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)*

Well-Woman Visit Initiatives

Objective 1.1: Increase the proportion of women program participants receiving a high-quality, comprehensive preventive medical visit.

Well-Woman Promotion Efforts: The Women/Maternal Health Consultant continued to include a link to purchase Well Woman cards in the Tailored Resource Packet provided to MCH grantees, as well as a link to resources and recommendations developed by the Women's Preventative Services Initiative. The cards were also distributed at several conferences throughout the year, including the Governor's Public Health Conference and the Kansas Breastfeeding Conference. Order form for materials, including but not limited to Well-Woman cards were shared regularly during webinars with local MCH programs and partners.

Medicaid Policy Improvements: Kansas Medicaid began covering doula services on July 1, 2024. To support both our Kansas Medicaid partners and doulas, the Title V Women/Maternal Health Consultant developed a doula toolkit available on KDHE's website. The toolkit includes policy information, enrollment documents, and resources to promote doulas in English and Spanish. Additionally, Title V hosted a webinar on Doula Coverage and Support for Birthing Persons led by the Kansas Doula Alliance. This organization shared about the development of a Kansas Doula Directory, as well as trainings and enrollment support plans for doulas across the state.

Maternal Depression Screening (MDS): Effective January 2021, Kansas Medicaid (KanCare) adopted a Maternal Depression Screening (MDS) policy that supports an unlimited number of depression screenings to occur during pregnancy and the 12-months postpartum period. MDS services can be billed under the mother's Medicaid ID (CPT 96160) or under the child's Medicaid ID (CPT 96161). Title V developed a MDS Billing and Policy Guidance document to help increase awareness of and education for providers of the policy.

In partnership with KDHE Division of Health Care Finance (Kansas Medicaid) (DHCF), Title V completes an annual analysis of MDS claims submitted. In the first three years of the policy change (2021-2023), over 12,000 individuals have been screened for depression during pregnancy or 12-months postpartum period. Of these, 23% were billed under the mother's Medicaid ID and 77% were billed under the child's Medicaid ID. On average, each individual was screened twice (24,824 MDS claims were processed from 2021-2023). Following trends in 2021 and 2022, 2023 MDS services were predominantly provided by physicians and billed under the child's Medicaid ID (70%). Additionally, of the 4,343 women screened in 2023 (CPT 96160), 235 received a psychiatric evaluation following the screening (5.4%). About half (48.7%) received a psychiatric evaluation at a Certified Community Behavioral Health Clinic (CCBHC).

Based on findings, several opportunities for quality improvement have been noted: 1) to increase education on recommendations from various professional organizations on screening recommendations (e.g., ACOG recommends screening for perinatal depression and anxiety at the initial prenatal visit, later in pregnancy, and at the postpartum visit; AAP recommends screening for maternal depression by 1-month and at the 2, 4, and 6-month pediatric visits; PSI recommends screening for perinatal mental health disorders at the first prenatal visit, at least once in the second trimester, at least once in the third trimester, at the first postpartum visit, at the 6 and/or 12-months in OB and primary care settings, and at the 3, 9, and 12-month pediatric visits); 2) to increase education with prenatal care providers about the availability of Medicaid reimbursement for MDS services provided, potentially clarifying that MDS is not packaged in the maternity global fee; and 3) increase timely access to quality services provided by CCBHCs in Kansas.

Several activities were facilitated during this Report period aligning with identified quality improvement opportunities for MDS:

- As part of the Third Thursday Webinar Series, and in alignment with Maternal Mental Health Awareness Month (May), the MCH Behavioral Health Director facilitated a *Maternal Mental Health Screenings, Reimbursement, and Clinic Workflow* presentation with MCH ATL Grantee, Barton County Health Department. The presentation included resources, policy information, and data review, highlighting the screening frequency recommendations and opportunities to increase the number of times a perinatal individual is screened. Barton County HD was invited to co-facilitate as, of the 2023 beneficiaries who were screened (n=4,361), 10% were screened by a public health agency. Of those, 33% were screened by Barton County HD (n=146). Barton County HD shared their training plan, program workflow, and billing protocol with the goal of other MCH ATL programs being able to replicate their process, thus increase the number of MDS claims submitted in 2024 by public health agencies. 117 providers registered for the session and receive a link to the webinar recording; 47 attended the live event.
- The MCH Behavioral Health Director, a perinatal psychiatrist, and a clinician from a CCBHC (Bert Nash) co-facilitated a perinatal mental health training at an all-CCBHC webinar. The presentation focused on perinatal system transformation (e.g., KanCare MDS coverage, Postpartum Medicaid Extension) and treatment best practices as a call to action for CCBHCs to become trained in perinatal mental health to better meet the needs of the perinatal clients they treat. A clinician from Bert Nash shared how they have integrated specific programs for perinatal clients into their services, as well as recognizing perinatal individuals as a priority population. About ninety providers attended the live session.
    - As a follow-up to this training, staff from KDADS looked into MDS billing for CCBHCs, as it was mentioned CCBHCs could not be reimbursed by Medicaid for MDS services. In working with KDADS and DHCF, it was discovered that there were coding issues within the KanCare claims processing system for MDS. CPT 96160 was coded correctly, but 96161 was not. DHCF worked with their contractor to resolve the issue making 96161 a CCBHC “trigger code” for their negotiated prospective-payment system (PPS) rate. The MDS Policy and Billing Guidance was updated accordingly. This resolution should help increase CCBHC willingness to administer MDS and provide timely, quality care.

Through the Kansas Connecting Communities (KCC) program, three one-day trainings were facilitated in Summer 2024 in Kansas City (urban), Wichita (urban) and Hays (rural) focusing on perinatal behavioral health screening implementation, including MDS and SBIRT billing/reimbursement opportunities. 25 providers were trained through this opportunity. Partnered with the Kansas Academy of Family Physicians (KAFP) for Dr. Oller, family physician and maternal mental health physician champion, to facilitate a Maternal Depression Screening virtual training. This was a 1-hour training to the KAFP member network with a goal of increasing awareness of the KanCare MDS policy to increase the number of claims submitted by family medicine physicians. Only 10 physicians attended the live training, however it was recorded and KAFP is working to secure Enduring CEs and will make the recording available to their members for a year.

