

## Title V Maternal & Child Health State Action Plan

Period: 2016-2020 **INTERNAL DRAFT – DO NOT DISTRIBUTE**

**PRIORITY 1: Women have access to and receive coordinated, comprehensive services before, during and after pregnancy**  
(Domain: Women & Maternal)

- NPM 1:** Well-woman visit (Percent of women, ages 18-44, with a preventive medical visit in the past year)
- o ESM: Percent of women program participants (18-44 years) that received education on the importance of a preventive medical visit in the past year
  - o ESM: Percent of women program participants (18-44 years) with a preventive medical visit in the past year (New 2018)
- NPM 14:** Smoking during Pregnancy and Household Smoking (Percent of women who smoke during pregnancy; Percent of children, ages 1 through 17, who live in households where someone smokes)
- o ESM: Percent of women program participants who smoke referred to an evidence-based program and enrolled/accepted services
- SPM 1:** Percent of preterm births (<37 weeks gestation)
- o ESM: Percent of pregnant Medicaid participants with history of prior spontaneous preterm birth receiving at least one dose of progesterone

**OBJECTIVE 1.1:** Increase the proportion of women receiving a preventive medical visit annually.

- 1.1.1 Increase the number of health departments and health centers educating on the importance of an annual well visit and providing on-site assistance for accessing health care coverage (certified application counselors or Medicaid eligibility workers), especially to ensure coverage beyond the post-partum period.
- 1.1.2 Utilize peer and social networks for women, including group education models, to promote and support access to preventive care.
- 1.1.3 Promote individuals' responsibility through the development and documentation of personal health plans that include the annual visit.
- 1.1.4 Promote consumer awareness about the importance of preconception care, and inter-conception care, and birth spacing.

**OBJECTIVE 1.2:** Increase the proportion of women developing a reproductive life plan annually. (New 2018)

- 1.2.1 Develop, evaluate, and disseminate culturally competent reproductive life planning tools.
- 1.2.2 Increase number of health departments and health centers utilizing reproductive life planning tools including One Key Question®.
- 1.2.3 Promote consumer awareness about the importance of reproductive life plans, including birth spacing.
- 1.2.4 Increase provider knowledge of the importance of reproductive life plans and improve reproductive life planning counseling skills.

**OBJECTIVE 1.3:** Increase the number of communities utilizing the MCH collaborative model and prenatal education curriculum by at least 5 annually by 2020.

1.3.1 Develop new community collaborations and programs, targeting cities, counties, and regions with health disparities and poor birth outcomes (follow the Healthy Start model).

1.3.2 Integrate evidence-based tobacco/smoking, safe sleep, breastfeeding, and mental health interventions into community-based services.

1.3.3 Engage Federally Qualified Health Centers (FQHCs) in more communities across the state with the goal of increasing coordination and access to a variety of services for those at greatest risk.

1.3.4 Develop regional models to implement or support rural expansion of community collaboratives.

1.3.5 Integrate web-based education and telehealth capabilities within the existing community collaborative models in targeted areas.

**OBJECTIVE 1.4:** Increase the percent of pregnant women on Medicaid with a previous preterm birth who receive progesterone to 40% by 2018 and increase annually thereafter.

1.4.1 Increase patient, family and community understanding of progesterone use and full-term births.

1.4.2 Promote universal practice protocol and tools to timely, reliably, and effectively screen women for history of preterm birth and short cervix.

1.4.3 Develop protocol and guidelines, including utilization of progesterone to prevent preterm birth (ACOG and Optum Health).

1.4.4 Utilize Medicaid claims data and data linkages with Vital Records to increase the number of women prescribed progesterone.

**OBJECTIVE 1.5:** Increase the proportion of smoking women referred to evidence-based cessation services to 95% or higher by 2020.

1.5.1 Promote provider training on tobacco use and smoking with focus on pregnancy, identifying resources and interventions available including Nicotine Replacement Therapy (NRT).

