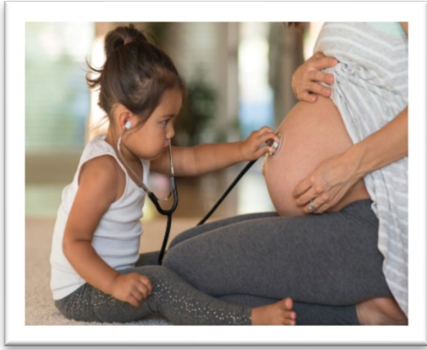


Women / Maternal Work Group Packet

Priority Overview Page: This includes the priority, a list of the objectives, and the selected performance measures (NPM = National Performance Measure / SPM = State Performance Measure).

Priority State Action Plan (SAP) Table: This outlines the key strategies within each objective. This also outlines another level of measurement (ESM = Evidence-based/-informed Strategy Measure).

Priority Resources: This outlines key initiatives, partners, websites, and other resources that you might want to look at or dig into related to your priority. These include a reference of where it might align in the SAP…but may or may not be directly called out in the table.

Priority Key Acronyms and Data: A compilation of acronyms that you might come across in conversations with your priority work. The key data outlines National Outcome Measures (NOMs) that are related to your priority population. This is in addition to the NPMs, SPMs, and ESMs noted elsewhere. Another resource is the NPM-NOM_Measures Table – this is where you can find the data trends for all of the measures associated with our work.

Priority Data Summaries: These are the data summaries that will be included in the 2023 MCH Services Block Grant Application that will be submitted with our plan in August 2022.

PRIORITY 1

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

WOMEN & MATERNAL

OBJECTIVE 1.1
Increase the proportion of women program participants receiving a high-quality, comprehensive preventive medical visit by 5% by 2025.

OBJECTIVE 1.2
Increase the proportion of women receiving education or screening about perinatal mood and anxiety disorders (PMADs) during pregnancy and the postpartum period by 5% annually through 2025.

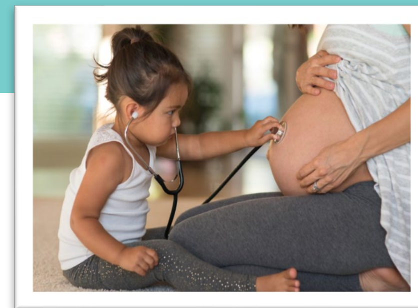
OBJECTIVE 1.3
Increase the proportion of high-risk pregnant and postpartum women receiving prenatal education and support services through perinatal community collaboratives by 10% annually by 2025.

OBJECTIVE 1.4
Increase the proportion of women receiving pregnancy intention screening as part of preconception and inter-conception services by 10% by 2025.

NPM 1: *Well-woman visit (Percent of women, ages 18-44, with a preventive medical visit in the past year)*

SPM 1: *Postpartum Depression (Percent of women who have recently given birth who reported experiencing postpartum depression following a live birth)*

PRIORITY 1: Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy.



Domain: Women & Maternal Health

NPM 1: Well-woman visit (Percent of women, ages 18-44, with a preventive medical visit in the past year)

ESM: Percent of women program participants (18-44 years) with a preventive medical visit in the past year

SPM 1: Postpartum Depression (Percent of women who have recently given birth who reported experiencing postpartum depression following a live birth)

ESM: Percent of MCH program participants screened for depression and anxiety during pregnancy and/or the postpartum period using the Edinburgh Perinatal/Postnatal Depression Scale (EPDS)

ESM: Percent of pregnant/postpartum MCH program participants who received a referral in response to a positive screen for depression or anxiety through the Edinburgh Perinatal/Postnatal Depression Scale (EPDS)

OBJECTIVE 1.1: Increase the proportion of women program participants receiving a high-quality, comprehensive preventive medical visit by 5% by 2025.

Strategy	Description
1.1.1	Provide resources and tools to support local health agencies on educating women about the importance of a high quality, comprehensive annual preventive medical/well visit, assessing for insurance coverage, and assisting women to obtain insurance if needed.
1.1.2	Provide on-site assistance for accessing health care coverage through certified application counselors or Medicaid eligibility workers to ensure coverage before, during, and after pregnancy.
1.1.3	Utilize peer and social networks for women, including peer group education models, to promote and support access to preventive care.
1.1.4	Provide technical assistance to support local health agencies in developing policies and protocols that incorporate women's goal-setting and health screenings to assess for basic needs and health status (e.g., substance use, tobacco use, mental health, social determinants of health, intimate partner violence [IPV]) into all preventive medical visits for women.
1.1.5	Promote and support Medicaid policy change to expand pregnancy coverage through 12 months postpartum and the inclusion of screening for PMADs as a covered service.

OBJECTIVE 1.2 Increase the proportion of women receiving education or screening about perinatal mood and anxiety disorders (PMADs) during pregnancy and the postpartum period by 5% annually through 2025.

Strategy	Description
1.2.1	Integrate evidence-based mental health interventions into community-based services.
1.2.2	Increase consumer and provider awareness about the importance of screening pregnant/postpartum women and new fathers for PMADs.
1.2.3	Increase the number of local health agencies screening pregnant/postpartum women and fathers for postpartum/paternal PMADs.
1.2.4	Partner with Medicaid and pediatric providers to implement parental depression screening during the child well visit to assess the needs of the family to support child social-emotional development, healthy family functioning, and ensure referral and early intervention.

OBJECTIVE 1.3: Increase the proportion of high-risk pregnant and postpartum women receiving prenatal education and support services through perinatal community collaboratives by 10% annually by 2025.

Strategy	Description
1.3.1	Strengthen existing perinatal community collaborations and programs, with a focus on expanding community-specific supports (e.g., doula services) and targeting disparities in birth outcomes.
1.3.2	Engage FQHCs in more community collaboratives across the state to increase coordination and access to a variety of services for those at greatest risk.
1.3.3	Develop regional models and innovative approaches to increase reach and support rural expansion of perinatal community collaboratives.
1.3.4	Integrate web-based education and telehealth capabilities within the existing perinatal community collaborative models in targeted areas.
1.3.5	Increase the number of Kansas Perinatal Community Collaboratives implementing postpartum education sessions.

OBJECTIVE 1.4: Increase the proportion of women receiving pregnancy intention screening as part of preconception and inter-conception services by 10% by 2025.

Strategy	Description
1.4.1	Increase consumer/family and provider awareness about the importance of preconception and inter-conception care, counseling/planning, and pregnancy intention screening by utilizing social media, infographics, data briefs, and partner networks.
1.4.2	Provide resources and education specific to preconception and inter-conception care to providers in support of quality services and comprehensive visits during these critical periods.
1.4.3	Increase the number of local health agencies utilizing evidence-based pregnancy interventions including One Key Question® and support implementation into practice through in-person or virtual skills building sessions, increase provider capacity to implement pregnancy intention screening into their practice.

