Priority 1: Women have access to and utilize integrated, holistic, and patient-centered care throughout the preconception, pregnancy, and postpartum periods.

Domain: Women & Maternal

National Performance Measure (NPM): Postpartum Visit (Percent of women who attended a postpartum checkup within 12 weeks after giving birth).

Evidence-Based Strategy Measure (ESM): Percent of Title V program participants that report attending their postpartum visit.

Objective 1.1: By 2030, increase the postpartum visit attendance rate from 92.1% to 94.4%.

Strategy	Description
1.1.1	Provide resources and tools to support local health agencies in educating women about the importance of the postpartum visit and the comprehensive medical services available to them throughout the postpartum period.
1.1.2	Assess the feasibility of contracting with CNMs, RN home visitors, and/or Doulas to provide the postpartum visit for populations with limited access to care.
1.1.3	Continue supporting hospitals and health care systems to ensure the postpartum visit is scheduled for every postpartum woman prior to discharge.

Objective 1.2: By 2030, reduce the number of pregnancy-related deaths from 18 per 100,000 live births to 14.

Strategy	Description
1.2.1	Explore and pilot/assess quality care improvement frameworks that address the core drivers of maternal mortality.
1.2.2	Engage with community members and those with lived experience to co-design and implement community-based programs that prioritize those most affected by maternal mortality and morbidity.
1.2.3	Provide trainings, such as CUES, and resources to providers, local health agencies, and community organizations to reduce maternal deaths due to violence.

Objective 1.3: By 2030, increase the percentage of pregnant women that report being asked about using illicit drugs during routine prenatal care visits from 77.7% to 88%.

Strategy	Description
1.3.1	Support recovery and care coordination models for pregnant and postpartum women and their families impacted by SUD.
1.3.2	Increase provider capacity to screen and treat substance use disorder during the perinatal period by offering trainings, technical assistance, and other resources.
1.3.3	Develop resources and tools to support local agencies in educating women about the risk of using substances during the perinatal period and work with partners to address the stigma associated with substance use during pregnancy.

Priority 2: All infants and families are supported by robust community systems that promote optimal infant health and well-being.

Domain: Perinatal & Infant

National Performance Measure (NPM): Breastfeeding (Percent of children ages 6 months through 2 years, who breastfed exclusively for 6 months).

ESM: Percent of WIC non-Hispanic black infants breastfed exclusively through six months.

State Performance Measure: Safe Sleep (Percent of infants placed to sleep; (A) on their backs; (B)on separate sleep surface; and (C) without soft objects and loose bedding).

ESM: Percent of Kansas Perinatal Community Collaboratives (KPCC) participants who placed their infants to sleep (A) on their backs; (B) in a crib/bassinet or portable crib.

Objective 2.1: By 2030, increase the rate of exclusive breastfeeding at 6 months by 2.5% annually through cross-sector breastfeeding policies, practices, and community supports/programs.

Strategy	Description
2.1.1	Ensure that comprehensive breastfeeding support services—including peer-to-peer support, International Board-Certified Lactation Consultants (IBCLCs), and other lactation support providers—are available, accessible, culturally congruent, and fully integrated into health care and community systems.
2.1.2	Support local breastfeeding coalitions for under-served communities that connect health care providers and the community to local information and resources, in partnership with the Kansas Breastfeeding Coalition (KBC).
2.1.3	Increase access to consistent, evidence-based breastfeeding education and support by promoting shared messaging, coordinated referrals, and collaboration across healthcare, public health, and community sectors, including WIC, Aid to Local programs, and clinical partners, with attention to behavioral health integration where appropriate.

Objective 2.2: Promote and support safe sleep practices and cross-sector initiatives to reduce the SUID rate by 10% by 2030.

Strategy	Description
2.2.1	Provide technical assistance to Certified Safe Sleep Instructors to ensure consistent safe sleep messaging across the state and continuity of supports in partnership with the Kansas Infant Death and SIDS (KIDS) Network.
2.2.2	Align and strengthen safe sleep education in partnership with the KIDS Network through professional trainings and resources offered to local MCH agencies, Home Visiting programs, hospitals, and provider offices to support safe sleep practices and accurate, consistent safe sleep messages.

2.2.3	Partner with local coalitions and community organizations leading efforts to support safe sleep, breastfeeding, perinatal mental health and substance use prevention to provide active learning opportunities, direct education and referrals to families at high risk for adverse outcomes through Safe Sleep Community Baby Showers.
2.2.4	Support local maternal and child health providers in facilitating meaningful conversations with parents and caregivers to identify and understand the cultural, geographic, and community-specific barriers that impact the implementation of safe sleep practices.