1.5.2 Promote referral to the Quitline, [Baby & Me Tobacco Free program](#), [Smoking Cessation and Reduction in Pregnancy Treatment \(SCRIPT\) program](#), and other evidence-based interventions where available.

1.5.3 Place toolkits (screening, referral, resources, and programs) in the hands of providers.

1.5.4 Standardize smoking history and screening forms to collect information at initial and follow-up visits.

1.5.5 Enlist support of pediatricians to inquire about smoking, counseling, and referrals postpartum.

**OBJECTIVE 1.6:** Implement the Vermont Oxford Network (VON) Neonatal Abstinence Syndrome (NAS) Universal training program statewide in partnership with the Kansas Perinatal Quality Collaborative (KPQC) and birthing centers (Target: 65 centers). (New 7-2018)

1.6.1 Assist 85% of participating birthing facilities enrolled in the NAS Universal Training Program with achieving "Center of Excellence" designation.

1.6.2 Reduce the percent of infants at risk for NAS admitted directly to the NICU to less than 50%.

1.6.3 Decrease the percent of infants at risk for NAS who require pharmacological treatment by 25%.

1.6.4 Decrease the hospital length of stay for infants with NAS treated pharmacologically by two days.

**PRIORITY 2: Developmentally appropriate care and services are provided across the lifespan (Domain: Child)**

**NPM 6:** Developmental screening (Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year)

- o ESM: Percent of program providers using a parent-completed developmental screening tool

**NPM 7:** Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9)

- o ESM: Number of free car seat safety inspections completed by certified child passenger safety technicians

**SPM 2:** Percent of children 6 through 11 who are physically active at least 60 minutes/day

**OBJECTIVE 2.1:** Increase the proportion of children aged 1 month to kindergarten entry statewide who receive a parent-completed developmental screening annually.

2.1.1 Conduct an environmental scan to identify providers conducting developmental screening and determine the tools being utilized to maximize resources and eliminate duplicate screening.

2.1.2 Improve coordination of referral and services between early care and education, home visitors, medical homes, and early intervention.

2.1.3 Build MCH capacity for screening and follow-up through complete referrals to providers and community-based services.

2.1.4 Provide training to MCH grantees on messaging the importance of ongoing developmental screening and use of Ages and Stages Questionnaires (e.g., ASQ-3; ASQ:SE2).

**OBJECTIVE 2.2:** Provide annual training for child care providers to increase knowledge and promote screening to support healthy social-emotional development of children.

2.2.1 Develop a standard and consistent message to communicate importance of developmental screening among child care programs.

2.2.2 Make available and provide training to child care providers on social-emotional development, milestones, and age-appropriate activities using the Kansas Early Learning Standards.

2.2.3 Build child care provider capacity to support coordination and referrals with other providers and community-based services.

2.2.4 Partner with statewide networks such as Child Care Aware of Kansas (CCA-KS) and Kansas Child Care Training Opportunities (KCCTO) to assess the training needs of providers and develop training to meet their needs.

**OBJECTIVE 2.3:** Increase by 10% the number of children through age 8 riding in age and size appropriate car seats per best practice recommendations by 2020.

2.3.1 Increase the number of MCH grantees, as a lead for or partner of local Safe Kids Coalitions, providing education and installation of car seats.

2.3.2 Increase the number of trained car seat technicians, support additional check lanes for MCH, and incorporate information and check lane locations into prenatal and postpartum education and information.

2.3.3 Provide targeted training and technical assistance to child care providers related to regulatory and transportation requirements.

**OBJECTIVE 2.4:** Increase the proportion of families receiving education and risk assessment for home safety and injury prevention by 2020.

2.4.1 Enhance home safety information and education provided as part of prenatal and postnatal visits/sessions

2.4.2 Provide education and support through use of online systems and tools to assist parents with selecting a child care setting that meets health and safety requirements.

