2020 KANSAS HOME VISITING

Statewide Needs Assessment

Kansas Department of Health and Environment

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About CPPR

Our mission at the University of Kansas Center for Public Partnership and Research (CPPR) is to optimize the well-being of children, youth, and families by generating responsive solutions that improve practice, inform policy, and advance knowledge. CPPR works closely with national, state, and local agencies, nonprofit organizations, and private foundations to assist partners in solving complex social problems and evaluating the impact and effectiveness of those efforts. CPPR staff have experience and expertise in education, psychology, child welfare, substance use, behavioral health, maternal and child health, and early childhood systems.

We are committed to representing the data herein responsibly and equitably and we therefore make every effort to be transparent in that process. The content of this report was carried out for the Kansas Department of Health and Environment under the direction of Brooke Sisson. The primary authors were Pegah Naemi Jimenez, Ph.D, Heather Schrotberger, MA, and Gina Byrd-Stadler, MS. Eliza Bullock created the design.

EXECUTIVE SUMMARY

In Kansas, home visitation programs are a key component of our state's robust early childhood system. Kansas has an array of home visiting programs with diverse strategies and approaches and provides services in varied modes based on identified risk factors to support pregnant women and families with young children. This MIECHV Statewide Needs Assessment update will assist in providing a current understanding of the needs for home visiting services in Kansas.

*The **PURPOSE** of the **NEEDS ASSESSMENT UPDATE***

1

Identify Risk

Identify communities with concentrations of risk

2

Identify Quality & Capacity of Programs

Identify the quality and capacity of existing programs or initiatives for home visiting in the state

3

Understand Needs for Substance Use Abuse Services

Understand the state's resources and capacity for providing substance abuse treatment and counseling services to individuals in need of these services

4

Coordinate with Other Assessments

Coordinate and align with the following:

Title V Maternal Child and Health Block Grant Needs Assessment

Head Start Collaboration Strategic Planning and Needs Assessment

Community-based Child Abuse and Neglect Prevention (CBCAP) Needs Assessment

Part C Needs Assessment

The Kansas Early Childhood (PDG) Needs Assessment

Design

In collaboration with the Kansas Department of Health and Environment (KDHE), the University of Kansas Center for Public Partnerships and Research (CPPR) convened a committee of researchers to prepare the 2020 MIECHV Statewide Needs Assessment update. To meet the goals of the document, the needs assessment team engaged key stakeholders including KDHE staff, the Statewide Home Visiting Leadership Group, program leaders from home visiting organizations, representatives of other state agencies, and home visiting families. For over a year the needs assessment team collected and gathered information from multiple data sources, existing state and community needs assessment, Kansas MIECHV evaluations, and feedback from the leadership group and considered three main factors when evaluating home visiting programs in Kansas:

- gaps in the delivery of home visiting programs
- the extent to which home visiting programs meet the needs of families
- resource gaps in the successful delivery of home visiting programs, with measurable impact, in each of the identified high-need counties

What Was Learned

Home visiting has long been considered a vital program within the Kansas Early Childhood System and this MIECHV Statewide Needs Assessment further illuminates its significance within the broader state landscape. The findings and recommendations of this Needs Assessment are in alignment with the major findings of our state's comprehensive Early Childhood Needs Assessment (PDG Needs Assessment) conducted in 2019 through the federal

Preschool Development Grant and the resulting **All in for Kansas Kids** Strategic Plan. Based on the input of nearly 6100 stakeholders, providers, and community members from all 105 Kansas counties, the Strategic Plan outlines plans to align the early childhood care and education system at the state level, to improve coordination amongst early childhood providers and partners at the local level, increase equitable opportunities for Kansas families to access services, strengthen public-private collaboration, foster and sustain a strong early childhood workforce, and support high-quality early childhood care and education environments. There were several areas of alignment between this Needs Assessment and the **All in for Kansas Kids** Strategic Plan.

This MIECHV Assessment found that:

- Current investments in home visiting and the existing delivery of home visiting services positively impact Kansas families with young children, especially those in high-need counties, including current MIECHV home visiting counties, echoing the many bright spots conveyed in the PDG Needs Assessment.
- The positive impact of home visiting could be magnified by addressing key gaps and barriers for families served in home visiting programs, especially in high-need and geographically isolated communities. Doing so would align with the broader efforts to address equitable accessibility and availability across all early childhood care and education services and supports.
- While Kansas Home Visiting is an important partner in the Kansas Early Childhood System, opportunities for further alignment and coordination exist. Such findings echo and support efforts to increase coordination and alignment at both the state and local level across the comprehensive early childhood system.

SNAPSHOT of MIECHV NEEDS ASSESSMENT FINDINGS

1. Investments in home visiting positively impacts Kansas families with young children.
2. Addressing key gaps and barriers for families served in home visiting programs could magnify the positive impact of home visiting.
3. There are opportunities for further alignment and coordination.
4. High-need families struggle to access necessary services.

- High-need families, especially those impacted by substance use disorders and mental health needs, struggle to access services necessary for addressing these concerns, especially when coupled with other indicators of needs such as poverty and unemployment. Addressing this barrier would also address the broader need to increase access to basic supports and services for families with young children in across the state.

THE NUMBERS

82%

The percentage of Kansas children under 5 in poverty who are being served by home visiting services.

60%

The percentage of high-need counties that are meeting the needs of their children.

50%

The percentage of children under 5 in poverty whose needs are being met in each of the 20 identified high-need counties.

In addition to the key findings that aligned with findings from the PDG Needs Assessment, other important key findings were revealed from this MIECHV Statewide Needs Assessment capacity and quality assessment that further enhance our understanding of the findings in the PDG Needs Assessment. The MIECHV capacity assessment included the extent to which home visiting programs meet the needs of eligible families in Kansas—defined as children under 5 in poverty. The findings revealed that Kansas home visiting programs serve an estimated 81.9% of children under 5 in poverty and 60% of the identified high-need counties (12 out of the 20 counties) meet the needs of over 50% of children under 5 in poverty in their respective counties. It's important to note that this estimate speaks to the percentage of children who *can* be served by existing home visiting programs. This in an important distinction because who is currently served may not reflect all the children that should be served. Not all children served by Kansas home visiting programs may be under 5 and in poverty.

These findings provide the possibility of two opportunities:

- Expansion of Maternal Child and Health (MCH) Home Visiting services throughout the state to have a further reach of children and families who can be served.
- A strategic approach to data collection and impact to help understand the extent to which home visiting programs are meeting the needs of Kansas families and children and to help guide decision-making about funding and connection to more community resources and services.

This MIECHV Statewide Needs Assessment quality assessment also highlighted important findings regarding substance abuse disorder (SUD) and mental health services, home visiting services for indigenous communities in the state, and impacts related to COVID-19. First, a major barrier to SUD and mental health services is access. Addressing the needs of pregnant women and women with children requires that more SUD facilities with residential options and assistance with child care are made available. Medicaid expansion could help increase access to families without the financial resources to participate in these needed services. Second, although home visiting programs have the potential to have positive effects on Kansas tribal communities, it is important that home visiting programs consider ways to expand their services to be community driven and align with indigenous values. Finally, impacts of COVID-19 revealed the resilience of home visiting services in Kansas. Although providers and state leaders reported that COVID-19 exasperated families' need to basic essentials, mental health services, and access to technology, they also reported several positive impacts in the areas of retention, family engagement, and communication with their families and internal team members. Parents took a more active role in engaging with their children and communicated more with their home visitors even as they faced technology barriers.

SHORT TERM PRIORITIES

- Two identified high-need counties, Harper and Rawlins County, include home visiting programs (Early Head Start (EHS) and Attachment and Biomedical Catch-up (ABC) Intervention) that have eligibility requirements. Expansion of home visiting programs (e.g. MCH home visiting) that do not have specific eligibility requirements may provide a larger reach of serving families and children in need of home visiting services in those high-need counties.

- Two identified high-need counties, Crawford and Bourbon County, showed concentration of risk across all five risk domains (socioeconomic status, adverse perinatal outcome, substance use disorder, crime, and child maltreatment). A review of both home visiting programs and other community services and resources in those counties will help to ensure whether the appropriate services are available to families and children to meet their needs in all the identified risk domains.

- Although the following counties were not identified as high-need counties, Edwards, Kiowa, Comanche, Barber, and Kingman counties currently have no home visiting programs. There is an opportunity to expand home visiting services, like MCH home visiting, to these counties to meet the needs of children and families eligible for home visiting services.

- Several other counties not identified as high-need (e.g. Greenwood, Pratt, Rush, Wabaunsee, Ness, and Clark) only have one type of home visiting program available in the county (either EHS, ABC, or Healthy Families America (HFA)), which have specific eligibility requirements. Expansion of home visiting programs with no specific eligibility requirement (e.g. MCH home visiting or PAT) may help to reach more families and children of need of home visiting.

LONG TERM PRIORITIES

- Assure that efforts to strengthen the Kansas early childhood infrastructure and create greater systems alignment at state and local levels reflect a commitment to home visiting with the broader early childhood care and education (ECCE) system. Examples include opportunities identified in this needs assessment to create support systems for cross sector screening and referrals, fully realize the early childhood integrated data system, continue implementation of a common funding application, and set funding priorities.

- Develop a large-scale public awareness campaign to help Kansans know what home visiting is, what it is *not*, and why it is important for pregnant women and families with small children to be supported for a strong start in life. Engage the early childhood education community, K-12 system, and medical professionals statewide in helping to spread the message.

This Needs Assessment highlights the ways in which Kansas home visiting programs and its workforce across our urban, rural, and frontier communities are part of the rich continuum of the robust early childhood system in the state. With a statewide vision that all children and families thrive, as outlined in the **All in for Kansas Kids** strategic plan, Kansas home visiting can both maximize its impact and address its existing gaps and barriers while strengthening and contributing to the broader work of the Kansas early childhood system.

INTRODUCTION

This mandatory document is in compliance with section 50603 of the Bipartisan Budget Act of 2018 which requires states to conduct a statewide needs assessment since the first statutory mandate to complete a statewide needs assessment in 2010. Conducting this Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program Statewide Needs Assessment update (referred to as the MIECHV Statewide Needs Assessment update in this document) is a condition of receiving FY 2021 Title V Maternal and Child Health (MCH) Block Grant funding.

The purpose of this MIECHV Statewide Needs Assessment update is to: (1) identify communities with concentrations of risk; (2) identify the quality and capacity of existing programs or initiatives for early childhood home visiting in the state; (3) discuss the state's capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatments or services; and (4) coordinate and align with the Title V MCH Block Grant program needs assessment, strategic planning and needs assessments conducted in accordance with section 640(g)(1)(C) of the Head Start Act; and the inventory of current community-based programs and activities to prevent child abuse and neglect, under section 205(3) of Title II of Child Abuse Prevention and Treatment Act (CAPTA). In order to ensure that home visiting is part of a continuum of early childhood services within Kansas, to the extent possible and within existing time limits, this needs assessment has also been coordinated with the needs assessment and strategic plans of the Part C Needs Assessment, and the Kansas Early Childhood (PDG) Needs Assessment.

Kansas home visiting programs collaborate across multiple agencies on both the state and local levels to ensure effective home visiting and early childhood systems through the State Home Visiting Leadership Group. The mission of these stakeholders is *"to elevate and sustain the early childhood home visitation system, assuring lifelong benefits and values for all Kansas children and families."* Kansas home visiting programs are designed: (1) to strengthen and improve programs and activities carried out under Title V MCH Block Grant; (2) to improve coordination of services for communities with concentrations of risk; and (3) to identify and provide comprehensive services to guide families in the state on issues such as maternal child and health, child development and growth, positive parenting, school readiness, safe home environments, and learning.

This Needs Assessment is complementary and in alignment with our state's Kansas Early Childhood (PDG) Needs Assessment and All in For Kansas Kids Strategic Plan. Funded by the Preschool Development Grant to Kansas, the Strategic Plan highlights our robust early childhood system which includes the rich continuum of evidence-based home visitation models and its vibrant professional workforce across our urban, rural, and frontier communities. With a statewide vision in which all children and families thrive, this targeted Needs Assessment provides pathways for further aligning our early childhood system to maximize the impact home visitation has on outcomes for children and families.

IDENTIFYING COMMUNITIES & CONCENTRATIONS OF RISK

In collaboration with the Kansas Department of Health and Environment (KDHE), the University of Kansas Center for Public Partnerships and Research (CPPR) convened a committee of researchers to prepare the 2020 MIECHV Statewide Needs Assessment update. CPPR worked with various early childhood stakeholders in home visiting (e.g. state leaders, directors, program leaders) to help guide the data collection process and information included in the update.

TERMINOLOGY

High-need
Replaces "at-risk" when describing groups of people or communities that have a concentration of need necessary resource

Systemically Underserved Groups
Refers to general groups of people whose needs are based on being underserved or on having a lack of resources

In this Kansas MIECHV Statewide Needs Assessment update we use the terminology "high-need" in replace of "at-risk" when describing groups of people or communities. Researchers have previously discussed best practices regarding how and when to use the terminology "at-risk" (see Best, 2020 for a comprehensive guide on how and when to use "at-risk"). Although "at-risk" has practical usages, it is a term that lacks a uniform definition and often has a stigmatizing effect when applied to groups of people. As such we refer to general groups of people as "systemically underserved groups" to emphasize that their needs are based on being underserved or having a lack of resources. We also refer to communities within the state of Kansas as "high-need" to describe that these communities have a concentration of need for necessary resources.

Phase 1

To identify the communities—which we refer to as counties in this needs assessment update—and concentration of risk we utilized the Health Resources and Services Administration's (HRSA) simplified method, which included nationally available county-level data based on indices of risk in five domains: socioeconomic status, adverse perinatal outcomes, child maltreatment, crime, and substance use disorder. Each indicator within each domain aligns with the characteristics described in statue to identify counties within concentration of risk.[1] *Tables A.1-A.4 in Appendix A* summarizes each of the five risk domains, its corresponding indicators, and the data sources.

PHASE 1 RAW DATA TABLES

Table A.5	Raw data for socioeconomic status domain
Table A.6	Raw data for adverse perinatal outcomes domain
Table A.7	Raw data for substance use disorder domain
Table A.8	Raw data for crime and child maltreatment domains

Simplified Method Overview

Indicators were selected by HRSA and the Maternal and Child Health Bureau (MCHB) to align with statutorily-defined criteria to identify target counties. Issues such as data availability and reliability for county-level data were considered by HRSA/MCHB in selecting the final list of indicators. These indicators were then grouped into the five risk domains. For each indicator,[2] HRSA/MCHB provided the raw data *(Table A.5 shows raw data for socioeconomic status domain; Table A.7* shows raw data for substance use disorder domain; *Table A.6* shows raw data for adverse perinatal outcomes domain; *Table A.8* shows raw data for crime and child maltreatment domains—all tables are located in *Appendix A*),

descriptive statistics (e.g. means, standard deviations, missing data etc.; see *Tables A.9-A.12 in Appendix A* for these statistics), and standardized indicator values (z-scores) for each county. At least half of the indicators within at least two domains needed to have z-scores greater than or equal to one standard deviation higher than the mean of all counties in the state in order to be considered a high-need county.

Findings of Identified High-need Counties with Concentration of Risk

Based on the data and simplified method provided by HRSA, 20 counties emerged as high-need in Kansas. *Figure 1* shows where each of the 20 high-need counties are located within the state. *Table 1* lists all of the Kansas high-need counties with the risk domains identified for each.

Figure 1
Kansas Counties Identified as High-need

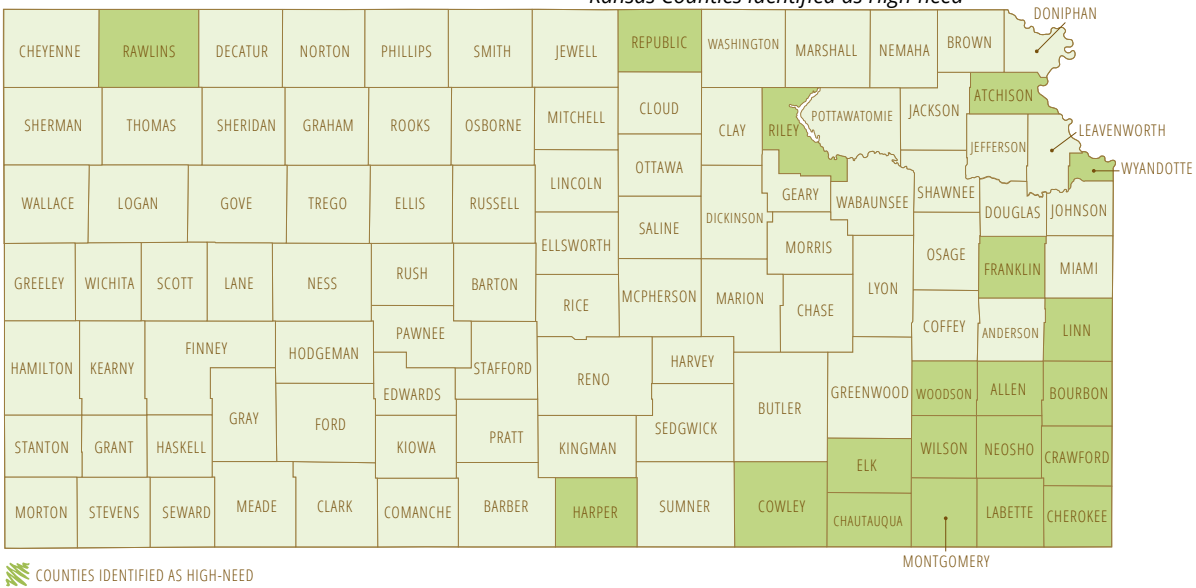


Table 1

High-Need Counties and the Risk Domains for Each

Risk Domain Key

- CURRENT MIECHV COUNTY
- SOCIOECONOMIC STATUS
- ADVERSE PERINATAL
- SUBSTANCE USE DISORDER
- CRIME
- CHILD MALTREATMENT

County	*Risk Domains*
Allen	
Atchison	
Bourbon	
Chautauqua	
Cherokee	
Cowley	
Crawford	
Elk	
Franklin	
Harper	
Labette	
Linn	
Montgomery	
Neosho	
Rawlins	
Republic	
Riley	
Wilson	
Woodson	
Wyandotte	

Currently, MIECHV home visiting programs exist in six of the counties that were identified as high-need in this MIECHV Statewide Needs Assessment update. Those counties are Cherokee, Labette, Montgomery, Neosho, Wilson, and Wyandotte. Each of the 20 counties varied on their concentration of risk domain; there was no common domain across all the counties and all the domains appeared for at least one of the high-need counties. For two of the counties, Bourbon and Crawford, their concentration of risk was across all five risk domains. The next section will take a deeper look at each of the concentrations of risk domains including how the identified high-need counties compared to the other counties in the state, and how the current MIECHV counties compared to other counties in the state.

Socioeconomic Status (SES) Domain

The raw data for this domain is shown in *Table A.1* (*see Appendix A*). There are two key takeaways for the SES domain, (1) among the 20 high-need counties, the current six MIECHV home visiting counties have the highest concentration of poverty and unemployment rates compared to the rest of the counties in the state; and (2) the 20 high-need counties (including the current MIECHV home visiting counties) fall within the same range as the majority of Kansas counties for both the high school dropout and income inequality indicators.

Poverty Indicator

The percent of the population that falls below 100% of the federal poverty level (FPL) ranges from 10.5% to 20.4% across the 20 high-need counties. Across the rest of the state, 60% of Kansas counties also fall within this range, while the remaining 20.9% of counties fall below this range. This shows that the majority of Kansas counties (approximately 80%) fall between the range of the 10.5% to 20.4% of the population who live below 100% FPL. A closer look at the current MIECHV counties shows that the percent of the population that falls below 100% FPL ranges from 15.3% – 18.4%. In comparison to the rest of the state, the majority of the counties (83.8%) fall below this range identified for the MIECHV counties, indicating that the current MIECHV counties include the highest concentrations of the population living under 100% FPL.

The majority of Kansas counties fall between the range of the 10.5% to 20.4% of the population who live below 100% federal poverty level.

Unemployment Indicator

The data shows that 93% of the counties in Kansas have an unemployment rate between 2.3% – 5.9%, thus indicating that most of Kansas has a similar unemployment rate as the 20 identified high-need counties. The current MIECHV counties fall within a slightly higher percentage of unemployment, 3.9% - 5.2% along with about 16.2% of other counties. In this respect, most of the other counties (77.1%) fall below this range of unemployment, indicating again, that the current MIECHV home visiting counties have the highest concentration of unemployment rates in the state.

High School Dropout Indicator

The data shows that the percent of 15 to 19-year-old people not enrolled in school and who have no high school diploma falls within a range of 0% - 19.5% across the 20 high-need counties. Most Kansas counties (96.2%) also fall within this range of high school dropout rates. A closer look at the current MIECHV home visiting counties shows that these counties range between 1.3% - 9.0%, and that 55.3% of other counties also fall within this range. Thus, it appears that like many other counties in Kansas, the 20 high-need counties which includes those that are current MIECHV home visiting counties, have a similar concentration of high school dropout rates as most counties in Kansas.

Inequality

Similar to the previous indicator, the Gini Coefficient—a statistical measure of distribution often used to gauge economic inequality—all counties in Kansas, except for Wabaunsee, fall within the range of 0.4 – 0.5 indicating a big income gap. Wabaunsee has an index of 0.3 indicating adequate equality. Thus, the 20 high-need counties including the current MIECHV counties similarly show a big income gap compared to the rest of the state.

Adverse Perinatal Outcomes Domain

The raw data for this domain is shown in *Table A.6 in Appendix A.* For both the preterm birth and low birth rate indicators, the 20 high-need counties, including the current MIECHV home visiting counties, compare similarly to the majority of counties in Kansas (85.9% of counties fall within 6.8% - 13.9% of live births at less than 37 weeks, which is the same range found for the 20 high-need counties; 84.1% of counties falls within 5.1% - 9.1% of live births less than 2500g, which is the same range found for the high-need counties). The current MIECHV home visiting counties fall between 7.6% - 11.0% and 6.7% – 8.5% for preterm birth and low birth rates, respectively. Most Kansas counties (64.1% including the current MIECHV home visiting counties) fall within the same preterm birth range. For low birth rate, a total percentage of 45.4% of counties fall within the range found for MIECHV home visiting counties, while only a slightly higher percentage of counties (46.6%) fall below the range found for MIECHV home visiting counties. Although this may suggest that the MIECHV counties fall within a concentrated range of risk for the low birth weight rate, the data shows nearly equal percentages of counties that fall within the range and below the range that was found for MIECHV home visiting counties.

Substance Abuse Disorder Domain

The raw data for this domain is shown in *Table A.3 in Appendix A*. For each of the five indicators, a majority of counties fell within the prevalence rate range found for the 20 high-need counties. The needs assessment team compared the prevalence rates of the MIECHV home visiting counties to that of the other 14 high-need counties for a more nuanced look. This showed that for alcohol, marijuana, illicit drugs, and pain relievers substance abuse disorder indicators, the concentration of risk was highest for the six MIECHV home visiting counties with the prevalence rates for these four indicators higher than the other 14 high-need counties. Approximately, 83.3% of the MIECHV home visiting counties ranked in the higher ranges of prevalence use for the four substance abuse indicators, whereas only about 50-70% of the other high-need counties fell within the same prevalence rates across these indicators. For cocaine use, the concentration of risk was similar between the MIECHV home visiting counties and the other 14 high-need counties, indicating that their prevalence rate for cocaine use was similar, and similar to the rest of the counties in the state.

Crime and Child Maltreatment Domains

The raw data for both these domains is shown in *Table A.4* in *Appendix A*. For the crime reports indicator, although the data shows that 85.3% of Kansas counties—including the 20 high-needs counties—have crime report rates that fall between the range of 7.9 – 53.1 per 1000 residents, the concentration of risk is highest for the current six MIECHV home visiting counties showing a crime report rate range of 19.3 – 53.1 per 1000 residents. Only about 40% of Kansas counties, including the MIECHV home visiting counties, have crime rates within this range, with the remainder of Kansas counties falling below this crime reports range. However, for both the juvenile arrests and child maltreatment indicators, most Kansas counties, including the 20 high-need counties, fall within the same range (76.1% of counties fall within a range of 41.8 – 2845.4 arrest per 100,000 people aged 0-17 years; 95.2% of counties fall within a range of 0.3 – 13.1 maltreatment victims per 1000). These percentages were similar for the ranges found for the current MIECHV home visiting counties showing that most counties have a similar concentration of risk as the 20 high-need counties.

Phase 1 KEY FINDINGS & RECOMMENDATIONS

Key Findings

- Twenty counties in Kansas were identified as high-need counties using HRSA's simplified method and data.
- Of those 20 counties, the current six MIECHV home visiting counties—Cherokee, Labette, Montgomery, Neosho, Wilson, and Wyandotte—were also identified as among the high-need counties in the state.
- The data from each risk domain showed that the current MIECHV home visiting counties had the highest risk concentration on the following risk indicators: poverty, unemployment, alcohol use, marijuana use, illicit drug use, pain reliever use, and crime reports. For all other indicators, the 20 high-need counties, including the current MIECHV home visiting counties, fell within similar concentration of risk ranges as most counties in the state.

Recommendations

- Provide targeted services addressing specific risk indicators which the data showed to be in high concentration for current MIECHV home visiting counties.
- Review each identified 20 high-need counties and their corresponding risk domains to provide services that may target those risk domain areas.

Phase 2

Additional Vulnerable Communities in Kansas

For this MIECHV Statewide Needs Assessment update, it is important to discuss the influence of home visiting programs on Kansas indigenous communities. The simplified method used to identify the 20 high-need counties in Kansas is not an appropriate methodology to identify and describe the risk factors in indigenous communities. In this section, the needs assessment team discusses a brief background of the federally-recognized tribes in Kansas, and how aligning and assessing statutory criteria to determine risk factors in Kansas tribes is not the best approach to identify that indigenous communities in Kansas can benefit from home visiting programs. The needs assessment team makes the argument that home visiting programs have the potential to meet the needs of Kansas tribes and provides qualitative support in Identifying Quality and Capacity of Existing Programs of this needs assessment update to describe the impact that home visiting has had on Kansas indigenous communities.

Background

Home visiting can be an effective model for delivering early childhood and family supports in indigenous communities. Federal agencies like the Administration for Children and Families (ACF) and the Substance Abuse and Mental Health Services Administration (SAMHSA) have recognized this through their funding of tribal home visiting programs. However, to be truly effective, home visiting program models require intentional adaptations and integrative strategies rooted in indigenous values and intergenerational practices that are developed by and for indigenous communities themselves. Assessing early childhood and maternal-infant needs in these communities also requires a thorough recognition of the historical traumas inflicted on generations of indigenous families and a commitment to interrogating "traditional" Western assessment practices that have so often silenced and devalued indigenous family structures, livelihoods, and perspectives.

Today, four federally-recognized tribes call Kansas lands home: the Prairie Band Potawatomi Nation, the Kickapoo Tribe in Kansas, the Iowa Tribe of Kansas and Nebraska, and the Sac and Fox Nation of Missouri in Kansas and Nebraska. These tribal nations operate under sovereign terms with state and federal governments, providing services and programs for their tribal members on their reservation lands and maintaining their own population and community data systems as best fit their needs. For state and federal initiatives, this means that standardized methods of determining systemically-underserved population counts and assessing needs for tribal nations is fraught with historical, structural, and jurisdictional tensions—especially for indigenous groups living on reservation lands.