Substance Use Screening: KanCare adopted a [Substance Use] Screening, Brief Intervention, and Referral for Treatment (SBIRT) policy in 2013 (updated in 2017). For the first time, Title V worked with KDHE Division of Health Care Finance (DHCF) (Kansas Medicaid) to obtain an SBIRT claims report. The received report included SBIRT claims (CPT codes 99408, 99409, H0049 and H0050) for 2019-2023 (included all claims, not specific to perinatal beneficiaries). Overall, there is a very low number of claims:

	2019	2020	2021	2022	2023
SBIRT Claims	150	206	130	318	379

Title V hypothesized that low claim count could be due to unawareness of the reimbursement policy. To help increase provider education, a SBIRT Billing and Policy Guidance resource was created and published as part of the Perinatal Substance Use Toolkit. The resource outlines the components of SBIRT, training requirements to bill for SBIRT services, approved provider types, covered places of service codes, allowable CPT codes, and available resources. DHCF agreed to provide SBIRT claims annually, along with the MDS claims report for ongoing monitoring and quality improvement opportunities. Further, Title V submitted a SBIRT Policy Change Request to the Kansas Department for Aging and Disability Services (KDADS), the Behavioral Health Authority in Kansas. The policy request asked for two changes:

1. Lift the screening frequency restrictions. Currently, only one screening annually is reimbursable by Medicaid, limiting billable services from occurring during pregnancy and the 12-months postpartum period.
2. Include a validated substance use screening tool for perinatal populations as an approved tool under the KanCare SBIRT policy. Currently, only the CRAFFT 2.1+N is approved and validated for perinatal populations however the age validation is only through 21 years old.

The policy change request is under review by KDADS leadership.

Transforming Maternal Health: KDHE Division of Health Care Finance (DHCF) led activities to apply for CMS' Transforming Maternal Health (TMaH) Model program. This is a 10-year (1/20/25 - 1/19/35) project with 15 awards available ($17 million per recipient) supporting a 3-year pre-implementation period followed by a 7-year implementation period. The TMaH Model is organized into three pillars designed to address the key issue areas that affect maternal health outcomes: Pillar 1: Access, Infrastructure and Workforce; Pillar 2: Quality Improvement and Patient Safety; Pillar 3: Whole-Person Care Delivery. DPH supported application drafting by aligned public health programs within the transformation proposal, capturing initiatives such as AIM Patient Safety Bundle work led by KPQC, MMRC, doula coverage, CHW integration, supporting the behavioral health needs of perinatal individuals (KCC), addressing IPV concerns and SDOH (MAVIS), home visiting, and prenatal education. (We received notification in December 2024 that our application was successful!)

Maternal and Infant Health Roadmap: In 2024, KDHE formed an internal state Maternal and Infant Health Workgroup to identify the cross-sector of efforts and objectives that the Division of Public Health and Division of Health Care Finance pursue. The workgroup included the two co-Bureau Directors of the Bureau of Family Health and the Title V MCH Director. The mission of the workgroup was to build recommendations around maternal and infant health initiatives that would need Medicaid support and Public Health infrastructure to implement. Roadmap objectives for the recommendations include access to care, increased data transparency that drives initiatives, and workforce development.

- Access to care: Health care access is the ability to obtain healthcare services such as prevention, diagnosis, treatment, and management of diseases, illness, disorders, and other health-impacting conditions. For healthcare to be accessible it must be affordable and convenient.

- Data utilization: Utilizing data transparently on a continuous basis to drive policy and public health programming that improves health outcomes for maternal and infant populations strategically and with cost savings.
- Workforce development: Improve health outcomes by enhancing training, skills, and performance and building capacity through developing infrastructure that allows for the efficient use of funds.

Actions to achieve these recommendations may require legislation or further study of the data which would require research and time. Timeframes were included in the roadmap's three-year plan, indicating when each recommendation would begin implementation. The workgroup's roadmap was driven by the collective vision that investment into the health and well-being of our Kansas mothers and families is the sustainable way to bring measurable and lasting outcome.

Perinatal Mental Health Initiatives

Objective 1.2: Objective 1.2: Increase the proportion of women receiving education or screening about perinatal mental health during pregnancy and the postpartum period.

Kansas Connecting Communities (KCC): Mental Health conditions are the most common complication of pregnancy and childbirth and are a leading cause of maternal mortality and morbidity, both nationwide and in Kansas. These conditions are commonly referred to as "Perinatal Behavioral Health conditions" and include depression, anxiety, and substance use disorders. They can occur during pregnancy or up to one year postpartum and affect the health and wellbeing of the whole family. Anyone who is pregnant or postpartum is at risk of experiencing a perinatal behavioral health condition, but biological, psychological, and social stressors may increase risk.

It is the responsibility of all healthcare providers to universally educate and screen every pregnant and postpartum patient for behavioral health conditions and connect them to support and treatment when indicated. In recognition of World Maternal Mental Health Month, an Action Alert was created to increase awareness and issue a call to action for all perinatal providers to incorporate best practices for screening and education into their care, take part in public awareness campaigns, and work to ensure all the moms in your life and community have the support needed to be healthy and well.

Managed by the MCH Behavioral Health Director and funded by the HRSA Maternal Mental Health and Substance Use Disorder (MMHSUD) (originally awarded in October 2018, re-awarded in October 2023), Kansas Connecting Communities (KCC) strives to increase health care providers' capacity to screen, assess, treat, and refer pregnant and postpartum women for depression, anxiety, and substance use disorders. KCC is a partnership between the Kansas Department of Health and Environment (KDHE), the University of Kansas Medical Center Research Institute (UKMCRI), University of Kansas Center for Public Partnerships and Research (CPPR), and Postpartum Support International (PSI; Kansas Chapter).
KCC provides tailored support services directly to perinatal providers to increase their capacity and confidence to deliver evidence-based behavioral health care through three components:

- **Education**: Trainings and toolkits for perinatal PCPs on evidence-based guidelines for early identification through universal screening practices, assessment, brief intervention, treatment, referral, and monitoring following evidence-based, culturally and linguistically appropriate, trauma informed, and patient-centered services.
- **Consultation**: Real-time psychiatric consultation between a provider and the KCC Perinatal Behavioral Health Team, which includes a peripartum psychiatrist, addictions

psychiatrist, an obstetrician-gynecologist with perinatal mental health certification, and a social work care coordinator.

- **Resource and referral support**: Linkages with community-based mental health resources including individual and group therapy, support groups, and other resources to support health and wellness.