2.4.3 Develop a standard home visiting tool for MCH home visitors to assess environments for potential harm or injury in the home environment.

2.4.4 Track changes to the home environment between visits in response to education and consultation provided by MCH home visitors to reduce the potential for harm or injury.

**OBJECTIVE 2.5:** Increase the percent of children participating in at least 60 minutes of daily physical activity per CDC recommendations to decrease risk of obesity by 2020.

2.5.1 Provide training and resources to child care providers related to healthy practices and regulatory requirements to encourage and support implementation of daily routines involving physical activity.

2.5.2 Increase the number of community programs, including early care settings, collaborating with MCH programs to promote participation in regular physical activity including engaging and educating families.

2.5.3 Support local health departments, early care settings, schools, and community centers in local initiatives to promote physical activity and utilization of safe walking and biking trails (Ex. Walking School Bus).

**PRIORITY 3: Families are empowered to make educated choices about infant health and well-being (Domain: Perinatal & Infant)**

**NPM 4:** Breastfeeding (Percent of infants who are ever breastfed; Percent of infants breastfed exclusively through 6 months)

- o ESM: Percent of WIC infants breastfed exclusively through six months in designated "Communities Supporting Breastfeeding"

**SPM 3:** Number of Safe Sleep (SIDS/SUID) trainings provided to professionals

- o ESM: Percent of safe sleep training participants who increased their knowledge of safe sleep between pre and post tests

**OBJECTIVE 3.1:** Increase the number of communities that provide a multifaceted approach to breastfeeding support across community sectors by at least 10 by 2020.

3.1.1 Support capacity to expand the number of communities that achieve the criteria for the *Community Supporting Breastfeeding* designation.

3.1.2 Partner with the [Kansas Breastfeeding Coalition](#) (KBC) and WIC in their efforts to promote and support breastfeeding with businesses through the [Breastfeeding Welcome Here](#) and [Business Case for Breastfeeding](#) initiatives.

3.1.3 Develop standard curriculum for prenatal parent education about infant feeding for use by local communities across the state, integrating it into education sessions.

3.1.4 Increase access to professional and peer breastfeeding support, including Certified Lactation Consultants and Breastfeeding Peer Counselors, through training, referrals, and linkages between birthing facilities and community resources.

3.1.5 Partner with Medicaid and Managed Care Organizations to increase awareness of and access to breastfeeding support benefits such as access to lactation consults and breastfeeding supplies as recommended by the U.S. Preventive Services Task Force.

**OBJECTIVE 3.2:** Increase the proportion of live births delivered in birthing facilities that provide recommended care for breastfeeding mothers by 2020. (Revised 7-2017)

3.2.1 Partner with WIC and KBC to expand the [High 5 for Mom and Baby](#) program by increasing the number of hospitals implementing the program.

3.2.2 Support the Kansas hospitals seeking to achieve the Baby-Friendly Hospital designation in partnership with United Methodist Health Ministries Fund (UMHMF), KBC and WIC.

3.2.3 Provide access to education to hospital and maternity care/OB staff to support implementation of evidence-based maternity care policies and practices known to increase breastfeeding initiation and duration rates.

**OBJECTIVE 3.3:** Increase the proportion of mothers and pregnant women receiving education related to optimal infant feeding by 2020. (Revised 2017)

3.3.1 Deploy evidence-based breastfeeding education tools through WIC and Home Visiting programs, hospitals, and provider offices to support an accurate, consistent message about infant feeding for women and families.

3.3.2 Align and strengthen optimal infant feeding education and support through existing programs, including Maternal & Child Health, Home Visiting, and WIC.

3.3.3 Increase the number of referrals to WIC and WIC Breastfeeding Peer Counselors for breastfeeding support and education, including the expansion of WIC Breastfeeding Peer Counseling sites.

**OBJECTIVE 3.4:** Implement a multi-sector (community, hospitals, maternal and infant clinics) safe sleep promotion model by 2020.