Data (Mis)representation in Indigenous Communities

According to the U.S. Census Bureau, "Data indicate American Indians and Alaskan Natives Alone or in Combination living on Indian reservations have much higher net undercounts than those living elsewhere in the country" (O'Hare, 2019, p. 103). The Census Bureau identifies "hard-to-count (HTC) characteristics" (such as high poverty and unemployment rates, non-Western housing systems, and low levels of literacy) as contributing factors to the high undercount and omission rates of American Indian and Alaska Native (AIAN) groups living on reservations. In the 2010 Census, the net undercount rate for American Indians and Alaskan Natives Alone or in Combination living on reservations was 4.9%, while the omissions rate for the same group was 13.7% (O'Hare, 2019, p. 103). Similarly, the Census Bureau's National Advisory Committee recognizes that barriers to indigenous population counts are created by Census considerations of citizenship. At its Spring 2018 meeting, the Committee reported that some indigenous individuals "would not identify as being citizens of the United States, because they feel they are citizens of their tribal nation" (O'Hare, 2019, p. 107).

Structural and systemic challenges to recognizing indigenous populations as they choose under their sovereign rights are critically important for state home visiting programs and early childhood leaders to understand. Historically, indigenous groups have been resistant to state and national data collection efforts, recognizing that "providing demographic

information could be dangerous for a variety of reasons...[including being] used to assess the military capabilities of Native American groups, disclose illegal cultural practices...[and to] help locate suspected criminals or highlight children who could be forced to attend residential schools" (Hoy, 2015, p. 742-3). Thus, tribes have a vested interest in protecting their communities through their sovereign data practices such as self-determination of identifying characteristics and tribal enrollments. Mainstream methods for determining "need" may not be useful or appropriate for indigenous communities, requiring that state and program leaders develop meaningful and ongoing partnerships with tribal leaders to repair harm and restore trust.

This is especially true of past national home visiting efforts. Novins et al note that "while strong research evidence has indicated that home visiting is an effective intervention strategy for improving outcomes for vulnerable families, less is known about the benefit of these services specifically in tribal settings. Applicability of the research evidence on home visitation to services in tribal communities is subject to similar concerns facing other evidence-based health and human services interventions, including the limited participation of tribal people in the research that was conducted to develop these interventions and establish their effectiveness as well as the unique geographic, historical, cultural, infrastructural, socioeconomic, and epidemiologic circumstances of tribal communities" (Novins et all, 2018, p. 261). Still, many tribes have recognized the value and potential of home visiting programs to support child and family needs.

Value and Potential of Home Visiting Programs in Kansas Tribes

Home visiting can help meet the holistic needs of indigenous families and children through targeted early childhood developmental practices rooted in culture, language, and community. Effective indigenous home visiting models can provide collaborative strategies for tribal leaders to meet their families where they live, work, and play, and elevate family voice through meaningful partnerships between caregivers and home visitors. Finally, home visiting programs offer a critical way for historically and systemically oppressed indigenous communities to connect with a broad network of services and supports while challenging the inherent norms of such services to better meet the needs of indigenous children and families. In the following section, the needs assessment team will discuss the quality of home visiting programs in Kansas tribes.

Phase 2 ***KEY FINDINGS & RECOMMENDATIONS***

Key Findings

- Standardized mainstream methods of determining systemically-underserved population counts and assessing needs for tribal nations may not be useful or appropriate methods to understand needs of indigenous communities.
- Indicators commonly used to identify systemically-underserved communities (e.g. poverty and unemployment rates) are contributing factors to the high undercount and omission rates of American Indian and Alaska Native (AIAN) groups living on reservations.
- Home visiting can be an effective model for delivering early childhood and family supports in indigenous communities given that the curriculum and delivery methods are centered around indigenous culture and community.

Recommendations

- State and home visiting program leaders should develop meaningful and ongoing partnerships with tribal leaders to continue to build meaningful relationships with indigenous communities.
- Assessing early childhood and maternal-infant needs in these communities requires methodologies that include indigenous family structures, livelihoods, and perspectives.

QUALITY AND CAPACITY OF EXISTING PROGRAMS

The needs assessment team used a multi-method approach to assess the quality and capacity of existing home visiting programs in the state. The approach included both quantitative and qualitative methods to determine the capacity of home visiting services and to better understand the number of families and children who may need services but are not receiving them. Data were gathered at the state and county levels. The needs assessment team used existing data and collected new data specifically for capacity assessment at the county level. For the purposes of this needs assessment, "early childhood home visiting programs" or "home visiting programs" were defined as any programs that utilize home visiting as a primary intervention strategy for providing services to pregnant people and/or children from birth to kindergarten entry.

Data Sources Used for Assessing Quality and Capacity of Existing Home Visiting Programs

A brief summary of existing and new data sources used in this needs assessment to assess quality and capacity of the existing programs or initiative for home visiting programs in the state.

Reported in this Section

1. ***Data Sources***
2. ***Capacity Assessment***
3. ***Quality Assessment***

Capacity Assessment

- Method for Assessing Capacity of Existing Home Visiting Programs
- Findings from the Capacity Data
  In this section the needs assessment team reports the following:
  - » Primary funding sources and total funding received in Fiscal Year (FY) 2018 and MIECHV funding received in FY19.
  - » Statewide capacity numbers for each of the key home visiting programs in Kansas
  - » Statewide demographic information for the key home visiting program in Kansas, which discusses the number and types of individuals and families who ware receiving services under home visiting programs and initiatives
  - » Home visiting capacity findings by high-need counties, which includes the numbers of families and children served for each of the high-need counties (report of all counties is also included) aggregated across all home visiting programs in Kansas.
- Assessment of need in the state, which discusses the extent to which programs are meeting the needs of eligible families.

Quality Assessment

- Method for assessing quality of the existing home visiting programs
- Findings from the Quality Assessment — In this section the needs assessment team reports:
  - » Quality of existing home visiting programs
  - » Gaps in the delivery of early childhood home visiting services
  - » Extent to which home visiting services meet the needs of families in Kansas
  - » Gaps in staffing, community resources, and other requirements for delivering evidence-based home visiting services in high-need counties
  - » Impact of COVID-19 on Home Visiting Services
  - » Quality of home visiting programs in Kansas Tribes

Data Sources used for Assessing Quality and Capacity of Existing Home Visiting Programs

Existing Data Sources

Title V Maternal and Child Health (MCH) Block Grant Needs Assessment

KDHE is a recipient of the Title V MCH Services Block Grant Program funds. They are required to complete a statewide needs assessment every five years to identify need for (1) prevention and primary care services for pregnant women, mothers, and infants up to age one; (2) prevention and primary care services for children, and; (3) services for children with special health care needs. Kansas' five-year needs assessment covering the years 2016 to 2020 was completed at the same time as this MIECHV Statewide Needs Assessment. In a joint effort to best understand the needs of pregnant women, mothers, and families with small children within Kansas' home visiting programs, we reviewed data from the Title V MCH Block Grant needs assessment to inform this MIECHV Statewide Needs Assessment update.

Head Start Collaboration Strategic Planning and Needs Assessment

In accordance with the Administration of Children and Families federal grant requirements, the Kansas Head Start (HS) Collaboration Office conducts an annual needs assessment to identify the gaps in collaboration among HS and Early Head Start (EHS) agencies, their partners, and other service providers. The purpose is to describe community strengths, needs, and resources within the priority areas of children experiencing homelessness and disabilities, child welfare and state child care systems, child care, family literacy, health care, community services, professional development systems, and partnership/coordination with state systems. The results were used to create a five-year strategic plan that defines how the Kansas Head Start Collaboration Office (KHSCO) will support HS programs in the key areas identified from the needs assessment. The assessments were completed between 2016 – 2018 through online surveys that featured several open-ended questions. HS also conducted a series of focus groups in 2018 which included program directors. While not every program includes a home-based EHS option, those which are center-based or child care partnerships still interact with the home visiting systems in their communities and offer a valuable perspective.

Community-based Child Abuse and Neglect Prevention (CBCAP) Needs Assessments

The 2019 Kansas Prevention Investments Annual Report highlights the array of programs supported across the state by federal Community Based Child Abuse Prevention (CBCAP) funding, many of which include home visiting components. Coupled with individual needs assessments of the current seven grantees, it illustrates the experiences of providers in regions most at risk for child abuse and neglect. Home visitors in these programs often have an extraordinary perspective, as grantees are selected based on innovative interventions designed for a community's unique needs.

Kansas Home Visiting Capacity Data via the Data Application and Integration Solutions for the Early Years (DAISEY)

DAISEY is a shared measurement system designed to help communities see the difference they are making in the lives of children, youth, and families. Implementation of DAISEY allow KDHE Bureau of Family and Health and their grantees to improve data quality, track progress of shared goal, and enhance communication and collaboration. All current MIECHV home visiting programs use DAISEY to assess home visiting benchmark performance and capacity data. Data is reported for FY '19 for both MCH home visiting capacity numbers by county and Team for Infants Endangered by Substance Abuse (TIES) capacity numbers by county.

Part C Needs Assessment – Community-level data for Infant Toddler Services

The Part C Needs Assessment update included data across State Fiscal Years (SFY) from 2017 – 2019 and identified strengths and priority needs of the tiny-k programs in the state. Part C Needs Assessment reviewed the capacity of the current system, screening and service delivery practices, and family and community experiences with the tiny-k programs. The 2019 Kansas Infant Toddler Services (Part C) Needs Assessment, while not directly addressing the eight home visiting programs, also provides additional context for understanding the quality and reach of home visiting programs in the state.

Kansas Early Childhood Needs Assessment (PDG Needs Assessment)

This needs assessment was a comprehensive review of specific needs and issues Kansas families face. It specifically described current early childhood care and education (ECCE) systems in the state, informed the availability of connected, coordinated, and accessible ECCE services across the state, and was used to inform and provide rationale for an actionable state strategic plan. Home visiting is one of many ECCE systems and as such this needs assessment was used to help provide us with a broad sense of the impact and infrastructure of the ECCE systems in Kansas.

Parent Experiences of Home Visiting – MIECHV Formula Year 2018 and Innovation Evaluations

CPPR coordinated and collaborated with KDHE to conduct several different evaluation projects. Some of these evaluations studied different perceptions and experiences of families regarding home visiting practices, their relationships with their home visitors, and their experiences with access to services. We included what we learned from those evaluations in this MIECHV Statewide Needs Assessment update to capture some parent voice regarding their experiences with home visiting services in Kansas.

New Data Sources

State- and Community-level Surveys

The directors and program leaders of evidence-based and non evidence-based home visiting programs were contacted via email to provide data about their programs, including numbers of families and children served, waiting list status, open slot status, referral information, funding sources, and demographic information of families served. In some instances, statewide directors were only able to share statewide data for their programs, thus, the needs assessment team contacted each program individually and asked them to complete a Qualtrics survey to gather their programs' capacity data. In both the email and survey methods of collecting this information, the needs assessment team included open-ended questions for the directors and program leaders to share their thoughts about bright spots, challenges, and gaps pertaining to home visiting services in the state. Data were collected from the following eight key home visiting programs in Kansas: Early Head Start (EHS), Parents as Teachers (PAT), Healthy Families America (HFA), Team for Infants Endangered by Substance Abuse (TIES), Nurse Family Partnerships (NFP), Infant Toddler Services (tiny-k), Maternal Child Health (MCH) home visiting, and Attachment and Biobehavioral Catch-up (ABC) Intervention. Emails and Qualtrics surveys asked all the same questions and sought to gather county level information where available.

State-Level Surveys-Impacts of COVID-19

Like many other states, the COVID-19 pandemic has impacted the process of providing effective home visiting services to families in the state of Kansas. The needs assessment team distributed a survey, which included open-ended questions, via Qualtrics to home visiting state program leaders and program supervisors. The purpose of the survey was to understand their perspectives of the impacts of the pandemic on their home visiting programs. Particularly we were interested in bright spots, challenges, and what changes they were able (or unable) to make as they worked to continue to provide home visiting services to families.

Provider and Community Surveys from Title V MCH Block Grant Activities

As part of our efforts to align this MIECHV Statewide Needs Assessment with the Title V MCH Block Grant Needs Assessment, the needs assessment team included newly collected data from the 2020 Title V MCH Block Grant Needs Assessment that was specific to home visiting, pregnant women, or families with young children. Below are the two data sources we included for this MIECHV Statewide Needs Assessment update:

MCH Provider Self Reflection Survey – Home Visitor responses

- The National Family Support Network offers a staff self-reflection checklist consisting of 15 self-reflection items that were designed for MCH staff to use as a daily reminder to carry out day-to-day work in a manner consistent with the quality standards. With permission of the National Family Support Network, CPPR adapted the self-reflection checklist to an online version of the tool in Qualtrics to summarize and analyze aggregate results across Kansas. The 15 items are first-person statements which the respondents rated on a five-point Likert-type scale from "strongly disagree" to "strongly agree." MCH-funded staff at all Kansas MCH programs were encouraged to complete the self-reflection in October 2019. All MCH program directors/coordinators were contacted via email by CPPR staff and asked to disseminate the Qualtrics self-assessment web link to all program staff. Only results from home visitor respondents were analyzed and reported for this MIECHV Statewide Needs Assessment.

MCH Regional Open House – MIECHV home visiting services

- In January 2020 CPPR hosted six regional open houses across Kansas in Lawrence, Salina, Hays, Chanute, Hutchinson, and Garden City. Open houses were held in public spaces (e.g. libraries) to encourage participation by members of the community. The events were approximately two hours long. Each open house had stations

that asked for input about issues impacting the health of women, infants, and children. Specifically, there were stations about workforce adequacy/availability, home visiting programs, MCH performance (Kansas data on National Performance Measures and Outcomes Measures), a prioritization exercise where participants created a budget by allocating resources to various topics, and an opportunity to provide open-ended comments about bright spots, challenges, and ideas to enhance the health of women, infants, and children in the state. In addition to members of the public, MCH staff from many programs around the state participated in the open houses. At each event there was a series of stations to inform and educate participants, and to seek feedback/input. For the purposes of this MIECHV Statewide Needs Assessment, there was a station that asked about participants awareness and use of MIECHV home visiting services. The data from this specific station was synthesized to inform this needs assessment.

- For the MIECHV station, there were a total of 89 respondents (out of 135 total participants) of which 46 identified as service providers (43 members of the public comprised the remainder of the respondents).

Capacity Assessment

Method for Assessing Capacity of Existing Home Visiting Programs

To assess capacity of existing home visiting programs, the needs assessment team used quantitative methods. The methodology for each of these is described below:

Home visiting funding data The needs assessment team requested statewide primary funding sources and total funding received from the State Home Visiting Leaders via email and phone. Total funding received was reported for FY18 and MIECHV funding received—data for MIECHV funding collected from KDHE's Home Visiting Program Manager—was reported for FY19.

Statewide capacity data for each of the key home visiting programs in Kansas The needs assessment team contacted the State Home Visiting Leaders of the key evidence-based and non evidence-based home visiting programs in Kansas via email or phone and asked them to provide statewide data for the most recent Fiscal Year they had data to report. Each leader submitted data by either responding directly to the email or a phone call, attaching an annual report (see Reference section for a complete list of reports submitted), or the needs assessment team pulled the data from the DAISEY data system (specifically for reporting MCH and TIES capacity numbers). The data that was available or reported for each of the home visiting models varied. All programs reported number of children served and type of funding source, and most, excluding Infant Toddler Services, reported number of families served for Fiscal Year 2019. Some programs had some data to report referral data—number of referrals sent and received, open slot status—how many slots of families or children the program is funded to serve—waitlist data, and demographic information of the families served. Additionally, each leader was asked to report their perceptions of bright spots, challenges, and gaps of their home visiting programs.

Statewide demographic data The team requested statewide demographic data from the State Home Visiting Leaders for the key home visiting programs in Kansas in order to discuss the number and types of individuals and families who received services under home visiting programs and initiatives. The data was collected from the leaders via email or over the phone. Demographic data was not reported by the ABC and NFP state leaders and is not reported in this needs assessment. Additionally, the team reported demographic data for the state from the American Community Survey (ACS) 2018 5-year estimates Census data in order to compare the demographic statistics of the state of Kansas to the demographic statistics of those served by Kansas home visiting programs.

County-level capacity data for all Kansas counties During the statewide capacity data collection process, the needs assessment team as requested county-level data from the State Home Visiting Leaders. Some provided the data for each of the counties served, while others explained that county-level data would need to be requested from each individual organization across the state. Specifically, the needs assessment team had to collect county-level data from each organization for the EHS and PAT programs in Kansas. The team created a Qualtrics survey that included questions about numbers of children and families served, waitlist data, referral data, open slot data, and three open-ended questions that asked about perceptions of bright spots, challenges, and gaps of their home visiting services. These surveys were sent to the main contact of each home visiting organization for the EHS and PAT programs. The team received back surveys from all the PAT organizations and from 90% of the EHS organizations. Reporting period of the data was for FY2019. Similar to the statewide data, we received complete data for number of children and families served. However, the responses for the remaining quantitative data was incomplete. The needs assessment team reported number of children and families served aggregated across each of the eight key home visiting program for each county in Kansas.

Data Duplication Worthy to note are issues related to data duplication. Some organizations collected and reported number of families served which may be a duplicated count that includes number of children, while other organizations collected number of families and number of children separately. Another issue of duplication is that some organizations count number of pregnant women as part of both their number of families and number of children counts. Thus, the capacity data may include duplicated counts for numbers of families/children served by a home visiting organization.

Weighted calculations for county data when needed Some organizations collected their data by individual counties they serve, while others only report a total number for each data field across all the counties they serve. For organizations that reported total numbers for all data fields across all counties served, we did a weighted calculation to estimate the county-level data for each county the organization serves. Numbers were weighted by using population data (total population and population of children under 5) from the ACS 2018 5-year estimates Census data for each county in Kansas. If the organizations reported total number of families served across all their counties, weighted rates for each individual county was based on the total population Census data. If the organizations reported total number of children served across all their counties, weighted rates for each individual county was based on total population under 5 Census data. Some programs only reported total number of children served across all their counties, thus, we used total population under 5 Census data to calculate individual rates for each data field. Weights were calculated by taking the total number of people (either families or children or both, depending on what data the organization reported) served by the organization and dividing by the total population of all the counties served by that organization. This number was then multiplied by the population of the specific counties the organization served. For example, if Organization A reported serving a total of 10 families across both Allen and Anderson counties, we added population numbers from both those counties as noted in the Census data (*Table B.1 in Appendix B* – 754 + 491 = 1245). Then we divided Organization A's reported total families served number by that total population of 1245 (10/1245 = .008). Finally, we multiplied this rate by the individual Census county population: Allen county = .008*754 = 6.03; Anderson county = .008*491 = 3.93. Thus, based on these calculations we estimated that Organization A served approximately 6 families in Allen county and 4 families in Anderson county which comprised the 10 families total they reported serving.

Assessment of need in the state To assess the extent to which home visiting programs are meeting the needs of eligible families, the needs assessment team utilized an alternative indicator to align with previous needs assessments (e.g. PDG Needs Assessment) that CPPR has collaborated on. For this MIECHV Statewide Needs Assessment update, we used population numbers of children under 5 in poverty from the ACS 2018 5-year county estimates. The needs assessment team chose this measurement to be more inclusive of eligible families. It is predicated on the notion that children and families

should have access to needed services and are more than simply their eligibility criteria. Thus, we included this broader measure of need using two criteria—children under 5 (which is a target population of many home visiting programs) and poverty (which is risk factor that identifies populations and counties of high-need).

Findings from the Capacity Assessment

Kansas has an array of existing MIECHV and non-MIECHV funded home visiting programs that support pregnant women and families with young children. There is no state-specific home visiting model. The Center for Disease Control and Prevention (CDC) defines several different strategies and approaches used in prevention of child maltreatment, including enhancing parental skills to promote healthy child development. Early childhood home visiting falls within this prevention approach, and Kansas programs provide services in varied modes based on identified risk factors. Below are the different levels of interventions Kansas home visiting programs use to support pregnant women and families with young children.

- Universal services apply to everyone and rely on policy interventions and broad social change techniques that treat all families the same
- Selected services are focused on identified risk factors that are experienced by high-need groups and include individualized programs to help meet needs
- Targeted/Indicated services include treatment with therapeutic goals for those who have experienced substance related disorders, usually through one-on-one strategies and support services

A summary of each of the eight key home visiting programs in the state are described in *Table B.2 in Appendix B.*

Statewide Home Visiting Capacity Findings by Home Visiting Programs

Funding Source Findings for Kansas Home Visiting Programs

There are approximately seven primary funding sources in Kansas across the eight key home visiting programs. For FY2018 the total funding for home visiting services was approximately $24,152,144 (see *Table B.3 in Appendix B* for a breakdown of funding for each of the primary funding sources located in the notes section). For FY2019, federal MIECHV funding was approximately $3,011,030 across the evidence-based and promising practice MIECHV home visiting programs.

Additional Home Visiting Funding and Expansion in Kansas

In February of 2018, the Family First Prevention Services Act (FFPSA) was signed into law providing exciting possibilities for communities within Kansas to be responsive, supportive, and meet specific needs of children, teens, and families in the state. Through federal funding, the Kansas Department of Children and Families (DCF) can expand the network of home visiting services across the state. *Table B.4 in Appendix B* shows the home visiting programs that were awarded Family First Funding, their program model, counties the programs will serve, and the projected number of families to be served. It is estimated that these programs will begin using these funds to expand the reach of their home visiting services between October 2019 to Spring 2020.

Statewide Capacity Findings

Table B.3 in Appendix B outlines the service delivery characteristics, total number of families and children served (statewide data), and primary funding streams for each of the eight key home visiting programs in Kansas. For FY2019, Kansas home visiting served approximately 14,853 families and 27,777 children. Of note, these numbers may be duplicated as programs may count pregnant women as part of their families served count and their children served count. Additionally, some programs define number of families as a primary caregiver with one eligible child. These programs may define number of children as any eligible child served, thus, it may include multiple children within a household which also includes the eligible child that was counted as part of the number of families served count (creating a duplicated count). According to the ACS 2018 5-year county estimates, there are a total of 33,908 children under 5 in poverty who can potentially be served by a home visiting service. Kansas home visiting programs serve approximately 27,777 children. Thus, Kansas home visiting programs reach approximately 81.9% of children under 5 in poverty who can be served by home visiting. Of importance, the children served may not all have a risk factor of poverty so this percentage of the population of children served is only an estimate of the percentage of the population served.

Statewide Demographic Findings for Home Visiting Programs

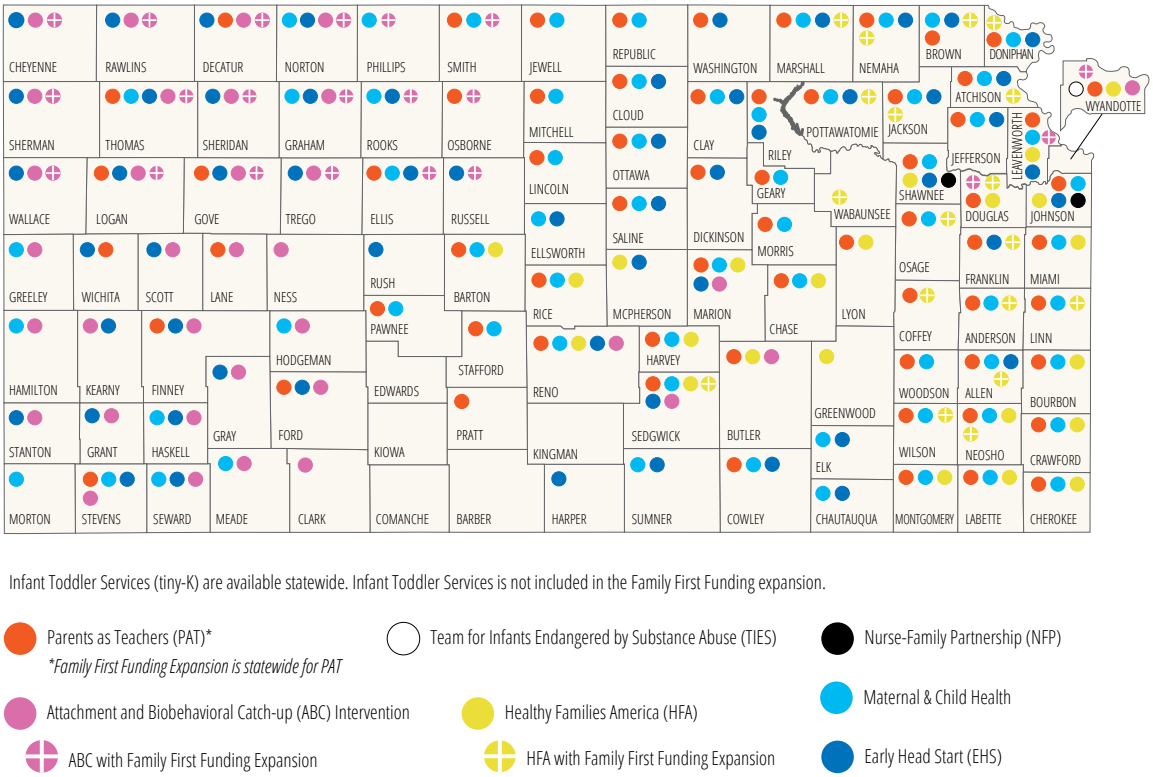
Statewide demographic findings are shown in *Table B.5 in Appendix* B. The findings show that the majority of families served across the key home visiting programs in the state are White and non-Hispanic identified groups. Compared to the ACS demographic data estimate, it appears that White and non-Hispanic identity groups make up the largest demographic percentages for children under 5 in poverty in Kansas. Thus, it is expected that these groups are the highest served in home visiting programs. Of note, it appears that none of the home visiting programs serve multi-racial identified groups (percentages range from 1.40% - 8.21%) at percentages that reach the population estimate (11.12%) for children under 5 in poverty. Two Kansas home visiting programs (EHS and HFA) serve Hispanic/Latinx families at percentages that reach the population estimate (30.70%) of children under 5 in poverty; all other programs serve 15 – 20.48% of Hispanic/Latinx families. Additionally, only one home visiting program serves Black/African American families (TIES – 33.33%) at double the population estimate (15.10%) for children under 5 in poverty, while the other programs serve 3.37% - 12.70% of Black/African American families. Finally, at least half of the home visiting programs serve the other racial groups at percentages that are equal to or greater than the population estimate for that group for children under 5 in poverty.

Home Visiting Capacity Findings for High-need Counties

Figure 2 below shows a map of Kansas and its counties and includes the locations of the eight key Kansas home visiting programs across the state. Infant Toddler (tiny-k) programs are statewide. Family First funding expansion for home visiting services is also denoted for ABC, HFA, and PAT programs. PAT Family First funding expansion is statewide *(see Table B.4 in Appendix B* for details of the Family First funding expansion). The map shows that there is at least one evidence-based or promising approach (e.g. TIES) home visiting program in each of the high-need counties. There is also at least one type of home visiting program that does not have any specific eligibility requirement (either PAT or MCH) provided in all but two of the (Harper and Rawlins) high-need counties.