Throughout this Report period, KCC continued its robust and multimodal training program facilitating several workforce development opportunities. In total, over 500 professionals were trained from October 2023 – September 2024; 200 of these providers participated in multiple trainings. A summary of key training activities:

- *Kansas Moms In Mind (KMIM) Case Consultation Clinics*: KCC facilitated bi-monthly virtual case consultation clinic that includes a brief training presentation by a member of the KCC clinical team. This Project ECHO style session will serve as an opportunity for perinatal providers to discuss de-identified clinical cases about screening, assessment, treatment, referral, and management of perinatal individuals. In this "all-teach all-learn" environment, all attendees can gain knowledge, skills, and increased comfort in caring for perinatal individuals with behavioral health conditions. The aim for the Case Consultation Clinic is to establish an additional method for consultation, thus increasing accessibility of the KCC clinical team's expertise. Targeted providers for this training opportunity are prescribing physicians (e.g., OB/GYN, Family Medicine), and training content will focus on perinatal prescribing best practices and increasing practitioner comfort in developing and support treatment plans, but no provider types are excluded from attendance. Topics covered during this Report period includes acute stress disorder, perinatal medication management, antipsychotics in the perinatal period, and ADHD.
- *Bi-Monthly Webinars*: In partnership with the Kansas Chapter of PSI, three live, one-hour, virtual training opportunities were made available. Additionally, two live, two-hour, virtual "advanced" trainings were also facilitated. Session presenters are recruited by the PSI-KS board and include local and national experts. Topics covered during this Report period: Emotions After Abortion; A Deep Dive into the World of Perinatal Relationships (and Coming Up for Air); Therapeutic Insights for Working with Foster and Adoptive Families; Lactation for Mental Health Providers: The Fundamentals; and The Village Circle Approach: An Overview of the Hakima Tajunzi Payne's Afro-Centric Group Prenatal Care Model.
- *Ad Hoc Training Requests*: KCC offers free perinatal mental health and substance use trainings (virtual and in-person) by request of any perinatal provider, program, or clinic. Training requests can be made by calling the toll-free provider consultation line (1-800-332-6262). Some of the trainings facilitated during this Report period include:

    - Perinatal Mental Health training for University of Kansas School of Medicine's Pediatric Residents (12 physicians trained)
    - Perinatal Substance Use Education, Intervention, and Conversations for Becoming a Mom (BaM) programs to increase perinatal behavioral health education and intervention and awareness of bias, stigma, barriers, and harm reduction opportunities (96 attendees)
    - Perinatal Substance Use Screening and Implementation as part of Overland Park Regional Medical Center's Birth It Forward Conference (25 attendees)
- *Perinatal Mental Health Training Scholarships*: In partnership with PSI-KS, KCC offers, administers, and manages scholarships for perinatal providers to cover registration costs for external trainings, such as those offered by PSI, Centimano Counseling, and Mass General. The PSI-KS Board of Directors identified quality evidence-based trainings that will expand provider competency in perinatal mental health conditions. This includes, but is not limited to, trainings that included on the approved list as part of the Perinatal Mental Health Certification (PMH-C) process. PSI-KS developed scholarship criteria prioritizing providers in all geographic regions who work with vulnerable populations (e.g., low-income, uninsured/underinsured). Scholarship recipients will complete a pre/post self-efficacy survey to measure knowledge, skills, and confidence changes based on the training. During this Report period, 157 training scholarships were made available to 131 Kansas providers. The most requested training to be covered by the scholarships were:
    - PSI Perinatal Mood Disorders 2-Day Components of Care (60 scholarships)
    - PSI Advanced Psychotherapy (20 scholarships)
    - Seleni: Bundle Perinatal Loss and Grief and PMADs (16 scholarships)
    - PSI Advanced Psychopharmacology (12 scholarships)

As part of its robust educational services array, KCC provides technical assistance (TA) to clinics, birthing facilitating, and local programs. TA includes meetings (onsite or via telephone or video call) and follow-up communications to assist with planning, implementing, or improving processes or policies related to perinatal behavioral health screening, brief intervention, and referral or treatment. This can include reviewing current processes or policies, brainstorming solutions, problem solving pain points, providing resources and best practice recommendations. TA is facilitated by programmatic support team and one or more members of the Perinatal Behavioral Health Team, depending on the specific needs expressed by the clinic or hospital. During this Report period, fourteen agencies, serving a combined total or more than 17,000 perinatal patients annually, participated in TA activities with KCC. Of these, only 2 had a screening and referral process in place at the time of requesting TA. Fifty percent of the requests were for support on universal screening implementation; 36% were for aligning screening and referral procedures following best practice guidelines, and 14% were more in-depth TA (e.g., coordinating screening across inpatient and outpatient settings, building referral partnerships, or improving EHR/billing processes).

Developing a system to fully support the holistic needs of perinatal individuals requires more than workforce development training opportunities. As an alternative modality to supporting perinatal professionals in providing mental health care within their practice, KCC established and launched a centralized access point (Consultation Line), for use by all perinatal providers in Kansas, in March 2021. The KCC Social Worker triages all inquiries (e.g., calls and emails) to the Consultation Line and connects the provider to support needed, including resource and referral support, connection to KCC training and technical assistance resources, and provider-to-provider case consultation with the clinical team, as needed. When a provider requests a case consultation, University of Kansas Health System practitioners on KCC clinical team work to provide consult within 1-business day: Dr. Erin Bider (peripartum physiatrist) and Dr. Tara

Chettiar (board-certified OB/GYN with PMH-C). Case consultations predominately focus on diagnostic support, treatment planning, and medication and dosage recommendations.
The KCC Social Worker also provides resource and referral assistance through the Consultation Line and program outreach activities. This includes offering support identifying and referral for a mental health or substance use assessment following a positive/at-risk screening, answering questions and sharing best-practice recommendations related to perinatal behavioral health identification and intervention, and coordinating practitioner-to-practitioner case consultations and training requests with the clinical team.

Further, KDHE contracted with PSI-KS to promote, vet, and enhance the Kansas Maternal Behavioral Health Provider Directory. PSI-KS has developed an application to collect information from Kansas providers with special training or expertise in the perinatal period. The application requires providers to share their demographic information to help make referrals for people who prefer to see providers with the same identity as them (e.g., gender identify, race/ethnicity, language), as well as treatment provision (e.g., professional role/provider type, certifications, catchment area, availability of telehealth services, accepted insurance types, years of experience treating perinatal populations). As part of the vetting process, PSI-KS assesses the qualifications, experience, and continuing education needs of the providers completing the application. The Directory is shared between the KCC Social Worker as a resource for Consultation Line inquiries and with PSI-KS Support Coordinators who triage calls from perinatal individuals seeking support to ensure both perinatal providers and individuals can receive referral options to a behavioral health treatment provider with perinatal specific training.