3.4.1 Enhance safe sleep instructor skill sets to include training home visitors and health care providers and facilitating community baby showers expanding to address safe sleep, smoking cessation, and breastfeeding.

3.4.2 Provide essential supplies including sleep sacks and pack and plays to families and caregivers identified as at risk and in need.

3.4.3 Expand promotion of the [American Academy of Pediatrics](#)' (AAP) Safe Sleep guidelines by activating the Safe Sleep Instructors to roll out the Hospital Safe Sleep Bundle Intervention and the Safe Sleep Toolkit for outpatient clinics.

3.4.4 Increase the number of Safe Sleep instructors by approximately 5 per year through targeted recruitment in areas with identified need for instructors, high rates of sleep-related injury or mortality, and low levels of related resources.

**PRIORITY 4: Communities and providers support physical, social and emotional health (Domain: Adolescent)**

**NPM 10:** Adolescent well-visit (Percent of adolescents, 12 through 17, with a preventive medical visit in the past year)

- o **ESM:** Percent of adolescent program participants (12-22 years) that received education on the importance of a preventive medical visit in the past year

**OBJECTIVE 4.1:** Develop a cross-system partnership and protocols to increase the proportion of adolescents receiving annual preventive services by 2020.

4.1.1 Engage health care providers, Medicaid and Managed Care Organizations to promote annual well-child visits through adolescence into adulthood.

4.1.2 Partner with KAAP and KAFP to provide professional development events on using the Bright Futures Guidelines.

4.1.3 Increase accessibility to preventative care and well visits by piloting School Based Health Centers in at least 2 school districts.

4.1.4 Engage school nurses to identify and refer children and adolescents with an Individualized Healthcare Plan (IHP) who have not had a well visit in the past year.

**OBJECTIVE 4.2:** Increase the number of adolescents aged 12 through 17 years accessing positive youth development, prevention, and intervention services and programs by 2020.

4.2.1 Partner with state Department of Education Family and Consumer Science (FCS) Coordinator and local FCS teachers to update the Personal & Wellness Curriculum, including supplemental teaching tools on adolescent health topics (i.e. bullying, suicide prevention, distracted driving, healthy relationships, contraceptive choices, etc.).

4.2.2 Partner with schools and existing groups to set up youth focus groups to determine their views on health, what services are available, and what tools they need to navigate the health care system.

4.2.3 Develop standardized toolkits and educational materials for local MCH grantees on adolescent empowerment and health promotion.

4.2.4 Partner with other HRSA and SAMHSA initiatives to provide events and programs, including those related to bullying and suicide prevention, that promote protective factors and empower youth to reduce risky behaviors.

4.2.5 Identify methods to increase adolescent awareness of services and programs available to them in their community.

<b>OBJECTIVE 4.3:</b> Increase access to programs and providers serving adolescents that assess for and intervene with those at risk for suicide.
4.3.1 Develop follow-up protocols for families to be referred for behavioral health services and offer additional support as needed to assure services are received.
4.3.2 Provide school-based access to confidential mental health screening, referral and treatment that reduces the stigma and embarrassment often associated with mental illness, emotional disturbances and seeking treatment.
4.3.3 Partner with KU Pediatrics, Kansas Department of Aging and Disability Services, and Kansas Association for the Medically Underserved to provide mental health fellowship training opportunities to pediatric primary care providers through the REACH Institute.
4.3.4 Promote evidence-based suicide prevention initiatives and accessible crisis services through school and out-of-school activities.

**PRIORITY 5: Professionals have the knowledge and skills to address the needs of maternal and child health populations**  
 (Domain: Cross-cutting/Life course)

**SPM 5:** Number of MCH grantees, families and partners that participated in a state sponsored workforce development event. (New 2018)

**OBJECTIVE 5.1:** Build MCH capacity and support the development of a trained, qualified workforce by providing professional development events at least four times each year through 2020.