Figure 2

Map of Kansas Home Visiting Programs Across the State



Capacity data for the twenty identified high-need counties in Kansas are presented in *Table B.6* and capacity data for all counties in Kansas are presented in *Table B.7 in Appendix B.*

Assessment of Need in State

As required by the Supplemental Information Request (SIR) for this MIECHV Statewide Needs Assessment update, we completed the "At-Risk Counties- Table 7" *(see Table B.8 in Appendix B)* of the Needs Assessment Data Summary. The table includes an alternative measure (see the method section for details) of need of eligible families, children under 5 in poverty, for each Kansas county[3]. To understand whether current home visiting programs in Kansas meet the needs of pregnant women and families with young children, *Table B.9 in Appendix* B shows the percentages of children under 5 in poverty that *can* be served by existing home visiting programs (using the alternative need measure). The emphasis on *can* in the estimates are important because these estimates of need do not necessarily reflect the actual percentage of eligible families served. The reported number of children served by the home visiting programs may include those who meet the eligibility criteria of the need measure, but it also may not. Although the alternate estimate of need is representative of target populations for home visiting services, it is not a precise estimate; not all children under 5 in poverty are enrolled in home visiting services, and others without poverty as a risk factor may be enrolled in home visiting services.

Percentages for each data field were calculated by dividing the total number of children served by the estimated need of eligibility (e.g. For Allen county: total number of children served / population under 5 in poverty (163/176 = 93%)). The following subsection includes the summary of the results of estimated need of eligible families using need estimates for the 20 at-risk counties in the state *(see Table B.9 in Appendix B* for a review of the estimated need for the high-need counties in Kansas and *Table B.10 in Appendix B* for a review of the estimated need for all counties in Kansas).

Percentages of children under 5 in poverty that can be served by existing home visiting programs

The data shows that home visiting programs in four counties (Cherokee, Rawlins, Republic, and Riley) appear to meet the needs of children under 5 in poverty. Of the remaining high-need counties, home visiting programs in eight counties meet the needs of about 22% - 46% of children under 5 in poverty. Home visiting programs in the remaining high-need counties meet the needs of 52% - 93% of children under 5 in poverty. In sum, home visiting programs in 12 out of the 20 high-need counties (60%) appear to be meeting the needs of over 50% or more of children under 5 in poverty (*see Table B.9 in the Appendix B*). In reviewing the larger landscape of Kansas, the data show that 67.6% of counties in Kansas meet the needs of over 50% of more of children under 5 in poverty. This suggests that high-need and all other counties are similarly meeting the need of children under 5 in poverty.

KEY FINDINGS & RECOMMENDATIONS

Key Findings

- During FY2019, Kansas home visiting served approximately 14,853 families and 27,777 children
- FY2018 funding across primary funding sources was $24,152,144
- FY2019 Federal MIECHV funding was $3,011,030
- 60% of the high-need counties meet the needs of 50% or more of children under 5 in poverty

Recommendations

- Home visiting programs in Kansas collect a wealth of data. It is recommended to find ways to use the data in effective ways across all home visiting programs to understand the collective impact of home visiting on outcomes of interest. It is important to find a system in which the county-level data across programs can be collected and analyzed in meaningful ways to better understand how home visitation programs are meeting the needs of families and children in the State.
- It is important to collect unduplicated counts of families and children that have accessed home visiting programs and having a unique identifier for child-level data. Duplicated counts of capacity data are not accurately representative of the reach and accessibility of home visiting services in the state.
- Demographic data of who is served by all home visiting models is not collected or available for all home visiting programs at the county level. These data are important to have across all home visiting programs to better understand the backgrounds (race, ethnicity etc.) of families served and whether the needs of families with different demographic backgrounds are disproportionately affected by home visiting programs.

Quality Assessment

Method for Assessing Quality of Existing Home Visiting Programs

For the purposes of this MIECHV Statewide Needs Assessment update, the quality of existing home visiting programs in Kansas is defined by considering three factors.

FACTORS CONSIDERED WHEN EVALUATING HOME VISITING PROGRAMS IN KANSAS

1. ***Gaps in the delivery of home visiting programs in the state.***
2. ***The extent to which home visiting programs meet the needs of families.***
3. ***Resource gaps in the successful delivery of home visiting programs, with measurable impact, in each of the identified high-need counties.***

A variety of perspectives and data sources inform the understanding of the quality, based on this definition, of existing home visiting programs in Kansas. Home visiting providers and programs, as well as state home visiting leaders, shared both gaps and bright spots of the existing home visiting network in the state. Existing home visiting data reflect both strengths and opportunities for improvement. Additionally, the perspectives of community members and stakeholders, including home visiting families, surface through a variety of existing state and community needs assessments, as well as the Kansas MIECHV FY18 and Innovation evaluation reports.

To assess quality of existing home visiting programs, the needs assessment team used a qualitative methodology. We conducted a content analysis of program perspectives collected through online surveys, email, and phone interviews of home visitors and program directors within EHS, PAT, NFP, HFA, ABC, and MCH programs. Additionally, as part of the Title V MCH Block Grant Needs Assessment process, home visiting-focused input was collected via open house-style meetings in six locations across the state. Providers described both bright spots and perceived barriers in administering home visits to families in their communities, while also addressing desired improvements for professional development and their experiences interacting with the broader network of early childhood systems.

State leaders across seven of the eight key Kansas home visiting programs answered three free response questions regarding gaps and bright spots of Kansas home visiting, providing a state leadership/stakeholder perspective:

- What barriers have you encountered?
- What are your program's bright spots?
- What professional development challenges have you encountered?

Method for Assessing Existing Needs Assessments

Kansas Home Visiting is situated within the broader Kansas early childhood system and is considered a core program for supporting Kansas families. Key findings and themes from needs assessments across the Kansas early childhood system help inform the understanding of quality of existing home visiting programs, providing additional information from the community, family, provider, and state leader perspectives. Specifically, the needs assessment team reviewed the existing CBCAP, Part C, PDG, and HS Needs Assessments and conducted a content analysis of these needs assessments for emerging themes to further understand the quality of existing home visiting programs.

Head Start The 2019 Needs Assessment and Strategic Plan focuses on professional development, resources and referral services, connections within communities and school systems, and participation in the greater statewide early childhood system. While not every program includes a home-based EHS option, those which are center-based or are child care partnerships still interact with home visiting systems in their communities and offer a valuable perspective.

CBCAP The 2019 Kansas Prevention Investments Annual Report highlights the array of programs supported across the state by federal Community Based Child Abuse Prevention (CBCAP) funding, many of which include home visiting components. Coupled with individual needs assessments of the current seven grantees, it illustrates the experiences of providers in regions most at risk for child abuse and neglect. Home visitors in these programs often have an extraordinary perspective, as grantees are selected based on innovative interventions designed for a community's unique needs.

Part C The 2019 Kansas Infant Toddler Services (Part C) Needs Assessment, while not directly addressing the seven home visiting programs, also provides additional context for understanding the quality and reach of home visiting programs in the state.

PDG Needs Assessment In 2019 Kansas undertook a comprehensive Early Childhood Needs Assessment process, funded through the federal Preschool Development Grant. Engaging nearly 6100 stakeholders, providers, and community members from all 105 Kansas counties, the final document provides key findings about the gaps and bright spots of the Kansas Early Childhood System, with evidence-based home visiting included as a core service of the early childhood care and education system. Gaps and bright spots identified as part of the comprehensive needs assessment process reflect all perspectives: community, program, and state leadership.

Method of Assessing the Impact of COVID-19 on Home Visiting in Kansas

The needs assessment team conducted a content analysis to understand the impacts of COVID-19 on home visiting services in the state. State and program leaders provided their perceptions of how COVID-19 affected the delivery of home visiting services in the state via an online survey. We sent all state and program leaders a link to a Qualtrics survey that asked the same three questions previously stated as it related to the pandemic, including some additional free response questions (e.g. types of delivery methods, connecting families to resources, changes to referral process, and impact on enrollment and retention). The Qualtrics survey was sent to 33 state and program leaders. Twenty-three respondents began the survey but not all completed it. Thirteen participants responded to at least 1 question, 11 responded to all of the questions, and ten did not complete any of the survey.

Family Findings from Quality Assessment

This MIECHV Statewide Needs Assessment process identified a wide range of gaps and bright spots in home visiting, which are described below. From these, key findings at the family/child, program, and systems levels help inform the recommendations at the end of this section for strengthening the overall home visiting network for the state, as well as targeting home visiting for families in communities with high needs.

Family/Child

- The positive impact on children and families is a bright spot, with numerous examples available of the successes and accomplishments of children and families alike.
- Not all children receive timely developmental screenings, reducing the opportunity for proper referrals and intervention.
- Challenges in accessibility and availability of resources beyond home visiting, especially mental health resources and basic necessities, creates barriers for families successfully engaging in home visiting services.

Program

- A consistent bright spot is the home visiting workforce and the positive relationships developed between home visitors and the families they serve.
- Programs are also impacted by the gaps in cross-sector resources for families, especially in mental health, health, and basic needs. This is reflected in the indicated need for additional professional development in these areas.
- While the home visiting workforce is a bright spot, varying qualifications, competencies, and pathways into home visiting across program models continues to create a barrier to a comprehensive approach to workforce preparation and retention.

System

- Community collaboration and partnerships, where they exist and are well-functioning, are a bright spot, creating opportunities for cross-sector referrals and wrap-around services for home visiting families and children.
- At the same time, the challenges in creating and sustaining such networks creates a gap in fully implementing home visiting programs, especially in communities with high need.
- High-need counties in Kansas have diverse populations with varying needs. Challenges exist related to accessibility and availability of culturally and linguistically diverse home visiting services.

Gaps in the Delivery of Early Childhood Home Visiting Services

Home visitors and home visiting programs articulated a number of gaps in the delivery of services in their communities, which are reflected in barriers and challenges for families/children served, for programs, and across the home visiting system. When discussing direct service provision to families, home visitors consistently reported challenges related to three main areas: language barriers and cultural trust, a lack of mental health professionals available for referral, and establishing concrete supports such as housing and affordable medical care.

- Many of the high-need counties in Kansas have diverse populations with multiple languages spoken and a combination of immigrant and refugee experiences. Gaps exist in providing appropriate materials and translations, but also in earning the trust of a family who may be fearful of deportation or whose cultural customs do not align with early childhood services, particularly in the home. Concerns about privacy were frequently referenced in regard to enrolling and retaining families in programs.

- While Kansas has made great strides in increasing developmental screenings across the state, home visitors report obstacles in referring results to appropriate professionals when mental health or social-emotional and behavioral needs arise. The lack of mental health providers coupled with the even lower number of those who specialize in young children is difficult. With much of the state classified as rural or frontier, this is further compounded by the expense and logistics of travel.

- Underlying all barriers is that many families are laboring to obtain basic needs related to health and safety. There may be few options for medical and dental care in a region, and even fewer which accept Medicaid. Similarly, parents in poverty must often locate specific child care and housing based on accepted subsidies. It is tough to begin working toward goals in home visiting intervention if a family is still struggling to secure physical foundations.

Not surprisingly, the gaps identified by providers on the program level align very much with their perceived barriers for families. Professionally, providers see a great need for language and translation assistance, cultural competency, mental and social-emotional health education, and help with care coordination. Many reported that required training by agencies or funders can become repetitive, while other necessary topics are missed due to lack of time or funding. Commonly mentioned desired subjects included adverse childhood experiences, violence in the home, and substance use disorders. From an employment perspective, the key gaps reported surround larger issues across the field regarding low wages, high burnout, and stress related to workload in light of excessive turnover. Recruitment and retention of providers is a constant challenge, which in turn negatively affects the ability to make strong connections and establish trust with families. Long hours of driving plus upkeep of paperwork and regulation compliance were also mentioned as contributors to losing staff.

Providers were consistent in their assessment of gaps in the larger system, with a need for increased public awareness being the dominant theme across all models and regions. To effectively promote the positive benefits of early childhood home visiting, programs suggested broad campaigns incorporating elected officials, business owners and employers, early childhood educators, and other community service agencies. With a comprehensive backing from these visible entities, stigma and uncertainty about home visiting services could be reduced and families who might otherwise not have known can begin to access help.

In addition to the larger public realm, many programs indicated that a significant gap lies in the network between home visiting and the medical community. Without buy-in from obstetricians and pediatricians, a number of families who could benefit from prenatal, perinatal, or early childhood visits may be falling through the cracks. Because a medical appointment might be the only professional contact a family has beyond home, bridging this gap and maintaining the connections is critical.

State leaders responded similarly to the question, "What barriers have you encountered?", as staff members of home visiting programs. They identified a range of challenges at the family /child, program, and system levels. For families and children, challenges exist related to accessing necessary cross-sector services and resources, including a need for more accessible and affordable child care, housing, health care, prenatal care, immigrant services, substance abuse services, mental health services, translation and interpretation, and transportation. Additionally, they reported difficulties related to follow-through by parents on referrals to such resources and services, a lack of knowledge or understanding by parents about the importance of such resources and services, and community availability of services.

At the program level, there can be a mis-match between the duration and intensity of interventions to family level of need—unavoidable challenges related to family situations and circumstances, such as language, mobility, and immigration—and the need for more training and professional development of home visitors, especially in the use of evidence based practices. At the systems level, gaps related to the full delivery of and engagement in home visiting services include administrative barriers, such as funding or policy barriers, especially for immigrant families.

State leaders also articulated the way that these various issues interact to create challenges in the delivery of comprehensive home visiting services. While the example below pertains to one home visiting model in an urban, high-need community, the challenge itself is not unique to only the urban communities of the state.

"There is not sufficient capacity for mental health services for either parents or children. Public services are difficult to access and private practitioners often do not accept Medicaid, which is the only source of payment for the vast majority of families. There is no residential, or even outpatient, SUD treatment available in Wyandotte County where mothers can take their minor children with them. Combined, this makes it difficult for parents to secure any services for their typically dual needs for mental health and substance use treatment. While training and mental health consultation is received to screen for and identify mental health and substance use needs, the loss of funded services to connect families to once issues are identified is problematic. Also, Kansas City is a large, bi-state region and families are mobile. Maintaining continuity when families move across county or even state lines is challenging with funding source restrictions."

In the 2019 PDG Needs Assessment, some of the key findings around delivery gaps pertain to the home visiting system, primarily around issues of navigation across the system and challenges around transitions, especially for children in foster care and child welfare systems. Additionally, as found in that needs assessment process, home visiting only reaches 9% of all Kansas families with children ages birth to five, a gap that was echoed by community members and stakeholders across the state, and the needs within communities vary greatly by region. It's important to note that this particular finding from the PDG Needs Assessment is different from what is reported in the previous Capacity findings regarding the assessment of need in the state. The PDG Needs Assessment did not include Infant Toddler Services numbers served in its calculation and compared the numbers served to census data for children under age 5 to calculate the reach of home visiting services in Kansas. For the Capacity section we specifically used children under 5 in poverty as the measure of need and as a result the percentage of reach is different. Based on these differences, home visiting services do have a positive reach in the state based on the Capacity findings, but it's important to remember that this is based on the notion of who *can* be served. As explained previously, who can be served and who is being served may not align. Home visiting services do not all serve children up to age five, or children in poverty, and many are not ongoing home visiting interventions. Keeping this in perspective when thinking of the reach of home visiting services in the state is important because it does raise important considerations of who is being served and who can be served and the complexity within these considerations when home visiting programs may not align exactly with the needs of families to best support them.

HS Community Needs Assessments from all regions of the state reflect similar gaps to those reported by providers and state leaders. With a growing number of families who speak languages other than English, the need for translators and more diverse staff is echoed in the findings. Further, the struggle for quality child care, affordable housing, and acceptance of Medicaid is reiterated in almost every community, while population decline in several regions only exacerbates those challenges. Because much of central and western Kansas is sparsely populated and dominated by large expanses of the agriculture industry, transportation to and from educational, medical, and social services can be an added difficulty. A home visitor is often a singular connection for rural families with young children, yet in areas where only Part C or EHS are operating, those who don't meet developmental or income qualifications may miss that opportunity.

CBCAP programs describe comparable barriers within service capabilities to those reported in other needs assessments, but with a somewhat magnified intensity due to the extremely high-risk nature of the populations involved. Shortages in affordable housing, Medicaid providers, and child care options which accept subsidies are consistently mentioned. These align with the same barriers to providing service noted across all social programs working amongst extreme poverty. When basic needs are not being met, case management and home visiting goals must shift.

Findings in the 2019 Kansas Part C Needs Assessment reflected a workforce with a wide range of backgrounds and skills, indicating that workforce preparation and pathways is not a challenge unique to home visiting, but a workforce challenge across the early childhood system. Additionally, while Local Interagency Coordinating Councils (LICCs) often serve as the coordinating body for early childhood partners in local communities, including home visiting programs, the level and effectiveness of coordination varies from community to community. Finally, the Part C Needs Assessment indicates that while the state has made great strides in the area of developmental screenings, there is still much work to be done to assure that all children are screened.

Extent to which home visiting services meet the needs of families in Kansas

In general, providers from home visiting programs identified the positive impact for children and families served by home visiting as the most prevalent bright spot, including a wide range of impact areas and outcomes under this bright spot: positive home visitor and family relationships, social connections between families, family and child progress and goal accomplishment, and family well-being and self-sufficiency.

Other bright spots, at the program and system levels, included community partnerships (though this appears to be equally both a bright spot and a gap or challenge), program quality, staff and home visitor knowledge and expertise, program recruitment and enrollment, cultural sensitivity, and the reach of home visiting programs to families across the state. Additionally, providers indicate that home visiting programs collect a wealth of program data (considered a bright spot), but there is little consistency across models in the type and frequency of data collection (a gap or challenge).

In response to the question, "What are your program's bright spots?", state leaders, like program leaders, shared many examples of the positive impact of home visiting for children and families across the state, including success of families in reaching goals and achieving significant accomplishments, strong relationships and communication between staff and parents, family well-being and wellness, and growth in family self-esteem and self-efficacy. One state leader reported:

"Linking clients with services that make a difference in their lives, assessing child health and development, birth outcomes and maternal health are all the bright spots we have observed."

Additionally, staff leaders highlighted the impact of connecting children and families with other community resources and the important role of community partnerships in serving families in home visiting, suggesting that while availability and accessibility of cross-sector services is a gap and challenge, it is also an area where home visiting programs have a great amount of impact. Other bright spots, though less frequently mentioned, include family retention in programs, low staff turnover, well trained and competent staff, professional development opportunities, and technology.

Families served in MIECHV programs in high-need communities in Kansas echoed these sentiments in surveys conducted as part of the MIECHV Formula Year 2018 evaluation conducted in collaboration with KDHE. Of the families interviewed in each community, most parents indicated that they felt more independent and confident meeting family needs and goal setting.

"I feel a little more confident, simply because I can actually talk with someone about my goals. Not just have them by myself."

"I would say having someone on my side, and telling me you can get it done, you can do this, that positive influence was something that was not always there and is now."

An existing bright spot, which strengthens the capacity of home visiting programs to meet the needs of families, and spurred by MIECHV funding in Kansas, has been the Integrated Referral and Intake System (IRIS). Currently in 11 Kansas communities, and originally launched in MIECHV communities as a referral network between home visiting programs, IRIS is a web-based communication tool for referrals that can be customized to include any partner from across the broader ECCE system within a community who wishes to participate. Communities determine the referral processes and systems for their local networks and utilize IRIS to visibly track referrals between partners, program capacity for referrals, and referral status. In this way, home visiting programs participate in a cross-sector referral network that benefits home visiting families and children and tackles many of the gaps created by referral barriers and challenges. Evaluation of the initial pilot of the IRIS system with the MIECHV funded home visiting programs in high-need communities identified IRIS as a potential strategy for effectively engaging, sustaining, and retaining families. Additionally, important program leadership actions, such as communication and a willingness to collaborate with other programs, were found to be key to successful implementation of a referral network.

The Kansas MIECHV Innovation Grant furthered the work of the IRIS pilot and supported the implementation of a Connected Communities, Connected Families model, of which expanding the referral network beyond home visiting programs to include cross-sector partners, as identified by the home visiting programs in each local community, was a key component. The evaluation of this component focused on the strength of network density and connections, cross program communication and coordination, and impact on parents. Findings were generally positive regarding the impact: as partners in the cross-sector referral network increased, so did the number of possible referral connections; partners receiving referrals typically accepted them quickly, within community agreed upon time periods, and most referrals were completed, per community agreed upon definitions—and parents identified positive benefits of being connected to known resources. Parents, also, however, indicated barriers to accessing the referral services, due to barriers such as time/scheduling and transportation. These findings reinforce the perspectives shared by programs and state leaders: when well-functioning, partnerships and cross-sector referral networks enhance the capacity of home visiting services in high-need communities; when such networks are lacking, parents face challenges in navigating services.

Several bright spots emerged through the 2019 PDG Needs Assessment that impact or reflect the work of home visiting across the state. Home visiting often fills the gaps created by other birth to five programs, especially in rural communities across the state. Home visiting also serves as a key connector for families to other necessary services in communities, with

home visiting programs and networks in some communities serving as the central hub for referrals across local systems. This was especially true for connections to local Part C programs. Home visiting programs are often integral to community level early childhood collaboratives, especially to LICCs, which, when well-functioning, are a bright spot across the state.

HS Community Assessments echo the bright spots of the 2019 Kansas Early Childhood Needs Assessment about home visiting helping rural connections for geographically isolated families. The flexibility of EHS programs to offer home-based only or a combination of home- and child care-based services gives rural families options in selecting the service model which most suits their needs. In areas where quality child care is scarce, making the home visiting connections through EHS during ages 0-3 also helps families easily transition to programs meeting high HS standards for ages 3-5. Programs see increased screenings, referrals, and follow-up assessments for families who might otherwise be disconnected.

A consistent bright spot reported by the 2019 CBCAP programs is the high level of collaboration achieved within communities. Because CBCAP services are targeted at very specific needs of the local population, their success is dependent upon a strong network of different groups linking families, programs, and the larger system. Five of the eight current grantees incorporate a home visiting component to their service approach, making home visitors invaluable to the building and maintenance of these connections. Critical cooperation occurs with direct service entities such as hospitals, churches, food banks, domestic violence shelters, health departments, and libraries, and is further supported by strong relationships with larger agencies such as the Housing Authority, United Way, and law enforcement. An additional bright spot is the focus on outreach to specific populations, including fathers, military, homeless, refugees, and those affected by substance use.

A key bright spot that emerged in the 2019 Part C Needs Assessment was that all communities, due to the existence of Part C programs in all communities throughout the state, have at least the basis for a referral system. Many children enter the early childhood system, and potentially home visiting programs, via local child find activities conducted in coordination with other providers.

Gaps in staffing, community resource, and other requirements for delivering evidence-based home visiting services in high-need communities

Since 2010, MIECHV funding in Kansas has been used to both increase the capacity of home visiting programs in targeted high-need communities, in terms of program numbers, as well as increase the capacity of the broader home visiting network across the state through increased resources and program supports, professional development, and cross-sector collaboration. All of these efforts support the delivery of at least one evidence-based home visiting service delivery model, with successful gains for eligible families, in the high-need Kansas counties. However, some challenges identified as part of this MIECHV Statewide Needs Assessment Update remain as potential barriers, as indicated by programs/staff, state leadership, and the broader community.

While some programs indicated that they had plenty of professional development resources, other program providers and leaders identified a range of gaps in professional development for the home visiting workforce. These gaps included resource challenges, including time and funds for necessary and required training—a need for specific trainings, especially in the areas of mental health, Adverse Childhood Experiences (ACEs) and trauma informed care, self-care, and substance abuse—and travel distance in certain regions.

"Mental health is such a big daunting piece that everybody has to stay on board with. You have to stay on top of it for your own mental health, for the mental health of the children and families that we serve. It's just something that you have to just be continually doing."

Providers describe struggles regarding the necessary paperwork and extensive reporting requirements associated with both federal, state, and national agency funders. Often, a program blending and braiding monies will encounter the need to hire additional administrative staff just to assure compliance with all the various entities involved. Tracking all regulations correctly and maintaining updated records can prove confusing and exhausting, not to mention the additional stress when a family changes eligibility status and may no longer qualify for service.

In addition to answering the question about barriers, state leaders also answered the question, "What professional development challenges have you encountered?", providing insight into resource and staffing challenges across the home visiting network that impact the delivery of home visiting services in at-risk communities. A range of challenges exists: staff capacity, staff well-being and mental health, staff burnout and stress associated with hard to engage clients, lack of sufficient resources to fully equip and train staff, and funding and administrative requirements and standards.

Since the implementation of MIECHV in Kansas in 2010, program data for participating home visiting programs have been collected in the DAISEY system, including data on the MIECHV Performance Benchmarks. The positive, as mentioned above, is that home visiting programs collect and report a wide range of data regarding children and families served, as well as staff and program data. Additionally, as part of the MIECHV program, home visiting programs have participated in Continuous Quality Improvement plans.

The challenges regarding data and quality improvement exist around uniformity. Because the numerous home visiting programs may differ in several aspects, including intensity of approach, measures of family success, and professional training expectations, difficulties arise in attempting to utilize data meaningfully. While all home visiting programs focus on improving family life, they do so with varied methods, and they report accordingly to meet national agency and funders' requirements.

Similar challenges exist around referral data; while IRIS captures a wealth of data about number and focus of referrals, not as much is known about follow-through or service access, which echoes the barriers described above by program and state leaders, as well as home visiting families.

In the 2019 PDG Needs Assessment, several gaps related to the home visiting system, as part of the broader early childhood system emerged, all of which impact the delivery of home visiting in high-need communities. First and foremost, the lack of unique identifiers or common measures across programs impacts but is not limited to home visiting programs. While the DAISEY system surfaced as a bright spot, the lack of workforce data, the lack of measure alignment, duplicated counts, and the variation in measures and data elements emerged as a gap across the system. Importantly, the DAISEY system only includes data for the MIECHV home visiting programs and MCH home visiting programs, not all home visiting organization in the state. Workforce challenges around preparation, compensation, and retention also emerged as a gap across the early childhood system, including those particular to the home visiting workforce. Additionally, the need for greater systems alignment across the early childhood system echo some of the systems level challenges mentioned by home visiting stakeholders, especially alignment of funding and administrative regulations.

HS providers and directors indicate that maintaining a workforce which meets the high standards of qualification can prove very difficult in areas with dwindling populations or few higher educational opportunities. As wages remain low with little

promise of increasing, programs must become creative to incentivize employment and try to combat turnover. With regard to professional development, the reported gaps are clear: rarely enough funding nor time for adequate training on mental health, substance use disorder, and trauma. Further, once trained in identification and referral, helping families actually receive social-emotional help is complicated.

"Access to services in our area is difficult, not because there's a lack, it's just that the hours that they're available. Oftentimes, they're not convenient for families. They don't have evening hours available to go in for an intake. They seem to not be able to get themselves there because of work schedules, and quite frankly, the process is not real kid-friendly." (KS-HSCO Needs Assessment 2019)

HS and CBCAP programs also note unique legal challenges related to serving the most high-need communities. Home visitors are sometimes called upon to navigate parts of the court system, foster system, and DCF, particularly regarding children removed from substance-abusing homes. Providers can feel unprepared for these potentially complex aspects of the field and express the need for more intensive training in these areas.