Women/Maternal Resources

See also the Women/Maternal and Perinatal/Infant Supporting Document from the recent MCH Block Grant Application.
https://www.kdhe.ks.gov/DocumentCenter/View/5320/Program-Activities-Women-Maternal-and-Perinatal-Infant-PDF

Obj	Description	Website
1.1.1	**Well-Woman Visit Integration Toolkit (for providers and communitites):** Recommended components of a well woman visit; barriers faced by women that prevent them from receiving annual preventive care and recommendations to address these barriers; and resources for communities and providers.	www.kdhe.ks.gov/457/MCH-Integration-Toolkits
1.1.1	**Preparing for Your Well-Woman Visit:** A checklist to help women get ready for their well-woman visit.	www.kdhe.ks.gov/DocumentCenter/View/15435/Preparing-for-Your-Well-Woman-Visit-PDF
1.1.1	**Annual Well-Woman Examination Flyer:** Info about what should happen during well-woman visits.	www.kdhe.ks.gov/DocumentCenter/View/15432/Well-Woman-Education-Flier-PDF
1.1.5	**Perinatal Mental Health Integration Plan:** Plan with associated toolkit to provide coordinated and comprehensive mental health services to women before, during and after pregnancy; developed for use by the KPCC's utilizing the March of Dimes Becoming a Mom® (BaM) curriculum in a group setting.	www.kdhe.ks.gov/DocumentCenter/View/2864/BAM-Perinatal-Mental-Health-Integration-PDF
1.2.1	**Behavioral Health Integration Toolkit:** Resources for KS providers screening pregnant/postpartum women for perinatal mood and anxiety disorders (PMADs). Resources to support maternal depression, paternal postpartum depression, PMAD screening, screening algorithms, and implementation templates for local use.	www.kdhe.ks.gov/520/Mental-Health
1.2.2	**Paternal Postpartum Depression Brochure:** Brochure to raise awareness of postpartum depression among fathers.	www.kdhe.ks.gov/DocumentCenter/View/2885/Brochure-for-Families-Online-Version-PDF
1.2.3	**MCH Screening in MCH Programs Guidance:** Guidance to local MCH grantees with resources and information on implementing screening for perinatal mood and anxiety disorders (PMADs).	www.kdhe.ks.gov/DocumentCenter/View/2860/MCH-Screening-in-MCH-Programs-Guidance-PDF
1.2.3	**Kansas Connecting Communitites:** Grant to improve the mental health and well-being of pregnant/postpartum women through increased screening, timely assessment, effective referrals and reducing barriers to accessing treatment; Focused on provider capacity to treat/refer through access to psychiatric consultations, telehealth, peer support referrals, and training opportunities	www.kansasmch.org/connecting-communities.asp
1.2.4	**Maternal Depresssion Screening Medicaid Policy Guidance:** Medicaid billing guidance for individuals conducting maternal depression screening.	www.kdhe.ks.gov/DocumentCenter/View/2861/Medicaid-Policy-Guidance-PDF
1.2.4	**Postpartum Depression Screening in Well Child Checks:** Clinical guidelines for screening for postpartum depression during well child checks.	www.kdhe.ks.gov/DocumentCenter/View/2867/KAAP-Screening-in-Well-Child-Visit-Guidance-PDF
1.3.1	**Kansas Perinatal Community Collaboratives (KPCC):** A community model that brings together public health and clinical care services to assure comprehensive and coordinated perinatal supports. This model of shared risks, resources, and rewards help communities leverage existing resources and funding to more effectively serve perinatal clients.	www.kdhe.ks.gov/549/Perinatal-Community-Collaboratives
1.3.1	**KPCC Introductory Webinar:** Video (mp4) about the KPCC model.	https://www.kdhe.ks.gov/565/Collaborative-Model-Overview
1.4.1	**Reproductive Life Plan (RLP) Workbook:** A workbook to help women decide if and when to have the healthiest pregnancy possible.	www.kdhe.ks.gov/DocumentCenter/View/15437/Reproductive-Life-Plan-PDF
1.4.1	**Long Acting Reversible Contraceptives (LARC) Toolkit:** For intended use by local MCH and Title X/Family Planning programs to help integrate awareness and promotion of LARCs.	www.kdhe.ks.gov/500/Long-Acting-Reversible-Contraceptive
1.4.3	**One Key Question®:** Provides a framework for routinely asking patients about pregnancy desires and goals and offer personalized counseling and care based on their response.	https://powertodecide.org/one-key-question
Other	**Count the Kicks®:** A stillbirth prevention campaign that teaches expectant parents about the importance of tracking fetal movements.	www.kansasmch.org/countthekicks.asp

Women/Maternal Key Acronyms

Acronym	Definition
ACOG	American College of Obstetriciants and Gynecologists
BaM	Becoming a Mom®
BMTF	Baby & Me Tobacco Free
CTK	Count the Kicks
EPDS	Edinburgh Postnatal Depression Scale
IMR	Infant Mortality Rate
KBC	Kansas Breastfeeding Coalition
KCC	Kansas Connecting Communities
KMMRC	Kansas Maternal and Mortality Review Committee
KPCC	Kansas Perinatal Community Collaborative
KPQC	Kansas Perinatal Quality Collaborative
LARC	Long Acting Reversible Contraceptives
MDS	Maternal Depression Screening
MMR	Maternal Mortality Rate
MOD	March of Dimes
NAS	Neonatal Abstinence Syndrome
OKQ	One Key Question®
PAMR	Pregnancy-associated mortality ratio
PMAD	Perinatal Mood and Anxiety Disorder
PMI	Pregnancy Maintenance Initiative
PRAMS	Pregnancy Risk Assessment Monitoring System
RLP	Reproductive Life Plan
SBIRT	Screening, Brief Intervention, Referral, and Treatment
SCRIPT	Smoking Cessation & Reduction in Pregnancy Treatment Program
TPTCM	Teen Pregnancy Targeted Case Management
UHV	Universal Home Visiting
WPSI	Women's Preventive Services Initiative

Women/Maternal Key Data (Related to NPMS 1, 2, and 3)

Alignment based upon Table 3 in the Block Grant Guidance Appendices

Measure	Description
NOM 1	Percent of pregnant women who receive prenatal care beginning in the first trimester
NOM 2	Rate of severe maternal morbidity per 10,000 delivery hospitalizations
NOM 3	Maternal mortality rate per 100,000 live births
NOM 4	Percent of low birth weight deliveries (<2,500 grams)
NOM 5	Percent of preterm births (<37 weeks gestation)
NOM 6	Percent of early term births (37, 38 weeks gestation)
NOM 7	Percent of non-medically indicated early elective deliveries
NOM 8	Perinatal mortality rate per 1,000 live births plus fetal deaths
NOM 9.1	Infant mortality rate per 1,000 live births
NOM 9.2	Neonatal mortality rate per 1,000 live births
NOM 9.3	Postneonatal mortality rate per 1,000 live births
NOM 9.4	Preterm-related mortality rate per 100,000 live births
NOM 10	Percent of women who drink alcohol in the last 3 months of pregnancy
NOM 11	Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations
NOM 23	Teen birth rate, ages 15 through 19, per 1,000 females
NOM 24	Percent of women who experience postpartum depressive symptoms following a recent live birth

Table 3. Evidence-based/informed National Performance and Outcome Measure Linkages*

