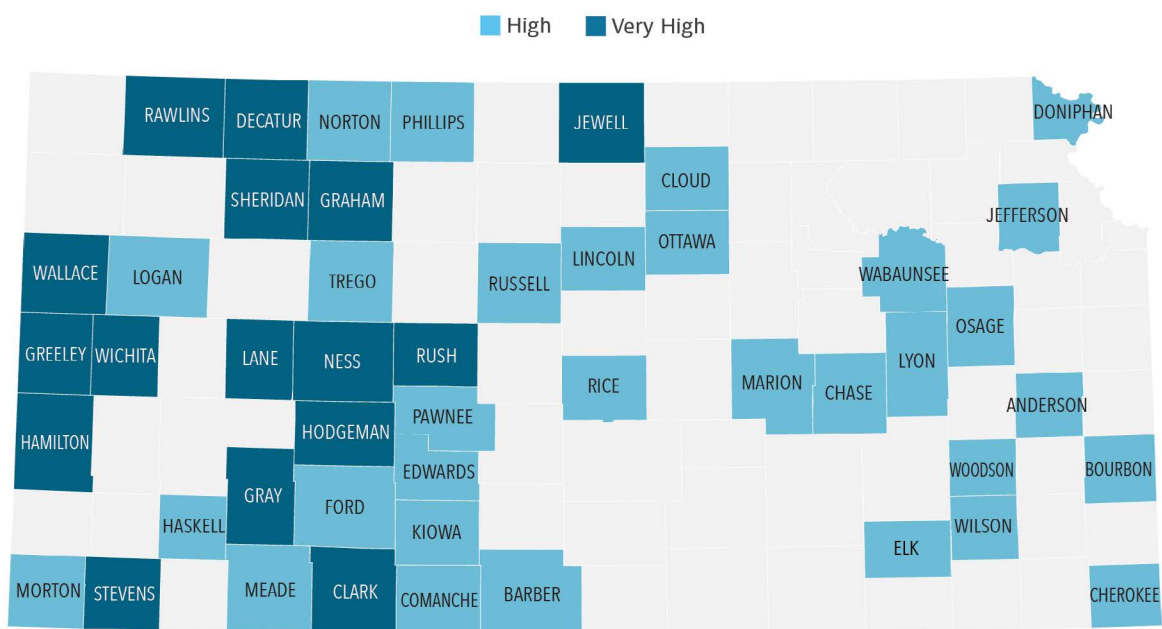


## Sub-scores

### Reproductive Healthcare

This sub-score evaluates factors influencing maternal health outcomes by assessing access to and quality of reproductive services. This sub-score comprises indicators such as the availability of family planning services, access to skilled birth attendants, and the presence of comprehensive reproductive health services, including abortion care ([Figure D.4.2. below](#)). It is worth noting that counties with very high vulnerability in reproductive healthcare are found in rural counties in the western half of the state.

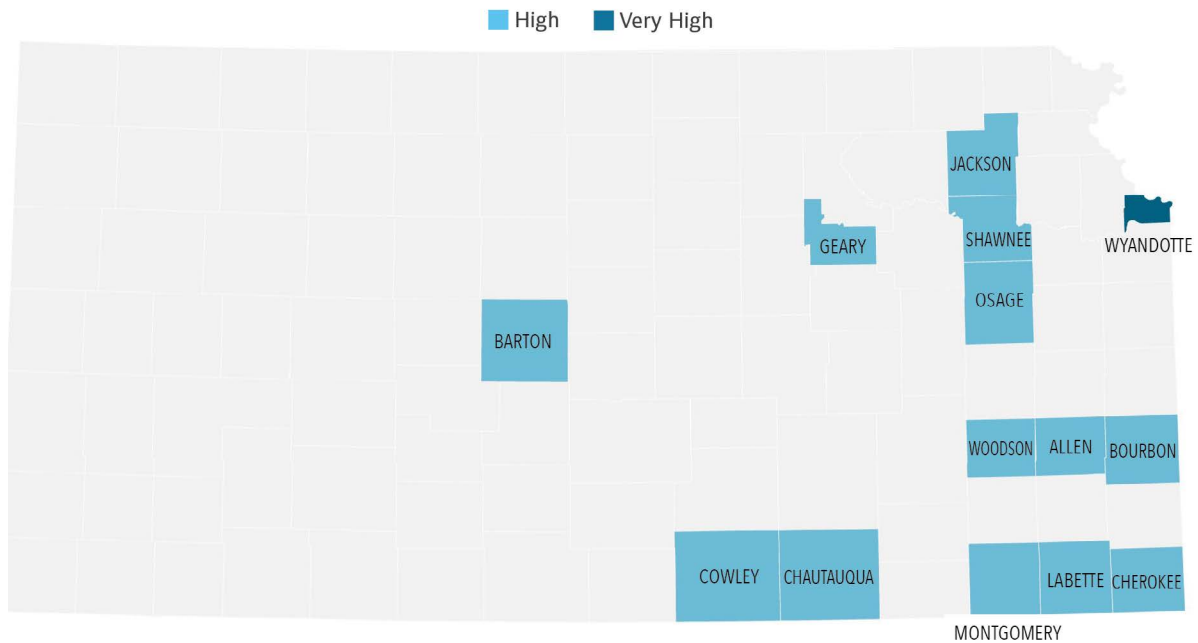
Figure F.4.2.  
**Kansas County Reproductive Maternal Vulnerability Score.**



## Physical Health

The physical health sub-score evaluates the prevalence of noncommunicable diseases such as diabetes, hypertension, and obesity, as well as the incidence of sexually transmitted infections (STIs) within a given population ([Figure F.4.3. below](#)). Wyandotte County (89) has the highest MVI sub-score for physical health. A number of southeastern counties, including Cherokee (75), Labette (75), and Montgomery (71), are identified as high vulnerability areas for physical health.

Figure F.4.3.  
**Kansas County Physical Health Maternal Vulnerability Score.**

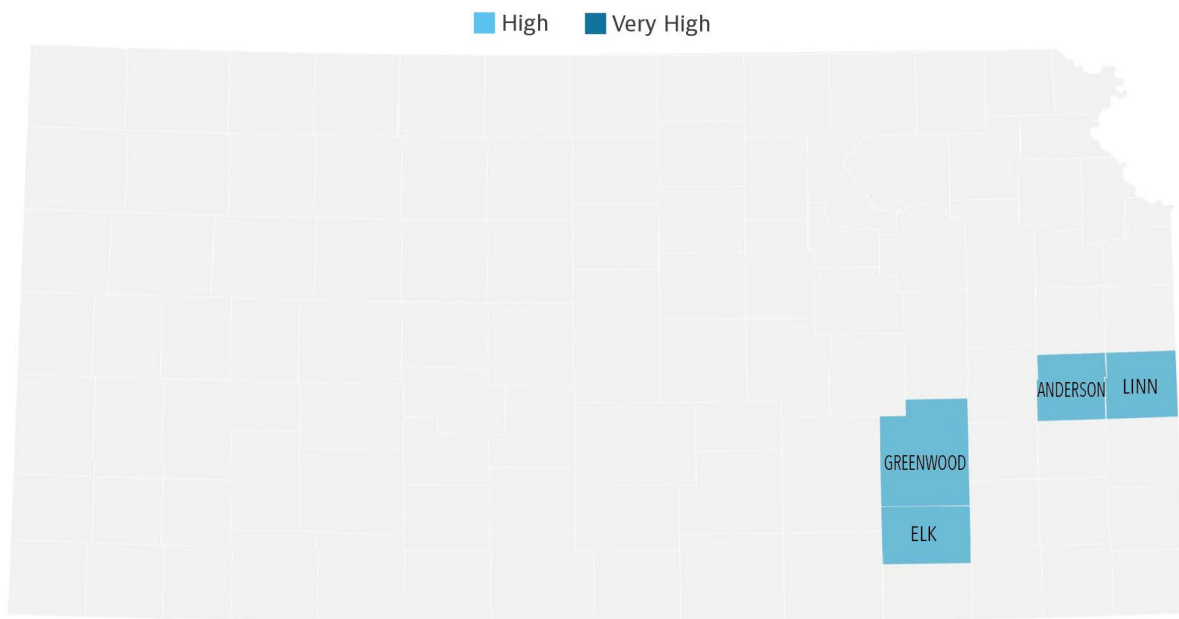


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## Mental Health and Substance Abuse

The mental health and substance abuse sub-score captures factors related to the prevalence of mental health conditions such as depression and anxiety, as well as substance use disorders, including alcohol and drug abuse ([Figure F.4.4 below](#)). Counties in southeast Kansas, including Greenwood (61), Anderson (65), and Linn (67), exhibit high vulnerability for maternal mental health and substance abuse, signaling areas for targeted intervention.

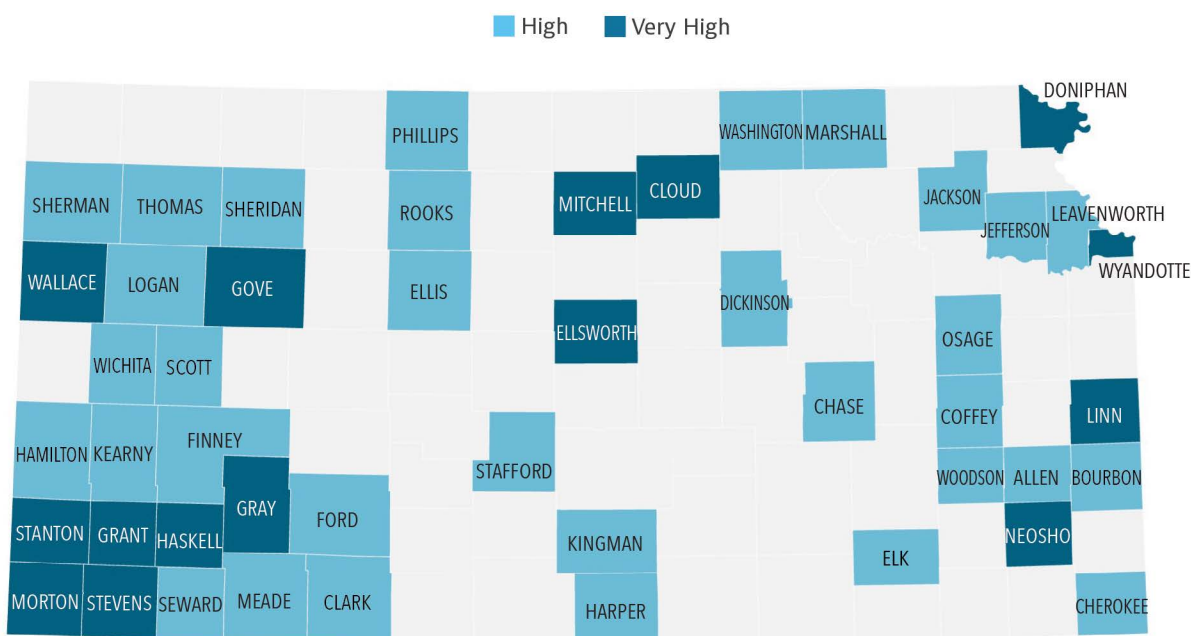
Figure F.4.4.  
**Kansas County MVI Reproductive Mental Health and Substance Abuse Maternal Vulnerability Score.**



## General Healthcare

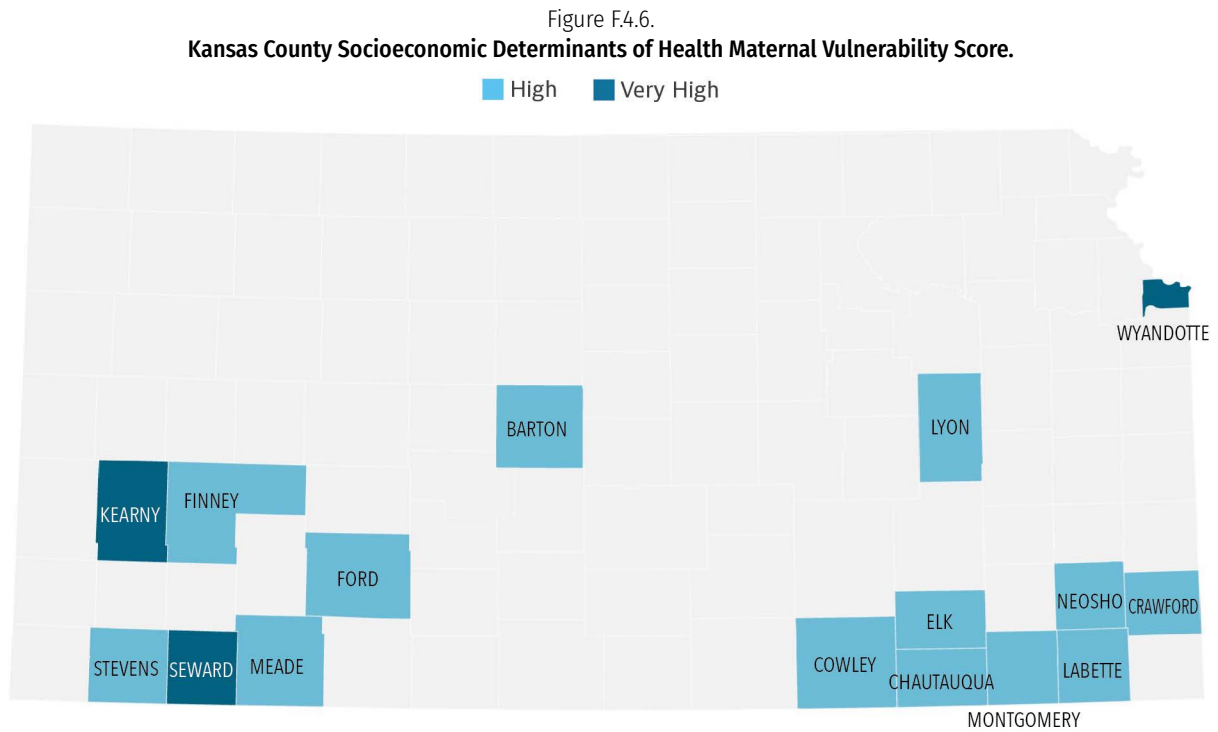
General healthcare measures accessibility, affordability, insurance coverage, and utilization of healthcare services ([Figure F4.5. below](#)). Fifteen counties have very high general healthcare vulnerability sub-scores. Those with the highest vulnerability scores in this domain are the western counties of Haskell (95), Morton (94), Gray (93), and Gove (92). Most of the state's westernmost counties score either high or very high in this domain. However, there are counties across other parts of the state that also score very high, including rural counties in north central, southeast, and northeast Kansas, as well as urban Wyandotte County.

Figure F4.5.  
**Kansas County General Health Maternal Vulnerability Score.**



## Socioeconomic Determinants of Health

The socioeconomic determinants of health sub-score evaluates factors including educational attainment, poverty levels, food insecurity, employment status, housing stability, and the availability of social support networks ([Figure F4.6. below](#)). Seward (80), Kearny (81), and Wyandotte (94) counties are particularly affected by socioeconomic challenges, with high vulnerability in this domain.



The physical environment theme assesses environmental factors such as exposure to pollution, access to transportation, and the prevalence of violent crime ([Figure F.4.7 below](#)). Urban Wyandotte County (86) scores very high on this domain, as do two neighboring counties, Riley (93) and Geary (90), and a cluster of southeastern counties including Crawford (94), Montgomery (96), and Labette (83).

■ High    ■ Very High



Table F.4.1 Maternal Vulnerability Index by County.

\* High risk (scores 60-79), \*\* Very high risk (scores 80-100)

County	Region	MVI (Overall)	MVI (Reproductive)	MVI (Mental health and substance abuse)	MVI (General healthcare)	MVI (Physical health)	MVI (Socioeconomic determinants)	MVI (Physical environment)
Allen	Southeast	46	26	47	62*	60*	49	41
Anderson	Southeast	54	68*	65*	50	37	39	59
Atchison	Northeast	50	33	41	56	53	57	62*
Barber	South Central	44	61*	54	49	38	49	26
Barton	South Central	50	39	32	39	60*	65*	67*
Bourbon	Southeast	68*	70*	55	60*	60*	56	67*
Brown	Northeast	17	21	35	26	49	21	25
Butler	South Central	29	56	43	54	28	12	30
Chase	Northeast	32	69*	18	70*	50	19	4
Chautauqua	Southeast	44	46	55	23	53	62*	40
Cherokee	Southeast	71*	63*	55	78*	75*	42	66
Cheyenne	Northwest	25	55	25	36	49	33	10
Clark	Southwest	41	86**	32	65*	51	14	17
Clay	North Central	11	20	13	53	39	11	14
Cloud	North Central	51	67*	36	87**	46	35	32
Coffey	Southeast	29	28	29	69*	58	12	23
Comanche	South Central	16	79*	22	36	16	4	3
Cowley	South Central	52	32	45	43	65*	69*	55
Crawford	Southeast	56	39	43	49	35	65*	94**
Decatur	Northwest	39	80**	30	39	51	53	4
Dickinson	North Central	40	55	31	70*	47	27	34
Doniphan	Northeast	48	65*	36	85**	30	38	41
Douglas	Northeast	29	33	38	49	9	54	39
Edwards	South Central	28	74*	25	39	51	27	2
Elk	Southeast	59	77*	60*	62*	48	62*	28
Ellis	Northwest	37	58	25	67*	12	41	48
Ellsworth	North Central	39	56	25	81**	45	8	43
Finney	Southwest	48	36	16	69*	53	62*	59
Ford	Southwest	55	70*	14	63*	33	69*	72*
Franklin	Northeast	30	21	56	35	21	28	60*
Geary	Northeast	48	28	33	31	65*	47	90**
Gove	Northwest	29	57	21	92**	42	7	3
Graham	Northwest	37	87**	20	48	47	34	17

County	Region	MVI (Overall)	MVI (Reproductive)	MVI (Mental health and substance abuse)	MVI (General healthcare)	MVI (Physical health)	MVI (Socioeconomic determinants)	MVI (Physical environment)
Grant	Southwest	35	27	22	82**	38	52	21
Gray	Southwest	37	83**	22	93**	13	30	10
Greeley	Southwest	34	87**	31	19	52	40	9
Greenwood	Southeast	42	45	61*	59	38	38	30
Hamilton	Southwest	54	87**	43	65*	56	47	19
Harper	South Central	47	49	43	69*	56	50	18
Harvey	South Central	17	33	23	33	20	39	28
Haskell	Southwest	53	68*	32	95**	26	50	42
Hodgeman	Southwest	32	86**	19	35	37	53	2
Jackson	Northeast	36	21	37	63*	63*	32	26
Jefferson	Northeast	25	62*	34	61*	31	4	14
Jewell	North Central	34	85**	31	36	42	33	10
Johnson	Northeast	2	20	17	27	7	10	15
Kearny	Southwest	43	45	28	70*	47	81**	5
Kingman	South Central	33	45	41	69*	33	6	39
Kiowa	South Central	31	73*	28	42	41	30	13
Labette	Southeast	63*	40	55	31	75*	68*	83**
Lane	Southwest	32	87**	23	39	36	25	18
Leavenworth	Northeast	45	45	38	62*	48	16	71
Lincoln	North Central	25	71*	25	57	21	19	12
Linn	Southeast	73*	59	67*	81**	56	45	76*
Logan	Northwest	31	74*	26	76*	30	15	7
Lyon	Northeast	51	67*	26	52	37	60*	70*
Marion	South Central	36	68*	42	47	46	23	19
Marshall	Northeast	20	27	19	77*	42	7	14
McPherson	South Central	14	48	20	27	29	17	19
Meade	Southwest	45	65*	9	66*	56	62*	26
Miami	Northeast	26	45	51	56	13	9	37
Mitchell	North Central	21	23	24	86**	30	19	8
Montgomery	Southeast	72*	46	55	45	71*	79*	96**
Morris	Northeast	23	25	29	45	49	18	19
Morton	Southwest	45	67*	10	94**	50	51	9
Nemaha	Northeast	8	32	19	52	24	5	9
Neosho	Southeast	58	33	54	89**	59	71*	29
Ness	Southwest	35	87**	22	51	37	34	11
Norton	Northwest	27	61*	24	51	26	40	9

County	Region	MVI (Overall)	MVI (Reproductive)	MVI (Mental health and substance abuse)	MVI (General healthcare)	MVI (Physical health)	MVI (Socioeconomic determinants)	MVI (Physical environment)
Osage	Northeast	49	67*	47	70*	61*	25	28
Osborne	North Central	22	39	29	42	38	19	28
Ottawa	North Central	17	77*	33	36	23	3	2
Pawnee	South Central	26	65*	22	42	50	24	5
Phillips	Northwest	29	77*	23	68*	40	12	2
Pottawatomie	Northeast	10	23	19	55	18	5	26
Pratt	South Central	18	27	38	30	21	36	27
Rawlins	Northwest	23	86**	23	41	19	19	7
Reno	South Central	48	56	31	35	39	58	75*
Republic	North Central	15	38	27	46	35	7	12
Rice	South Central	42	66*	43	46	49	43	22
Riley	Northeast	38	42	16	34	9	59	93**
Rooks	Northwest	18	29	33	78*	28	8	4
Rush	South Central	28	86**	35	32	34	11	20
Russell	North Central	35	60*	29	49	33	21	49
Saline	North Central	35	37	40	30	52	41	38
Scott	Southwest	24	58	20	60*	34	18	11
Sedgwick	South Central	46	35	44	30	51	59	69*
Seward	Southwest	51	38	9	72*	46	80**	62*
Shawnee	Northeast	41	39	31	32	66*	46	52
Sheridan	Northwest	22	85**	23	67*	8	7	4
Sherman	Northwest	43	50	29	62*	57	33	41
Smith	North Central	17	46	28	31	34	15	21
Stafford	South Central	40	56	28	73*	42	35	4
Stanton	Southwest	20	30	28	82**	17	27	4
Stevens	Southwest	60*	89**	11	84**	51	76*	28
Sumner	South Central	46	57	52	52	64*	26	35
Thomas	Northwest	33	44	28	72*	19	37	33
Trego	Northwest	19	76*	17	56	25	9	0
Wabaunsee	Northeast	17	71*	29	55	14	2	5
Wallace	Northwest	34	86**	23	87**	21	13	8
Washington	North Central	6	13	14	60*	23	19	2
Wichita	Southwest	39	87**	17	60*	39	27	26
Wilson	Southeast	57	76*	50	50	59	33	61*
Woodson	Southeast	58	78*	56	76*	62*	43	17
Wyandotte	Northeast	81**	12	53	83**	89**	94**	86**

## Appendix F.5 Workforce

The assessment of the MCH workforce involves two components including the development of staff profiles for all Title V funded programs in the state and a workforce survey, as described earlier in the Methods section.

### MCH Local Program Workforce

The Title V- funded Aid-to-Local grants for MCH services Kansas MCH support MCH Programs staffed predominantly with home visitors, nurses, care coordinators, and administrative positions.

Home visitors and nurses represent the largest number of staff (82 home visitors, 87 nurses, and 8 Nurse Practitioners/APRNs) and FTEs (36.1 FTE home visitors, 28.9 FTE nurses, and 3.3 FTE Nurse Practitioners/APRNs) in the MCH workforce in the state. There are sixty-eight (68) administrative/fiscal management and support positions (14.4 FTEs) supported through the MCH Program and another 20 agency managers and/or supervisors (5.5 FTEs). Twelve care coordinators are part of the state's MCH workforce, and unlike other positions that are often part-time in nature, most care coordinators are full-time, or close to full-time staff; the 12 care coordinators represent almost eleven full-time (10.8 FTE) positions. A smaller number of positions in social work, medicine, nutrition (dietitians, and breastfeeding counselors/educators). In total the MCH Program supports over 400 positions, which represent 143.3 FTEs.

Table F.51. Statewide staffing of Title V-funded MCH Programs in Kansas

Position Type	Total Positions	Total FTEs
Administrative/Fiscal Management & Support	68	14.4
Agency Administration	34	6.1
Agency Managers/Supervisors	20	5.5
Breastfeeding Peer Counselor/Educator	4	1.4
Case Manager/Care Coordinator/Navigator	12	10.8
Dietitian/Nutritionist	2	0.1
Home Visitor	82	36.1
Interpreter/Translator	6	2.6
MCH Program Director/Supervisor	12	5.9
Nurse Clinician	87	28.9
Nurse Practitioner/APRN	8	3.3
Other/Unknown	79	21.4
Physician/Medical Director	3	0.2
Social Work/Counselor	9	3.5
Special Health Care Needs Staff	13	3.1
<b>TOTAL</b>	<b>439</b>	<b>143.3</b>

[\*Table F.5.2. Allocation of MCH staff positions \(local agencies\) across regions\*](#) below provides a breakdown of local MCH staffing by region. Over half (50.7%) of the local MCH staff work in the Northeast region, followed by the South Central region (19.2%) and Southeast region (14.7%). The three other regions are much more rural in nature, and have much lower levels of staffing. The number of MCH staff in the Northwest region seems particularly small. The Northwest region does have only three funded programs (LiveWell Northwest Kansas, Phillips County Health Department, and Rooks County Health Department). Rooks County Health Department provides funding to Norton and Graham counties, and it is possible there are contract position not documented through the methods employed to collect data.

Table F.5.2. Allocation of MCH staff positions (local agencies) across regions

Position Type	North Central	Northwest	Northeast	South Central	Southwest	Southeast
Administrative/Fiscal Management & Support	1.49	0.41	4.20	3.68	1.36	3.31
Agency Administration	0.44	0.32	3.54	0.24	0.41	1.11
Agency Manager/Supervisor	1.02	0.00	3.34	0.65	0.00	0.46
Breastfeeding Educator/Peer Counselor	0.25	0.00	0.00	0.00	1.00	0.10
Case Manager/Care Coordinator/Navigator	0.00	0.00	10.80	0.00	0.00	0.00
Dietitian/Nutritionist	0.00	0.00	0.05	0.03	0.00	0.00
Home Visitor	2.68	0.09	11.90	10.75	4.11	6.59
Interpreter/Translator	0.00	0.00	1.61	1.03	0.00	0.00
MCH Program Director/Supervisor	0.00	0.00	0.75	2.09	0.90	2.15
Nurse Clinician	1.95	0.33	17.60	1.75	3.78	3.52
Nurse Practitioner/APRN	0.00	0.14	2.12	0.50	0.00	0.50
Other	0.43	0.10	13.28	4.39	0.98	2.27
Physician/Medical Director	0.00	0.00	0.00	0.03	0.00	0.21
Social Work/Counselor	0.00	0.00	1.90	1.56	0.00	0.00
Special Health Care Needs Staff	0.00	0.00	1.49	0.76	0.00	0.86
TOTAL	8.25	1.39	72.57	27.45	12.54	21.07
Regional percentages as part of statewide total	5.8%	1.0%	50.7%	19.2%	8.8%	14.7%

Aid-to-Local applications also note how positions are funded, which demonstrates the importance of Title V funding in support of MCH staffing, as 53.5% of salaries of MCH staff in local programs are paid with Title V funds. Local funds are as vital, however, constituting almost half (46.5%) of program funding.

Table F.5.3. Allocation of funding for MCH staff positions (local agencies) between Title V and local funds

Position Type	Percent salaries paid with Title V grant funds	Percent salaries paid with local resources
Administrative/Fiscal Management & Support	39.1%	60.9%
Agency Administration	30.9%	69.1%
Agency Managers/Supervisors	43.1%	56.9%
Breastfeeding Peer Counselor/Educator	40.6%	59.4%
Case Manager/Care Coordinator/Navigator	27.2%	72.8%
Dietitian/Nutritionist	62.5%	37.5%
Home Visitor	81.3%	18.7%
Interpreter/Translator	64.7%	35.3%
MCH Program Director/Supervisor	63.2%	36.8%
Nurse Clinician	47.3%	52.7%
Nurse Practitioner/APRN	60.7%	39.3%
Other/Unknown	36.0%	64.0%
Physician/Medical Director	14.9%	85.1%
Social Work/Counselor	90.8%	9.2%
Special Health Care Needs Staff	60.3%	39.7%
<b>ALL POSITIONS</b>	<b>53.5%</b>	<b>46.5%</b>

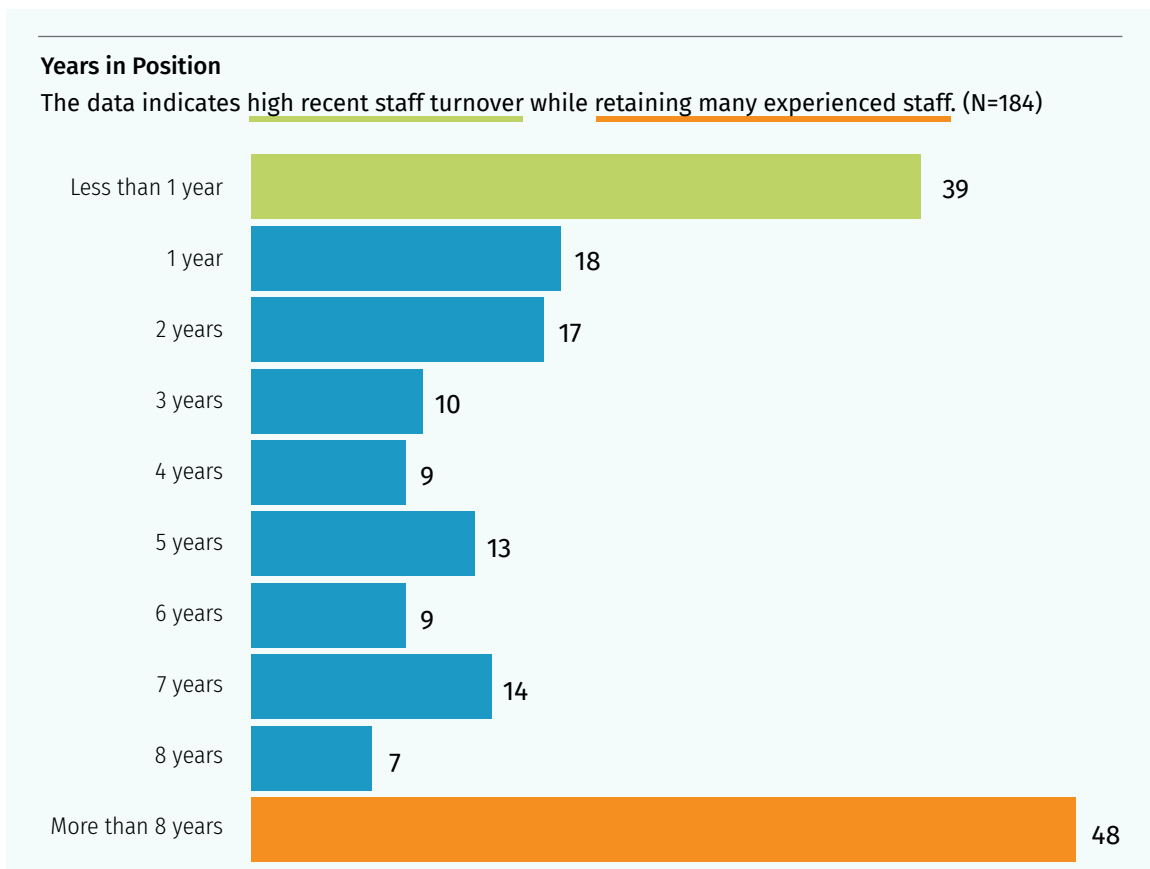
## MCH Staff Survey

In 2022, CPPR developed a survey in partnership with the state MCH Program that was distributed to all local MCH Programs. The purpose was to collect detailed demographic data as well as information on perceived challenges in meeting client needs, workload, level of engagement in their work, and their sense of meaning and accomplishment in their work. To incentive participation, CPPR made each respondent eligible for a drawing to receive one of 250 \$100 pre-paid gift cards.

### Characteristics of Respondents to the Workforce Survey

#### Years in Position

The average number of years worked among workforce survey respondents is seven years. A high number of staff have been in their current position for less than one year (suggesting there has been a high degree of recent staff turnover among programs) but also for more than eight years, indicating that there are a large number of experienced, trained staff that have continued working in the MCH field despite many challenges faced by MCH Programs and staff in recent years.



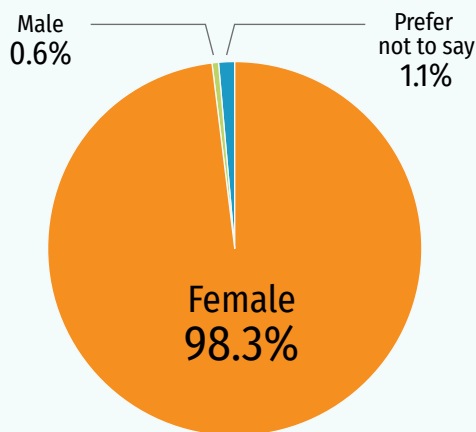
## Demographics

Demographic information were collected from respondents to the MCH Workforce Survey. In total, respondents to the workforce survey were:

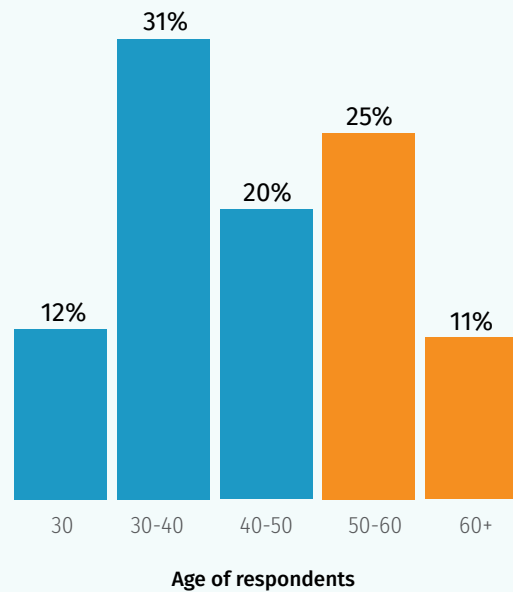
- ◆ Almost universally female (98.3%).
- ◆ Older than the Kansas population (36.4% of respondents were over 50, compared to 22.6% of the general population).
- ◆ Generally reflective of the Kansas racial and ethnic diversity, but different from the state's MCH client population.

These data suggest that overall demographics of MCH staff statewide has not changed substantially since the last Needs Assessment. The demographics of respondents are similar to those for the state as a whole, but are less representative of the client population of the MCH Program across the state. While the current study focuses on the workforce statewide and does not address geographic differences in racial and ethnic diversity in the state, these findings nevertheless point to an ongoing need for strategies to diversify the MCH workforce.

When asked to indicate their gender, respondents identify overwhelmingly as female. (N=178)

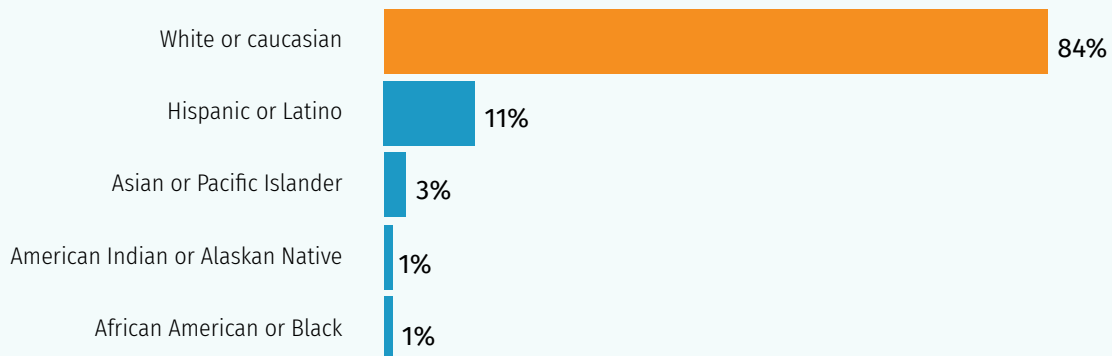


Over one-third of respondents indicate that they are over 50 years old. (N=170)



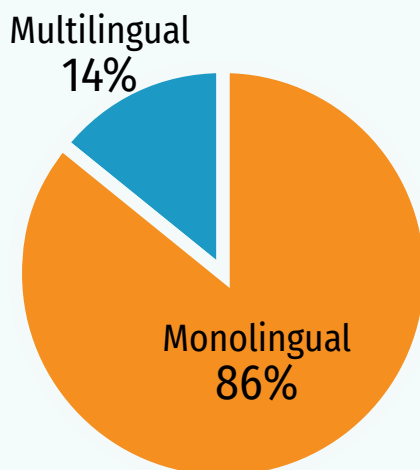
Specifically, while the sample size of the current survey was small, the percentage of respondents identifying as Black/African-American is far less than that in the state. Also, there does not appear to have been any growth in the percentage of Hispanics represented in the MCH workforce. This is of significant concern, given that almost one-third of the clients served in MCH Programs across the state identify as Hispanic/Latino. There also is notable growth in the population of young Hispanic/Latinos in the state. The percentage of Kansas children from birth to five who are Hispanic/Latino increased from 16.0% in 2017 to 18.9% in 2020 (while the percentage of children in that age range for every other ethnicity decreased). Growth of the state's Hispanic population is only expected to continue.

Race is overwhelming identified as White/Caucasian by respondents. (N=183)



*Languages Spoken*

The large majority of respondents indicate they speak only one language. (N=153)



## Perceptions of Work (Workforce Survey)

### Emotional State at Work

Several questions focused on the emotional state of staff related to their work. These questions showed a wide array of emotions among MCH staff related to work. For example, on a ten-point scale asking about the extent to which staff felt anxious or depressed, responses were fairly evenly distributed across the continuum from “strongly disagree” to “strongly agree.” Almost one-third (32%) of selected responses fell into the top four categories leaning towards “strongly agree,” indicating feelings of anxiety or depression (although only 4% fell into the highest two categories). Conversely, 40% of respondents fell into the lower four categories, indicating they did not feel anxious or depressed (view the data on the next page).

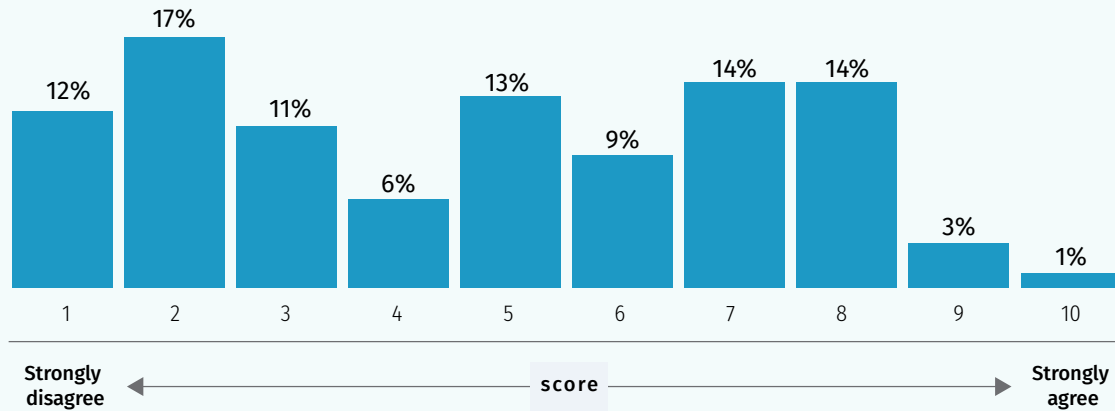
The scale for the question about burnout was more highly skewed towards “strongly agree.”

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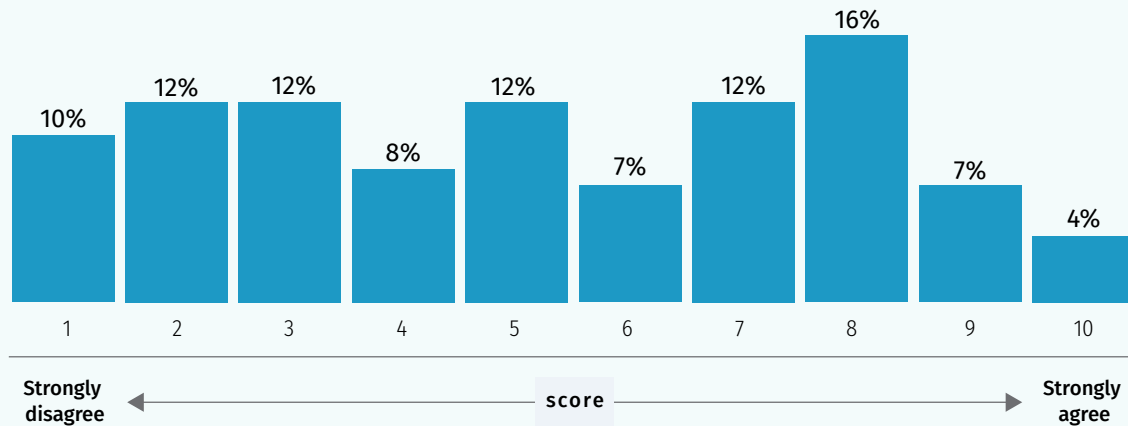
*Based on survey results, many MCH staff, even those who indicated sometimes feeling anxious, depressed, or burned out, also experience joy in the work that they do.*

These mixed findings can occur in situations in which people find inherent satisfaction in the work they do, but at the same time may feel overwhelmed for a variety of reasons.