Additional information about maternal/perinatal behavioral health activities and KCC are included in the Cross-Cutting Report.

Maternal Mental Health Treatment Project: To further increase the identification of postpartum women experiencing perinatal mental health disorders and improve access to mental health treatment (counseling/therapy), Title V partnered with Russell Child Development Center (RCDC) on a Maternal Mental Health Treatment Pilot Project (May 2021 – June 2024). RCDC is a Part C, Infant Toddler Services program, that provides early childhood services in 19 rural/frontier counties in Southwest Kansas. All 19 counties are designated Mental Health Provider Shortage Areas, and timely access to quality perinatal mental health treatment is limited. The aim of the pilot is to increase the availability, accessibility, and affordability of evidence-based maternal mental health treatment services by:

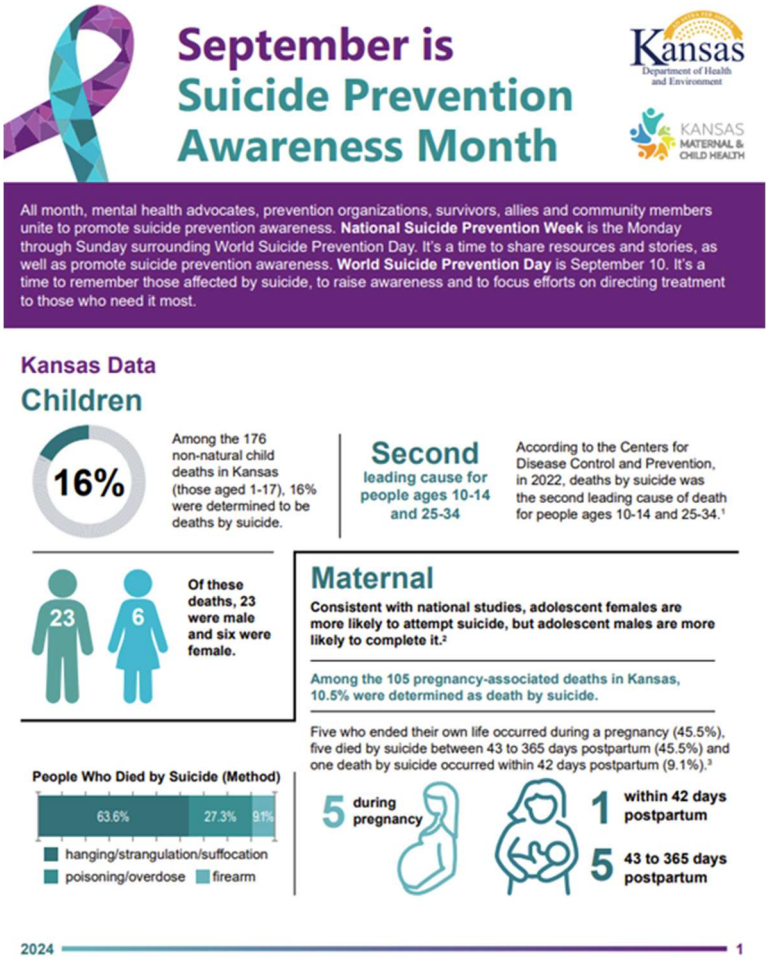
- Increasing timely detection, assessment, and treatment of perinatal mental health disorders in postpartum populations using evidence-based practices.
- Increasing RCDC staff capacity to provide maternal mental health specialty treatment services to caregivers of children participating in RCDC services; and
- Supporting infrastructure development and create a replicable and sustainable model for addressing maternal mental health conditions through early childhood systems.

RCDC employs two licensed master's social worker's (LMSW) who obtained their Perinatal Mental Health Certification (PMH-C) during the pilot. The clinicians accept referrals for treatment from RCDC program staff after screening for risk of experiencing a mental health condition is administered. Maternal mental health therapy services were made available in-person and by telehealth and in collaboration the individuals' healthcare providers to coordinate comprehensive care for the caregiver and the family. The pilot allowed infants and toddlers (0-3) and their caregivers to receive therapeutic services from one organization. While reducing barriers in accessing care, the pilot also increased local capacity by expanding the mental health professional network and subject-matter expertise in a mental health professional shortage area. On-site interactive training was provided to the entirety of the staff at RCDC where best

practices and prevalence were presented, and the referral process was refined in a collaborative all-staff meeting with guidance from MCH staff and KCC facilitators. To support sustainability, RCDC has established a Medicaid billing process for screening and referral treatment and applied for 2024 MCH aid-to-local funding (awarded). The RCDC team reports positive experience in engagement and treatment but has experienced challenges in the billing and reimbursement process. These challenges have been largely clerical, with rejected claims resulting in troubleshooting for billing identification. RCDC continues to explore alternative opportunities to expand their maternal mental health treatment services array.

Local MCH Agencies: The University of Kansas School of Medicine-Wichita Center for Research for Infant Birth and Survival's (CRIBS) Baby Talk Program (a local MCH/Becoming a Mom Program) received a mini grant to offer 'Growing Hope Mental Health Kits' for pregnant participants. Kit recipients were offered the resource if they screened positive for perinatal depression, anxiety, or substance use or disclosed a pre-existing diagnosis of depression or anxiety. The Kits are a result of collaboration between CRIBS and Wichita State University's Health Outreach Prevention and Education Services, which has been distributing similar mental health kits since 2015. CRIBS adapted these kits and made changes for the perinatal population with guidance from Kansas Title V and Kansas-based perinatal mental health experts. The Kits include: a HOPE box, love letter explain the box and its content, gun and medication locks, an activities flash card deck, an adult coloring book, the book "Good Moms Have Scary Thoughts" by Karen Kleiman, the National Maternal Mental Health Hotline promotional material, and other state and local resources. Grant funding supports distribution of up to 250 Kits; distribution began in Fall 2024.