- 5.1.1 Increase knowledge of providers, partners, and consumers, including families, as it relates to Kansas Maternal and Child Health: purpose, scope, target populations, programs, services, and more.
- 5.1.2 Develop a system to capture increases in MCH staff and grantees completing trainings, such as the MCH navigator self-assessment.
- 5.1.3 Incorporate MCH competencies more intentionally into MCH position descriptions.
- 5.1.4 Incorporate health equity, disparities, and cultural appropriateness/competence concepts into all workforce development activities.

**OBJECTIVE 5.2:** Deliver annual training and education to ensure that providers have the ability to promote diversity, inclusion, and integrate supports in the provision of services for the Special Health Care Needs (SHCN) population into adulthood.

- 5.2.1 Offer information and training to child care and education providers to support inclusion within those settings and assure higher quality care for CYSHCN.
- 5.2.2 Host webinars and online trainings for health providers on caring for CYSHCN, adapting from the Caring for People with Disabilities course.
- 5.2.3 Partner with the National Alliance on Mental Illness (NAMI) to offer youth and adult education programs to KS-SHCN clients.

**OBJECTIVE 5.3:** Increase the number of providers with capacity to provide mental health services/supports and trauma-informed care by 2020.

5.3.1 Increase MCH state staff and partner awareness and knowledge of trauma-informed care and hope-infused approaches.
5.3.2 Conduct an environmental scan to identify the types of trauma-informed care occurring in the state and the providers offering it.
5.3.3 Provide training for MCH grantees including home visitors on trauma-informed care and mental health first aid.
5.3.4 Train professionals working with families on strategies to address risk of immediate harm to support safe, stable and nurturing environments.
<b>OBJECTIVE 5.4:</b> Implement collaborative oral health initiatives to expand oral health screening, education, and referral by 2020.
5.4.1 Integrate oral health education, services, and referral into MCH, SHCN, and WIC clinic visits; dental visits; and home visits.
5.4.2 Promote and support on-site oral health screenings at child care facilities through the <i>Healthy Smiles</i> initiative.
5.4.3 Continue offering the existing training and develop level 2 and 3 courses to build on education through <i>Healthy Smiles</i> .
5.4.4 Educate health care professionals regarding consistent messaging and the need for ongoing screenings and oral health education.

**PRIORITY 6: Services are comprehensive and coordinated across systems and providers**  
**(Domain: Children & Youth with Special Health Care Needs - CYSHCN)**

**NPM 11:** Medical home (Percent of children with special health care needs having a medical home)  
 ○ ESM: Percent of families who experience an improved independent ability to navigate the systems of care

<b>OBJECTIVE 6.1:</b> Increase family satisfaction with the communication among their child's doctors and other health providers to 75% by 2020.
6.1.1 Support family-centered medical homes through increased awareness among families, including communicating with their doctors and building effective health advocacy skills.
6.1.2 Provide professional development opportunities to health care providers to increase family-centered medical home supports.
6.1.3 Implement communication and referral protocols for SHCN Care Coordinators and providers.
<b>OBJECTIVE 6.2:</b> Increase the proportion of families who receive care coordination supports through cross-system collaboration by 25% by 2020.
6.2.1 Explore new and existing partnerships that promote collaboration between primary care and behavioral health providers.
6.2.2 Expand KS-SHCN to have care coordinators located in all six Kansas public health regions.
6.2.3 Engage Managed Care Organizations and primary care providers in collaborative coordination for SHCN clients.
6.2.4 Provide support to agencies working with foster homes and the foster care system in serving CYSHCN in foster care.



6.2.5 Develop, monitor and evaluate a patient-centered care coordination action plan for all SHCN clients who chose to participate in the care coordination program.

**OBJECTIVE 6.3:** Develop an outreach plan to engage partners, providers, and families in the utilization of a shared resource to empower, equip, and assist families to navigate systems for optimal health outcomes by 2020.

