MIECHV Expansion

Community Readiness Assessment
Final Report

KU THE UNIVERSITY OF KANSAS | Center for Public Partnerships and Research

KANSAS HOME VISITING

Acknowledgements

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Executive Summary and Recommendations

MIECHV Expansion: County Selection

Three counties were selected as high priority to explore MIECHV expansion opportunities: Allen, Cowley, and Wyandotte counties. In all three counties, the need for home visiting services far exceeds the current need-based home visiting service reach.

Community Context

According to the County Health Rankings, all three counties rank in the bottom 15% in Kansas for overall health outcomes: Allen, 89; Cowley, 93; and Wyandotte, 103. Compared to the state, each of these counties has higher food insecurity and fewer mental health providers and primary care providers per the population. Wyandotte County is designated as urban, and both Cowley and Allen counties are designated as densely settled rural counties in southeast Kansas. MIECHV is currently implemented in Wyandotte. Allen borders other southeast Kansas counties that implement MIECHV. Cowley does not directly border any counties that are currently implementing MIECHV.

Community Readiness Stage

Each of the three selected counties is at different a different Community Readiness Stage. Allen is at Stage 7 (Stabilization) because multiple evidence-based home visiting program models are active and stable. Cowley is in between stages 5 (Preparation) and 6 (Initiation) because only one evidenced-based program model is implemented in this community. Wyandotte is in between stages 7 (Stabilization) and 8 (Confirmation/Expansion) because multiple evidence-based home visiting program models are active in the community and are stable. Moreover, Wyandotte county programs are already implementing MIECHV.

Recommendations for MIECHV Expansion Activities

Improve Home Visiting Service Reach and Access

Explore expansion of evidenced-based home visiting services in Allen, Cowley, and Wyandotte counties. In all three counties, less than a quarter of families were served by need-based home visiting programs. Expansion activities in all three counties focused on increasing community awareness of home visiting could be beneficial for improving reach and access. In Allen and Cowley counties, the greatest barrier to home visiting access for families was the lack of awareness. In Wyandotte, families reported that the greatest difficulty families in their community face accessing home visiting was the lack of providers that speak languages other than English. Consider a focus on recruitment and retention of high-quality home visiting staff who speak languages other than English in Wyandotte county.

Improve Community Awareness of Family Needs and Home Visiting

All three counties need to improve community knowledge of family needs and of home visiting. In Allen and Cowley counties, families reported the greatest difficulty families in their community face when accessing home visiting services in not having enough information or awareness about the service. These counties should consider how home visiting leadership and stakeholders can increase awareness of family needs and home visiting.

Support Community Leadership and increase Resources that Support Home Visiting

Leverage available resources and identify where more resources are needed, especially in Allen and Cowley counties. Identify and assist community leaders and home visiting champions who can prioritize and support home visiting programs and efforts.

Share these Findings with the Community

Use this report and the supplemental Expansion Community Profiles to generate productive discussions in counties about community strengths and barriers to implementation and expansion of need-based home visiting services. Home visiting stakeholders in these communities should dig deep into what specific resources and supports will be needed to implement and expand need-based home visiting.

Address Challenges Experienced by the Home Visiting Workforce

The home visiting workforce data show significant challenges with the home visiting profession in Kansas—turnover, hiring difficulties, few opportunities for advancement, signs of burnout, low compensation, high workload, staying on top of each case in caseload, administrative burden, filling vacant slots for families. Kansas may consider providing support for small-scale innovation pilots that attempt to address these challenges and could provide potential pathways for scalable system innovation.

Improve Data Collection and Reporting on Families Served

Some home visiting program models cannot easily track and provide accurate data on how many children and families are being served by their home visiting programs and where families are being served. This information is vital to understanding the reach of home visiting programs and access and availability of home visiting programs. Kansas may consider requiring and supporting home visiting programs to track and report these data annually. Ideally, visiting programs would all use a consistent system across programs who receive state and federal funding for tracking who is being served, where, by what model, and outcomes.

Purpose & Background

This technical report provides the methods, results, and recommendations for Kansas MIECHV expansion from the updated Home Visiting Risk, Reach, and Readiness Assessments. Upon completion of the 2020 Kansas MIECHV Needs assessment, Kansas was ready to consider MIECHV program expansion. However, MIECHV expansion efforts were delayed because of the COVID-19 pandemic. Although Kansas is now ready to move forward with MIECHV expansion, the Kansas 2020 Home Visiting Needs Assessment data are outdated (i.e., data from 2012 to 2017).

Therefore, to inform expansion of the MIECHV program in Kansas, Kansas completed an updated statewide risk and home visiting service reach assessment, as well as targeted community readiness assessments. The updated risk and reach assessments used multiple years of recent data to show where community risks and needs are high, and a significant percentage of children are born having multiple risk factors. To update the Home Visiting service reach assessment, we compiled updated data on families and children served from all need-based home visiting programs across Kansas at the community level. We also gathered information on community strengths, needs, and readiness for Home Visiting expansion from the perspectives of home visiting programs and expectant parents and families with young children. Collectively, these data were used to inform priority communities for MIECHV expansion, and specific expansion recommendations for high priority communities.