Impact of COVID-19 on Home Visiting Services

The findings from the free-response Qualtrics survey illuminated and supported many of the findings previously discussed. State and program leaders described bright spots in the areas of retention, family engagement, and communication with families and with their teams. The majority of respondents noted that retention was steady and continued to be high for home visiting services despite facing service delivery challenges (e.g. not conducting in-person home visits). Respondents described a perceived boost in family engagement. Specifically, they observed that parents engaged more with their children during virtual visits and they began to notice a difference in parent/child interactions. Parents took more of an active role in doing the activities with their children since home visitors were not present in the homes. Additionally, the respondents said that parents reviewed resources prior to virtual or phone visits to work on skills and activities without home visitor initiation. One respondent said "Some families continued to elaborate on the activity to add even more enrichment for their child."

Another main bright spot was that respondents perceived stronger communication with families and their work teams due to COVID-19. Families guided more of the conversation to discuss what was important to them especially in sharing their feelings about the unknown of the pandemic with their home visitors. Respondent said their home visitors did frequent check-in with families to ask about whether their basic needs were met and listen to their concerns and fears. This level of communication transferred to the home visiting team members as well. Respondents noted that they had regular check-ins as a group, continued with reflective supervision, and engaged in open communication with the staff to ensure they were supported and connected as a team.

Respondents reported main challenges around enrollment of new families and providing needed resources, especially technology resources, to families. Although retention was described as a bright spot, all of the respondents said that enrollment was lower and more difficult due to COVID-19. The respondents used virtual means to enroll new families (e.g. platforms such as Zoom or via phone) but said it was challenging to engage new families virtually driving enrollment down. Due to the sensitive nature of the screening process during enrollment, some respondents mentioned that staff struggled at first to make families feel comfortable to answer their questions, however mentioned that staff are "…rising to the challenge and using their skills to make families feel as comfortable as possible." A very real challenge to family enrollment was when staff numbers were down due to illness or quarantine, which led to a reduction of work to keep up with contacting and following up with potential new enrollees.

Resources were the other main challenge respondents discussed. Specifically, lack of access to technology was the primary concern for many families. Many did not own smart phone or other devices, like tablets, for virtual video visits. Others needed internet hotspots for consistent access to internet services for visits. However, home visitors were creative and connected with families via phone or messaging platforms to keep in communication when other modes of technology were not available to their families. Another resource-related theme discussed in previous sections was an increase in the need for basic essentials. Families requested support and access to food, personal hygiene, diapers, and other basic needs due to the impacts of COVID-19. In addition to the increased basic needs, respondents discussed that there was also an increased need for mental health services.

The themes that emerged from the survey highlighted that home visiting services continued to provide families with resources to engage with their children and gain support during unpredictable times despite the impacts of the pandemic. However, the need for basic essentials was even more exacerbated because of COVID-19, leaving families struggling to provide and care for their families.

Quality of Home Visiting Programs in Kansas Tribes

Currently, two of four Kansas Tribes operate HS/EHS programs (Prairie Band Potawatomi Nation and Kickapoo Tribe in Kansas), and both offer home visiting services. From 2014-2019, the Kickapoo Tribe in Kansas also received Project LAUNCH funding from SAMHSA to support home visiting as part of a broader early childhood systems development project. Both Kansas tribal HS/EHS programs operate at full or near-capacity, serving children ages birth to five and their families along with providing prenatal services for expectant mothers and their families.

For the Kickapoo Tribe in Kansas, the Project LAUNCH home visiting program was widely successful and well-received across the community while it operated. Vice Chairwoman Johanna Thomas, who led the Project LAUNCH work for several years, reports that families in the community still check in with her about Project LAUNCH home visiting, though it is no longer offered. Among the important findings from their home visiting program, five specific components were critical to its success and resonate with findings from similar federally-funded home visiting programs in indigenous communities:

- Strategic planning must be community driven and aligned with indigenous values
- Home visiting staff should be trusted tribal members, reflective of the community they serve
- Program model curriculum and delivery methods must be adaptable
- Community culture and language must be prioritized and integrated into home visits
- Programs must offer flexible performance measurement and evaluation requirements to best meet the data needs of the community.

Findings from other national tribal home visiting efforts such as the Maternal, Infant, and Early Childhood Home Visiting Program ("Tribal MIECHV") through ACF have reported similar outcomes from indigenous home visiting models. One MIECHV grantee reported in 2018 that, "Home visiting is a new concept for many of the communities served and there is some initial resistance due to historical experiences. It is important to be out in the community to build an understanding of the purpose of the program and garner trust" (Morales et al., 2018, p. 317). Another tribal MIECHV grantee stated in the same report that, "Benchmark data does not capture the cultural relevancy or irrelevancy of data collected for different tribal communities. Some data collection elements are not relevant to the cultural norms and/or traditions of some communities like birth spacing. Data does not report on cultural adaptations that have been made in regards to what is important to tribal communities, like tribal language attainment as it affects wellness of the family" (Morales et al., 2018, p. 318). ACF has

recommended through its tribal MIECHV efforts that "better tools to measure qualitative impact" are needed for indigenous home visiting programs, including outcome measurements centered on cultural and traditional understandings of progress, growth, and success, rather than "program centric" measurement models (Morales et al., 2018, p. 318).

RECOMMENDATIONS

- Expand home visiting services to high-need counties where there are few types of programs available for families. For example, Harper County only has EHS program and Rawlins County only has EHS and ABC programs. There may be families who don't meet the eligibility requirements of these programs, but may still benefit from home visiting services. Although some counties were not identified as high-need from the analysis conducted for this needs assessment, Edwards, Kiowa, Comanche, Barber, and Kingman counties do not have any home visiting programing except for Infant Toddler Services. It may be beneficial to expand some home visiting programming in these counties.
- Strengthen work with existing local collaborative organizations, so the unique needs of individual communities are being considered in planning and service implementation. Build and maintain connections within early childhood, K-12 school systems, the medical community, and municipal entities such as libraries and law enforcement.
- Introduce the web-based Integrated Referral and Intake System (IRIS) in more high-need counties, which has potential to strengthen and create opportunities for cross-sector referrals and wrap-around services for home visiting families and children.
- Bolster efforts to assure that all children in home visiting programs receive timely developmental screenings.
- Develop more robust cultural competency training across the state with particular focus in regions where language barriers pose the most challenges.
- Expand home visiting programs to Kansas tribal communities in ways that are community driven and align with indigenous values—including staff who are trusted tribal members, program curriculum and delivery methods that are adaptable, integrate community culture and language in home visits, and offer flexible performance measurement and outcomes that meet the data needs of the tribal community (more culture and community centered).

CAPACITY FOR PROVIDING SUBSTANCE USE DISORDER TREATMENT AND COUNSELING SERVICES

Substance Use Disorder (SUD) treatment facilities in Kansas fall primarily under the purview of the Behavioral Health Services system (BHS) in the Department for Aging and Disability Services (KDADS). Kansas is a community-based services state, meaning that the system is designed to ensure that individuals can receive necessary services in their community, instead of in an institution, whenever possible. For this Kansas MIECHV State-wide Needs Assessment update, we examined the comprehensive array of SUD programming overseen by BHS, as well as multiple initiatives geared toward specific groups with unique needs. The needs assessment team looked particularly closely at how the MIECHV populations of pregnant and parenting women interact with the current SUD treatment system. We identified successes and gaps, tracked consistent themes, and used this to inform recommendations for improvement.

Data Sources

Quantitative

For this update, data on the prevalence of SUD and available treatment services across Kansas were drawn from the following sources:

- HRSA-provided Needs Assessment Data Summary for Kansas
- 2018 National Survey of Substance Abuse Treatment Services (N-SSATS), Substance Abuse and Mental Health Services Administration (SAMHSA)
- Kansas FY 2020/2021 Block Grant Application: Substance Abuse Prevention and Treatment and Community Mental Health Services

These sources were used to guide the needs assessment team in summarizing the overall landscape of SUD services including types of care, formats of counseling, populations served, geographical locations, payment options, languages spoken, and frequency of other ancillary services offered.

Qualitative

Home visiting providers, directors, and community members submitted both professional and personal experience with SUD in the following (see full descriptions in Section 3):

- Kansas Early Childhood (PDG) Needs Assessment
- HS and CBCAP local program needs assessments
- State and Community Level Surveys
- HS Collaboration Strategic Planning and Needs Assessment

These assessments and surveys helped inform conclusions and provide context around perceived barriers to accessing treatment. By using local input and examining both providers' and community members' experiences with transportation, child care, language differences, and rural isolation, we were able to better understand and illustrate the struggles surrounding SUD in Kansas. While looking at statewide data is important, telling the true story of any issue in Kansas requires fully drilling down to regional needs and noting the differences between counties and towns.

Collaboration

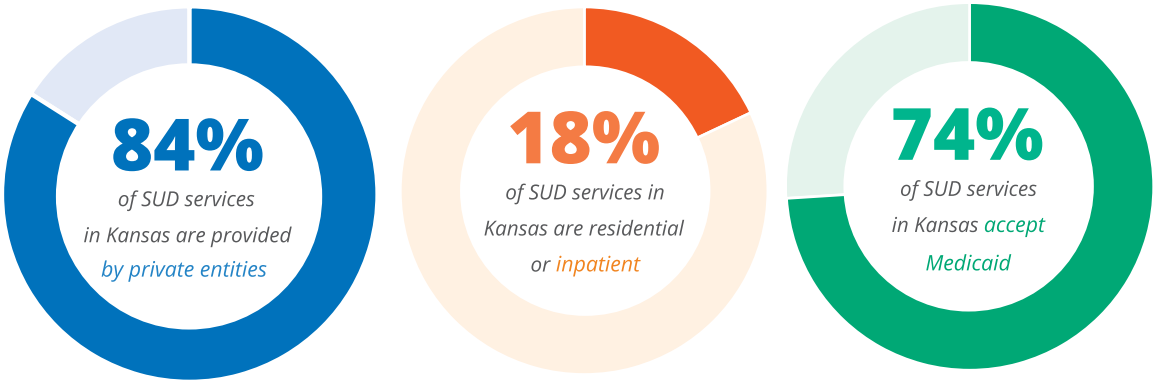
Sources informing statewide collaboration opportunities and ongoing initiatives to strengthen the overall system of care included the following:

- Governor's Behavioral Health Services Planning Council, Kansas Citizen's Committee on Alcohol and Other Drug Abuse (KCC, Annual Report, 2019)
- Kansas Prescription Drug and Opioid Misuse and Overdose Strategic Plan, July 2018
- Kansas Prescription Drug and Opioid Misuse and Overdose Strategic Plan Annual Report, 2019
- CBCAP Kansas Prevention Investments Annual Report 2019

Range of SUD Treatment and Counseling Services

Statewide

The 2018 N-SSATS reported data for 179 substance abuse treatment facilities in the state of Kansas *(see Table C.1 in Appendix C)*. With a survey response rate of 93.7%, this report gives an accurate depiction of the landscape of treatment available in the state. Unless otherwise noted, statistics cited in this section are from the N-SSATS survey results.



SUD services in Kansas are provided primarily by private entities, both non-profit and for-profit, which account for 84% of the 179 facilities. The other 16% are a combination of local, state, federal, or tribal government operations. Outpatient is the predominant type of care available across all settings, with just 18% offering a residential or inpatient option, and less than 3% including child care. Other notable large-scale descriptors include 74% acceptance of Medicaid, 83% incorporating family counseling, and 92% delivering transitional or continuing care post-treatment. *See Figures C.1 and C.2 in Appendix C.*

Kansas also has 26 Community Mental Health Centers which often work in conjunction with SUD treatment facilities to connect, refer, and simultaneously treat clients. With 55% of SUD facilities reporting that they conduct regular mental health screenings upon intake, and all but one indicating that individual counseling is a standard component of care, it is clear that mental health considerations are inextricable from SUD treatment.

To help address the opioid crisis, funding from the State Opioid Response (SOR) federal grant is currently being used to expand access to treatment, particularly evidence-based treatment, and to reduce the number of opioid-related deaths across our state. Four grantees cover services for all 105 counties in Kansas in different geographical locations and include a medical center/methadone clinic, a substance use disorder provider, a regional alcohol and drug assessment center, and a mental health center.

Pregnant Women and Families with Young Children

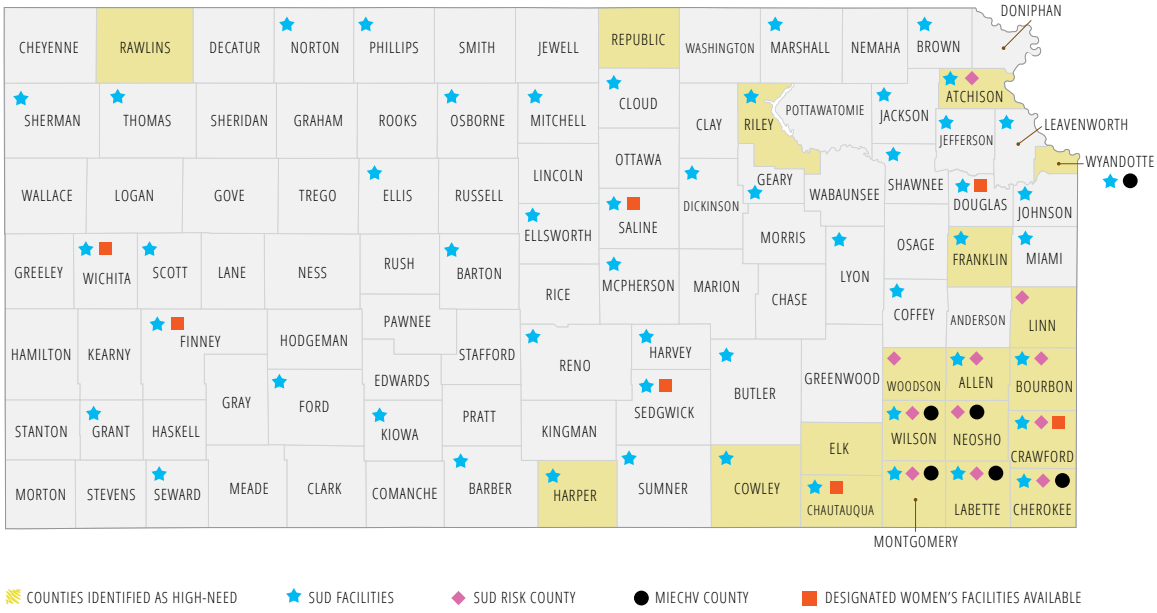
Regarding the unique needs of the MIECHV populations, SUD treatment options for pregnant women and families with young children do operate in each region of Kansas, but programming tailored specifically for them is limited. Forty percent of facilities have special services for adult women, yet only half of those report offering further targeted care for pregnant or postpartum women.

One hundred and six facility locations are currently funded under the federal Substance Abuse Prevention and Treatment Block Grant (SABG), overseen by KDADS. The block grant prioritizes treatment options for pregnant women and women with dependent children (PWWDC), requiring states to spend no less than an amount equal to that spent in prior fiscal years for these specialized services. Therefore, it is expected that each year the capacity and/or capabilities of programming for PWWDC will remain steady or improve.

In Kansas, there are five funded Designated Women's Facilities (DWF) grantees which serve nine different locations in seven counties. Several of the DWFs are understandably located in populous areas of the state, including the towns of Salina, Lawrence, and Wichita. Two are available in counties identified as high-need for this needs assessment update, in the towns of Sedan (Chautauqua County) and Pittsburg (Crawford County). *Figure* 3 shows the Kansas counties with SUD facilities, the 20 high-need counties identified for this needs assessment, the 11 counties identified as having SUD Risk, the six counties where MIECHV services exist, and the counties where DWFs are located (see also *Table C.2 in Appendix C*).

Figure 3

Map of Kansas Substance Use Disorder Need and Support



The Kansas 2020-2021 SABG Application details the priorities and full continuum of services of DWFs:

1. Treat the family as a unit and, therefore, admit both women and their children into treatment services, if appropriate.
2. Provide or arrange for primary medical care for women who are receiving substance abuse services, including prenatal care.
3. Provide or arrange for child care while the women are receiving services.
4. Provide or arrange for primary pediatric care for the women's children, including immunizations.
5. Provide or arrange for gender-specific substance use disorder treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting.
6. Provide or arrange for therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect.
7. Provide or arrange for sufficient case management and transportation services to assure that the women and their children have access to the services provided by (2-6) above.

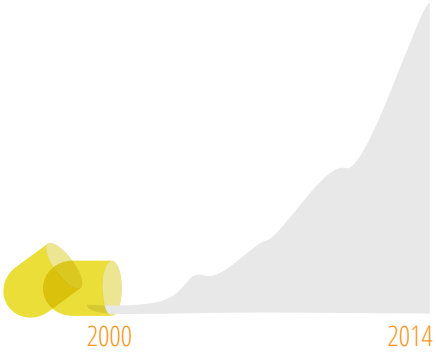
Oxford Houses are another potential SUD recovery route for the PWWDC populations in Kansas. The non-profit Friends of Recovery Association operates 126 Oxford Houses in Kansas with support from a combination of State General funds and SABG funds. The Oxford House Model is a community-based approach to addiction treatment which provides an independent, supportive, and sober living environment. They are not run by staff but are democratically operated by residents themselves in local neighborhoods. No time limits for participation exist, so people can support each other

through recovery while practicing skills for responsible family and community living. Further, the options for children are not limited to women-only facilities, as some are designated for men raising children as well. (https://friendsofrecovery.com/about-us/about-oxford-house).

Pregnant women and infants have also been prioritized by the Kansas Prescription Drug and Opioid Advisory Committee, who made combating Neonatal Abstinence Syndrome (NAS) a key component of their 2018 Strategic Plan. NAS refers to when a newborn has withdrawal symptoms from opioid exposure in utero, and its incidence increased in Kansas by 900% from 2000-2014. KDHE partnered with the Kansas Perinatal Quality Collaborative (KPQC) to bring a universal training program to every birthing center in the state. According to the Committee's 2019 Annual Report, 52.4% of centers have implemented the Vermont Oxford Network Universal NAS Training and Education. They are aiming for 85% of those trained to achieve "Center of Excellence" designation by October 2020 and have a goal to increase the total participants to 76.9% of birthing centers by 2022.

Figure 4

Neonatal Abstinence Syndrome (NAS) incidence in Kansas increased by 900% between 2000 and 2014.



High-Need Counties

Of the 20 counties assessed as high-need for this MIECHV Statewide Needs Assessment update, 11 were selected in part due to their high prevalence of indicators of SUD risk: Allen, Atchison, Bourbon, Cherokee, Crawford, Labette, Linn, Montgomery, Neosho, Wilson, and Woodson. All 11 have multiple home visiting programs operating, so the likelihood of home visitors working around substance-related issues may be greater in these counties than others. It is critical to note that all but one of the eleven counties comprise the Southeast corner of the state, meaning the heaviest concentration of risk, particularly around SUD, can be regionally tracked here.

It is critical to note that all but one of the eleven counties with SUD risk comprise the Southeast corner of the state.

All of our high-need counties have at least one SUD treatment facility or Community Mental Health Center operating nearby. However, individuals in counties with limited choices might need to travel to access appropriate treatment (see Geography in Gaps below). In general, the number of facilities available tracks proportionately to population density, meaning an urban county such as Wyandotte in Kansas City logically has more programs than a rural or frontier area like Rawlins near the Colorado/Nebraska borders. Notably, although not included in the high-need counties for this needs assessment, Sedgwick has a large number of treatment options due to the population of Wichita, presumably filling the need for some smaller surrounding counties within driving distance. Also of significance, Crawford County has multiple programs and is positioned as somewhat of a "service hub" for the aforementioned very high-need Southeast region.

Gaps in SUD Treatment and Counseling Services

Data

In analyzing the current Kansas data, our needs assessment team found the largest gap resides in the data reporting itself. In October of 2018, the state discontinued the use of the Kansas Client Placement Criteria, the data source used to report quarterly and annually on PWWDC in the DWFs. An interim system is currently in use, but does not report in the same manner for these specific demographic parameters, resulting in a pause in data and accurate numbers on PWWDC. The 2020-2021 SABG Application indicates that "Kansas is in the process of developing a new substance use disorder data system to enhance the monitoring and tracking of Block Grant data collection and monitoring elements related to DWFs and other Block Grant facilities. Block Grant monitoring processes are being reviewed and enhanced electronic Block Grant data collection and monitoring elements is being considered for the new system."

The most visible gap in fully meeting treatment needs is geographical, particularly for PWWDC.

Geography

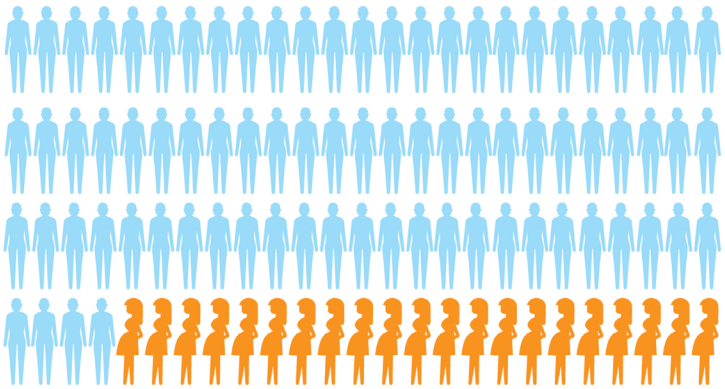
The most visible gap in fully meeting treatment needs, particularly for PWWDC, is geographical. The population density of the Eastern third of the state is significantly higher than the more rural Western and Central regions. Some of our most high-need counties have no SUD facilities and might not even have one in a neighboring or bordering county. In many cases, a rural family must consider full relocation to access appropriate treatment, which is generally deemed an impossibility, especially for a pregnant woman or a parent with small children. Further, although the Southeast region appears to have a number of program options, the high prevalence of multiple risk indicators in this area keeps facilities in demand. Home visitors and other social service providers still report wait lists and difficulty placing clients in a timely manner.

The Designated Women's Facilities (DWFs) show a similar picture geographically, with several concentrated in the Central region, mostly due to the populous county of Sedgwick with the city of Wichita. This cluster is understandable, as Sedgwick has the highest number of children receiving child care subsidies in the state, so the need for facilities with child-related services is obviously greater. Despite the high level of risk indicators identified in the Southeast region, only one DWF in Crawford serves the entire 12-county corner.

Additionally, five entire regions do not have a DWF, so women across a large portion of the state may have no treatment option where the family can attend together. Of the 179 facilities reported in the 2018 N-SSATS survey, only 21% offer programming for pregnant or postpartum women. For a home visitor in a less populous region attempting to make a referral for PWWDC struggling with drugs or alcohol, this presents a considerable challenge.

Figure 5

Percentage of Kansas SUD Facilities Offering Programming for Pregnant or Postpartum Women



Medication Assisted Treatment

Although considered a standard of care for opioid addiction, accessing Medical Assisted Treatment (MAT) can be difficult in Kansas with only 20 of 105 counties having a provider who offers this option. According to the 2018 Kansas Prescription Drug and Opioid Misuse and Overdose Strategic Plan, travel distance, stigma, and lack of Medicaid acceptance all contribute to this gap. The Plan has set both state and community level goals for expanded access - incorporating strategies for workforce development, insurance and payment changes, data and coding practices, and funding sustainability.

Barriers to Receipt of SUD Treatment and Counseling Services

Trends that emerged through our needs assessment process mirrored those of the recently completed PDG Needs Assessment, with providers, leaders, and community members voicing the same roadblocks repeatedly. The common issues facing all Kansas families with young children are only further magnified by the struggles which accompany SUD. For home visitors, the steps to helping a family access treatment can be steep and frustrating, as so many basic needs must be addressed to make it possible.

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Medicaid

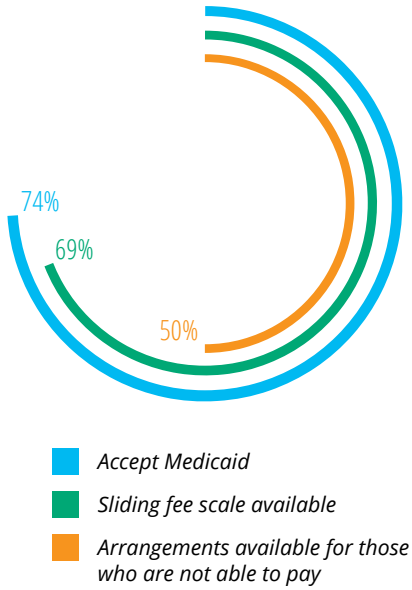
Kansas is one of the last states in its region to remain without Medicaid expansion, which limits the accessibility of all medical services for those living in poverty. Families report struggling with complexities of both qualifying for coverage and locating providers. N-SSATS shows that while 74.3% of Kansas SUD facilities do accept Medicaid, and 68.7% offer a sliding fee scale, only 50% work to make arrangements for those who cannot pay. Further, just because a facility may accept Medicaid does not mean it is geographically accessible nor offers the appropriate treatment, particularly for PWWDC.

Transportation

With geographical challenges noted as a common gap in services, transportation is not surprisingly a frequently cited barrier. With only 18% of SUD facilities providing a residential option, most clients must have a reliable source of transportation to and from outpatient treatment, which sometimes might be in a neighboring county. In some cases, assistance with transportation could be provided by insurance or Medicaid, but often this is not possible. For rural Kansans, accessing treatment is usually cost and time prohibitive due to distance, while urban and suburban clients face their own challenges with public transportation. Only 30% of SUD facilities report offering transportation assistance.

Figure 6

Payment for Service Options at Kansas SUD Facilities



Lack of child care

As a key finding of the PDG Needs Assessment, the overall lack of quality child care in the state affects families even under the best of circumstances. For those facing SUD, having only a handful of facilities where children can attend is a great barrier to receiving treatment. N-SSATS reports no SUD facilities offering help with child care besides the DWFs. Additionally, for many pregnant or parenting women who experience SUD, there may be a lack of support from others. Often, ties have been severed among those close friends and family who might traditionally assist with child care. Further, there is frequently concern that seeking help with one's children while battling SUD might result in involvement from DCF and a risk of parental rights.

Language

Home visiting providers and leaders indicate that as the number of non-English speaking families increases, securing translation to fully serve them can be a challenge. Forty percent of the SUD facilities offer services in a language besides English, but this is usually via an on-call interpreter and not an actual licensed counselor in the program. Diversifying the workforce is a key to reaching those populations who may currently be underserved due to language or culture barriers.

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Collaboration Opportunities

Several initiatives are underway in Kansas to strengthen collaboration and increase collective impact locally, regionally, and statewide. Multiple state agencies and government committees have partnered in prevention efforts, both for substance use disorders and child abuse and neglect, as well as in goal setting and implementation for the future.

The Governor's Behavioral Health Services Planning Council

The Governor's Behavioral Health Services Planning Council is actively involved in planning, implementing, monitoring, evaluating, and advising state government regarding Kansas' mental health services. It is comprised of a cross-section of mental health consumers, mental health professionals, state agency staff, and private citizens.

As a sub-committee under the Council, the Kansas Citizens' Committee on Alcohol and Other Drug Abuse (KCC) specifically advises on the following: Substance Use Treatment, Prevention, Problem Gambling services, and Recovery Oriented Systems of Care.