National Outcome Measure		National Performance Measure														
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
#	Short Title	Well-woman visit	Low-risk cesarean delivery	Risk-appropriate perinatal care	Breastfeeding	Safe sleep	Developmental screening	Injury hospitalization	Physical activity	Bullying	Adolescent well-visit	Medical home	Transition	Preventive dental visit	Smoking	Adequate insurance
1	Early prenatal care															
2	Severe maternal morbidity	X	X												X	
3	Maternal mortality	X	X												X	
4	Low birth weight	X													X	
5	Preterm birth	X													X	
6	Early term birth	X													X	
7	Early elective delivery															
8	Perinatal mortality	X		X											X	
9.1	Infant mortality	X		X	X	X									X	
9.2	Neonatal mortality	X		X											X	
9.3	Postneonatal mortality	X			X	X									X	
9.4	Preterm-related mortality	X		X											X	
9.5	SUID mortality				X	X									X	
10	Drinking during pregnancy	X														
11	Neonatal abstinence syndrome	X														
12	Newborn screening timely follow-up															
13	School readiness						X									
14	Tooth decay/cavities													X		
15	Child mortality							X								
16.1	Adolescent mortality							X		X	X					
16.2	Adolescent motor vehicle death							X			X					
16.3	Adolescent suicide							X		X	X					
17.1	CSHCN															
17.2	CSHCN systems of care										X	X	X	X		X
17.3	Autism															
17.4	ADD/ADHD															
18	Mental health treatment										X	X				X
19	Overall health status						X		X		X	X		X	X	X
20	Obesity								X		X					
21	Uninsured															
22.1	Child vaccination															X
22.2	Flu vaccination										X					X
22.3	HPV vaccination										X					X
22.4	Tdap vaccination										X					X
22.5	Meningitis vaccination										X					X
23	Teen births	X									X					
24	Postpartum depression	X														
25	Forgone health care											X				X

* Includes linkages based on expert opinion or theory in the absence of empirical scientific evidence. Associations with available empirical scientific evidence that is mixed or inconclusive are not included. This table is subject to revision as new scientific evidence becomes available. By definition, NPMs must be linked to at least one NOM; however, not all NOMs must have linked NPMs, as they may be important to monitor as sentinel health indicators regardless.

NPM1: Well-women visit

Annual routine medical checkups are important for preventive care. The American College of Obstetricians and Gynecologists recommends that well-women visits specifically include "screening, evaluation and counseling, and immunizations based on age and risk factors."[1] In 2020, an estimated 72.2% of Kansas women aged 18-44 years reported having a routine medical checkup within the past year (95% confidence interval [CI]: 69.4%-74.8%). This was not significantly different from the U.S. estimate of 71.2% (95% CI: 70.4%-72.0%).

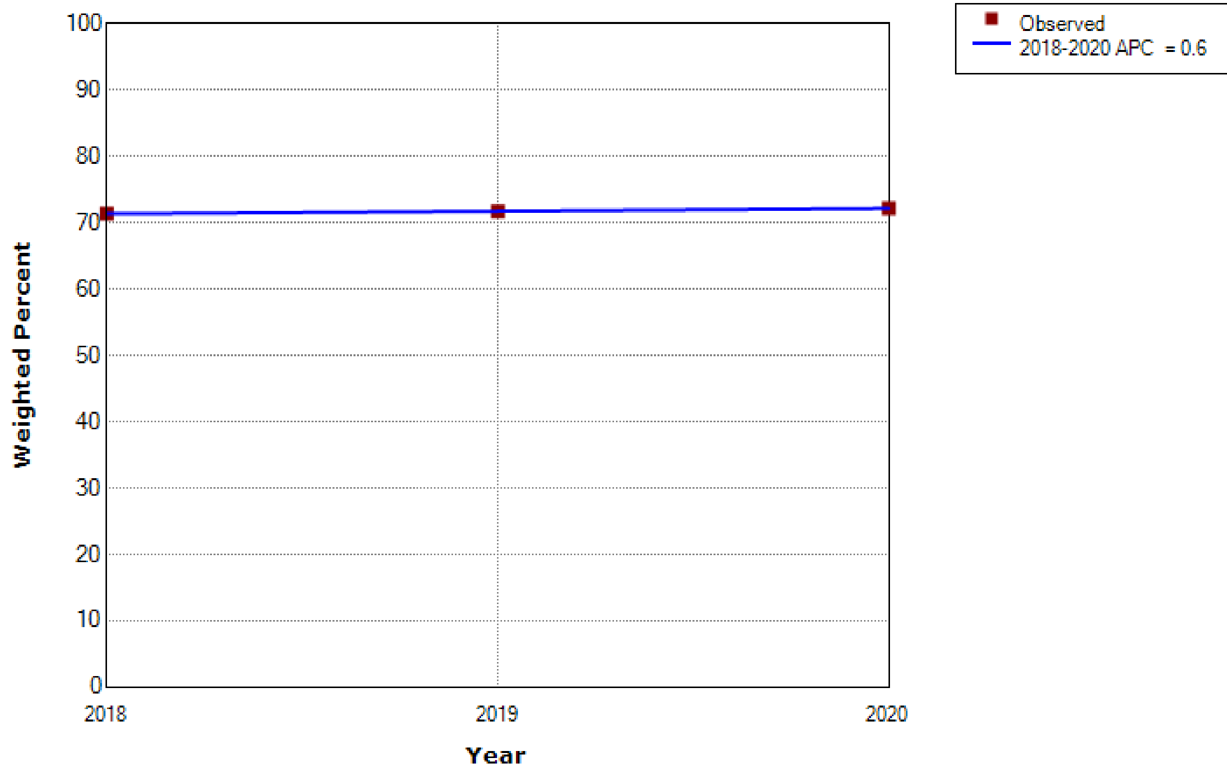
Utilization of a routine medical checkup within the past year varied by household income and health insurance status. A significantly higher percentage of women in households with an income of $75,000 or more reported having a routine checkup within the past year (77.6%; 95% CI: 73.0%-81.7%), compared to women in households earning $25,000 to $49,999 (67.5%; 95% CI: 61.1%-73.2%). A significantly lower percentage of women without health insurance coverage (45.1%; 95% CI: 37.0%-53.5%) reported having had a routine checkup within the past year compared to those with health insurance coverage (76.6%; 95% CI: 73.8%-79.2%).

There was no significant difference in reporting a routine checkup within the past year for non-Hispanic Black women* (78.0%*; 95% CI: 64.1%-87.6%), non-Hispanic White women (72.3%; 95% CI: 69.2%-75.2%), or Hispanic women (72.4%; 95% CI: 63.7%-79.7%). There was also no significant variation across the three age groups for women ages 18-24 (70.5%; 95% CI: 64.3%-76.0%), 25-34 (71.3%; 95% CI: 66.6%-75.6%), or 35-44 (74.4%; 95% CI: 70.3%-78.2%). There was no significant difference in reporting having a routine checkup within the past year between married women (74.6%; 95% CI: 70.6%-78.2%) and unmarried women (70.1%; 95% CI: 66.1%-73.8%). Place of residence was not associated with utilization of routine checkups, with 72.3% of those in metropolitan counties reporting that they had routine checkups within the past year (95% CI: 68.8%-75.5%), versus 72.1% among those in nonmetropolitan counties (95% CI: 67.4%-76.3%).

* Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution.

The estimated percentage of Kansas women aged 18-44 years who reported having a routine medical checkup in the past year did not change significantly from 2018 to 2020.

Weighted Percent of Kansas Women, Ages 18-44, Reporting a Routine Medical Checkup within the Past Year, 2018-2020



The Annual Percent Change (APC) was not found to be significantly different from zero at the alpha = 0.05 level.
Source: Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System (BRFSS), 2018-2020

1. ACOG Committee Opinion No. 755: Well-Woman Visit. *Obstet Gynecol*. 2018;132(4):e181-e186. doi:10.1097/AOG.0000000000002897

Data note: The routine checkup items changed in 2018 and is not comparable to previous survey years. The definition of a routine checkup as a general physical exam, not an exam for a specific injury, illness, or condition, is no longer part of the standard question and only provided if a respondent asks for clarification: “About how long has it been since you last visited a doctor for a routine checkup?”