Methodology

Measures

High-need Communities: Community Risk and Birth Risk Data

To identify communities with the highest community and birth need, we generated indices of risk in five domains — socioeconomic status, perinatal outcomes, substance use, crime, domestic violence, and child maltreatment — using nationally available county-level data. Indicators within each domain align with the characteristics described in the MIECHV-authorizing statute to identify at-risk communities. See Data Cleaning and Analysis below for additional details and Appendix A for specific data sources.

Need-based Home Visiting Service Reach

Data were collected on the number of families and children served from all home visiting programs in Kansas, at the community-level (i.e., county-level, school district-level) when available. These data were collected to see where families were being served and underserved. Data were from the following home visiting programs: Parents as Teachers (PAT), Early Head Start (EHS), Healthy Families America (HFA), and Attachment Behavioral Catchup (ABC), Play and Learning Strategies (PALS), and Nurse-Family Partnership (NFP). Home visiting service reach data are reported only in the aggregate and not at the program-level.

Data reported here were from the most recently completed fiscal year data available in fall 2022 for each program. Data year ranges were between 2021-2022 because the start and end date varied by program. For ABC, one agency provided numbers of two counties and county estimates were made based on the population of each county. For EHS, estimates were based on the ratio of total families served in the federal EHS system to slots for each county. Thus, each county's slots were multiplied by the overall number of families served in Kansas/total number of slots. For PAT, school district-level and consortium-level data were used for families served. Based off the Kansas USD map and U.S. census population estimates, weights were developed for each county within each school district and consortium representing the percent of USD/consortium population by county. These were multiplied by the total number

of families provided county-level estimates of families served within each consortium and school district.

Community Readiness

To identify a community's readiness stage, we used the Stages of Community Readiness described in Exhibit 7 of the Community Readiness Toolkit (Higman et al., 2020, p. 24). We then reviewed program and administrative data to place communities recommended for exploring expansion in one of the following nine stages: No awareness; denial/resistance; vague awareness; pre-planning; preparation; initiation; stabilization; confirmation/expansion; and/or high level of community ownership. To assess Community Readiness Dimensions, we utilized survey data from the home visiting workforce (see Home Visiting Workforce Survey below). The five dimensions assessed were: Community Knowledge of Family Needs (Issues); Community Knowledge of Home Visiting (Efforts); Community Climate; Community Leadership; Community Resources. These items were developed using the Community Readiness toolkit developed for MIECHV programs (Higman et al., 2020) as well as the Community Readiness for Community Change handbook (Tri-Ethnic Center Community Readiness Handbook 2nd edition, 2014). Collectively, these data were used to determine readiness stage for expansion and what activities will be most beneficial and appropriate given where a community falls in the stages and dimensions of readiness.

Home Visiting Workforce Perspective

A survey was developed to assess the five domains of readiness and inform expansion activities: Community Knowledge of Family Needs (Issues); Community Knowledge of Home Visiting (Efforts); Community Climate; Community Leadership; Community Resources. We also asked about the home visiting workforce questions about their employee wellbeing, workload, workplace supports, and turnover intentions. Participants were incentivized with a $100 gift card for their participation. Items were assessed using 5-point Likert scales, with higher scores indicating greater endorsement of an item. Data collection occurred between September and December 2022.

The Home Visiting Workforce Survey was distributed to the home visiting workforce using multiple contacts, programs, and networks. Specifically, the survey was distributed through the following channels: DCCA distributed the survey to participants at the State Home

Visiting Conference; through the state home visiting leadership group to their networks; through MIECHV LIAs; through the All in for Kansas Kids newsletter; during the All in for Kansas Kids video conference call; through connected individuals and leads for each home visiting model, including Part C (Early Childhood Developmental Services) to all agencies implementing the model.

Family Perspective

A survey was developed to assess the relevant dimensions of families' need for and beliefs about home visiting. These dimensions included family resources and supports, help-seeking stigma, and beliefs about the effectiveness of community-based programs like home visiting. English and Spanish versions of the survey were developed and disseminated. Items were assessed using 5-point Likert scales, with higher scores indicating greater endorsement of an item. Data collection occurred between September and December 2022.

The family survey was distributed via Facebook, Spotify, and YouTube. Social media advertisements were created in both English and Spanish. Surveys were also distributed via email by local and state organizations serving families. Mailers with a survey QR code were sent to all WIC clinics across the state for dissemination to families coming to their clinic. Mailers were also printed and distributed via USPS to specific regions/demographics across Kansas. KDHE and the Kansas Children's Cabinet also distributed the survey through their networks. Families were incentivized with a $100 gift card for their participation.

Besides the distribution via social media outlets, the research team employed targeted outreach via in-person data collection for the Kansas counties that were indicated as priority for additional outreach and data collection (i.e., due to lack of response or representation in the data and being indicated as high-need counties.) Those counties were Allen, Bourbon, Brown, Cherokee, Labette, Montgomery, Wilson, and Wyandotte. The research team reached out to various public libraries in the other named counties to plan visits during the libraries' existing story times to recruit parents of children under the age of 6 to complete the family survey. For libraries that did not have an existing story time, the team offered to provide one and created promotional materials (i.e., digital post and printable flier) to aid in advertising. The scheduling and planning of these visits was done in collaboration with the libraries' managers or directors of children's programming. This effort was done in partnership with

KDHE, who sent a representative to attend each story time the team scheduled and brought free teddy bears and board books for each child in attendance.