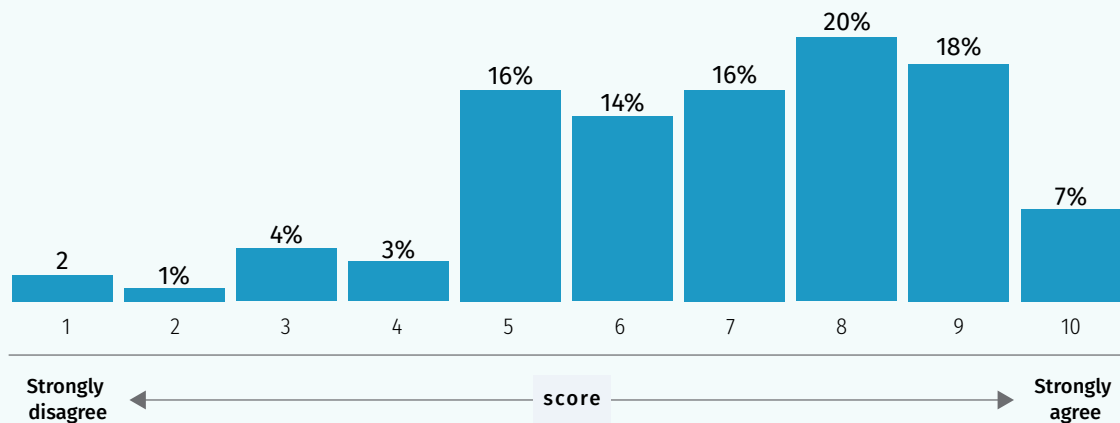
Feeling anxious or depressed is common among respondents. (N=148)



Feeling burnout is common among respondents. (N=113)

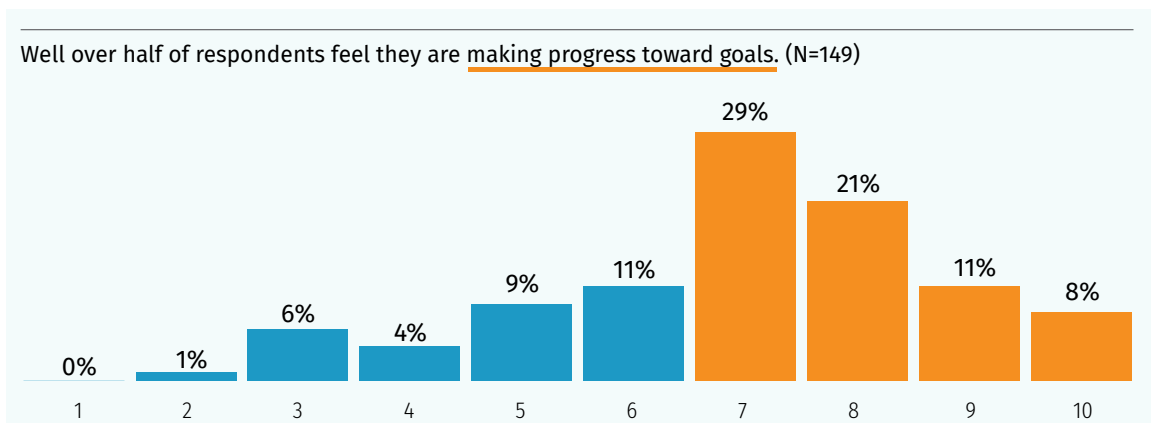
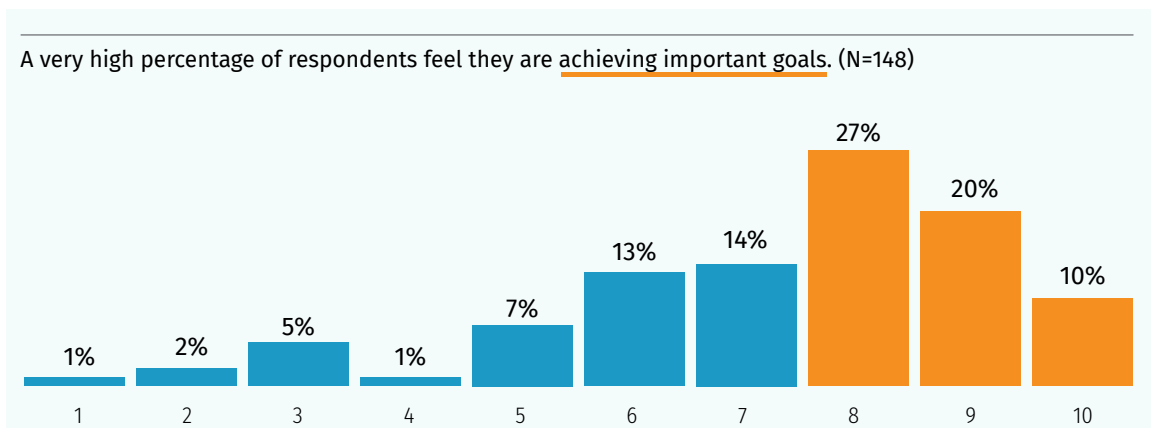
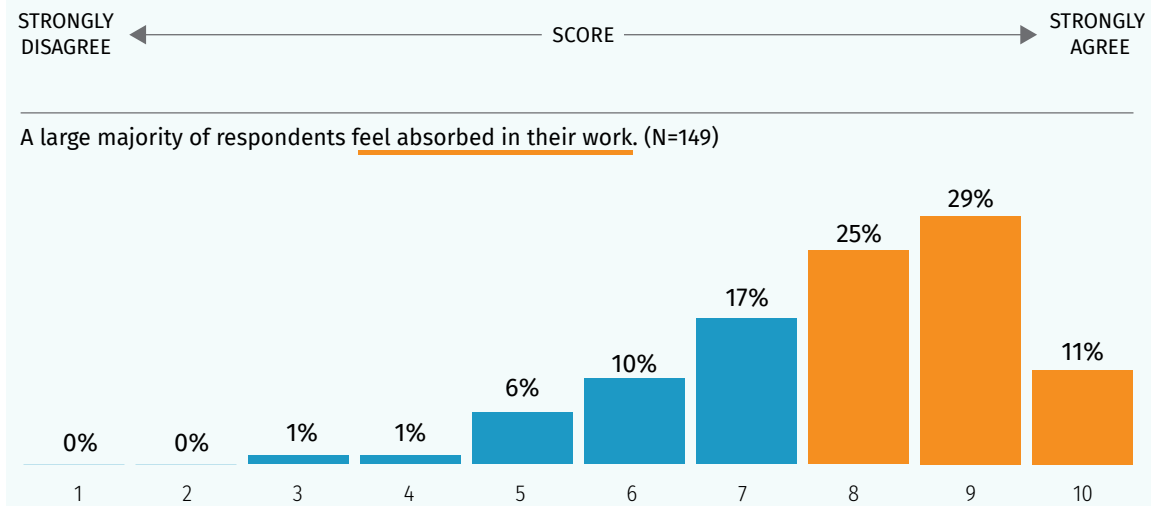


Many staff feel joyful at work. (N=148)



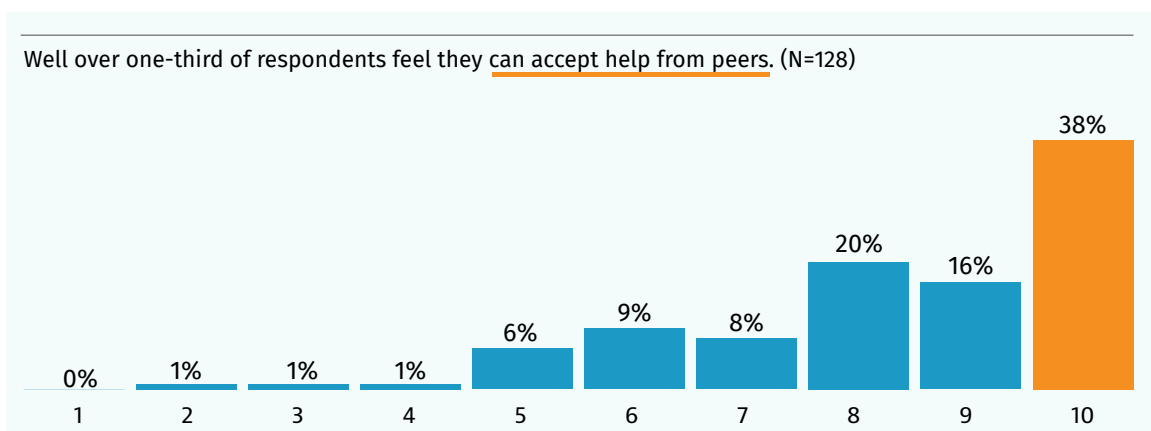
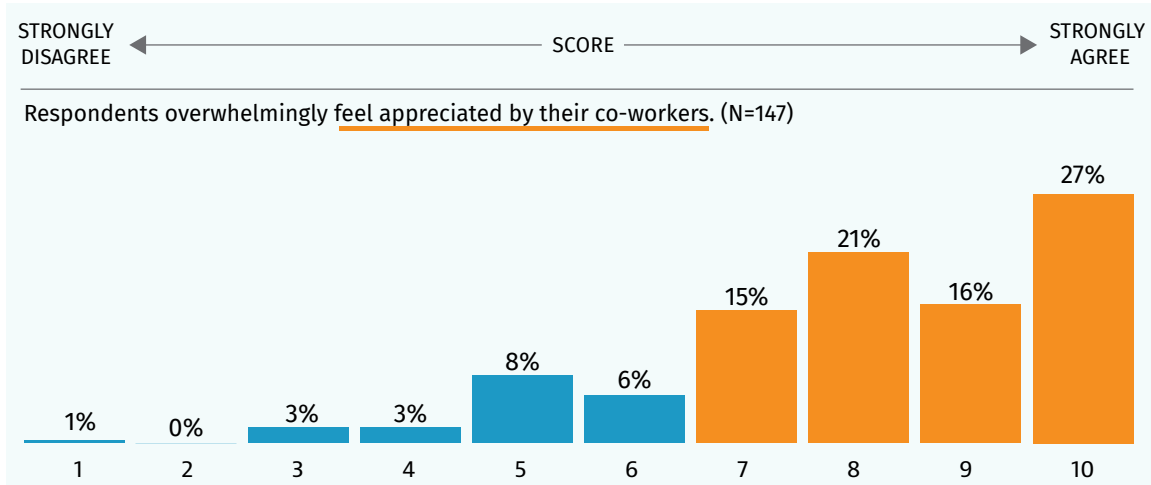
### Feeling Engaged and Accomplished at Work

The set of questions related to the sense of engagement and accomplishment experienced by MCH staff corroborates the findings above and show that overwhelmingly MCH staff feel engaged in their work. A very high percentage of MCH professionals feel absorbed in their work, and nearly as many feel they are achieving important goals, although a small minority are at the “strongly disagree” end of the goal statement. A nearly similar proportion also feel they are currently making progress towards goals.



### Peer Support at Work

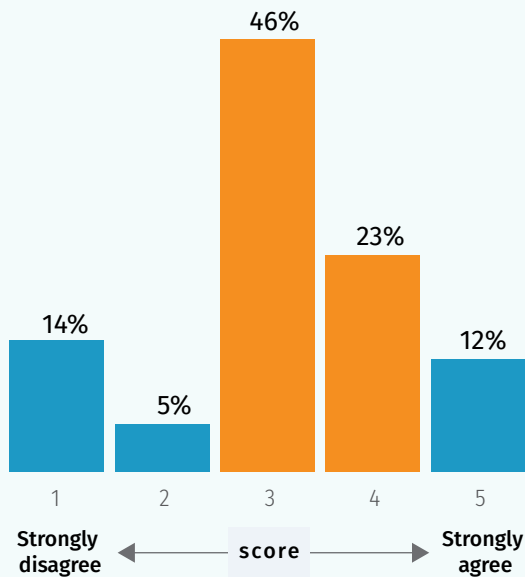
Responses to questions about peer support show that the vast majority of MCH staff feel positive about relationships with their peers. Most of MCH professionals feel appreciated by coworkers, and they were even more likely to report they agreed or strongly agreed that they receive help from their peers (well over one-third chose strongly agree). At the same time, close to one in five gave a more negative response to the question about feeling appreciated. A strong majority expressed satisfaction with their professional relationships in the workplace.



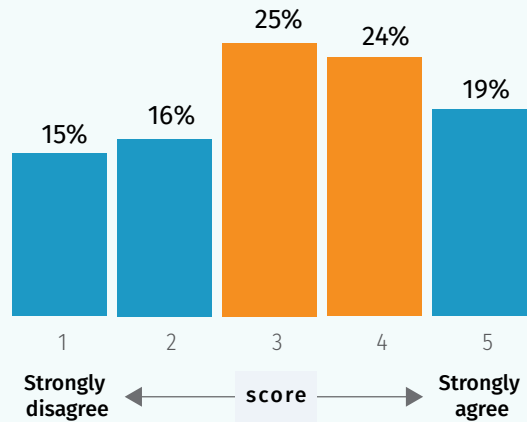
### Staffing and Workload

Opinions regarding the adequacy of staffing vary considerably across survey respondents. While more respondents than not feel like their organization is adequately staffed, more than one third of respondents (35%) agreed or strongly agreed that their workload is higher than ideal. A slightly smaller percentage (31%) felt their workload was higher than their peers. However, a majority of respondents were either neutral or disagreed with these questions.

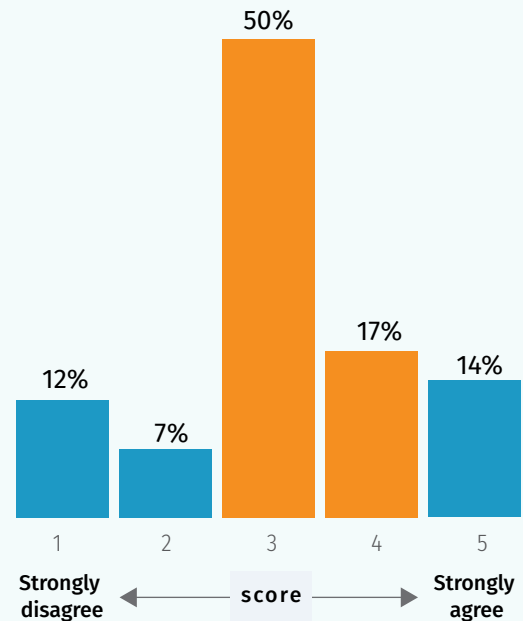
I feel my workload is higher than the ideal workload for me. (N=147)



My organization is staffed adequately to meet workload demands. (N=146)



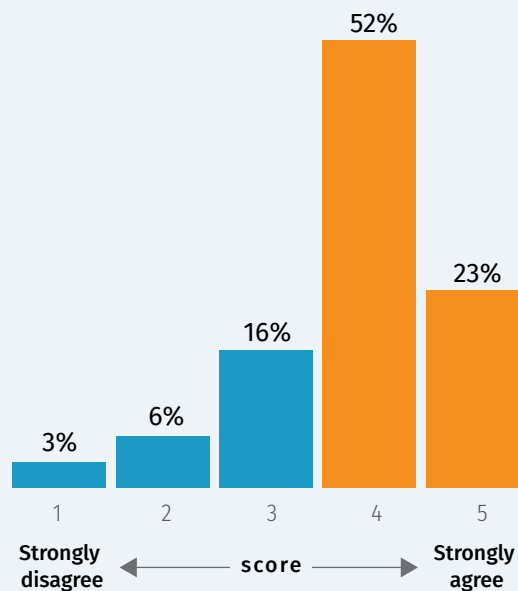
My workload is higher than colleagues in the same or similar position.. (N=145)



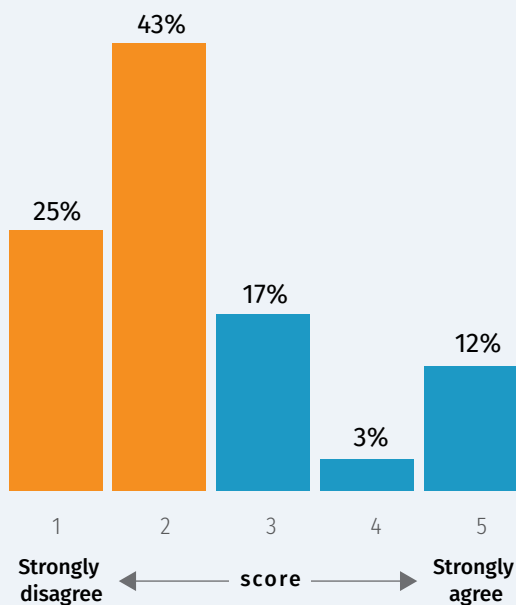
Despite some respondents feeling their workload is higher than ideal, three out of four respondents either agree or strongly agree that their current caseload is manageable, and only a small percentage (15%) agree or strongly agree with the statement that they “struggle to stay on top of cases” (although 12% of those strongly agree, evidence that a number of MCH staff feel they are not able to keep up with work demands)

Most survey respondents feel their work provides them adequate work-life balance, giving them adequate time for their personal/family life. Over two-thirds (67%) agree or strongly agree they have time for personal/family life (and only 14% disagree and 2% strongly disagree).

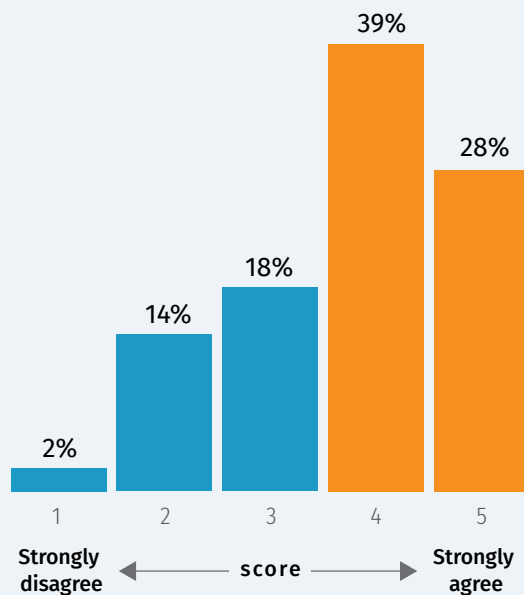
**Most respondents indicate their caseload is manageable. (N=147)**



**Most respondents indicate they DO NOT struggle to stay on top of cases. (N =146)**

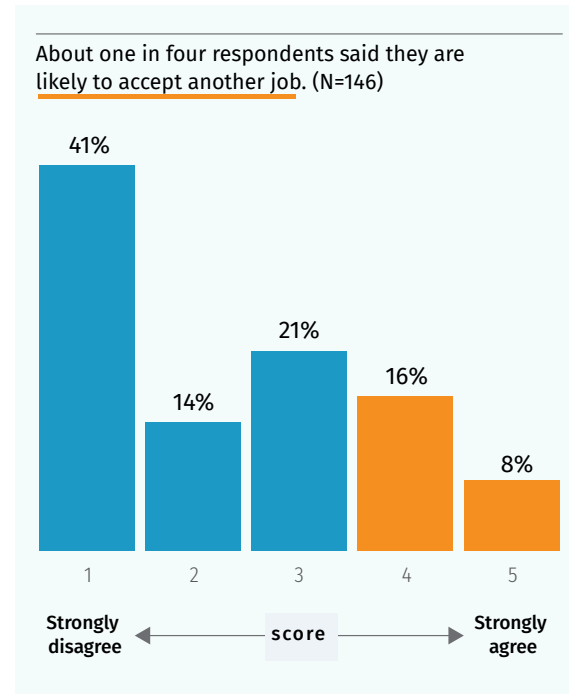
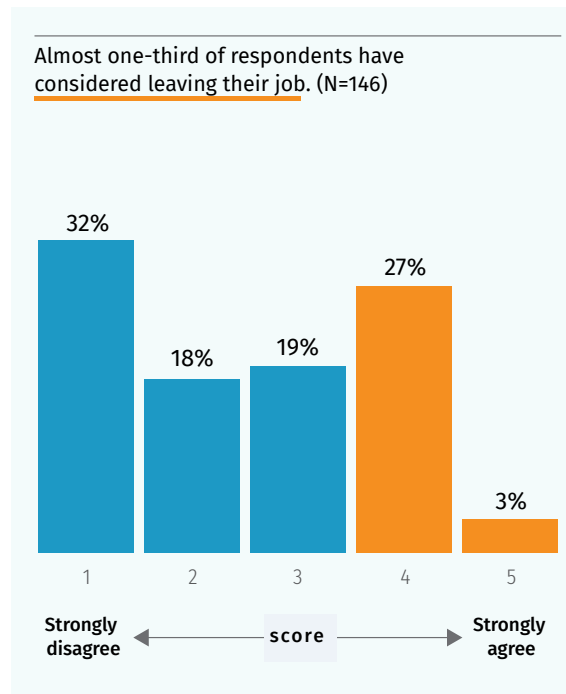


**Most respondents indicate there is time for personal/family life. (N=147)**



### Job Retention

Despite the relatively positive responses overall to questions about workplace environment, a number of MCH professionals have considered leaving their job. Almost one-third (30%) of respondents agreed or strongly agreed when asked if they considered leaving their job. A lower number indicated they were likely to accept another job. Still, about one in four said it was likely they would accept another job. So while the majority of MCH professionals are not considering leaving their position, recruitment and retention should still be seen as a challenge to MCH Programs around the state given substantial numbers of local program staff are considering leaving or are already indicating they are likely to accept another position.



## Appendix F.6. Partner Survey Summary

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### Survey Distribution and Response

A survey was distributed to 85 organizations between late June and early August 2024, resulting in 92 completed responses, by individuals associated with the organizations. Participants included Title V MCH grantees, other local health departments, Kansas MCH Council members, and partner organizations identified by the Kansas MCH Program leadership. Of the respondents, 40% had over 10 years with their organization, 25% had 6-10 years, and roughly one-third had 1 to 5 years.

The survey asked which MCH domains were relevant to respondents (they could select one or more), and were then asked questions pertinent to the chosen domains. The Women/Maternal domain was relevant to 53% of participants, followed by the Infant/Perinatal domain (49%), the Children domain (47%), and the Adolescents domain (41%). The least represented domain was Children and Youth with Special Health Care Needs, with 25% of respondents.

Eighty-eight percent (88%) of participants rated their familiarity with the Kansas MCH Program at KDHE as 7 or higher on a 10-point scale.

### Interaction and Relationships

Survey respondents frequently engage with the Kansas Title V Program, with more than half reporting weekly or monthly interactions.

In terms of contact with MCH Program staff at the Kansas Department of Health and Environment (KDHE), 10% reported daily interactions. About one-third of participants indicated weekly interactions, while 36% reported interacting monthly. Additionally, 24% noted quarterly interactions, 14% interacted less frequently than quarterly, and 5% had no interaction at all with MCH Program staff.

The Kansas Title V Program has developed strong relationships with its partners, and many feel that the Maternal and Child Health (MCH) program is effectively using these relationships to drive system and policy changes.

When asked to rate the effectiveness of their relationship with MCH Program staff at the Kansas Department of Health and Environment (KDHE), 88% of participants rated it 7 or higher on a 1 to 10 scale. When evaluating the MCH Program's effectiveness in engaging partners to address system and policy changes related to MCH health priorities in Kansas, over two-thirds of respondents (70%) gave a rating of 7 or higher. [\*Table D.6.1. Effectiveness of Relationships with MCH and Engagement of Partners\*](#) provides further details on these responses.

Table F.6.1: Effectiveness of Relationships with MCH and Engagement of Partners

Rank	Effectiveness of "Your Relationship with MCH" (No. of Responses)	Effectiveness of "Your Relationship with MCH" (% of Responses)	Effectiveness of MCH's Engaging Partners (No. of Responses)	Effectiveness of MCH's Engaging Partners (% of Responses)
1	1	1.7	1	1.7
2	2	3.4	3	5.0
3	1	1.7	1	1.7
4	0	0.0	4	6.7
5	3	5.1	5	8.3
6	0	0.0	4	6.7
7	15	25.4	17	28.3
8	11	18.6	15	25.0
9	14	23.7	3	5.0
10	12	20.3	7	11.7
<b>Total</b>	<b>59</b>	<b>100.0</b>	<b>60</b>	<b>100.0</b>

## Open-ended questions about MCH Program relationships

### Strengths

The MCH Program at KDHE is viewed positively for its collaborative approach, responsive communication, commitment to education, and support for local health initiatives.

Survey respondents were provided the opportunity to respond to open-ended questions regarding the strengths and opportunities for improvement of the Kansas MCH Program. The responses regarding the strengths of the state MCH Program highlight several key aspects of its effectiveness. First, some respondents noted that the program excels in collaboration and inclusion, effectively engaging various agencies—both large and small—in discussions about funding and program development, thereby fostering a collaborative environment. Respondents noted an increase in community partner engagement, particularly among those with lived experiences.

In terms of communication, respondents appreciated the program's responsiveness to inquiries. Many highlighted the helpfulness and availability of MCH staff, who provide prompt replies to emails and calls, contributing to positive interactions. The MCH Program also offers valuable educational opportunities, such as webinars and Q&A sessions, which participants found beneficial. Furthermore, the dissemination of evidence-based practices and successful program models from other states was recognized as a commendable effort.

Support for local health departments was frequently highlighted as a strong point, as the program provides essential resources, tools, and funding that enable local agencies to deliver vital services. This support includes effective outreach and connection-building within the community. Many respondents emphasized the dedication and expertise of MCH staff, noting their commitment to innovation and improving maternal and child health outcomes.

Effective communication channels, including regular updates via Govdelivery bulletins, have improved the flow of information regarding programs and initiatives, enhancing awareness among providers. The MCH Program is also praised for its problem-solving orientation, actively listening to concerns and collaborating to find solutions, which fosters a supportive atmosphere.

The program's focus on maternal and child health is recognized as a significant contribution to community health, particularly its efforts to improve prenatal and postnatal care, along with initiatives aimed at special needs populations. Feedback mechanisms, such as quarterly meetings to seek input, allow for ongoing dialogue and the incorporation of frontline staff suggestions into program improvements.

Finally, many respondents acknowledged recent improvements in education and support from KDHE staff, indicating a trend toward more effective collaboration and program delivery. Overall, the MCH Program at KDHE is viewed positively for its collaborative approach, responsive communication, commitment to education, and support for local health initiatives.

## Opportunities for Improvement

Survey feedback underscores a perceived need for simplification, improved communication, increased funding, and enhanced support structures within the MCH Program to better serve providers and the communities they support.

Feedback from respondents regarding areas for improvement in the MCH Program at KDHE reveals several critical themes. Many expressed a need for streamlined reporting and grant processes, emphasizing that current requirements are time-consuming and repetitive. They seek clearer guidance on grant objectives and a reduction in the administrative burden on local staff. Improved coordination and communication among programs and providers statewide (while also cited as a strength) were also highlighted as areas for ongoing attention and improvement, with suggestions for regular statewide meetings to clarify expectations, especially regarding federal requirements. Additionally, there is a demand for more structured training opportunities, akin to those provided by other programs, and easier access to educational resources, as the current MCH Navigator has been deemed confusing.

Funding challenges were a significant concern, with respondents noting inadequate coverage for staff salaries and an overall sense of being overextended. Suggestions for enhancing the DAISEY reporting system included significant improvements to usability and data interpretation, as the existing documentation requirements are excessive. Increased engagement with community partners, particularly underrepresented communities, was advocated to better inform program development and practices. Respondents also called for clearer guidelines and consistency in messaging, alongside more transparency regarding funding and program changes. Navigating bureaucratic barriers was a common frustration, with recommendations for better succession planning and training to address staff turnover.

There is a desire for increased support to enhance direct service provision, including improved referrals and comprehensive pre- and post-natal education to effectively support all pregnant women, regardless of where they live. Lastly, many respondents emphasized the importance of focusing on child wellness initiatives, addressing childhood obesity and behavioral health, and integrating maternal and family health programs more effectively.

## Perception of Progress on the Kansas MCH 2021 to 2025 State Action Plan

Survey respondents rated the progress on objectives from the Kansas MCH 2021-2025 State Action Plan on a scale of 1 to 5, with 1 representing “little progress” and 5 representing “considerable progress.” The number of responses varied, ranging from 32 to 52 per question. The survey results indicate mixed perceptions of progress, with some areas showing significant advancement while others lag ([Table D.6.2: Percentage of respondents reporting perceived progress toward objectives of the Kansas MCH 2021 to 2025 State Action Plan](#)).

Notable progress was reported in areas such as breastfeeding, screening and education for perinatal mood and anxiety disorders, and efforts to reduce Sudden Unexpected Infant Death (SUID). However, there are still areas in the State MCH Action Plan that require further improvement.

**High Progress Areas:** Objectives focused on reducing Sudden Unexpected Infant Death (SUID), increasing exclusive breastfeeding through six months, and improving education and screening for perinatal mood and anxiety disorders received the highest progress ratings. Over 40% of respondents reported “considerable” or “near considerable” progress in these areas, indicating strong efforts and success in these initiatives.

**Moderate Progress Areas:** Increasing the proportion of women receiving pregnancy intention screening and enhancing MCH Universal Home Visiting services for pregnant and postpartum women showed moderate progress. Around 34 to 38% of respondents rated these areas as having high progress, though more work is needed.

**Areas Needing Improvement:** Objectives related to adolescents, families of children and youth with special health care needs, and wellness exams for children and adolescents received lower ratings. In these areas, most respondents rated progress as mid-range (3 or below), suggesting a need for increased focus and resources to achieve more significant improvements.

Table F.6.2: Percentage of respondents reporting perceived progress toward objectives of the Kansas MCH 2021 to 2025 State Action Plan

Objective	Considerable/ Near Considerable Progress (4-5)	Moderate Progress (3)	Little/No Progress (1-2)
Reducing Sudden Unexpected Infant Death (SUID)	40%	35%	25%
Increasing Exclusive Breastfeeding Through 6 Months	42%	32%	26%
Education/Screening for Perinatal Mood/Anxiety Disorders	41%	34%	25%
Pregnancy Intention Screening	36%	38%	26%
MCH Universal Home Visiting for Pregnant/Postpartum Women	34%	37%	29%
Adolescents' Health Priorities	28%	40%	32%
Children and Youth with Special Health Care Needs	26%	42%	32%
Wellness Examinations for Children and Adolescents	27%	39%	34%

# Perceptions on How Well the Kansas Public Health and Health Care System is Addressing MCH Issues

Respondents recognize progress in addressing key health issues for women and children in Kansas, but they also see significant room for improvement.

Survey participants rated how well Kansas is tackling various maternal and child health (MCH) issues on a scale from 1 (not very well) to 5 (extremely well).

It is notable that no issue received 50% or higher, when combining ratings of the state’s efforts as “well” (4) or “extremely well” (5). This indicates that many partners feel additional work can be done to address all of the topics highlighted in the survey.

The highest levels of satisfaction (noted by a combined percentage of scores of 4 and 5) were found in addressing alcohol use during pregnancy (43%, N=46), adolescent vaccination (41%, N=46), and prenatal care in the first trimester (42%, N=48). However, significant concerns persist in several areas, including childhood obesity (4%, N=47), adolescent suicide (14%, N=43), and mental/behavioral health treatment for children (15%, N=46), which received notably lower positive ratings ([Table F.6.3. Percentage of Respondents Reporting How Well Kansas is Addressing Various Health Issues](#)).

Table F.6.3. Percentage of Respondents Reporting How Well Kansas is Addressing Various Health Issues (N=43-50)

Health Issue	Not Very Well (1)	2	3	4	Extremely Well (5)	Combined 4 and 5
Childhood Obesity	11%	49%	36%	0%	4%	4%
Adolescent Suicide	14%	30%	42%	12%	2%	14%
Treatment or Counseling for Children with Mental/Behavioral Health Conditions	17%	28%	39%	13%	2%	15%
Teen Birth Rate	4%	29%	51%	13%	2%	16%
Adolescent Motor Vehicle Safety	14%	36%	31%	10%	10%	19%
Inductions or Cesarean Deliveries Without Justifying Conditions Prior to 39 Weeks of Pregnancy	9%	26%	37%	21%	7%	28%
Timely Follow-Up and Intervention for Newborns with “Out of Range” Screening Results for Heritable Disorders	23%	40%	25%	8%	33%	33%
Influenza Vaccination of Children	6%	33%	29%	22%	10%	33%
Drug Use During Pregnancy	6%	17%	43%	23%	11%	34%
Health Insurance Coverage for Children	6%	28%	30%	26%	10%	36%
Postpartum Mental Health	8%	12%	41%	29%	10%	39%
Vaccination of Adolescents (HPV, Tdap, Meningococcal)	4%	22%	33%	33%	9%	41%
Prenatal Care in the First Trimester	4%	21%	33%	38%	4%	42%
Alcohol Use During Pregnancy	4%	22%	30%	33%	11%	43%

## Open-ended responses on system efforts to address MCH health

Survey respondents were provided the opportunity to elaborate on health issues they believe to be impacting MCH populations that need to be systematically addressed to improve health outcomes. The responses suggest a comprehensive approach is needed to address healthcare access, mental health, social determinants, and system-wide barriers for MCH populations.

The feedback underscores several significant concerns regarding the health of MCH populations. Firstly, access to healthcare and affordability emerged as critical concerns, particularly for immigrant populations and men. Challenges such as limited access to maternity care, mental health services, and workforce shortages, especially in rural areas, were highlighted. There is a notable lack of available providers, particularly in mental health, compounded by high turnover rates that disrupt consistent care. Respondents called for Medicaid expansion to enhance access to necessary care and resources.

Substance use and mental health services also represent significant challenges. Issues related to substance abuse, cigarette smoking, and vaping during pregnancy were raised, along with low referral rates to tobacco cessation programs. Additionally, insufficient screening and referrals for mood disorders and mental health issues during pregnancy were concerning, particularly regarding postpartum depression and anxiety. Families often lack access to mental health services, exacerbating these issues.

The impact of social determinants of health and the needs of special populations were also emphasized. Food insecurity, driven by rising costs, affects many families, alongside challenges faced by families with special needs children and those experiencing infant loss. Some respondents believe the aging population and kinship families are not adequately served within current MCH services.

The need for better reproductive health and education was identified, including improved access to affordable contraception for childbearing populations. Health behaviors and conditions also pose challenges, with high rates of obesity and asthma among children, along with concerns regarding excessive screen time and insufficient physical activity. Additionally, low breastfeeding rates among minority groups, including Black, Indigenous Peoples, Asian, Pacific Islanders, and Native Hawaiians, were noted.

Finally, systemic and structural issues play a significant role in these challenges, including low public health funding and reimbursement difficulties for services like home visiting. A lack of real-time data hampers the understanding of community health trends, while there is a clear need for more aggressive health promotion, education efforts, and improved outreach for Medicaid programs.

## Impact of Interventions

As previously mentioned, survey respondents identified specific Maternal and Child Health (MCH) domains relevant to their work. For each domain, they ranked a list of interventions based on their perceived potential impact on health.

### Maternal Health

Respondents believe that focusing on preventive medical visits for women has the greatest potential impact on women's health. The top priorities for maternal health interventions include annual preventive medical visits for women of reproductive age and ensuring access to appropriate hospital services for high-risk deliveries. Seventy-four percent (74%) of respondents selected annual preventive medical visits as their first or second choice, while ensuring that high-risk mothers and/or newborns have access to necessary hospital delivery services was also prioritized ([Table F.6.4. Percentage of Survey Respondents Ranking the Impact of Maternal Health Interventions](#)). Interventions aimed at smoking cessation and reducing unnecessary Cesarean deliveries are also deemed important.

Table F.6.4. Percentage of Survey Respondents Ranking the Impact of Maternal Health Interventions (N=42)

Maternal Health Intervention	Greatest Impact (1)	2	3	4	Least Impact (5)	Combined 1 and 2
Increasing the percent of women who have a preventive dental visit during pregnancy	5%	2%	14%	26%	52%	7%
Reducing the percent of Cesarean deliveries for women with low-risk first births	2%	26%	26%	29%	17%	29%
Decreasing the percent of women who smoke during pregnancy	19%	21%	14%	31%	14%	40%
Ensuring high-risk mothers/newborns deliver at hospitals with appropriate services (i.e., neonatal intensive care units)	24%	26%	26%	7%	17%	50%
Increasing the proportion of women of reproductive age who have an annual preventive medical visit	50%	24%	19%	7%	0%	74%

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## Open-ended Responses for Maternal Health

Survey respondents were provided the opportunity to suggest strategies for improving maternal health in Kansas. Suggested interventions emphasize the importance of expanding mental health care, enhancing education and preventive services, improving access to reproductive health resources, and utilizing data and communication to optimize maternal health outcomes.

The proposed strategies to enhance MCH focus on several key areas. First, improving mental health support is crucial, particularly in rural regions. Respondents suggest this can be achieved by increasing access to effective mental health care through a broader range of therapy options. Additionally, interventions specifically targeting maternal mental health should be developed to address the unique challenges mothers face today, alongside expanding resources and services for postpartum depression and overall emotional well-being.

Second, enhancing health education and preventive care is vital. Comprehensive prenatal and pre-pregnancy education should be provided, covering essential topics such as safe sleep and infant feeding practices. There should also be an emphasis on increasing awareness of healthy behaviors during pregnancy, including substance avoidance, maintaining a healthy diet, and undergoing STI screenings. Additionally, providing more prenatal vitamins and educating expectant mothers on pregnancy health and the early identification of conditions like preeclampsia is important.

Third, improving access to reproductive health services is necessary, particularly by expanding the availability of free or affordable contraception and reproductive health education for individuals of reproductive age.

A fourth area of focus is Medicaid expansion and health coverage. Expanding Medicaid in Kansas is viewed as essential for increasing healthcare access and improving maternal health outcomes.

Fifth, better data collection and communication are needed to establish data-driven resources for monitoring community health trends and efficiently allocating resources. Enhanced communication between hospitals, clinics, and health departments will support early engagement with pregnant women.

Finally, providing support for specialized care, such as doulas and other maternal health professionals, is vital for reducing maternal morbidity and ensuring comprehensive care. There is also a need to address substance use during pregnancy and to ensure early screenings for depression and other health risks.

## Infant/Perinatal Health

Respondents emphasize that efforts to promote safe sleep practices are essential for improving infant health in the state.

When ranking the impact of interventions related to safe sleep and breastfeeding, an overwhelming majority of survey participants (91%) prioritized safe sleep interventions, while only 9% considered breastfeeding to be the most important focus area. This indicates a strong consensus on the critical need for initiatives aimed at ensuring safe sleep for infants ([Table F.6.5: Percentage of Survey Respondents Ranking the Impact of Infant/Perinatal Health Interventions](#)), although there was also emphasis on ensuring consistent effort, and messaging, focused on both safe sleep and breastfeeding, to improve outcomes in both areas.

Table F.6.5: Percentage of Survey Respondents Ranking the Impact of Infant/Perinatal Health Interventions (N=21)

Impact	1 <sup>st</sup> place on impact	2 <sup>nd</sup> place on impact
Increasing the percent of infants who are breastfed	0%	9%
Increasing the percent of infants who experience safe sleep practices	91%	0%

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## Open-ended Responses for Perinatal/Infant Health

Survey respondents were then provided the opportunity to suggest strategies for improving perinatal and infant health in Kansas. Overall, the responses suggest a holistic approach that combines mental health support, safe sleep promotion, home visiting, safety education, and targeted community-based interventions.

Several suggested strategies focused on critical areas of intervention. First, addressing the mental health of both parents is essential, as it significantly impacts breastfeeding, safe sleep practices, and overall attachment health. Emphasizing the treatment of underlying factors such as anxiety is vital for promoting healthy behaviors.

Second, promoting safe sleep and reducing Sudden Unexpected Infant Death (SUID) is a priority. This involves increasing focus and resources on preventing SUID, which is the leading cause of death for infants aged 28 days to one year. Additionally, there needs to be a concerted effort to reconcile the tension between breastfeeding advocacy and safe sleep recommendations to ensure consistent messaging that improves outcomes in both areas.

Third, expanding home visiting services is crucial. By increasing the availability and utilization of universal home visiting (UHV) services, families can receive the support and guidance they need, thereby making the healthcare community feel more accessible and supportive.

Fourth, addressing environmental and safety concerns is imperative. This includes efforts to prevent exposure to drugs, alcohol, and smoking, as well as educating families about seat belt safety, the dangers of leaving children in hot cars, and the risks associated with secondhand marijuana smoke. Furthermore, emphasizing lead testing is essential to prevent long-term health and behavioral issues.

Lastly, tailoring interventions to meet community needs is critical. Recognizing that issues such as breastfeeding and safe sleep may not be universal concerns across all communities suggests the necessity of prioritizing interventions based on specific local contexts and requirements.

## Child Health

Increasing the percentage of children who are continuously and adequately insured was identified as the most impactful intervention, with 60% of respondents ranking it as having the greatest or second greatest impact (combined ranks 1 and 2). Notably, 40% of respondents rated it as having the “greatest impact.” Strong support was also shown for increasing the percentage of children receiving developmental screenings, with 55% of respondents rating it in the top two categories of impact and 23% identifying it as having the “greatest impact.” Additionally, increasing the percentage of children who have a medical home received support from 30% of respondents ranking it as the first or second highest priority, while enhancing physical activity among children was prioritized by 23% of respondents in the same way.

Table F.6.6: Percentage of Survey Respondents Ranking the Impact of Child Health Interventions (N=40)

Child Health Intervention	Greatest Impact (1)	2	3	4	5	6	No or Minimum Impact (7)	Combined 1 and 2
Increasing the percent of children who have annual preventive dental visits	0%	3%	15%	13%	30%	18%	23%	3%
Decreasing the percent of children who live in households where someone smokes	8%	8%	13%	23%	10%	10%	30%	15%
Decreasing the percent of children experiencing unintentional injuries requiring hospitalization	8%	8%	15%	18%	33%	8%	13%	15%
Increasing the percent of children who are physically active, consistent with national guidelines	10%	13%	18%	15%	15%	28%	3%	23%
Increasing the percent of children who have a medical home	13%	18%	13%	10%	8%	20%	20%	30%
Increasing the percent of children who receive developmental screening	23%	33%	15%	10%	5%	15%	0%	55%
Increasing the percent of children who are continuously and adequately insured	40%	20%	13%	13%	0%	3%	13%	60%

## Open-ended Responses for Child Health

Survey respondents were then provided the opportunity to suggest strategies for improving child health in Kansas. The responses indicate a strong need for a diverse range of interventions aimed at improving child health in Kansas. Overall, the suggested interventions for both children and adolescents emphasize a multi-faceted approach focusing on nutrition, developmental and mental health, improving access to healthcare, and fostering community engagement.

Key recommendations include promoting good nutrition by creating conditions where children opt for healthier snacks instead of high-fat, high-sugar options and treating food as medicine while advocating for well-balanced diets with minimally processed and/or fast foods. Enhancing developmental health is also crucial, with an emphasis on increasing awareness among families and healthcare providers regarding the significance of developmental screenings, alongside supporting developmental health through behavioral health interventions.

Additionally, addressing substance exposure is essential, with a focus on reducing the percentage of children exposed to drugs and alcohol. This also includes providing mental health support for parents who struggle with substance use and/or mental health issues. Expanding mental health services for children is another critical area, requiring increased availability and accessibility of counseling and treatment.

Improving insurance and healthcare access, including Medicaid expansion in Kansas, is vital to ensure that children can access a medical home and necessary healthcare services. Even without expansion of public insurance, however, it should be a priority to undertake efforts to make sure all children touched by Title-V funded programs have health insurance coverage.

## Adolescent Health

In terms of improving adolescent health, respondents prioritized practices that ensure adolescents have annual preventive medical visits, with 53% rating this intervention as having the greatest or second greatest impact. Closely following this is the focus on reducing bullying among adolescents, identified by 50% of respondents as a critical area for intervention ([Table F.6.7: Percentage of Survey Respondents Ranking the Impact of Adolescent Health Interventions](#)).

Efforts to decrease unintentional injuries among adolescents are also considered important, with 35% ranking this intervention as having a significant impact. Additionally, preparing adolescents for transitions to adult health care and promoting physical activity were high priorities for approximately one-third of respondents, indicating a strong emphasis on comprehensive adolescent health initiatives.

Table F.6.7: Percentage of Survey Respondents Ranking the Impact of Adolescent Health Interventions (N=34)

Adolescent Health Intervention	Greatest Impact (1)	2	3	4	No or Minimum Impact (5)	Combined 1 and 2
Increasing the percent of adolescents who are physically active (consistent with national guidelines)	18%	12%	41%	15%	15%	29%
Increasing the percentage of adolescents who receive services to prepare them for transitions to adult health care	6%	26%	6%	24%	38%	32%
Decreasing the percent of adolescents experiencing unintentional injuries (serious enough to require hospitalization)	18%	18%	26%	24%	15%	35%
Reducing the percent of adolescents who are bullied or bully others	26%	24%	15%	18%	18%	50%
Increasing the percent of adolescents who have an annual preventive medical visit	32%	21%	12%	21%	15%	53%

## Open-ended Responses for Adolescent Health

Survey respondents were then provided the opportunity to suggest strategies for improving adolescent health in Kansas. Overall, the suggested interventions focus on reducing risky behaviors, promoting healthy lifestyle choices, supporting mental and behavioral health, and providing comprehensive sexual health education and community engagement opportunities.

Potential interventions center on reducing substance use, specifically targeting the decrease of vaping, smoking, and drug and alcohol use among this age group. Promoting healthy lifestyles is another focus, encouraging adolescents

to make healthier food choices and increasing physical activity by promoting local resources such as skate parks and trails to inspire participation.

Mental and behavioral health support is highlighted as an area in need of development, with calls for implementing interventions that address the specific mental and behavioral health needs of adolescents and providing greater access to mental health resources. Furthermore, quality sexual health education is deemed necessary, advocating for programs taught by well-trained professionals that engage students with relevant strategies while connecting them to health services and involving parents and community partners.

Lastly, encouraging civic and community engagement is important, promoting opportunities for adolescents to participate in civic organizations where they can be mentored and learn valuable life skills.

## Children and Youth with Special Health Care Needs

Among a small group of respondents (N=7) who completed this section of the survey, there was unanimous agreement (100%) on the significance of focusing on transition services for adolescents with special health care needs as the most impactful intervention.

Table F.6.8: Percentage of Survey Respondents Ranking the Impact of Interventions Addressing Children and Youth with Special Health Care Needs (N=7)

Impact	1 <sup>st</sup> place on impact	2 <sup>nd</sup> place on impact
Increasing the percent of children and youth with special health care needs who have a medical home	0%	100%
Increasing the percent of adolescents with special health care needs who receive services to prepare them for transitions to adult health care	100%	0%

## Open-ended Responses

The responses indicate several key interventions aimed at supporting the health of children and youth with special health care needs (CYSHCN) in Kansas. The suggested interventions emphasize the need to expand access to healthcare and educational resources, improve mental health care, and enhance referrals and support for CYSHCN and their families.

Improving access to services is essential, with a focus on increasing the availability of necessary services and ensuring a smoother transition to adult healthcare, irrespective of medical home access.

Enhancing education and support is also vital, offering more educational opportunities for families and healthcare providers will help them better understand and address the unique needs of CYSHCN. Additionally, expanding mental health care is crucial, with calls for greater access to mental health services specifically tailored to this population.

Boosting program referrals and participation is highlighted as an important intervention. This involves increasing referrals and participation in programs such as CYSHCN and creating additional referral opportunities for children and their families.

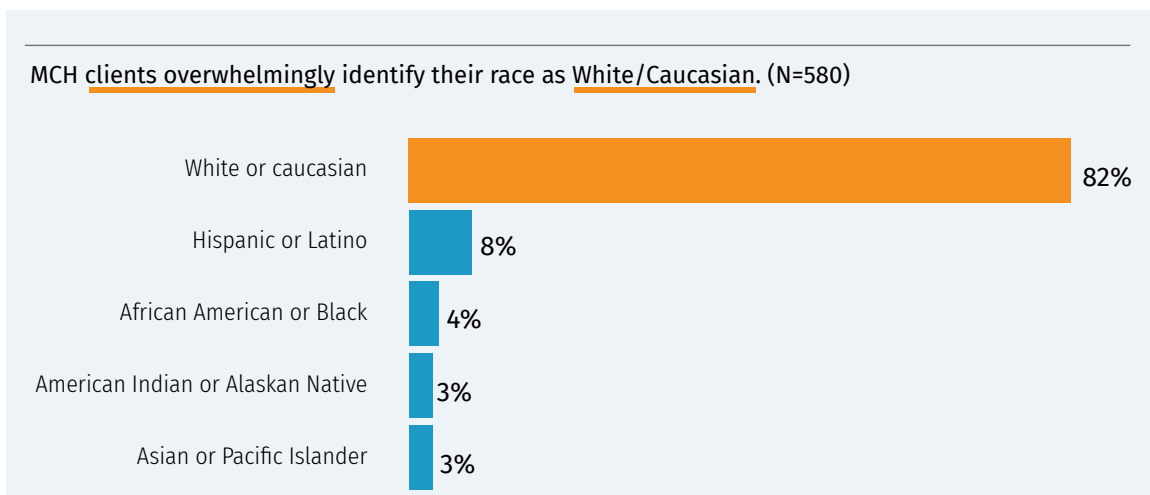
## Appendix F.7 MCH Client/Population Survey

In 2022 CPPR developed a survey that was distributed through multiple means to individuals across the state who have received, or are eligible to receive, MCH Program services. A central feature of this Needs Assessment update was a survey distributed to MCH Program clients through the programs and other means. A set of questions was developed for each of the MCH population domains and some of the key objectives for each domains that are part of the current MCH State Action Plan.