Objective 2.3: Maintain at least two quality cross-sector initiatives focused on improving maternal, perinatal, and infant health in partnership with the Kansas Perinatal Quality Collaborative (KPQC) by 2030.

Strategy	Description
2.3.1	Maintain at least two quality cross-sector initiatives focused on improving maternal, perinatal, and infant health in partnership with the Kansas Perinatal Quality Collaborative (KPQC) by 2030.
2.3.2	Strengthen provider knowledge and uptake of perinatal risk screening, brief interventions, and coordinated referrals by disseminating actionable resources (e.g., toolkits, action alerts, webinars) based on Kansas Maternal Mortality Review Committee findings and other evidence-based recommendations.
2.3.3	Advance statewide adoption of evidence-based maternal health improvement strategies by continued participation in the Alliance for Innovation on Maternal Health (AIM) initiative and implementing selected patient safety bundles in appropriate care settings.

Priority 3: Children and families' access and benefit from developmentally appropriate services and supports within collaborative, integrated community and health care systems.

Domain: Child

National Performance Measure (NPM): Medical Home (Percent of children without special health care needs ages 0 through 17, who have a medical home).

ESM: Number of children served in Title V-funded programs that parents report their child has a medical home.

Objective 3.1: Increase the percentage of families who participate in a Title V funded program that report their child has a medical home by 10% by 2030.

Strategy	Description
3.1.1	Explore community health factors (transportation, childcare, housing stability, etc.) impacting families' ability to obtain a medical home and increase resources and referrals to address them.
3.1.2	Partner with MCH programs and other community-based organizations to educate families on what a medical home is and why it matters.
3.1.3	Collaborate with the Kansas Chapter of the American Academy of Pediatrics to identify and address barriers to implementation of a medical home model.

Objective 3.2: By 2030, increase the percent of children, ages 9 through 35 months, who received a parent-completed developmental screening using a parent-completed screening tool in the past year to 45%.

Strategy	Description
3.2.1	Strengthen referral coordination through utilization of the Help Me Grow Centralized Access Point.
3.2.2	Promote evidence-based programs and initiatives for community and health care providers regarding healthy child development and early learning.
3.2.3	Develop resources, programs, and policies across local and state agencies that support early identification of mental health and developmental disorders such as DC:0-5.

Objective 3.3: By 2030, Increase the percentage of families who report being able to successfully navigate and obtain needed services for their child(ren) to 83%.

Strategy	Description
3.3.1	Develop and lead sessions to increase awareness and build skills in navigating systems like healthcare, early intervention, special education, and social services.
3.3.2	Equip MCH professionals with tools to communicate clearly and effectively with families, particularly about referrals and next steps for their child's care.

Priority 4: Ensure that adolescents and young adults have consistent access to and actively engage with comprehensive, patient-centered care that supports their physical, social, and emotional well-being.

Domain: Adolescent

National Performance Measure (NPM): Adolescent Well-Visit (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year).

ESM: Percent of adolescents and young adults (ages 12-17) enrolled in KanCare with a well-visit in the last year.

Objective 4.1: By 2030, increase the percent of adolescents, ages 12 to 17, that have had a preventive health visit, which included a behavioral health screening, in the past year to 60%.

Strategy	Description
4.1.1	Engage adolescent-serving programs and partners to promote the importance of an annual adolescent well visit to parents and adolescents.
4.1.2	Conduct annual provider education and technical assistance on Bright Futures guidelines for comprehensive adolescent care.
4.1.3	Develop protocols to identify behavioral health needs, support timely referrals and care coordination for adolescents/young adults and their families.

Objective 4.2: By 2030, increase the number of adolescents and young adults engaged in Title V funded programs and initiatives by 10%.

Strategy	Description
4.2.1	Utilize an existing youth council, or establish one if necessary, to create age-appropriate materials on health and wellness topics using a mix of media (websites, social media, printed materials, and school-based programs) and programs aimed to reduce risky behaviors while equipping youth with essential life skills for transitioning into adulthood, such as budgeting, independent living, continuing education, securing employment, stress management, and building healthy relationships.
4.2.2	Partner with state agencies and community-based organizations to raise awareness and promote resources aimed at reducing the stigma associated with mental illness, emotional challenges, and seeking treatment.

Priority 5: Individuals with SHCN, their families, communities, and providers have the knowledge, skills, and comfort to offer coordinated care and support transition.