SPM1: Postpartum Depression (Percent of women who have recently given birth who reported experiencing postpartum depression following a live birth)

Perinatal depression, including postpartum depression, can affect maternal and family well-being. Perinatal depression may endanger maternal or infant safety, impair maternal bonding with children, hinder utilization of health care, or result in delays in infant development.[1] Due to the risks of perinatal depression, the American College of Obstetricians and Gynecologists recommends screening for perinatal depression at least once using a validated screening tool, and conducting a "full assessment of mood and emotional well-being (including screening for postpartum depression and anxiety with a validated instrument) during the comprehensive postpartum visit."[2] Efforts to increase screening and referral for perinatal mood and anxiety disorders can be guided, in part, through ongoing surveillance of the impact of postpartum depression in Kansas.

Data on postpartum depression have been collected through the Pregnancy Risk Assessment Monitoring System (PRAMS). Kansas-specific PRAMS data have been collected by the Kansas Department of Health and Environment since 2017, in partnership with the Centers for Disease Control and Prevention. Through PRAMS, Kansas residents who have recently given birth in Kansas to a live infant are asked about their health and experiences before, during, and in the months following pregnancy.

Postpartum Depressive Symptoms

Respondents are indicated as having postpartum depressive symptoms if they answer that since the birth, they "often" or "always" either felt down, depressed, or hopeless, or had little interest or little pleasure in things they usually enjoyed.

Among Kansas residents with a recent live birth in 2020, about one in seven (14.3%) were indicated as having postpartum depressive symptoms. There was not enough evidence to show that this was significantly different from the prevalence for 2019 (13.5%).

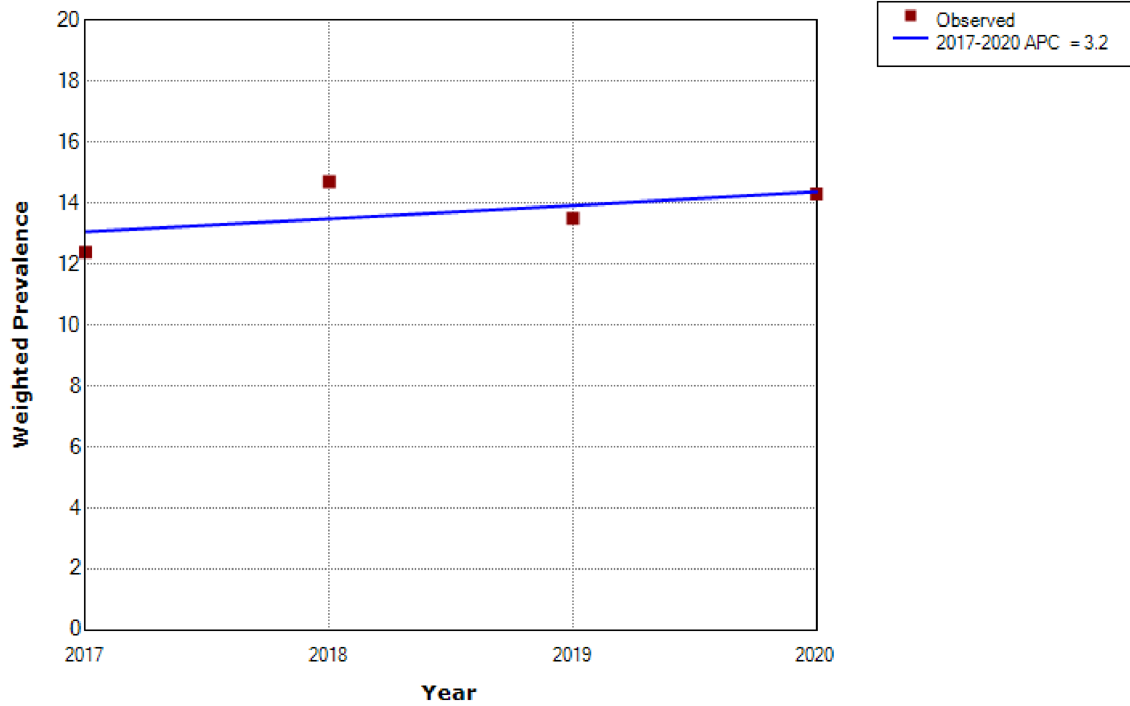
Weighted Prevalence of Postpartum Depressive Symptoms, by Year of Infant's Birth, as Reported by Kansas Residents with a Recent Live Birth, 2017-2020

Birth Year	Weighted Prevalence	95% Confidence Interval
2017	12.4	9.9-15.4
2018	14.7	11.9-18.0
2019	13.5	11.0-16.6
2020	14.3	11.9-17.0

Source: Kansas Department of Health and Environment, Kansas Pregnancy Risk Assessment Monitoring System (PRAMS), 2017-2020

From 2017 to 2020, no statistically significant change was observed in the prevalence of postpartum depressive symptoms, despite an increasing trend.

Prevalence of Self-Reported Postpartum Depressive Symptoms Among Kansas Residents with a Recent Live Birth, 2017-2020



The Annual Percent Change (APC) was not found to be significantly different from zero at the alpha = 0.05 level.
Source: Kansas Department of Health and Environment, Kansas Pregnancy Risk Assessment Monitoring System (PRAMS), 2017-2020

Among Kansas residents with a recent live birth in 2020, whose deliveries were indicated on the birth certificate as being paid for by **Medicaid**, 19.0% were indicated as having postpartum depressive symptoms. This was significantly higher than among those with a non-Medicaid payment source for the delivery (12.4%).

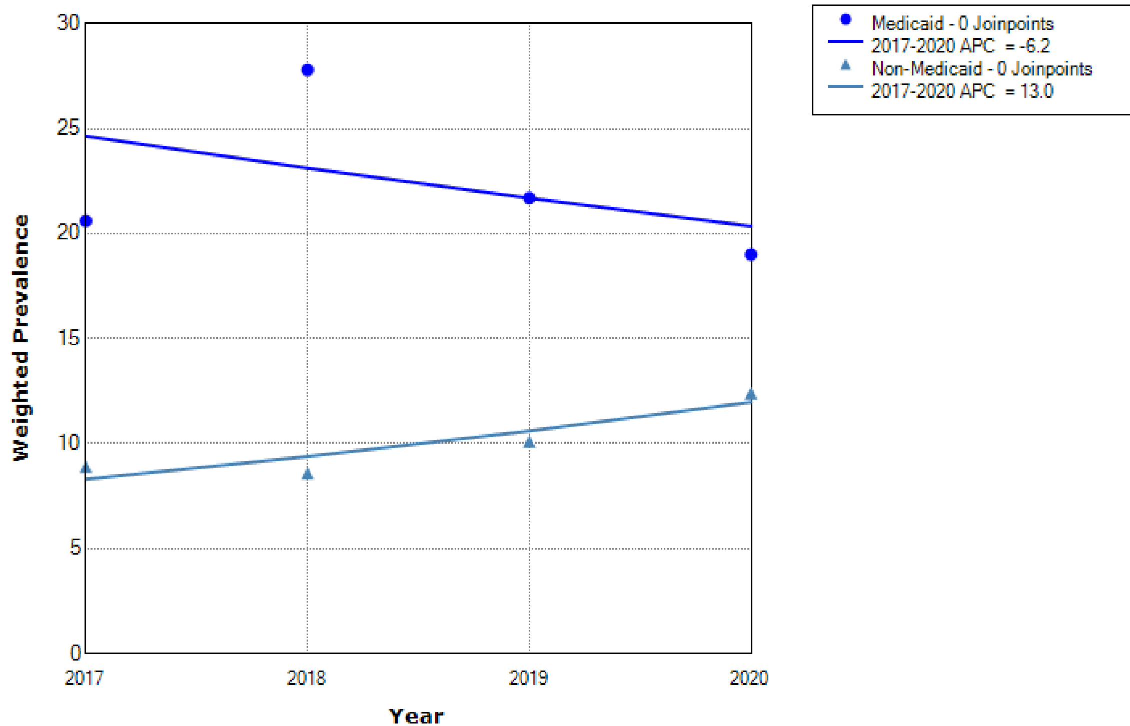
Weighted Prevalence of Postpartum Depressive Symptoms, by Infant's Birth Year and Payment Source for the Delivery,* as Reported by Kansas Residents with a Recent Live Birth, 2017-2020