The KCC 2019 Annual Report focuses on 4 key areas: Increased Funding, Improved Access and Service Integration, Workforce Crisis, and Prevention. Current recommendations directly impacting MIECHV providers and populations include:

- Allow addiction providers to address co-occurring mental health issues with clients
- Support Medicaid expansion to ensure coverage for behavioral health services
- Support telehealth initiatives to improve access
- Address policies that interfere with access and use of county-level data
- Establish funding for prevention of ACEs

Additionally, The Rural and Frontier Subcommittee (RF) collaborates through research to statistically understand and promote accessibility and availability of mental health services in frontier and rural Kansas counties. The RF advocates for the unique needs of less populous regions of the state and ensures that they are considered in fiscal issues and policy development. They work to strengthen the continuum of care by addressing a lack of resources, depopulation, a higher percentage of non-English speaking residents, and a shortage of behavioral health providers, which can all be barriers to getting the quality care these areas need and deserve.

Governor's Substance Use Disorders Task Force 2018

Under then Governor Jeff Colyer, the Substance Use Disorders Task Force was formed in 2018 and convened monthly for 8 months to gather information about SUD in Kansas, particularly opioid and heroin overdoses and methamphetamine addiction. The Task Force aimed to evaluate and leverage resources in Kansas healthcare and to execute a statewide response. 34 detailed recommendations were put forth, many of which prioritize the MIECHV populations of PWWDC:

- Provide education, screening, intervention, and support to substance-using women to reduce the number of infants born substance-exposed (Neonatal Abstinence Syndrome, NAS), including supporting the use of Vermont Oxford Network's NAS Universal Training Program to Kansas birthing centers
- Promote best practices to reduce stigma and promote standardized care for NAS; develop a standard reporting process
- Increase number and capacity of designated women and family treatment centers
- Increase access to medication-assisted treatment (MAT) for pregnant women
- Fully expand Medicaid

Recommendations and goals from the Task Force continue to inform the work of SUD treatment professionals across the state, including the three initiatives detailed below.

Kansas Partnerships for Success 2015 Prescription Drug Initiative

A state-level collaboration of multiple counties and programs, the Kansas Partnerships for Success 2015 Prescription Drug Initiative works to prevent non-medical use of prescription drugs in high-need areas. It is funded through SAMHSA, overseen by KDADS, and administered by DCCCA in Douglas County (technically Northeast Kansas Counseling and Resource Center, but retains its original historical acronym). Efforts include funding community coalitions, coordinating prevention activities across the state, and facilitating the Kansas Prescription Drug and Opioid Advisory Committee. County-level reach includes coalitions in Finney, Atchison, and Sedgwick, as well as medication disposal sites in the towns of Pratt, Hesston, Salina, Erie, Ottawa, and Hutchinson.

Kansas Data-Driven Prevention Initiative

Funded through the Center for Disease Control and administered through KDHE, the Kansas Data-Driven Prevention Initiative is a collaborative effort to address the drug and opioid crisis through data collection, prevention, and work with medical professionals (e.g. pharmacies, physicians, and hospitals), law enforcement, and the general public. This initiative also supports the Task Force recommendations above concerning NAS.

Kansas Prevention Collaborative: Community Initiative (KPCCI) coalitions

The Kansas Prevention Collaborative, also part of KDADS, works to increase and enhance local level capacity and readiness. 13 coalitions in 3 regions currently mobilize community members in strategic planning and implementing data-driven, culturally competent substance use prevention approaches. Four more coalitions are in the planning phases, including the high-need counties in this MIECHV Statewide Needs Assessment update of Crawford, Franklin, Wyandotte, as well as Clay County, which borders Riley.

Community Based Child Abuse Prevention (CBCAP) Grantees

CBCAP programs across the state work in conjunction with SUD treatment providers regularly in an effort to combat the high-risk connections between drug and alcohol addiction and child abuse and neglect. Two examples of successful collaboration across sectors are the Response Advocate Program and the Drug Endangered Child Program.

The Response Advocate Program operates under the Family Resource Center in Pittsburgh and pairs case managers to work side-by-side with local law enforcement, assisting families identified as high-need for child maltreatment. Due to the high prevalence of drug-related law enforcement calls in high-need Crawford County, the program is able to provide intervention for many families with young children who might be using substances. They are a true community collaboration, linking families as needed to home visiting options, mental health facilities, nearby substance abuse providers, and the local health department.

The Drug Endangered Child Program operates under the Kansas Children's Service League (KCSL) in Topeka and supports mothers working to overcome substance abuse. The program includes early identification of parents who are abusing substances and offers intensive, weekly support through case management and home visits. The program collaborates with hospital intake centers for screening, helps families access treatment and concrete supports, and provides connections to postpartum and pediatric care.

KEY FINDINGS & RECOMMENDATIONS

With many efforts currently underway to strengthen the experience of Kansas families with young children, home visitors are energized and dedicated to working closely with SUD treatment programs for their clients. Through this MIECHV Statewide Needs Assessment update, we found that several common themes emerged repeatedly across professional sectors, geographic regions, and various populations, highlighting key areas on which to focus future research and service provisions.

Key Findings

- Pregnant and parenting women have more limited options for SUD treatment specially tailored to their unique needs, and even fewer options for Designated Women's Facilities which offer services, care, and residence for children.
- Geography is a significant indicator of availability of and access to SUD and mental health treatment, whether influenced by population density, county need level, or rural isolation and travel time. Transportation is a closely related complication.
- Southeast Kansas has a cluster of counties assessed as high-need overall with significant poverty, while also showing an additional concentration of those deemed to be at greatest risk of SUD.
- Data from DWFs is incomplete and inconclusive at this time due to the use of a temporary collection system while KDADS selects and transitions to an improved one.
- Kansas has many State agencies, regional committees, and local organizations working toward similar goals for women and children affected by SUD, so opportunities for collaboration abound, but they are not all connected seamlessly nor communicating regularly for efficient effort vs. impact.

Recommendations

- To fully address the unique needs of women and children, more SUD facilities must be funded for residential options and provide assistance with child care. Even if outpatient programs that are not specifically designed for PWWDC could offer some options for child care during appointments, this would be a step toward better access.
- Rural outreach, including a workforce trained for the unique needs of small or isolated communities, must be a priority. This may appear as increased satellite locations, better use of telehealth for less populous regions of the state, or flexible policies regarding community mental health and SUD provider overlap.
- Expansion of Medicaid could help many families seek treatment who are currently unable to afford it, or who need transportation assistance to a different county to gain access, particularly in the Southeast region.
- As leaders across the state continue to engage in strategic planning based on the Kansas Early Childhood Needs Assessment, special consideration should be given to SUD treatment and how it affects the whole field of early childhood service, including home visiting. Specifically, we should see efforts to improve collaboration and merge the recommendations of multiple high-level State committees with that of the workforce directly serving clients.

COORDINATION WITH TITLE V MCH BLOCK GRANT, HEAD START, & CAPTA NEEDS ASSESSMENTS

The Kansas MIECHV program coordinates with key stakeholders and programs across the broader Kansas early childhood system through ongoing opportunities for needs assessment alignment and regular communication. Key stakeholders include the funders, leadership, and staff of the Kansas Title V MCH Block Grant, EHS and HS organizations, and CAPTA programs, as well as Part C programs, SUD treatment programs, and mental health partners. Additionally, home visiting stakeholders, staff, and families contributed to the 2019 Kansas PDG Needs Assessment. The key findings of this Kansas MIECHV Statewide Needs Assessment update, especially regarding risk, unmet need, and gaps in high-need counties, are informed by these coordinated efforts.

Coordination & Alignment Across Needs Assessments

While the HS, CAPTA, PDG, and Part C Needs Assessments were already completed and available during the data collection phase for this Kansas MIECHV Statewide Needs Assessment update, the Kansas Title V MCH Block Grant Five-Year Needs Assessment was ongoing. For needs assessments already complete and available, the needs assessment team considered their findings and results when identifying areas of risk, unmet needs, and gaps in care for the quality and capacity of home visiting in high-need counties. To maximize resources and ensure quality data collection, this Kansas MIECHV Statewide Needs Assessment team coordinated efforts with the MCH Needs Assessment team for identifying needs of home visiting programs in Kansas through a Provider Community Survey and through Regional Open Houses (both data collection methods are fully described in the Quality and Capacity of Existing Programs section of this document). The MIECHV Statewide Needs Assessment team analyzed responses from home visiting providers and community responses pertaining to home visiting to inform this document.

Key Findings

Below are each of the reviewed needs assessments as well a summary of key information learned from these. The needs assessment team focused on home visiting service gaps, service duplication, barriers to service access, and opportunities to strengthen and improve coordination of services. Each needs assessment is more fully described in the Quality and Capacity of Existing Programs section.

Title V MCH Block Grant Needs Assessment

This Kansas MIECHV Statewide Needs Assessment update process included a review of data from the Title V MCH Block Grant needs assessment, including data gathered from the survey and focus groups described above. Only one MCH open house occurred in an high-need county but others drew responses from families that experience similar risk factors as those in high-need counties, as well as the staff that work with them.

Key findings pertaining to home visiting

- Families need additional support to navigate and follow through on referrals both into home visiting programs and from home visiting programs to other critical services.
- Barriers to service access include transportation, geography, and culture/language.
- Additional coordination between providers of services across systems would benefit home visiting families.

Community-based Child Abuse and Neglect Prevention (CBCAP) Needs Assessment

The Kansas Children's Cabinet and Trust Fund (the Cabinet) Services serves as the lead agency for CBCAP grant programs in Kansas and provides a CBCAP Annual Report with a snapshot of CAPTA programs and services that support young children and their families. CBCAP services exist in four of the Kansas high-need communities.

Key findings pertaining to home visiting

- Navigation of key prevention services and systems is complicated for families and staff alike, especially for families with multiple risk factors.
- Families interacting with CAPTA programs often face a range of ongoing needs.
- Strong collaboration between critical service providers is especially important for families with high-needs.
- In high-need counties, access to health services and medical care is a barrier, as are the high levels of crisis due to poverty, drug violations, and lack of basic resources.

Head Start Collaboration Strategic Planning and Needs Assessment

As part of this MIECHV Statewide Needs Assessment update, both local HS and EHS agencies community assessments were reviewed as well as the 5-year strategic plan of the Kansas HS Collaboration Office (KHSCO), including a review of needs assessments from several high-need counties.

Key findings pertaining to home visiting

- For families facing isolation, especially in rural and western regions of Kansas, home visiting is a connector and provides a critical opportunity for screenings, referrals, and follow-up for families otherwise disconnected from the system.
- Workforce challenges create a significant gap, including the need for diverse, bilingual staff who can meet the needs of culturally diverse families. Additional challenges include turnover, low wages, and gaps in the professional development system, especially in mental health, substance abuse, trauma support services.

- Complicated referral systems exist, especially for access to critical mental health services.
- Home visitors must navigate parts of the court system, foster care system and substance abuse system, especially in high-need counties. Connected networks of providers are especially important.

PDG Needs Assessment

The Kansas PDG Needs Assessment was a comprehensive review of specific needs and issues Kansas families face, including home visiting needs and gaps, as well as strengths. This needs assessment provided details regarding home visiting within the infrastructure of the early childhood care and education systems in Kansas and included input from all high-need counties.

Key findings pertaining to home visiting

- Home visiting often fills gaps resulting from lack of other services, especially in rural counties. Home visiting connects families and is a central hub for referrals, or an entry point, in many communities
- Challenges exist around transitions and navigations, especially for children in foster care and child welfare.
- The broader early childhood system faces workforce challenges, especially in preparation, compensation, and retention of qualified staff, including home visitors.
- Across the early education system, including home visiting, a need exists for greater alignment of data measures and elements. Kansas has in place the foundational structure for an early childhood integrated data system that has not been fully realized.

2019 Kansas Infant Toddler Services (Part C) Needs Assessment

The Part C Needs Assessment provides a review of the capacity and needs of Part C programs across the state, including those serving high-need counties.

Key findings pertaining to home visiting

- Part C serves as a vital referral partner for home visiting programs and referral systems in high-need counties.
- A concerning number of young Kansas children do not receive timely developmental screenings.

Ongoing Coordination and Communication

Several examples exist of coordination between home visiting and key stakeholders, both for the purposes of this needs assessment and for ongoing communication. For the purposes of this MIECHV Statewide Needs Assessment, our team engaged in conversations and feedback loops with stakeholders and members of other teams, including the Title V Needs Assessment Team. Members of both teams reviewed a crosswalk of the MCH and MIECHV needs assessments and identified opportunities for shared data collection. The Kansas MIECHV Statewide Needs Assessment team also collected data via email and surveys from the directors and program leaders of evidence-based and non evidence-based home visiting programs, including numbers of families and children served, waiting list status, open slot status, referral information, funding sources, and demographic information of families served. This included data collection from eight key home visiting models in Kansas.

DATA COLLECTION SOURCES

Early Head Start (EHS)

Parents as Teachers (PAT)

Healthy Families America (HFA)

Team for Infants Endangered by Substance Abuse (TIES)

Nurse Family Partnerships (NFP)

Infant Toddler (Part C) services (tiny-k)

Maternal Child Health (MCH) home visiting

Attachment and Biobehavioral Catch-up (ABC) Intervention

The Kansas Home Visiting Leadership Team serves to assure ongoing communication and coordination across MIECHV and home visiting stakeholders. Including representation from Title V MCH Block Grant, HS and CAPTA agencies, providers in MIECHV high-need counties, as well as other state early education and home visiting agencies and stakeholders, this team focuses on strengthening the capacity of home visiting in Kansas, especially for high-need counties. This team provided input and review for this MIECHV Statewide Needs Assessment update. Additional activities of this team include:

- Providing guidance and resources in response to emergent needs facing home visiting agencies and families, such as the recent pandemic.
- Aligning resources and opportunities that strengthen the capacity of home visiting, including centralized referral systems through the expansion of the centralized referral systems, professional development, funding, and data/measurement alignment.
- Coordinating statewide conferences and meetings related to home visiting.
- Increasing awareness of home visiting and its positive impacts through coordinated messaging.

KEY FINDINGS & RECOMMENDATIONS

Several overlapping key findings emerge across these various needs assessments and aligned efforts that can further the impact of home visiting in Kansas high-need counties.

Key Findings

- Across various needs assessments, no evidence of duplication of services arises. Rather, home visiting often fills gaps in communities with very few services available for systemically underserved families.
- Barriers to service access include follow-through by families, often due to complications with navigating systems; challenges particularly for families with high-needs involved with foster care or substance abuse services; and insufficient workforce.
- Kansas home visiting programs are data rich but the data live in many different systems and in many different forms.

Recommendations

- Early childhood integrated data system is one key strategy in bringing together diverse home visiting data to share across programs and organizations in meaningful ways.
- Greater coordination between providers, especially pertaining to coordinated referrals and entry points; cross sector services, including mental health services; and developmental screenings benefit home visiting families in high-need counties.

CONCLUSION

This Kansas MIECHV Statewide Needs Assessment update considers and assesses several factors regarding the availability and accessibility of evidence-based home visiting programs in Kansas for families of young children birth to kindergarten entry who live in high-need counties. This update included four components.

THE FOUR COMPONENTS OF THIS NEEDS ASSESSMENT

1

Identification

Identification of high-need counties using HRSA's simplified method. Additionally, Kansas considered the needs of the four federally-recognized tribes that call Kansas lands home and which are often under- or mis-represented in traditional needs assessment processes.

2

Assessment

A quantitative and qualitative assessment of the quality and capacity of existing home visiting programs.

3

Evaluation

An evaluation of the capacity to treat substance use disorders and provide counseling across Kansas, especially to pregnant and parenting women.

4

Review

A review and discussion of the alignment and coordination between home visiting programs and other key early childhood programs and stakeholders.

Major Findings

For each section of this Kansas MIECHV Statewide Needs Assessment update, key findings and recommendations summarize both strengths, gaps, and potential opportunities pertaining to that particular aspect of home visiting in high-need communities across Kansas. When synthesized, these findings, and their corresponding recommendations, align into four major findings regarding Kansas Home Visiting.

Major Finding #1: Investments Matter

Current investments in home visiting and the existing delivery of home visiting services positively impact Kansas families with young children, especially those in high-need communities, including current MIECHV home visiting counties. In fact, home visiting often fills gaps in high-need communities where very few services are available for those systemically underserved.

Recommendations

- Provide services to target needs of families around the specific indicators that the data showed had the highest concentrations of risk for the current MIECHV home visiting programs.
- Review each identified 20 high-need counties and their corresponding risk domains to provide services that may target those domain areas.

- Expand home visiting services to high-need counties where there are few types of programs available for families (e.g. Harper and Rawlins counties), and in counties where only Infant Toddler Services are available, although these counties were not identified as high-need counties (e.g. Edwards, Kiowa, Comanche, Barber, and Kingman counties).

Major Finding #2: Address Key Gaps in Programs and Understand Needs

The positive impact of home visiting could be magnified by addressing key gaps and barriers for families and children served in home visiting programs, especially in high-need communities. Additionally, better understanding the needs of under-represented communities is critical.

Recommendations

- Bolster efforts to assure that all children in home visiting programs receive timely developmental screenings.

- Develop more robust cultural competency training across the state with particular focus in regions where language barriers pose the most challenges. State and home visiting program leaders should develop ongoing partnerships with tribal leaders to repair harm and restore trust with indigenous communities.

    - » Assessing early childhood and maternal-infant needs in these communities that includes indigenous family structures, livelihoods, and perspectives.

    - » Expand home visiting programs to Kansas tribal communities in ways that are community driven and align with indigenous values—including staff who are trusted tribal members, program curriculum and delivery methods that are adaptable, integrate community culture and language in home visits, and offer flexible performance measurement and outcomes that meet the data needs of the tribal community (more culture and community centered).

Major Finding #3: Further Alignment and Coordination Needed

Kansas Home Visiting is a key partner in the Kansas Early Childhood System but opportunities for further alignment and coordination exist.

Recommendations

- Achieve greater coordination between providers, especially pertaining to coordinated referrals and entry points; cross sector services, including mental health services; and developmental screenings benefit home visiting families in high-need communities.

- Use the wealth of home visiting data in effective ways across all home visiting programs to understand the collective impact of home visiting on outcomes of interest. It is important to find a system in which the county-level data across programs can be collected and analyzed in meaningful ways to better understand how home visitation programs are meeting the needs of families and children in the state.

- Collect unduplicated counts of families and children that have accessed home visiting programs and to have a unique identifier for child-level data. Duplicated counts of capacity data are not accurately representative of the reach and accessibility of home visiting services to children and families in the state.

- Collect demographic data of who is being served by all home visiting programs at the county. These demographic data are important to have across all home visiting programs to better understand the backgrounds (race, ethnicity etc.) of families served whether the needs of families with different demographic backgrounds are disproportionately affected by home visiting programs.

- Utilize an early childhood integrated data system as one important strategy in bringing together diverse home visiting data to share across programs and organizations in meaningful ways.

- Strengthen work with existing local collaborative organizations, so the unique needs of individual communities are being considered in planning and service implementation. Build and maintain connections within early childhood, K-12 school systems, the medical community, and municipal entities such as libraries and law enforcement.

- Introduce IRIS in more high-need counties, which has potential to strengthen and create opportunities for cross-sector referrals and wrap-around services for home visiting families and children.

Major Finding #4: Easier Access to Services is Needed

High-need families, especially those impacted by substance use disorders and mental health needs, struggle to access services necessary for addressing these concerns, especially when coupled with other indicators of needs such as poverty and unemployment.

Recommendations

- Fund more SUD facilities that include residential options and provide assistance with child care. Even if outpatient programs that are not specifically designed for PWWDC could offer some options for child care during appointments, this would be a step toward better access and to meet the unique needs of women and children.

- Prioritize rural outreach, including a workforce trained for the unique needs of small or isolated communities. This may appear as increased satellite locations, better use of telehealth for less populous regions of the state, or flexible policies regarding community mental health and SUD provider overlap.

- Expand Medicaid to help families seek treatment who are currently unable to afford it, or who need transportation assistance to a different county to gain access, particularly in the Southeast region.

- Improve collaboration and merge the recommendations of multiple high-level state committees with that of the workforce directly serving clients with special consideration given to SUD treatment and how it affects the whole field of early childhood service, including home visiting.

Dissemination

The existing Kansas MIECHV programs was informed by the original 2010 Kansas MIECHV Needs Assessment, which provided a comprehensive look of the state of home visiting in the state and provided information to guide decision making about home visiting investments. Likewise, this update will provide a roadmap for decision making regarding home visiting, especially in high-need counties, for the coming years. The major findings and recommendations from this will be highlighted in an Executive Summary for dissemination to key decision makers in state and local leadership to inform programmatic, alignment, funding, and infrastructure decisions. Additionally, the State Home Visiting Leadership Group will utilize the assessment for establishing its priorities. The update will also be readily available to all home visiting stakeholders at the state and community levels. Various opportunities for dissemination include:

- Program- and community-level dissemination via existing home visiting and program networks.
- Placement on the KDHE website for accessibility to the general public.
- Information shared via multiple formats including briefs, presentations, posters, and social media will be used as is appropriate to the audience.
- Findings will be shared with local MIECHV partners and statewide home visiting partners through the Kansas Home Vising collaboration.
- The Kansas Home Visiting collaboration will disseminate findings to the larger statewide audience through presentations at statewide and regional conferences/meetings (e.g. Governor's Conference Prevention of Child Abuse and Neglect, KS Public Health Association conference, KS HS Association) as appropriate to the audience.

APPENDICES

APPENDIX A: IDENTIFYING COMMUNITIES & CONCENTRATIONS OF RISK

Table A.1: Description of Risk Domains, Indicators, and Data Sources by Socioeconomic Status (SES) Domain

Indicator	*Indicator Definition*	*Alignment with statute definition of high-need counties*	*Year*	*Source*
Poverty	% population living below %100 FPL	Poverty	2017	Census Small Area Income and Poverty Estimates
Unemployment	Unemployed percent of the civilian labor force	Unemployment	2017	Bureau of Labor Statistics
High School Dropout	% of 16-19 year olds not enrolled in school with no high school diploma	High school dropouts	2017	American Community Survey
High School Dropout	% of 16-19 year olds not enrolled in school with no high school diploma	High school dropouts	2013-2017	American Community Survey
High School Dropout	% of 16-19 year olds not enrolled in school with no high school diploma	High school dropouts	2013-2017 or 2017	American Community Survey
Income Inequality	Gini Coefficient - 1 Yr Estimate	N/A	2017	American Community Survey
Income Inequality	Gini Coefficient - 5 Yr Estimate	N/A	2013-2017	American Community Survey
Income Inequality	Gini Coefficient - 1 Yr or 5 Yr Estimate	N/A	2013-2017 or 2017	American Community Survey

Table A.2: Description of Risk Domains, Indicators, and Data Sources by Adverse Perinatal Outcomes Domain

Indicator	*Indicator Definition*	*Alignment with statute definition of high-need counties*	*Year*	*Source*
Preterm Birth	% live births <37 weeks	Premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect or other indicators of high-risk prenatal, maternal, newborn, or child health	2013-2017	NVSS - Raw Natality File
Low Birth Weight	% live births <2500 g	Premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect or other indicators of high-risk prenatal, maternal, newborn, or child health	2013-2017	NVSS - Raw Natality File

Table A.3: Description of Risk Domains, Indicators, and Data Sources by Substance Use Disorder Domain

Indicator	*Indicator Definition*	*Alignment with statute definition of high-need counties*	*year*	*Source*
Alcohol	Alcohol use disorder in past year	Substance abuse	2014-2016	SAMHSA - National Survey of Drug Use and Health
Marijuana	Marijuana use disorder in the past month	Substance abuse	2014-2016	SAMHSA - National Survey of Drug Use and Health
Illicit Drugs	Use of illicit drugs, excluding Marijuana, in past month	Substance abuse	2012-2014	SAMHSA - National Survey of Drug Use and Health
Pain Relievers	Nonmedical use of pain medication in past year	Substance abuse	2012-2014	SAMHSA - National Survey of Drug Use and Health
Cocaine	Cocaine use in the past year	Substance abuse	2014-2016	SAMHSA - National Survey of Drug Use and Health

Table A.4: Description of Risk Domains, Indicators, and Data Sources by Crime and Child Maltreatment Domains

Indicator	*Indicator Definition*	*Alignment with statute definition of high-need counties*	*year*	*Source*
Crime Reports	# reported crimes/1000 residents	Crime	2016	Institute for Social Research-National Archive of Criminal Justice Data
Juvenile Arrests	# crime arrests ages 0-17/100,000 juveniles aged 0-17	Crime	2016	Institute for Social Research-National Archive of Criminal Justice Data
Child Maltreatment	Child Maltreatment	Rate of maltreatment victims aged <1-17 per 1,000 child (aged <1-17) residents	2016	ACF

Table A.5: Social Economic Status Domain - Raw Data for all Indicators as Provided by HRSA/MCHB

* Counties currently with Kansas MIECHV home visiting programs

† Counties identified as high-need using the HRSA/MCHB simplified methodology

County	Poverty	Unemployment	HS dropout	HS dropout 1 Yr	HS dropout 5 Yr	Income Inequality 1 Yr	Income Inequality 5 Yr	Income Inequality
Allen†	16.7	4.9	5.3	n/a	5.3	n/a	0.4	0.4
Anderson	13.3	4.0	18.3	n/a	18.3	n/a	0.4	0.4
Atchison†	14.3	5.2	3.1	n/a	3.1	n/a	0.5	0.5
Barber	12.2	2.9	1.1	n/a	1.1	n/a	0.5	0.5
Barton	15.6	3.6	2.8	n/a	2.8	n/a	0.4	0.4
Bourbon†	18.3	4.5	0.8	n/a	0.8	n/a	0.4	0.4
Brown	15.0	3.2	1.5	n/a	1.5	n/a	0.4	0.4
Butler	10.1	3.8	4.3	n/a	4.3	0.4	0.4	0.4
Chase	11.2	2.6	0.0	n/a	0.0	n/a	0.4	0.4
Chautauqua†	16.8	4.7	3.2	n/a	3.2	n/a	0.4	0.4
Cherokee*	15.8	3.9	4.7	n/a	4.7	n/a	0.4	0.4
Cheyenne	12.8	2.6	9.3	n/a	9.3	n/a	0.4	0.4
Clark	12.0	2.5	0.0	n/a	0.0	n/a	0.4	0.4
Clay	10.6	3.8	6.0	n/a	6.0	n/a	0.5	0.5
Cloud	12.6	4.4	0.0	n/a	0.0	n/a	0.4	0.4
Coffey	10.2	5.3	1.4	n/a	1.4	n/a	0.4	0.4
Comanche	11.2	2.9	8.5	n/a	8.5	n/a	0.4	0.4
Cowley†	17.6	3.8	3.8	n/a	3.8	n/a	0.4	0.4
Crawford†	18.9	4.2	2.4	n/a	2.4	n/a	0.5	0.5
Decatur	14.5	3.1	6.9	n/a	6.9	n/a	0.5	0.5
Dickinson	9.9	3.8	5.3	n/a	5.3	n/a	0.4	0.4
Doniphan	14.8	3.5	2.0	n/a	2.0	n/a	0.4	0.4
Douglas	15.9	3.2	1.1	n/a	1.1	0.5	0.5	0.5
Edwards	11.2	3.0	0.0	n/a	0.0	n/a	0.4	0.4
Elk†	15.8	4.3	0.0	n/a	0.0	n/a	0.4	0.4
Ellis	15.2	2.5	0.0	n/a	0.0	n/a	0.5	0.5
Ellsworth	11.5	3.1	4.0	n/a	4.0	n/a	0.4	0.4