Maternal Suicide Prevention: Among the 105-pregnancy-associated deaths in Kansas (2016-2020), 10.5% were determined as death by suicide. To increase awareness of the critical public health issue, an Action Alert was created recognizing September as Suicide Prevention Awareness Month. The Action Alert highlighted Kansas specific data for the adolescent and perinatal populations and key resources. There was a call for action that integrated the #BeThe1To five action steps to help someone who might be experiencing a crisis. These steps have been proven to help others find hope and support. Several social media posts, in English and Spanish, were also included in the Action Alert.



MMH Report Card & Government Fellows: The Policy Center for Maternal Mental Health released the 2024 Maternal Mental Health Report Cards. This is a comprehensive view into the state of maternal mental health in America. Kansas earned an overall grade of D. The Report Cards grades states in three domains: Providers and Programs (Kansas = D), Screening and Screening Reimbursement (Kansas = F), and Insurance Coverage and Treatment Payment (Kansas = C).

To begin addressing improvement areas outlined within the Report Card, KDHE Division of Public Health connected with leaders in the KDHE Secretary's Office and the Kansas Department for Aging and Disability Services (KDADS) and applied to participate in the 2024-2025 Maternal Mental Health Government Agency Policy Fellows Program. The application was successful! Throughout the Fellowship, participants will learn federal 'state of the state' in MMH, federal agency programs addressing MMH, review of state-level data, Zero Suicide Framework, public awareness campaigns, best practices, and racial and rural disparities. A work plan will be created during the Fellow Program, but potential work plan includes strategies to improve our Maternal Mental Health Report Card grade (e.g., incentivizing maternal depression screening HEDIS measures) and other Medicaid policy enhancements (e.g., coverage of perinatal anxiety screening and SUD screening policy improvements).

CARA Workgroup: The Kansas Department for Children and Families (DCF) restarted their Comprehensive Addiction and Recovery Act (CARA) Workgroup in July 2024 to include

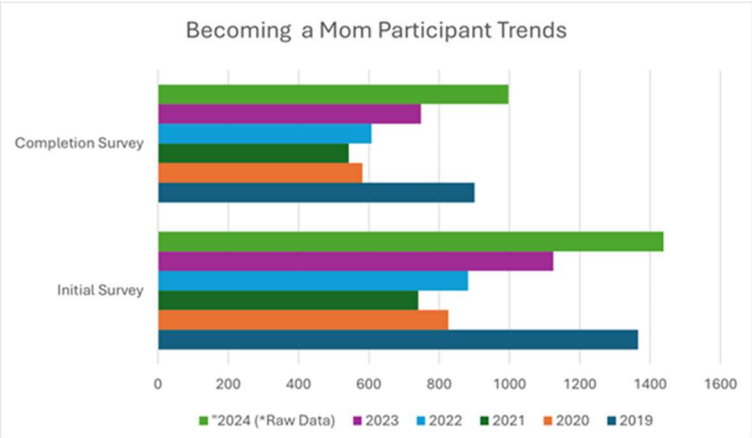
Reporting Center, Child Protective Services, Program and Policy, Families First, staff Family Preservation staff ranging from direct service workers to Directors, while also including the KDHE MCH Behavioral Health Director and a member of the KCC Team. For reference, CARA legislation reads "(A) to enhance flexibility in the use of funds designed to support family-based services for pregnant and postpartum women with a primary diagnosis of a substance use disorder, including opioid use disorders; "(B) to help State substance abuse agencies address identified gaps in services furnished to such women along the continuum of care, including services provided to women in nonresidential-based settings; and "(C) to promote a coordinated, effective, and efficient State system managed by State substance abuse agencies by encouraging new approaches and models of service delivery." The workgroup will ensure Kansas is meeting CARA requirements and will review and discuss opportunities to improve policy and procedure for Prevention and Protection Services and Assessment and Prevention programs.

Prenatal Education and Support Services Initiatives

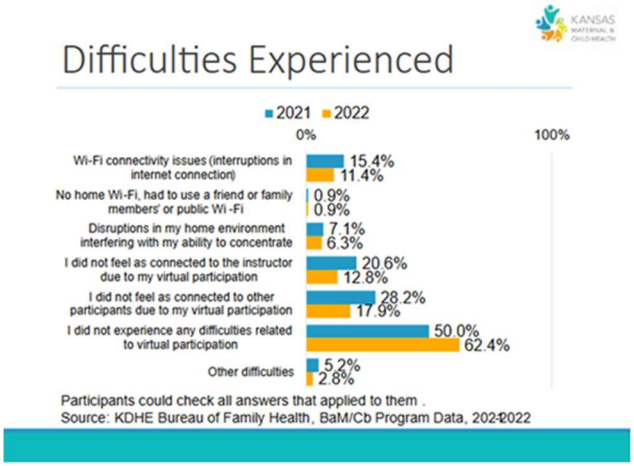
Objective 1.3: Increase the proportion of high-risk pregnant women receiving prenatal education and support services through perinatal community collaboratives.

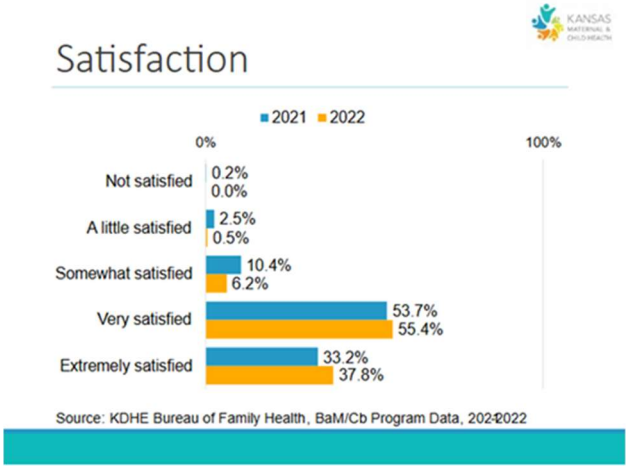
Prenatal Education (BaM/Cb) Program Support for Growth and Sustainability: With proven success, Kansas MCH remains committed to infrastructure development that supports implementation and sustainability of the Becoming a Mom® (BaM) / Comenzando bien® (Cb) prenatal education program. KDHE's Title V commitment to this program is greater than just increasing the number of BaM programs across the state. Rather it is our desire to support the model through continuous improvements that ease the burden of local implementation as well as improving reach and relevance for all populations, especially those at most risk of poor health outcomes. Continual growth and sustainability are priority.