### Characteristics of Survey Respondents

#### *Race, Age, and Gender*

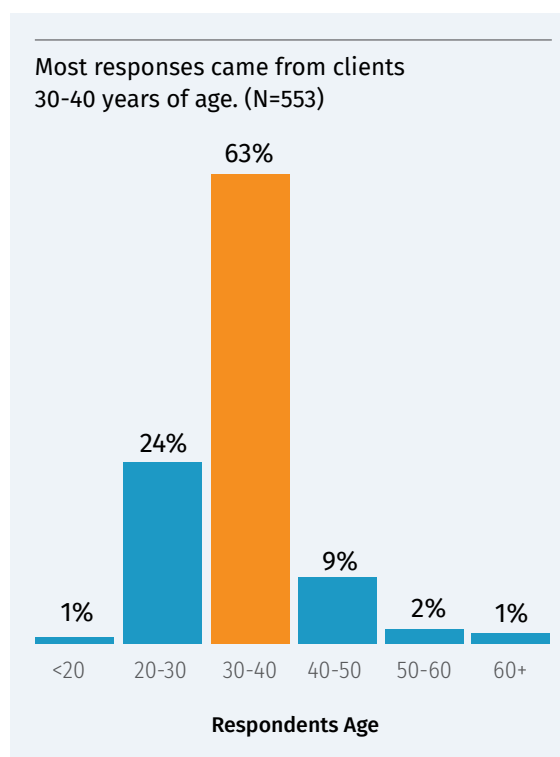
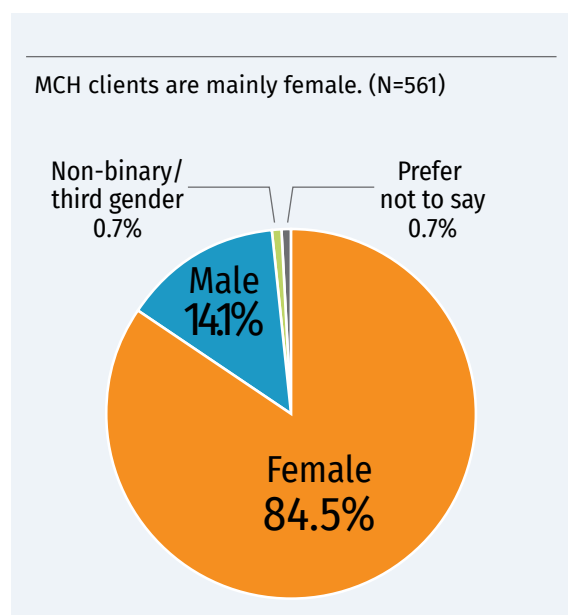
Approximately four out of five (82%) of respondents were white. The state's largest racial and ethnic minority populations are somewhat underrepresented in the respondent population, as the percentage of Hispanic/Latino respondents (7.9%) and Black/African Americans (4.8%) are lower than the population of the state as a whole. These numbers are also lower than those for the MCH population served by the state.



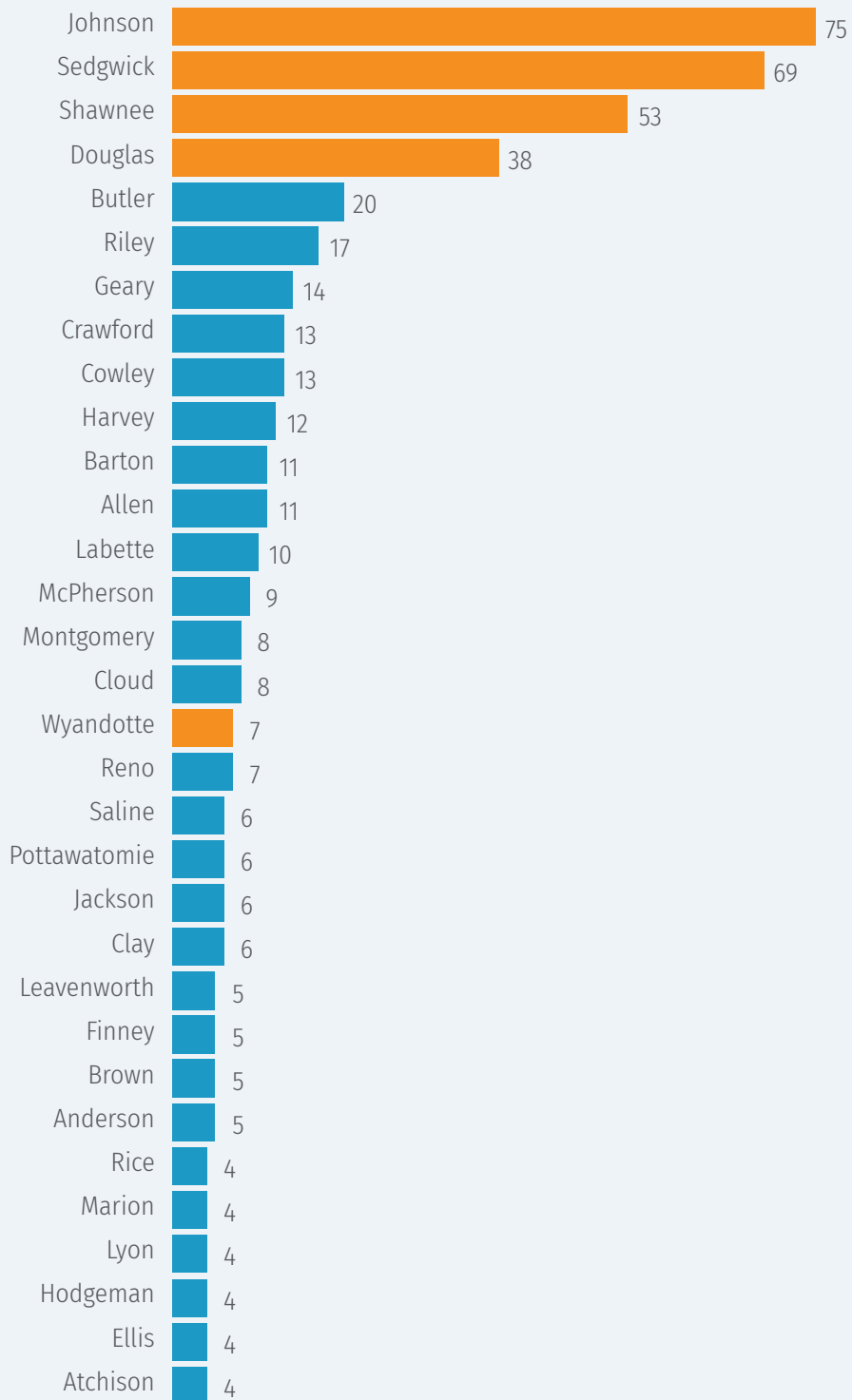
Responses to the survey were overwhelmingly female, with 85% of respondents indicating they were female; 14.1% were male and <1% were non-binary/third gender. The highest number of responses came from individuals 30 to 40 years of age, with far fewer respondents older than 40 participating.

### County Representation of Respondents

The greatest number of respondents came from the state's largest counties, with the three largest counties (Johnson, Sedgwick, and Shawnee) having the greatest number of respondents. However, several of the largest counties in Kansas (Wyandotte, Leavenworth, Reno, and Saline, all among the largest ten counties) are not represented among the counties in the top ten number of responses. Counties that stand out as “overrepresented” are Allen County (36<sup>th</sup> largest county, but with the 12<sup>th</sup> highest number of responses, and Labette County (27<sup>th</sup> largest county; 13<sup>th</sup> highest number of responses).



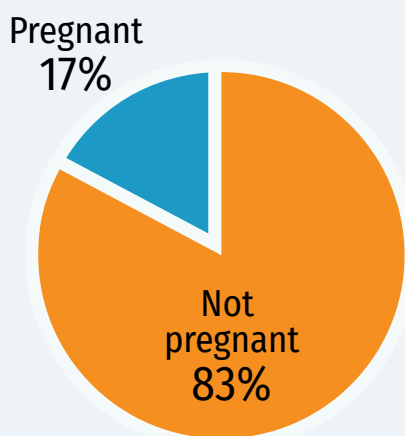
Survey respondents were equally divided among urban and rural counties.  
(N=463)



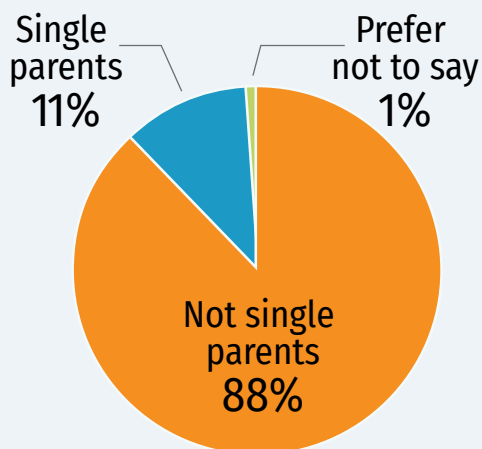
## Pregnancy and Parenting Status

More than four out of five (83%) respondents indicated they were not pregnant, while 17% indicated they were pregnant. Only 11% of survey respondents indicated they were single parents, a figure suggesting this population may be underrepresented in survey responses. The average number of children among survey responses was close to two children, but the highest number of responses came from those indicating that have one child. When asked how many children they had under the age of five, well over half indicated they had one child under five, followed by two children under five, and then those with no children under five.

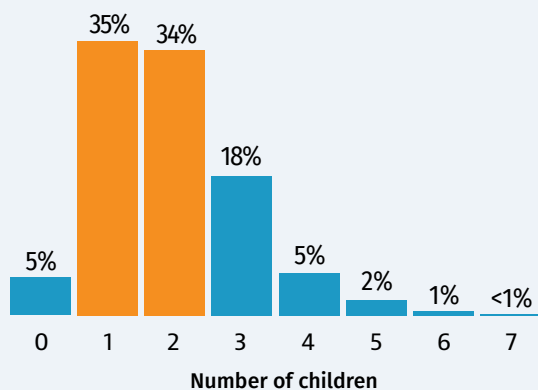
The majority of respondents report that they are not pregnant. (N=558)



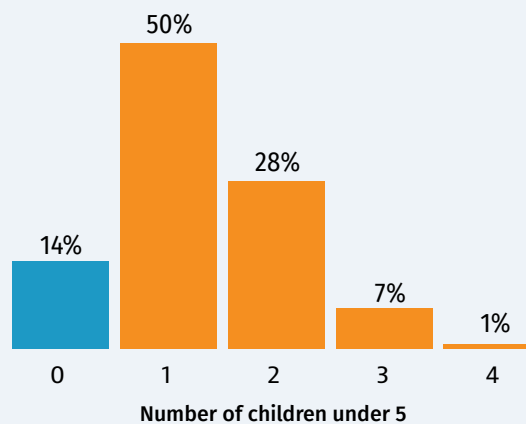
The majority of respondents report that they are not single parents. (N=558)



On average, respondents report that they have 2 children. (N=555)



Well over half of respondents report that they have children under the age of 5. (N=553)

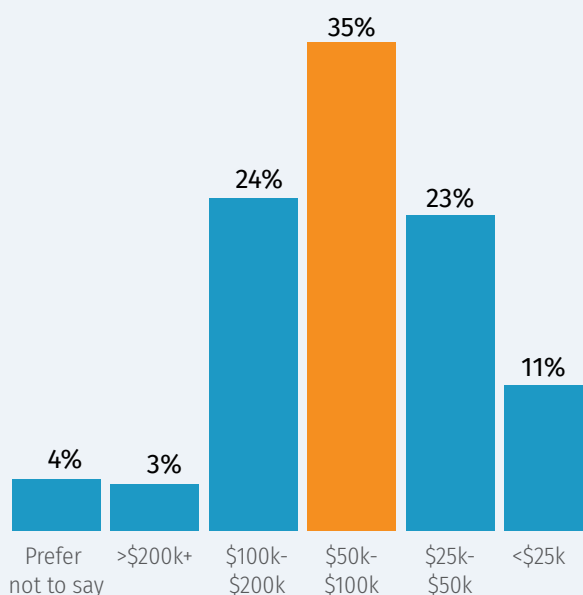


## Income and Employment

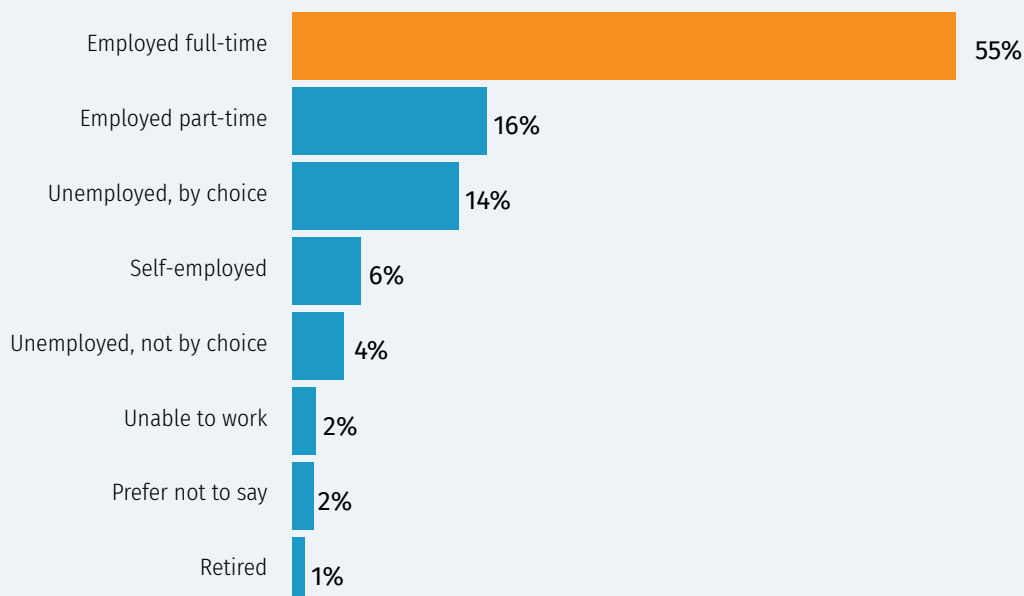
Household income was distributed across all income categories. The highest number of responses came from respondents in households with annual incomes of \$50,000 to \$100,000, which encompasses the Kansas median household income (about \$64,000). This was a little over one-third of responses. Close to one in four responses indicated they lived in households with annual incomes of \$25,000 to \$50,000 and with incomes of \$100,000 to \$200,000. About 11% live in households with annual incomes under \$25,000.

The majority of respondents are employed full-time or part-time. A number are unemployed by choice. Only a small number of respondents indicate being unemployed (not by choice) or unable to work.

Household income for most respondents is between \$50,000 to \$100,000. (N=560)



Over half of respondents indicate they are employed full time. (N=562)



### MCH Client and Domain

The vast majority of respondents do not recognize themselves as clients of MCH Programs, but are an expectant parent and/or the parent/guardian of a child under the age six. A very small number of responses came from parents/guardians of adolescent children, and no respondent indicated they themselves were an adolescent. There were a limited number of responses from parents/guardians of children and youth with special health care needs.

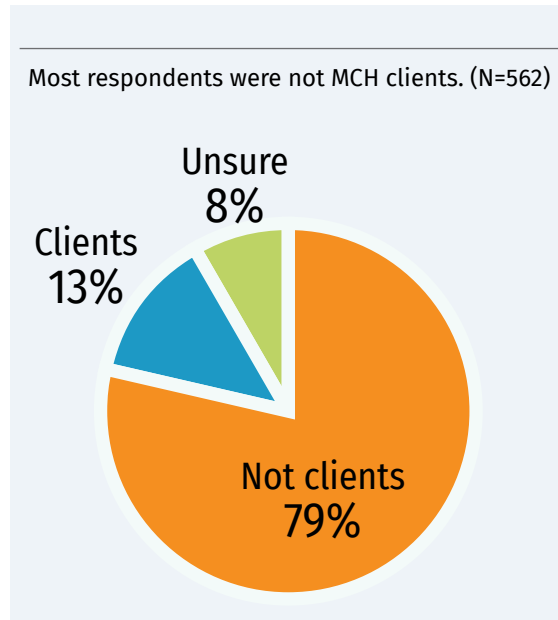


Table F.6.9 The majority of respondents indicate that they are an expectant parent and/or the parent/guardian of a child under 6.

Respondent Domain	Number
I am an expectant parent or parent/guardian of a child under six	548
I am the parent/guardian of a child six to eleven years old	30
I am the parent/guardian of an adolescent (twelve to twenty-one years old)	8
I am an adolescent	0
I am the parent/guardian of a child or adolescent with special health care needs	9
None of these apply to me	5

## *Representativeness of Response Population*

Convenience sampling was employed for this survey, which often leads to under-representation of diverse populations. That is to a certain degree true of the respondents here, although there is a mix of representation based on the following:

**Race/ethnicity:** The state's largest ethnic/racial minorities (Hispanic, Black/African-American) are underrepresented, but American Indian/Alaska Natives representation (2.9%) was greater than their representation in the overall population (1.2%).

**Single parenting:** Representation of single parents was low.

**Income:** The relative distribution of responses across household incomes is reasonably even compared to the actual distribution in the population, but those with lowest incomes (<\$25,000) were the least represented (only 11% of respondents reside in households with annual incomes of less than \$25,000 while over 21% of Kansas families experience that level of household income).

**Geography:** Thirty-two counties are represented. Overall there was good representation in both urban and rural counties.

**Age:** A range of ages is represented across survey responses, although younger populations are less well represented, particularly adolescents (no responses).

**Special health care needs:** Parents of children and youth with special needs are not well represented.

In sum, the diversity among staff survey responses summarized here is reasonably strong for a survey distributed using convenience sampling. However, the needs of populations known to experience some of the greatest barriers to care are not represented. Ample evidence suggests that ethnic racial/minorities, people with low-incomes, people who are single parents, and children/families with children and youth with special health care needs face particularly significant barriers to care and experience poor health outcomes. Future study warrants particularly attention to the perceptions and needs of these populations.

## Survey Responses: Women/Maternal Domain

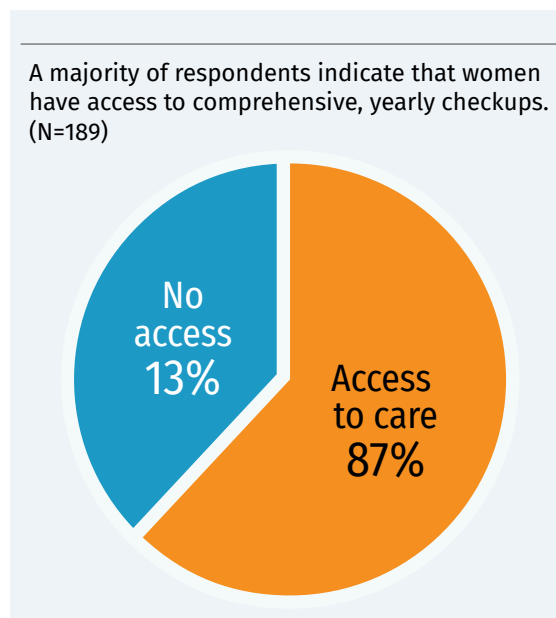
### Access to Care

A high percentage of respondents indicated that they have access to high-quality, comprehensive annual checkups, but a high percentage of respondents also indicated that they felt women in their communities experienced significant barriers to accessing annual well-woman care.

While a majority of respondents felt like those barriers were not significantly impacted by the pandemic, over 40% did feel like the pandemic exacerbated barriers to care. The barriers cited most often were lack of insurance (104 responses), lack of child care (93 responses), problems related to transportation (57 responses), and issues of convenience of service (services not offered at convenient times received 43 responses, and services offered at inconvenient locations received 33 responses). A shortage of providers were highlighted in 35 responses.

While the number of responses related to diversity were less in number, given the small percentage of survey respondents who indicated they were an ethnic/racial minority, it was significant to hear that there were perceived barriers based on:

- ◆ Lack of respect for diversity (18 responses)
- ◆ Lack of services provided to non-English speakers (15 responses)



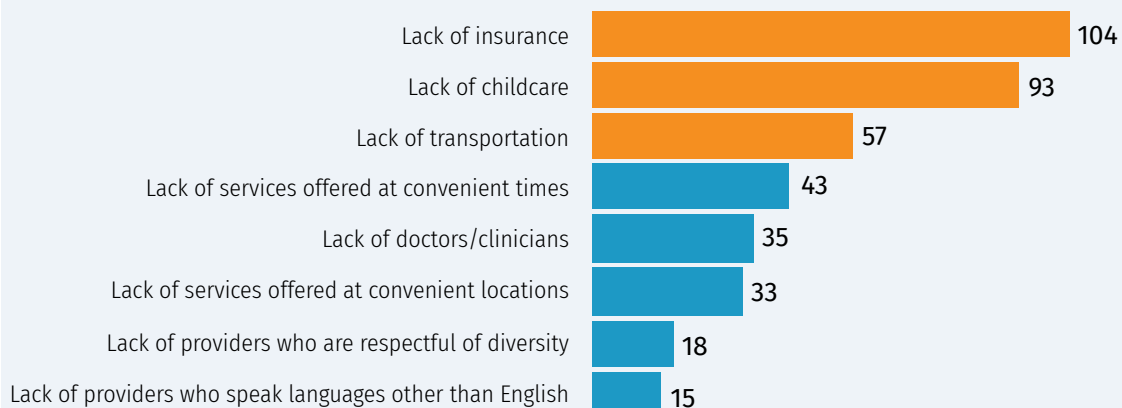
## Barriers in Accessing Checkups

Most respondents believe that women face barriers to accessing checkups in their community. Nearly half of those believe these barriers were influenced by the pandemic. (N=146)



When discussing barriers to women's services here are some examples of survey responses:

Barriers to annual well-woman care center most on lack of insurance, childcare and transportation.



*"Transportation and childcare were important factors, since working from home was less flexible than I imagined. Sometimes zoom or conference calls were beyond the traditional work day, and sometimes internet access was down. I could not teleconference with a pediatrician or schedule a trip to the clinic."*

*"Job loss and therefore insurance loss, lack of reliable transportation and dropped bus routes."*

*"Shortage of providers to see all of the patients who are seeking care now after the pandemic."*

## Experienced and Sought Help for Anxiety or Depression

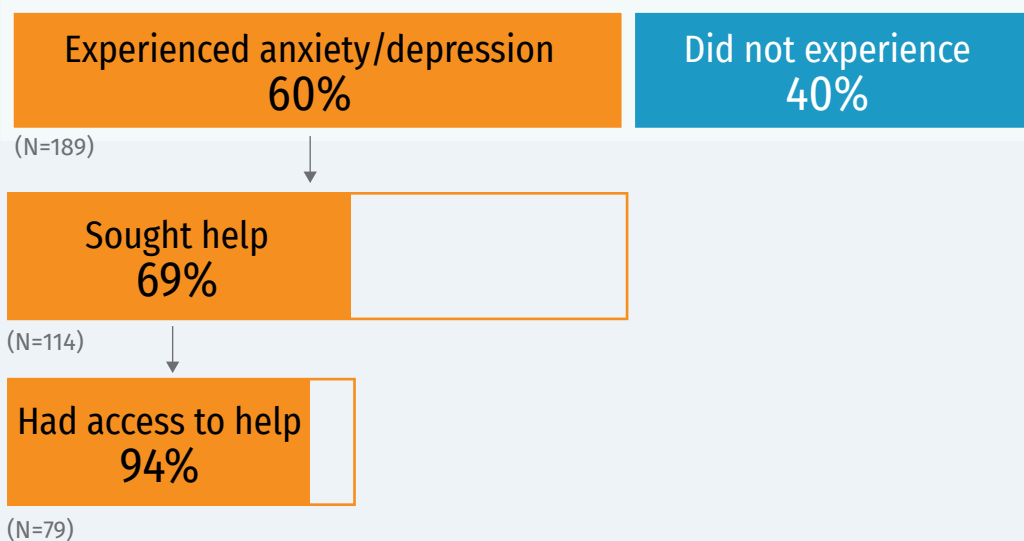
In the process of developing the Kansas MCH 2025 Needs Assessment and State Action Plan, leaders of the Kansas MCH Program heard that access to behavioral health services was one of the most urgent issues/concerns for women and children in the state. In interactions with youth, families, local MCH staff, and community leaders across the state mental health was universally cited as an issue needing immediate attention. Survey responses gathered for this report are consistent with those views. More than 60% of respondents indicated they had experienced anxiety or depression regularly during the past year. This number far exceeds comparable data collected for the Kansas population as a whole, and may reflect stressors associated with the pandemic. According to a 2022 poll by the Fort Hays State University Docking Institute of Public Affairs, half of Kansans said their family's mental health has been affected by the pandemic. (The Docking Institute of Public Affairs, 2022)

*"Going through a national crisis like we did during the height of the pandemic, it really brought to the forefront how important mental wellness is in our overall health."*

~ Jessica Provines, Wichita State University psychologist

Almost 7 of 10 respondents indicated they had sought help for anxiety and depression, but nearly one-third (30.7%) indicated they did not. Those who did seek help almost universally indicated they were able to get it.

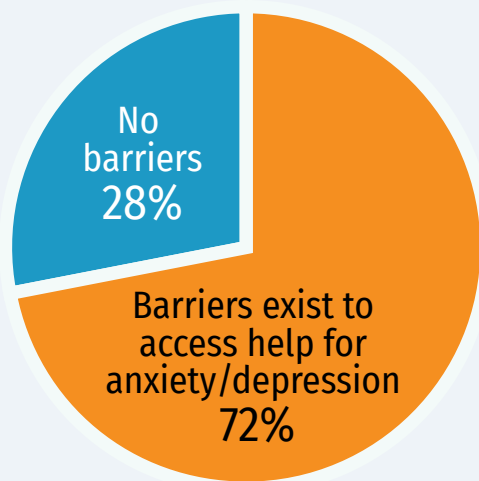
Most respondents indicate that women regularly experienced anxiety or depression during the last year and a majority sought and received help.



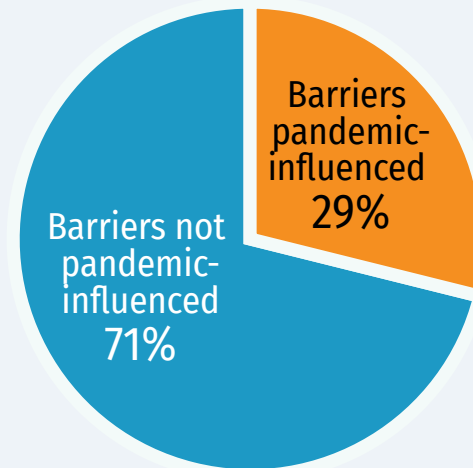
## Barriers in Accessing Help for Anxiety and Depression

While respondents were able to access mental health care, there was recognition that women experienced significant barriers to care for anxiety and depression in communities across the state; 72% of respondents indicated they believed barriers existed in their community. A majority (71%) felt these barriers were not fundamentally affected by the pandemic, but 29% felt the pandemic played a role in creating barriers to care.

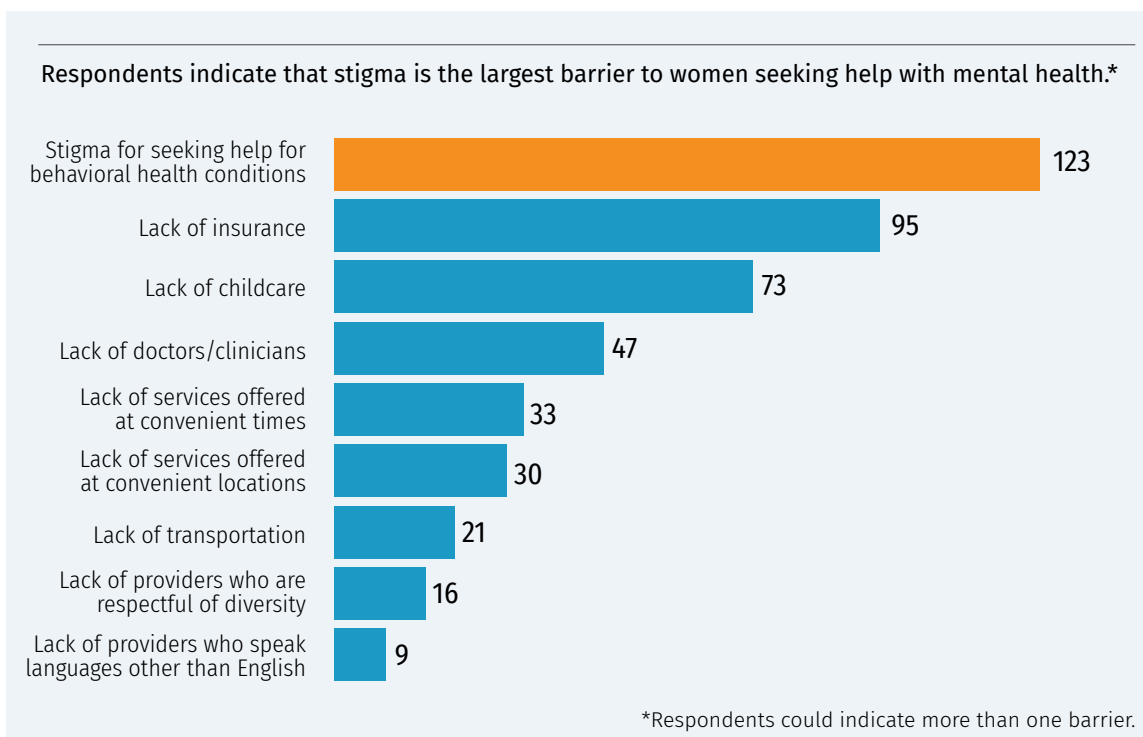
Most respondents agree that there are barriers for accessing help for anxiety or depression. (N=237)



Most respondents report that the barriers for accessing help for anxiety or depression are not pandemic-related. (N =170)



Many of the identified barriers were similar to those identified for well-women care (insurance status, availability of providers, childcare, lack of convenient access due to times/locations of service availability), but by far the greatest barrier cited by survey respondents was stigma associated with seeking care for mental health issues.



Some examples of survey responses discussing barriers to mental health services for women:

*"More doctors/psychiatrists have retired recently due to the pandemic. It is difficult to find another psychiatrist accepting new patients when your doctor has announced retirement."*

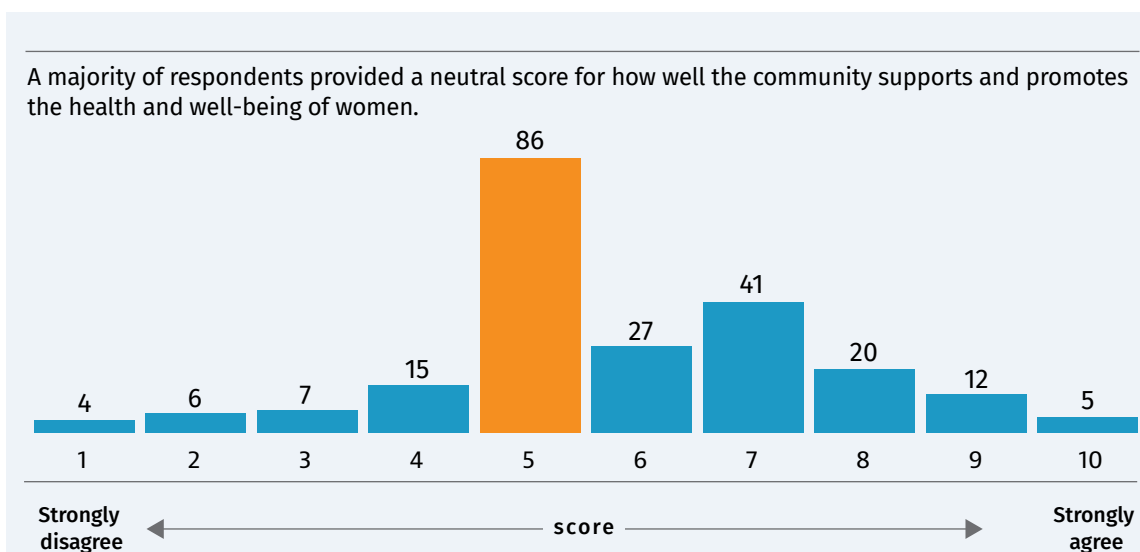
*"Not having a local clinic, reliable transportation, or childcare created obstacles."*

*"Worsening mental health through the pandemic so large mental health patient influx with not enough providers."*

*"Wait lists for mental health services are very long currently."*

## Community Support

Respondents were asked, “How well does your community – through its policies, environments, and programs – support and promote the health and well-being of women?” Negative responses (1-4 on a 10-point scale with 1 being “strongly disagree” and 10 being “strongly agree”) were a relatively small number of responses (about 10%), but less than 10% scored 9 or 10 at the strongly degree end of the spectrum. The majority of scores for community support were more neutral with a score of 5 (neither agree or disagree) being the most commonly selected score (almost four of ten responses).



When discussing community support for women’s health here are some examples of positive survey responses:

*“Our community offers a mom to mom group, PAT, and Learn and Play. We have general doctors and practitioners at the hospital and clinic. The health department offers WIC services and breastfeeding services.”*

*“Dr office in one town, FQHC in another town, Heath dept available to do well women exams.”*

*“Local moms groups, health department services, food pantry, clothing donations, PAT programs.”*

## Survey Responses: Perinatal/Infant Domain

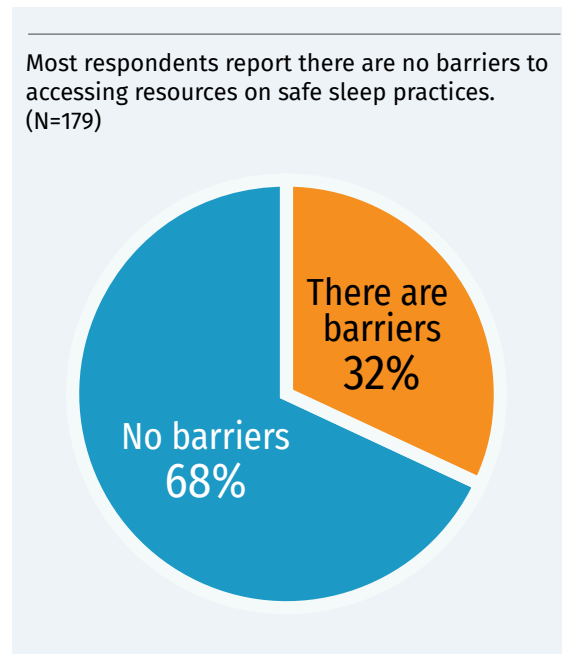
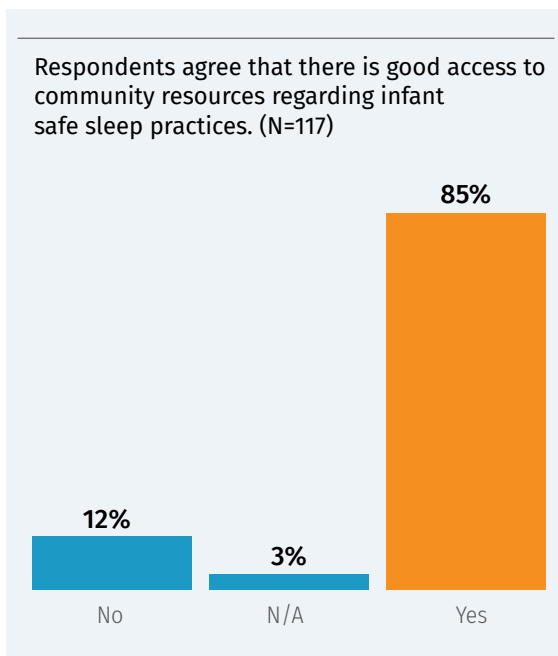
Questions in the survey related to this domain focused on:

- ◆ State Action Plan objective: Safe Sleep
- ◆ State Action Plan objective: Breastfeeding
- ◆ Overall community support/resources that promote the health and well-being of infants

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### Access to Safe Sleep Resources

The vast majority of respondents indicated they had access to community resources they needed to learn about safe sleep practices, and a strong majority of respondents felt that caregivers did not face significant barriers when accessing resources on safe sleep practices. Still, almost one in three (31.8%) respondents indicated there were barriers to this information.



When discussing barriers to safe sleep education here is a sample of what respondents had to say:

*"The current "safe sleep" recommendations can cause a lot of stress on women. For example, breastfeeding and following safe sleep rules is NOT conducive to a mothers best health. It makes them even more sleep deprived. Safe sleep recommendations need to be adjusted to understand the symbiotic relationship between breastfeeding and mother/child sleep, and separate out safe cosleeping situations from unsafe ones (eg being under the influence, sleeping on couch/chair, etc.)."*

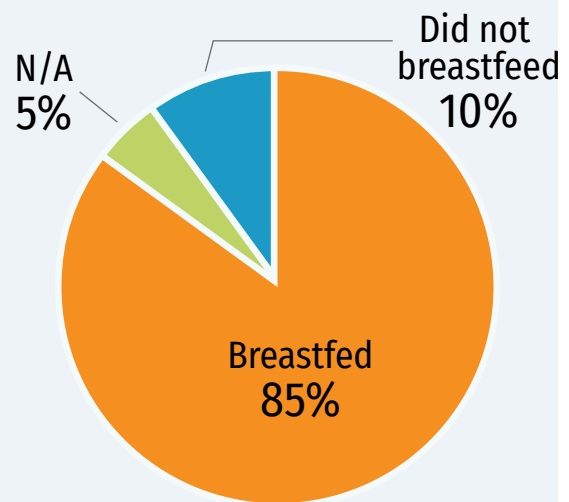
*"In my local community there was very limited classes/training for new parents. I participated in a class but had to drive over 30 miles."*

*"There's a lot of ESL families around us and not enough information written in their language."*

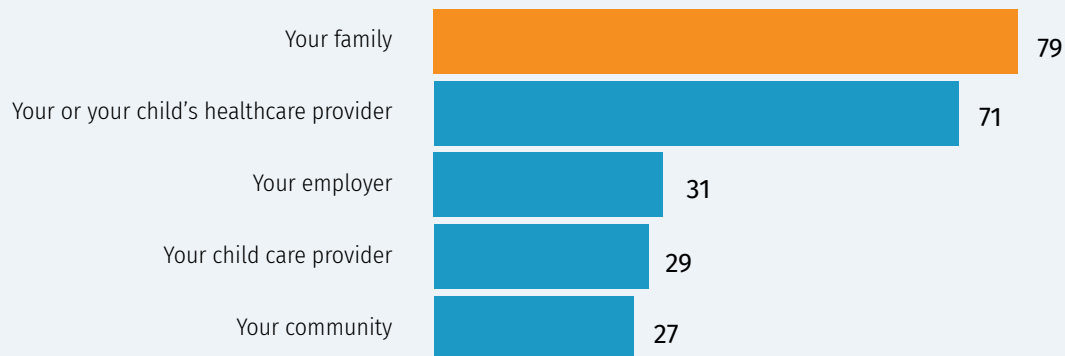
## Breastfeeding

A strong majority of respondents indicated that they did breastfeed their baby. Respondents were asked who supported their efforts to breastfeed (multiple responses were possible) and family and health care providers were most frequently cited as sources of support; others included employers, child care providers, and communities in general.

A majority of respondents indicate that they have breastfed their new baby. (N=117)

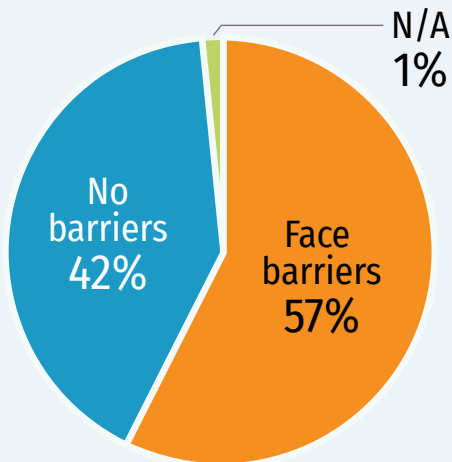


Respondents report finding the most support for their breastfeeding efforts from their family.

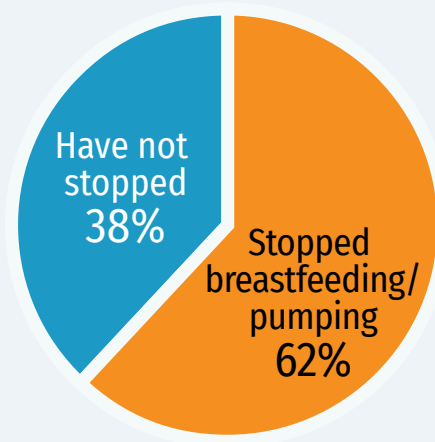


A majority of respondents indicated they did face barriers when it came to breastfeeding.

Respondents indicating if they face barriers making it difficult to breastfeed their new baby outnumbered those who do not. (N=98)



Most respondents indicate that they no longer breastfeed or pump to feed their baby. (N=98)



Comments around barriers included:

*"40 minute drive to lactation consultant."*

*"I had my child during the pandemic so there were no lactation consultant's to help me therefore I had to switch to formula."*

*"Going back to work. While they allow me time to pump, they don't respect it. I still have a full workload, and have to carve out time to pump."*

*"The hospital never taught me how to properly pump and when I did get my pump finally, it never came with the right size flanges."*

*"Lack of instruction at the hospital, separation from my baby immediately following birth, anatomy not conducive to easy breastfeeding, lack of information and support for exclusive pumping."*

Some of the themes cited in comments about why women stopped breastfeeding touched on some of the same themes:

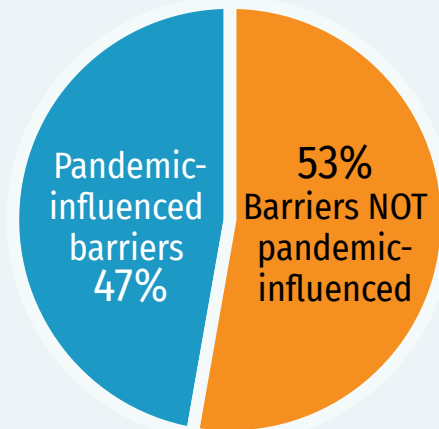
*"Low milk supply, mental health was suffering because I was stressing about the lack of milk my baby was getting. Lactation consultants provided by the hospital gave me conflicting information and I was stressing about what to do because my baby's weight was decreasing so I decided to formula feed."*

*"Even though I had a nice, clean office space it was very time consuming to have to keep pumping during my 9 hour workday. I also had a huge dip in supply because I came back so early to work, and I don't feel my supply was established nor was it able to increase as my baby grew. I have a workplace that says they are okay with breastfeeding but in reality there's really not much support."*

*"I was overwhelmed with how much time was necessary to breastfeed and I was pumping and dumping while feeding my child formula. It was exhausting and I was trying to become clean so he would be healthier."*

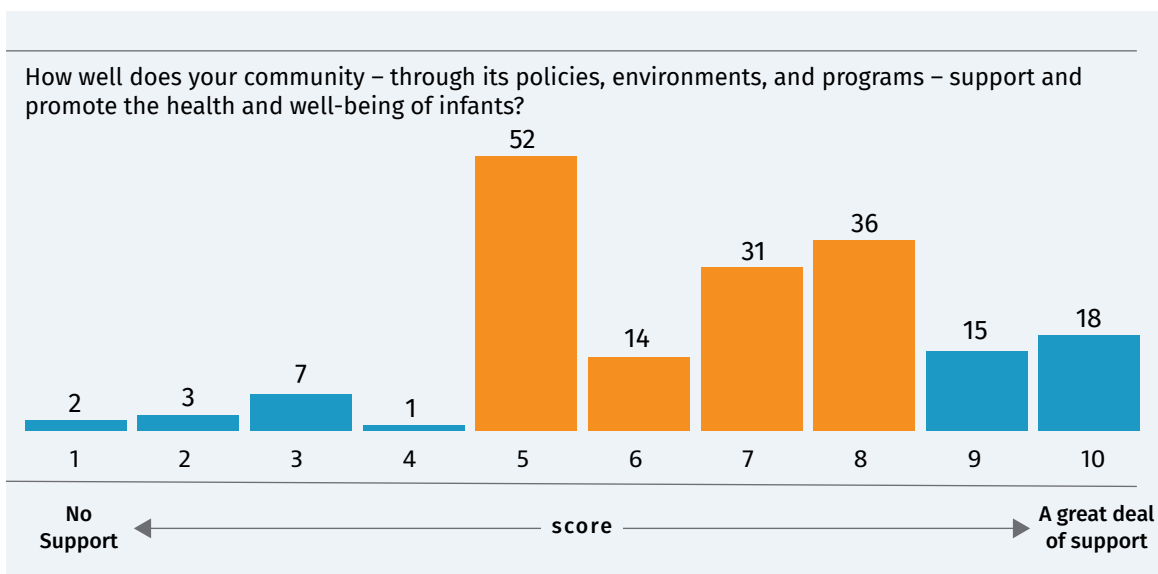
A majority of respondents did not feel barriers to infant health and well-being were particularly influenced or impacted by the pandemic, but a significant minority did indicate there were barriers. The barriers cited were predominantly related to services being provided remotely/virtually during the pandemic, which was more problematic for some families (due to factors such as disparate access to technology versus difficulty in scheduling versus concerns that referrals were harder to get through remote/telehealth visits), isolation that made it “difficult to lean on a village of support,” and general deterioration in capacity caused by the pandemic: “What is a caregiver to do when exhausted, frustrated, sick, broke, hungry?”