County	Poverty	Unemployment	HS dropout	HS dropout 1 Yr	HS dropout 5 Yr	Income Inequality 1 Yr	Income Inequality 5 Yr	Income Inequality
Finney	13.2	2.7	4.6	n/a	4.6	n/a	0.4	0.4
Ford	12.7	2.8	4.9	n/a	4.9	n/a	0.4	0.4
Franklin†	10.5	3.7	3.8	n/a	3.8	n/a	0.4	0.4
Geary	12.0	5.0	4.3	n/a	4.3	n/a	0.4	0.4
Gove	9.8	2.3	1.5	n/a	1.5	n/a	0.4	0.4
Graham	12.8	3.6	4.3	n/a	4.3	n/a	0.4	0.4
Grant	12.3	3.2	18.2	n/a	18.2	n/a	0.4	0.4
Gray	7.6	2.0	21.8	n/a	21.8	n/a	0.4	0.4
Greeley	10.8	1.8	0.0	n/a	0.0	n/a	0.4	0.4
Greenwood	15.3	4.3	3.5	n/a	3.5	n/a	0.4	0.4
Hamilton	13.0	2.4	6.3	n/a	6.3	n/a	0.4	0.4
Harper†	14.5	3.7	2.2	n/a	2.2	n/a	0.4	0.4
Harvey	9.1	4.0	4.5	n/a	4.5	n/a	0.4	0.4
Haskell	10.1	2.3	26.6	n/a	26.6	n/a	0.4	0.4
Hodgeman	10.8	2.5	8.7	n/a	8.7	n/a	0.4	0.4
Jackson	11.0	3.1	3.9	n/a	3.9	n/a	0.4	0.4
Jefferson	8.5	3.6	3.2	n/a	3.2	n/a	0.4	0.4
Jewell	12.8	3.4	5.2	n/a	5.2	n/a	0.4	0.4
Johnson	5.3	3.0	2.6	2.6	1.9	0.4	0.5	0.4
Kearny	10.5	2.5	5.1	n/a	5.1	n/a	0.4	0.4
Kingman	12.1	3.7	5.5	n/a	5.5	n/a	0.4	0.4
Kiowa	11.6	2.5	18.5	n/a	18.5	n/a	0.4	0.4
Labette*	15.3	4.5	2.1	n/a	2.1	n/a	0.4	0.4
Lane	10.2	3.4	24.1	n/a	24.1	n/a	0.4	0.4
Leavenworth	7.4	3.9	2.3	n/a	2.3	0.4	0.4	0.4
Lincoln	11.8	2.8	0.0	n/a	0.0	n/a	0.4	0.4
Linn‡	14.1	5.9	4.8	n/a	4.8	n/a	0.5	0.5
Logan	9.7	2.1	0.0	n/a	0.0	n/a	0.5	0.5
Lyon	15.9	3.8	2.3	n/a	2.3	n/a	0.5	0.5
Marion	10.9	3.6	4.7	n/a	4.7	n/a	0.4	0.4
Marshall	10.8	2.8	3.3	n/a	3.3	n/a	0.4	0.4

County	Poverty	Unemployment	HS dropout	HS dropout 1 Yr	HS dropout 5 Yr	Income Inequality 1 Yr	Income Inequality 5 Yr	Income Inequality
McPherson	8.5	2.8	10.4	n/a	10.4	n/a	0.4	0.4
Meade	9.9	2.4	14.1	n/a	14.1	n/a	0.4	0.4
Miami	7.3	3.7	0.7	n/a	0.7	n/a	0.4	0.4
Mitchell	12.0	2.7	0.7	n/a	0.7	n/a	0.4	0.4
Montgomery*	16.8	5.2	6.4	n/a	6.4	n/a	0.4	0.4
Morris	11.2	3.1	0.0	n/a	0.0	n/a	0.4	0.4
Morton	10.9	3.7	0.5	n/a	0.5	n/a	0.4	0.4
Nemaha	8.2	2.4	1.1	n/a	1.1	n/a	0.4	0.4
Neosho*	15.5	5.2	1.3	n/a	1.3	n/a	0.5	0.5
Ness	11.1	2.9	4.4	n/a	4.4	n/a	0.5	0.5
Norton	12.3	2.2	2.9	n/a	2.9	n/a	0.4	0.4
Osage	11.7	4.0	6.8	n/a	6.8	n/a	0.4	0.4
Osborne	12.5	2.8	0.0	n/a	0.0	n/a	0.5	0.5
Ottawa	11.4	3.1	4.4	n/a	4.4	n/a	0.4	0.4
Pawnee	13.0	3.3	6.2	n/a	6.2	n/a	0.4	0.4
Phillips	11.6	3.0	0.0	n/a	0.0	n/a	0.4	0.4
Pottawatomie	9.8	3.1	3.6	n/a	3.6	n/a	0.4	0.4
Pratt	11.2	3.3	0.2	n/a	0.2	n/a	0.4	0.4
Rawlins†	11.9	2.3	0.0	n/a	0.0	n/a	0.4	0.4
Reno	13.4	3.9	4.2	n/a	4.2	n/a	0.4	0.4
Republic†	11.7	2.8	0.0	n/a	0.0	n/a	0.4	0.4
Rice	12.3	3.2	1.0	n/a	1.0	n/a	0.4	0.4
Riley†	20.4	3.0	1.1	n/a	1.1	0.5	0.5	0.5
Rooks	10.9	3.8	1.1	n/a	1.1	n/a	0.4	0.4
Rush	12.1	3.2	5.0	n/a	5.0	n/a	0.4	0.4
Russell	14.2	3.3	0.0	n/a	0.0	n/a	0.4	0.4
Saline	11.8	3.2	2.8	n/a	2.8	n/a	0.4	0.4
Scott	7.6	2.2	0.0	n/a	0.0	n/a	0.4	0.4
Sedgwick	14.2	4.2	6.6	6.6	4.3	0.4	0.5	0.4
Seward	14.9	3.5	1.8	n/a	1.8	n/a	0.4	0.4
Shawnee	11.7	3.7	6.4	6.4	4.0	0.4	0.4	0.4

County	Poverty	Unemployment	HS dropout	HS dropout 1 Yr	HS dropout 5 Yr	Income Inequality 1 Yr	Income Inequality 5 Yr	Income Inequality
Sheridan	11.5	2.3	0.0	n/a	0.0	n/a	0.4	0.4
Sherman	13.2	2.9	38.6	n/a	38.6	n/a	0.4	0.4
Smith	12.8	2.8	1.6	n/a	1.6	n/a	0.5	0.5
Stafford	13.2	3.3	7.0	n/a	7.0	n/a	0.4	0.4
Stanton	10.2	2.7	0.9	n/a	0.9	n/a	0.4	0.4
Stevens	10.3	3.2	15.8	n/a	15.8	n/a	0.4	0.4
Sumner	11.8	3.8	1.8	n/a	1.8	n/a	0.4	0.4
Thomas	11.5	2.6	7.3	n/a	7.3	n/a	0.5	0.5
Trego	11.6	3.3	0.0	n/a	0.0	n/a	0.4	0.4
Wabaunsee	7.6	3.2	2.3	n/a	2.3	n/a	0.3	0.3
Wallace	11.2	2.5	0.0	n/a	0.0	n/a	0.5	0.5
Washington	10.0	3.0	2.5	n/a	2.5	n/a	0.4	0.4
Wichita	11.6	2.4	7.7	n/a	7.7	n/a	0.4	0.4
Wilson*	15.3	4.7	9.0	n/a	9.0	n/a	0.4	0.4
Woodson†	15.6	4.5	19.5	n/a	19.5	n/a	0.4	0.4
Wyandotte*	18.4	5.2	7.5	7.5	8.6	0.4	0.4	0.4

Table A.6: Adverse Perinatal Outcomes Domain - Raw Data for all Indicators as Provided by HRSA/MCHB

* Counties currently with Kansas MIECHV home visiting programs

† Counties identified as high-need using the HRSA/MCHB simplified methodology

County	Preterm Birth	Low Birth Rate
Allen †	6.8	5.1
Anderson	6.6	5.0
Atchison †	7.6	6.8
Barber	7.1	6.4
Barton	10.0	7.4
Bourbon †	10.5	6.2
Brown	7.4	5.0
Butler	9.9	7.1
Chase	n/a	n/a
Chautauqua †	13.9	7.2
Cherokee*	10.7	8.1
Cheyenne	16.2	6.0
Clark	n/a	10.1
Clay	7.3	6.9
Cloud	5.8	5.5
Coffey	7.0	6.5
Comanche	n/a	n/a
Cowley †	12.9	8.0
Crawford †	13.4	7.6
Decatur	n/a	n/a
Dickinson	10.9	8.0
Doniphan	6.5	4.4
Douglas	8.7	6.8
Edwards	9.7	6.5
Elk †	10.0	n/a
Ellis	7.7	6.1
Ellsworth	9.2	6.5
Finney	8.6	7.2
Ford	6.9	6.9
Franklin †	8.6	6.7
Geary	8.6	6.8
Gove	6.7	n/a
Graham	n/a	n/a
Grant	9.3	6.9
Gray	6.6	4.1
Greeley	n/a	n/a
Greenwood	8.7	6.2
Hamilton	7.7	6.0
Harper †	10.6	7.9
Harvey	9.4	7.9
Haskell	7.4	4.3
Hodgeman	n/a	n/a
Jackson	10.0	6.5
Jefferson	7.0	5.7
Jewell	8.9	n/a
Johnson	8.2	6.5
Kearny	8.9	7.6
Kingman	6.4	5.4
Kiowa	n/a	n/a
Labette*	11.0	8.2
Lane	n/a	n/a
Leavenworth	9.2	7.4
Lincoln	8.8	n/a
Linn †	7.9	5.5
Logan	8.7	6.8
Lyon	9.1	7.7
Marion	8.8	5.0
Marshall	6.8	6.0
McPherson	9.8	6.6
Meade	7.9	7.2
Miami	7.8	5.9
Mitchell	8.0	5.5
Montgomery*	9.4	6.9
Morris	7.8	5.8
Morton	7.6	7.6
Nemaha	7.2	4.3
Neosho*	8.5	7.1
Ness	8.3	n/a
Norton	5.3	5.3
Osage	7.8	5.7
Osborne	8.3	6.5
Ottawa	5.9	5.1
Pawnee	10.0	9.1
Phillips	8.9	9.5
Pottawatomie	7.4	5.3
Pratt	6.9	5.8
Rawlins †	8.8	8.1
Reno	9.4	7.1
Republic †	7.5	9.1
Rice	8.8	6.5
Riley †	8.4	6.3
Rooks	4.4	5.0
Rush	12.6	9.4
Russell	7.2	5.0
Saline	9.1	7.5
Scott	8.7	9.4
Sedgwick	9.9	7.8
Seward	6.6	6.0
Shawnee	9.2	6.9
Sheridan	7.6	7.6
Sherman	11.5	9.0
Smith	7.4	n/a
Stafford	6.0	n/a
Stanton	7.0	7.6
Stevens	5.2	3.4
Sumner	10.6	6.5
Thomas	9.3	6.7
Trego	n/a	7.1
Wabaunsee	8.2	5.2
Wallace	n/a	n/a
Washington	8.3	8.3
Wichita	n/a	n/a
Wilson*	7.6	6.7
Woodson †	n/a	n/a
Wyandotte*	9.8	8.5

Table A.7: Substance Use Disorder Domain - Raw Data for all Indicators as Provided by HRSA/MCHB

* Counties currently with Kansas MIECHV home visiting programs

† Counties identified as high-need using the HRSA/MCHB simplified methodology

County	Alcohol 2016	Marijuana 2016	Illicit Drugs	Pain Relievers	Cocaine 2016
Allen †	5.9	7.3	3.1	4.2	1.2
Anderson	5.9	7.3	3.1	4.2	1.2
Atchison †	5.6	7.4	2.7	4.1	1.2
Barber	5.5	6.6	2.7	3.9	1.0
Barton	5.5	6.6	2.7	3.9	1.0
Bourbon †	5.9	7.3	3.1	4.2	1.2
Brown	5.6	7.4	2.7	4.1	1.2
Butler	5.5	6.6	2.7	3.9	1.0
Chase	5.9	7.3	2.7	3.9	1.2
Chautauqua †	5.9	7.3	2.7	3.9	1.2
Cherokee*	5.9	7.3	3.1	4.2	1.2
Cheyenne	5.7	6.4	2.7	3.9	1.4
Clark	5.7	5.9	2.7	3.9	1.3
Clay	5.7	6.4	2.7	4.1	1.4
Cloud	5.7	6.4	2.7	4.1	1.4
Coffey	5.9	7.3	2.7	3.9	1.2
Comanche	5.7	5.9	2.7	3.9	1.3
Cowley †	5.5	6.6	2.7	3.9	1.0
Crawford †	5.9	7.3	3.1	4.2	1.2
Decatur	5.7	6.4	2.7	3.9	1.4
Dickinson	5.7	6.4	2.7	4.1	1.4
Doniphan	5.6	7.4	2.7	4.1	1.2
Douglas	5.6	7.4	3.3	4.1	1.2
Edwards	5.7	5.9	2.7	3.9	1.3
Elk †	5.9	7.3	2.7	3.9	1.2
Ellis	5.7	6.4	2.7	3.9	1.4
Ellsworth	5.7	6.4	2.7	4.1	1.4
Finney	5.7	5.9	2.7	3.9	1.3
Ford	5.7	5.9	2.7	3.9	1.3
Franklin †	5.6	7.4	3.3	4.1	1.2
Geary	5.6	7.4	2.7	4.1	1.2
Gove	5.7	6.4	2.7	3.9	1.4
Graham	5.7	6.4	2.7	3.9	1.4
Grant	5.7	5.9	2.7	3.9	1.3
Gray	5.7	5.9	2.7	3.9	1.3
Greeley	5.7	5.9	2.7	3.9	1.3
Greenwood	5.9	7.3	2.7	3.9	1.2
Hamilton	5.7	5.9	2.7	3.9	1.3
Harper †	5.5	6.6	2.7	3.9	1.0
Harvey	5.5	6.6	2.7	3.9	1.0

County	Alcohol 2016	Marijuana 2016	Illicit Drugs	Pain Relievers	Cocaine 2016
Haskell	5.7	5.9	2.7	3.9	1.3
Hodgeman	5.7	5.9	2.7	3.9	1.3
Jackson	5.6	7.4	2.7	4.1	1.2
Jefferson	5.6	7.4	2.7	4.1	1.2
Jewell	5.7	6.4	2.7	4.1	1.4
Johnson	5.6	7.4	3.3	4.1	1.2
Kearny	5.7	5.9	2.7	3.9	1.3
Kingman	5.5	6.6	2.7	3.9	1.0
Kiowa	5.7	5.9	2.7	3.9	1.3
Labette*	5.9	7.3	3.1	4.2	1.2
Lane	5.7	5.9	2.7	3.9	1.3
Leavenworth	5.6	7.4	3.3	4.1	1.2
Lincoln	5.7	6.4	2.7	4.1	1.4
Linn †	5.9	7.3	3.1	4.2	1.2
Logan	5.7	6.4	2.7	3.9	1.4
Lyon	5.6	7.4	2.7	3.9	1.2
Marion	5.5	6.6	2.7	3.9	1.0
Marshall	5.6	7.4	2.7	4.1	1.2
McPherson	5.5	6.6	2.7	3.9	1.0
Meade	5.7	5.9	2.7	3.9	1.3
Miami	5.6	7.4	3.3	4.1	1.2
Mitchell	5.7	6.4	2.7	4.1	1.4
Montgomery*	5.9	7.3	3.1	4.2	1.2
Morris	5.6	7.4	2.7	3.9	1.2
Morton	5.7	5.9	2.7	3.9	1.3
Nemaha	5.6	7.4	2.7	4.1	1.2
Neosho*	5.9	7.3	3.1	4.2	1.2
Ness	5.7	5.9	2.7	3.9	1.3
Norton	5.7	6.4	2.7	3.9	1.4
Osage	5.6	7.4	2.7	4.1	1.2
Osborne	5.7	6.4	2.7	3.9	1.4
Ottawa	5.7	6.4	2.7	4.1	1.4
Pawnee	5.7	5.9	2.7	3.9	1.3
Phillips	5.7	6.4	2.7	3.9	1.4
Pottawatomie	5.6	7.4	2.7	4.1	1.2
Pratt	5.5	6.6	2.7	3.9	1.0
Rawlins †	5.7	6.4	2.7	3.9	1.4
Reno	5.5	6.6	2.7	3.9	1.0
Republic †	5.7	6.4	2.7	4.1	1.4
Rice	5.5	6.6	2.7	3.9	1.0
Riley †	5.6	7.4	2.7	4.1	1.2
Rooks	5.7	6.4	2.7	3.9	1.4
Rush	5.7	5.9	2.7	3.9	1.3
Russell	5.7	6.4	2.7	3.9	1.4

County	Alcohol 2016	Marijuana 2016	Illicit Drugs	Pain Relievers	Cocaine 2016
Saline	5.7	6.4	2.7	4.1	1.4
Scott	5.7	5.9	2.7	3.9	1.3
Sedgwick	5.5	6.6	3.0	4.0	1.0
Seward	5.7	5.9	2.7	3.9	1.3
Shawnee	5.6	7.4	2.7	4.1	1.2
Sheridan	5.7	6.4	2.7	3.9	1.4
Sherman	5.7	6.4	2.7	3.9	1.4
Smith	5.7	6.4	2.7	3.9	1.4
Stafford	5.5	6.6	2.7	3.9	1.0
Stanton	5.7	5.9	2.7	3.9	1.3
Stevens	5.7	5.9	2.7	3.9	1.3
Sumner	5.5	6.6	2.7	3.9	1.0
Thomas	5.7	6.4	2.7	3.9	1.4
Trego	5.7	6.4	2.7	3.9	1.4
Wabaunsee	5.6	7.4	2.7	4.1	1.2
Wallace	5.7	6.4	2.7	3.9	1.4
Washington	5.7	6.4	2.7	4.1	1.4
Wichita	5.7	5.9	2.7	3.9	1.3
Wilson*	5.9	7.3	3.1	4.2	1.2
Woodson †	5.9	7.3	3.1	4.2	1.2
Wyandotte*	5.6	7.4	3.3	4.1	1.2

Table A.8: Crime and Child Maltreatment Domain - Raw Data for All Indicators as Provided by HRSA/MCHB

* Counties currently with Kansas MIECHV home visiting programs

† Counties identified as high-need using the HRSA/MCHB simplified methodology

County	Crime Reports	Juvenile Arrests	Child Maltreatment
Allen †	37.1	2845.4	0.3
Anderson	15.3	517.6	5.1
Atchison †	29.2	2260.2	1.5
Barber	12.4	761.9	0.9
Barton	27.3	525.3	4.4
Bourbon †	33.5	2085.0	11.3
Brown	22.5	579.2	11.4
Butler	23.3	830.0	1.5
Chase	5.3	0.0	0.0
Chautauqua †	16.4	428.6	12.7
Cherokee*	24.0	252.0	6.0
Cheyenne	11.3	178.9	6.8
Clark	6.3	392.2	5.7
Clay	12.9	675.0	1.9
Cloud	24.9	1130.2	8.2
Coffey	15.4	1540.9	6.3
Comanche	15.2	0.0	15.8
Cowley †	34.8	2298.1	2.2
Crawford †	38.4	1281.8	10.3
Decatur	10.8	177.3	8.9
Dickinson	18.8	1349.9	2.4
Doniphan	12.3	824.4	13.2
Douglas		4.4	0.9
Edwards	8.8	434.8	2.9
Elk †	7.9	197.6	13.1
Ellis	27.4	946.7	4.8
Ellsworth	12.6	88.7	5.8
Finney	32.7	1261.6	4.2
Ford	31.1	1565.2	3.5
Franklin †	24.6	1717.3	8.6
Geary	22.1	1794.3	3.0
Gove	14.9	0.0	6.7
Graham	5.8	0.0	0.0
Grant	11.2	494.4	0.8
Gray	10.8	792.8	3.4
Greeley	8.2	0.0	3.7
Greenwood	16.0	1098.9	3.6
Hamilton	3.3	0.0	1.3
Harper †	33.0	2360.5	1.4
Harvey	27.4	3249.7	5.9
Haskell	7.2	87.4	2.5
Hodgeman	4.3	0.0	4.8
Jackson	15.6	841.3	3.8
Jefferson	16.4	824.4	2.7
Jewell		0.0	3.4
Johnson	17.7	491.4	2.1
Kearny	20.9	0.0	3.5
Kingman	23.5	244.2	0.6
Kiowa	8.2	0.0	5.4
Labette*	37.0	41.8	5.5
Lane	8.5	0.0	5.1
Leavenworth	26.2	925.3	2.8
Lincoln	5.9	0.0	1.4
Linn †	13.5	490.2	9.8
Logan	10.6	154.6	4.6
Lyon	24.7	1508.5	5.7
Marion	12.0	1301.2	4.2
Marshall	13.4	173.3	4.8
McPherson	23.7	257.0	1.9
Meade	12.5	0.0	6.2
Miami	20.0	779.2	6.0
Mitchell	13.0	70.4	2.1
Montgomery*	45.3	1390.3	11.8
Morris	14.9	88.1	2.5
Morton	21.0	276.6	6.1
Nemaha	11.5	448.8	1.1
Neosho*	21.6	249.2	10.2
Ness	11.8	0.0	0.0
Norton	8.0	575.3	2.9
Osage	14.2	107.6	1.6
Osborne	19.0	0.0	1.3
Ottawa	17.4	217.5	0.7
Pawnee	22.0	1254.2	6.8
Phillips	6.0	0.0	4.7
Pottawatomie	15.3	932.3	2.8
Pratt	43.4	4520.3	3.0
Rawlins †	18.0	1495.3	10.0
Reno	40.1	1521.6	4.7
Republic †	12.0	1791.4	7.4
Rice	22.8	434.0	6.1
Riley †	20.2	1580.6	2.2
Rooks	2.7	0.0	11.2
Rush	25.7	336.1	6.2
Russell	20.0	1499.3	2.7

County	Crime Reports	Juvenile Arrests	Child Maltreatment
Saline	40.3	2681.4	4.1
Scott	12.1	302.6	3.4
Sedgwick	53.7	1220.9	1.5
Seward	17.1	445.6	2.6
Shawnee	51.5	149.4	5.4
Sheridan	16.5	0.0	1.7
Sherman	15.8	1485.1	6.3

County	Crime Reports	Juvenile Arrests	Child Maltreatment
Smith	17.2	0.0	0.0
Stafford	12.7	1082.7	9.7
Stanton	0.0	0.0	0.0
Stevens	5.8	422.7	1.7
Sumner	28.4	211.7	2.2
Thomas	18.6	602.1	3.9
Trego	15.9	1303.5	12.7

County	Crime Reports	Juvenile Arrests	Child Maltreatment
Wabaunsee	17.2	180.0	4.0
Wallace	0.0	0.0	0.0
Washington	5.1	399.0	3.1
Wichita	14.6	0.0	7.9
Wilson*	19.3	879.8	13.1
Woodson †	21.6	443.8	4.4
Wyandotte*	53.1	165.3	3.4

Table A.9: Descriptive Statistics for Each Indicator by Socioeconomic Status Domain as Provided by HRSA

Indicator	Indicator Definition	Year	Missing (n)	Missing %	Mean of Counties	SD	Median	Interquartile Range	Min	Max	State Estimate
Poverty	% population living below %100 FPL	2017	0.0	0.0	12.3	2.7	11.8	3.4	5.3	20.4	11.9
Unemployment	Unemployed percent of the civilian labor force	2017	0.0	0.0	3.4	0.8	3.2	1.0	1.8	5.9	3.6
High school dropout (1 Yr Estimate)	% of 16-19 year olds not enrolled in school with no high school diploma	2017	101.0	96.2	5.8	2.2	6.5	2.6	2.6	7.5	4.2
High school dropout (5 Yr Estimate)	% of 16-19 year olds not enrolled in school with no high school diploma	2013-2017	0.0	0.0	4.9	6.4	3.2	4.2	0.0	38.6	3.7
High school dropout (1 Yr or 5 Yr Estimate)	% of 16-19 year olds not enrolled in school with no high school diploma	2013-2017 OR 2017	0.0	0.0	4.9	6.3	3.2	4.9	0.0	38.6	n/a
Income Inequality	Gini Coefficient - 1 Yr Estimate	2017	97.0	92.4	0.4	0.0	0.4	0.1	0.4	0.5	0.5
Income Inequality	Gini Coefficient - 5 Yr Estimate	2013-2017	0.0	0.0	0.4	0.0	0.4	0.0	0.3	0.5	0.5
Income Inequality	Gini Coefficient - 1 Yr or 5 Yr Estimate	2013-2017 OR 2017	0.0	0.0	0.4	0.0	0.4	0.0	0.3	0.5	n/a

Table A.10: Descriptive Statistics for Each Indicator by Adverse Perinatal Outcomes Domain

Indicator	Indicator Definition	Year	Missing (n)	Missing %	Mean of Counties	SD	Median	Interquartile Range	Min	Max	State Estimate
Preterm Birth	% live births <37 weeks	2013-2017	13.0	12.4	8.5	1.9	8.5	2.0	4.4	16.2	9.4
Low Birth Rate	% live births <2500 g	2013-2017	18.0	17.1	6.7	1.3	6.7	1.8	3.4	10.1	7.0

Table A.11: Descriptive Statistics for Each Indicator by Substance Use Disorder Domain

Indicator	Indicator Definition	Year	Missing (n)	Missing %	Mean of Counties	SD	Median	Interquartile Range	Min	Max	State Estimate
Alcohol	Prevalence rate: Alcohol use disorder in the past year	2014-2016	0.0	0.0	5.7	0.1	5.7	0.1	5.5	5.9	5.6
Marijuana	Prevalence rate: Marijuana use in the past month	2014-2016	0.0	0.0	6.7	0.6	6.4	0.9	5.9	7.4	7.0
Illicit Drugs	Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month	2012-2014	0.0	0.0	2.8	0.2	2.7	0.1	2.7	3.3	3.0
Pain Relievers	Prevalence rate: Nonmedical use of pain medication in past year	2012-2014	0.0	0.0	4.0	0.1	3.9	0.2	3.9	4.2	4.0
Cocaine	Prevalence rate: Cocaine use in the past year	2014-2016	0.0	0.0	1.2	0.1	1.3	0.2	1.0	1.4	1.2

Table A.12: Descriptive Statistics for Each Indicator by Crime and Child Maltreatment Domains

Indicator	Indicator Definition	Year	Missing (n)	Missing %	Mean of Counties	SD	Median	Interquartile Range	Min	Max	State Estimate
Crime Reports	# reported crimes/1000 residents	2016	2.0	1.9	18.9	11.3	16.4	12.2	0.0	53.7	31.0
Juvenile Arrests	# crime arrests ages 0-17/100,000 juveniles aged 0-17	2016	0.0	0.0	722.1	821.5	443.8	1132.7	0.0	4520.3	870.8
Child Maltreatment	Rate of maltreatment victims aged <1-17 per 1,000 child (aged <1-17) residents	2016	0.0	0.0	4.7	3.6	3.9	4.1	0.0	15.8	3.3

Table A.13: Identified High-need Counties and Risk Domains

◆ Counties presenting risk factors in one or more domains. Counties presenting risk factors in 2 or more risk domains were identified as a high-need county as instructed in HRSA's simple methodology.