The research team could schedule with the following counties: Allen, Bourbon, Cherokee, Labette, Montgomery, Wilson, and Wyandotte, for 7 data collection sessions. The team joined families as they sat through the children's story times at the library, and before, during, and after, distributed iPads with the survey pulled up to parents who were interested in completing the survey, which they completed individually. Parents were informed they would be eligible to receive a $25 Visa gift card for their participation. Attendance at the sessions varied, especially as the priority counties that the team visited were smaller, rural communities.

While there was a visit scheduled with Allen County's public library during their story time, the research team had to pivot and collect data using other methods when story time was cancelled last minute. The team first called other local community organizations that may have contact with parents of young children and visited local businesses and discuss the survey with people in the vicinity to see if they would be eligible to complete the survey or knew of another space in the community that may have eligible participants. A community member recommended that the research team visit a local restaurant that parents frequented often . While eating lunch, the team connected with several patrons, one who was a school nurse at a local elementary school who offered to distribute the survey link via email to all her school's staff, parents of children in kindergarten-1st grade, the local health department, and the local preschool. In doing so, the team could garner over 80 survey responses in a day. The team continued to discuss the survey in other local businesses to ensure recruitment efforts were widespread before leaving Allen County.

Data Cleaning and Analysis

High-need Communities: Community Risk and Birth Risk Data

The methodology used for identifying high-need communities was a variation of the simplified method developed by HRSA. We generated indices of risk in five domains — socioeconomic status, perinatal outcomes, substance use, crime, domestic violence, and child maltreatment — using nationally available county-level data. Indicators within each domain align with the characteristics described in the MIECHV-authorizing statute to identify at-risk communities. This method identifies a county as at-risk if 2 or more domains have at least half of the indicators with z-scores greater than or equal to 0.8 standard deviation higher than the mean of all counties in the state. To determine community risk, we took data from three years (2019, 2020, 2021) and used an average of indicator values across all three years. We also incorporated data on live births with 2 or more birth risks to identify counties with high community need. We took the following steps to implement this method:

Determining Community Risk

1. To determine community risk, we collected county-level data on each indicator under each domain from different sources of data.
    a. Socio-economic status:
        i. Poverty: Census Small Area Income and Poverty Estimates
        ii. Unemployment: Bureau of Labor Statistics
        iii. % High Schoolers who did not graduate: KSDE Graduation Rate Report
        iv. Dropout Rate: KSDE Dropout Rate Report
    b. Perinatal Outcomes:
        i. Preterm Birth: KDHE Annual Summary Report
        ii. Low Birth Weight: KDHE Annual Summary Report
        iii. No Breastfeeding Initiation: KDHE Annual Summary Report
        iv. Percent Inadequate Prenatal Care: KDHE Annual Summary Report
    c. Substance Use:
        i. Opioid Prescription Rates: Kansas Board of Pharmacy
        ii. Maternal Smoking: KDHE Annual Summary Report

d. Crime:
    i. Crime Reports per 1000 residents: Kansas Bureau of Investigation
    ii. Juvenile Arrests: Kansas Bureau of Investigation
e. Domestic Violence
    i. Number of Domestic Violence Incidents per 1000 residents: Kansas Bureau of Investigation
f. Child Maltreatment
    i. Number of Substantiated CPS Incidents per 1000 juveniles: Kansas Department of Children and Families

2. We then took an average of all indicator values across 2019, 2020 and 2021 for each indicator.
3. We standardized this average indicator value using the mean and standard deviation across all counties for that indicator.
4. We flagged domains where at least half of the indicators had z-scores greater than or equal to 0.8 standard deviation higher than the mean of all counties in the state.

Determining Birth Risk

1. To determine birth risk, we collected data on percent live births in each county with 2 or more birth risks from KDHE.
2. We standardized this value using the mean and standard deviation across all counties.
3. We flagged counties where the z-score for birth risk was greater than or equal to 0.8 standard deviation higher than the mean of all counties in the state.

Determining Overall Community Need

1. To identify counties with high community need, we used the flagged counties from the previous steps.
2. We identified a county as having high community need if they were flagged as having high community risk (see Step 4 from Determining Community Risk) and as having high birth risk (see Step 3 from Determining Birth Risk).

Key Considerations on this method. The method for determining community need comes from flagging high community risk and high birth risk in all counties in Kansas. The method for determining community risk involves collecting data on indicators in six domains. The number of indicators in each domain is unbalanced, with some domains such as socio-economic status having 4 indicators, while other domains such as domestic violence having just 1 indicator. This may lead to some unbalanced weights on the overall community risk score from the unbalanced number of indicators in each domain. Data availability is also an important consideration to make when interpreting these numbers. While the team worked hard to source high quality data on all relevant domains, there were some data availability issues that the team encountered. For example, to calculate substance use, the team used data on opioid prescription rates and maternal smoking. While these are important indicators to consider when thinking about substance use, they do not cover all aspects of substance use. Another aspect to consider is the geographical distribution of the data. The data collected for this exercise was at the county level. However, county-level data might not appropriately capture risk in a large heterogenous county where there may be smaller geographical pockets of need that are masked when considering the county.