About half of respondents indicate that barriers to care for newborns and babies were influenced by the pandemic. (N=177)



### Community Support

As with the woman/maternal domain, the highest response regarding community support for the health and well-being of infants fell in the “neutral” category, indicating neither a strong sense of support or strong barriers. There were fewer negative and more positive responses in the perinatal/infant domain.



Respondents comments about community support revealed a number of themes that are highlighted here:

*"We have a wonderful health department that provides infant vaccines and also has a provider able to do wellness visits that saves parents from having to travel to a pediatricians office. They also provide applications for medical cards and great education to new parents."*

*"Daycare providers are baby/breastfeeding friendly, the health department offers WIC, immunization, and breastfeeding services"*

*"Hospital lactation services, parents as teachers program, library story times."*

*"There are many classes available. Our community had a baby shower in June that was very nice to get information about all the resources available."*

Respondents also cited opportunities to improve available supports:

*"Overall, our community is a good place to raise a child, however I do believe it could be better. I think that access to mental health resources, more breast-feeding support and universal maternity and family leave would help enhance the parenting experience."*

*"Access to affordable high quality infant child care."*

*"There aren't many cheap indoor activities suitable for young children. We play outside and at parks any time the weather is nice, but we have nothing to do for the majority of the year when it's too hot or cold."*

*"Find ways to continue the same kind of support outside of the hospital and they do before they leave the hospital."*

*"More languages and culturally appropriate information."*

## Survey Responses: Child Domain

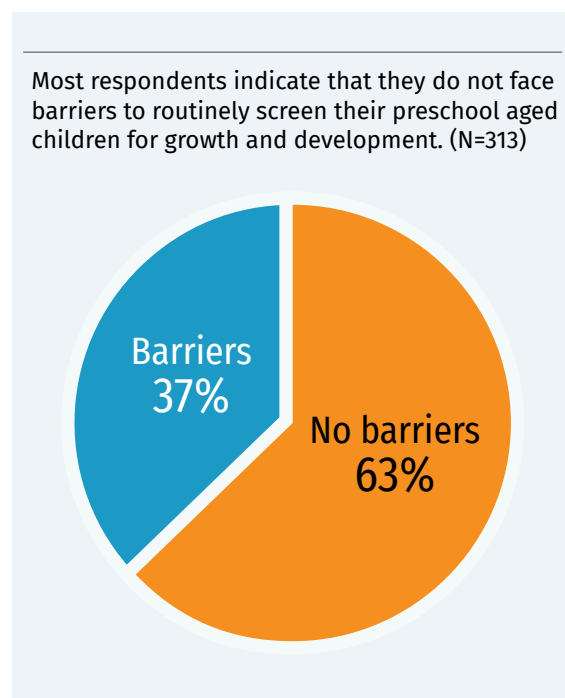
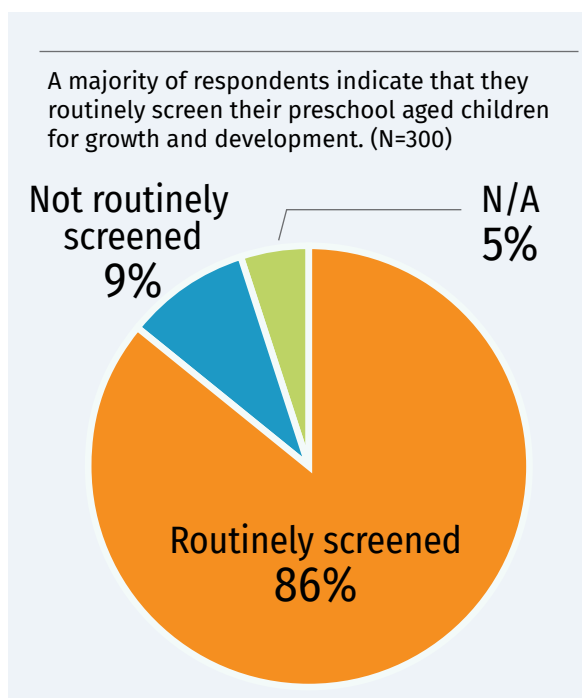
Questions focused on two primary goals:

- ◆ developmental screening and annual preventive/routine check-ups
- ◆ overall community support for child health

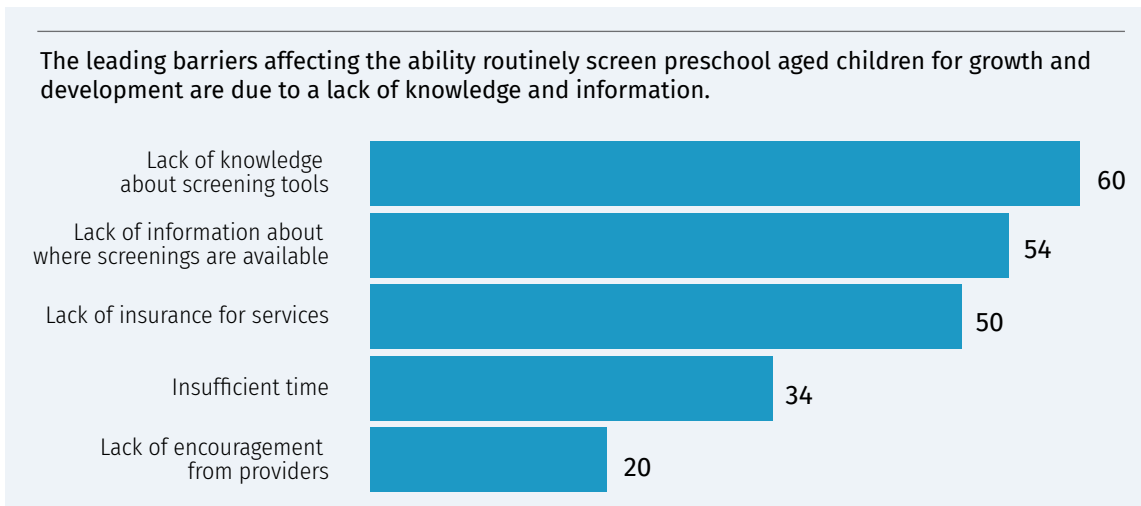
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### Screening for Growth and Development and Yearly Check-ups

Developmental screening of young children is a primary goal not only of the MCH Program but of the broader early childhood care and education system, cited in the current All in For Kansas Kids Strategic Plan. The early childhood strategic plan for Kansas was developed in 2019 through a collaborative process led by the Kansas Children's Cabinet and Trust Fund in collaboration with many public and private partners. When asked if they routinely screen their preschool aged children for growth and development, respondents replied affirmatively in very high numbers. Almost two-thirds of respondents also felt there were few barriers to screening.

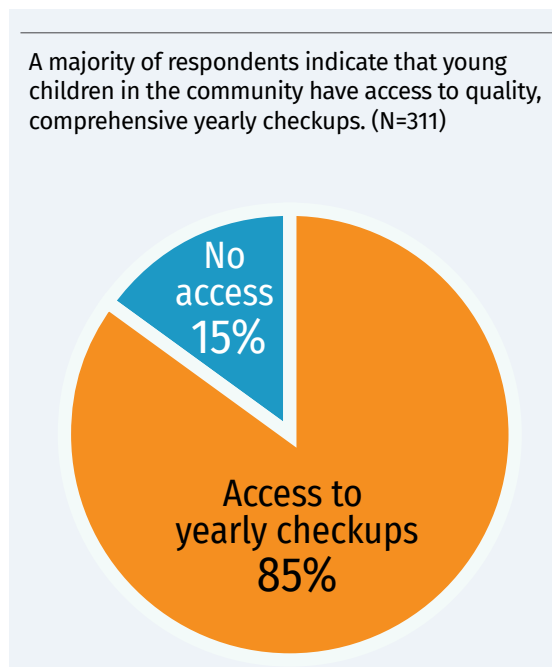
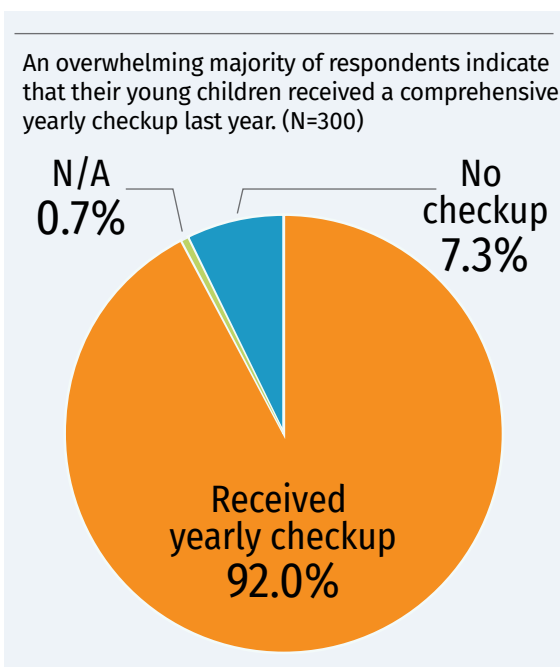


Those who did feel barriers exist cited a lack of knowledge of screening tools, lack of awareness of where screenings were available, and lack of insurance for services.

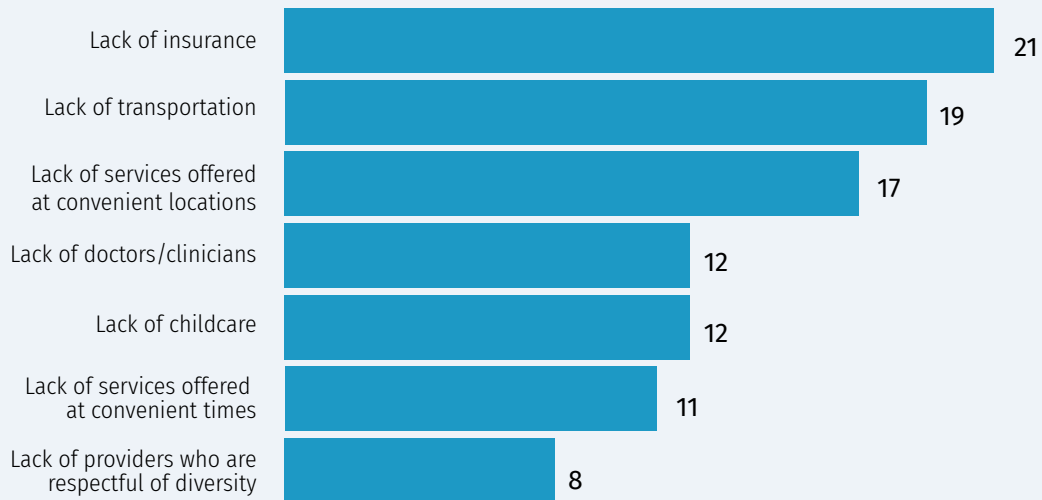


## Yearly Check-up

Respondents with young children overwhelmingly indicated those children had received a comprehensive annual check-up in the last year; respondents also felt that most young children had ready access to quality, comprehensive yearly check-ups. Barriers that were cited were similar to those cited earlier for other types of care: barriers to insurance, lack of transportation, and inconvenient locations to access services.



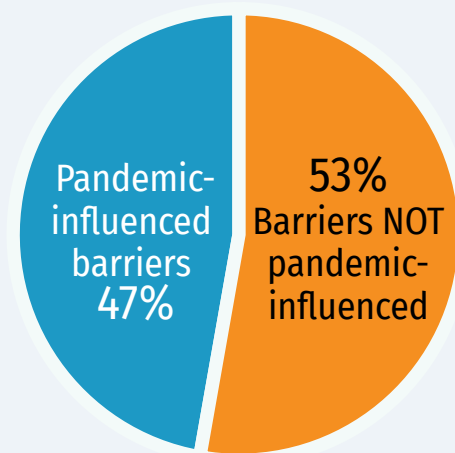
The leading barriers affecting the ability to routinely screen preschool aged children for growth and development are due to a lack of knowledge and information.



### *Barriers due to the Pandemic*

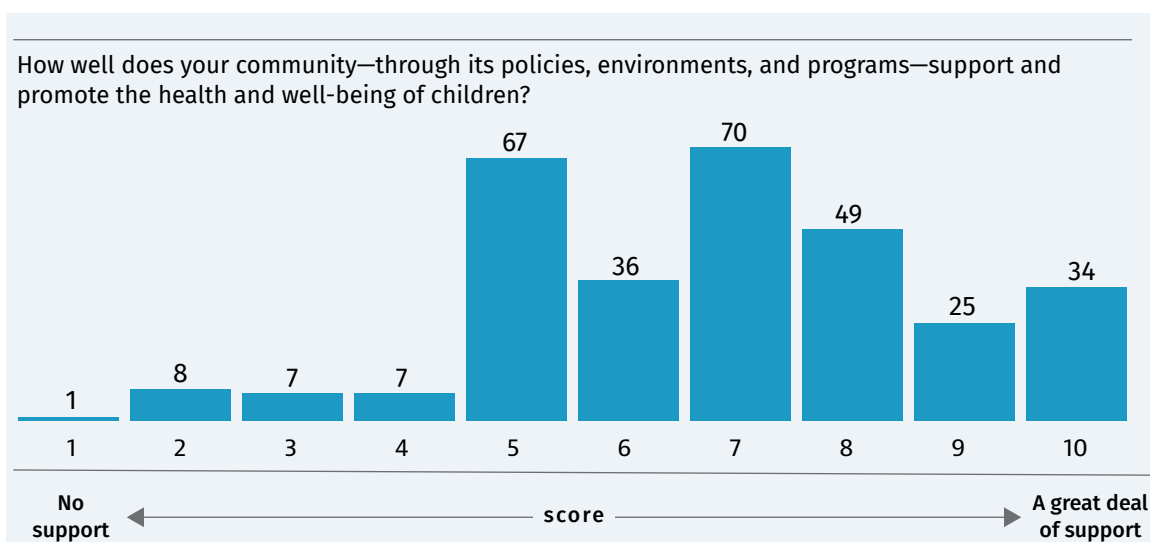
There were significant concerns during the pandemic that respondents felt were barriers to care. Some clinics shut down or limited service hours, and some parents were reticent to take kids in for fear of potentially exposing them to COVID. It was also noted that, because children were out of school, they were unable to receive services from school-based support staff (social workers, speech language pathologists, counselors, therapists, and others) that were routinely available to them at school.

About half of respondents indicate that barriers to care for newborns and babies were influenced by the pandemic. (N=177)



## Community Support

Scores for community support for child health were higher overall than scores for women and for infants. Respondents noted their appreciation for the availability of services from pediatricians and other primary care providers, health departments, home visiting programs, schools, and other community-based providers such as libraries. There were many comments about how school- and community-based screenings for vision, oral health, and hearing made it convenient to monitor these important health conditions.



Some opportunities to improve opportunities for child health were cited. One concern were costs associated with health-promoting activities like classes and sports teams, and lack of low-cost activities and amenities like parks, trails, and other recreational areas. It was pointed out these are important not only for physical health but for preventing social anxiety and mental health problems. Some advocated for more clinical health services, particularly in settings convenient to families. Others felt like education about available services could be improved.

## Survey Responses: Adolescent Domain

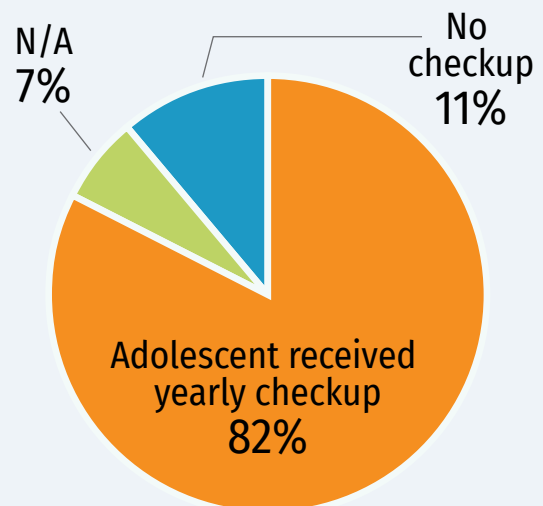
The questions in this domain were related to:

- ◆ annual check-ups
- ◆ behavioral health services

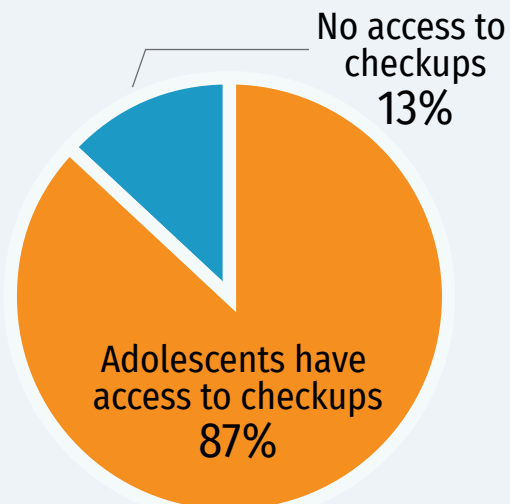
### Yearly Check-up

Respondents to the question about whether their adolescent child had received a yearly exam almost universally responded yes, and they also responded in a similar manner when asked if adolescents in their community were able to access quality, comprehensive yearly checkups. Respondents, when asked where care was received, most often answered that their adolescent child was seen by a pediatrician or other primary care provider, although a handful of responses also noted their child received such care in a school setting or at a health department. Few barriers were cited, but in the few instances where some barrier to care was noted, they were similar to those for other MCH populations; insurance, transportation, and lack of care offered at convenient times were all cited.

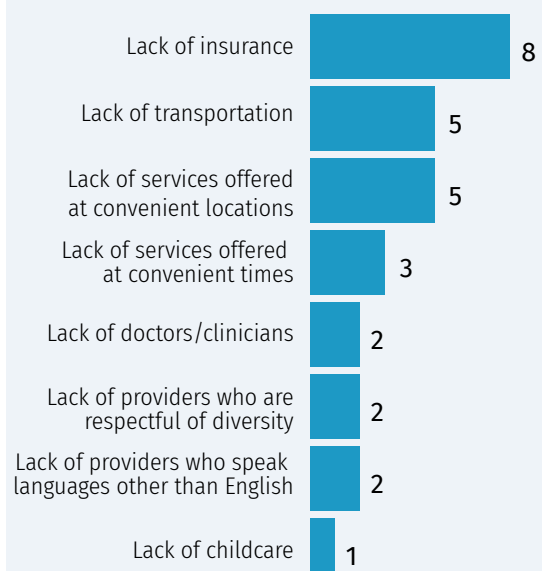
An overwhelming majority of respondents indicate that their adolescents received an annual comprehensive checkup last year. (N=46)



An overwhelming majority of respondents indicate that adolescents have access to an annual comprehensive checkup. (N=69)

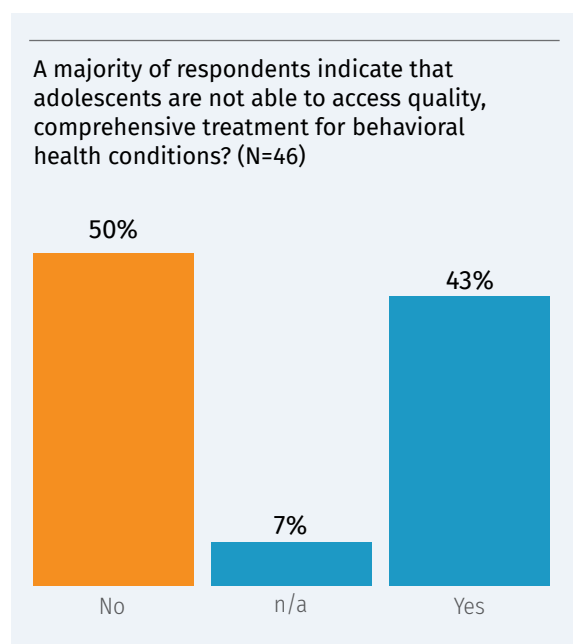


Barriers affecting the ability for adolescents to receive yearly checkups.

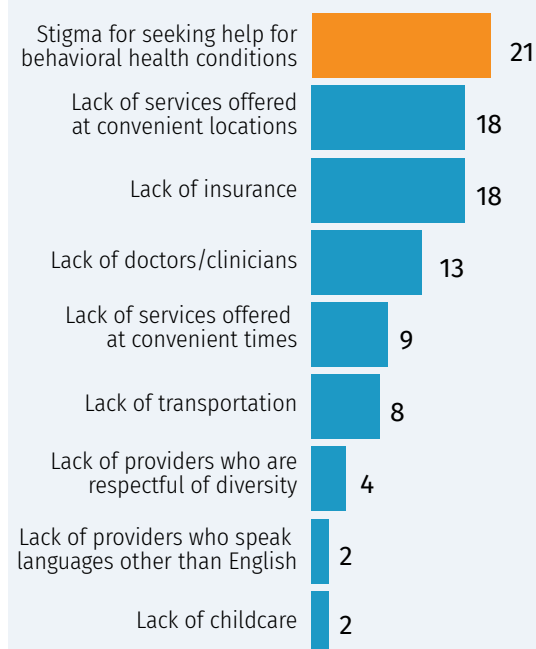


## Behavioral Health Conditions

Answers were far different when it came to the question about access to behavioral health care for adolescents. In this case, more respondents answered “no” when asked if adolescents could receive quality, comprehensive treatment for behavioral health conditions in their community. An insufficient number of providers, a lack of services offered at convenient locations, and lack of insurance covering needed services were all cited. The most frequent response, however, was that stigma for seeking help for behavioral health conditions posed a barrier to accessing services.



### Stigma was cited as the largest barrier to adolescents receiving behavioral health treatment:



\*Respondents could select more than one

### Barriers due to the Pandemic

There was also a concern that the pandemic significantly influenced the barriers to behavioral health care for adolescents. Some of the concern was the impact school closure had on access to services:

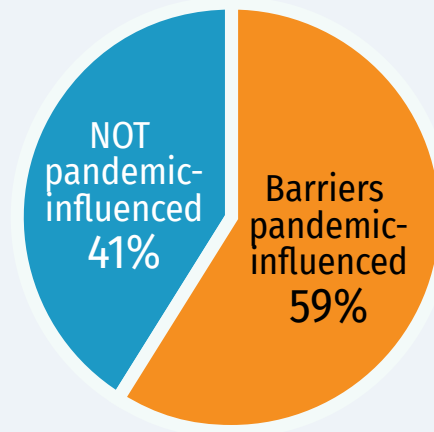
*"During height of the pandemic some facilities had reduced hours which made it difficult to schedule times. Also children missed out on daily services provided at schools when schools went to remote learning."*

However, other concerns recognized that the pandemic itself had a negative impact on the mental health of adolescents and led to a greater need for support.

*"Most kids need mental health care since the pandemic."*

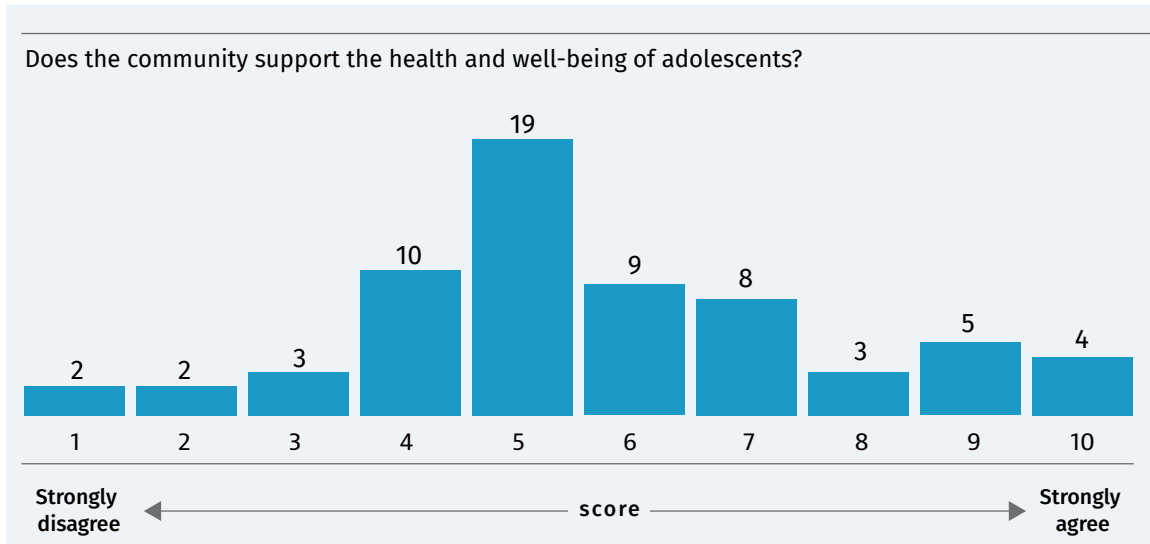
*"Huge influx of need for mental health services for teens."*

A little more than half indicate that barriers to care for adolescents were influenced by the pandemic. (N = 64)



### Community Support

When asked about the degree to which their community supported the health and well-being of adolescents, scores fell primarily at or close to the mid-point, indicating most respondents did not strongly agree or disagree these resources were adequate in their community.



Concerns about the adequacy of supports for adolescents generally fell into three categories: the need for more school-based services and supports to increase access, the importance of increasing and enhancing behavioral health supports, and the need to ensure more amenities and resources outside of schools such as parks, trails, and after-school programs.

## Survey Responses: Children and Youth with Special Health Care Needs Domain

In this section, respondents were asked questions in the following three areas regarding care for children and youth with special health care needs (CYSHCN) and their families:

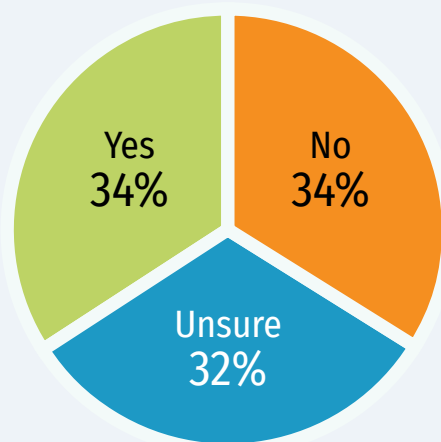
- ◆ Access to quality, comprehensive health care (and barriers to access)
- ◆ Availability of supports to help with the transition into the adult health care system
- ◆ Quality and functioning of the system of care

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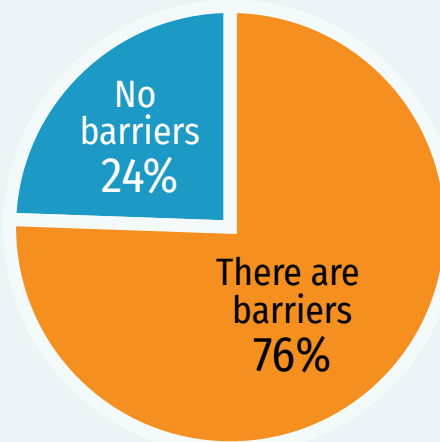
### Care

When asked if children and youth with special needs are able to access quality, comprehensive health care, responses were nearly split equally among yes, no, and unsure. In addition, respondents clearly are concerned with barriers to accessing high-quality health care services for their CYSHCN, as three out of four respondents indicated they experienced barriers when seeking care for their child(ren).

Respondents are evenly split when asked if they have access to care for their children with special needs. (N = 47)



Respondents largely agree that there are barriers to high quality care for children with special needs. (N = 33)



The primary barriers cited were a lack of providers. In the case of CYSHCN, specialists tend to be more concentrated in urban areas, so it was not surprising to hear respondents indicate that there was a lack of local specialty providers and that services are not offered in convenient locations for them. Lack of insurance was also cited as a barrier.

Table F.6.10 A lack of specialty providers and services were cited as the primary barriers to care for CYSHCN.

Barriers to Care	Number of responses
Lack of specialty providers in our community	14
Lack of doctors/clinicians	11
Lack of services offered at convenient locations	11
Lack of insurance	7
Lack of transportation	6
Lack of services offered at convenient times	3
Lack of providers who speak languages other than English	3
Lack of providers who are respectful of diversity	2
Lack of childcare	1

Some examples of the concerns shared by respondents are:

*"There aren't any providers in my town that give quality care to kids with needs like mine has. I have to drive to another town to take my kids to appointments. Not everyone is able to do that, so they're stuck with subpar care or no care at all."*

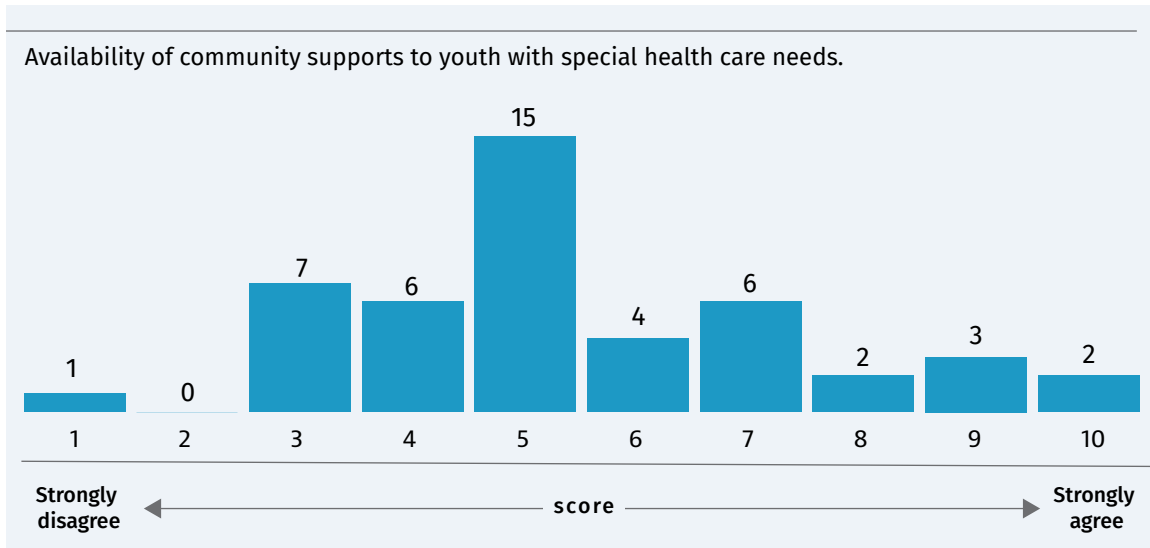
*"We live in Western Kansas, in a county that borders Colorado. Fortunately, my son has dual insurance coverage--BCBS through me and my work, Medicaid through the TA waiver. He was born in Denver and has seen specialists in Denver his whole life. Denver is a 3.5 to 4 hour drive (one way) from our hometown. If he lost his private insurance, we would be forced to transfer his care to Wichita (a 5 hour drive) or Kansas City (7 to 8 hour drive ONE way). This terrifies me. There aren't any specialists closer to where we live."*

*"There are barely any services here for kids with autism or behavioral concerns."*

A majority of respondents also noted that barriers were exacerbated by the pandemic. The overall sentiment when asked about barriers were that the pandemic reduced or even closed down some services, and some of those provided remotely weren't always an adequate "replacement" for face-to-face care.

## Community Support

In this section, we asked the question, “How would you rate the supports available to youth with special health care needs in your community to be able to easily transition into the adult health care system?” While there were a handful of respondents who believe there are a great deal of supports available in their community, there are more responses found between “no” and “some” support.



Some of the supporting narrative answers of respondents provided additional insight:

*“Services can be available but often you have too much red tape to work through or have to be referred out to specialists at least 2 hours away.”*

*“Our local parks were updated a few years ago with the intention of being handicap accessible, but the equipment is not easily accessed by those in wheelchairs.”*

*“Pre school and early head start provide minimal services for children with behavioral disorders.”*

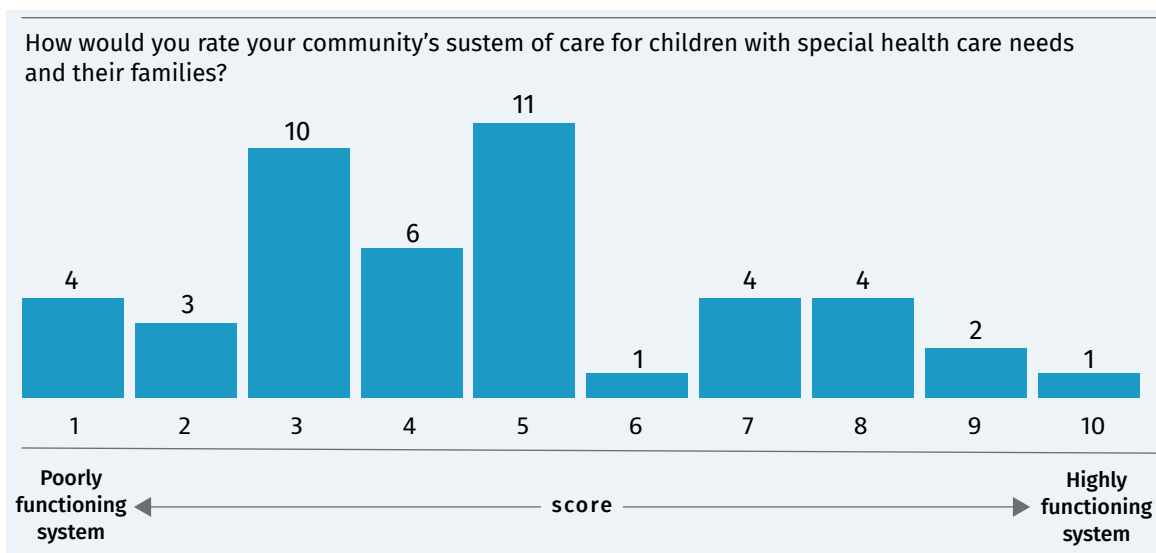
Most comments about what should be done focus on having more providers available at a local level, doing more to ensure affordability of services not just for those who are poor but for middle-income families that often are not eligible for subsidies but find specialty care unaffordable, and ensuring a better “built environment” for individuals with disabilities. In their own words:

*“Have easier or closer access to specialists.”*

*“The built environment could use some work--sidewalks, door accesses/handicap buttons, play equipment.”*

### System of Care Rating

When asked to rate their community’s overall system of care for CYSHCN and their families, scores trended lower than community support questions in other domains. Eleven responses scored 5 (which on this scale stood for “A reasonably well-functioning system”), but the second highest number of responses were a scored of 3 (toward the lower end of the scale, towards “a poorly functioning system”).



When asked why, some responses included...

*“Getting evaluations done takes an extremely long time. When help is needed at the present moment, waiting over a year to even be seen is discouraging.”*

*“[COVID] created longer waitlists. Services were done virtually which is not as effective for some with special needs.”*

*“Everyone is overworked and burnt out not giving patients the care that they actually need and deserve.”*

# Appendix F.8 Community Engagement Sessions

## Introduction and Methods

As described in the report, in May and June of 2024 CPPR hosted six community engagement events across Kansas, one in each of the six Maternal and Child Health (MCH)-designated regions, to gather public input on issues impacting the health of women, infants, and children in Kansas. Sessions featured a series of interactive “stations” designed to encourage engagement and gather attendee responses.

Table F.8.1. Community Engagement Events

Region	City	Date
Southwest region	Garden City	May 8
Northwest region	Hays	May 10
North Central region	Salina	May 30
South Central region	Wichita	May 31
Northeast region	Kansas City	June 27
Southeast region	Pittsburg	June 28

## Findings

### Participants

Between the six events, 110 people filled out the demographic profile in our sign-in document. Since signing-in was voluntary, not every participant completed a profile, and an exact number of participants was not collected. Completed profiles were collected for 10 participants in the Southwest, 9 in the Northwest, 15 in North Central, 30 in South Central, 28 in Northeast, and 18 in the Southeast. Participants came from the following twenty counties:

Allen (1), Butler (2), Clay (1), Crawford (15), Ellis (7), Ellsworth (1), Finney (8), Ford (1), Harvey (2), Jackson (1), Johnson (9), Kearny (1), Leavenworth (1), Montgomery (2), Pawnee (1), Russell (1), Saline (13), Sedgwick (26), Shawnee (2), Wyandotte (14)

Using KDHE’s urban/rural classification system, 48% of participants were from urban counties, 31% from semi-urban, 17% from densely settled rural, 4% from rural, and 1% from frontier counties. Other demographics are summarized in the table below. Since information was provided voluntarily, not every participant completed every field on the form, so totals differ slightly among categories (the number of completed items varied from 94 for income to 109 for education).

Table F.8.2. Participant demographics by gender

Gender	Number of participants	Percentage
Female	100	96.2%
Male	4	3.8%

Table F.8.3. Participants by age

Age group	Number of participants	Percentage
Under 18	3	2.8%
18-44	60	55.6%
45-64	35	32.4%
65+	10	9.3%
<b>TOTAL</b>	<b>108</b>	<b>100.0%</b>

Table F.8.4. Participants by race/ethnicity

Race/Ethnicity	Number of participants	Percentage
White/Caucasian	73	68.9%
Hispanic	17	16.0%
Asian	6	5.7%
Black/African American	8	7.5%
Pacific Islander	2	1.9%
<b>TOTAL</b>	<b>106</b>	<b>100.0%</b>

Table F.8.5. Participants by race/ethnicity

Primary language	Number of participants	Percentage
English	96	90.6%
Spanish	9	8.5%
Urdu	1	0.9%
<b>TOTAL</b>	<b>106</b>	<b>100.0%</b>

Table F.8.6. Participants by educational attainment

Education	Number of participants	Percentage
Less than high school	3	2.8%
High school/GED	11	10.1%
Some college	15	13.8%
College graduate	41	37.6%
Graduate degree	39	35.8%
<b>TOTAL</b>	<b>109</b>	<b>100.0%</b>

Table F.8.7. Participants by family income level

Income	Number of participants	Percentage
<\$15,000	5	5.3%
\$15,000-\$49,999	28	29.8%
\$50,000-\$99,999	40	42.6%
\$100,000+	21	22.3%
<b>TOTAL</b>	<b>94</b>	<b>100.0%</b>

## Budgeting

Results below were collected at the station at which participants were provided with \$100 of play/fake money (ten \$10 “bills”) and asked to budget/allocate their money among eight topics. The figure below depicts relative allocation of dollars across the eight topics. There was some variation in how participants allocated their funds across the regions, as seen in the table below.

Figure D.8.1. Allocation of funds across selected topics

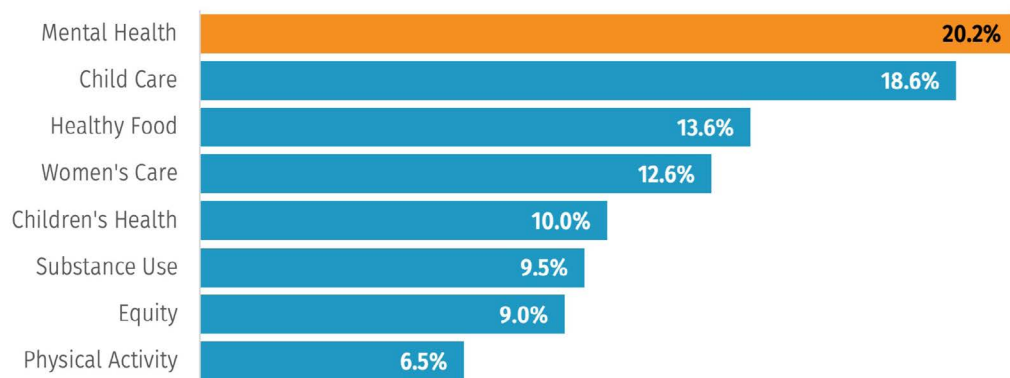


Table F.8.8. Issue Prioritization by Region

Topic	North Central	Northeast	Northwest	South Central	Southwest	Southeast
Child Care	22.1%	17.1%	11.0%	20.8%	13.8%	<b>21.2%</b>
Children's Health	12.1%	11.6%	5.0%	9.4%	11.0%	9.0%
Equity	7.4%	6.1%	11.0%	11.9%	4.6%	11.1%
Healthy Food	12.1%	16.5%	15.0%	12.1%	<b>18.3%</b>	9.0%
Mental Health	<b>24.2%</b>	<b>18.3%</b>	<b>26.0%</b>	<b>21.0%</b>	16.5%	17.5%
Physical Activity	4.7%	6.1%	15.0%	4.0%	13.8%	4.8%
Substance Use	8.7%	10.4%	10.0%	6.2%	6.4%	16.4%
Women's Care	8.7%	13.8%	7.0%	14.6%	15.6%	11.1%

Mental health was the highest funded topic overall, in four of six regions. Healthy food received the highest level of funding among participants in the Southwest region (18%), with mental health a close second (17%). Mental health was also the second-highest priority in the Southeast, where Child Care was the top issue (21% of allocated funding). In addition to being the highest funded topic in the Southeast, Child Care was a close second in another three regions (North Central, Northeast, and South Central).

### *Priorities in the Community*

There were two questions asking participants to choose one issue they saw as the most important in their community. One question focused on specific health outcomes that are of growing concern to MCH providers because of troubling temporal trends in the data or the presence of disparities among subpopulations. These three outcomes were adolescent suicide, disparities in pregnancy-related deaths, and maternal mental health (anxiety, depression). Across the state maternal mental health was selected as the priority 54% of the time, adolescent suicide 28%, and disparities in pregnancy-related death 13.1%.

The second question focused primarily on the issue of access: do women have adequate access to prenatal care, do families have access to developmental screening during early childhood, do youth have adequate access to insurance coverage? Responses were evenly split between prenatal care (38%), developmental screening (32%), and youth insurance (30%).

For both questions, the most frequent response was “Other,” and participants were asked to provide an open-ended response if they chose this category. These open-ended responses are summarized at right ([Table F.8.9. Categorization of “Other” Responses](#)).