Birth Year	Medicaid		Non-Medicaid	
	Weighted Prevalence	95% CI	Weighted Prevalence	95% CI
2017	20.6	14.8-27.9	8.9	6.6-12.0
2018	27.8	21.1-35.7	8.6	6.3-11.7
2019	21.7	16.0-28.6	10.1	7.5-13.3
2020	19.0	14.2-24.8	12.4	9.9-15.5

* As indicated on the infant's birth certificate.
95% CI = 95% Confidence Interval
Source: Kansas Department of Health and Environment, Kansas Pregnancy Risk Assessment Monitoring System (PRAMS), 2017-2020

From 2017 to 2020, for individuals with either a Medicaid or non-Medicaid payment source for the delivery, there was not a statistically significant change in the prevalence of postpartum depressive symptoms.

Prevalence of Self-Reported Postpartum Depressive Symptoms, by Payment Source for the Delivery, Among Kansas Residents with a Recent Live Birth, 2017-2020



Payment source for the delivery was derived from the infant's birth certificate.
The Annual Percent Change (APC) was not found to be significantly different from zero at the alpha = 0.05 level.
Source: Kansas Department of Health and Environment, Kansas Pregnancy Risk Assessment Monitoring System (PRAMS), 2017-2020

Among those who gave birth in 2019-2020 (two years combined), some subpopulations were more commonly indicated as having postpartum depressive symptoms, including:

- Those who were under 25 years old (20.6%), compared to those who were 25-34 years old (12.0%) or 35 years or older (9.2%)
- Those whose highest level of education was a high school diploma/GED (21.6%), compared to those with at least some college education (10.3%)
- Those who received WIC food during pregnancy (19.4%), compared to those who did not receive WIC food (12.1%)
- Those whose deliveries were indicated on the birth certificate as being paid for by Medicaid (20.4%), compared to those with non-Medicaid payment sources for the delivery (11.2%)

There was not enough evidence to show that the prevalence of postpartum depressive symptoms varied significantly by race/ethnicity or urban/rural residence (among those with a live birth in 2019-2020).

Prevalence of Self-Reported Postpartum Depressive Symptoms, by Selected Characteristics, Among Kansas Residents with a Recent Live Birth, 2019-2020

Characteristic	Unweighted Numerator	Weighted Numerator (Estimated Population Affected, 2019-2020)	Weighted Prevalence	95% Confidence Interval
Age				
<25 years	118	3541	20.6	16.5-25.6
25-34 years	185	4654	12.0	10.0-14.4
35+ years	41	833	9.2	5.9-14.0
Race/Ethnicity*				
Non-Hispanic White	229	6240	13.2	11.2-15.5
Non-Hispanic Black	45	844	18.7	12.2-27.6
Hispanic	45	1300	13.2	8.7-19.4
Non-Hispanic Other Race, Including Multiracial	25	644	19.3	11.7-30.1
Education Level				
Less than HS/GED	38	1019	15.4	10.0-22.9
High School Diploma/GED	128	3860	21.6	17.4-26.5
At least some college education	177	4145	10.3	8.5-12.4
Payment Source for Delivery†				
Medicaid	148	3946	20.4	16.5-24.8
Non-Medicaid	195	5078	11.2	9.4-13.4
WIC Status During Pregnancy				
WIC Recipient	128	3156	19.4	15.5-24.1
Not a WIC Recipient	215	5868	12.1	10.2-14.3
Urban/Rural Residence (NCHS 2013 Classifications)				
Urban	227	5567	12.7	10.6-15.0
Rural	117	3461	16.4	13.1-20.3

* Note on race/ethnicity: To yield more reliable estimates, 2019 and 2020 data have been combined in this table. However, due to issues with mapping of ethnicity fields from the Kansas birth certificate for the PRAMS weighted datasets, not all persons of Hispanic ethnicity were classified as Hispanic in 2017-2019 data. This issue has been fixed beginning with 2020 data. Although the effect of this issue on weighted estimates is believed to have been minor, caution should be used when interpreting race/ethnicity estimates when pre-2020 data are compared/combined with 2020 data.

† As indicated on the infant's birth certificate.

Source: Kansas Department of Health and Environment, Kansas Pregnancy Risk Assessment Monitoring System (PRAMS), 2019-2020

1. Rafferty J, Mattson G, Earls MF, Yogman MW; COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH. Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice. Pediatrics. 2019;143(1):e20183260. doi:10.1542/peds.2018-3260
2. ACOG Committee Opinion No. 757: Screening for Perinatal Depression. Obstet Gynecol. 2018;132(5):e208-e212. doi:10.1097/AOG.0000000000002927

Additional Trends Related to SPM1: Postpartum Depression

Screening for Perinatal Depression

The PRAMS questionnaire asks respondents who went for (a) prenatal care visits or (b) a postpartum checkup for themselves, whether they were asked by a health care worker if they were feeling “down or depressed” during these visits. Although this information does not capture whether a validated screening tool was used to ask about depression, it can be used as a proxy measure to estimate the prevalence of perinatal depression screening (or at least, whether health care workers asked about feelings of depression).

Among Kansas residents with a recent live birth in 2020 who went for prenatal care, 82.3% reported being asked by a health care worker if they were feeling down or depressed during a prenatal care visit. Among those who went for a postpartum checkup for themselves, 91.1% reported that a health care worker asked if they were feeling down or depressed during that visit.