6.3.1 Complete the online navigational toolkit to provide resources and services, including expansion to Help Me Grow.

6.3.2 Increase access to primary and specialty care in underserved areas.

6.3.3 Increase utilization of Medicaid, CHIP, and Health Insurance Exchange services through education and referrals.

6.3.4 Connect SHCN care coordinators with foster care and Managed Care Organization case managers to provide technical assistance and support for SHCN clients.

6.3.5 SHCN providers will have access to care coordinators for support and assistance in their community (in-person or remote access).

**PRIORITY 7: Information is available to support informed health decisions and choices (Domain: Cross-cutting/Life course)**

**SPM 4:** Percent of adults who report that it is somewhat difficult or very difficult to understand information that doctors, nurses and other health professionals tell them

**OBJECTIVE 7.1:** Increase the proportion of MCH grantees that provide health information education to clients to improve health decision making among women, pregnant women, children, adolescents, and children and youth with special health care needs annually.

7.1.1 Identify a baseline proportion of MCH grantees using DAISEY who are providing health information education.

7.1.2 Provide resources to increase education and knowledge of healthy decision making.

7.1.3 Work with partners to ensure that well visits incorporate best practices.

**OBJECTIVE 7.2:** Increase youth-focused and youth-driven initiatives to support successful transition, self-determination, and advocacy by 2020.

7.2.1 Implement the youth leadership program, *Faces of Change*.

7.2.2 Distribute [\*The Future is Now THINK BIG – Preparing for Transition Planning\*](#) workbooks to schools for distribution to children and adolescents as part of orientation.

7.2.3 Explore opportunities for increased youth leadership.

**OBJECTIVE 7.3:** Incorporate information regarding changes to the health care system into existing trainings and technical assistance by 2020.

7.3.1 Identify opportunities to optimize changes in the health care system to maximize service delivery to families.

7.3.2 Provide training and technical assistance to local health departments on MCH service planning and delivery.

7.3.3 Support connection between local health departments and Navigators to increase families' access.

7.3.4 Review and identify steps to incorporate information from the [Peer-to-Peer Technical Assistance for State Title V MCH Programs on Implementation of the Affordable Care Act \(ACA\)](#).

7.3.5 Review and incorporate [Standards for Systems of Care for CYSHCN](#).

**OBJECTIVE 7.4:** Increase opportunities to empower families and build strong MCH advocates by 2020.

7.4.1 Provide family and sibling peer supports for those interested in being connected to other families with similar experiences (e.g., Foster Care, Children and Youth with Special Health Care Needs (CYSHCN), others).

7.4.2 Conduct *Care Coordination: Empowering Families* trainings for parents of CYSHCN.

7.4.3 Increase the number of fathers and male support persons that are engaged in family health activities.

7.4.4 Provide opportunities for parents to improve their skills in seeking out quality health-related information.

NPM: National Performance Measure

SPM: State Performance Measure

ESM: Evidence-based or Informed Strategy Measure

\*The Title V Maternal and Child Health (MCH) Services Block Grant was authorized in 1935 as part of the Social Security Act. Title V's mission is to improve the health and well-being of the nation's mothers, infants, children and youth, including children and youth with special health care needs and their families. The program is funded through the Health Resources and Services Administration's Maternal and Child Health Bureau (MCHB) and administered by the Kansas Department of Health and Environment, Bureau of Family Health. States are required to conduct a statewide needs assessment every five years and identify priority needs and measures for six MCH Population Domains: Women & Maternal, Perinatal & Infant, Child, Adolescent, Children & Youth with Special Health Care Needs, and Cross-cutting/Life course. Although each state priority is linked with an individual domain, Kansas recognizes that many priorities and objectives may address needs across populations and is dedicated to focusing on aligning efforts as necessary for maximum impact. Find more information at [www.kansasmch.org](http://www.kansasmch.org) or [www.kdheks.gov/bfh](http://www.kdheks.gov/bfh).