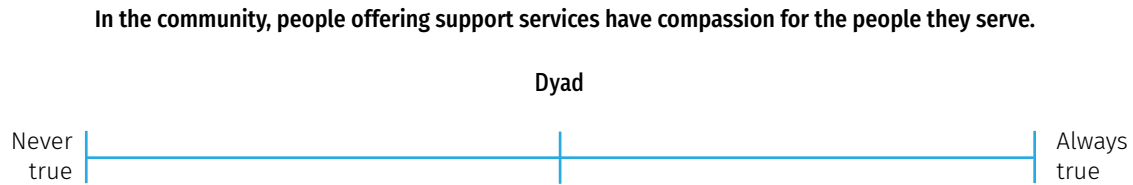
Table F.8.9. Categorization of “Other” Responses

Issue	Responses
<b>Childcare</b>	<b>4</b>
<b>Dental care</b>	<b>4</b>
<b>Drug use (included two specifically for adolescents, one for parents)</b>	<b>4</b>
Lack of providers (two specific to pediatrics)	3
Maternal alcohol use	3
Insurance coverage (for adults and children)	3
Parenting	3
Lack of services for fathers	3
Safe sleep	3
Child/adolescent mental health	3
Affordability of health care services	2
Child health	2
Childhood trauma	2
Afterschool care	1
Pregnancy/postpartum services for undocumented women	1
Health equity	1
Resources for seniors	1
Homelessness	1
Quality of care	1
ADHD screening and treatment (other than meds)	1
Birth spacing	1
Perinatal health	1
Lack of awareness of services	1
Long waiting times for services	1
Postpartum care (one visit is not enough)	1
Insurance for undocumented youth and parents	1
Housing	1
Prenatal care for people who speak other languages and dialects	1
Transportation	1
Accessible/free activities to maintain active children	1

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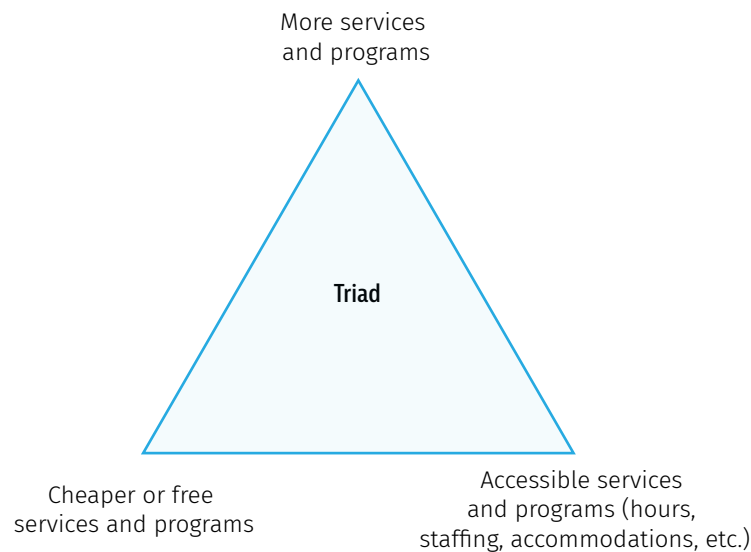
## Sensemaking

At the sensemaking station at the community engagement sessions, there were two prompts. In the first prompt, participants were asked to place a dot on a horizontal slider (dyad) to best describe their perceptions about support service providers and compassion. The question prompt was:



For the second prompt, participants were asked to place a dot on the area in a triangle (triad) that best describes their experience in the community as it relates to maternal child health. The question prompt was:

**When I think about what's available to people in my community, we need...**



Each corner of the triangle represented one of three options:

**More services and programs.**

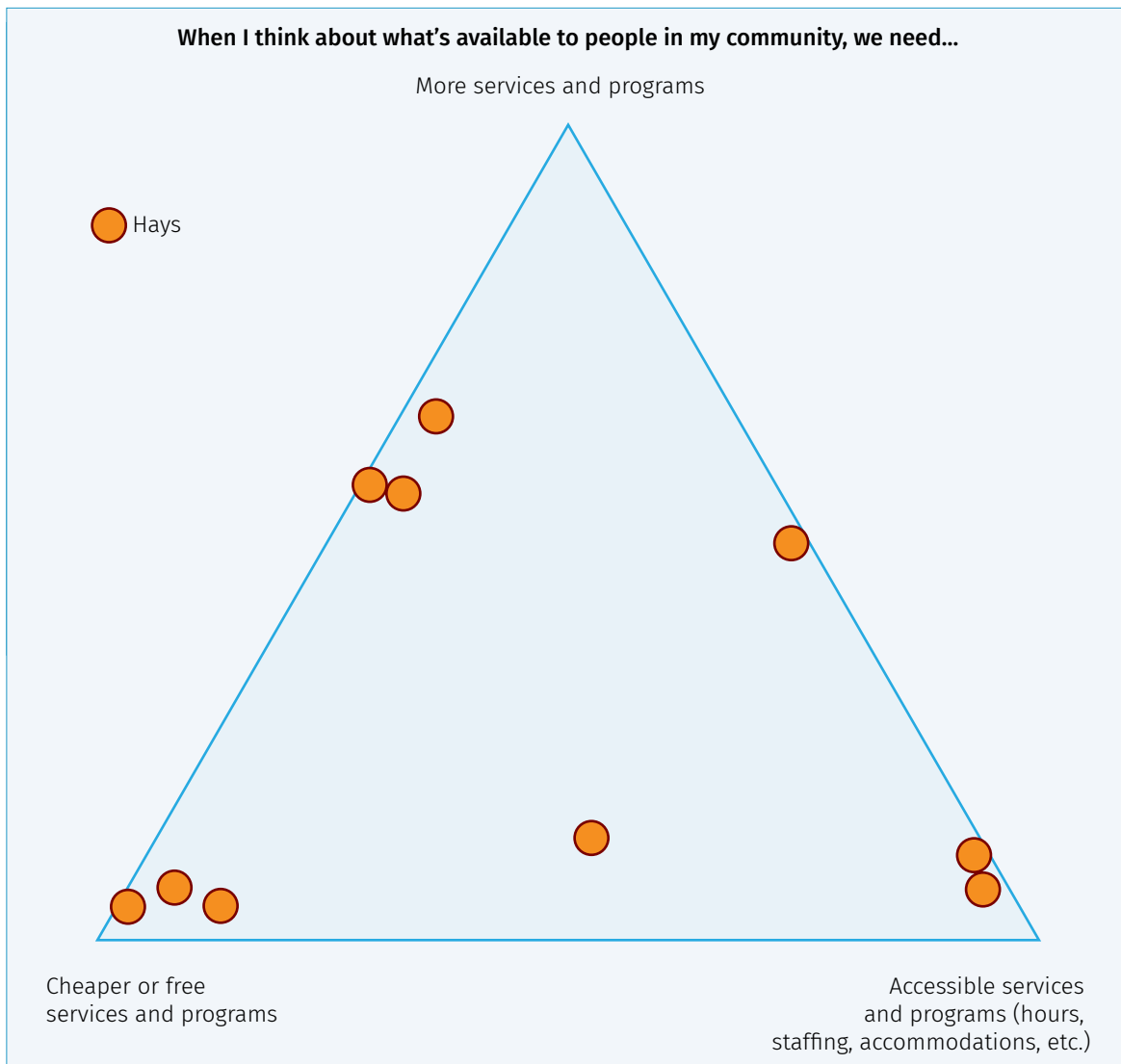
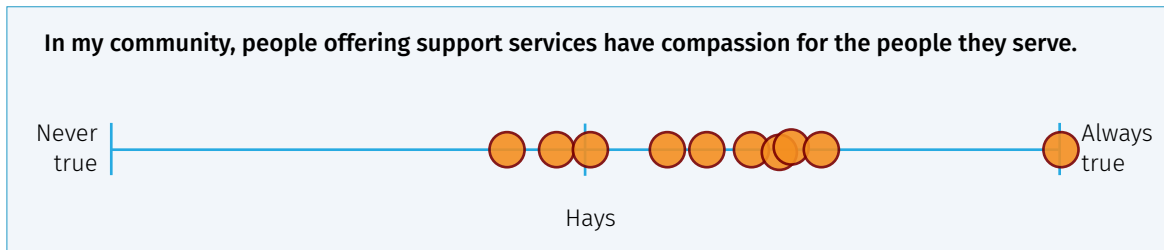
**Cheaper or free services and programs.**

**Accessible services and programs (hours, staffing, accommodations, etc.).**

Responses by region, and then collectively across all six regions in the state, are provided through the next several pages.

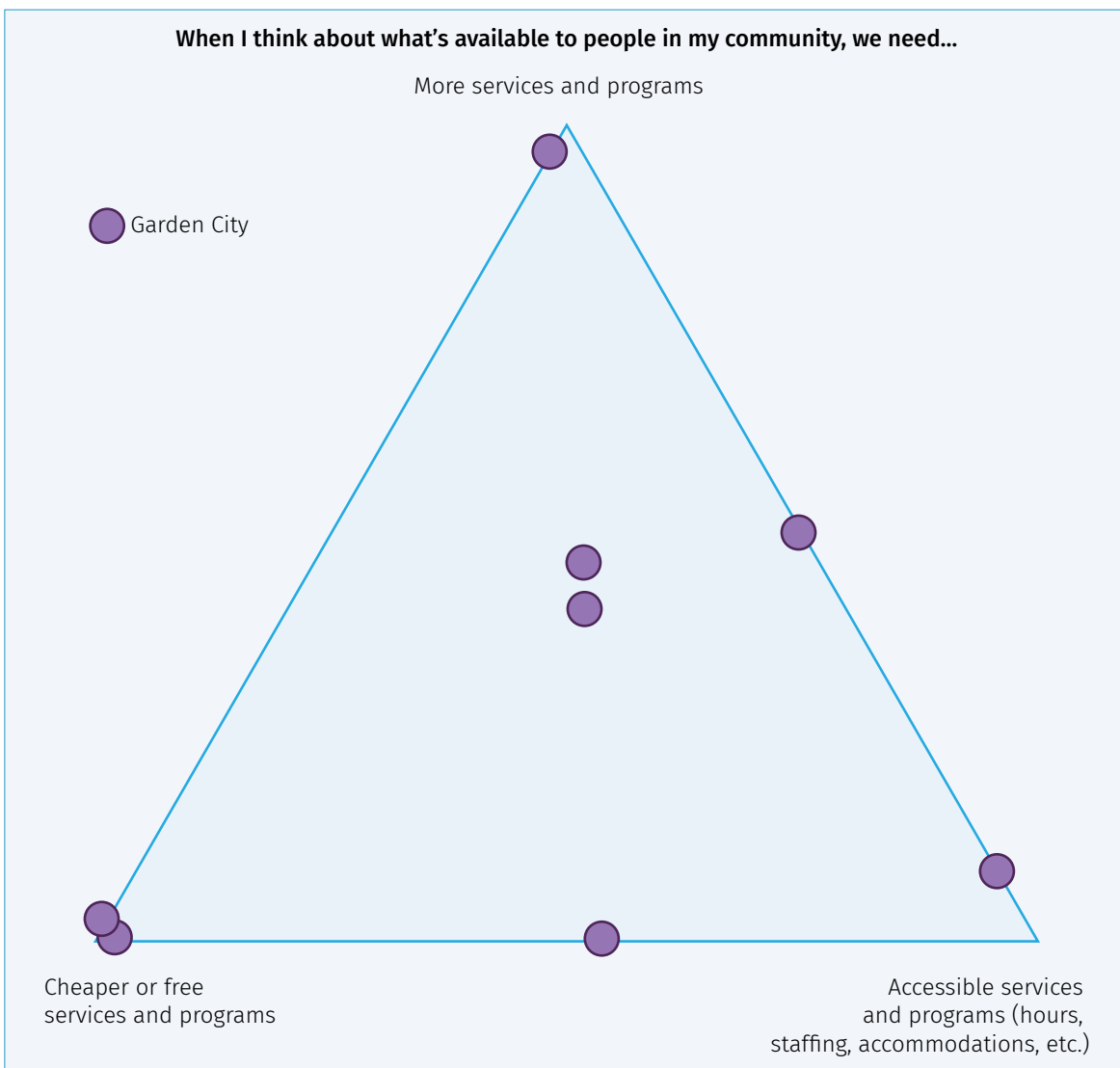
## Northwest Region

The dyad below suggests that most participants from the Northwest (Hays) believe that providers show compassion most of the time. This suggests that there is a general positive perception of compassion coming from providers in their community. The triad suggests that although there may be a need for more services and programs, the responses leaned more towards prioritizing affordability and accessibility.



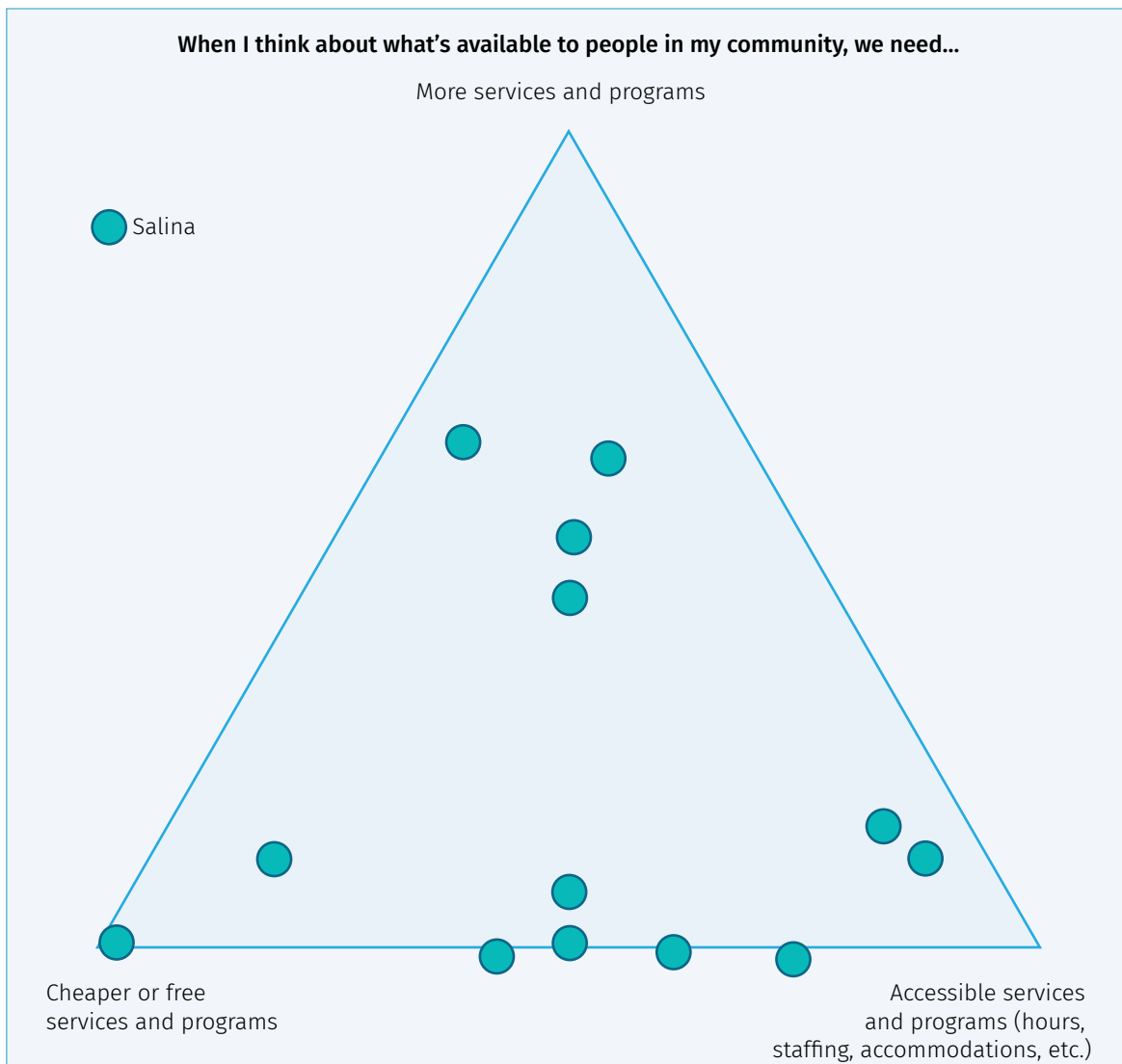
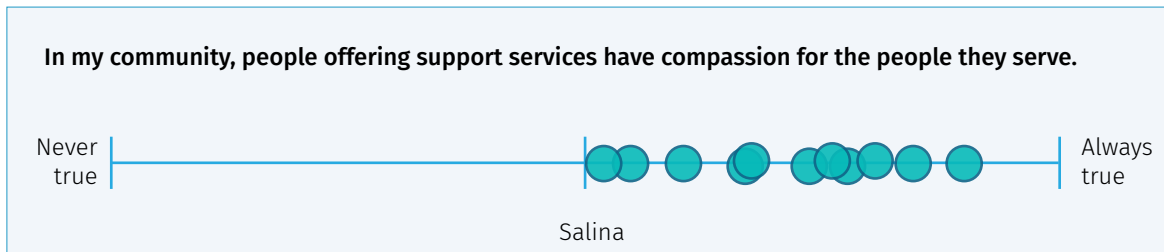
## Southwest Region

The dyad below suggests that most participants in the Southwest Region (Garden City) believe that providers have compassion for those they serve most of the time. This suggests that there is a general positive perception of compassion coming from providers in their community. The triad suggests that participants from the Southwest region may have diverse experiences and needs when it comes to services and programs. Responses lean distinctly towards each corner while also being rooted in the middle.



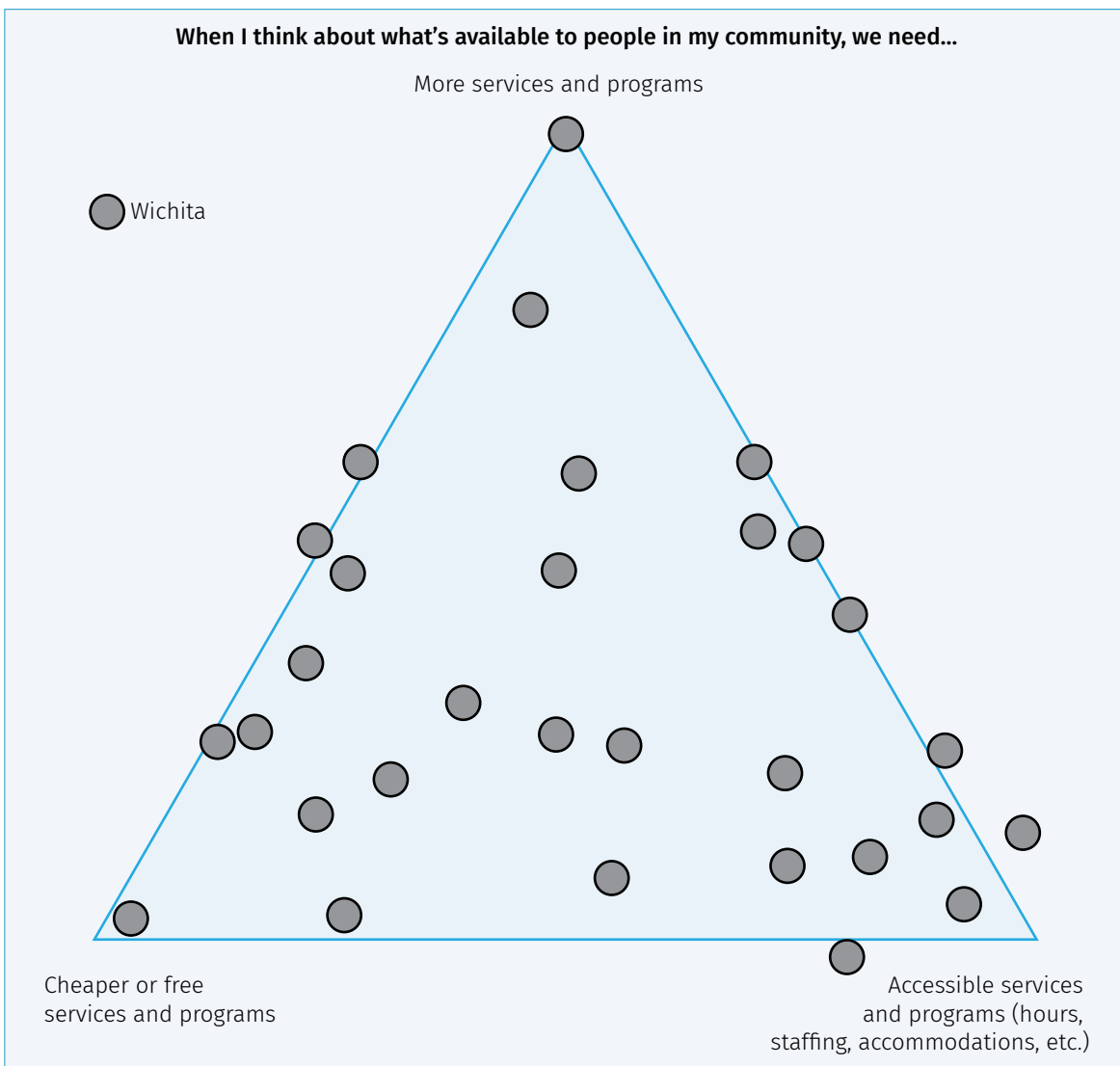
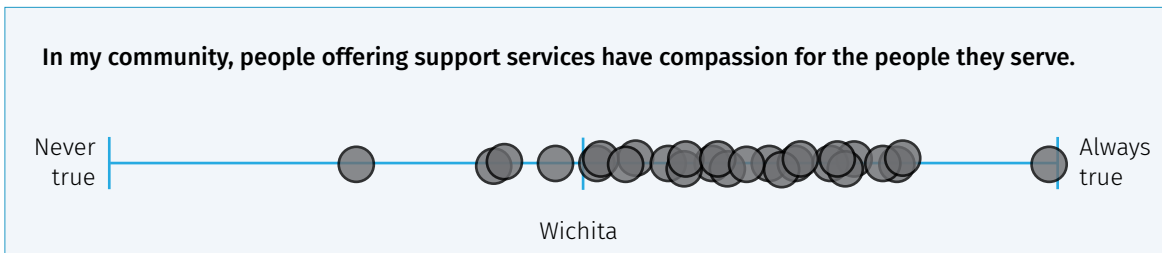
## North Central

In the dyad below, the majority of responses from the North Central region (Salina) were clustered towards *Always True*, suggesting that most participants believe that people providing support services in the community are compassionate towards those they serve. This suggests a generally positive perception of the level of empathy and compassion within the community's service providers. The triad suggests that the majority of participants from the community placed their dot on or between *cheaper or free services and programs* or *accessible services and programs* compared to *more programs and services*. This grouping suggests that participants may have greater need for affordable and accessible programs in their community.



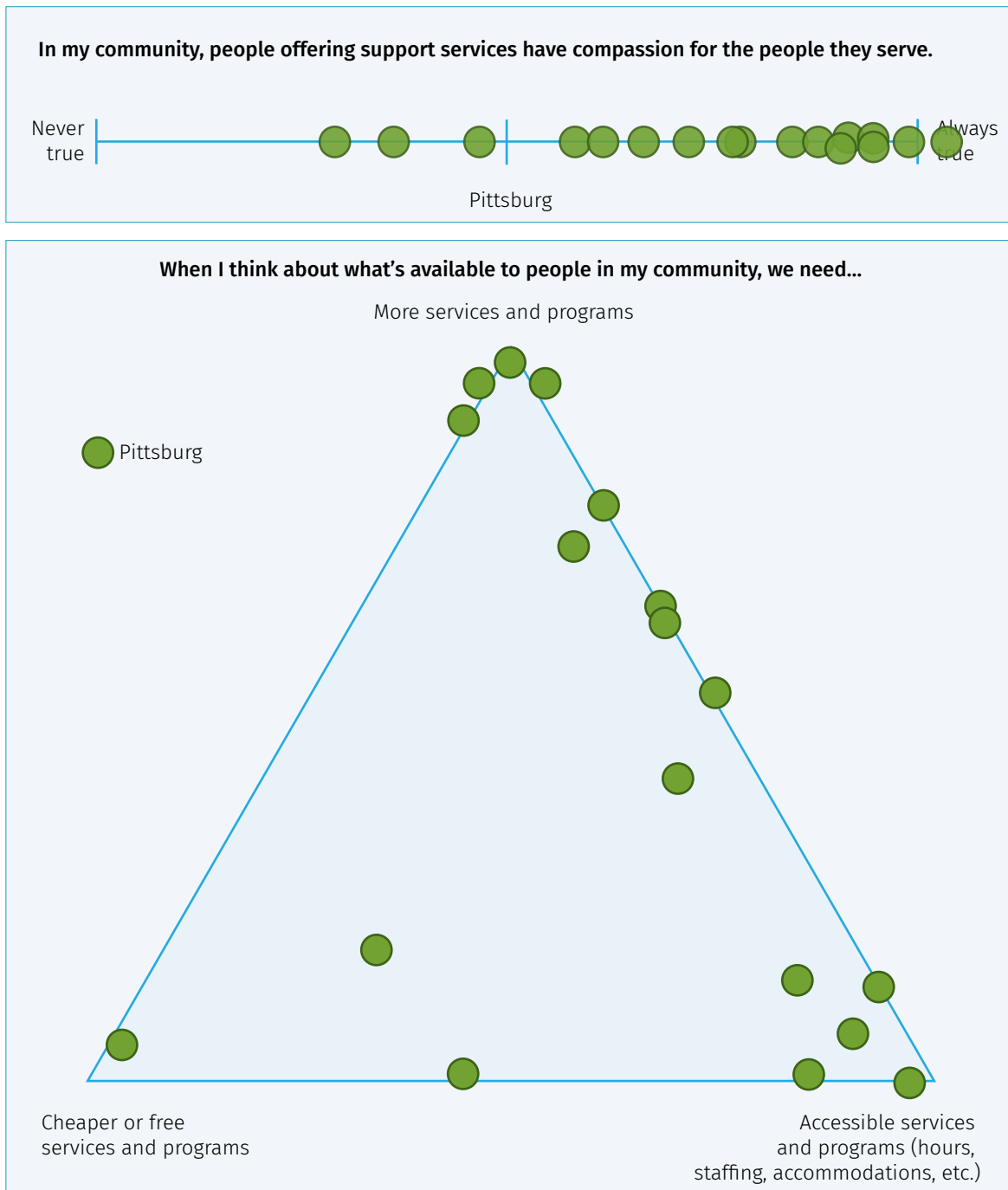
## South Central

The dyad below suggests that the majority of participants from the South Central region (Wichita) clustered their responses towards *Always True*, indicating that most participants agreed that people providing support services in the community are compassionate towards those they support, with some responses leaning slightly towards *Never True*. The triad suggests a diverse set of priorities in the community of the importance of addressing all three areas (services, affordability, and accessibility) and that participants from this community may be experiencing a diverse set of needs and when it comes to programs and services all needs should be considered and prioritized.



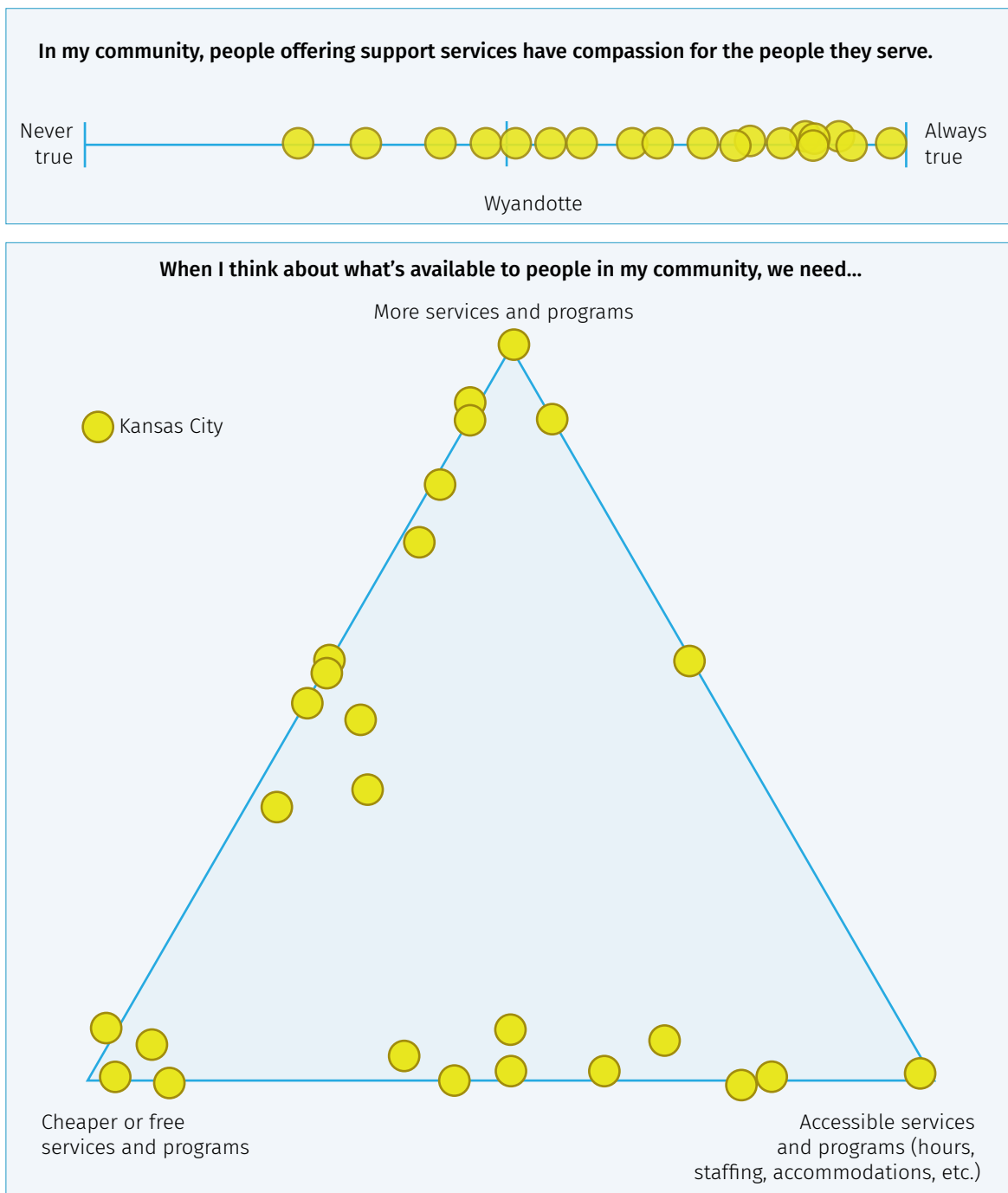
## Southeast

The dyad below shows that the majority of responses from participants from the Southeast region (Pittsburg) were clustered towards *Always True*, indicating that most participants strongly agreed that people providing support services in the community are compassionate towards those they serve. This suggests a generally positive perception of the level of empathy and compassion among the area's service providers, with some responses leaning slightly towards *Never True*. The triad suggests that most participants prioritized having more services and accessibility over affordability. Most people leaned toward the need for more services and accessible services (hours, staffing, and accommodation), with a significant portion highlighting the importance of accessibility. The relatively low placement on cheaper or free services suggests that while affordability is a concern, it may not be the area's current primary focus.



## Northeast

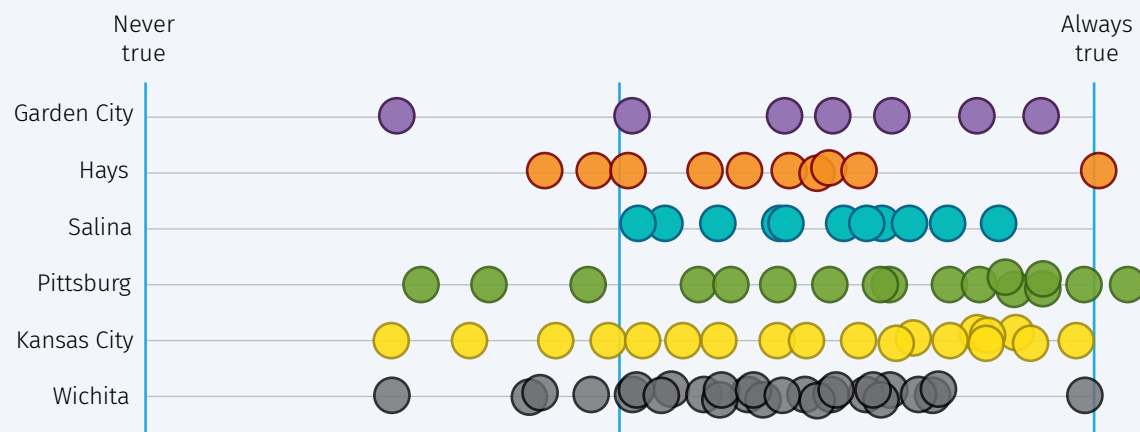
The dyad below suggests that participants' answers from the Northeast region (Kansas City) were clustered towards the *Always True* end, indicating that most participants agreed that people providing support services in the community are compassionate towards those they offer support to. This suggests a generally positive perception of the level of empathy and compassion within the community's service providers, with some responses leaning slightly towards *Never True*. In the triad there appears to be a skew towards the left side of the triangle, with more respondents placing their response with *cheaper or free services and programs*, or *more services and programs*, or somewhere between the two. There are also a group of dots on the lower side of the triangle, with responses reflecting the importance of cost and accessibility.



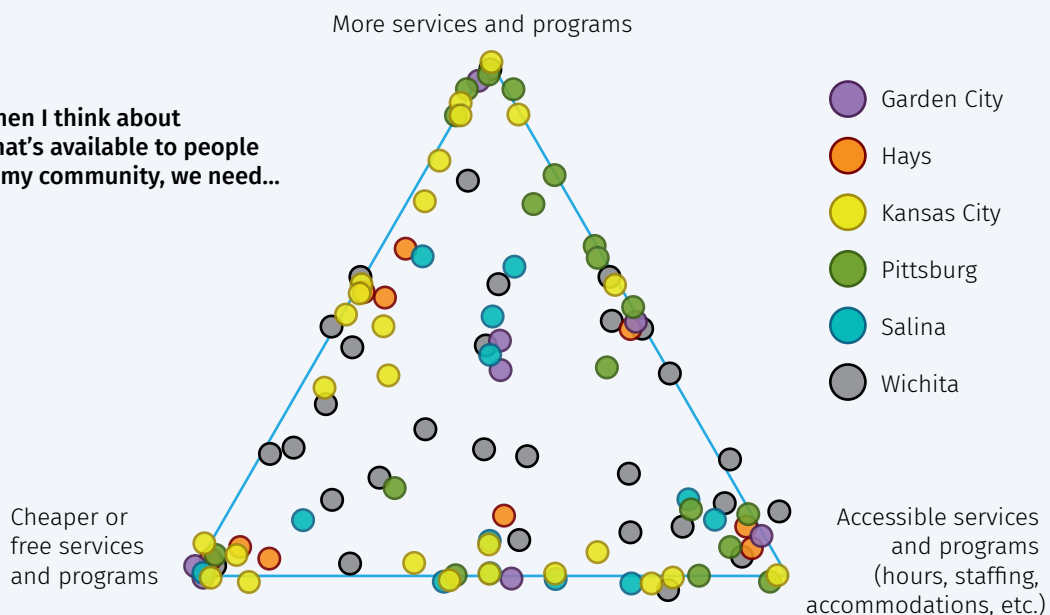
## All Combined Data

In the dyad below, data from all regions seem to lean towards the positive. Out of these locations it shows that participants in Pittsburg, Kansas City, and Wichita had more responses leaning towards the negative side but still all suggesting their perception is generally positive. The pattern of combined responses in the triad, with all six regions represented, suggest diverse perspectives. There are clusters at each apex of the triangle, indicating some respondents have a specific opinion of community need in one of the three areas (*more services, cheaper or free services, and more accessible services*). There are also clusters along the lines at the mid-point between two corners. In these instances, respondents feel a combination of two changes is needed, with the third being less important. There is no specific and discernible pattern, with varied responses statewide. **The variability among responses underscores the importance of tailoring health programs to the specific needs of each community to enhance care accessibility, affordability, and compassion across Kansas.**

**In my community, people offering support services have compassion for the people they serve.**



**When I think about what's available to people in my community, we need...**



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## Open-Ended Comments

In addition to specific questions, participants could provide open-ended responses in their own words.

The prompts were:

What are the **BRIGHT SPOTS** for women and children's health in your area? (149 responses)

What are the greatest **CHALLENGES** to health for women and children in your area? (214 responses)

What **IDEAS** do you have to improve the health and well-being of women and children in your area? (177 responses)

### BRIGHT SPOTS

In response to the prompt about bright spots, or what is working well, there were a wide array of responses discussing available resources and services aimed at improving the well-being of families, with an overarching emphasis on healthcare, education and recreation, and support services for women and children. Overall, communities and public and private agencies across the state were recognized for providing a wide array of resources and services aimed at improving the well-being of women, infants, children, and families.

#### Healthcare Access and Services

- ◆ Clinics for underserved, low-income families, and refugees (including Community Health Centers and health departments)
- ◆ Kid-friendly doctor and dentist offices
- ◆ Good hospital prenatal and birthing services
- ◆ Access to medical care for seniors
- ◆ Good access to prenatal care
- ◆ Good, caring pediatricians and providers for women's health
- ◆ Access to dental care and mental health programs for women
- ◆ Maternal community health workers
- ◆ Advocacy for abortion access and reproductive health services
- ◆ Coordinated care among local agencies.

#### Support Services

- ◆ 1-800-CHILDREN
- ◆ WIC support
- ◆ Free meal services, including summer meal programs
- ◆ Home visiting services
- ◆ Community baby showers
- ◆ Breastfeeding education
- ◆ Perinatal mental health support
- ◆ Intimate partner violence and sexual assault services
- ◆ Access to diapers, wipes, and supplies through programs
- ◆ Support groups for new mothers
- ◆ Strong community foundations filling gaps in services
- ◆ Programs to keep families together and support early childhood development (like Part C/Early Intervention)

## Educational and Recreational Activities

- ◆ Active libraries with programs for all ages
- ◆ Education opportunities through clinics and through programs like Head Start
- ◆ Parks, splash pads, and other recreational spaces for youth and families
- ◆ Programs and activities for parents and children to do together
- ◆ Free community activities and events
- ◆ Sunflower Summer App
- ◆ Programs for infant safety education

## CHALLENGES

Open-ended responses to the question of challenges to health yielded results across a broad array of themes. This summary captures the main challenges reported in the document, highlighting the complex and interconnected issues that women and families face in optimizing their health. Summarizing responses resulted in seven overarching themes:

### Childcare and Early Education

- ◆ Prohibitive cost and limited availability of quality childcare
- ◆ Lack of school-age afterschool care and summer programs

### Healthcare Access and Quality

- ◆ Shortage of healthcare providers, especially OBGYNs and pediatricians
- ◆ Need for more diverse and culturally competent healthcare providers
- ◆ Lack of reproductive care and family planning services
- ◆ Need for better prenatal and postpartum care
- ◆ Lack of support for breastfeeding and lactation services

### Transportation and Accessibility

- ◆ Lack of reliable public transportation
- ◆ Long distances to services, especially for rural populations
- ◆ Need for better walkability and built environments to foster healthy, active lifestyles

### Mental Health and Support

- ◆ Limited availability of mental health services, especially for women and children
- ◆ Need for maternal mental health services, particularly postpartum support
- ◆ Long waiting times for mental health services
- ◆ Lack of support for families dealing with trauma and/or PTSD

### Awareness and Access Barriers to Services

- ◆ Difficulty in knowing what services are available
- ◆ Need for better information about health care options and programs
- ◆ Burdensome application processes for social services

### Special Population Needs

- ◆ Language barriers and need for bilingual services
- ◆ Lack of services for undocumented individuals and families
- ◆ Limited support for LGBTQ+ communities

### Social Determinants of Health

- ◆ Financial constraints, including the prohibitive cost of health care services, childcare, and other necessities
- ◆ Poverty and income inequality
- ◆ Food deserts and lack of access to healthy food options
- ◆ Inadequate housing options, especially for low-income families

## IDEAS

Participants provided ideas for policy, system, and environment changes aimed at improving services to enhance the health of women (with considerable focus on expectant mothers), children, and families. Ideas can be summarized into these key thematic areas:

### Enhance access to health care providers

- ◆ Develop mechanisms to make mental health services more accessible
- ◆ Enhance availability of childcare and transportation to lessen barriers to seeking health care services
- ◆ Make midwives and doulas more accessible through insurance coverage or assistance programs
- ◆ Develop and implement more mobile programs to promote access in communities and neighborhoods
- ◆ Enhance prevention and care of substance use disorders and mental health. Some of the comments around mental health mirror those for health care access in general (transportation, affordability). Several mentioned access for youth, including school-based programs. There was also a mention of implementing drug courts.

### Improve affordability of health care

- ◆ Offer more free and low-cost options for healthcare
- ◆ Expand Medicaid coverage (for citizens and the undocumented population) and incentivize providers to accept Medicaid patients
- ◆ Provide access to more affordable insurance options

### Improved access to healthy food

There were several ideas about mechanisms to make healthy food more affordable and accessible.

These included:

- ◆ Provide food (and housing) subsidies for low-income families
- ◆ Increase use of programs like the Child and Adult Care Food Program to enhance access to nutritious food for children
- ◆ Enhance food quality in schools
- ◆ Use policy change to limit access to processed food

### Improve access and navigation to services and resources

- ◆ Consolidate and centralize resource information to make it easier to families to know where to go
- ◆ More widely and publicly share/advertise information about available services/resources
- ◆ Develop and implement more and better initiatives to increase education. Some topics that were highlighted included parenting, reproductive health, ADHD, and fetal alcohol spectrum disorders.
- ◆ Centralize application processes for benefits and assistance

- ◆ Improve collaboration among service providers
- ◆ There is a general sense that collaboration at the state and community level would help promote better health. Building collaboration among clinical providers and support providers (like community health workers) in the clinical setting was cited as one opportunity for improvement.
- ◆ Encourage stronger community collaboration
- ◆ Work on coordinating with multiple organizations in town that provide services
- ◆ Share data among overlapping systems to reduce family overwhelm
- ◆ Collaborate with local services and resources
- ◆ Integrate OB providers and maternal and child health workers at visits

### Improve community facilities

Primarily focused on recreational facilities such as walking paths, trails, and swimming areas. This included having more facilities and maintaining existing infrastructure.

Actual comments are provided below.

### BRIGHT SPOTS: SOUTHWEST SESSION

- ◆ Library Storytime and zoo story time is great
- ◆ Clinics for underserved and low-income families and refugees and families with no health insurance
- ◆ We have places for kids' activities
- ◆ Options for different types of healthcare
- ◆ Kid friendly doctor offices
- ◆ More kid friendly offices such as dentist offices
- ◆ Education opportunities
- ◆ Active library for all ages
- ◆ Healthy activities for all ages
- ◆ Lakin clinic great with kids
- ◆ Compass has meds for under 18 now
- ◆ Had a good prenatal and birth at Saint Catherine's
- ◆ Lots of community activities for families
- ◆ WIC support
- ◆ This library is one of the best places to bring my grandson but it's not always a safe place because of drugs and homeless
- ◆ Better well being

### BRIGHT SPOTS: NORTHWEST SESSION

- ◆ Good health care for seniors
- ◆ Good access to medical care
- ◆ High percentage of prenatal care
- ◆ Addressing childcare
- ◆ Home visiting services
- ◆ Solidarity among women
- ◆ Good, caring pediatricians
- ◆ Excellent, compassionate care
- ◆ Excellent local providers for women's health

### NORTH CENTRAL SESSION BRIGHT SPOTS

- ◆ Small town feel. Upgrades to downtown.
- ◆ Parks and sites in town to see.
- ◆ Ellsworth Co. Medical Center has clinic hours in Holyrood which has provided services to both younger and older residents.
- ◆ Bringing back infant and caregiver bonding courses and creating a community lactation closet.
- ◆ Parks and splash pad
- ◆ Health programs
- ◆ Access to dental care
- ◆ Community foundations are doing amazing work to "fill the gaps"
- ◆ ICD was a lifesaver for us in care for our child with a disability
- ◆ Parents interested in youth success
- ◆ Activities for parents and children to do together.
- ◆ Large number of programs/organizations.
- ◆ Having a relatively caring and supportive community.
- ◆ Our health department was a WIC educator interested in connecting more with people.
- ◆ Many excellent programs that serve women/children in our community: Head Start, Salina Family Health Care, K-State Research & Extension, and many others.

## BRIGHT SPOTS: SOUTH CENTRAL SESSION

- ◆ Well maintained parks and rec spaces
- ◆ Safe sleep education
- ◆ Local blogs on things to do
- ◆ Project access
- ◆ Community resources
- ◆ 1800 children summer app parks and rec
- ◆ Health dept
- ◆ Parks and rec
- ◆ Free meal services
- ◆ Great library programs
- ◆ Summer food program
- ◆ Kansas Birth Justice Society
- ◆ Free home visiting services
- ◆ Multilingual services
- ◆ Intimate partner violence and sexual assault services
- ◆ Community baby showers
- ◆ Safe sleep community baby showers
- ◆ Summer food program
- ◆ USD 259
- ◆ Breastfeeding education/support
- ◆ Access to knowledge community services
- ◆ Summer food program
- ◆ Safe sleep
- ◆ Star for charity
- ◆ Library
- ◆ Lots of food resources
- ◆ Healthy babies program
- ◆ 1-800-Children Kansas Children's Service League
- ◆ Bay talk prenatal ed
- ◆ Lots of home visiting programs
- ◆ Great Plains nature center
- ◆ Education through child advocacy center for Sedgwick County - ACES infant safety mandatory reporting etc.
- ◆ Free consent education and sexual assault services
- ◆ Community baby showers
- ◆ Baby talk
- ◆ Perinatal mental health
- ◆ Advanced Learning library and branch library
- ◆ Parks and Rec playgrounds splash pad
- ◆ Abortion access for SGCO
- ◆ Early intervention is key
- ◆ WIC
- ◆ Healthy babies program
- ◆ Flourish Wellness Collective
- ◆ Kansas Birth Justice Society
- ◆ Community baby showers
- ◆ The Sunflower summer app
- ◆ Access to abortion in our city
- ◆ So many resources for families and children
- ◆ Safe sleep clinics
- ◆ WIC
- ◆ Sedgwick County Health Dept
- ◆ Expanded Food and Nutrition Education Program
- ◆ DCF
- ◆ Comcare
- ◆ Abortion access
- ◆ Wesley Birth Center

## BRIGHT SPOTS: NORTHEAST SESSION

- ◆ Prenatal classes and access to low-cost prenatal care
- ◆ In my area there are multiple clinics.
- ◆ Get support
- ◆ To be an advocate and not to judge
- ◆ Maternal Community Health Workers
- ◆ Caring helpers once connected
- ◆ Access to safety net clinics
- ◆ Mental Health Programs for women who don't do drugs
- ◆ Homeless -get them in places off of the street
- ◆ Programs & resources that want to help preventative programs
- ◆ Happy bottom diapers
- ◆ Food pantries in the area
- ◆ Access to safety net clinics
- ◆ Child Care/Head Start programs
- ◆ Easy access to programs (WIC, Happy Bottoms)
- ◆ Resources for women specifically
- ◆ New mother and children have access to health care
- ◆ Plenty in the community for both women and children to do
- ◆ Mom and baby support groups
- ◆ Great ongoing collaborations in Topeka - Resources for new parent, home visiting programs, community baby shower
- ◆ Free community fun events
- ◆ Access to support groups, diapers, wipes, supplies, etc.
- ◆ CHC (Wyandotte County)
- ◆ Different resources for women, especially for children
- ◆ The ECC program does a fabulous job with kids, we went in speaking only 3 words and are about average in 1 year. They always have food/diapers if in need and it has been an overall great experience.