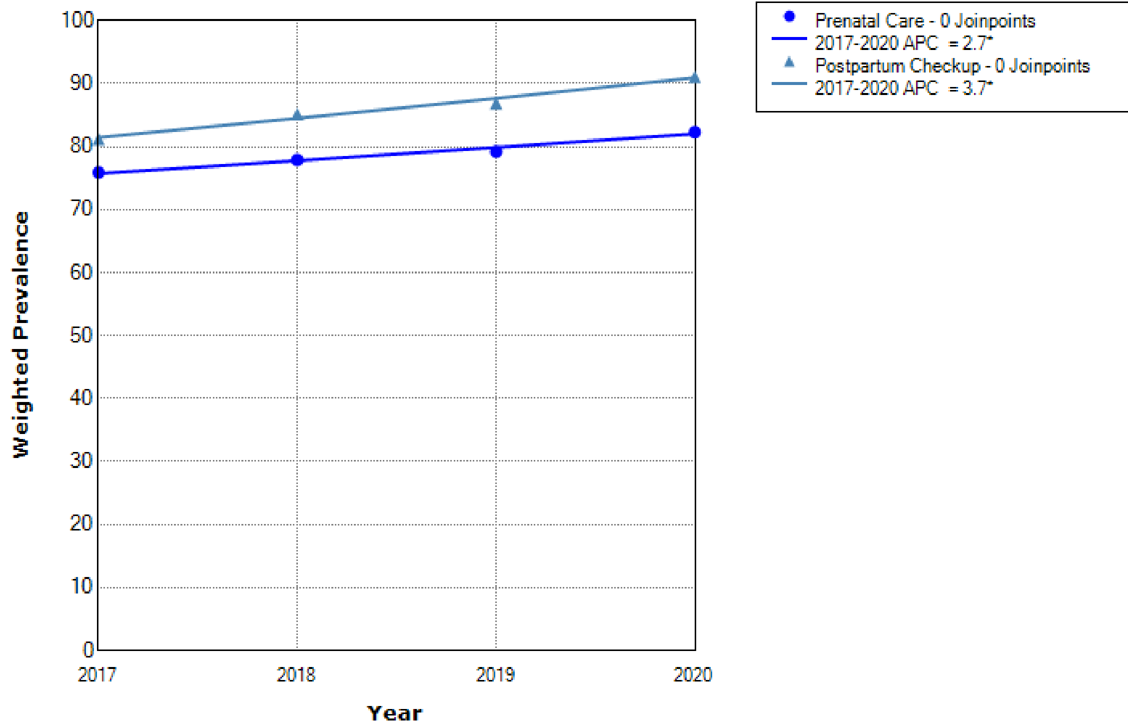
Weighted Prevalence of Being Asked About Feeling Down or Depressed During Prenatal Care Visits and the Postpartum Checkup, by Year of Infant’s Birth, as Reported by Kansas Residents with a Recent Live Birth, 2017-2020

Birth Year	Prenatal Care Visit		Postpartum Checkup	
	Weighted Prevalence	95% CI	Weighted Prevalence	95% CI
2017	75.9	72.3-79.2	81.2	77.5-84.3
2018	77.9	74.4-81.1	85.2	82.0-87.9
2019	79.2	75.7-82.3	86.9	83.8-89.6
2020	82.3	79.4-84.9	91.1	88.7-93.0

95% CI = 95% Confidence Interval
Source: Kansas Department of Health and Environment, Kansas Pregnancy Risk Assessment Monitoring System (PRAMS), 2017-2020

For both types of visits, the prevalence of being asked about feeling down or depressed improved from 2017 to 2020. The postpartum checkup experienced the most improvement, with a statistically significant annual percent change of 3.7% (95% Confidence Interval [CI]: 2.1%-5.4%). For prenatal care visits, the prevalence also increased significantly, with an annual percent change of 2.7% (95% CI: 1.4%-4.0%).

Weighted Prevalence of Being Asked About Feeling Down or Depressed During Perinatal Health Care Visits, by Type of Visit, as Reported by Kansas Residents with a Recent Live Birth, 2017-2020

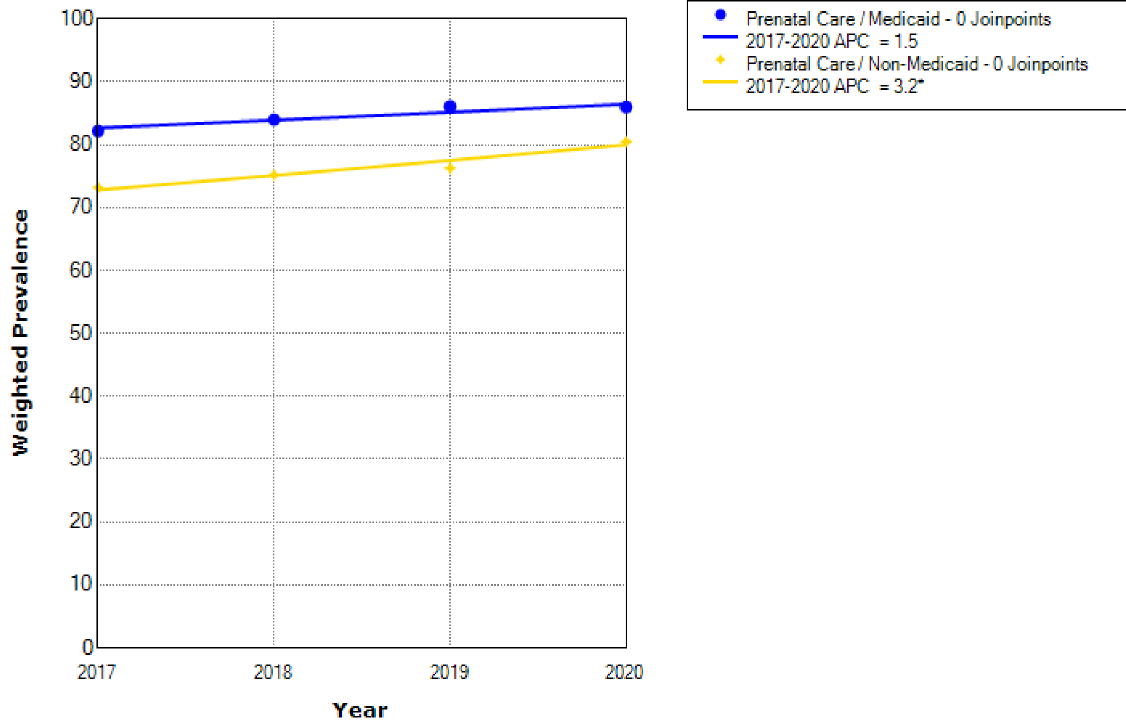


* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level.
Source: Kansas Department of Health and Environment, Kansas Pregnancy Risk Assessment Monitoring System (PRAMS), 2017-2020

Among those with a recent live birth in 2020, there was not enough evidence to show that the prevalence of being asked about feeling down or depressed varied by whether Medicaid was indicated as the payment source for the delivery on the infant's birth certificate, for either the postpartum checkup or for prenatal care visits.

Those whose births were indicated as having a **Non-Medicaid** payment source for the delivery experienced a significant increase in being asked about feeling down or depressed during **prenatal care visits**, between 2017 and 2020. The annual percent change was 3.2% (95% CI: 0.8%-5.6%). Although those with Medicaid-covered births also experienced an increase, it was non-significant.