Survey Data

The Home Visiting Workforce and Family Surveys were examined to identify and remove fake, bot-produced data. To remove these responses, data were filtered out sequentially based on eight filtering criteria. First, data were removed from the dataset if the case had a reCAPTCHA Score less than .5. Second, data were removed from the dataset if the latitude and longitude did not correspond to Kansas. Third, data were removed from the data set if the IP address appeared in the dataset 3 or more time. Fourth, data were removed from the dataset if the case had an invalid response in the "State" variable (i.e., not "Kansas" or "KS"). Firth, data were removed from the dataset if the completion rate was less that 10%. Sixth, data were removed from the dataset if response was started between midnight and 5:00 AM. Seventh, data were removed from the dataset if the Relevant Fraud Score was greater than or equal to thirty. Eighth, data were removed from the dataset if they had no address information.

For the Home Visiting Workforce Survey specifically, data were examined at the county, model, and agency information to verify they were Kansas programs the model was implemented in the county selected.

Participants

Workforce Survey

Participants were 455 staff at home visiting programs in Kansas. Of these, 26% (n = 120) were home visiting program supervisors and 74% (n = 335) were home visitors. On average, participants had been in their position for approximately 7 years. The following home visiting models were represented in our sample: Attachment and Bio-behavioral Catch-up; Play and Learning Strategies; Early Head Start- Home Based Option; Parents as Teachers; Healthy Families America; Nurse Family Partnership; Team for Infants Exposed to Substance Abuse; Early Childhood Developmental Services (tiny-k); MCH (Universal) Home Visiting. Nearly all participants identified as female (99%, n = 449), with only 1% identifying as male (n = 5). The following racial and ethnic identities were represented in our sample: African American or Black (3%, n = 14); American Indian or Alaskan Native (1%, n <10); Asian or Pacific Islander (1%, n <10); Hispanic or Latino (12%, n = 55); White or Caucasian (86%, n = 389); Biracial (<1%; n = <10); and Other (<1%; n = <10). The mean age of home visiting staff was 46 years old. In our sample, 13% (n = 59) of participants reported fluency in two languages. Home visiting staff from 69% (n = 72) of counties in Kansas completed the survey.

Family Survey

Participants were 553 families surveyed who were pregnant (14%, n =80) or had children under 6 (85%, n = 471). Most participants identified as female (87%, n = 483), 12% identified as male (n = 64), <1% identified as non-binary/third gender (n <10), and <1% preferred not to share their gender identify (n <10). The following racial and ethnic identities were represented in our sample: African American or Black (4%, n = 21); American Indian or Alaskan Native (2%, n =10); Asian or Pacific Islander (3%, n = 15); Hispanic or Latino (7%, n = 36); White or Caucasian (88%, n = 493); and Other (<1%; n = <10). The employment status of families in our sample was reported as employed full-time (58%, n =321), employed part-time (14%, n = 80), unemployed by choice (16%, n = 88), self-employed (6%, n =31), retired (<1%, n <1%), unable to work (2%, n =11), prefer not to say (1%, n <10). Most participants reported they were not single parents (85%, n = 472), 13% identified as a single parent (n = 70), and <1% preferred not to say (n <10). Families reported the following income ranges: less than $25,000 (11%, n = 60); $25,000-$50,000 (23%, n = 130); $50,000-$100,000 (36%, n = 198); $100,000-$200,000 (23$, n = 129); more than $200,000 (3%, n = 16); prefer not to say (4%, n = 20). Families from 70% (n = 74) of Kansas counties completed the survey.

Results

County Selection

Using the approach outlined in Methods, we identified high-need communities as those counties with the highest birth risk and moderate to high community risk. This yielded 21 highest-need counties: Allen, Barton, Bourbon, Brown, Chautauqua, Cherokee, Cloud, Cowley, Crawford, Finney, Ford, Graham, Greenwood, Labette, Montgomery, Neosho, Norton, Pawnee, Wilson, Woodson, and Wyandotte counties (see Appendix B for levels of community and birth risk across all Kansas counties). Next, in collaboration with KDHE partners, we examined the community risk and birth risk data alongside the need-based home visiting service reach data so the high priority counties could be identified for MIECHV expansion activities.

Allen, Cowley, and Wyandotte counties were identified for MIECHV expansion activities.

For Allen County, the specific recommendation is to explore the expansion of the MIECHV program in this community. The home visiting service reach is 21% of families in need in Allen County. Though MIECHV does not currently fund services is this community, partners in this community also support implementation of MIECHV-funded programs in other communities and are aware of MIECHV requirements. This may make expansion of one of the existing evidence-based programs in this community feasible. For Cowley County, the specific recommendation is to explore expansion through capacity building and monitoring. Only one evidence-based program model currently serves this community. Home visiting service reach is low (approximately 10% of families in need served), and additional expansion support efforts through capacity building activities may be needed initially. In Wyandotte County, the specific recommendation is to explore the expansion of MIECHV-funded services in this community. Wyandotte county currently serves 21% of families in need of home visiting services (i.e., families with births between 2019 and 2021 that also had three or more birth risks). Moreover, agencies implementing the evidenced-based home

visiting programs in this county have experience with overseeing and implementing MIECHV-funded home visiting programs. They are familiar with MIECHV requirements and policies, including data collection, reporting, and evaluation.

For the remaining 18 highest need counties, the priority level was moderate, and the specific expansion recommendation was to continue to monitor these counties for potential expansion in the future. Counties not identified as the highest need were considered a low priority for expansion activities and therefore the recommendation at present is to not expand MIECHV in these communities. See Appendix C for the expansion priority level and expansion recommendations for all counties.