## BRIGHT SPOTS: SOUTHEAST SESSION

- ◆ As a newcomer everyone has been welcoming to mom and child
- ◆ VIE Medical
- ◆ CHC SEK
- ◆ CHC SEK Services
- ◆ Agencies working together to keep families together
- ◆ Mother to mother
- ◆ Family First Services
- ◆ Birth to 3
- ◆ Crawford County Health Department Programs
- ◆ CHC SEK
- ◆ Home Visiting Programs
- ◆ Readily available resources
- ◆ Coordinated resources
- ◆ Community Health Center at Southeast Kansas and what they provide
- ◆ Coordination of care with other agencies
- ◆ Crawford County Health Dept and all they have to offer
- ◆ CHC-SEK being accessible and the services
- ◆ Countywide services that exist.
- ◆ Crawford County Health Dept!
- ◆ Community Health center of SEK
- ◆ Good hospitals and healthcare providers
- ◆ CHC SEK services
- ◆ My family outreach and referral intake
- ◆ Home visitation programs
- ◆ Community resources/partnerships
- ◆ Low-income women qualify for Medicaid prenatally
- ◆ Mental health options
- ◆ Early childhood programs

## CHALLENGES: SOUTHWEST SESSION

- ◆ Childcare and pre-k
- ◆ Some kids are on “grade level” but need the extra/early schooling for social purposes
- ◆ Childcare
- ◆ Not enough OBGYN providers in the area. We NEED more OBGYN providers!
- ◆ Need more resources for expecting mothers in terms of support and education
- ◆ Expensive childcare
- ◆ More cost-friendly health offices
- ◆ High cost of childcare for working parents
- ◆ Need more toddler friendly activities
- ◆ Bridging income gap between people who are “desperate” and “comfortable.” Some of the families have enough currently but can’t consider a new mouth to feed.
- ◆ I couldn’t get any help for infertility in town; 4-hour trips to Wichita because my family planning wasn’t Christian enough
- ◆ Need more practitioners who really get to know your family and their needs
- ◆ More affordable childcare
- ◆ Need more kid friendly activities.
- ◆ Knowing qualifications for WIC and Food Stamps and KanCare.
- ◆ Peer support for mothers with children in casual settings
- ◆ More education about personalized healthcare for infants/children (not one size fits all)
- ◆ Need major resources for post-partum parents
- ◆ Having time to do anything besides go to work.
- ◆ More honest info for us about healthcare
- ◆ We are magnesium lacking
- ◆ Non-traditional healthcare options
- ◆ Need more parent-led friendly practitioners
- ◆ Not everyone has health insurance, especially immigrants

## CHALLENGES: NORTHWEST SESSION

- ◆ Lack of MCH Program
- ◆ Getting people to participate in programs
- ◆ Mental health
- ◆ Lactation services
- ◆ Mental health
- ◆ Nutrition
- ◆ Affordable exercise locations
- ◆ Childcare
- ◆ Access to mental health services within the schools
- ◆ More health care services available for special needs
- ◆ Mental health/support services
- ◆ Mental health
- ◆ Finding out what is available
- ◆ Exercise options
- ◆ Knowing what is available
- ◆ Being able to get there (services) with kids in tow
- ◆ Availability of services

## CHALLENGES: NORTH CENTRAL SESSION

- ◆ Mental health
- ◆ Youth services
- ◆ Autism services
- ◆ Service providers, schools, health care, therapy, etc. need knowledge on trauma informed care.
- ◆ Service providers have limited availability to take on patients
- ◆ Better health care and more therapists
- ◆ More take-home activities to do at home
- ◆ Lack of collaboration between providers of similar services
- ◆ Access and availability of mental health services is very limited
- ◆ Mental health services
- ◆ Dental services
- ◆ Food equity
- ◆ Access to reliable health care
- ◆ Mental health
- ◆ Cost of products
- ◆ Access to health care for undocumented people
- ◆ Access to health care specifically for undocumented individuals and families
- ◆ Proper nutrition and access to a variety of health, fresh foods
- ◆ Not reaching families who can use some of the services available
- ◆ Qualified therapists
- ◆ Cost and convenience

## CHALLENGES: SOUTH CENTRAL SESSION

- ◆ Anti-LGBTI
- ◆ Transportation
- ◆ Medicaid expansion
- ◆ No Medicaid expansion
- ◆ Behavior school
- ◆ Transportation
- ◆ Mental Health services
- ◆ Access to dental health care
- ◆ Professionals mixing personal with professional opinions
- ◆ Quality childcare
- ◆ Shifting focus midstream
- ◆ Racist structures
- ◆ Behavior/social emotion help for early childhood
- ◆ Reliable transportation
- ◆ Transportation
- ◆ Childcare
- ◆ Providers lack of connection to resources
- ◆ Confidence in themselves
- ◆ Knowledge of how to access services
- ◆ Reproductive care/abortion care
- ◆ Sleep related death is leading cause to infant death for 1 mo.- 1yr children higher than drowning car accidents combined
- ◆ Poverty and other social determinants of health
- ◆ Birth spacing
- ◆ Reproductive care
- ◆ Services in their language
- ◆ Awareness of resources
- ◆ Abortion/reproductive care
- ◆ Unplanned pregnancy
- ◆ Patriarchy

- ◆ Food deserts
- ◆ Childcare services
- ◆ Getting families to take advantage of community resources
- ◆ Mixing the message of safe sleep with family bed/co-bedding messages
- ◆ Clear path to services
- ◆ Walkability to things/transportation
- ◆ No investment in public education
- ◆ Access to resources
- ◆ Infant mortality
- ◆ Mental health services
- ◆ Poor transit routes
- ◆ Transportation
- ◆ Mental health services/substance abuse
- ◆ Waiting list for therapy/mental health services
- ◆ Low literacy
- ◆ Lack of affordable housing
- ◆ Not enough school age care-neighborhood options for summer care
- ◆ Access to services within rural communities
- ◆ Mental health services for women and young children
- ◆ Give schools resources to help families more than social workers
- ◆ Lack of effective public transportation
- ◆ Equitable care for people of color
- ◆ Birth spacing
- ◆ Transit
- ◆ Difficult to apply for social services (childcare assistance)
- ◆ Support service workers not always experienced
- ◆ Internet access for low income
- ◆ Wait times!
- ◆ Mental health availability
- ◆ Housing! There's not enough for section 8 families
- ◆ Language barriers
- ◆ Lack of built environments (sidewalks, grocery stores, rec spaces, community resources)
- ◆ Poverty and violence and a culture of silence around these issues
- ◆ Feeling heard and understood
- ◆ Housing! There's not enough for section 8 families
- ◆ Transportation
- ◆ Access services
- ◆ Obtaining health care coverage
- ◆ School age reproductive education
- ◆ Too many drug addicted people walking around because of these free services

## CHALLENGES: NORTHEAST SESSION

- |  |   |
|--|---|
| ◆ Childcare  | ◆ Childcare   |
| ◆ Healthy food   | ◆ Prenatal care   |
| ◆ Lack of transportation   | ◆ Maternal and infant mortality   |
| ◆ Help the homeless more get them off the street                     | ◆ Lack of health care providers & facilities  |
| ◆ Access to doulas before and after birth                            | ◆ Maternal and infant mortality   |
| ◆ Clothing stations for baby-teen                                    | ◆ Shelters for women not a part of intimate partner violence                              |
| ◆ Lack of access to transportation                                   | ◆ Lack of health providers  |
| ◆ Costs for undocumented pregnant women                              | ◆ Transportation in Johnson County  |
| ◆ Low access to financial assistance for ultrasounds                 | ◆ Lack of health providers of color often times they are afraid to speak due to judgement |
| ◆ Transportation   | ◆ Lack of transportation  |
| ◆ Lack of affordable childcare                                       | ◆ Access to healthy food  |
| ◆ Equitable prenatal care for all                                    | ◆ Reduced cost mental health services   |
| ◆ Lack of access to equitable insurance                              | ◆ Lack of diverse maternal clinics  |
| ◆ Lack of information  | ◆ Transportation  |
| ◆ Lack of support  | ◆ Affordable childcare  |
| ◆ No reliable transportation   | ◆ Not knowing where to access supports  |
| ◆ Healthy food   | ◆ Difficult relationships in home   |
| ◆ Health care  | ◆ Fetal and infant mortality  |
| ◆ Day care   | ◆ Lack of shelters/space  |
| ◆ Jobs   | ◆ Language access   |
| ◆ Insurance programs, but hard to get into                           | ◆ Diversity in maternal/child health workforce  |
| ◆ Housing and financial help to assure stability and quality of life | ◆ Lack of support and resources for individual and families impacted by PTSD              |
| ◆ How can I go around the world?                                     | ◆ Postpartum support  |
| ◆ To have reliable resources for all areas                           | ◆ Pay the childcare workers   |

## CHALLENGES: SOUTHEAST SESSION

- ◆ Lack of providers
- ◆ Transportation
- ◆ Health Insurance
- ◆ Language barriers and support
- ◆ Language barrier
- ◆ Lack of trust and connection
- ◆ Childcare needs
- ◆ Transportation
- ◆ Providers
- ◆ Childcare
- ◆ Childcare
- ◆ Insurance cover
- ◆ Providers Pediatricians and OB
- ◆ Insurance Coverage
- ◆ Post Partum Support
- ◆ FASD Prevention services unavailable for people with an FASD
- ◆ OB & Pediatric providers in rural communities
- ◆ Childcare
- ◆ Childcare
- ◆ Truancy
- ◆ Loss of support networks like mother-to-mother
- ◆ Parenting teens & elementary
- ◆ Post partum services
- ◆ Translators
- ◆ Income based services limited assistance
- ◆ Bilingual services (language barrier)
- ◆ Bilingual services
- ◆ Maternal Mental Health Services
- ◆ Lack of Specialist BTT/addiction re maternity & early childhood
- ◆ Housing needs
- ◆ Transportation
- ◆ Medical Providers
- ◆ Health Insurance
- ◆ Insurance support, Post Partum, Equality for Dads Formula costs
- ◆ Affordable childcare

## IDEAS: SOUTHWEST SESSION

- ◆ The state and health clinic work closely for the greater good of the patients.
- ◆ Maybe offering more programs to help expecting mothers.
- ◆ Things for grandparents and grandchildren to do together.
- ◆ Taking care of what Garden City already has, like the zoo. It looks abandoned and depressing. Safe place to take children to play.
- ◆ More support groups for moms in different situations.
- ◆ Women live longer and better child outcomes with community.
- ◆ Affordable and trustworthy mental healthcare
- ◆ Share more widely with new parents about state resources
- ◆ Provide a list of resources and therapists in the area that deal with pregnancy and postpartum.
- ◆ Pro and cons of homeopathic versus medical
- ◆ Have income guidelines for different services clearly placed on wall/websites for things like WIC, Food Stamps, Medicare, etc. instead of going through process first.
- ◆ Resources for new mom support groups.
- ◆ Provide one free therapy session to all new parents
- ◆ Infertility care not at a Christian hospital; same with abortion/D&C care for medically necessary issues.
- ◆ Host info sessions with different birthing options
- ◆ Have better opportunities to access low-cost medical care.
- ◆ Meeting with all expectant mothers at first OB/GYN appointment to talk through costs, options, etc.
- ◆ Give info sessions about vaccines (unbiased, factual based)

## IDEAS: NORTHWEST SESSION

- ◆ Provide transportation to and from mental health services for youth (without need for parents to leave work)
- ◆ MCH Program
- ◆ Getting more people involved in existing programs
- ◆ Better access to mental health
- ◆ Affordable transportation
- ◆ Provide more low-cost options for health care
- ◆ Make midwives and doulas accessible through insurance coverage or assistance programs
- ◆ Help with cost for mental health services
- ◆ Low-cost availability
- ◆ Increased access to mental health services - transportation, providers, etc.

## IDEAS: NORTH CENTRAL SESSION

- ◆ I am not sure how to fix immigration reform, but this would be needed to improved health access for those who are undocumented.
- ◆ Better activities for kids with other kids
- ◆ Collaboration among community service providers with local
- ◆ Trying to identify other community partners I can work with to leverage impact on issues.
- ◆ Systems overlap -- share the data --families are overwhelmed and don't know where to go.
- ◆ Events and fundraisers
- ◆ Another swim area
- ◆ More to do for children in town
- ◆ ADHD education for schools and parents
- ◆ Work on coordinating with MULTIPLE organizations in town that provide services
- ◆ More paths and walk trails
- ◆ Stronger community collaboration
- ◆ More activities in safe environments for children.
- ◆ More childcare centers for children.
- ◆ Hosting public events to model best practices.
- ◆ Expanding outreach to areas not thought of before or reshaping access (digital)
- ◆ Collaboration.
- ◆ Training grants for providers
- ◆ I am working towards a television production to communicate research-based best practices in parenting on public television.

## IDEAS: SOUTH CENTRAL SESSION

- ◆ LARC available at pharmacy
- ◆ Supplement income
- ◆ Parent support groups
- ◆ More funding for mental health services
- ◆ More funding for DCF
- ◆ Improved advertising for services and resources
- ◆ More childcare access
- ◆ Expanding bus system
- ◆ Expanding parent leave
- ◆ Better education and support pre-pregnancy
- ◆ Better and free public transportation
- ◆ Clinics (OB, ped, family medicine) become safe sleep certified
- ◆ More food and housing subsidies (housing is unaffordable)
- ◆ Elevate sleep related death to the public health priority it is
- ◆ LARC education
- ◆ Collaboration with local services/resources
- ◆ More services co-located and/or in walkable areas
- ◆ One social media location with all resources (especially free services)
- ◆ Free childcare or workplace provided childcare
- ◆ Translating services and access to medical care
- ◆ More training for physicians on DEI
- ◆ Access for all incomes to community services and resources

- ◆ Long-term care and resources
- ◆ Groups for connectedness
- ◆ Hospitals obtain safe sleep certification
- ◆ School based reproductive health education taught by medical providers
- ◆ Expand abortion access
- ◆ Deconstruct the patriarchy
- ◆ Real policy changes
- ◆ Medicaid expansion
- ◆ Abortion access
- ◆ Services in their language
- ◆ LARC available at mobile health clinics
- ◆ Universal home visitation (start in clinic and move to virtual or in-home as trust is built)
- ◆ Mental health tied to schools
- ◆ One Key Question in all services
- ◆ Medicaid expansion
- ◆ Expand Medicaid
- ◆ Have free transportation for health services
- ◆ Free/reduced fee for childcare!!
- ◆ More public transit
- ◆ Subsidize childcare so workers are paid better so we can have more providers
- ◆ Statewide fetal infant mortality review
- ◆ More money into MCH services
- ◆ Embed birth spacing education in all perinatal services
- ◆ Improve transit and walking paths to services families need
- ◆ Providing Medicaid to moms who do not have a legal immigration status immigration at least prenatally to 1 year postpartum
- ◆ More childcare using CAPCF program so the food is more nutritious
- ◆ Universal home visitation
- ◆ Expand literacy services via existing program on site
- ◆ Mobile unit

## IDEAS: NORTHEAST SESSION

- ◆ Incentives for providers and facilities
- ◆ More daycare
- ◆ Holding community meetings for residents in different languages for them to know what services they can enroll in
- ◆ Finding safe low-cost childcare
- ◆ More day care
- ◆ Educational- more support and flexibility
- ◆ Holding community fairs to share resources
- ◆ Integrated OB providers and MCHWS/CHWs at visits
- ◆ Free public transportation
- ◆ Programs for Ultrasound check like financial assist
- ◆ Medicaid expansion for undocumented families
- ◆ Increased childcare
- ◆ Better info to parents for programs like police athletic league, for example, let people know that these programs exist and are free of charge
- ◆ Improve availability of nutritious foods
- ◆ Provide free childcare for all low-income families
- ◆ Homeless people on the street
- ◆ Medicaid expansion

- ◆ Incentives for providers to practice and take Medicaid
- ◆ Education
- ◆ More awareness, meetings for mothers in the community
- ◆ Free or more affordable childcare
- ◆ Give lots of love
- ◆ Free transportation
- ◆ More diaper/wipes resources relational peer supports easily accessible
- ◆ Relational/peer supports easily accessible
- ◆ Access childcare for free
- ◆ Doula support in hospitals/hospital Doula programs
- ◆ Health services for uninsured/undocumented
- ◆ Reduced cost for care
- ◆ Affordable housing/safe housing
- ◆ Paid work leave
- ◆ Affordable childcare
- ◆ Looking to open a home or building to assist with needs.
- ◆ Donated bus passes
- ◆ Access to government phones
- ◆ Safe section 8 laws
- ◆ Easy to search for resources
- ◆ Less requirements and more supports
- ◆ More access to free public education for families
- ◆ More affordable insurance
- ◆ Always exercise OK
- ◆ Some can't afford care which leads them not being able to work which declines their success
- ◆ Increase school funding for activities leads to better mental health and life options
- ◆ Make it easier and less hard for young pregnant to get into youth transition programs
- ◆ Better food in schools
- ◆ Legislation on extra processed food to decrease accessibility to everyone
- ◆ Edu childcare
- ◆ Women's Health
- ◆ Work safe Come home safe resources

## IDEAS: SOUTHEAST SESSION

- ◆ Fetal Alcohol Spectrum Disorders (FASD) prevention education for health care providers
- ◆ Services for those with an FASD
- ◆ A birthing and parenting center
- ◆ More Mommy and Me groups - social needs
- ◆ For families to use our resources we have in Crawford County
- ◆ Medicaid expansion
- ◆ Affordable easy enroll
- ◆ Education
- ◆ Businesses NEED on-site childcare
- ◆ Improved Drug and Alcohol services
- ◆ Drug court
- ◆ Childcare
- ◆ Access to affordable healthcare
- ◆ More social groups for moms and family
- ◆ More advertisement and publicity about resources
- ◆ Prenatal Yoga classes
- ◆ Mommy and Me groups
- ◆ Affordable childcare
- ◆ More advertisements of resources in the community “Best kept Secret”
- ◆ Resources
- ◆ Business on-site Daycare
- ◆ Increased education
- ◆ More bilingual resources and programs
- ◆ Mommy and Me groups
- ◆ Transportation expanded
- ◆ Childcare expansion
- ◆ One application for assistance such as insurance, EBT, TANF, childcare, and make it easy for families to understand
- ◆ Childcare, Post-Partum AFFORDABLE
- ◆ Expansion of Medicare/Medicaid
- ◆ Mental specialist maternity early childhood, a new Rachelle Mengarelli

# Appendix F.9

## Key Informant Interviews and Focus Groups

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### Introduction

The University of Kansas Center for Public Partnerships & Research (KU-CPPR) conducted interviews and focus groups to gather qualitative insights into the health and health needs of Maternal and Child Health (MCH) populations in Kansas. A diverse group of participants, including healthcare providers, researchers, advocates, program clients, and other individuals with lived experience, provided valuable perspectives on challenges faced by these populations and resources available to help them achieve better health. The findings highlighted several key themes, including barriers to care (financial constraints, complex eligibility processes, cultural insensitivity), workforce capacity issues, challenges in healthcare navigation, and concerns about poor health outcomes and disparities among some MCH populations. In response to the data collected, KU-CPPR is offering recommendations for programmatic changes and priorities aimed at addressing these systemic issues. These recommendations focus on scaling effective practices, improving workforce capacity, and promoting policy changes to enhance MCH outcomes and ensure better care for Kansas families.

### Details of Qualitative Data

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#### Barriers to Healthcare Access for Women and Children in Kansas

Our qualitative data collections highlighted significant barriers faced by women and children in accessing healthcare. These barriers can be grouped into five main categories:

**Social Determinants of Health:** Economic factors such as employment instability, housing insecurity, and the cost of basic necessities like food and childcare were cited as major barriers. These financial pressures often prevent families from seeking necessary healthcare services, with one young adult highlighting concerns about the affordability of care post-college. Healthcare costs, especially without insurance, exacerbate this issue, with one rural provider noting that many families are excluded from essential services due to the lack of Medicaid expansion.

**Program Eligibility and Access:** The complexity and inefficiency of the application processes for public assistance programs were frequently mentioned. Families often struggle with duplicative paperwork and unclear eligibility requirements across various programs. Providers also noted that small increases in income can result in the abrupt loss of benefits, leaving families in a precarious position. One provider emphasized the need for a centralized, streamlined application process to reduce duplication and ease the burden on families.

**Language and Cultural Barriers:** As Kansas becomes more diverse, language and cultural insensitivity remain significant barriers. Participants noted the need for more bilingual providers, especially in areas like southwest Kansas. The use of family members as translators can be problematic, as it may lead to discomfort or a lack of

honesty in medical discussions. Expanding professional interpreting services was seen as a crucial step in addressing these gaps in care.

**Mistrust and Fear:** Mistrust of government systems, particularly related to child welfare, was a prevalent theme. Many families are hesitant to seek care, especially for behavioral health issues, due to fears of punitive measures like child removal. Historical trauma, especially among Indigenous communities, contributes to this mistrust. Participants called for more community-based, culturally aligned services, such as home visits from trusted local figures rather than government representatives. Shifting away from a punitive approach to a more supportive, non-judgmental framework was seen as essential to rebuilding trust.

**Stigma:** There is considerable stigma associated with behavioral health, including substance use disorder. Individuals often feel internalized shame and also feel judged by providers and the community at large. Stigma is a powerful barrier to seeking needed care. Multi-faceted approaches are clearly needed to reduce the societal impact of stigma on individuals with behavioral health challenges.

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## Socioeconomic Factors and Social Determinants of Health

Several participants talked about hesitance to seek care due to the high cost of medical services. One young adult (mid 20s) shared that...

*"Some people are afraid to get the help with their health that they need because of expenses and everything, especially as younger people . . . . There's people who are like me, recently graduated [from college], and don't really have an option or the means to get the help that they need because of the prices and everything."*

The young adult's statement highlights a pervasive fear of seeking healthcare due to the high costs associated with medical services, especially for those who are newly out of school and lack health insurance.

Lack of access to insurance was also noted as a barrier to care by several providers. One rural provider noted...

*"If they don't have insurance, which without Medicaid expansion, there's a larger number of those folks that fall into that. won't get access to some of those services just because they don't have the insurance or cash to pay for that. So, there is a challenge."*

Several providers noted that the broader economic and social conditions many Kansas families face — unstable employment, housing challenges, food insecurity, the cost of childcare, the cost of other basic necessities — directly affect health and well-being. One provider noted...

*"When kids grow up in a household that's housing insecure, of course they're going to go to kindergarten with behavioral challenges. When women who are pregnant are working two jobs and don't have enough food, of course they're going to have low birth weight babies. So, from my perspective, the economic and social context that birthing people and children often live in in our country is the driver of a large amount of the disparities and issues that we're trying to address."*

Another noted...

*"I think some of the challenges that we are seeing, in the last year, is the difficulty getting financial resources for utilities, rent. The COVID funds are gone. It's hard to focus on your health or get to your OB appointments or take your kid to the pediatrician if your electricity's not on or you're having to go someplace to boil water to have hot water, don't have a working refrigerator, things like that. I'm seeing lots of increased SDOH [social determinants of health] needs and feeling a little more helpless with that."*

A consistent theme across discussions was the barrier to care caused by a lack of childcare and parental leave. One physician noted...

*"We've got this challenge in this particular population of accessible daycare and time off if they're employed in order to travel to obtain those services. And so, there's always not a lot of consideration of the out-of-pocket cost to the individual in order to seek access to these services. And that's obviously one of the downsides to Title V funding, is that you basically can't use the funding to give to the individual for those services. But I think we've got to figure out a way that we have good childcare services available."*

Another provider agreed, saying...

*"We don't have paid maternity leave, so having a baby or having kids is devastating if your kids are sick, so having some support when that happens [is needed]."*

Several participants cited language as a barrier. A provider shared...

*"We need probably more Spanish-speaking service providers, especially in southwest Kansas. And then there's [other cities] where there's quite a few different minority groups. So it's probably worth considering paying for a translating service or seeing if you can recruit people from within those communities who not only understand the language, but then are more likely to understand some of the underlying cultural influences . . . I know sometimes we've had to rely on family members to translate, which I wouldn't say is inherently bad, but I know sometimes you as a kid are not going to want to be 100% honest about what's going on when Mom or Sister or Aunt is the one who's translating. There's stuff you might just not want them to know. And so having a neutral person to be that person could be helpful in having kids be more forthcoming."*

Another provider agreed with the need to address language barriers, saying...

*"I think if we could expand interpreting services, that would be huge . . . that's an area that is a big barrier, especially with more and more immigrants from different countries always coming to the Midwest. They trickle in from the coast, and I'm seeing more and more different populations all the time. I think that'd be fantastic."*

A financial concern cited by one group of participants was the refusal of some healthcare providers to see patients with outstanding bills, regardless of the amount owed. During that focus group, a Medicaid managed care representative shared...

*"If you owe a bill, they will not schedule you. They will not see you. If you owe \$50, \$100, they will not see you. They know they're their only option, so they hold true to that. And they say it's because, 'We don't want you to have cancellations. We don't want people just to not show up.' But there's a better way to do that than to charge someone money that they already don't have. Maybe help in understanding what SDOH is around that. Is it transportation? Could we maybe set things up? Things like that. And I just don't see anybody willing. They're just flat-out saying no."*

A number of participants talked about possible approaches to address some of the barriers that exist on account of social determinants. They included...

*"And that could even be just like we see with nursing homes for elderly with respite . . . They may not take their kids to that daycare on a regular basis, but from time to time, they need access to somebody to watch over their child while they travel to seek care services elsewhere."*

*"My hopes and dreams? That all the money that we can come up with or that we can spend or funnel goes to a paid time off system where people if they choose to have paid time off that that would be accessible to them. Paid time off from work for pregnancy and childcare and postpartum. I think universal access to early childhood education. I would love for them to take all that money and put it into healthcare and childcare."*

*"If I could cite anything for a state to implement, Oregon's paid time off program. I think it's revolutionary and wonderful and accessible, and it's for people leaving toxic homes can use it. People escaping interpersonal violence can be used for any type of family leave. So really advocating and picking up a structure for that and then for wraparound supports during that time for whatever reason."*

*"It would be great to have the state have a policy in place that actually allows for payers to use Medicaid funds to address more of those social determinants of health needs . . . and could be very impactful."*

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## Program Eligibility

Participants shared significant challenges in accessing public assistance programs, including overwhelming application processes, inconsistent eligibility requirements, and systemic barriers for communities of color. Families face duplicative paperwork, strict income thresholds that penalize modest earnings increases, and inequities that disproportionately affect Black and Brown communities.

Both providers and families mentioned the often-confusing process of applying for benefits. The lack of a centralized system means that families must navigate different eligibility criteria and paperwork for each program, often leading to mistakes completing forms that result in denials. The duplication of paperwork and lack of coordination across agencies can lead to frustration and cause families to drop out of the application process altogether, further entrenching their financial instability.

A provider shared how difficult it can be to apply for benefits, particularly given a lack of a centralized system. They shared...

*"There's eligibility then on your income. Who is in your household? What does it count to be in your household? What does it mean to be homeless? And how do you count . . . ? And every agency might look a little bit—they have a lot of similarities, but it's different as well. All the information, the forms, the documents, the information that you have to have and the forms to fill out, the duplication of that, it's just so overwhelming for families that they're not making it through. Because if you don't fill out a box in one application, they'll just deny you for not filling out that—I mean, it's really simple as that. If you don't fill out this box, you could get denied. And then it takes forever to get through an appeal process for things."*

Another provider shared similar sentiments, saying...

*"We need to address that and maybe gather these metrics in a way that's not inherently harmful to the community. So maybe there's a way that we can check people's income without them having to provide all of these proofs. Maybe it's enough that you live in a certain zip code where the median household income is lower than the federal— whatever the poverty line is. Maybe it's enough that you have already gone through the vetting process for your children to have free lunch. Maybe it's enough that you're a Medicaid recipient. But why are we unnecessarily duplicating steps in there instead of evaluating somebody's income and household size 27 million times for every single state program? Why aren't we centralizing that? Make it make sense."*

The challenges of inconsistent and inflexible eligibility requirements for public assistance programs, including food stamps, create significant barriers for low-income families, especially those in the "in-between" income zone where slight increases in earnings result in the abrupt loss of vital benefits. As one mother explained...

*"So, we have food stamps. I think we would probably starve to death if we didn't . . . but I am in that in-between place. Once I get my first paycheck and I turn to food stamps saying, 'Hey, I'm back at work,' they're going to cut my food stamps in half. They say that I make too much, but I don't actually make enough to pay for anything."*

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## Language and Cultural Barriers

A provider shared how difficult it can be to offer interpretation services, and expressed concern about how utilizing translation services has the potential to impact care, explaining...

*"There's still a long ways to come with our Spanish-speaking population because that is a huge population, but whenever there's a patient that doesn't speak Spanish, then people are like, 'What?' Today in clinic, we had a Vietnamese-speaking family, and it created a whole tizzy of like, 'Oh, how do we get an interpreter for this?' and 'Oh, now this appointment is going to take longer.' And so, then I felt like there's already a stigma going into this room that now because we have to use an interpreter online, that it's going to take longer. And then if you're not giving a patient the same time that you're giving another patient, then the quality of care is going to be different. So, I think if we could expand interpreting services, that would be huge because having a good interpreter that the patient can hear well. Because a lot of times it's on the phone, and I've used those a lot, and it's hard to hear. But I think that's an area that is a big barrier, especially with more and more immigrants from different countries always coming to the Midwest. They trickle in from the coast, and I'm seeing more and more different populations all the time."*

And while language barriers generally apply to those with limited English proficiency, one situation was shared where MCH services were only available in Spanish, and not in English...

*"I learned that Becoming a Mom classes in [Name] County are only available to Spanish-speaking women at this time. So that means that there are no health education classes for only English-speaking women in that county. And then I'm sure that there are places in frontier Kansas that only offer English-speaking classes. Because it's beholden to the health department's capacity and discretion largely, it's limiting who we can provide services for."*



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## Mistrust and Fear

The interviews and focus groups revealed that mistrust and fear of state systems prevent Kansas families from seeking needed support, especially in behavioral health and child welfare contexts. Punitive practices, including mandatory reporting, discourage families from accessing resources, as they fear losing their children. Participants stressed the importance of culturally responsive, community-driven approaches, like home visits from trusted local figures, to rebuild trust. Historical injustices, including those faced by Indigenous communities, exacerbate this mistrust, highlighting the need for culturally aligned services and systemic reforms to foster more supportive and non-punitive environments.

A parent and non-profit organization leader highlighted the issue, saying...

*"If we gave our teachers or therapists, if we gave our medical staff the support and training, they needed . . . I can't tell you how many districts have paid me to come and do a training on, 'What if we weren't just mandated reporters? How can we help a family instead of just calling DCF on them?' When I was working for the district, it was drilled in your head, 'Don't question it. Report everything. Report everything. We don't want to be held liable.' That mindset shifted. You're seeing it in pockets and places, but we could do some broad strokes if we work together."*

Another participant echoed the need for more community-driven, non-punitive approaches to support families.

*"After they give birth, in an ideal situation, they would have home visits and not by a state-run entity because it's not helpful to send in mandated reporters to folks who are already vulnerable. They would have home visits from somebody from their own community, somebody maybe kind of like a doula or an auntie or a grandma. What used to happen prior to the medical industrial complex popping up and saying, 'We're going to do birth,' is the community would come to you after you had a baby. The community would bring you casseroles after you had a baby. You would have that in-group support."*

Fear of repercussions seems even greater when behavioral health issues are involved. One provider noted...

*"People are still being reported for sharing their mental health and substance use things in ways that are not equitable. So, people aren't comfortable. So, they keep breaking trust. So, people keep breaking trust, and so the narratives continue to persist because there's not enough of the interactions where people are trustworthy and supportive and helpful."*

Said a second...

*"How can we demystify behavioral health and the use of drugs so that moms are not afraid of reporting it for the fear of getting their babies taken away? How can we do a lot of that work that is actually a lot of individuals' internal work so that we see the world in a different place and we're more welcoming?"*

Among some populations, mistrust is the result of long-term, historical racism. A member of a Kansas tribe commented on efforts to have a WIC breastfeeding peer counselor provide services on the reservation, and while grateful for the efforts, indicated that...

*"Although she did help support them, there was just not a good rapport and a sense that they didn't feel safe or confident enough with her. And I absolutely understand why, because she just wasn't Indigenous, and she wasn't a part of our community. We have a lot of generational trauma that we are healing from. And there's a lot of things in Indigenous communities that we have a fear of when it comes to healthcare systems and such like that."*

Several participants talked of ways to build trust and encouraged more meaningful engagement of people with lived experience and organizations with a history of service to marginalized populations in the work...

*"There are already organizations doing the real work. They're [the MCH Program] struggling with the pivot because they're trying to figure out how to reinvent the wheel . . . Respect the value of those that are truly on the ground doing the work and not having ownership of everything."*

*"I think the youth today really do feel like their voice has value. And it does. It absolutely does . . . Let them dictate the how and the what and the when."*

*"There is a felt sense of safety when a person's skin tone is like yours or they perceive you to be like them . . . I think there's something really valuable about prioritizing having people who identify as BIPOC in the spaces."*

Others felt better access would be facilitated by removing state "branding" from programs and/or having state agencies partner with community-based organizations to sponsor and offer shared programming...

*"[If] there's a picture of the State of Kansas it makes my families think, 'Oh, it's a state-run thing.' I've asked them, 'Hey, would you use this?' And they're like, 'State centralized. It's called intake. No. Anything called intake? Anything called referral? Anything with the State of Kansas on it? Nope, I'm out.' Quit saying you're with DCF. They're just going to rip your poster off the wall of the library and throw it in the trash. Stop it. Just say, 'This is a parenting resource.' Does DCF really need that credit or they're going to pull the funding? Do they care that much? Can we just take that off of there?"*

*"We have Becoming a Mom at the hospital, but my families don't want anything to do with the hospital. They go there, they might lose their kid, right? They're not going to those classes. So how do we make that accessible? And so, we talked about hosting it in a school, hosting it off site, come here, host it at [Community Organization], right? Where can we host these things just to increase accessibility, just to increase people wanting to be a part of it that right now have those barriers?"*

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## Stigma

A prevalent topic of discussion in both project focus groups and interviews was the outsized role of stigma associated towards mental health and substance use challenges as a major barrier to seeking and receiving quality care. Behavioral health stigma is multi-faceted and manifests itself in person and in more systemic and structural ways that keep people from receiving optimal care.

Participants consistently highlighted the pervasive stigma surrounding behavioral health and its impact on individuals seeking help. They emphasized how stigma prevented individuals from seeking help due to feelings of shame, fear of judgment, and perceptions, particularly around substance use, that substance use disorder (SUD) is a moral failing rather than a health condition.

A family member of an individual who had struggled with mental health and substance use talked about how difficult it was to admit the need for help in a small community where everyone knows one another. They offered...

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*"I think stigma is always just huge. Yeah. I think the stigma of seeking help, it's hard. And it's hard to go to your doctor and tell them . . . "I'm hooked on this," or . . . "I need help with this," or whatever, especially if you haven't been since you were in elementary school together."*

An individual in recovery from substance use disorder shared...

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*"My personal experience through my chaotic substance use, a lot of times I felt really alone and disconnected and that stigma and that shame really kept me isolated."*

A provider primarily working with the LGBTQ+ community shared...

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*"There's, one, not enough being done around prevention, generally, and two, very, very little being done with specific audiences for whom, perhaps, the message is even more important. And part of me wonders, is that also tied to stigma? Because so many of the populations who have high prevalence also are populations who, unfortunately, suffer from stigma arguably more than other populations."*



## Recommendations

### Policy and Practice: Barriers to Care

Breaking down barriers to care requires not only more flexible eligibility criteria and accessible services but also a shift in how services are framed and delivered, ensuring they are culturally competent and sensitive to the concerns of historically marginalized communities. Opportunities for improvement reside in:

**Streamlining Eligibility Criteria:** Kansans seek simplified and flexible eligibility determination processes that reduce barriers for all individuals. This includes utilizing alternative documentation methods, straightforward application processes, and improving accessibility to ensure equitable access for everyone, especially for marginalized and underserved communities who face the greatest challenges in accessing services.

**Addressing Mandatory Reporting Concerns:** Promote updating mandatory reporting laws to ensure they do not unintentionally discourage families from seeking necessary help. Train providers to fully understand reporting requirements and emphasize the importance of creating safe, confidential spaces that encourage families to access support services without fear.

**Improving Cultural Competency:** Improving healthcare for marginalized communities requires culturally sensitive services and language accessibility, including high-quality interpretation, translation, and cultural competency training for providers. Ensuring that medical interpretation training is available statewide helps bridge communication gaps and builds trust in healthcare systems. Tailoring services can reduce health disparities and improve outcomes.

**Rebuilding Trust Through Community-Led Approaches:** Engaging community leaders in service design and delivery builds trust and ensures services address family needs. Increasing the representation of diverse individuals in the healthcare workforce enhances cultural competence and improves patient outcomes, reducing healthcare disparities.

**Redesigning Data Collection:** Improving data collection practices ensures transparency and minimizes unnecessary gathering to prevent perceptions of surveillance and exploitation. Clear communication about data collection purpose builds trust and encourages participation, particularly in marginalized communities.

**Foster Program Access through Collaboration:** Minimize state branding of programs and build partnerships with trusted community-based organizations. This approach reduces mistrust and promotes greater utilization of services by families.

**Address Upstream Social Determinants of Health:** Tackle root causes of health disparities by addressing socioeconomic barriers to access and promoting programs that reduce income inequality, including TANF, SNAP, and parental leave.

**Addressing Stigma Across the Care Continuum:** Public health has a vital role to play in addressing stigma since stigma is deeply-rooted in systems (health care, mental health, and the substance use disorder systems, all of which operate in distinct and separate silos) and within communities. Multi-faceted strategies are needed, including anti-stigma community campaigns, anti-stigma training for providers, and peer-based supports to help individuals with behavioral health challenges access and navigate the complex system of care.

## Workforce Capacity

Our data collection highlighted several key barriers that impact access to healthcare, particularly for maternal and child populations in Kansas. These barriers can be grouped into four main themes:

**Healthcare Access in Rural Areas:** Rural areas face significant challenges in accessing adequate healthcare services due to provider shortages. Many rural regions in Kansas are classified as “maternity deserts,” with few or no obstetric providers. This lack of access to maternal care leads to higher risks for adverse pregnancy outcomes. Long travel distances to healthcare facilities and limited availability of specialized care were cited as major obstacles. Recommendations include expanding telehealth services and incentivizing healthcare professionals to work in rural regions to improve access.

**Workforce Challenges and Retention:** High turnover rates and workforce shortages are particularly prevalent in rural Kansas, where healthcare providers often face burnout due to heavy workloads and inadequate support systems. This turnover makes it difficult to establish long-term patient-provider relationships, which are essential in maternal and child healthcare. Strategies for improving workforce retention include offering competitive compensation packages, providing mental health support for providers, and increasing Medicaid acceptance to ensure broader access to services.

**Behavioral Health Needs for Youth:** Behavioral health services for children and adolescents remain a critical gap in Kansas. Limited access to mental health care, long wait lists, and stigma surrounding mental health issues discourage many families from seeking the help they need. This is compounded by a shortage of mental health professionals, particularly in rural regions. Expanding school-based health services and integrating telehealth options for mental health care are important steps toward addressing these challenges.

**Culturally Competent and Diverse Workforce:** As Kansas becomes more diverse, cultural and linguistic barriers to care have become more pronounced. Participants noted a significant need for bilingual healthcare providers, especially in areas with large Hispanic populations. In addition, the lack of cultural sensitivity among providers can lead to discomfort and mistrust. Expanding professional interpreting services and providing cultural sensitivity/competency training for healthcare providers will help bridge these gaps in care.

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## Primary care

Participants frequently cited concerns about lack of access to primary care providers. Examples were provided of long wait times for appointments and difficulty establishing a routine source of primary care due to a lack of available providers. Participants described waiting weeks or months for appointments or having to resort to urgent care or the emergency room for non-urgent care. High rates of turnover were also cited as a barrier to establishing a trusted medical home. While these barriers are frequently thought of as a rural concern, these issues are not exclusive to rural areas of the state. Residents in both rural and urban communities reported struggling to find routine, timely primary care, and experiencing long wait times for appointments. Even in communities with providers, access may be a challenge for low-income families when providers are unwilling to accept Medicaid and/or uninsured patients.

One woman participating in a focus group explained her challenge finding primary care, saying...

*"I have one [primary care provider] listed on my chart through the [Health System], but I have seen her once, and it was about four years ago. Since I was kicked off my parents' healthcare and had to get my own insurance, it's been about two years since I've seen a primary care provider, and I still haven't found one."*

Another participant shared...

*"One time, I started getting really severe migraines kind of all at once, and so I went to the urgent care and they said, 'Well, you need to go to a primary care physician for this.' I said, 'Okay,' and they made an appointment. It was like a month out. So, I was kind of dealing with these headaches for so long with no availability. So yeah, even though I do live in a little bit bigger town, it's still kind of an issue . . . there's just still kind of a lack of resources where I'm at."*

A managed care representative noted that many families, particularly in rural areas, often rely on ERs as their primary care resource, sharing...

*"I think especially in rural, ER is their choice. I mean, it's the only thing they have . . . The family practitioners have to rely on the ER as their backup . . . If my kid has a sniffle and they can't get me in for a week... they don't have the capacity to build in the sick visits, so you go to the ER."*

Use of the ER for routine care, particularly for after-hours care, is not limited to rural areas, as one provider noted...

*"There's a gap with after-hours care . . . they're walking into the ER, which is already overflowed, especially in Wichita. You will have at least a three-hour wait."*

Provider turnover was also cited as a barrier to quality primary care by one participant, who stated...

*"I have been going to an Indian health clinic ever since at least the age of 10 . . . The provider rotation is crazy. How are we able to establish a relationship, a rapport, a feeling of safety with our provider if they're not going to be there that long?"*

A social service provider spoke specifically to the importance of trust among youth patients, stating...

*"I work with a lot of teenagers who—it's hard for them to open up to an adult. And then by the time they do, they never see that adult again. That's more detrimental than helpful. Why even start the services? So, we have kids who are like, it's not worth their time, and they're right. It's not."*

Beyond geographic challenges, finding providers who accept Medicaid is another significant issue. A provider explained...

*"Finding pediatricians in a lot of areas is a struggle. A lot of the offices are like, 'We're full to Medicaid. We're not accepting new members who have this or that.'"*

The high turnover in behavioral health services further complicates this issue. A rural physician emphasized...

*"Even though they're all served by area mental health centers, they too have that high turnover . . . so patients just feel they can never quite get a relationship established . . . and then too month later, they've got to turn around and do it again because they lost that provider."*

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## Obstetrical care

Rural Kansas, in particular, faces critical challenges in maternal healthcare due to a shortage of obstetrical providers, lack of obstetric capacity in many small, rural hospitals, and the outright closure of birthing units in some rural hospitals. These factors have resulted in "maternity deserts" in many rural areas of the state. These areas, where expectant mothers are forced to travel long distances to access prenatal and/or delivery care, experience increased risks of adverse pregnancy outcomes, including complications during labor and delivery.

One provider shared...

*"Women are expected to travel two or three counties over to receive services, and that's just not realistic for a lot of women."*

A physician involved in health care workforce research explained...

*"We surveyed all the rural hospitals in the state of Kansas . . . our results did show a significant decrease in providers, which has increased maternity deserts . . . which increases adverse pregnancy outcomes, both for mom and baby."*

While there have been efforts to develop a "hub and spoke" model for some specialty services like obstetrics, in many rural areas of the state the effectiveness of the model is strained by limited capacity even within the hub hospitals. The rural health researcher explained...

*"Some of the supportive hospitals are not tertiary care facilities. Maintaining that hub is a lot. A hub for one network is Garden City, and they've got one Ob/Gyn and a waiting list for maternal care access."*

One specific need shared by one participant was the need to develop more capacity for diagnostic services in rural communities, saying...

*"We need ultra sonographers in rural communities who can obtain the images necessary to ensure the patient receives the right level of care."*

There was also recognition that pregnant women with high-risk pregnancies who live in rural communities often don't live near birthing facilities that can meet their needs, and how important it is to have systems that can get them to the right care at the right time.