Weighted Prevalence of Being Asked About Feeling Down or Depressed During Prenatal Care Visits, by Payment Source for the Delivery, as Reported by Kansas Residents with a Recent Live Birth, 2017-2020



* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level.
Payment source for the delivery was derived from the infant's birth certificate.
Source: Kansas Department of Health and Environment, Kansas Pregnancy Risk Assessment Monitoring System (PRAMS), 2017-2020

Weighted Prevalence of Being Asked About Feeling Down or Depressed During Prenatal Care Visits, by Infant's Birth Year and Payment Source for the Delivery,* as Reported by Kansas Residents with a Recent Live Birth, 2017-2020

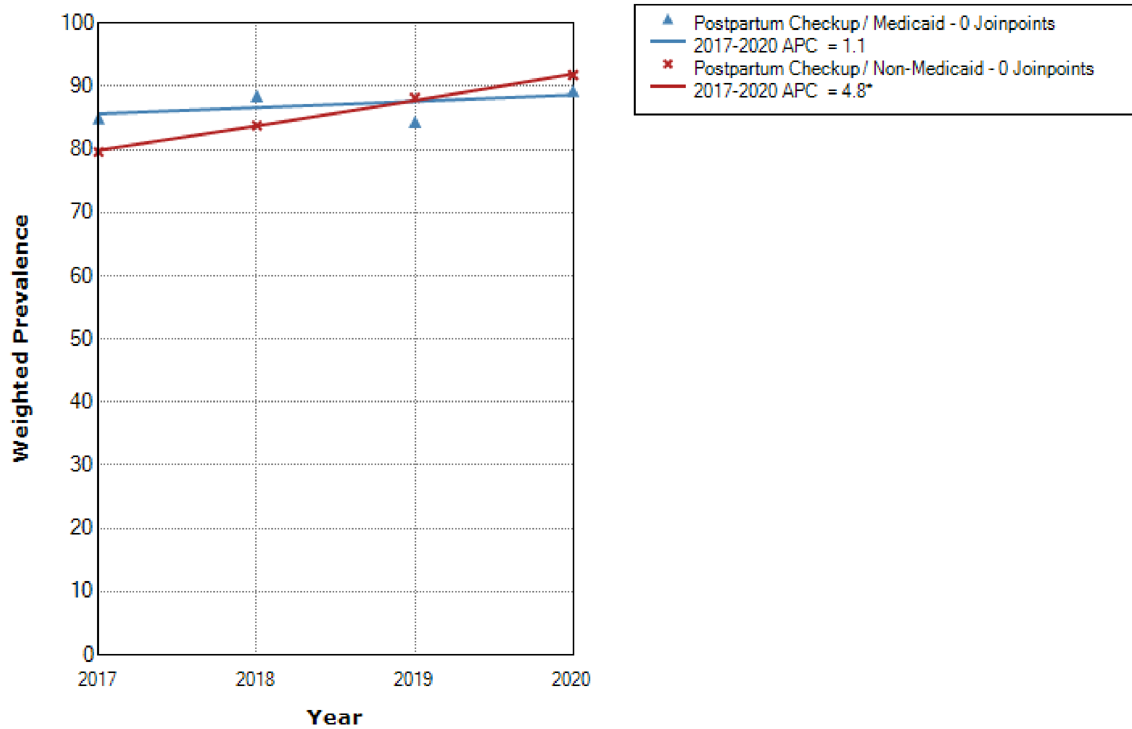
Birth Year	Medicaid		Non-Medicaid	
	Weighted Prevalence	95% CI	Weighted Prevalence	95% CI
2017	82.2	75.2-87.5	73.2	68.8-77.1
2018	84.0	77.3-89.0	75.2	70.9-79.0
2019	86.1	79.7-90.7	76.3	72.0-80.1
2020	86.0	80.7-90.1	80.5	76.9-83.7

* As indicated on the infant's birth certificate.
95% CI = 95% Confidence Interval
Source: Kansas Department of Health and Environment, Kansas Pregnancy Risk Assessment Monitoring System (PRAMS), 2017-2020

From 2017 to 2020, those whose births were indicated as having a **Non-Medicaid** payment source for the delivery also experienced significant improvement in being asked about feeling down or depressed during a **postpartum checkup**. The annual percent change was 4.8% (95%

CI: 3.9%-5.7%). Those with Medicaid-covered births did not experience a statistically significant change.

Weighted Prevalence of Being Asked About Feeling Down or Depressed During a Postpartum Checkup, by Payment Source for the Delivery, as Reported by Kansas Residents with a Recent Live Birth, 2017-2020



* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level.
Payment source for the delivery was derived from the infant's birth certificate.
Source: Kansas Department of Health and Environment, Kansas Pregnancy Risk Assessment Monitoring System (PRAMS), 2017-2020

Weighted Prevalence of Being Asked About Feeling Down or Depressed During a Postpartum Checkup, by Infant's Birth Year and Payment Source for the Delivery,* as Reported by Kansas Residents with a Recent Live Birth, 2017-2020

Birth Year	Medicaid		Non-Medicaid	
	Weighted Prevalence	95% CI	Weighted Prevalence	95% CI
2017	85.0	77.7-90.3	79.6	75.3-83.3
2018	88.5	82.1-92.8	83.8	79.9-87.0
2019	84.4	77.5-89.5	88.2	84.5-91.0
2020	89.3	84.1-93.0	91.8	89.0-94.0

* As indicated on the infant's birth certificate.
95% CI = 95% Confidence Interval
Source: Kansas Department of Health and Environment, Kansas Pregnancy Risk Assessment Monitoring System (PRAMS), 2017-2020

Access to Treatment or Counseling for Postpartum Depression

The PRAMS questionnaire asks all respondents, “Since your new baby was born, was there a time when you thought you needed treatment or counseling for depression but didn’t get it?” From this question, information can be gathered about access to care for postpartum depression.

Among Kansas residents with a recent live birth in 2020, about one in six (16.7%) reported that there was a time since the birth when they thought they had needed treatment or counseling for depression but didn’t get it.

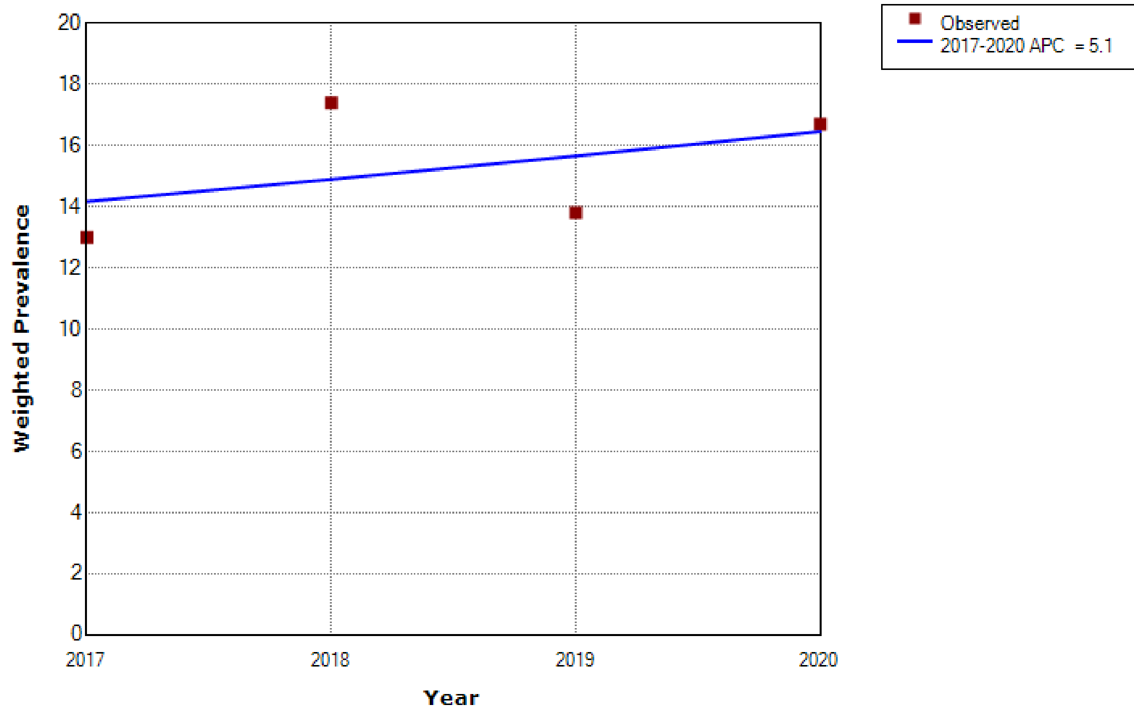
Weighted Prevalence of Not Getting Treatment or Counseling for Postpartum Depression When Needed, by Year of Infant’s Birth, as Reported by Kansas Residents with a Recent Live Birth, 2017-2020

Birth Year	Weighted Prevalence	95% Confidence Interval
2017	13.0	10.4-16.0
2018	17.4	14.4-21.0
2019	13.8	11.2-16.9
2020	16.7	14.2-19.5

Source: Kansas Department of Health and Environment, Kansas Pregnancy Risk Assessment Monitoring System (PRAMS), 2017-2020

There was not enough evidence to show that the prevalence changed significantly from 2017 to 2020, despite an increasing trend.