Counties	*High-need and current MIECHV HV county*	*SES*	*Adverse perinatal*	*SUD*	*Crime*	*Child Maltreatment*
Allen ◆	no	**Yes**	no	**Yes**	**Yes**	no
Anderson	no	no	no	**Yes**	no	no
Atchison ◆	no	**Yes**	no	**Yes**	**Yes**	no
Barber	no	no	no	no	no	no
Barton	no	no	no	no	no	no
Bourbon ◆	no	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Brown	no	no	no	no	no	**Yes**
Butler	no	no	no	no	no	no
Chase	no	no	no	no	no	no
Chautauqua ◆	no	**Yes**	**Yes**	no	no	**Yes**
Cherokee ◆	**Yes**	no	**Yes**	**Yes**	no	no
Cheyenne	no	no	**Yes**	no	no	no
Clark	no	no	**Yes**	no	no	no
Clay	no	no	no	no	no	no
Cloud	no	no	no	no	no	no
Coffey	no	no	no	no	no	no
Comanche	no	no	no	no	no	**Yes**
Cowley ◆	no	no	**Yes**	no	**Yes**	no
Crawford ◆	no	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Decatur	no	no	no	no	no	**Yes**
Dickinson	no	no	**Yes**	no	no	no
Doniphan	no	no	no	no	no	**Yes**
Douglas	no	**Yes**	no	no	no	no
Edwards	no	no	no	no	no	no
Elk ◆	no	**Yes**	no	no	no	**Yes**
Ellis	no	**Yes**	no	no	no	no
Ellsworth	no	no	no	no	no	no
Finney	no	no	no	no	**Yes**	no
Ford	no	no	no	no	**Yes**	no
Franklin ◆	no	no	no	no	**Yes**	**Yes**
Geary	no	no	no	no	**Yes**	no
Gove	no	no	no	no	no	no
Graham	no	no	no	no	no	no
Grant	no	no	no	no	no	no
Gray	no	no	no	no	no	no
Greeley	no	no	no	no	no	no
Greenwood	no	**Yes**	no	no	no	no
Hamilton	no	no	no	no	no	no

Counties	High-need and current MIECHV HV county	SES	Adverse perinatal	SUD	Crime	Child Maltreatment
Harper ◆	no	no	**Yes**	no	**Yes**	no
Harvey	no	no	no	no	no	no
Haskell	no	no	no	no	no	no
Hodgeman	no	no	no	no	no	no
Jackson	no	no	no	no	no	no
Jefferson	no	no	no	no	no	no
Jewell	no	no	no	no	no	no
Johnson	no	no	no	no	no	no
Kearny	no	no	no	no	no	no
Kingman	no	no	no	no	no	no
Kiowa	no	no	no	no	no	no
Labette ◆	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	no
Lane	no	no	no	no	no	no
Leavenworth	no	no	no	no	no	no
Lincoln	no	no	no	no	no	no
Linn ◆	no	no	no	**Yes**	no	**Yes**
Logan	no	no	no	no	no	no
Lyon	no	**Yes**	no	no	no	no
Marion	no	no	no	no	no	no
Marshall	no	no	no	no	no	no
McPherson	no	no	no	no	no	no
Meade	no	no	no	no	no	no
Miami	no	no	no	no	no	no
Mitchell	no	no	no	no	no	no
Montgomery ◆	**Yes**	**Yes**	no	**Yes**	**Yes**	**Yes**
Morris	no	no	no	no	no	no
Morton	no	no	no	no	no	no
Nemaha	no	no	no	no	no	no
Neosho ◆	**Yes**	**Yes**	no	**Yes**	no	**Yes**
Ness	no	no	no	no	no	no
Norton	no	no	no	no	no	no
Osage	no	no	no	no	no	no
Osborne	no	no	no	no	no	no
Ottawa	no	no	no	no	no	no
Pawnee	no	no	**Yes**	no	no	no
Phillips	no	no	**Yes**	no	no	no
Pottawatomie	no	no	no	no	no	no
Pratt	no	no	no	no	**Yes**	no
Rawlins ◆	no	no	**Yes**	no	no	**Yes**
Reno	no	no	no	no	**Yes**	no
Republic ◆	no	no	**Yes**	no	**Yes**	no
Rice	no	no	no	no	no	no

Counties	High-need and current MIECHV HV county	SES	Adverse perinatal	SUD	Crime	Child Maltreatment
Riley ◆	no	**Yes**	no	no	**Yes**	no
Rooks	no	no	no	no	no	Yes
Rush	no	no	Yes	no	no	no
Russell	no	no	no	no	no	no
Saline	no	no	no	no	**Yes**	no
Scott	no	no	**Yes**	no	no	no
Sedgwick	no	no	no	no	**Yes**	no
Seward	no	no	no	no	no	no
Shawnee	no	no	no	no	**Yes**	no
Sheridan	no	no	no	no	no	no
Sherman	no	no	**Yes**	no	no	no
Smith	no	no	no	no	no	no
Stafford	no	no	no	no	no	**Yes**
Stanton	no	no	no	no	no	no
Stevens	no	no	no	no	no	no
Sumner	no	no	**Yes**	no	no	no
Thomas	no	no	no	no	no	no
Trego	no	no	no	no	no	**Yes**
Wabaunsee	no	no	no	no	no	no
Wallace	no	no	no	no	no	no
Washington	no	no	**Yes**	no	no	no
Wichita	no	no	no	no	no	no
Wilson ◆	**Yes**	**Yes**	no	**Yes**	no	**Yes**
Woodson ◆	no	**Yes**	no	**Yes**	no	no
Wyandotte ◆	**Yes**	no	**Yes**	no	**Yes**	no

APPENDIX B: IDENTIFYING QUALITY & CAPACITY OF EXISTING PROGRAMS

Table B.1. Population Estimates Based on American Community Survey 2018 Five Year Census Data

County	Total Population	Children under 5
Allen	12444	754
Anderson	7878	491
Atchison	16193	961
Barber	4472	318
Barton	26111	1681
Bourbon	14653	1016
Brown	9598	647
Butler	66765	3898
Chase	2629	143
Chautauqua	3309	182
Cherokee	20015	1098
Cheyenne	2660	139
Clark	2005	137
Clay	7997	510
Cloud	8729	532
Coffey	8233	442
Comanche	1748	89
Cowley	35218	2177
Crawford	39019	2294
Decatur	2871	167
Dickinson	18717	1194
Doniphan	7682	386
Douglas	121436	6129
Edwards	2849	175
Elk	2508	132
Ellis	28710	1824
Ellsworth	6196	335
Finney	36611	3288
Ford	33888	3233
Franklin	25631	1483
Geary	32594	4219
Gove	2612	139
Graham	2492	124
Grant	7336	609
Gray	6033	422
Greeley	1227	71
Greenwood	6055	288
Hamilton	2607	213
Harper	5506	360
Harvey	34210	2091
Haskell	3997	282
Hodgeman	1818	124
Jackson	13280	826
Jefferson	18975	984
Jewell	2841	157
Johnson	597555	37685
Kearny	3943	279
Kingman	7310	375
Kiowa	2516	164
Labette	19964	1324
Lane	1560	128
Leavenworth	81352	5115
Lincoln	3023	143
Linn	9750	529
Logan	2844	190
Lyon	33406	1833
Marion	28537	1554
Marshall	11950	636
McPherson	9722	601
Meade	4146	304
Miami	33680	1883
Mitchell	6150	422
Montgomery	32120	2123
Morris	5521	289
Morton	2667	181
Nemaha	10155	715
Neosho	15951	1024
Ness	2840	187
Norton	5430	328
Osage	15941	862
Osborne	3475	208
Ottawa	5802	306
Pawnee	6562	285
Phillips	5317	302
Pottawatomie	24277	1867
Pratt	9378	710
Rawlins	2508	124
Reno	62342	3517
Republic	4664	238
Rice	9531	570
Riley	73703	4306
Rooks	5013	335
Rush	3093	154
Russell	6907	413
Saline	54401	3416
Scott	4897	352
Sedgwick	513607	36658
Seward	21780	1979
Shawnee	177499	11360
Sheridan	2533	143
Sherman	5899	413
Smith	3603	177
Stafford	4178	230
Stanton	1987	132
Stevens	5559	430
Sumner	22996	1387
Thomas	7711	551
Trego	2793	130
Wabaunsee	6899	411
Wallace	1503	105
Washington	5420	353
Wichita	2105	121
Wilson	8665	560
Woodson	3183	159
Wyandotte	165324	13352
Kansas State	2911505	191392

Note: *Click here to link to data source for population estimates by county in Kansas to calculate number served in each county for programs that only reported total served across all counties.*

Table B.2. Summary of Key Home Visiting Programs in Kansas

Programs	*Services provided*	*Intended recipient of service*	*Eligibility*	*Targeted goals/outcomes*	*Intensity of services*
Early Head Start (EHS)	Quality early education; parent education; family support service; access to comprehensive health and mental services (includes services to women before, during, and after pregnancy, and nutrition services)	Pregnant women and families with infants and toddlers	Family's income is equal to or below the poverty line OR Family is eligible for or, in the absence of child care, would be potentially eligible for public assistance, including TANF child-only payments OR the child is homeless OR the child is in foster care	Pregnant women and newborns to thrive; infants and children thrive; children live in stable and support-ed families; children enter school ready to learn	Weekly one-on-one visits for 90 minute sessions
Parents As Teachers (PAT)	Home visits, personal visits, group visits, play groups, and socialization opportunities. Developmental screenings to help support and connect parents with other community networks	All families who are expecting a child or with children up to kindergarten entry	Low income; Teen parents; Low parental education; Family history of drug abuse; Chronic health conditions affecting child or parents	Increase parent knowledge of early childhood development and improve parent practices; provide early detection of developmental delays and health issues; parent child abuse and neglect; increase children's school readiness and success	One visit every 4-6 weeks for 60 minute sessions
Healthy Families America (HFA)	Home visits and routine screenings and assessments to support positive parent-child interactions and social-emotional well-being	Pregnant women and families with children up to 3 - 5 years.	Eligibility is determined through the Parent Survey, an HFA tool which screens for risk factors related to child abuse and neglect	Cultivate and strengthen nurturing parent child relationships; Promote healthy childhood growth and development; Enhance family functioning by reducing risk and building protective factors;	Once a week for 60 minute sessions initially, with visits becoming less frequent as family functioning improves

Programs	*Services provided*	*Intended recipient of service*	*Eligibility*	*Targeted goals/outcomes*	*Intensity of services*
Team for Infants Endangered by Substance Abuse (TIES)	Home visits including crisis intervention, support for substance abuse treatment, supportive counseling, child health development, parenting education and connection to other community services	Pregnant and postpartum women and their families with children up to 2 years, affected by substance abuse or HIV	Families of pregnant and postpartum women with HIV or affected by substance abuse	Substance use reduction; improved parenting; appropriate health and mental needs for family and child; gaining economic stability; maintaining adequate housing	Weekly one-on-one visits
Nurse Family Partnership (NFP)	Home visits by trained nurses to learn how to provide stable and secure futures for parent and child.	Pregnant women and first time moms through child's second birthday	First-time mothers, low-income	Improve pregnancy outcomes; improve child health and development through teaching parents how to provide responsible and competent care; improve economic self-sufficiency of family	not known
Attachment and Biobehavioral Catch-up (ABC) Intervention	Home visits to support caregivers in nurturance, promote healthy child attachment, and positive parenting	Prenatal and caregivers of infants 6 months to 2 years	High-risk birth parents and caregivers of young children in foster care, kinship care, and adoptive care	Increase caregiver nurturance, sensitivity, and delight; decrease caregiver frightening behaviors; increase child attachment security and decrease disorganized attachment; increase child behavioral and biological regulation	Weekly one-hour sessions for 10 sessions

Programs	*Services provided*	*Intended recipient of service*	*Eligibility*	*Targeted goals/outcomes*	*Intensity of services*
Infant Toddler Services (tiny-k)	"Family training, counseling, and home visits; Special instruction; Speech-language pathology and audiology services, and sign language and cued language services; Occupational therapy Physical therapy; Psychological services; Services coordination; Medical services as needed for diagnostic or evaluation purposes; Early identification, screening, and assessment; Health services necessary to enable participation in other services; Social work services; Vision services; Assistive technology devices and services; Transportation and related costs to facilitate participation"	Families with infants and toddlers, birth to 3 years, with disabilities	Eligibility is determined using parent report, clinical opinion, and evaluation and assessment measures	Enhance the development of infants and toddlers with disabilities; minimize their potential for developmental delays; recognize development delays; enhance capability of families to meet the special needs of their infants and toddlers with disabilities	As needed
Maternal Child Health Home Visiting (MCH)	Home visits include to educate, initiate referrals, and assist mothers and families in accessing community system of care	Pregnant women and families with infants up to 1 year	None; Target population; Intended as a "bridge" to connect families	Promote social and emotional well-being and connect families to resources in the community	Typically 1-2 home visits, prenatal and postpartum visit, for 60 minutes; number of visits are based on family need

Table B.3: Statewide Home Visiting Capacity Data

Programs	*Reporting period of data*	*Families served defined as…*	*Children Served defined as…*	*Total # of Families Served*	*Total # of Children Served*	*Primary Funding Sources*
Healthy Families America (HFA) - KCSL	1/1/2018 - 12/31/2018	count primary caregiver with at least one qualifying child	prenatal - age 3	554	554	MIECHV, TANF, Family First, ECBG
Healthy Families America - DG Co. Health Department	7/1/2018 - 6/30/2019	Count of primary caregiver	prenatal - age 3	80	83	MIECHV, ECBG, other state and local funding
Healthy Families America - Wy Co. Health Department	10/1/2018 - 9/30/2019	Count of primary caregiver which includes pregnant women	prenatal - age 3	61	50	MIECHV, OPEI
Parents as Teachers (PAT)	7/1/2018 - 6/30/2019	Number of families includes pregnant women or family with at least one qualifying child	prenatal - age 5	6721	8792	KSDE PAT Grant, Local School Districts, MIECHV, ECBG, Family First, United Way, KSDE, Kansas Children Trust Fund, Kansas Preschool Program, United Way of Greater Topeka, Promise 1000, other private and local funding
Early Head Start (EHS)	7/1/2018 - 6/30/2019	Number of families includes pregnant women or family with at least one qualifying child	prenatal - age 3	2637	3177	MIECHV, EHS state and federal funding, Child-care Partnerships, Kansas DCF, ECBG, PAT state and federal, DHHS, other local funding
Kansas EHS	7/1/2018 - 6/30/2019	Number of families includes pregnant women or family with at least one qualifying child	prenatal - age 3	1509	1547	TANF and CCDF
Maternal Child Health (MCH) Home Visiting	7/1/2018 - 6/30/2019	unduplicated count of primary caregiver who completed at least one MCH home visit.	< 1 year	2919	2679	Title V Block Grant, CIF funding, other state, local funding
Team for Infants Endangered by Substance Abuse (TIES) Wy Co.	10/1/2018 - 9/30/2019	Unduplicated count of primary caregiver (includes pregnant women)	prenatal - age 2	42	41	MIECHV, Children's Mercy, Promise 1000
Nurse-Family Partnerships (NFP) - SN Co.	7/1/2018 - 6/30/2019	count of pregnant women or primary caregiver	prenatal - age 2	87	64	OPEI, ECBG, Local Tax Allocation
Nurse-Family Partnerships - JO. Co.	7/1/2018 - 6/30/2019	count of pregnant women or primary caregiver	birth to age 2	78	60	local and state funding

Programs	Reporting period of data	Families served defined as…	Children Served defined as…	Total # of Families Served	Total # of Children Served	Primary Funding Sources
Attachment and Biobehavioral Catch-up (ABC) Intervention	5/1/2018 - 4/30/2019	number of families defined as one primary parent with one target child	6 mos - 2 years	165	165	United Health Ministries, Family First
Infant Toddler Services	7/1/2018 - 6/30/2019	N/A	birth to age 2	N/A	10565	CIF (Children's Initiative fund, Local tax funding, United Way funding, other local and private funding
N/A	N/A	N/A	State TOTALS	14853	27777	N/A

Note: *ECBG = Early Childhood Block Grant funding; CIF = Children's Initiative Fund; OPEI = Outreach Prevention and Early Intervention; KSDE = Kansas State Department of Education; DHHS = Department of Health and Human Services; TANF = Temporary Assistance for Needy Families funds; CCDF = Child Care and Development Fund; CBCAP = Community-Based Child Abuse Prevention funds. The primary funding sources across the eight key home visiting models in Kansas for Fiscal Year 2018 were: CIF = $13,242,483; TANF = $4,937,376; CCDF = $4,301,266; *Private = $2,682,373; MIECHV funding FY2018 = $1,234,524; MIECHV funding FY2019 = $3,011,030 (HFA = $903,811, PAT = $1,155,150, EHS = $391,491, TIES = $560,578); ECBG = $360,784; and CBCAP = $75,711. *Private funding includes: United Methodist Health Ministry Fund, Kansas Health Foundation, REACH Healthcare Foundation, Hutchinson Community Foundation, and Wyandotte Health Foundation. Early Head Start is the federally funded Head Start program serving pre-natal to age 3 and Kansas EHS is the state program administered through Department of Children and Family (DCF) also serving the same target population (prenatal to age 3).*

Table B.4. Family First Extension Funding

Organization	Model	Counties	Estimated Served
Great Circle	HFA	Chautauqua, Woodson, Coffey, Anderson, Linn, Franklin, Osage, Wabaunsee, Pottawtomie, Jackson, Marshall, Nemaha, Brown, and Doniphan	132
Great Circle	HFA	Douglas and Atchinson	100
Kansas Children's Service League (KCSL)	HFA	Sedgwick, Allen, Neosho, and Wilson	60
Project Eagle - University of Kansas Medical Center (KUMC)	ABC	Wyandotte, Douglas, Leavenworth, Cheyenne, Rawlins, Sherman, Thomas, Wallace, Logan, Decatur, Norton, Sheridan, Graham, Gove, Trego, Phillips, Smith, Rooks, Osborne, Ellis, and Russell	172
Success by 6	HFA	Douglas	20
Kansas Parents as Teachers	PAT	Statewide	229

Table B.5. Statewide Demographics of those Served by Kansas Home Visiting Programs

	Early Head Start (EHS) A	*Early Head Start (EHS) B*	*Parents as Teachers (PAT)*	*Healthy Families America (HFA)*	*Team for Infants Endangered by Substance Abuse (TIES)*	*Infant Toddler Services (tiny-k)*	*Maternal Child Health (MCH) Home Visiting*	*Kansas*
American Indian/Alaskan Native	0.25%	1.96%	1.40%	<1.5%	3.60%	0.52%	0.59%	0.83%
Asian	0.04%	1.75%	4.60%	3.20%	0%	2.35%	1.14%	2.87%
Black/African American	0.61%	11.72%	3.70%	12.70%	33.33%	6.04%	3.37%	5.84%
Native Hawaiian/Other Pacific Islander	0.02%	0.09%	0.20%	<1.5%	1.20%	0.14%	0.16%	0.07%
White	21.98%	41.37%	82.30%	75.30%	55.42%	85.15%	71.56%	84.59%
Multi-racial	3.01%	8.21%	7.10%	2.80%	8.40%	5.80%	1.40%	3.47%
Other	8.10%	0.27%	0.40%	4.00%	0%	n/a	0%	2.32%
Not answered	0.50%	0.11%	0.40%	0%	0%	n/a	21.78%	n/a
Hispanic/Latinx	n/a	n/a	15.00%	33.80%	20.48%	n/a	16.90%	11.71%
Non-Hispanic/Latinx	n/a	n/a	84.70%	65.50%	79.52%	n/a	59.68%	88.29%
Not answered	n/a	n/a	0.30%	0%	0%	n/a	23.42%	n/a

Notes:

EHS *- Percentages for Early Head Start A are # of children /pregnant women (Hispanic/Latino origin) and percentages for column B are # of children /pregnant women (Non-Hispanic or Non-Latino origin). These percentages represent demographic information for all Head Start and Early Head Start programs in Kansas, not only home visiting programs. Reporting period Fall 2018 - Spring 2019.* ***PAT*** *- Race and Ethnicity information are for children served. Reporting period 7/1/2018 - 6/30/2019.* ***HFA*** *- includes organization a part of the KCSL HFA program and both the Douglas County and Wyandotte County health departments that provide HFA home visiting services. Reporting period 1/1/2018 - 9/30/2019.* ***TIES*** *- Race and Ethnicity information includes children and families served. Reporting period 10/1/2018 - 9/30/2019; NFP; ABC;* ***tiny-K*** *- These percentages represent demographic information for children served. Reporting period 7/1/2018 - 6/30/2019.* ***MCH*** *- Race and Ethnicity information are for primary caregivers served. Reporting period 7/1/2018 - 6/30/2019. American Community Survey (ACS) 2018 5-year estimates was used for statewide race and ethnicity demographic information. We were unable to get statewide demographic data for the Nurse Family Partnership (NFP) and Attachment and Biobehavioral Catch-up (ABC) Intervention home visiting programs and, therefore, they are not included.*

Table B.6. Capacity Data for High-Need Counties

County	Total Families Served	Total Children Served
Allen	*102*	*163*
Atchison	*75*	*140*
Bourbon	*147*	*262*
Chautauqua	*14*	*6*
Cherokee	*130*	*298*
Cowley	*356*	*439*
Crawford	*167*	*434*
Elk	*4*	*8*
Franklin	*82*	*158*
Harper	*8*	*26*
Labette	*62*	*141*
Linn	*80*	*36*
Montgomery	*203*	*417*
Neosho	*67*	*134*
Rawlins	*9*	*11*
Republic	*51*	*79*
Riley	*272*	*716*
Wilson	*15*	*50*
Woodson	*23*	*30*
Wyandotte	*369*	*967*

Table B.7. Capacity Data for All Counties

County	Total Families Served	Total Children Served
Allen	102	163
Anderson	48	46
Atchison	75	140
Barber	1	29
Barton	162	239
Bourbon	147	262
Brown	47	95
Butler	86	349
Chase	3	11
Chautauqua	14	6
Cherokee	130	298
Cheyenne	3	8
Clark	1	17
Clay	127	224
Cloud	132	179
Coffey	47	139
Comanche	0	6
Cowley	356	439
Crawford	167	434
Decatur	9	20
Dickinson	146	335
Doniphan	45	69
Douglas	285	778
Edwards	1	16
Elk	4	8
Ellis	181	403
Ellsworth	18	54
Finney	234	654
Ford	181	465
Franklin	82	158
Geary	157	758
Gove	20	34
Graham	21	20
Grant	17	69
Gray	9	30
Greeley	0	6
Greenwood	20	19
Hamilton	13	33
Harper	8	26
Harvey	152	194
Haskell	11	31
Hodgeman	3	16
Jackson	79	148
Jefferson	72	151
Jewell	17	34
Johnson	2119	4751
Kearny	5	31
Kingman	0	19
Kiowa	0	9
Labette	62	141
Lane	13	25
Leavenworth	319	728
Lincoln	40	45
Linn	80	36
Logan	17	25
Lyon	26	205
Marion	129	252
Marshall	100	192
McPherson	98	220
Meade	12	31
Miami	86	138
Mitchell	41	96
Montgomery	203	417
Morris	58	79
Morton	14	22
Nemaha	79	150
Neosho	67	134
Ness	4	36
Norton	21	52
Osage	84	143
Osborne	33	56
Ottawa	74	110
Pawnee	53	66
Phillips	1	44
Pottawatomie	136	307
Pratt	22	63
Rawlins	9	11
Reno	197	890
Republic	51	79
Rice	45	138
Riley	272	716
Rooks	2	34
Rush	4	20
Russell	8	110
Saline	572	829
Scott	9	32
Sedgwick	669	2738
Seward	253	231
Shawnee	1004	2189
Sheridan	4	10
Sherman	26	50
Smith	21	19
Stafford	28	60
Stanton	2	19
Stevens	30	57
Sumner	75	181
Thomas	47	60
Trego	5	22
Wabaunsee	5	32
Wallace	5	7
Washington	45	100
Wichita	129	195
Wilson	15	50
Woodson	23	30
Wyandotte	369	967

Table B.8: High-need Counties

At-Risk Counties	The county is served, in whole or in part, by at least one home visiting program	The county is served, in whole or in part, by at least one home visiting program that implements evidence-based home visiting service delivery models eligible for implementation by MIECHV	The county is served, in whole or in part, by home visiting programs which are funded by MIECHV	Estimated number of children served by a home visiting program located in the county in the most recently completed program fiscal year	*Estimate of need in the county (data provided by HRSA)	Alternate estimated need of eligible families in the county: Population under 5 in poverty (ACS - 2018 5-year county estimates)
Allen	**Yes**	**Yes**	no	163	150	176
Atchison	**Yes**	**Yes**	no	140	60	64
Bourbon	**Yes**	**Yes**	no	262	173	325
Chautauqua	**Yes**	**Yes**	no	6	7	30
Cherokee	**Yes**	**Yes**	**Yes**	298	113	191
Cowley	**Yes**	**Yes**	no	439	217	527
Crawford	**Yes**	**Yes**	**Yes**	434	218	622
Elk	**Yes**	**Yes**	no	8	5	34
Franklin	**Yes**	**Yes**	no	158	302	246
Harper	**Yes**	**Yes**	no	26	66	67
Labette	**Yes**	**Yes**	no	141	114	411
Linn	**Yes**	**Yes**	no	36	113	148
Montgomery	**Yes**	**Yes**	**Yes**	417	182	794
Neosho	**Yes**	**Yes**	**Yes**	134	90	259
Rawlins	**Yes**	**Yes**	no	11	6	6
Republic	**Yes**	**Yes**	no	79	11	29
Riley	**Yes**	**Yes**	no	716	403	551
Wilson	**Yes**	**Yes**	**Yes**	50	17	108
Woodson	**Yes**	**Yes**	no	30	6	45
Wyandotte	**Yes**	**Yes**	**Yes**	967	3277	4362

**The data for the indicator of need provided by HRSA is included here, however, the assessment of need in the state is interpreted using the alternate estimate of need provide in the last column of this table.*

Table B.9. Calculation of Need for High-Need Counties

County	Total number of children receiving home visiting services	Population under 5 in poverty	Percent of population under 5 in poverty that can be served by existing home visiting programs	Total number of families receiving home visiting services	Total number of eligible families in need (data provided by HRSA)	Percent of families that can be served by existing home visiting programs
Allen	163	176	93%	102	150	68%
Atchison	140	342	41%	75	60	Over 100%
Bourbon	262	325	81%	147	173	85%
Chautauqua	6	30	20%	14	7	Over 100%
Cherokee	298	191	Over 100%	130	113	Over 100%
Cowley	439	527	83%	356	217	Over 100%
Crawford	434	622	70%	167	218	77%
Elk	8	34	24%	4	5	80%
Franklin	158	246	64%	82	302	27%
Harper	26	67	39%	8	66	12%
Labette	141	411	34%	62	114	54%
Linn	36	148	24%	80	113	71%
Montgomery	417	794	53%	203	182	Over 100%
Neosho	134	259	52%	67	90	74%
Rawlins	11	6	Over 100%	9	6	Over 100%
Republic	79	29	Over 100%	51	11	Over 100%
Riley	716	551	Over 100%	272	403	67%
Wilson	50	108	46%	15	17	88%
Woodson	30	45	67%	23	6	Over 100%
Wyandotte	967	4362	22%	369	3277	11%