For historical context, efforts throughout FFY2023 were largely focused on reinvigorating local efforts that had suffered greatly during the pandemic. Fallout from the pandemic had not only left local coalitions/collaboratives struggling to reengage partners and program participants, but it had also left many BaM programs unstaffed and in mere survival mode. Following P/I Consultants' support to stabilize and rally existing programs in FFY2023, FFY2024 has been a year of renewed energy and growth. Recent data trends on program participation are promising and demonstrate the impact of these support efforts. The below graph shows program enrollment (Initial Survey) and program completion (Completion Survey) rates pre-through-post pandemic, depicting the huge impact the pandemic had on participation rates and the tremendous recovery that programs have made in the past two years since the end of the pandemic.



Part of these efforts have included analysis of program data comparing virtual vs. in-person participation, to help guide implementation mode options moving forward. While the pandemic created a need for virtual services, it also increased a preference for this format of learning, as well as removed barriers such as transportation, distance and childcare access. While wanting to support virtual expansion for these reasons, outcomes comparison between the two modes needed to be assessed to make sure there were no negative ramifications among virtual participants such as a lower degree of knowledge gain or behavior change. Contrary to initial concern, results of analysis in July 2024 found statistically significant increases in knowledge and optimal behavior for most health topics (2021-2022 program data). This suggests that the virtual option offers equitable gains in knowledge compared to in-person participation and hence supports continued provision and expansion of this mode of delivery. Interestingly, differences in answers to specific questions between modes of participation were noted and will prompt further review for future quality improvement. Over time, we will continue to monitor participant satisfaction and differences in knowledge gains between modes to identify any area of need for additional adaptation, TA and support. The below two figures show ratings of difficulties experienced and overall satisfaction with the virtual mode. Worth noting is the significant improvements from 2021 to 2022, indicating programs' ability to quickly adapt and improve this new mode of service delivery. View the full report for more information on participant demographics by mode of participation, post-course changes in knowledge and behavior, as well as participants' feedback about their experience with virtual learning.



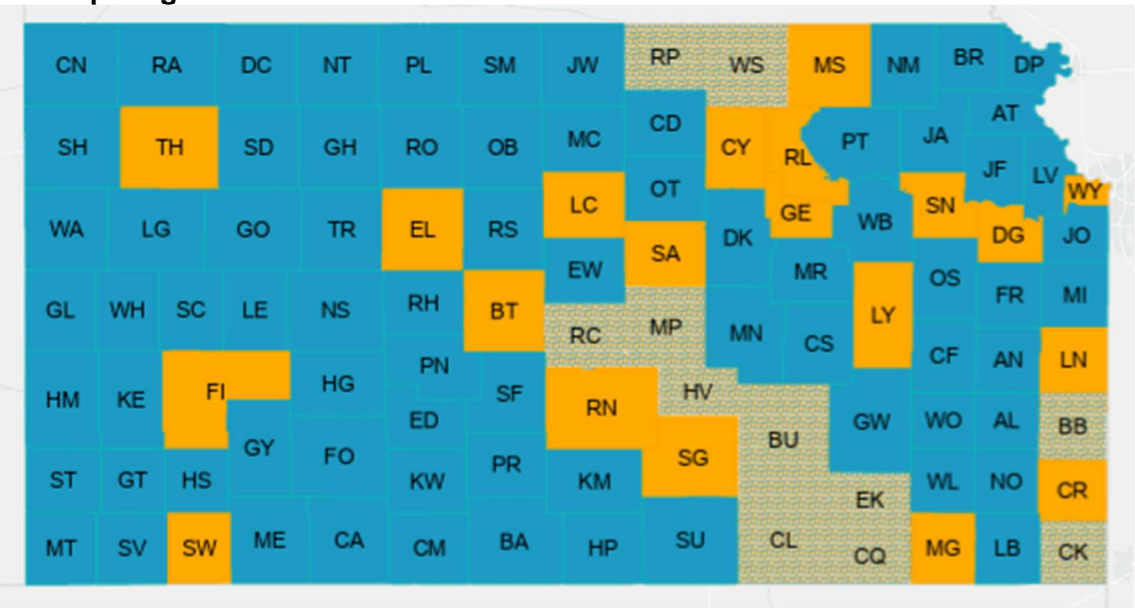


With the above data in mind, expansion during FFY2024 has been focused primarily on regional expansion through in-person and virtual class offerings in communities surrounding lead BaM sites. Expansion sites include the following:

Lead Site	Regional Expansion Site
Crawford County	Cherokee County; Bourbon County (hybrid – virtual from lead/in-person local)
Marshall County	Washington County (in-person & virtual)
Saline County	McPherson County (in-person); Republic County; Rice County (virtual)
Sedgwick County	Butler County; Chataqua County; Cowley County; Elk County (virtual); Harvey County (in-person & virtual)

As the below map depicts, these regional expansion sites are indicated with yellow hatching. This map can be accessed on the Participating Communities webpage, where an online referral form is located. The map is interactive, with program information populating the drop-down menu based on selected location. Additionally, virtual statewide access for all KanCare members is promoted and provided by our Sedgwick County program, locally branded as “Baby Talk”, through a partnership with state MCO Aetna. Many existing program sites who do not have capacity to offer the program in Spanish, refer to Baby Talk for their virtual program, while Baby Talk refers back to local in-person programs when a KanCare referral is received for a member located near a lead site. Upon much success, Baby Talk requested Title V funding for SFY2025 to support the service of any non-Medicaid pregnant persons residing outside an existing BaM service area in the state.