Community Readiness Stage

For the three communities identified as a high priority for expansion (i.e., expansion communities), we used the Stages of Community Readiness described in Exhibit 7 of the Community Readiness Toolkit (Higman et al., 2020, p. 24) along with program data to place communities along the continuum of readiness stages. See Appendix C for the Stages. Allen County is in stage 7, Stabilization because multiple evidence-based home visiting program models are active in the community. Cowley county falls between Stage 5 (Preparation) and Stage 6 (Initiation) because although evidence-based home visiting is present in community, there is currently only one program model in this community and capacity-building work may be needed. Wyandotte County is in between Stage 7 (Stabilization) and Stage 8 (Confirmation/Expansion). Multiple evidence-based home visiting program models are active in the community and home visiting activities have been evaluated.

Community Readiness Dimensions
Home Visiting Workforce Perspective

Using the Community Readiness Dimensions data collected from the Workforce Survey, we identified types of expansion activities that may be helpful in the three expansion communities from the perspective of the home visiting workforce. To contextualize the three expansion communities, we examined mean levels on each of the five dimensions (i.e., Community Knowledge of Family needs, Community Knowledge of Home Visiting,

Community Climate, Community Leadership, and Community Resources) at the state-level. See the Community Readiness Toolkit (Higman et al., 2020) for additional information about the dimensions, as well as examples of activities to support each of these dimensions.

In Allen County, Community Resources scored the lowest of the five dimensions, and was lower than the state average (see Table 1). Expansion efforts focused on increasing resources to support home visiting may be helpful in moving this community forward with home visiting expansion. In Cowley County, both Community Knowledge of Family Needs and Community Resources scored relatively low and lower than the state average. In this community, expansion efforts may be best focused on increasing community awareness and knowledge of needs of families in the community and how home visiting may address these needs. Additionally, expansion efforts to increase community resources for home visiting is also needed in Cowley County. In Wyandotte county, Community Knowledge of Family Needs scored relatively low, and at the same level as the state. In this community, expansion activities may need to be focused on increasing awareness and knowledge of needs of families in the community. See Table 1 below for, number of participants, means, and standard deviations for the community readiness dimensions at the state-level and for each of the three expansion counties. Data in Allen and Cowley counties should be interpreted with caution because of small sample sizes.

Table 1. Community Readiness Dimensions
Statewide and Expansion Communities

Area	Community Knowledge of Family Needs	Community Knowledge of Home Visiting	Community Climate	Community Leadership	Community Resources
Statewide (*n* = 455)	2.51 (.61)	2.95 (.52)	3.01 (.58)	2.90 (.78)	2.69 (.71)
Allen County (*n* = 3)	2.63 (1.22)	2.90 (.52)	2.75 (.45)	2.62 (1.16)	2.44 (1.18)
Cowley County (*n* = 8)	2.17 (0.53)	2.93 (0.47)	2.80 (0.53)	2.86 (0.53)	2.33 (0.50)
Wyandotte County (*n* = 32)	2.51 (0.67)	2.92 (0.54)	3.11 (0.58)	3.10 (0.79)	3.08 (0.70)

Note. Each cell contains the mean and standard deviation, M(SD). Items were assessed on a 1-5 Likert scale with greater numbers indicating greater endorsement.

Home Visiting Workforce Wellbeing, Workload, Turnover, & Capacity

Besides the Community Readiness Dimensions, we also asked the home visiting workforce questions about their employee wellbeing, workload, workplace supports, and turnover intentions. These data are reported only at the aggregated state-level because small sample sizes at the county-level could identify staff.

In terms of strengths, most home visitors agreed or strongly agreed with: their workplace provides the resources and tools needed to effectively support their work (79%), they have the support they need to effectively do their job (81%); their organization provides at least some flexibility in scheduling the work week (evening hours, 4-day work weeks, flex-time, 90%); the benefits at their job meet their needs and the needs of their family (86%); and their caseload is mostly manageable or completely manageable (82%). Additionally, most home visiting program supervisors and administrators reported some interest in expanding home visiting services (73%).

Needs for the home visiting workforce emerged from these data, as well. Specifically, most Kansas home visitors are not aware of the Kansas Home Visiting Learning Management System and few are using it: 65% have never heard of it, and only 2% have used it. When considering employee wellbeing, these data show that 34% of home visitors were identified as at-risk of distress using the Mayo Clinic Expanded Well-Being Index and 49% of home visiting supervisors and administrators reported their program staff show signs of burnout. Turnover intentions were also a need, with approximately 20% of home visitors meeting the criteria for intention to leave their job. For both home visitors and supervisors or administrators, the top three reasons provided for turnover included insufficient compensation, burnout, and life events. About half of home visitors reported they did not feel they were paid in the salary range commensurate with their education, training, and experience (42%) and that there were no opportunities for promotion or advancement at their workplace (53%). Additionally, most home visitors struggle with staying on top of their cases at least sometimes (73%) and nearly 24% of home visitors struggle with staying on top of their cases half the time or more.