*"In the military, we had something called stork nesting, and we used to go get the mothers and then bring them to the tertiary care facility because maybe they were at a base where they couldn't get deliveries. We really see a need. If we build this process in which we identify patients that need the next level of care, when we send them for that care, they need somewhere to stay. And so, I really feel like another thing that we need to work on in terms of funding is, for lack of a better word, like a Ronald McDonald House for mothers."*

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## Midwifery/Mid-level Providers

The role of midwives and similar mid-level providers remains a contentious issue in the state. Many see expanding the work of midwives to be essential to ensuring access to prenatal and birthing services in Kansas, but others are dubious of their value and role. One physician said...

*"The role of mid-level providers in solving this is essential. Western Kansas—I mean, rural Kansas, and even urban areas, depending on what you're looking at—healthcare can't function without mid-level providers, period."*

Another provider shared...

*"We have multiple hospital systems, almost all of them that I know of, that will not give these APRNs privileges at their hospitals because of the political implications of pissing doctors off. If we could get past that, I think we could address this maternal healthcare desert issue in a meaningful way. Those are the mid-level practitioners you would expect to see in any other state. There was that bill two sessions ago that gave APRNs their full scope, but that's meaningless if they can't get hospital privileges."*

Another provider shared...

*“Look at the UK. Almost every baby is caught by a midwife. You aren’t seeing a physician—maybe once or twice in your pregnancy, but you aren’t seeing them as your primary care provider. And that would be a cost savings for all of our systems because, one, we would get better outcomes. Two, people would get more customized care because you have that with a midwife. You have more time. We need to look at how we can incentivize people to go into midwifery and how we can incentivize physicians to allow midwifery inside these systems.”*

A doula shared her perspective on opportunities to expand the midwife workforce, saying...

*“One of my personal goals is to train more home birth midwives. While we can’t get professional liability insurance to do this work, we can handle scenarios like twin births and breech births in a home setting—situations that are often disallowed in other states but have shown amazing outcomes with the right provider. It takes someone with the proper skills, and unfortunately, those are becoming skills of the past.”*

Others, however, expressed concern about the practical integration of mid-level providers into the system. A physician emphasized the challenges of managing emergencies in rural settings, stating...

*“With midwifery, we just don’t graduate enough in the state of Kansas, number one. And they’ll slowly trickle out as the need increases. But the challenge is what happens when the certified nurse midwife gets into trouble? If we’re looking at 90 miles to the nearest hospital capable of doing an emergent C-section and hysterectomy, that’s a lot of distance between where they’re providing a service and where they need to get definitive care.”*

A nurse agreed, noting...

*“If you’ve got a little tiny hospital, there’s this idea that midwives could be assisting women there—and they can. But if you’ve only got so much money to hire a care provider, and you are now hiring someone who can only see a small scope of patients and cannot perform surgeries like C-sections, then what are you going to hire? You’re going to hire a family medicine physician who can meet the entire needs of that facility.”*

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## Behavioral Health

Access to mental health services in rural Kansas is a significant challenge due to provider shortages, high turnover rates, and logistical barriers. Many families report traveling long distances to access care, with some resorting to virtual/telehealth services. However, these services may not be accessible for all, particularly in areas with poor broadband infrastructure. Adolescents, in particular, face difficulties navigating the mental health system. They often struggle with stigma, lack of awareness, and logistical issues including scheduling conflicts with school hours.

One physician emphasized...

*"Child psych services ... are just rare. It's tough to get those services. Rural families may be required to travel great distances, sometimes up to an hour or more, just to access basic mental health services."*

As one Family Advisory Council member explained...

*"In rural areas, you have to drive an hour, hour and a half to get mental health care...maybe even Denver because we're a hole."*

Another parent shared this frustration, explaining they resorted to telehealth services for her child...

*"I had to pull my kid out of school to do a virtual session... I couldn't find availability even between two metro areas."*

In some communities, turnover of providers has caused significant disruptions in care continuity, leaving many people feeling unable to establish a trusting relationship with their providers.

A behavioral health provider shared...

*"Patients feel like they can never quite get a relationship established...and then two months later, they've got to start over with someone new."*

While school-based services are often touted as a solution to behavioral health access for youth, youth in a focus group said they were unaware of available mental health resources in their schools and were unsure how to access them. One adolescent explained...

*"I didn't know where the social worker's office was...it's like they're hiding it."*

Another teen shared a similar experience...

*"At my middle school, the social worker's room was hidden... you couldn't even see the door because it was the same color as the hallway."*

Even when care is available, sometimes the stigma among providers can serve as a barrier to effective treatment. A provider admitted that stigma is commonplace among providers, and noted the need for more empathy and understanding, saying...

*"More than anything, these people are not going to engage and they're not going to disclose the struggles that they're going through if they're not being met with open, accepting arms and a safe space to disclose all of these things in."*

A mental health center director shared a similar observation, admitting that...

*"The struggle that I've heard from clients, from staff, from my director, from the prescribers, is that they don't understand the clients. The clients feel judged. And they feel like the prescribers try to make them feel like they're drug-seeking when they come in for medication."*

A mother of a young person struggling with mental health, including substance use, expressed frustration with the way her child was approached by providers, sharing...

*"It is a lot about the stigma, and it is a lot about the approach to helping people that's 'this way or the highway.' It's very black and white, or it's almost like you're being punished. Part of the reason why a lot of these people are using substances in the first place is because they're already feeling shame or unhappiness or experiencing mental health issues. None of those are positive feelings. So to put more negativity surrounding recovery, to me, just seems very counterproductive. I mean, it should be accessible. It should be inclusive, and it should have some sort of benefit, reward other than 'You can get your life back.' They're like, 'Well, the life I had kind of sucked before that. That's why I'm using drugs, you idiot.'"*

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## Workforce Development Needs

A number of participants discussed training and other workforce development supports that they felt would help promote workforce development and quality care for women and children. Some of the themes around workforce support included the following:

*"Maybe each county gets X number of dollars for health equity workforce training. That's what I would put maybe a third of it [Title V funding] in."*

*"There needs to be some new training on mandated reporting. I still see that some of the narratives are just being passed down from one to the next to the next to the next. I think the child welfare system in Kansas has done an amazing job talking about addressing the racial disparities within there, but I think that they need to go out of house and do a really intentional campaign that's to reach any and every person who is a mandated reporter to help them become a part of their community of learning or practice so they can grow in their understanding of some of the racial disparities and how bias shows . . . People are still being reported for sharing their mental health and substance use things in ways that are not equitable. So, people aren't comfortable. So, they keep breaking trust, and so the narratives continue to persist because there's not enough of the interactions where people are trustworthy and supportive and helpful."*

*"I'd love to be able to have some requirements put in place that require that continuing education of the professionals of specific things they have to be educated on, like how to talk to youth with disabilities, how to educate themselves on those disabilities."*

*"So, we do a lot of-- all my staff has trauma-informed training. All of our volunteers, our childcare workers. My background working with kids in the mental health field and in the classroom was very trauma-informed practices, trauma responsive practices, that's what I push people towards, right? It's not just knowing about it, but it's how do we respond in a way that makes them feel safe. Understanding those brain states and when we are fight or flight, we talk a lot in our office."*

*"Building career ladders. Healthcare is not great, especially in the US, with career ladders. If you're a physical therapy assistant, that doesn't get you anything to then go be an RN. If you're a paramedic, that doesn't get you anything, even, I think, to be a certified MA. I guess PA is the one career that kind of absorbs people's other experience. So, anything to do to help build career ladders where people can be working in the field and advancing at the same time. And then it would take state-level work and other things, but building crosswalks between professions, and especially for returning military members. There's lots of military who are coming back with amazing medical and healthcare skills who basically have to begin at the beginning to work in the civilian workforce because we don't have crosswalks to slot them into more appropriate positions."*

Another participant also noted the need to train more people of color, and to ensure that appropriate supports are in place to promote success among these students. They shared...

*"Many social work students come into the programs because they have lived experiences that bring them into that space. And I did some research on mental health and supports for students and found that, especially those students that identify as Black and Indigenous and persons of color from more impoverished backgrounds, those are the ones who had histories of struggling with their mental health and who also had issues with accessing services and supports. And so, I think that it starts there, how you support the workforce in higher education. And then once they graduate, especially social workers anyways, there are issues with the licensing process. And so, there's a need for more support, especially for Black, Indigenous, person of color students, to be well supported in that process of being able to pass the license to become a licensed social worker or a mental health professional. There's national news about the racial disparities in licensing, and that is an issue in our state as well. It is a gatekeeping barrier that is not allowing us to bring people into the work."*

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## School-based programs

Another theme was the development and staffing of school-based programs as a mechanism to promote accessibility of services among students and the opportunity to meet students' health needs where they are at most days, namely in school. Some participants shared...

*"One thing that's been nice is that the Community Mental Health Center is in our town. They have been putting case managers in the schools, and so everybody has access to those case managers, and it's really helped versus trying to find people that you have to go to . . . The schools are really focusing on the mental health piece."*

*"The schools are also starting to hire their own case managers and therapists to come in. In my kids' school district, each school they've been in has had their own case manager. They have two different case managers, and then a therapist."*

*I know it's [Community in Schools] in different places in the state. And so, this is just an extra staff person in some of the buildings that builds a relationship. They work like a counselor, but they're not constrained to what teachers have to do. They go to homes. They transport whole families to doctor's appointments. They are kind of like that liaison between the school, the family, and community needs. It's making a huge difference, especially in our lowest-income schools."*



## Recommendations

### Policy and Practice: Workforce

Building and supporting a health care workforce to meet the health needs of women and children in the state is a considerable challenge and one that will require significant investment in resources and time. Some of the opportunities for improvement highlighted by participants included:

**Invest in Training and Workforce Development:** Prioritize investments in workforce training, with a focus on cultural sensitivity, trauma-informed care, stigma reduction, and supporting individuals with disabilities or special health care needs. Promote the creation of career ladders in health care to encourage professional growth and retention.

**Promoting Workforce Diversity:** The current MCH workforce in Kansas does not mirror the state's population, particularly among women and children served through the MCH Program. Systematic, targeted initiatives are essential to remove barriers and promote equitable workforce representation. Strengthen efforts to recruit and retain individuals from diverse backgrounds, particularly individuals who reflect the communities served by MCH Programs. Develop systems of support to help students from underrepresented backgrounds complete degrees and obtain professional certifications.

**Expanding Midwifery and Mid-Level Provider Care in Kansas:** Integrating midwifery and other mid-level providers into the Kansas health systems is crucial for improving maternal and child health outcomes. These efforts should engage diverse healthcare professionals to build consensus on workforce development, regulations, and reimbursement policies, addressing the state's needs while promoting access to quality care.

**Promoting Regional Systems of Care for Prenatal/Postpartum and Birthing Services:** Establishing regional systems of care for prenatal, postpartum, and birthing services has become critical. A statewide discussion is needed to develop coordinated networks that meet the needs of all women, particularly those requiring higher-level care, ensuring equitable access to maternal health services regardless of geography.

**Promoting School-Based Health Services for Young People:** Expanding school-based health services, including mental health supports, is essential to improving access to care for young people in Kansas, especially for those facing barriers to traditional healthcare settings.

## Challenges with Care Navigation

**Challenges with Care Navigation:** Families in Kansas often encounter significant barriers when trying to access essential healthcare services due to the absence of robust referral systems and care navigation supports. The complexity of the healthcare system, combined with a lack of clear guidance, leaves many families struggling to connect with necessary resources. Providers have expressed concerns about the inefficiency of the current referral system, with many parents unaware of available support programs unless they happen to be connected to someone who knows about them. Participants in focus groups highlighted the critical need for formal and proactive care coordination systems, including the use of community health workers, doulas, and other specialized care navigators, particularly for high-risk populations.

**Inadequate Referral Systems:** One key issue identified by participants is the inadequate referral systems in place. A parent from a focus group for children with special healthcare needs shared their frustration, stating that unless parents happen to encounter someone who knows about the available programs, they remain unaware of these resources. Providers echoed this concern, noting that healthcare professionals, such as obstetricians, often lack awareness of community resources, making it difficult for them to connect families with the services they need. This lack of communication and connection results in families struggling to find proper support during critical times, especially for new parents or families with complex health needs.

**Care Navigators:** The need for a more robust workforce of care navigators, including community health workers, doulas, and peer support specialists, was emphasized by many providers and participants. These roles help guide families through the complex healthcare system and ensure they are connected with appropriate services. Several participants shared positive experiences, such as a peer counselor who helped a family member through a difficult healthcare journey, and a doula program that significantly reduced C-section rates and improved breastfeeding outcomes. Participants expressed strong support for expanding the use of doulas and community health workers, recognizing that these roles not only provide essential support but also help foster stronger relationships between healthcare providers and communities.

**Prioritizing Care Coordination for High-Risk Populations:** Efficient care coordination is particularly crucial for high-risk populations, including those facing poverty, chronic health conditions, or other systemic barriers. Participants noted that identifying at-risk families early and providing them with dedicated care navigation could significantly improve health outcomes. Programs already collect data that identifies high-risk populations, such as expectant mothers or families facing financial hardships. Targeting these groups for additional care coordination—whether through community health workers, case managers, or other supportive services—was seen as a critical step toward reducing disparities and improving overall health outcomes.

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## Inadequate referral systems

A parent from a focus group of children with special healthcare needs shared their frustration, explaining...

*"Parents are not hearing about these programs unless they just happen across somebody that knows... if you go into a pediatrician's or a special needs clinic or something, 9 times out of 10, they're not passing information out. So, unless a parent knows to ask questions, they're just struggling, not knowing that there's help."*

A doula also shared a concern about how the health system fails to adequately connect clients to needed resources, saying...

*"I don't know if that means we need more OBs or if we need more community access to community health workers . . . . But our OBs—our healthcare providers—are still not connected to the community enough to even know what's out there." They explained that lack of awareness leaves many families without proper guidance, and recounted an example: "Well, who did you refer this client to?" And they're like, 'Well, I don't know. I gave her a pamphlet.' 'Oh, okay. But she just had a baby. She's not looking at your pamphlet. So how did you tell her about this program? Do you know about this program?'"*

An early childhood provider spoke about the needs of families they see on an ongoing basis, explaining...

*"Our goal is around ensuring kindergarten readiness, and that means a lot of things from health and education and wellness across the board. When you see a parent who just joins us and really has not a clue about any of those developmental needs, how to advocate for their child, how to get to those appointments . . . . We've got parents who come back time and time again, who are referring us to their neighbors, their family, their friends. They can come and ask us, 'How do I get this?' And we're going to help them with that, being that central point of support for somebody."*

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## Care Navigators

Many cited the need for a more robust workforce of community health workers, doulas, and/or other specialists who could help enhance health care navigation for women and children in need.

A provider asked...

*"Why are we not resourcing those people and paying those people? That community health worker model . . . if we actually use that with the people who are already in the community to serve other people in the community, we would see larger changes in outcomes."*

A representative of one of the state’s Medicaid MCOs also expressed support for developing doula support in the state. They noted...

*“As a labor and delivery person, when they first came to me about doulas, I’m like, ‘Wait. Doula? What are you talking about?’ I was like, ‘No.’ And then I learned how much doulas have changed. I think some of our offices are open to that. Some of them are very, very much not. Doula is still a dirty word to a lot of OB practices. And I think not only having the doulas but having the understanding of what they offer and that they’re part of the team versus an opposing force really needs to improve.” A nurse-based care coordination pilot project is already underway in the state. The project lead described the program this way: “When the physicians at the small facilities call there’s OB navigators available. They are the person for your mothers to find out the resources they don’t know about. They’re your person that they call . . . And I didn’t mention this, but if nothing else, rural is used to—they need to be able to pick up a phone and talk to somebody because that’s what they’re used to. They’re not used to sending an email and waiting for some respond.”*

A doula also described their existing program and highlighted their project success, saying...

*“We have what I believe to be the most effective doula pilot project of any that I know of in the nation. Sharp declines in C-section rates, NICU admissions, preeclampsia, sharp inclines in breastfeeding initiation and duration to a year.”*

One participant who has worked with a wide range of maternal and child health programs across the state had this to share when asked what they felt could help improve the care of women and children statewide...

*“The first thing I would say is have a community health worker division, honestly, because that’s been the most feedback that I’ve gotten from just different surveys. We’ve done community listening sessions, partner focus groups. And the most common thing I get back is how needed a community health worker is and just how appreciated they are.”*

A physician overseeing a chronic care management program agreed with the importance of having “health coaches” to support families and connect them to care, saying...

*“Our health coaches that do the chronic care management . . . develop a relationship with a patient, and healthcare is all about relationships. We’ve been more successful with that. We really think that model will work across all ages.”*

In several discussions the important role of behavioral health peer support specialists was specifically discussed as a critical component of care for individuals with behavioral health challenges.

A parent of a young person whose child experienced mental health conditions, and ultimately suffered an overdose, credited peer workers with helping their daughter take the first step towards recovery, saying...

*"I know that helped my daughter when she was on the fence about getting into treatment. It wasn't the social worker. It wasn't the high pressure from the doctors in the ICU. It wasn't me. She already knows what I wouldn't want her to do. It was because she made the choice on her own, and she made a phone call to or one of the facilities reached out to her, I guess. And it was a peer counselor person who said, 'It's going to be hard, but I'm so glad I did it,' and talked to her for about a half an hour. I don't know what was all said, but I do know that that was the one thing that changed her mind."*

A provider was lamenting the shortage of inpatient beds for intensive inpatient treatment, and discussed mechanisms to provide adequate outpatient services during a waiting period, saying...

*"What are we doing with those people who are on the wait list? What services are they receiving while they're waiting? How do we engage those people? A lot of the answer to that is peer support because we can engage those people better to receive services at those lower levels of care or those less intensive levels of care if they're connected to a peer as opposed to a clinician. That's just the way it is. They connect better. There are able to have more points of contact."*

Another provider simply stated...

*"I just know my SUD peer mentor takes a whole lot of burden off me. So, she can't do the counseling, she can't do the treatment planning, but she can provide a lot of supports for our people in between when they see me."*

Several participants noted how navigation services could be of particular valuable to women and children at higher risk for poor health outcomes. One social services provider questioned...

*"Why aren't we putting advocates with at-risk families? We see them coming a mile away. The school sees them, the hospital sees them. The health department sees them. The police see them coming, right? We know these families. Why aren't we putting something in there before the bottom drops out?"*

A representative of one of the state’s Medicaid Managed Care Organizations agreed, noting that they utilize a system of acuity to identify expectant mothers in need of care coordination and support. They explained...

*“Every year we do analysis of our birth outcomes by race, ethnicity, and we also look at geographic location. We’ve identified what everyone else has been seeing. There is a disparity affecting African American communities more than anyone else. And we have seen that improve tremendously on the last two years... We have a risk certification system for acuity—low risk, rising risk, and high risk. And for some parts of the state, we treat our African American moms as high-risk pregnancies, even if they’re identified as healthy. In this way, we’re trying to guarantee that in those counties where we see the deepest disparities and the highest rates, we are impacting those. And what data is showing us is that we are impacting those.”*



## Recommendations

### Policy and Practice: *Challenges with Care Navigation*

It is imperative that systemic efforts are undertaken to develop a system of support that helps families navigate the increasingly complex health care delivery system. Some systematic approaches to consider are:

**Promoting Effective Resource Hubs for Women and Children’s Health:** There is a general lack of awareness and satisfaction with current health information hubs for women and children. Strengthening and leveraging community-based organizations to create accessible, well-connected resource hubs can help address these gaps and ensure that women and children, especially those in underserved areas, have access to necessary health information and support.

**Promoting Care Coordination Through Community-Based Support:** Community health workers, health coaches, doulas, and peer support specialists play a critical role in helping women, children, and families access essential services. These community-based workers serve as navigators, connecting families to resources and guiding them through complex healthcare systems. With health system reform often progressing slowly, these roles are vital in addressing immediate needs and improving continuity of care for underserved populations.

**Prioritizing Care Coordination for High-Risk Populations:** Effective care coordination is essential for populations with the greatest need, particularly those at high risk due to factors like poverty, chronic health conditions, and systemic barriers. Programs already have access to data that can identify these populations, and using this information to prioritize them for care navigation can ensure that resources are directed to those who need them most. Supporting these vulnerable groups through community health workers, case managers, and other forms of assistance helps reduce disparities and improve health outcomes.

## Adverse Health Outcomes and Disparities

Kansas faces significant disparities in maternal and child health, disproportionately affecting rural, low-income, and BIPOC communities. These disparities manifest in rising rates of obesity, chronic conditions like gestational diabetes, and higher maternal and infant mortality rates. Addressing these disparities requires tackling upstream social determinants of health, integrating violence prevention strategies, and adopting strengths-based approaches in health programs. Prioritizing clinical outcomes such as C-sections and preeclampsia, while empowering community-based organizations, is essential to reducing health disparities and improving health outcomes statewide.

**Increasing concerns regarding poor population health status:** Focus group discussions and interviews with healthcare providers have highlighted growing concerns about the physical health status of women and children in Kansas. Obesity, lower education levels, and decreased physical activity, particularly in rural areas, are contributing to a rise in chronic health conditions like gestational diabetes and eclampsia. One physician noted...

*"The physical health status of the population prior to childbirth is less than it used to be," with an increasing number of complications from these conditions. The need for policies that allow Medicaid funds to address social determinants of health was also emphasized, as this could have a significant impact on improving maternal and child health.*

**Racial Disparities:** Racial disparities in maternal health were also identified as a significant issue. A midwife mentioned that Black women, in particular, face higher rates of preeclampsia, which can contribute to stillbirths. A health researcher noted that Kansas has the highest Black maternal mortality rate in the U.S. during the first 42 days postpartum, highlighting the critical connection between maternal health and infant mortality. These disparities are further compounded by systemic factors, such as living in under-resourced or rural areas, which lead to a higher likelihood of infant death, developmental delays, and mental health challenges among children.

**High C-Section Rates:** High rates of C-sections in Kansas were also raised as a concern, with one provider calling the state's performance "horrendous." C-sections pose risks for both mothers and babies, including complications during delivery. Despite new evidence from studies like the ARRIVE study, which suggest that certain C-sections may be preventable, many healthcare providers continue to rely on outdated practices.

**Violence and its Public Health Impact:** Violence against women and children, including domestic violence and sexual assault, is an emerging concern in Kansas. Public health officials emphasized the need for programs targeting perpetrators, rather than focusing solely on victims. One official noted that early conversations with men about healthy relationships could help prevent violence and reduce its harmful effects on women and children.

**Youth Concerns: Mental Health and Substance Abuse:** Adolescent health, particularly mental health, emerged as a key issue for high school-aged youth in focus groups. Issues like depression, stress from school, social media bullying, drug abuse, violence, and vaping were identified as primary concerns. Teens expressed feeling that social media plays a significant role in increasing stress and mental health issues, especially when dealing with bullying and the pressure to conform.

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## Increasing health concerns

Compared to discussions about concerns in the system of care, focus groups and interviews generated fewer comments about the health status of women and children in the state, but several providers in particular did offer perspectives. One physician noted...

*"We see increased rates of obesity, poverty, lower educational levels across our rural communities compared to urban . . . I think the physical health status of the population prior to childbirth is less than what it used to be. I assume that has a little bit to do with decreased physical activity, less healthy eating, . . . [when I started] I didn't see a lot of complications from some of the chronic conditions that we're facing now."*

Another physician shared a similar outlook, sharing...

*"With the changing landscape of general health of Kansas—women, infants, and child included—we're starting to see different risk factors that lead to things including gestational diabetes, eclampsia in pregnancy, especially the second one, things that—I thought I probably will never see, an individual become eclamptic in my career. I would hope not. But I've seen it. I've seen it personally out here in [Town] . . . When I was going through my training at KU in Kansas City, Wichita and Salina, that I would have never thought I'll actually see it get to this point. And here we are."*

A physician noted how helpful it would be to be able to use resources like Medicaid to address these issues, sharing...

*"It would be great to have the state have a policy in place that actually allows for payers to use Medicaid funds to address more of those social determinants of health needs . . . and could be very impactful."*

## Racial disparities

A midwife and health researcher also mentioned eclampsia, and the presence of racial disparities. The midwife noted...

*"We know that Black women in particular have higher rates of preeclampsia and that preeclampsia is a factor that can lead to higher rates of stillbirth. And so, I would like to see more focus on evidence strategies like that. The aspirin protocol, I think, is one that would make a huge dent in these number of stillbirths. It's not been taken up . . . They're not talking about it. And this is something that could have a tangible effect on these outcomes."*

The health researcher went further, stating...

*"If you have preeclampsia, then you also have a higher incidence of preterm birth and low birth weight, which is the number one cause of infant mortality among Blacks, right? Right now, according to the American Health Rankings, Kansas has the highest Black maternal mortality rate in the US in the first 42 days after delivery, right? And so if you're losing moms within 42 days and you're losing babies within 28 days, their neonatal period, then the issue is about the mom's health."*

Another health researcher and professor also emphasized racial disparities, noting...

*"... there are significant and persistent racial disparities that are impacting women and infants in our state and across the nation. Some of those racial disparities are related to maternal mortality and morbidity, the near deaths, the chronic conditions that women experience, especially those who are Black, Indigenous, and people of color, and also those who live in or experiencing under-resourced spaces, rural areas, and deep poverty, those kind of things. And honestly, it's those same families who are the parents of infants who are also, in many ways, more likely to be at risk of infant death and also to be exposed to different things in their environments that lead them to experiencing the developmental delays and disabilities, which were the kind of children that I was working with, and mental health challenges because of just being under-resourced, being exposed to violence in their communities, and just struggling with a number of different kinds of things."*

Even certain aspects of the popular Becoming a Mom program, offered through many health departments, were questioned in terms of their impact on some families. Said one public health official...

*"Becoming a Mom is not very effective because it assumes that participants need help because they don't know how to be a parent. That's not true. Inequities persist not because we don't know how to give birth or parent but because we're interfacing with deeply racist systems."*

The practice of providing supplies to families upon completion of BaM was also criticized for being less about incentivizing participation and more about not trusting families to undertake efforts to improve their family's health.

Given the long-standing and persistent disparities in maternal and child health documented across the state, a number of participants spoke to the importance of more meaningfully engaging people with lived experience and community leaders who are involved in work with the populations experiencing these disparities. They suggested...

*"If we continue to work in silos, we're going to all be stressed out and burnt out... We can no longer work in silos. We have to rub shoulders with people who might not have the same degree as us to know something because we don't know everything and be more community oriented."*

*"There are already organizations doing the real work. They're [MCH Program] struggling with the pivot because they're trying to figure out how to reinvent the wheel... Respect the value of those that are truly on the ground doing the work and not having ownership of everything."*

## Cesarean sections

High C-section rates were also identified as an issue requiring urgent attention. A provider commented on the high rates of C-section rates in Kansas, stating...

*"Number one on my list would be C-section rates. We are doing poorly in this state. Horrendous even." They pointed out that C-sections can lead to greater risks for both mothers and babies, including a higher likelihood of complications or death compared to vaginal births. The provider also referenced the ARRIVE study and noted how many physicians continue to use outdated practices despite new evidence. "We know why these things are happening. And to me, the metric that I look the most critically at is those C-section rates because it's preventable."*

## Violence

Violence against women and children in the form of intimate partner violence, sexual assault, and homicide are a growing concern in the state. Several youth participants noted growing violence and schools and others talked about violence in the home. A public health official noted increasing rates of violence and the high rate of homicides experience by even young children. One public health official, noting this concern, shared that...

*"I would like to see earlier conversations happening with men, predominantly the perpetrators of domestic violence... Women are not the population perpetrating the violence. Healthy relationships are important and can be catered to the lifespan. Creating specific programs targeting the perpetrators, not just the people at the receiving end, is a missed opportunity."*

## Behavioral health

A social worker with an emphasis on maternal health, when asked their perceptions about the most pressing MCH health needs in Kansas, shared...

*"I feel like there are multiple factors that are impacting the needs. And so if I would say, 'Oh, I want to address depression or anxiety,' which are really prevalent, even if people don't have a diagnosis, right, those who are experiencing those symptoms and who are pregnant, parenting young children, I can't help but also think that their financial state is connected to those needs, and those financial stressors where they live is connected to those needs. Their ability to access supports and services in spaces they can trust is connected to that, the relationship with child welfare. You know what I mean? And so for me, it's hard to think about, what is the primary need? I feel like we need to figure out why people continue to die in our state, and not just women and birthing people but also their children. And so I guess that would be the most pressing thing. Why are people dying by suicide or overdose or intimate partner violence or just because of the stress of not being able to have the things that they need over time?"*

Two rural physicians agreed with the growing prevalence of behavioral health issues and the associated need for services, noting...

*"Obviously a need is behavioral and mental health services. In fact, one of the projects at the collaborative that we participated in, and are still working with even three years after the grant ended . . . we worked with 11 of our partners across the state, and we have telebehavioral health services in those communities. And two of those, they wanted to be the first two counties off the ground to get that established because they both were seeing a significant increase in suicidality and actual adolescent suicide rates."*

Among both providers and people with lived experience, there was frequent discussion about the high prevalence of substance use disorder and mental health conditions. One individual with lived experience suggested that lack of access to mental health services in rural parts of Kansas (and the stigma against using those services) meant people often turn to substances to address their pain. They explained...

*"People use drugs for a reason. The body tells us when we're not feeling well, and so we seek something out to make us feel differently . . . . If you're feeling crappy mentally, you go talk to someone in mental health, and you get something to address that. But for one, we have the fact that here you don't go to therapy, right? And also, you would get put on a six-month wait list anyway. So a lot of times, unfortunately, I feel like people self-medicate with substances."*

A health coalition leader in western Kansas shared similar thoughts, saying...

*"We run into it all the time where almost everybody that we see [for SUD] here are dual diagnosis. So they have an underlying mental health issue, and it's kind of the chicken or the egg. Sometimes they have the SUD that then causes depression and all of that, and sometimes it's the depression and all that that gets covered up with a substance abuse. So for some people, it's one way, and some people it's the other way."*

The focus group of high-school aged youth identified a number of health concerns for adolescents, and many of their comments centered around mental health issues and substance use. When asked to describe health problems they felt affected adolescents in their community, the first to share said...

*"I think adolescents are pretty healthy physically, but they have mental disabilities or something. Mental health concerns."*

A second agreed, stating...

*"I agree. I think that teens are—nowadays, they have way more mental health because of—grandparents and parents like to say it's because of social media/I don't know if that's all true, but they all have a lot more mental health. Social media does play a big part of it because people bully on there, and say stuff about other people on there, and it's just a way for people to get stressed. And it's also because of school. I feel like kids have a lot of depression from school, too."*

Other concerns shared by teens in this group included:

"Drug abuse."

**DRUG ABUSE**

"Violence. A lot of kids are into violence."

**VIOLENCE**  
"LOTS OF KIDS INTO VIOLENCE"

"I think vaping's a problem. In ads for vapes, they say it's better than cigarettes, but it's probably even worse than actual cigarettes and smoking. Yeah. A lot of kids die from vaping."

VAPING  
ADVERTISED TO US AS LIES  
"BETTER THAN CIGARETTES"  
"KIDS DO DIE FROM VAPING"

## Recommendations

### Policy and Practice: *Health Outcomes*

To address poor health outcomes among Kansas women and children requires strategies that address upstream determinants of health and focus on addressing the persistent disparities in outcomes among communities of color, rural location, and lower income. Some strategies highlighted in discussion around the state included:

**Addressing Obesity through Comprehensive Public Health Approaches:** Tackling obesity in Kansas requires a multifaceted approach, including promoting better diet and physical activity while addressing the social factors that contribute to poor health. Collaboration with community partners to combat food insecurity, develop local food systems, and create healthy environments is essential to reducing chronic diseases. Flexible funding mechanisms, including using Medicaid to support social determinants of health, could be transformative in addressing these challenges.

**Addressing Violence as a Public Health Priority:** Violence, including intimate partner violence, should be prioritized as a public health issue, as its effects on women, infants, and children extend beyond urban areas into all communities. Public health efforts must focus on understanding and addressing the root causes of violence while dedicating resources to preventive interventions. By incorporating violence prevention into broader health initiatives and ensuring access to support systems, MCH Programs can take significant steps in reducing violence's detrimental effects on vulnerable populations.

**Empowering Families Through Strengths-Based Approaches:** Programs should prioritize strengths-based approaches that focus on empowering families, moving away from potentially punitive or deficiency-focused approaches and frameworks. Participants noted that incentives like those offered in the “Becoming a Mom” program often feel coercive, suggesting that resources should be provided upfront to build trust and encourage participation. Additionally, education should emphasize peer support, where participants can share experiences and learn from each other, fostering a sense of community and personal development.

**Addressing Disparities in Maternal and Perinatal Health Outcomes.** Efforts should be focused on reducing pressing disparities in maternal and perinatal health outcomes, particularly in areas including C-sections, preeclampsia, and stillbirths. Prioritizing evidence-based practices, including fetal heart monitoring and addressing clinical conditions like preeclampsia, can significantly improve outcomes. Programs like “Count the Kicks” should be better resourced to help reduce stillbirths and other complications. Implementing these strategies, alongside continued education and support, is essential to tackling these critical health challenges.

**Engage in systematic efforts to enhance behavioral health outcomes through interdisciplinary approaches.** It is critical that screening for mental health and substance use issues be integrated into every conceivable care setting. Support for community-based prevention and treatment efforts is also a vital need, with specific focus on youth. Prevention strategies should focus not only on messaging, leadership development to foster youth connectedness, and school-based strategies to ensure access to needed services.

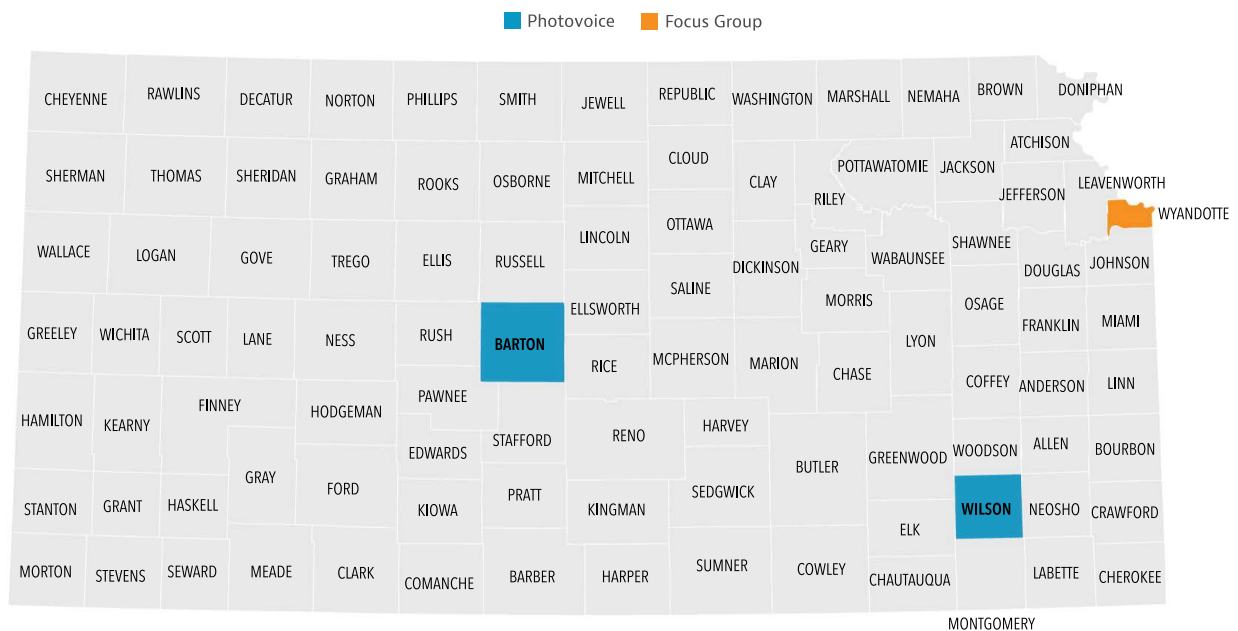
**Empowering Community-Based Solutions:** Public health efforts must shift power and resources to community-based organizations, which are closest to the challenges facing marginalized populations. These organizations should be central to the development of programs and policies, with public health entities actively engaging and contracting with them. This requires a dramatic restructuring of existing power systems to ensure communities have the resources and authority to address disparities that current health structures have failed to resolve. Empowering local leaders and organizations will lead to more effective, sustainable solutions tailored to community needs.

## Appendix F.10 Insights of Kansas Adolescents

Insights from adolescents were gathered through a number of means during the Needs Assessment process, but two specific activities (a focus group and two participatory research projects using Photovoice) focused on gathering specific input from adolescent Kansans. Photovoice is a participatory research method that enables individuals to capture and share their experiences and perspectives through photography and storytelling. In this project, local adolescents in two rural Kansas communities used photography to document their observations on factors in their community that impact the health of themselves, friends and family, and other MC populations living in their respective communities. For additional details, please refer to the Methodology section.

These efforts highlight three Kansas communities as seen through the eyes of these young participants. The youth were participants in an afterschool program in Kansas City, Kansas (focus group), and high school students from public school districts in Barton County and Wilson County (Photovoice). Their insights span multiple themes—Healthy vs. Unhealthy Eating, Environment, Physical Health, Medical Resources, and Mental Health—revealing a nuanced understanding of community health. The youth recognize both assets and areas for improvement, reflecting their desire for a healthier environment and enhanced lifestyle options.

Figure F.10.1  
Map of counties where participatory research was conducted with adolescents



# Photovoice Findings

The overarching themes for youth in these communities revolve around health, safety, social dynamics, and personal responsibility. These themes underscore the importance of developing healthy habits, being mindful of social and environmental impact, and promoting responsible, community-focused behaviors.

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## Key themes

### *Health and Wellness*

Both communities highlight the importance of physical health through recreational spaces and activities like swimming, flag football, and outdoor play. There is an emphasis on safe, active environments that encourage physical activity, as well as mental health support through community resources like libraries and mental health centers.

### *Social Interaction and Digital Balance*

Community 2 underscores the challenge of maintaining face-to-face interactions in a world increasingly dominated by digital distractions. Youth are encouraged to engage meaningfully with others while also being mindful of their digital habits.

### *Safety and Risk*

Both communities emphasize the importance of safety in physical activities, whether it's through the use of helmets for biking or the importance of supervising younger children in outdoor spaces. There is also a focus on environmental safety, such as avoiding the risks posed by pollution or vaping in shared spaces.

### *Environmental Stewardship*

Community 1 in particular stresses the importance of caring for the environment, addressing issues like pollution, litter, and the balance between resource extraction and environmental health. Youth are encouraged to take an active role in preserving their surroundings.

### *Personal Responsibility*

Both communities promote the idea of taking responsibility for one's actions. Whether it's through practicing fair play in sports, making healthier food choices, or respecting shared spaces by avoiding disruptive behaviors like vaping, youth are encouraged to contribute positively to their communities.

# Community 1

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## Healthy vs. Unhealthy Eating

The adolescents observe a disparity in food availability within their community, where fast food restaurants and convenience stores primarily offer unhealthy, highly processed food options. Although efforts like the nearby greenhouse aim to increase access to fresh produce, the prevalence of unhealthy options, along with targeted advertisements for snacks and energy drinks, reinforces a challenging environment for health-conscious eating.

*Student comment: The greenhouse is right outside of our school.  
The greenhouse sells plants to people in our community and they  
have planned to grow produce that can benefit students at school.*



*Student comment: This is unhealthy. There are no healthy food  
options available.*



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## Environment

The youth express pride in certain natural features, such as trees that improve air quality and flowers that add aesthetic value. However, they also raise concerns about environmental hazards, including littering, pollution from tires, and the potential risks from oil tanks and agricultural by-products. The students underscore the importance of environmental stewardship, noting that while farming and resource extraction such as oil drilling are vital to their local economy, they also affect the community's cleanliness and overall health.



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*Student Comment: Trees positively affect our environment because they give us oxygen to breathe. Our community has a lot of trees around town.*

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*Student comment: We are a farming community and our farmers grow crops to help produce food for the community.*

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*Student comment: On one hand, the oil provides a way to make money and make important fuels. On the other hand, taking fossil fuels from the earth is unhealthy for the environment.*

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*Student comment: In our town we have a tire shop where if the tires are burned they can release toxins and pollution that can affect the air and close fields that have growing crops.*



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*Student comment: These are very unhealthy for our environment . . . a lot of kids and adults are walking around town . . . and seeing this impacts them negatively.*



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## Physical Health

The adolescents identify various recreational spaces that promote physical well-being, such as local parks (including skate parks), gyms, and pools. These spaces offer essential outlets for exercise and community engagement, fostering both physical and social health. However, they also caution against underutilized spaces, like the dog park, that risk becoming neglected without sufficient community engagement.

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*Student comment: This is a park by our pool and softball fields, where kids can go and play while also getting exercise.*



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*Student comment: These trails are healthy for our community to have because they give everyone in our community a chance to get the exercise they need while also getting a good look at beautiful scenery.*



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*Student comment: The dog park could positively impact our town because it allows to people physically active while taking their dog out . . . but it could also be a negative effect if no one is using the park. It can become a waste of space, and we don't think there are a lot of people that take their dogs out to the dog park often.*



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## Medical Resources

The students acknowledge the range of healthcare resources available locally, including emergency medical services, primary care, and veterinary services. They particularly value the local health department and fire department for their role in managing health and safety within the community. The inclusion of veterinary care also reflects a holistic understanding that animal health impacts community well-being.

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*Student comment: This health care clinic allows loved ones to get assistance when they are ill.*



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*Student comment: Veterinary clinics improve pet health, consequently helping human health.*



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## Mental Health

The mental health resources recognized by these adolescents include the public library, a mental health center, and local churches. These spaces provide avenues for emotional and psychological support, encouraging relaxation, community connection, and spiritual well-being. The students' appreciation for these resources highlights the significance of mental health support within their rural community.



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*Student Comment: The mental health center allows people of the community to share and be talked through difficult times which can positively affect our mental health.*

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*Student comment: Church helps mental, spiritual, and overall health.*

## Community 2

This collection of themes illustrates the intersection of health, safety, personal responsibility, and social interactions in the lives of adolescents, emphasizing the importance of mindfulness in both recreational and social settings.

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### Physical Health and Safety in Outdoor Recreation

The students in this community highlight the significance of accessible recreational spaces, like swimming pools and splash pads, for encouraging physical activity, socialization, and sun safety. They emphasize the role of teen supervisors, who help ensure the safety of younger children and promote a healthy, secure environment for all participants. These students take pride in their responsibility and leadership, contributing to a positive, active atmosphere for their peers.

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*Student comment: Children enjoying time at the pool.*

*Teens are supervising the children to ensure that they are safe and following the pool rules.*



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### Guided Creative Play and Safety in Craft Activities

Older students serve as mentors during creative play and craft activities, helping younger students navigate hands-on projects. This theme emphasizes the importance of mentorship, as the students not only foster creativity and safety but also strengthen community ties. The older students model skills such as fine motor development while teaching their younger peers about safety and cooperation.

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*Student comment: Students worked on crafts and followed instructions. High schoolers helped with scissors and with tying also. Positive experiences.*



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## Social Interaction and Digital Balance

The students in this community acknowledge the challenges posed by digital distractions during social activities. While socializing in settings like bowling alleys or dining areas, many students find themselves distracted by phones, creating tension between virtual and meaningful face-to-face interaction. They discuss the importance of balancing digital engagement with in-person communication. This reflects their awareness of the role digital habits play in social connections and their commitment to maintaining real-world relationships.

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*Student comment: Although their peers are around them, they end up on their phones, watching a movie, playing a game, or texting someone that couldn't make it.*



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## Vaping and Its Impact on Social Interactions in Shared Spaces

Students in this community recognize that vaping can disrupt social settings, with the lingering effects of vape smoke potentially alienating others in shared spaces. They emphasize the importance of being mindful of the health impacts of vaping and the need to create respectful environments in which individual behaviors do not negatively affect the well-being of the wider community. The students express a strong sense of responsibility toward maintaining a healthy and supportive social atmosphere.

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*Student comment: These people were part of a large group waiting for a table. It is fun to talk to people in your group. However, someone was vaping in the group and people moved away from the smell and the smoke. The smoke bothered them. Some have allergies to smoke so they need the fresh air.*



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## Safety and Risk in Active Transportation

Adolescents in this community are mindful of the importance of safety when engaging in activities like biking or scootering. They emphasize the responsible use of protective gear, such as helmets, and stress the need to adhere to traffic safety rules. The students are concerned about the risks associated with reckless behavior, such as ignoring crosswalks or riding without helmets, and they encourage one another to prioritize safety to reduce the likelihood of injury. This highlights their commitment to personal responsibility and community well-being.