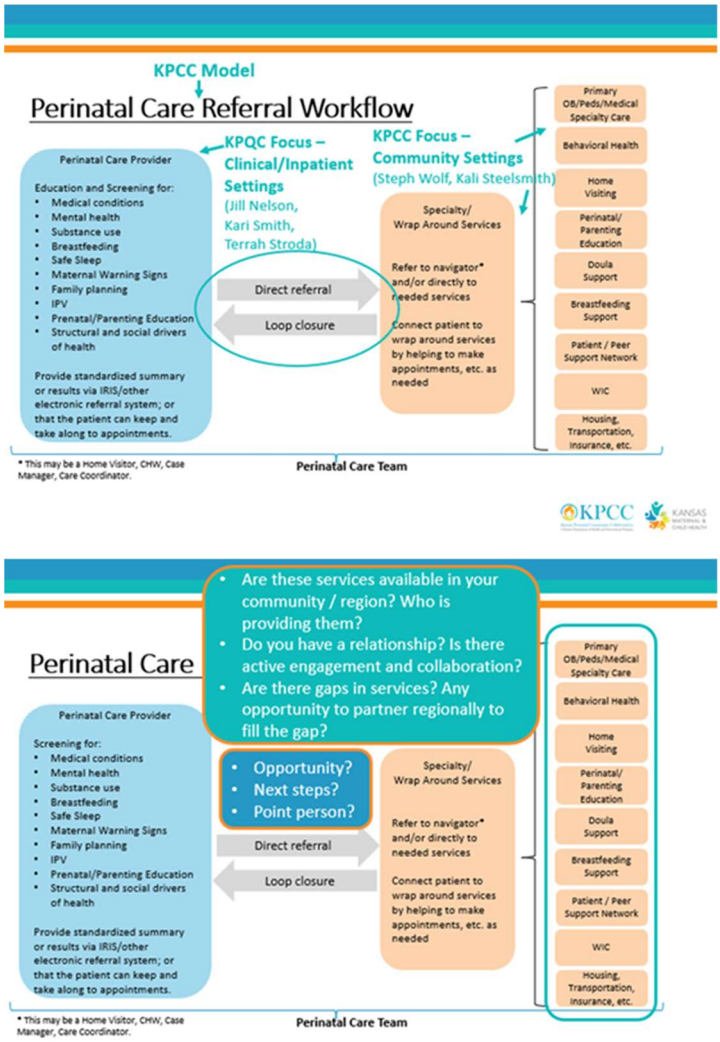
Participating Communities



KPCC Model Support and Expansion: Kansas MCH remains committed to supporting the expansion and sustainability of the KPCC initiative, providing training and technical assistance on community collaborative development and MCH program integration, as well as offering additional services and mechanisms to support the work of communities who’ve been historically disenfranchised and marginalized. KDHE’s Title V commitment to this model is greater than just increasing the number of KPCCs across the state; rather we support the model by strengthening the perinatal collaborations within local communities, as well as growing the programs and initiatives they implement in response to their local data, direct experience, and identifying areas of focus. Efforts in the past year focused on learning more about each community’s systems, programs, efforts, and challenges, and as needed, assisting with the reengagement and commitment of collaborative partners. Additionally, emphasis was placed on building/rebuilding regional partnerships to identify and begin filling gaps in MCH services that exist within regions. As rural and frontier regions face hospital closures, loss of OB providers, mental health and home visiting service shortages, etc., collaboration is needed now more than ever to assure access to needed services.

To support such collaboration, joint Fall Regional Trainings were kicked off September 30th and held in six regions of the state, combining MCH Home Visiting Programs and KPCCs. The afternoon portion was focused on the KPCC model, identifying roles within the clinical/inpatient

setting that are being supported by KPQC efforts, and roles of specialty and wrap around services provided in the community setting. Emphasis was placed on building partnerships to assure all needed services are accessible within a region and creating direct referral and loop closure systems to limit the probability of individuals falling through the cracks. Group activities supported locals in identifying gaps in services, opportunities for collaboration and filling these gaps, as well as next steps and point persons for continuation of these efforts upon return home from the training.

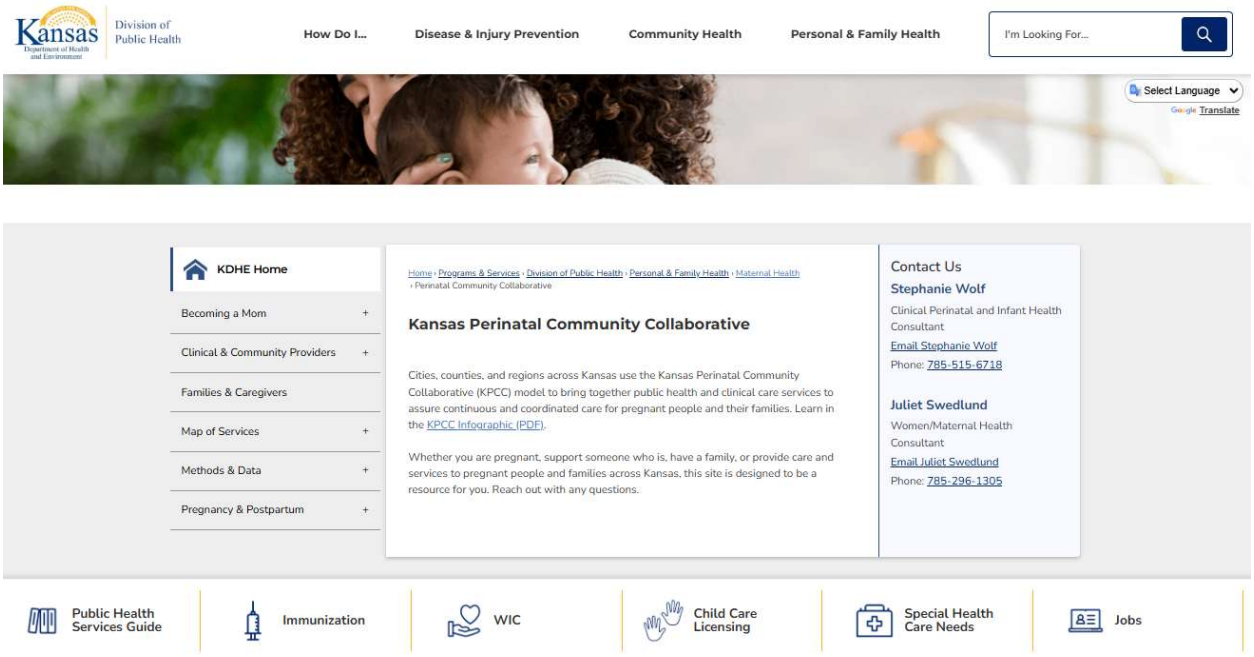


Further supporting local efforts, Title V has invested in piloting a training series that aims to support locals in building collaborative development skills to assist them with their community health and development work. See more details on this in the Cross-Cutting report, under the Title V Academy section.

Each community is unique in its population, services, and challenges. Furthermore, development of the KPCC model seeks to create individualized support melded with a group-setting focused conversation that facilitates connection to, and/or development of, programs, services, resources, and technical assistance. As well, strategic education about, and connection to, alternative community care providers, such as community-based doulas and

Community Health Workers, is integrated into the model, as these providers serve as the arms and legs of a community, often having a trusted connection to the families they serve, resulting in more positive health outcomes when their support is involved.