Program capacity was also a need for the home visiting workforce. Half of home visiting program supervisors and administrators reported the need for home visiting services

exceeded their program's capacity (53%). About a third of home visiting program supervisors and administrators reported their program had a waitlist and of these programs, 70% reported families had to wait 1 month or longer and 35% reported a 4-month or longer wait. Additionally, 39% of home visiting program supervisors and administrators reported their home visiting program was not fully staffed. For those that were not fully staffed, only 16% reported being able to fill the vacancy within 4 weeks; 41% in 1 to 3 months, 24% in 3 to 6 months; and 19% in over 6 months.

Family Perspective

To further inform community expansion efforts, we examined the perspective of families in the following areas: Awareness of home visiting in the community; Belief in Services; Help-seeking Stigma and Difficulty families may face accessing home visiting services in the community. To contextualize the three high-priority for expansion counties, we examined mean levels on each of these areas at the state-level. See Table 2 below for sample sizes, percent reporting, and means and standard deviations.

Table 2. Family Perspective
Statewide and Expansion Communities

Area	Awareness of Home Visiting	Belief in Services	Help-seeking Stigma	Greatest Difficulty Accessing Home Visiting
Statewide (*n* = 555)	71.6% Aware	4.26 (0.78)	1.89 (0.95)	Not enough information or awareness about the service (51.7%)
Allen County (*n* = 66)	67.7% Aware	4.16 (0.66)	1.92 (0.93)	Not enough information or awareness about the service (51.7%)
Cowley County (*n = 10)*	77.8% Aware	4.50 (0.41)	2.75 (1.26)	Not enough information or awareness about the service (100%)
Wyandotte County (*n* = 11)	72.7% Aware	4.34 (1.02)	1.86 (1.21)	Lack of providers who speak languages other than English (45.5%)

Note. Cells contain the percentage reporting or the mean and standard deviation, M(SD). Items were assessed on a 1-5 Likert scale with greater numbers indicating greater endorsement.

Overall, across the state and in each of the MIECHV expansion communities, awareness of home visiting in the community was high, as evidenced by most families (range from 68%-78%) reporting they had heard of home visiting. Additionally, families also reported a high degree of belief in services (means all greater than 4 on a 5-point scale). This shows that families agree that the community has a responsibility to and should offer programs and services that support expectant and new parents and their young children and that it is possible to improve parent and child wellbeing through providing home-based services. Families statewide and in Allen and Wyandotte counties reported a relatively low degree of high-seeking stigma (all means less than 2 on a 1–5-point scale). In Cowley County, help-seeking stigma was moderate (M = 2.75), suggesting that expansion activities and efforts to reduce stigma about help-seeking for parenting-related issues may be beneficial. Families statewide and in Allen and Cowley counties reported that the greatest difficulty families in their community may face accessing home visiting services was that there was not enough information or awareness about the service, indicating that increasing awareness of home visiting int these communities may be helpful. In Wyandotte county, the greatest difficulty reported was the lack of providers who speak languages other than English. This suggests expansion efforts focused on recruiting and retaining high-quality bilingual staff are needed in this community.

Appendix A

Community Risk & Birth Risk Data Sources

Domain	Indicator	Indicator Definition	Alignment with statute definition of at-risk communities	Years	Source	Source Link
Socioeconomic Status (SES)	Poverty	% population living below %100 FPL	Poverty	2019, 2020, 2021	Census Small Area Income and Poverty Estimates	www.census.gov/data/datasets/2020/demo/saipe/2020-state-and-county.html
Socioeconomic Status (SES)	Unemployment	Unemployed percent of the civilian labor force	Unemployment	2019, 2020, 2021	Bureau of Labor Statistics	www.bls.gov/lau/#cntyaa
Socioeconomic Status (SES)	HS Non-Graduation Rate	% of High Schoolers that did not graduate high school	High school non-graduates	2019, 2020, 2021	KSDE	datacentral.ksde.org/report_gen.aspx
Socioeconomic Status (SES)	School Dropout Rate	% of Students who dropped out of school	Dropouts	2019, 2020, 2021	KSDE	datacentral.ksde.org/report_gen.aspx
Adverse Perinatal Outcomes	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 at-risk prenatal, maternal, newborn, or child health	2019, 2020, 2021	KDHE	www.kdhe.ks.gov/DocumentCenter/View/12590/2019-Annual-Summary-Full-Report-PDF
Adverse Perinatal Outcomes	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 at-risk prenatal, maternal, newborn, or child health	2019, 2020, 2021	KDHE	www.kdhe.ks.gov/DocumentCenter/View/12590/2019-Annual-Summary-Full-Report-PDF