*Student comment: This person on the scooter took a real chance. She went across from one corner to the other and didn't stay in the crosswalks. She didn't have on any protective gear either. The lady walked out of the crosswalk to avoid her.*

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## Outdoor Play, Teamwork, and Teaching Responsibility

The students in this community also play a key role in promoting physical activity through team sports such as flag football. They value the lessons in teamwork, cooperation, and healthy physical activity that come with these games. Older students take on the responsibility of teaching younger peers about discipline, fair play, and respect, ensuring that the rules are followed and reinforcing the importance of sportsmanship. Through this guidance, the students help foster a culture of responsibility and mutual respect within their community.

*Student comment: It is important for children to get away from the technology and get outside and play. Flag football provides fun, cooperation, teamwork.*

*Student comment: Older students help the younger children by refing the game, and also teaching them right from wrong.*



## Comparison of Community 1 and 2

Students in Community 1 primarily focused on broader community issues related to health, environment, and resources. They highlighted challenges such as limited access to healthy food options and environmental concerns like pollution and litter. The community recognizes the importance of recreational spaces but is concerned about their underutilization. Additionally, there is an emphasis on the need for more collective action to address these issues, such as improving food availability and environmental stewardship. Local mental health resources like libraires and churches also play an important role in supporting community well-being.

In contrast, students in Community 2 primarily emphasized individual behaviors and social dynamics. They highlighted the importance of safe and supervised recreational activities, such as swimming, flag football, and crafting, with teens actively mentoring younger children. They also highlighted challenges of maintaining face-to-face social interactions in an increasingly digital world, with people frequently distracted by their digital devices in social settings. The theme of vaping is also prevalent in this community, emphasizing how it can disrupt social interactions and affect health. Additionally, they provided a strong focus on safety, particularly around the use of protective gear during physical activities like biking and scootering. Overall, Community 2's focus is on fostering personal responsibility and mindfulness in both recreational and social settings.

Students in both communities spoke of the importance of physical activity for good health and the need for healthy outdoor spaces for people to be active and spend time in nature and with others.

## Adolescent Focus Group Findings

The overarching themes from these Kansas City youth revolve around the complexity and cost of maintaining good health, growing concerns about the impact of substance use and mental health concerns for young people, financial and other barriers to needed health care, and the need for schools to serve as a hub for student health and wellness.



### *Maintaining Good Health*

It is costly to access to basic needs and health services that are important to young people. Access to healthy food was of particular concern. Accessing services can be difficult because parents are working and public transportation options are limited. School work and outside-of-school commitments like jobs also make it hard to focus on health. Young people need help with “simpler solutions” to maintain good health.

### *Health care*

Health care is important to good health, but it is both expensive and difficult to access. Services are not always available when needed, and transportation barriers inhibit access.

### *Substance Use and Mental Health*

Substance use is commonplace in classrooms. Students said tobacco, vapes, and marijuana use is prevalent, and they are all “easy to get.” Some expressed concern about drug dealing in schools, and said use of Percocet and fentanyl is on the rise. They discussed using drug-sniffing dogs and Narcan vending machines as ways to help address growing drug use. They also talked about the importance of having peers with whom they can share concerns.

Concerns were raised about increasing bullying and violence in schools. Social media promotes bullying, while in schools they see tasers, guns, and knives, which creates feelings of insecurity. These young people said there was inadequate security in their schools, and they “never see school security guards break up fights.” All of these stresses are weighing on these young people’s mental health.

### *Solutions and Support*

These youth want to see more services and support available for students, particularly for younger people, and easily accessible in the school setting. They supported the idea of more free before- and after-school programming in schools, and particularly wanted to see schools provide more in the way of support for mental health and addiction recovery. They feel adults in their schools need to do more to “take charge” and proactively address these concerns.

## Appendix G. References

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- ABC News. (2024). Husband of former Kansas City Chiefs cheerleader who died after stillbirth speaks out on his loss, lingering questions. <https://abcnews.go.com/GMA/Wellness/husband-former-kansas-city-chiefs-cheerleader-died-after/story?id=108767055>
- Adane, A. A., Bailey, H. D., Morgan, V. A., Galbally, M., Farrant, B. M., Marriott, R., White, S. W., & Shepherd, C. J. (2021). The impact of maternal prenatal mental health disorders on stillbirth and infant mortality: a systematic review and meta-analysis. *Archives of women's mental health*, 1-13.
- Agency for Healthcare Research and Quality. (2020). *Healthcare Cost and Utilization Project (HCUP) Fast Stats: Neonatal Abstinence Syndrome (NAS) among newborn hospitalizations*. <https://datatools.ahrq.gov/hcup-fast-stats/?tab=special-emphasis&dash=83>
- Alker, J., Osorio, A., Brooks, T., & Park, E. (2024). *Child Medicaid disenrollment data shows wide variation in state performance as continuous coverage pandemic protections lifted*. [https://ccf.georgetown.edu/wp-content/uploads/2024/05/Georgetown-CCF-Child-Medicaid\\_CHIP-Enrollment-Report-2024.pdf](https://ccf.georgetown.edu/wp-content/uploads/2024/05/Georgetown-CCF-Child-Medicaid_CHIP-Enrollment-Report-2024.pdf)
- Alvarado-Torres, R., Dunn Silesky, M., Helgenberger, S., Anderson, A., Granillo, C., Nared, T., & Bonnevie, E. (2024). Evaluation of a digital media campaign for reducing mental health stigma. *Health Education Journal*, 83(4), 383-394. <https://doi.org/10.1177/00178969231215761>
- America's Health Rankings. (2024). *Neonatal Abstinence Syndrome in Kansas*. United Health Foundation. <https://www.americashealthrankings.org/explore/measures/nas/KS>
- American Board of Pediatrics. (2024). General Pediatricians U.S. State and County Maps. <https://www.abp.org/dashboards/general-pediatricians-us-state-and-county-maps>
- Annie E. Casey Foundation. (2024). *Kids Count Data Center: Teen births by race and ethnicity in Kansas, 2020*. <https://datacenter.aecf.org/data/tables/9816-teen-births-by-race-and-ethnicity?loc=1&loct=2#detailed/2/18/false/574,1729,37,871,870/10,11,9,12,1,13,185/19106,19107>
- Association of Maternal & Child Health Programs. (2024). Life Course Indicators Online Tool. <https://amchp.org/resources/life-course-indicators-online-tool/>
- Bauman BL, K. J., Cox S, et al. . (2020). Vital Signs: Postpartum Depressive Symptoms and Provider Discussions About Perinatal Depression — United States, 2018. *Morbidity and Mortality Weekly Report*, 69, 575–581. <https://doi.org/http://dx.doi.org/10.15585/mmwr.mm6919a2>
- Beach, C. (2021). *A useful empirical tool box for distributional analysis*.
- Biggs, J., & Rowe, N. (2023). *Kansas MIECHV Expansion Community Readiness Assessment Final Report (prepared for the Kansas Department of Health and Environment by the University of Kansas Center for Public Partnerships and Research)*. [https://bogus-lunch.flywheelsites.com/wp-content/uploads/2023/12/Kansas-MIECHV-Community-Readiness-Technical-Report\\_Final21.pdf](https://bogus-lunch.flywheelsites.com/wp-content/uploads/2023/12/Kansas-MIECHV-Community-Readiness-Technical-Report_Final21.pdf)

Board, A., D'Angelo, D. V., Salvesen von Essen, B., Denny, C. H., Miele, K., Dunkley, J., Baillieu, R., & Kim, S. Y. (2023). Polysubstance use during pregnancy: The importance of screening, patient education, and integrating a harm reduction perspective. *Drug Alcohol Depend*, 247, 109872. <https://doi.org/10.1016/j.drugalcdep.2023.109872>

Bonnevie, E., Smith, S. M., Kummeth, C., Goldberg, J., & Smyser, J. (2021). Social media influencers can be used to deliver positive information about the flu vaccine: findings from a multi-year study. *Health education research*, 36(3), 286-294.

Bonnevie, E., Smith, S. M., Kummeth, C., Goldberg, J., & Smyser, J. (2021). *Social media influencers can be used to deliver positive information about the flu vaccine: findings from a multi-year study*. *Health Educ Res*, 36(3), 286-294. <https://doi.org/10.1093/her/cyab018>

Brewer B, P. S., Ratnayake IP, Mudaranthakam DP. (2023). Rurality Impacts Mammography Screening Adherence Among Mid-life Women in the Kansas Region. *Cancer Control*, 30. <https://doi.org/10.1177/10732748231187836>

Brownson, R. C., Fielding, J. E., & Green, L. W. (2018). Building Capacity for Evidence-Based Public Health: Reconciling the Pulls of Practice and the Push of Research. *Annu Rev Public Health*, 39, 27-53. <https://doi.org/10.1146/annurev-publhealth-040617-014746>

Bruzeliuss, E., & Martins, S. S. (2022). US trends in drug overdose mortality among pregnant and postpartum persons, 2017-2020. *Jama*, 328(21), 2159-2161.

Bureau of Health Workforce, HRSA. (2025). *Designated Health Professional Shortage Areas Statistics, First Quarter of Fiscal Year 2025*. <https://data.hrsa.gov/default/generatehpsaquarterlyreport>

Burns, B., Le, L., Watson, K., & Richards, J. (2024). *Adult mentor: what works evidence accelerator. Summarizing Effective Strategies for MCH*. <https://www.mchevidence.org/documents/accelerators/Adult-Mentor-Evidence-Accelerator.pdf>

Center for Healthcare Quality and Payment Reform. (2024). *Rural hospitals at risk of closing (October 2024)*. [https://ruralhospitals.chqpr.org/downloads/Rural\\_Hospitals\\_at\\_Risk\\_of\\_Closing.pdf](https://ruralhospitals.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf)

Center for Reproductive Rights. (2024). *Kansas Abortion Providers Challenge New Law Forcing Them to Give Patient Information to the State* <https://reproductiverights.org/kansas-abortion-providers-challenge-new-law-forcing-them-give-patient-information-state/>

Centers for Disease Control and Prevention. (n.d.). Diagnosed Diabetes - Total, Adults Aged 18+ Years, Age-Adjusted Percentage, Kansas. Retrieved from: <https://gis.cdc.gov/grasp/diabetes/diabetesatlas-surveillance.html#>

Centers for Disease Control and Prevention. (2021). *High School YRBS: Kansas 2021 Results*. <https://nccd.cdc.gov/youthonline/app/Results.aspx?LID=KS>

Centers for Disease Control and Prevention. (2022). *Telemedicine use: household pulse survey*. <https://www.cdc.gov/nchs/covid19/pulse/telemedicine-use.htm>

Centers for Disease Control and Prevention. (2023a). *Maternal Infant Health – preterm birth*. <https://www.cdc.gov/maternal-infant-health/preterm-birth/index.html>

Centers for Disease Control and Prevention. (2023b). *PRAMS: Selected 2016 Through 2021 Maternal and Child Health (MCH) indicators*. <https://beta.cdc.gov/prams/php/data-research/mch-indicators-by-site.html>

Centers for Disease Control and Prevention. (2024a). *2022 Summary of Diagnostics Among Infants Not Passing Hearing Screening*. <https://archive.cdc.gov/#/details?url=https://www.cdc.gov/ncbddd/hearingloss/2022-data/06-diagnostics.html>

Centers for Disease Control and Prevention. (2024b). *2022 Summary of Early Intervention (EI) Among Infants Identified as Deaf or Hard of Hearing*. <https://archive.cdc.gov/#/details?url=https://www.cdc.gov/ncbddd/hearingloss/2022-data/09-early-Intervention.html>

Centers for Disease Control and Prevention. (2024c). *Behavioral Risk Factor Surveillance System*. <https://www.cdc.gov/brfss/index.html>

Centers for Disease Control and Prevention. (2024d). *National Immunization Surveys*. <https://www.cdc.gov/nis/php/hcp/index.html>

Centers for Disease Control and Prevention. (2024e). *National Vital Statistics System*. <https://www.cdc.gov/nchs/nvss/index.htm>

Centers for Disease Control and Prevention. (2024f). *NIS - Child breastfeeding rates by state: 2021*. <https://www.cdc.gov/breastfeeding-data/about/rates-by-state.html>

Centers for Disease Control and Prevention. (2024g). *Teen Births*. <https://www.cdc.gov/nchs/fastats/teen-births.htm>

Centers for Disease Control and Prevention. (2024h). *Youth Risk Behavior Survey: Data summary & trends report, 2013–2023*. <https://www.cdc.gov/yrbs/dstr/index.html>

Charlton, P., Doucet, S., Azar, R., Nagel, D. A., Boulos, L., Luke, A., Mears, K., Kelly, K. J., & Montelpare, W. J. (2019). The use of the environmental scan in health services delivery research: a scoping review protocol. *BMJ Open*, 9(9), e029805. <https://doi.org/10.1136/bmjopen-2019-029805>

Clochard, A., Killewald, P., Larson, A., Leith, W., Paxton, N., Troxel, J., & Wong, M. (2023). *Family Planning Annual Report: 2022 National Summary*.

Community Care Network of Kansas. (2024). *Member clinics*. <https://www.communitycareks.org/member-clinics/>

Connecticut State Department of Public Health. (2025). *Hear Her*. <https://portal.ct.gov/dph/family-health/hear-her/hear-her>

County Health Rankings. (2024). *Kansas: Food Environment Index*. Retrieved 11/13/2024 from <https://www.county-healthrankings.org/health-data/kansas?year=2024&measure=Food+Environment+Index>

Cover, R., Parker, L., Young, C., & Ostapets, K. (2024). Entertaining information: Third-party influencers' role in COVID-safety health communication. *Media International Australia*, 192(1), 150-164. <https://doi.org/10.1177/1329878x231158880>

Dagher, R. K., & Linares, D. E. (2022). A Critical Review on the Complex Interplay between Social Determinants of Health and Maternal and Infant Mortality. *Children (Basel)*, 9(3). <https://pmc.ncbi.nlm.nih.gov/articles/PMC8947729/>

Data.gov. (n.d.). *IDEA Section 618 Data Products: Static Tables Part C Exiting Table 1*. Retrieved from: <https://catalog.data.gov/dataset/idea-section-618-data-products-static-tables-part-c-exiting-table-1-e8080>

DHHS Office of Disease Prevention and Health Promotion. (n.d.-a). *Healthy People 2030: Social determinants of health*. <https://health.gov/healthypeople/priority-areas/social-determinants-health>

DHHS Office of Disease Prevention and Health Promotion. (n.d.-b). *Healthy People 2030 Leading Health Indicators*. <https://odphp.health.gov/healthypeople/objectives-and-data/leading-health-indicators>

Douglas-Hall, A., Kost, K., & Kavanaugh, M. L. (2017). *State-Level Estimates of Contraceptive Use in the United States, 2017 (Table 3)*. <https://www.guttmacher.org/report/state-level-estimates-contraceptive-use-us-2017>

Economic Policy Institute. (2018). *Income inequality in Kansas*. <https://www.epi.org/multimedia/un-equal-states-of-america/#/Kansas>

Estabrooks, P. A., Brownson, R. C., & Pronk, N. P. (2018). Dissemination and Implementation Science for Public Health Professionals: An Overview and Call to Action. *Prev Chronic Dis*, 15, E162. <https://doi.org/10.5888/pcd15.180525>

Federal Reserve Bank of St Louis. (2024). *Unemployment Rate in Kansas*. <https://fred.stlouisfed.org/series/KSURN>

Ferreira Caceres, M. M., Sosa, J. P., Lawrence, J. A., Sestacovschi, C., Tidd-Johnson, A., Rasool, M. H. U. I., Gadamedi, V. K., Ozair, S., Pandav, K., Cuevas-Lou, C., Parrish, M., Rodriguez, I., & Fernandez, J. P. (2022). The impact of misinformation on the COVID-19 pandemic. *AIMS Public Health*, 9(2), 262-277. <https://doi.org/10.3934/publichealth.2022018>

Fitzhugh Mullan Institute for Health Workforce Equity. (2024). *Behavioral Health Workforce Tracker*. <https://www.gwhwi.org/behavioralhealth-workforce-tracker-v20.html>

Ghandour, R. M., Hirai, A. H., & Kenney, M. K. (2022). Children and Youth With Special Health Care Needs: A Profile. *Pediatrics*, 149(Suppl 7). <https://doi.org/10.1542/peds.2021-056150D>

Governor's Substance Use Disorders Task Force. (2018). Governor's substance use disorders task force report. <https://kgi.contentdm.oclc.org/digital/api/collection/p16884coll3/id/456/download>

Greenberg, J., Apuzzio, J., Chaudhary, Z., Gittens-Williams, L., Martino, C., & Williams, S. (2023). Implementation of the Hear Her Campaign [ID: 1339546]. *Obstetrics & Gynecology*, 141(5S), 58S. <https://doi.org/10.1097/01.Aog.0000930496.14331.53>

Halkos, G. E., & Aslanidis, P.-S., C. (2023). Causes and measures of poverty, inequality, and social exclusion: a review. *Economies*, 11(4), 110.

Health Resources and Services Administration. (2024a). *Maternal & Child Health, III.B. Overview of the State - Kansas*. <https://mchb.twisdata.hrsa.gov/Narratives/Overview/b558a511-5f0b-405b-aa20-3f49ad6b71d8>

Health Resources and Services Administration. (2024b). National Survey of Children's Health. <https://www.childhealthdata.org/browse>

Health Resources and Services Administration. (2024c). *Reporting Domains: Child*. <https://mchb.tvisdata.hrsa.gov/PopulationDomain/Detail/ChildHealth>

Health Resources and Services Administration. (2025). Federally Available Data (FAD) Resource Document Page. <https://mchb.tvisdata.hrsa.gov/Home/FADDocuments>

Hron, J., von Esenwein, S. A., Samaddar, S., Sprague-Jones, J., & Counts, J. (2025). *United to Transform: Kansas Substance Use Disorder Needs Assessment*. Manuscript in preparation.

Hunt, D. C., & Panas, L. J. (2018). *A Changing Kansas: Implications for Health and Communities*. <https://kansashealth.org/wp-content/uploads/2018/06/KHF-KHI-Demographic-Report-060518.pdf>

Ikotun, A. M., Ezugwu, A. E., Abualigah, L., Abuhaija, B., & Heming, J. (2023). K-means clustering algorithms: A comprehensive review, variants analysis, and advances in the era of big data. *Information Sciences*, 622, 178-210.

Immunize Kansas Coalition. (2024). *Data Dashboard*. <https://www.immunizekansascoalition.org/datadash.asp>

Ismail, A. (2022). The role of the Kansas Early Detection Works Program in Closing the

Disparity Gap in Female Breast Cancer Screening Rates. *Kansas Health Statistics Report*(93), 1-6. <https://www.kdhe.ks.gov/DocumentCenter/View/27084/December-2022-PDF>

Georgetown University. *National Center for Education in Maternal and Child Health*. <https://www.ncemch.org/>

Johnson, J. (2024). Outmigration in Kansas threatens rural towns. *The Kansas State Collegian*. <https://kstatecollegian.com/2024/04/18/outmigration-in-kansas-threatens-rural-towns/>

Jones, K., & Salzman, G. A. (2020). The Vaping Epidemic in Adolescents. *Mo Med*, 117(1), 56-58.

Kansas Action for Children. (2022). *Addressing housing affordability in Kansas through equitable tax relief*. [https://www.kac.org/addressing\\_housing\\_affordability\\_in\\_kansas\\_through\\_equitable\\_property\\_tax\\_relief](https://www.kac.org/addressing_housing_affordability_in_kansas_through_equitable_property_tax_relief)

KSKansas Action for Children. (2023). *Percent of infants born with birth weight under 2,500 grams, by race of mother*. <https://datacenter.aecf.org/data/tables/10527-low-birth-weight-babies-by-race-of-mother#detailed/2/any/false/1095,1729,37,871,870/816,6574,2605,641,185,3/20249>

Kansas Breastfeeding Coalition, I. (2024). *State of Breastfeeding in Kansas 2024*. <https://ksbreastfeeding.org/wp-content/uploads/2024/10/stateofBFinKS2024-Oct-web.pdf>

Kansas Bureau of Investigation. (2022). *Domestic violence, stalking, and sexual assault in Kansas*. <https://www.kansas.gov/kbi/stats/docs/pdf/DVStalking%20Rape%202022.pdf>

Kansas Cancer Partnership. (2018). *State-based advocacy: Kansas Cancer Partnership* <https://canceradvocacy.org/wp-content/uploads/2018/06/CPAT2018-04b-State-Based-Advocacy-Kansas-Cancer-Partnership.pdf>

Kansas Children's Cabinet and Trust Fund. (2021). *Progress for Kindergarten Readiness in Kansas*. <https://kschildrenscabinet.org/progress-for-kindergarten-readiness-in-kansas/>

Kansas Children's Cabinet and Trust Fund. (2023). *Early Childhood Integrated Data System Distinct Count Dashboard* <https://kschildrenscabinet.org/ecids-dashboard>

Kansas Children’s Cabinet and Trust Fund. (2024a). *2024 Kansas Early Childhood System Needs Assessment*. <https://kschildrenscabinet.org/project/2024-needs-assessment/>

Kansas Children’s Cabinet and Trust Fund. (2024b). *All in for Kansas Kids: 2024 Early Childhood Strategic Plan*. <https://kschildrenscabinet.org/wp-content/uploads/2023/11/Strategic-Plan-2024.pdf>

Kansas Department of Health and Environment. (n.d.-a). *Community Health Workers*. <https://www.kdhe.ks.gov/1770/Community-Health-Workers>

Kansas Department of Health and Environment. (n.d.-b). *Kansas injury prevention program: Injury & violence prevention programs*. <https://www.kdhe.ks.gov/1209/Injury-Violence-Prevention-Programs>

Kansas Department of Health and Environment. (n.d.-c). *Pregnancy Maintenance Initiative*. <https://www.kdhe.ks.gov/654/Pregnancy-Maintenance-Initiative>

Kansas Department of Health and Environment. (n.d.-d). *Pregnancy Risk Assessment Monitoring System*. <https://www.kdhe.ks.gov/1416/Pregnancy-Risk-Assessment-Monitoring-Sys>

Kansas Department of Health and Environment. (2018). *Kansas state plan for systems of care for children and youth with special health care needs*. [https://www.kansasmch.org/documents/domains/CYSHCNStatePlan\\_FINAL\\_11.2018.pdf](https://www.kansasmch.org/documents/domains/CYSHCNStatePlan_FINAL_11.2018.pdf)

Kansas Department of Health and Environment. (2019). *Female breast cancer fact sheet*. <https://www.coronavirus.kdheks.gov/DocumentCenter/View/42689/Breast-Cancer-Fact-Sheet-2019-PDF?bidId=#:~:text=Age%2Dadjusted%20rate%20per%20100%2C000,per%20100%2C000%20females%20in%20Kansas.>

Kansas Department of Health and Environment. (2020a). *Kansas Title V Needs Assessment, Priorities and Action Plan 2021-2025* <https://www.kdhe.ks.gov/DocumentCenter/View/5215/MCH-2025-Statewide-Needs-Assessment-PDF>

Kansas Department of Health and Environment. (2020b). *Kansas Unintentional Injury Prevention Plan 2021-2025*. <https://www.kdhe.ks.gov/DocumentCenter/View/11367/Kansas-Unintentional-Injury-Prevention-Plan-2021-to-2025-PDF>

Kansas Department of Health and Environment. (2021b). *Kansas Pregnancy Risk Assessment Monitoring System (PRAMS) 2021 Surveillance Report*. <https://www.kdhe.ks.gov/ArchiveCenter/ViewFile/Item/2841>

Kansas Department of Health and Environment. (2021c). *Kansas Primary Care Needs Assessment*. <https://www.kdhe.ks.gov/DocumentCenter/View/21195/Kansas-Primary-Care-Needs-Assessment-2021-PDF>

Kansas Department of Health and Environment. (2022a). *Engaging Families and Consumer in Program Planning, Implementation, and Evaluation Toolkit* [https://www.kansasmch.org/documents/Domains/Cross-Cutting/KS%20Title%20V%20Family%20Engagement%20Toolkit\\_v2022.05.pdf](https://www.kansasmch.org/documents/Domains/Cross-Cutting/KS%20Title%20V%20Family%20Engagement%20Toolkit_v2022.05.pdf)

Kansas Department of Health and Environment. (2022b). *Health Risk Behaviors of Kansans: 2020 Kansas Behavioral Risk Factor Surveillance System*. <https://www.kdhe.ks.gov/DocumentCenter/View/15669/2020-Kansas-BRFSS-Report-PDF>

Kansas Department of Health and Environment. (2022c). *Healthy Kansans 2030: State Health Assessment & Improvement Plan*. <https://www.kdhe.ks.gov/201/State-Health-Assessment-Improvement-Plan>

Kansas Department of Health and Environment. (2022d). *Kansas adolescent and teenage pregnancy report, 2020*. <https://www.kdhe.ks.gov/DocumentCenter/View/23491/Research-Summary-Adolescent-and-Teenage-Pregnancies-Kansas-2020-PDF>

Kansas Department of Health and Environment. (2022e). *Kansas Oral Health Plan 2022-2027*. <https://www.astdd.org/www/docs/kansas-state-oral-health-plan-2022-2027.pdf> (not 2024c as cited elsewhere)

Kansas Department of Health and Environment. (2023a). *Health Professional Underserved Areas Report, 2022*. <https://www.kdhe.ks.gov/DocumentCenter/View/36122/2022-Health-Professional-Underserved-Areas-Report-UAR-PDF>

Kansas Department of Health and Environment. (2023b). *Kansas Annual Summary of Vital Statistics, 2022*. <https://kgi.contentdm.oclc.org/digital/collection/p16884coll4/id/3397/>

Kansas Department of Health and Environment. (2023c). *Kansas Cancer Partnership. Kansas Cancer Prevention and Control Plan: 2022-2027*. <https://www.kdhe.ks.gov/DocumentCenter/View/42196/2022-2027-Kansas-Cancer--Prevention-Control-Plan-PDF?bidId=>

Kansas Department of Health and Environment. (2023d). *Kansas Maternal Mortality Report, 2016-2020*. <https://kmmrc.org/wp-content/uploads/2024/10/KS-Maternal-Morbidity-Mortality-Report-2016-2020-202312-Final.pdf>

Kansas Department of Health and Environment. (2023e). *Teen Pregnancy Targeted Case Management Annual Program Report (SFY2023)*. <https://www.kdhe.ks.gov/DocumentCenter/View/5553/Teen-Pregnancy-Targeted-Case-Management-Report-PDF>

Kansas Department of Health and Environment. (2023f). *Youth Behavioral Risk Factor Surveillance System*. <https://www.kdhe.ks.gov/2225/Data-Dashboard>

Kansas Department of Health and Environment. (2023g). *Youth Vaping and Mental Health in Kansas*. <https://www.kdhe.ks.gov/DocumentCenter/View/9410/Youth-Vaping-and-Mental-Health-in-Kansas-PDF>

Kansas Department of Health and Environment. (2024a). *Kansas Connecting Communities: Improving maternal & child health outcomes by addressing perinatal behavioral health*. [https://www.kansasmch.org/documents/KCC%20Impact%20Paper\\_DIGITAL.pdf](https://www.kansasmch.org/documents/KCC%20Impact%20Paper_DIGITAL.pdf)

Kansas Department of Health and Environment. (2024b). *Kansas FY2025 Title V MCH Block Grant Program application*. <https://www.kdhe.ks.gov/626/Maternal-Child-Health-Block-Grant> (there is also a block grant under n.d.)

Kansas Department of Health and Environment. (2024c). *Kansas Violent Deaths: 2017-2021 Facts and Figures*. <https://www.kdhe.ks.gov/DocumentCenter/View/28763/KS-Violent-Deaths-2016-2020-Facts-and-Figures-PDF>

Kansas Department of Health and Environment. (2024d). *Mid-Course Review For the 2022-2027 Kansas Cancer Plan*. <https://www.kdhe.ks.gov/DocumentCenter/View/41501/Cancer-Plan-Report---Mid-Course-Review>

Kansas Department of Health and Environment. (2024e). *Overdose data dashboard*. <https://www.kdhe.ks.gov/1309/Overdose-Data-Dashboard>

Kansas Department of Health and Environment. (2025). *Kansas Pregnancy Risk Assessment Monitoring System (PRAMS) 2022 Surveillance Report*. <https://www.kdhe.ks.gov/DocumentCenter/View/47094/Kansas-PRAMS-Report-2022-PDF>

Kansas Department of Labor. (2024). *Workplace laws FAQs*. Kansas Department of Labor. <https://www.dol.ks.gov/employers/workplace-laws/workplace-laws-faqs>

Kansas Division of the Budget. (2024). *Kansas Certified Population (Certified to the Secretary of State by Division of the Budget on July 1, 2024)*. [https://budget.kansas.gov/wp-content/uploads/2023\\_Kansas\\_Certified\\_Population-07.01.2024.pdf](https://budget.kansas.gov/wp-content/uploads/2023_Kansas_Certified_Population-07.01.2024.pdf)

Kansas Health Institute. (2023a). *Annual Insurance Update 2023: Health Insurance in Kansas*. <https://www.khi.org/wp-content/uploads/2023/06/2023-Annual-Insurance-Update-1.pdf>

Kansas Health Institute. (2023b). *Health insurance in Kansas 2022*. Kansas Health Institute. <https://www.khi.org/articles/infographic-health-insurance-in-kansas-2022/>

Kansas Health Matters. (n.d.-a). Percent of Births Where Prenatal Care began in First Trimester. Retrieved from: <https://www.kansashealthmatters.org/indicators/index/view?indicatorId=1370&localeId=19>

Kansas Health Matters. (n.d.-b). *Population White (Not Hispanic or Latino), 2022*. Kansas Health Matters. <https://www.kansashealthmatters.org/indicators/index/view?indicatorId=6393&localeTypeId=2&periodId=246>

Kansas Historical Society. (2023). *Agriculture in Kansas*. <https://www.kshs.org/kansapedia/agriculture-in-kansas/14188>

Kansas Home Visiting. (2023). *Community Readiness Technical Report*. <https://kshomevisiting.org>

Kansas Housing Resources Corporation. (2021). *Kansas Statewide Housing Needs Assessment 2021*. <https://kshousing-corp.org/kansas-statewide-housing-needs-assessment-2021/>

Kansas Maternal and Child Health. (2024). *Kansas Connecting Communities*. <https://www.kansasmch.org/connecting-communities.asp>

Kansas State Child Death Review Board. (2024). *2024 Annual Report (2022 Data)*. <https://www.ag.ks.gov/home/showpublisheddocument/22812/638671013497030000>

Kansas State Department of Education. (2019). *Kansas Blue Ribbon Task Force on Bullying Final Report*. <https://www.ksde.org/Portals/0/ECSETS/Bullying%20Taskforce/BRTFB%20Final%2012%202%2019.pdf?ver=2019-12-10-150403-097>

Kansas University Institute for Policy and Social Research. (2023). *Population Density Classifications in Kansas by County, 2023*. <https://ksdata.ku.edu/ksdata/ksah/population/popden2.pdf>

KFF. (2024a). *The HPV vaccine: access and use in the U.S.* <https://www.kff.org/womens-health-policy/fact-sheet/the-hpv-vaccine-access-and-use-in-the-u-s/>

KFF. (2024b). *State health facts: poverty rate by race/ethnicity, 2022*. Retrieved August 30, 2024 from <https://www.kff.org/other/state-indicator/poverty-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

- Ko, J. Y., D'Angelo, D. V., Haight, S. C., Morrow, B., Cox, S., von Essen, B. S., Strahan, A. E., Harrison, L., Tevendale, H. D., Warner, L., Kroelinger, C. D., & Barfield, W. D. (2020). *Morbidity and Mortality Weekly Report: Prescription Opioid Pain Reliever Use During Pregnancy — 34 U.S. Jurisdictions, 2019*. <https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6928a1-H.pdf>
- Krawiec, R., McGuire, K., McInerney, J., & Malik, N. (2021). *Successful digital public health campaigns*. <https://www2.deloitte.com/us/en/insights/industry/public-sector/successful-digital-public-health-campaigns.html>
- Krogman, S. (2024). *KSKidsMAP Annual Report 2023-2024*, University of Kansas School of Medicine-Wichita. <https://www.kumc.edu/documents/wichita/psychiatry/KSKidsMAP/KSKidsMAP-Annual-Report2024.pdf>
- Layla's Got You. (n.d.) <https://laylasgotyou.com/>
- Mahmood, A., Kedia, S., Wyant, D. K., Ahn, S., & Bhuyan, S. S. (2019). Use of mobile health applications for health-promoting behavior among individuals with chronic medical conditions. *DIGITAL HEALTH*, 5, 2055207619882181. <https://doi.org/10.1177/2055207619882181>
- Mann, E. S., Johnson, C. L., & Chen, A. M. (2024). Medicaid-Insured Women's Perceptions of Obstetric Care Quality: Implications for Reproductive Health Equity in the United States. *Women's Reproductive Health*, 1–15. <https://doi.org/10.1080/23293691.2024.2377958>
- March of Dimes. (2024). *2024 March of Dimes Report Card for Kansas*. <https://www.marchofdimes.org/peristats/reports/kansas/report-card>
- Matheson, G. O., Pacione, C., Shultz, R. K., & Klügl, M. (2015). Leveraging Human-Centered Design in Chronic Disease Prevention. *American Journal of Preventive Medicine*, 48(4), 472-479. <https://doi.org/10.1016/j.amepre.2014.10.014>
- MAXQDA. (2024). MAXQDA. <https://www.maxqda.com/>
- Mejia, D. (2024). *Computer and Internet Use in the United States: 2021 (American Community Survey Reports)* <https://www2.census.gov/library/publications/2024/demo/acs-56.pdf>
- Mid-America Regional Council. (n.d.). *Community Health Workers*. <https://www.marc.org/health/community-health-workers>
- Molina, Y. S., A.; Rauscher, GH. (2015). Racial/Ethnic Disparities in Time to a Breast Cancer Diagnosis: The Mediating Effects of Health Care Facility Factors. *Medical Care*, 53, 872-878. <https://doi.org/10.1097/MLR.0000000000000417>
- Mortillaro, G. A., & Bonnevie, E. (2023). Mental Health in the Digital Space: Key Lessons From a Cross-Sector Approach. <https://jaacapconnect.org/article/92188-mental-health-in-the-digital-space-key-lessons-from-a-cross-sector-approach>
- Moukarzel, S., Rehm, M., Del Fresno, M., & Daly, A. J. (2020). Diffusing science through social networks: The case of breastfeeding communication on Twitter. *PloS one*, 15(8), e0237471.



Office of the Surgeon General. (2020). *STRATEGIES AND ACTIONS: IMPROVING MATERNAL HEALTH AND REDUCING MATERNAL MORTALITY AND MORBIDITY*. Washington (DC): US Department of Health and Human Services  
Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK568218/>

Osterman, M. J. K., Hamilton, B. E., Martin, J. A., Driscoll, A. K., & Valenzuela, C. P. (2024). Births: Final Data for 2022. *National Vital Statistics Reports*, 73. <https://www.cdc.gov/nchs/data/nvsr/nvsr73/nvsr73-02.pdf>

Pfeifer, J. D. (2023). *Kansas higher education policies and the impact on college access: A critical policy analysis*. Kansas State University.

Polacko, M. (2021). Causes and consequences of income inequality—an overview. *Statistics, Politics and Policy*, 12(2), 341-357.

Prenatal-to-3 Policy Impact Center. (2024). *2024 Prenatal-to-3 State Policy Roadmap*. <https://pn3policy.org/pn-3-state-policy-roadmap-2024/>

Prenatal-to-3 Policy Impact Center. (2024). *Community-based doulas policies across states*. [https://pn3policy.org/wp-content/uploads/2024/11/PN3-Snapshot\\_doulas\\_final.pdf](https://pn3policy.org/wp-content/uploads/2024/11/PN3-Snapshot_doulas_final.pdf)

Primm, K. M. Z., H; Hernandez, D.C.; Chang, S. (2022). A Contemporary Analysis of Racial and Ethnic Disparities in Diagnosis of Early-Stage Breast Cancer and Stage-Specific Survival by Molecular Subtype. *Cancer Epidemiology, Biomarkers & Prevention*, 31(6), 1185–1194. <https://doi.org/https://doi.org/10.1158/1055-9965.EPI-22-0020>

Probst, J. C., Barker, J. C., Enders, A., & Gardiner, A. (2018). Current State of Child Health in Rural America: How Context Shapes Children’s Health. *J Rural Health*, 34 (Suppl. 1). <https://pmc.ncbi.nlm.nih.gov/articles/PMC5373918/#R12>

ProCare Therapy. (2024). *The State of School Lunch Report: an analysis of America’s school lunches*. <https://www.procarethrapy.com/blog/the-state-of-school-lunch-report-an-analysis-of-americas-school-lunches/>

Reinert, M., Fritze, D., & Nguyen, T. (2022). *The State of Mental Health in America 2023*. <https://mhanational.org/sites/default/files/2023-State-of-Mental-Health-in-America-Report.pdf>

Rowe, N. (2023). *Kansas Home Visiting Alignment Progress Report (prepared for the Kansas Department of Health and Environment by the University of Kansas Center for Public Partnerships and Research)*. <https://kschildrenscabinet.org/wp-content/uploads/2023/04/Home-Visiting-Alignment-Cabinet-Progress-Report-4.15.2023.pdf>

Rural and Minority Health Research Center. (2016). *Current State of Child Health in Rural America: How Context Shapes Children’s Health*. [https://www.ruralhealthresearch.org/recaps/9?utm\\_source=chatgpt.com](https://www.ruralhealthresearch.org/recaps/9?utm_source=chatgpt.com)

Rural Health Information Hub. (2024). *Telehealth and Health Information Technology in Rural Healthcare*. <https://www.ruralhealthinfo.org/topics/telehealth-health-it#challenges-for-rural-communities>

Shato, T., Kepper, M. M., McLoughlin, G. M., Tabak, R. G., Glasgow, R. E., & Brownson, R. C. (2024). Designing for dissemination among public health and clinical practitioners in the USA. *J Clin Transl Sci*, 8(1), e8. <https://doi.org/10.1017/cts.2023.695>

Shelton, R. C., Cooper, B. R., & Stirman, S. W. (2018). The Sustainability of Evidence-Based Interventions and Practices in Public Health and Health Care. *Annu Rev Public Health*, 39, 55-76. <https://doi.org/10.1146/annurev-publhealth-040617-014731>

SIECUS. (2024). *Kansas State Profile: Kansas's State of Sex Ed*. <https://siecus.org/stateprofiles/kansas-state-profile-23/>

Steiner, P. (2021). *Census data reveal a changing Kansas*. Kansas Health Institute. <https://www.khi.org/articles/2021-2020-census-data-reveal-a-changing-kansas/>

Stringer-Reasor, E. M., Elkhany, A., Khoury, K., Simon, M.A., & Newman, L.A. (2021). Disparities in Breast Cancer Associated With African American Identity. *American Society of Clinical Oncology Educational Book*, 41. [https://doi.org/10.1200/EDBK\\_319929](https://doi.org/10.1200/EDBK_319929)

Substance Abuse and Mental Health Services Administration. (2025). *National Survey on Drug Use and Health*. <https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases/2023>

The Public Good Projects. (n.d.). PGP. <https://www.publicgoodprojects.org/>

Thompson, R., DeJong, K., & Lo, J. (2019). Marijuana Use in Pregnancy: A Review. *Obstet Gynecol Surv.*, 74(7), 415-428. <https://pmc.ncbi.nlm.nih.gov/articles/PMC7090387/>

Tilden, C. D., Kuhn, N., & Gillam, R. (2019). *Kansas infant-toddler services (Part C) needs assessment*. <https://www.kdhe.ks.gov/723/Infant-Toddler-Needs-Assessment>

Tobacco Free Kansas Coalition. (2021). *Kansas tobacco control strategic plan 2021-2025*. <https://tobaccofreekansas.org/wp-content/uploads/2021/11/KS-Strat-Plan-Narrative-FINAL-11-1-21.pdf>

Trussell, J., & Aiken, A. R. A. (2018). Comparing typical effectiveness of contraceptive methods. In D. Kowal, R. A. Hatcher, A. L. Nelson, J. Trussell, C. Cwiak, P. Cason, M. S. Policar, A. B. Edelman, A. R. A. Aiken, & J. M. Marrazzo (Eds.), *Contraceptive technology* (21st ed.). Ayer Company Publishers, Inc.

UNC Gillings School of Global Public Health. *National MCH Workforce Development Center*. <https://mchwdc.unc.edu/>

Uddin, J., & Fariha, T. (2024). Bridging the Gap: Expanding Telehealth Services to Address Rural Health Disparities.

United Methodist Health Ministry Fund. (2024, August 29, 2024). *Community Health Workers vital to care teams*. <https://healthfund.org/a/community-health-workers-vital-to-care-teams/>

United Way. (2023). *ALICE in Kansas: A study of financial hardship (2023 report)*. <https://www.unitedforalice.org/state-reports-mobile>

US Census Bureau. (2023a). *Gini index of income inequality*. [https://data.census.gov/table/ACSDT5Y2022.B19083?q=Gini&g=040XX00US20\\$0500000](https://data.census.gov/table/ACSDT5Y2022.B19083?q=Gini&g=040XX00US20$0500000)

US Census Bureau. (2023b). *Racial and ethnic diversity in the United States: 2010 Census and 2020 Census*. <https://www.census.gov/library/visualizations/interactive/racial-and-ethnic-diversity-in-the-united-states-2010-and-2020-census.html>

US Census Bureau. (2024a). *American Community Survey*. <https://www.census.gov/programs-surveys/acs>

US Census Bureau. (2024b). *County Population by Characteristics: 2020-2023 (Annual County and Puerto Rico Municipio Resident Population Estimates by Selected Age Groups and Sex: April 1, 2020 to July 1, 2023)*. Retrieved July 5, 2024 from <https://www.census.gov/data/tables/time-series/demo/popest/2020s-counties-detail.html>

- US Census Bureau. (2024c). *Demographic and Housing Estimates, ACS 5-Year Estimates Data Profile, Table DP05, 2022*. Retrieved August 12, 2024 from [https://data.census.gov/table/ACSDP5Y2022.DP05?q=DP05&g=040XX-00US20,20\\$0500000](https://data.census.gov/table/ACSDP5Y2022.DP05?q=DP05&g=040XX-00US20,20$0500000)
- US Census Bureau. (2024d). National Population by Characteristics: 2020-2023. <https://www.census.gov/data/tables/time-series/demo/popest/2020s-national-detail.html>
- US Census Bureau. (2024e). *Selected Economic Characteristics. American Community Survey, ACS 5-Year Estimates Data Profiles, Table DP03, 2022*. Retrieved August 12, 2024 from [https://data.census.gov/table/ACSDP5Y2022.DP03?q=D-P03&g=040XX00US20,20\\$0500000](https://data.census.gov/table/ACSDP5Y2022.DP03?q=D-P03&g=040XX00US20,20$0500000)
- US Census Bureau. (2024f). *Selected Social Characteristics in the United States, ACS 5-Year Estimates Data Profile, Table DP02, 2022*. Retrieved August 12, 2024 from [https://data.census.gov/table/ACSDP5Y2022.DP02?q=DP02&g=040XX-00US20,20\\$0500000](https://data.census.gov/table/ACSDP5Y2022.DP02?q=DP02&g=040XX-00US20,20$0500000)
- US Department of Agriculture. (2025). WIC: USDA's Special Supplemental Nutrition Program for Women, Infants, and Children. <https://www.fns.usda.gov/wic>
- US Department of Health and Human Services. (2021). *Confronting health misinformation: The U.S. Surgeon General's advisory on building a healthy information environment*. Retrieved from <https://www.hhs.gov/sites/default/files/surgeon-general-misinformation-advisory.pdf>
- Valerio, V. C., Downey, J., Sgaier, S. K., Callaghan, W. M., Hammer, B., & Smittenaar, P. (2023). Black-White disparities in maternal vulnerability and adverse pregnancy outcomes: an ecological population study in the United States, 2014&#x2013;2018. *The Lancet Regional Health – Americas*, 20. <https://doi.org/10.1016/j.lana.2023.100456>
- Vanderpool, R. C., Stradtman, L. R., & Brandt, H. M. (2019). Policy opportunities to increase HPV vaccination in rural communities. *Hum Vaccin Immunother*, 15(7-8), 1527-1532. <https://doi.org/10.1080/21645515.2018.1553475>
- von Esenwein, S. A., & Tilden, C. (2024). *Young Adult Vaping Study Assessment 2024*.
- von Esenwein, S. A., Tilden, C. D., Zhao, H., & Carrillo, P. (2024). *2024 Kansas Title X Needs Assessment*.
- Wang, C., & Burris, M. A. (1997). Photovoice: concept, methodology, and use for participatory needs assessment. *Health Education and Behavior*, 24(3), 369-387. <https://doi.org/10.1177/109019819702400309>
- Weis, K. L., & Alsup, A. (2025). *Access to obstetrical care in Kansas*. University of Kansas School of Nursing.
- Wichita State University. (2024). *2024 Kansas Community Health Worker Symposium*.
- Ziller, E., & Milkowski, C. (2020). A century later: Rural public health's enduring challenges and opportunities. *American journal of public health*, 110(11), 1678-1686.