Domain: Children with Special Health Care Needs

National Performance Measure (NPM): Medical Home—Care Coordination (Percent of children with special health care needs, ages 0 through 17, who receive needed care coordination).

ESM: Percent of youth with special health care needs, ages 0 to 17, who report receiving care coordination.

National Performance Measure (NPM): Transition (Percent of adolescents with special healthcare needs, ages 12 through 17, who received needed services to prepare for the transition to adult care).

ESM: Percent of youth with special health care needs, ages 12 to 21, who have one or more transition goals included on their action plan.

Objective 5.1: Increase by 5% the proportion of adolescents and young adults (ages 12–21) who actively engage with their medical home provider to assess health care transition needs and develop a documented transition plan to adult health care by the end of 2030.

Strategy	Description
5.1.1	Conduct training sessions on how to initiate and document transitions conversations and introduce/reinforce tools such as “Got Transition” six core elements framework.
5.1.2	Create a standardized workflow within the SHCN program that includes assessment of readiness and a transition plan and integrate transition checklists and planning templates into care coordination visits
5.1.3	Develop and distribute educational materials (e.g. pamphlets, videos, patient portal messages) about the importance of health care transition and encourage shared decision-making during visits.

Objective 5.2: Increase by 10% the number of individuals with Special Health Care Needs (SHCN) and their families who report receiving cross-sector care coordination, by 2030.

Strategy	Description
5.2.1	Assess current system functionality through surveys or focus groups.
5.2.2	Improve cross-sector collaboration by establishing or strengthening partnerships between health care providers, schools, community organizations, social services, and other relevant sectors.
5.2.3	Provide training for professionals on family centered, cross sector coordination and continuous quality improvement.

Priority 6: Strengthen workforce capacity and enhance public health systems by investing in training, infrastructure, and cross-sector collaboration, ensuring a skilled, adaptable workforce and resilient systems capable of addressing current and emerging maternal and child health needs.

Domain: Cross-Cutting Workforce Development

SPM: Workforce Development (Percent of MCH workforce reporting increased knowledge and skills in maternal and child health, health justice, data tracking, and data-informed decision-making following participation in a Title V activity.

ESM: Percent of participants reporting increased knowledge after attending a state-sponsored workforce development event.

Objective 6.1: Increase the percent of providers and local MCH agencies that report increased knowledge and comfort addressing emerging MCH issues by 2% annually through 2030.

Strategy	Description
6.1.1	Develop and deliver training programs that build core competencies, such as data literacy, health justice, cultural competency, and systems thinking.
6.1.2	Explore career pathways and mentorship opportunities to support professional growth and workforce retention.
6.1.3	Provide technical assistance and resources to support MCH local agencies in becoming trauma-informed organizations following national standards focused on safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; respect for cultural, historical, and gender issues.

Objective 6.2: Improve data collection at the state-level which can be leveraged by Title V funded agencies to inform their programs and policies.

Strategy	Description
6.2.1	Explore opportunities to increase data collection and sharing at the state-level.
6.2.2	Investigate integrated platforms for cross-sector data analysis to identify disparities, guide resource allocation, and inform evidence-based interventions.
6.2.3	Enhance access to community-level public health data to engage stakeholders, monitor outcomes, and ensure accountability for improving maternal and child health.

Priority 7: Resources and services that recognize and build upon existing family strengths are accessible to support healthy relationships and family well-being.

Domain: Cross-Cutting Family and Consumer Partnership

SPM: Parenting Supports (Percent of parents and caregivers reporting that they had someone to turn to for day-to-day support with parenting or raising children).

ESM: Increase the percent of family leaders who are actively engaged in state level programming.

Objective 7.1: Increase the percentage of state Title V activities and programs that engage with families and consumers to 10% by 2030.

Strategy	Description
7.1.1	Expand peer support networks for families and consumers.
7.1.2	Continue supporting the Family Advisory Council and integrate their individual experiences more robustly across Title V activities and programs.
7.1.3	Revise and relaunch the Family Delegate program.
7.1.4	Provide trainings, such as the Iowa Family Leadership Training and Storytelling, to families and consumers to increase confidence in using their individual experiences to advance family-centered change across the MCH field.

Objective 7.2: Increase the number of non-traditional MCH populations participating in Title V funded initiatives by 10% by 2030.

Strategy	Description
7.2.1	Conduct focus groups with fathers and other non-traditional MCH populations to develop a robust understanding of their needs and challenges as it relates to parenting.
7.2.2	Increase participating of fathers and other non-traditional MCH populations on the Family Advisory Council.
7.2.3	Partner with father-serving organizations across the state to address the unmet needs of fathers.