Adverse Perinatal Outcomes	No Breastfeeding Initiation	% of live births	Premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect or other indicators of at-risk prenatal, maternal, newborn, or child health	2019, 2020, 2021	KDHE	www.kdhe.ks.gov/DocumentCenter/View/25772/2021-Annual-Summary-Full-Report-?bidId=
Adverse Perinatal Outcomes	Percent Inadequate Prenatal Care	% Live Births using Adequacy of Prenatal Care Utilization (APNCU) Index‡	Premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect or other indicators of at-risk prenatal, maternal, newborn, or child health	2019, 2020, 2021	KDHE	www.kdhe.ks.gov/DocumentCenter/View/25772/2021-Annual-Summary-Full-Report-?bidId=
Substance Abuse	Opioid Prescription Rates	Opioid Prescription rates per 100 residents	Substance abuse	2019, 2020, 2021	Kansas Board of Pharmacy	pharmacy.ks.gov/k-tracs/statistics/opioid-dashboard
Substance Abuse	Maternal Smoking	% Live Births by County of Residence with Mother's Reported Cigarette Use	Substance abuse	2019, 2020, 2021	KDHE	www.kdhe.ks.gov/DocumentCenter/View/12590/2019-Annual-Summary-Full-Report-PDF
Crime	Crime Reports	# reported crimes/1000 residents	Crime	2019, 2020, 2021	Kansas Bureau of Investigation	www.kansas.gov/kbi/stats/docs/pdf/CrimeIndex2019.pdf
Crime	Juvenile Arrests	# crime arrests ages 0-17/1000 juveniles aged 0-17	Crime	2019, 2020, 2021	Kansas Bureau of Investigation	www.kansas.gov/kbi/stats/docs/pdf/CrimeIndex2019.pdf
Domestic Violence	Domestic Violence	Number of Domestic Violence Incidents reported by KBI	Domestic Violence	2019, 2020, 2021	KBI	www.kansas.gov/kbi/stats/docs/pdf/DVStalking%20Rape%202019.pdf
Child Maltreatment	Child Maltreatment	Number of CPS incidents that are assigned as abuse	Child maltreatment	2019, 2020, 2021	DCF	www.dcf.ks.gov/services/PPS/Pages/CPSReports.aspx

Appendix B
MIECHV Expansion Priority Levels & Recommendations

County	MIECHV Expansion Priority	MIECHV Expansion Recommendation	Birth Risk	Community Need Level
Allen	High	Explore Expansion	High Birth Risk	High Community Need
Anderson	Low	No Expansion	Not High Risk	Moderate Community Need
Atchison	Low	No Expansion	Not High Risk	High Community Need
Barber	Low	No Expansion	Not High Risk	Moderate Community Need
Barton	Moderate	Monitor	High Birth Risk	Moderate Community Need
Bourbon	Moderate	Monitor	High Birth Risk	High Community Need
Brown	Moderate	Monitor	High Birth Risk	High Community Need
Butler	Low	No Expansion	Not High Risk	Moderate Community Need
Chase	Low	No Expansion	Not High Risk	Low Community Need
Chautauqua	Moderate	Monitor	High Birth Risk	High Community Need
Cherokee	Moderate	Monitor	High Birth Risk	Moderate Community Need
Cheyenne	Low	No Expansion	Not High Risk	Moderate Community Need
Clark	Low	No Expansion	Not High Risk	Low Community Need
Clay	Low	No Expansion	Not High Risk	Moderate Community Need
Cloud	Moderate	Monitor	High Birth Risk	Moderate Community Need
Coffey	Low	No Expansion	Not High Risk	Moderate Community Need
Comanche	Low	No Expansion	Not High Risk	Moderate Community Need
Cowley	High	Explore Expansion and Capacity Building	High Birth Risk	High Community Need
Crawford	Moderate	Monitor	High Birth Risk	High Community Need
Decatur	Low	No Expansion	Not High Risk	Moderate Community Need
Dickinson	Low	No Expansion	Not High Risk	Moderate Community Need
Doniphan	Low	No Expansion	Not High Risk	Moderate Community Need
Douglas	Low	No Expansion	Not High Risk	Moderate Community Need
Edwards	Low	No Expansion	Not High Risk	Moderate Community Need

Elk	Low	No Expansion	Not High Risk	Moderate Community Need
Ellis	Low	No Expansion	Not High Risk	Moderate Community Need
Ellsworth	Low	No Expansion	Not High Risk	Moderate Community Need
Finney	Moderate	Monitor	High Birth Risk	Moderate Community Need
Ford	Moderate	Monitor	High Birth Risk	Moderate Community Need
Franklin	Low	No Expansion	Not High Risk	Moderate Community Need
Geary	Low	No Expansion	Not High Risk	High Community Need
Gove	Low	No Expansion	Not High Risk	Low Community Need
Graham	Moderate	Monitor	High Birth Risk	Moderate Community Need
Grant	Low	No Expansion	High Birth Risk	Moderate Community Need
Gray	Low	No Expansion	Not High Risk	Low Community Need
Greeley	Low	No Expansion	Not High Risk	Moderate Community Need
Greenwood	Moderate	Monitor	High Birth Risk	Moderate Community Need
Hamilton	Low	No Expansion	High Birth Risk	Moderate Community Need
Harper	Low	No Expansion	Not High Risk	Moderate Community Need
Harvey	Low	No Expansion	Not High Risk	High Community Need
Haskell	Low	No Expansion	Not High Risk	Moderate Community Need
Hodgeman	Low	No Expansion	Not High Risk	Moderate Community Need
Jackson	Low	No Expansion	Not High Risk	Moderate Community Need
Jefferson	Low	No Expansion	Not High Risk	Moderate Community Need
Jewell	Low	No Expansion	Not High Risk	Moderate Community Need
Johnson	Low	No Expansion	Not High Risk	Low Community Need
Kearny	Low	No Expansion	Not High Risk	Moderate Community Need
Kingman	Low	No Expansion	Not High Risk	Moderate Community Need
Kiowa	Low	No Expansion	Not High Risk	Moderate Community Need
Labette	Moderate	Monitor	High Birth Risk	High Community Need
Lane	Low	No Expansion	Not High Risk	Low Community Need
Leavenworth	Low	No Expansion	Not High Risk	Moderate Community Need
Lincoln	Low	No Expansion	Not High Risk	Moderate Community Need
Linn	Low	No Expansion	Not High Risk	Moderate Community Need
Logan	Low	No Expansion	Not High Risk	Moderate Community Need
Lyon	Low	No Expansion	Not High Risk	Moderate Community Need
Marion	Low	No Expansion	Not High Risk	Moderate Community Need
Marshall	Low	No Expansion	Not High Risk	Moderate Community Need
McPherson	Low	No Expansion	Not High Risk	Moderate Community Need