Weighted Prevalence of Not Getting Treatment or Counseling for Postpartum Depression When Needed, as Reported by Kansas Residents with a Recent Live Birth, 2017-2020

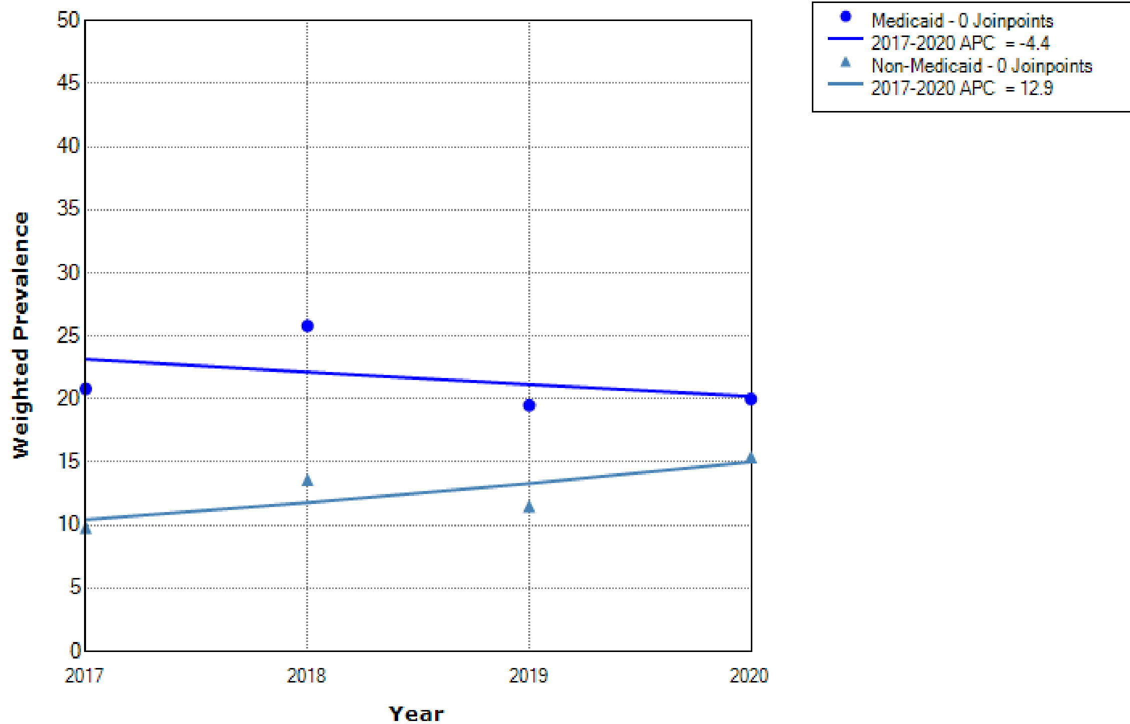


The Annual Percent Change (APC) was not found to be significantly different from zero at the alpha = 0.05 level.
Source: Kansas Department of Health and Environment, Kansas Pregnancy Risk Assessment Monitoring System (PRAMS), 2017-2020

Among those with a recent live birth in 2020, there was not enough evidence to show that the prevalence of not getting treatment or counseling for postpartum depression despite a perceived need varied by whether Medicaid was indicated as the payment source for the delivery.

From 2017 to 2020, no statistically significant changes were observed in this indicator, for those with either Medicaid or non-Medicaid sources of payment for the delivery.

Weighted Prevalence of Not Getting Treatment or Counseling for Postpartum Depression When Needed, by Payment Source for the Delivery, as Reported by Kansas Residents with a Recent Live Birth, 2017-2020



The Annual Percent Change (APC) was not found to be significantly different from zero at the alpha = 0.05 level.
Payment source for the delivery was derived from the infant's birth certificate.
Source: Kansas Department of Health and Environment, Kansas Pregnancy Risk Assessment Monitoring System (PRAMS), 2017-2020

Weighted Prevalence of Not Getting Treatment or Counseling for Postpartum Depression When Needed, by Infant's Birth Year and Payment Source for the Delivery,* as Reported by Kansas Residents with a Recent Live Birth, 2017-2020

Birth Year	Medicaid		Non-Medicaid	
	Weighted Prevalence	95% CI	Weighted Prevalence	95% CI
2017	20.8	15.0-28.1	9.8	7.3-13.0
2018	25.8	19.4-33.5	13.6	10.5-17.5
2019	19.5	14.1-26.4	11.5	8.8-14.8
2020	20.0	15.1-26.0	15.4	12.6-18.7

* As indicated on the infant's birth certificate.
95% CI = 95% Confidence Interval
Source: Kansas Department of Health and Environment, Kansas Pregnancy Risk Assessment Monitoring System (PRAMS), 2017-2020

The PRAMS questionnaire also asks about reasons for not getting treatment or counseling for depression since the birth. Among those with a recent live birth in 2017-2020 (four years of data

combined), who did not get treatment or counseling when needed, those with Medicaid and non-Medicaid delivery payment sources responded similarly to the reasons below.

Weighted Prevalence of Reasons for Not Getting Treatment or Counseling, by Payment Source for the Delivery,* as Reported by Kansas Residents with a Recent Live Birth Who Did Not Get Treatment or Counseling for Postpartum Depression When Needed, 2017-2020

Reason	Medicaid		Non-Medicaid	
	Weighted Prevalence	95% CI	Weighted Prevalence	95% CI
I had trouble finding a provider that I liked	31.7	24.0-40.6	22.5	17.2-28.7
It seemed too difficult or overwhelming	74.6	66.7-81.2	73.4	66.9-79.0
I was worried about the cost or could not afford it	53.0	44.2-61.7	56.8	49.9-63.4
I did not have time because of a job, childcare or another commitment	55.4	46.5-63.9	51.5	44.6-58.3

* As indicated on the infant's birth certificate.
95% CI = 95% Confidence Interval
Weighted prevalence estimates do not add up to 100% because respondents could check "no" or "yes" to each answer choice (not mutually exclusive).
In addition to these responses, this question had an additional answer choice, "I could not find a provider who spoke my language." This answer choice has not been included in this table, due to unreliability of estimates.
Source: Kansas Department of Health and Environment, Kansas Pregnancy Risk Assessment Monitoring System (PRAMS), 2017-2020