Note: *The percentage of population under 5 in poverty that can be served by existing home visiting programs was calculated by dividing the total number of children receiving home visiting services across all home visiting models by the population under 5 in poverty for each county. The percent of families that can be served by existing home visiting programs was calculated by dividing the total number of families receiving home visiting services across all home visiting models by the total number of families in need (data provided by HRSA). For both of these calculations, if the total number receiving home visiting services was greater than the total of those in need, this is represented as "Over 100%".*

Table B.10. Estimate of Need Across All Counties

Note: *The percentage of population under 5 in poverty that can be served by existing home visiting programs was calculated by dividing the total number of children receiving home visiting services by the population under 5 in poverty in each county. The percent of families that can be served by existing home visiting programs was calculated by dividing the total number of families receiving home visiting services by the total number of families in need. For both of these calculations, if the total number receiving home visiting services was greater than the total of those in need, this is represented as "Over 100%".*

County	*Total number of children receiving home visiting services*	*Population under 5 in poverty*	*Percent of population under 5 in poverty that can be served by existing home visiting programs*
Allen	163	176	93%
Anderson	46	64	72%
Atchison	140	342	41%
Barber	29	64	45%
Barton	239	445	54%
Bourbon	262	325	81%
Brown	95	142	67%
Butler	349	559	62%
Chase	11	33	33%
Chautauqua	6	30	20%
Cherokee	298	191	Over 100%
Cheyenne	8	18	44%
Clark	17	28	61%
Clay	224	60	Over 100%
Cloud	179	81	Over 100%
Coffey	139	97	Over 100%
Comanche	6	6	1
Cowley	439	527	83%
Crawford	434	622	70%
Decatur	20	42	48%
Dickinson	335	102	Over 100%
Doniphan	69	102	68%
Douglas	778	952	82%
Edwards	16	12	Over 100%
Elk	8	34	24%
Ellis	403	301	Over 100%
Ellsworth	54	42	Over 100%
Finney	654	726	90%
Ford	465	845	55%
Franklin	158	246	64%
Geary	758	792	96%
Gove	34	21	Over 100%
Graham	20	42	48%
Grant	69	40	Over 100%
Gray	30	10	Over 100%
Greeley	6	4	Over 100%
Greenwood	19	60	32%
Hamilton	33	50	66%
Harper	26	67	39%

County	Total number of children receiving home visiting services	Population under 5 in poverty	Percent of population under 5 in poverty that can be served by existing home visiting programs
Harvey	194	369	53%
Haskell	31	66	47%
Hodgeman	16	40	40%
Jackson	148	122	Over 100%
Jefferson	151	142	Over 100%
Jewell	34	60	57%
Johnson	4751	2709	Over 100%
Kearny	31	53	58%
Kingman	19	59	32%
Kiowa	9	11	82%
Labette	141	411	34%
Lane	25	13	Over 100%
Leavenworth	728	720	Over 100%
Lincoln	45	24	Over 100%
Linn	36	148	24%
Logan	25	2	Over 100%
Lyon	205	401	51%
Marion	252	156	Over 100%
Marshall	192	57	Over 100%
McPherson	220	93	Over 100%
Meade	31	72	43%
Miami	138	102	Over 100%
Mitchell	96	109	88%
Montgomery	417	794	53%
Morris	79	40	Over 100%
Morton	22	7	Over 100%
Nemaha	150	132	Over 100%
Neosho	134	259	52%
Ness	36	5	Over 100%
Norton	52	15	Over 100%
Osage	143	177	81%
Osborne	56	48	Over 100%
Ottawa	110	89	Over 100%
Pawnee	66	26	Over 100%
Phillips	44	56	79%
Pottawatomie	307	252	Over 100%
Pratt	63	177	36%
Rawlins	11	6	Over 100%
Reno	890	623	Over 100%
Republic	79	29	Over 100%
Rice	138	137	Over 100%
Riley	716	551	Over 100%
Rooks	34	25	Over 100%
Rush	20	10	Over 100%

County	Total number of children receiving home visiting services	Population under 5 in poverty	Percent of population under 5 in poverty that can be served by existing home visiting programs
Russell	110	28	Over 100%
Saline	829	515	Over 100%
Scott	32	14	Over 100%
Sedgwick	2738	7312	37%
Seward	231	495	47%
Shawnee	2189	2582	85%
Sheridan	10	0	Over 100%
Sherman	50	91	55%
Smith	19	37	51%
Stafford	60	29	Over 100%
Stanton	19	31	61%
Stevens	57	189	30%
Sumner	181	203	89%
Thomas	60	35	Over 100%
Trego	22	37	59%
Wabaunsee	32	22	Over 100%
Wallace	7	14	50%
Washington	100	62	Over 100%
Wichita	195	0	Over 100%
Wilson	50	108	46%
Woodson	30	45	67%
Wyandotte	967	4362	22%

Table B.11: Kansas Home Visiting Programs Available in Each County (data for figure 2 map)

County	Parents as Teachers (PAT)	Maternal and Child Health (MCH) Home Visiting	Healthy Families America (HFA)	Family First Funding Expansion	Early Head Start (EHS)	Attachment and Biobehavioral Catch-Up Intervention	Family First Funding Expansion
Allen	**Yes**	**Yes**	No	**Yes**	**Yes**	No	No
Anderson	**Yes**	**Yes**	No	**Yes**	No	No	No
Atchison	**Yes**	**Yes**	No	**Yes**	**Yes**	No	No
Barber	No	No	No	No	No	No	No
Barton	**Yes**	**Yes**	**Yes**	No	No	No	No
Bourbon	**Yes**	**Yes**	**Yes**	No	No	No	No
Brown	**Yes**	**Yes**	No	**Yes**	**Yes**	No	No
Butler	**Yes**	No	**Yes**	No	No	**Yes**	No
Chase	**Yes**	**Yes**	**Yes**	No	No	No	No
Chautauqua	No	**Yes**		**Yes**	**Yes**	No	No
Cherokee	**Yes**	**Yes**	**Yes**	No	No	No	No
Cheyenne	No	No	No	No	**Yes**	**Yes**	**Yes**
Clark	No	No	No	No	No	**Yes**	No
Clay	**Yes**	**Yes**	No	No	**Yes**	No	No
Cloud	**Yes**	**Yes**	No	No	**Yes**	No	No
Coffey	**Yes**	No	No	**Yes**	No	No	No
Comanche	No	No	No	No	No	No	No
Cowley	**Yes**	**Yes**	No	No	**Yes**	No	No
Crawford	**Yes**	**Yes**	**Yes**	No	No	No	No
Decatur	**Yes**	No	No	No	**Yes**	**Yes**	**Yes**
Dickinson	**Yes**	No	No	No	**Yes**	No	No
Doniphan	**Yes**	**Yes**		**Yes**	**Yes**	No	No
Douglas	**Yes**	No	**Yes**	**Yes**	No	No	**Yes**
Edwards	No	No	No	No	No	No	No
Elk	No	**Yes**	No	No	**Yes**	No	No
Ellis	**Yes**	**Yes**	No	No	**Yes**	No	**Yes**
Ellsworth	No	**Yes**	No	No	**Yes**	No	No
Finney	**Yes**	No	No	No	**Yes**	**Yes**	No

County	Parents as Teachers (PAT)	Maternal and Child Health (MCH) Home Visiting	Healthy Families America (HFA)	Family First Funding Expansion	Early Head Start (EHS)	Attachment and Biobehavioral Catch-Up Intervention	Family First Funding Expansion
Ford	**Yes**	No	No	No	**Yes**	**Yes**	No
Franklin	**Yes**	No	No	**Yes**	**Yes**	No	No
Geary	**Yes**	**Yes**	No	No	No	No	No
Gove	**Yes**	No	No	No	**Yes**	**Yes**	**Yes**
Graham	No	**Yes**	No	No	**Yes**	**Yes**	**Yes**
Grant	No	No	No	No	**Yes**	**Yes**	No
Gray	No	No	No	No	**Yes**	**Yes**	No
Greeley	No	**Yes**	No	No	No	**Yes**	No
Greenwood	No	No	**Yes**	No	No	No	No
Hamilton	No	**Yes**	No	No	No	**Yes**	No
Harper	No	No	No	No	**Yes**	No	No
Harvey	**Yes**	**Yes**	**Yes**	No	No	No	No
Haskell	No	**Yes**	No	No	**Yes**	**Yes**	No
Hodgeman	No	**Yes**	No	No	No	**Yes**	No
Jackson	**Yes**	**Yes**	No	**Yes**	**Yes**	No	No
Jefferson	**Yes**	**Yes**	No	No	**Yes**	No	No
Jewell	**Yes**	**Yes**	No	No		No	No
Johnson*	**Yes**	**Yes**	**Yes**	No	**Yes**	No	No
Kearny	No	No	No	No	**Yes**	**Yes**	No
Kingman	No	No	No	No	No	No	No
Kiowa	No	No	No	No	No	No	No
Labette	**Yes**	**Yes**	**Yes**	No	No	No	No
Lane	**Yes**	No	No	No	No	**Yes**	No
Leavenworth	**Yes**	**Yes**	**Yes**	No	**Yes**	No	**Yes**
Lincoln	**Yes**	**Yes**	No	No	No	No	No
Linn	**Yes**	**Yes**	No	**Yes**	No	No	No
Logan	**Yes**	No	No	No	**Yes**	**Yes**	**Yes**
Lyon	**Yes**	No	**Yes**	No	No	No	No
Marion	**Yes**	**Yes**	**Yes**	No	**Yes**	**Yes**	No

County	Parents as Teachers (PAT)	Maternal and Child Health (MCH) Home Visiting	Healthy Families America (HFA)	Family First Funding Expansion	Early Head Start (EHS)	Attachment and Biobehavioral Catch-Up Intervention	Family First Funding Expansion
Marshall	**Yes**	**Yes**	No	**Yes**	**Yes**	No	No
McPherson	No	No	**Yes**	No	**Yes**	No	No
Meade	No	**Yes**	No	No	No	**Yes**	No
Miami	**Yes**	**Yes**	**Yes**	No	No	No	No
Mitchell	**Yes**	**Yes**	No	No	No	No	No
Montgomery	**Yes**	**Yes**	**Yes**	No	No	No	No
Morris	**Yes**	**Yes**	No	No	No	No	No
Morton	No	**Yes**	No	No	No	No	No
Nemaha	**Yes**	**Yes**	No	**Yes**	**Yes**	No	No
Neosho	**Yes**	**Yes**	**Yes**	**Yes**	No	No	No
Ness	No	No	No	No	No	**Yes**	No
Norton	No	**Yes**	No	No	**Yes**	**Yes**	**Yes**
Osage	**Yes**	**Yes**	No	**Yes**	No	No	No
Osborne	**Yes**	No	No	No	No	No	**Yes**
Ottawa	**Yes**	**Yes**	No	No	**Yes**	No	No
Pawnee	**Yes**	**Yes**	No	No	No	No	No
Phillips	No	**Yes**	No	No	No	No	**Yes**
Pottawatomie	**Yes**	**Yes**	No	**Yes**	**Yes**	No	No
Pratt	**Yes**	No	No	No	No	No	No
Rawlins	No	No	No	No	**Yes**	**Yes**	**Yes**
Reno	**Yes**	**Yes**	**Yes**	No	**Yes**	**Yes**	No
Republic	**Yes**	**Yes**	No	No	**Yes**	No	No
Rice	**Yes**	**Yes**	**Yes**	No	No	No	No
Riley	**Yes**	**Yes**	No	No	**Yes**	No	No
Rooks	No	**Yes**	No	No	**Yes**	No	**Yes**
Rush	No	No	No	No	**Yes**	No	No
Russell	No	No	No	No	**Yes**	No	**Yes**
Saline	**Yes**	**Yes**	No	No	**Yes**	No	No
Scott	No	No	No	No	**Yes**	**Yes**	No

County	Parents as Teachers (PAT)	Maternal and Child Health (MCH) Home Visiting	Healthy Families America (HFA)	Family First Funding Expansion	Early Head Start (EHS)	Attachment and Biobehavioral Catch-Up Intervention	Family First Funding Expansion
Sedgwick	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	No
Seward	No	**Yes**	No	No	**Yes**	**Yes**	No
Shawnee*	**Yes**	**Yes**	**Yes**	No	**Yes**	No	No
Sheridan	No	No	No	No	**Yes**	**Yes**	**Yes**
Sherman	No	No	No	No	**Yes**	**Yes**	**Yes**
Smith	**Yes**	**Yes**	No	No	No	No	**Yes**
Stafford	**Yes**	**Yes**	No	No	No	No	No
Stanton	No	No	No	No	**Yes**	**Yes**	No
Stevens	**Yes**	**Yes**	No	No	**Yes**	**Yes**	No
Sumner	No	**Yes**	No	No	**Yes**	No	No
Thomas	**Yes**	**Yes**	No	No	**Yes**	**Yes**	**Yes**
Trego	No	No	No	No	**Yes**	**Yes**	**Yes**
Wabaunsee	No	No	No	**Yes**	No	No	No
Wallace	No	No	No	No	**Yes**	**Yes**	**Yes**
Washington	**Yes**	No	No	No	**Yes**	No	No
Wichita	**Yes**	No	No	No	**Yes**	No	No
Wilson	**Yes**	**Yes**	No	**Yes**	No	No	No
Woodson	**Yes**	**Yes**	No	**Yes**	No	No	No
Wyandotte◊	**Yes**	No	**Yes**	No	No	**Yes**	**Yes**

** Johnson and Shawnee counties additionally offer Nurse Family Partnership (NFP) program.*

◊ Wyandotte County additionally offers Team for Infants Endangered by Substance Abuse (TIES) program

APPENDIX C: CAPACITY FOR PROVIDING SUBSTANCE USE DISORDER TREATMENT AND COUNSELING SERVICES

Table C.1 Full Kansas Substance Use Treatment Facilities List: 2018 National Survey of Substance Abuse Treatment Services (N-SSATS)

County	Facility Name
Allen	Southeast Kansas Mental Health Ctr
Anderson	Southeast Kansas Mental Health Ctr Alcohol and Drug Abuse Services
Atchison	Guidance Center Atchinson
Atchison	Valley Hope Atchinson
Barber	Mirror Inc Medicine Lodge
Barton	Center for Counseling
Bourbon	Community MHC of Crawford County
Brown	Mirror Inc Hiawatha
Butler	Seventh Direction
Butler	Seventh Direction
Chautauqua*	City On a Hill Sedan
Chautauqua	Kisa Life Recovery
Cherokee	Spring River MH and Wellness
Cherokee	Spring River Mental Health and Wellness Inc
Cloud	Kerrs Counseling Concordia
Cloud	Pawnee Mental Health Services Concordia
Coffey	Therapy Services LLC
Cowley	Preferred Family Healthcare Inc Winfield Residential
Crawford	Community MHC of Crawford County Girard
Crawford	Community MHC of Crawford County
Crawford	Community MHC of Crawford County Outpatient
Crawford*	Community MHC of Crawford County Womens Renewal House
Crawford	DCCCA Inc Elm Acres Recovery Services
Dickinson	Central Kansas Foundation Abilene
Douglas	Addiction Recovery Counseling Services
Douglas	Alpha Recovery LLC Lawrence
Douglas	Center for Change Lawrence
Douglas*	DCCCA Inc First Step at Lake View
Douglas	DCCCA Inc Lawrence Outpatient Treatment Servs
Douglas	Heartland Clinical Consultants
Douglas	Mirror Inc Lawrence Outpatient Treatment Services
Ellis	Dream Inc
Ellis	High Plains Mental Health Center Hays
Ellis	Kelly Center FHSU Drug and Alcohol Wellness Network Hays
Ellis	Smoky Hill Foundation for Chemical Dep

County	Facility Name
Ellsworth	Counseling Inc
Finney*	City on a Hill
Finney	Compass Behavioral Health
Ford	New Chance Inc
Franklin	Elizabeth Layton Center Ottawa
Franklin	Recovery Services Center (RSC) Ottawa
Geary	Central Kansas Foundation Junction City
Geary	Restoration Center
Grant	Compass Behavioral Health Ulysses
Harper	Mirror Inc Anthony
Harvey	Mirror Inc Mens Program
Harvey	Mirror Inc Womens Program
Harvey	Mirror Inc Newton Outpatient
Harvey	Prairie View Inc Newton
Jackson	Prairie Band Potawatomi Health Clinic
Jefferson	Guidance Center
Johnson	Hal Nichols Associates
Johnson	Affordable Treatment Program Lenexa
Johnson	Chautauqua Counseling Center
Johnson	Heartland Regional Alcohol and Drug Assessment Center Inc
Johnson	Johnson County Mental Health Center Outpatient Addiction Services
Johnson	We Can Recover Counseling Services
Johnson	AppleCore Outpatient Treatment/Olathe
Johnson	Assessment Services
Johnson	Avenues to Recovery Olathe
Johnson	Choices Alcohol and Drug Assessments Education and Counseling
Johnson	Full Circle Education Counseling Center
Johnson	Johnson County Mental Health Center ACT Olathe
Johnson	Johnson County Mental Health Center Outpatient Addiction Services
Johnson	KidsTLC Outpatient Services
Johnson	Preferred Family Healthcare
Johnson	Add Csl Educ and Info Services (ACEIS)
Johnson	Addiction Treatment Services Overland Park
Johnson	Agape Christian Counseling
Johnson	Associates at Hope Harbor
Johnson	Awakenings KC

County	Facility Name
Johnson	Challenges Inc Overland Park
Johnson	Clinical Associates PA
Johnson	Doolittle and Harrington Healthcare
Johnson	Valley Hope
Johnson	We Care HCBS Alcohol and Drug Education/ DOT-SAP
Johnson	Accredited Addiction Recovery Services
Johnson	Johnson County Mental Health Center Adult Detox Unit
Johnson	Mirror Inc Shawnee
Johnson	Mirror Inc Shawnee Outpatient
Johnson	BHG Overland Park
Kiowa	Iroquois Center for Human Development
Labette	Labette Center for MH Services Inc
Leavenworth	Guidance Center
Leavenworth	Serenity Counseling and Wellness Ctr
Leavenworth	VA Eastern Kansas Health Care System Addiction Treatment Program LVN
Lyon	Corner House Inc
Lyon	Therapy Services LLC Emporia
Marshall	Pawnee Mental Health Services
McPherson	Carousel Live LLC DBA Client Centered Counseling
McPherson	Central Kansas Foundation McPherson
McPherson	Prairie View Inc
McPherson	Valley Hope Moundridge
Miami	Eagle Recovery Services
Miami	Sunflower Subst Abuse Recovery Servs
Miami	Sunflower Wellness Retreat
Miami	Elizabeth Layton Center
Mitchell	Pawnee Mental Health Services Beloit
Montgomery	Four County Mental Health Center
Norton	High Plains Mental Health Center Norton Branch Office
Norton	Valley Hope Norton
Osborne	High Plains Mental Health Center Osborne Branch Office
Phillips	High Plains Mental Health Center Phillipsburg Branch Office
Pratt	DCCCA Inc Pratt
Reno	Horizons Mental Health Center Inc Substance Abuse Services
Reno	Mirror Inc Hutchinson
Reno	Reno Alcohol Drug Services
Reno	Substance Abuse Center of KS
Riley	Pawnee Mental Health Services Manhattan
Riley	Restoration Center Manhattan
Saline*	Ashby House

County	Facility Name
Saline	Central Kansas Foundation Pathfinder Recovery Center
Saline	Saint Francis Community Services Residential
Saline	Saint Francis Community Services West Campus
Saline	Veridian Behavioral Health/SRHC
Scott	Compass Behavorial Health
Scott	City on a Hill
Scott	City on a Hill
Sedgwick	ABC Health Group Matrix Center/Wichita
Sedgwick	A New Dimension Inc
Sedgwick	ARROW Wichita
Sedgwick	Associated Word of Life Counselors
Sedgwick	Caring Center of Wichita
Sedgwick	Center for Change
Sedgwick	Center for Human Development Inc
Sedgwick	Change Your Life Enterprises Inc ADAPT
Sedgwick	Changing Habits LLC
Sedgwick	COMCARE of Sedgwick County Addiction Treatment Services
Sedgwick	DCCCA Inc Options Adult Services
Sedgwick*	DCCCA Inc Womens Recov Ctr of Central Kansas
Sedgwick	Fieldview at Holland
Sedgwick	HealthCore Clinic Inc
Sedgwick	Higher Ground Tiyospaye
Sedgwick	Hunter Health
Sedgwick	Metro Treatment Center Inc Behavioral Health
Sedgwick*	Miracles Inc Miracles House
Sedgwick	Miracles Inc Outpatient Behavioral Health Center
Sedgwick	Preferred Family Healthcare Inc Hillside
Sedgwick	Recovery Concepts Inc
Sedgwick	Recovery Unlimited West Douglas
Sedgwick	Road to Recovery Lawrence
Sedgwick	Seventh Direction
Sedgwick	STOP Program East Location
Sedgwick	Substance Abuse Center of KS Crossover Recovery Center
Sedgwick	Substance Use Disorder Clinic (SUDC) Robert J Dole VA Medical Center
Sedgwick	Valley Hope Wichita
Sedgwick	Wichita Comprehensive Treatment Ctr
Sedgwick	Wichita Treatment Center, Inc.
Sedgwick	Addictive Behavioral Change Health Group/ Matrix Center
Seward	Cimmarron Basin Community Corrections Alcohol/Drug Treatment Program
Seward	City On a Hill Liberal
Shawnee	Eastern Kansas VA Healthcare Systems Substance Abuse Treatment Team

County	Facility Name
Shawnee	Mirror Inc Topeka
Shawnee	New Dawn Wellness and Recovery Ctr Inc
Shawnee	Pathway Family Services Inc
Shawnee	Sims Kemper Clinical Counseling and Recovery Services
Shawnee	Topeka Treatment Center LLC
Shawnee	Valeo Recovery Center Topeka
Sherman	High Plains Mental Health Center Goodland Branch Office
Sumner	Mirror Inc Wellington
Sumner	Sumner Mental Health Center
Thomas	High Plains Mental Health Center Colby Branch Office
Wichita*	City On a Hill
Wilson	Road to Recovery

County	Facility Name
Wyandotte	Alcohol Safety Action Project
Wyandotte	BHG XXX LPC BHG Kansas City North
Wyandotte	Chautauqua Counseling Center KC
Wyandotte	Frontline Intervention Solution Today
Wyandotte	Kansas City Metro Methadone Prog
Wyandotte	MARS Consulting
Wyandotte	Wyandotte County Residential and Outpt
Wyandotte	Saint Francis Community Services
Wyandotte	Kansas University Physicians, Inc.

Figure C.1

Services Related to Women's and Children's Needs

Offered at Substance Use Disorder Treatment Facilities in Kansas

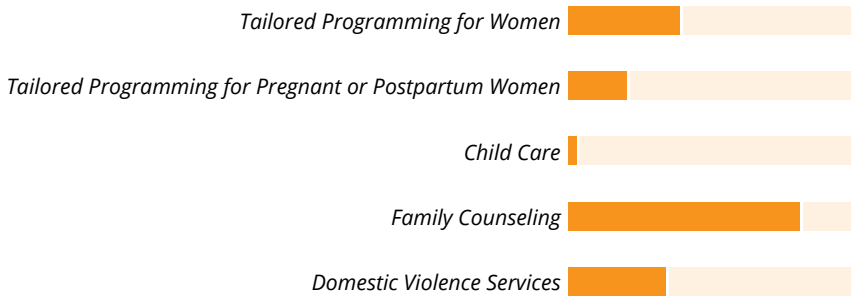

Figure C.2

Percent of Kansas Substance Use Disorder Treatment Facilities Offering Listed Services

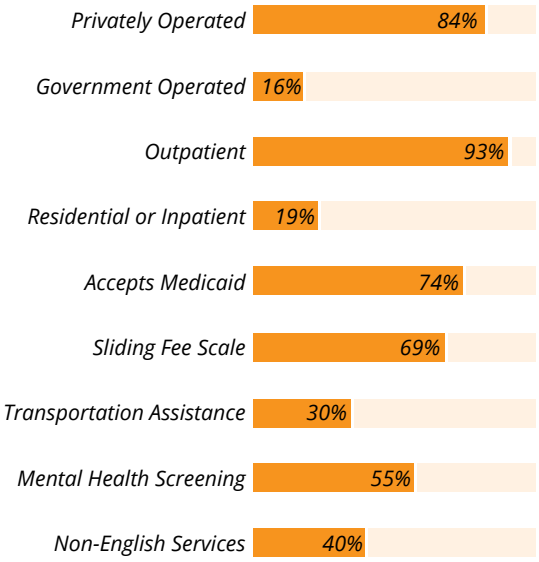

Table C.2: Kansas Counties Identified as High-need, Identified as having SUD Risk Indicators, and those with existing MIECHV Programs

High-need Counties	*County is Considered High-Need based on Substance Use Disorder Risk Indicators*	*County has 2020 MIECHV Programs*
Allen	**Yes**	No
Atchison	**Yes**	No
Bourbon	**Yes**	No
Chautauqua	No	No
Cherokee	**Yes**	**Yes**
Cowley	No	No
Crawford	**Yes**	No
Elk	No	No
Franklin	No	No
Harper	No	No
Labette	**Yes**	**Yes**
Linn	**Yes**	No
Montgomery	**Yes**	**Yes**
Neosho	**Yes**	**Yes**
Rawlins	No	No
Republic	No	No
Riley	No	No
Wilson	**Yes**	**Yes**
Woodson	**Yes**	No
Wyandotte	No	**Yes**

APPENDIX D: REFERENCES AND ENDNOTES

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Endnotes

[1] Social Security Act, Title V, § 511(b)(1)(A).

[2] Indicator data for the substance use disorder domain was provided from the National Survey for Drug Use and Health (NSDUH) sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). The indicators originally included in the HRSA/MCHB data included data from the 2012-2016 NSDUH data. When the data was updated, three of the four indicators was included in the 2014-2016 NSDUH data. Grantees updating this MIECHV Statewide Needs Assessment were given several options as to which indicators from the original and alternative sets of data to include to assess the substance use disorder domain. In collaboration with home visiting program leaders at KDHE, a combination of the original and alternative indicators was chosen to adequately capture the risk domain of substance use and disorder in the State (*Table A.3 in Appendix A* shows all of the substance abuse disorder indicators included in the final analysis to identify the high-need counties in Kansas).

[3] The indicator of need provided by HRSA was calculated using the American Community Survey (ACS) 2017 1-year Public Use Microdata Sample (PUMS) data. HRSA defined need as families and children under 6 years old that were living in poverty and met two additional risk factors (families in which the mother was low educational attainment—high school or less; families with pregnant women—a child less than 1 year in the past; or families with young mothers—aged under 21). The needs assessment team chose to use the alternative measure of need which included children under 5 in poverty with out the additional risk factors to be aligned with previous needs assessments (e.g. PDG Needs Assessment which used a similar indicator of need).