Meade	Low	No Expansion	Not High Risk	Moderate Community Need
Miami	Low	No Expansion	Not High Risk	Moderate Community Need
Mitchell	Low	No Expansion	Not High Risk	Moderate Community Need
Montgomery	Moderate	Monitor	High Birth Risk	High Community Need
Morris	Low	No Expansion	Not High Risk	Moderate Community Need
Morton	Low	No Expansion	Not High Risk	Moderate Community Need
Nemaha	Low	No Expansion	Not High Risk	Low Community Need
Neosho	Moderate	Monitor	High Birth Risk	Moderate Community Need
Ness	Low	No Expansion	Not High Risk	Low Community Need
Norton	Moderate	Monitor	High Birth Risk	Moderate Community Need
Osage	Low	No Expansion	Not High Risk	Moderate Community Need
Osborne	Low	No Expansion	Not High Risk	Moderate Community Need
Ottawa	Low	No Expansion	Not High Risk	Moderate Community Need
Pawnee	Moderate	Monitor	High Birth Risk	Moderate Community Need
Phillips	Low	No Expansion	Not High Risk	Moderate Community Need
Pottawatomie	Low	No Expansion	Not High Risk	Low Community Need
Pratt	Low	No Expansion	Not High Risk	Moderate Community Need
Rawlins	Low	No Expansion	Not High Risk	Moderate Community Need
Reno	Low	No Expansion	Not High Risk	High Community Need
Republic	Low	No Expansion	Not High Risk	Low Community Need
Rice	Low	No Expansion	Not High Risk	Moderate Community Need
Riley	Low	No Expansion	Not High Risk	Moderate Community Need
Rooks	Low	No Expansion	Not High Risk	Moderate Community Need
Rush	Low	No Expansion	Not High Risk	High Community Need
Russell	Low	No Expansion	Not High Risk	Moderate Community Need
Saline	Low	No Expansion	Not High Risk	High Community Need
Scott	Low	No Expansion	Not High Risk	Moderate Community Need
Sedgwick	Low	No Expansion	Not High Risk	High Community Need
Seward	Low	No Expansion	High Birth Risk	Moderate Community Need
Shawnee	Low	No Expansion	High Birth Risk	High Community Need
Sheridan	Low	No Expansion	Not High Risk	Low Community Need
Sherman	Low	No Expansion	Not High Risk	High Community Need
Smith	Low	No Expansion	Not High Risk	Low Community Need
Stafford	Low	No Expansion	Not High Risk	Moderate Community Need
Stanton	Low	No Expansion	Not High Risk	Low Community Need

Stevens	Low	No Expansion	Not High Risk	Low Community Need
Sumner	Low	No Expansion	Not High Risk	Moderate Community Need
Thomas	Low	No Expansion	Not High Risk	Moderate Community Need
Trego	Low	No Expansion	Not High Risk	Low Community Need
Wabaunsee	Low	No Expansion	Not High Risk	Low Community Need
Wallace	Low	No Expansion	Not High Risk	Low Community Need
Washington	Low	No Expansion	Not High Risk	Moderate Community Need
Wichita	Low	No Expansion	Not High Risk	Low Community Need
Wilson	Moderate	Monitor	High Birth Risk	High Community Need
Woodson	Moderate	Monitor	High Birth Risk	High Community Need
Wyandotte	Moderate	Explore Expansion	High Birth Risk	High Community Need

Appendix C
Stages of Readiness

Stage	Stage description
1	**No awareness.** The family needs identified by the awardee are not recognized as a problem by community stakeholders.
2	**Denial/resistance.** There is some recognition that the family needs identified by the awardee are a problem, but community stakeholders do not recognize them as a local problem or believe little can be done about them.
3	**Vague awareness.** Community stakeholders believe that the family needs identified by the awardee are a local problem, but motivation is lacking to address them.
4	**Pre-planning.** Community stakeholders recognize the family needs identified by the awardee as a problem, but the community lacks an organized approach to address them.
5	**Preparation.** Planning is ongoing to address the family needs identified by the awardee, and community leaders are engaged. Community support is modest.
6	**Initiation.** Enough information has been gathered to justify efforts, and home visiting activities have recently been implemented.
7	**Stabilization.** Home visiting activities are under way, viewed as stable, and supported by community leaders.
8	**Confirmation/expansion.** Home visiting activities are in place and being used by community members, and the community favors expansion. Data are being collected, and home visiting activities have been evaluated.
9	**High level of community ownership.** The community has an advanced knowledge of family needs, uses data to guide modifications to home visiting activities, and holds programs accountable.

Note. Content above was reproduced From Exhibit 7 in the Community Readiness Toolkit (Higman et al., 2020, p. 24).