Compilation and development of resources for regional and statewide implementation of KPCCs continues, which ensures both growth and sustainability of the initiative. The KPCC website serves as an access point to introductory information about the initiative. Full website redesign and expansion was completed during this reporting period. The website now includes tabs for "Clinical and Community Providers", "Families and Caregivers", Pregnant and Postpartum" individuals, as well interactive maps for accessing services. Additionally, it includes a "Methods and Data" page which provides resources for communities to access local data and to act on this data. The KPCC infographic, accessed from the KPCC website, continues to be used to aid communication and recruitment of new communities.



These efforts have continued despite a six-month vacancy in the Perinatal/Infant (P/I) Consultant position, as the P/I Consultant present at the beginning of the FFY transitioned to the Women/Maternal Consultant role in April 2024. This internal transfer of position has helped to support cross domain collaboration and continuation of efforts. A new P/I Consultant was hired in September 2024 and is now funded by Maternal Health Innovation grant to focus on strengthening of KPCC efforts at the local level, with an emphasis on increasing engagement of outpatient clinical perinatal care providers.

Addressing Disparities in Access to Prenatal Care and Education: Since inception in 2010, KPCCs have been a driving force behind improving birth outcomes in Kansas. In two of the longest running sites, infant mortality has decreased from pre-implementation to post-implementation. The Geary County infant mortality rate has decreased significantly from 11.9 infant deaths per 1,000 live births in 2005-2009, to 5.8 in 2019-2023. The Saline County infant mortality rate has decreased from 9.0 infant deaths per 1,000 live births in 2005-2009, to 6.1 in 2019-2023.

Infant Mortality Rate (Deaths per 1,000 live births)	Geary Collaborative (established July 2012)	Saline Collaborative (established Jan 2010)
2005-2009	11.9 (8.6-16.0)	9.0 (6.3-12.3)
2019-2023	5.8 (3.8-8.4)	6.1 (3.7-9.6)

Source: KDHE Bureau of Epidemiology and Public Health Informatics, Kansas birth and infant death data (resident)

Data from the 2023 BaM Aggregate State Report highlights the program's reach of disparity populations (see BaM Infographic), which is a target of Kansas Title V services. According to the report, mothers receiving education through the BaM prenatal education program were more likely than other mothers giving birth in the state to be racial/ethnic minorities; younger; lower education level; enrolled in WIC; and covered by non-private insurance. The education sessions and associated activities are aimed at improving pregnancy health and infant health outcomes for all Kansas mothers but are particularly targeted at disparity populations. Interestingly, with implementation of virtual sessions, the number of higher educated and privately insured participants has grown drastically, contributing to a bit of a shift in the demographics of the population served.

As mentioned previously, virtual prenatal education became a necessary option during the COVID-19 pandemic and has since become a mainstay option in most communities due to it improving program access. Resources continue to be built upon to support this mode of implementation, including a SMS text version of evaluation forms that were piloted with BaM programs January-June 2024. Having much success in the pilot phase, and upon request by local programs, screening forms as well as all forms in Spanish will soon be available through the SMS feature. Infrastructure components such as this are continuing to be improved, supported, and grown, to reach populations where programming and services are not currently available locally. As part of these efforts, during FFY2023, the Sedgwick County BaM program (locally branded as "Baby Talk") began a partnership with Aetna, a managed care organization, to begin offering the BaM program virtually to any pregnant Medicaid member who resides outside an existing BaM service area in the state. During the FFY24 reporting period, 107 Medicaid members participated in the BaM program through this partnership. Additionally, this local grantee has continued to partner with the Wichita Black Nurse Association to increase Baby Talk's reach and relevance in Wichita's Black communities. An additional 17 individuals have been served through this partnership during the FFY24 reporting period.

Additional efforts to address disparities in access to prenatal care and education are described in the Cross-Cutting Report under the Social Determinants of Health Initiatives section. In this location, you can learn about curriculum adaptations/ development for use across other ATL program models, service settings and with special populations (I.e. virtual format, low-literacy and non-English speaking immigrant populations, etc.) through our BaM Health Equity Opportunity Projects (HEOP) that kicked off in July 2023 and ran through June 2024.

Pregnancy Intention Screening Initiatives

Objective 1.4: Increase the proportion of women receiving pregnancy intention screening as part of preconception and interconception services.

Long-Acting Reversible Contraceptives (LARC) Toolkit: Throughout the reporting period, Title V staff continued to promote the LARC toolkit available on the KDHE website. However, access to LARC has continued to be limited across the state and perceptions of it continued to be mixed.

Universal NPM: Postpartum Visit

A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth and B) Percent of women who attended a postpartum checkup and received recommended care components.

According to the Kansas Pregnancy Risk Assessment Monitoring System (PRAMS), 92.1% of Kansas residents with a recent live birth in 2022 reported attending a postpartum checkup (95% confidence interval [CI]: 89.8%-93.9%). Moreover, 79.0% attended the postpartum checkup and received recommended care components (95% CI: 75.6%-82.0%).

Fourth Trimester Initiative (FTI): All FTI enrolled facilities continued to schedule a postpartum appointment for the postpartum woman prior to discharge from the FTI facility. Although Kansas has transitioned to a new Patient Safety Bundle, the team intends to continue supporting facilities having this practice as a standard procedure and look at ways to expand it to facilities that did not enroll in FTI.

Postpartum Visit Attendance Data Collection: During the last year, the Title V team had conversations regarding tracking attendance at the postpartum visit. Kansas has traditionally relied on data from PRAMS to determine this. However, the Title V team would like as close to real-time data has possible. This has led to discussions around how to achieve this, especially since it is hard to discern from Medicaid data due to the global fee structure. One idea that the team is currently considering is using our internal system, DAISEY, to collect this information. Better data collection methods will continue to be a topic of discussion over the coming months and years.

Other Women/Maternal Initiatives

Maternal Health Innovation Grant: In FFY23, Kansas received a notice of award for the Maternal Health Innovation grant funding opportunity. Built on existing partnerships and the work of the Kansas Maternal Mortality Review Committee (KMMRC) and Kansas Perinatal Quality Collaborative (KPQC), the Title V Team proposed the following program goals in line with the terms of the State MHI grant:

- *By Sept. 29, 2024, the Maternal Health Task Force (MHTF) MHTF will have developed a draft strategic plan to improve maternal health, including addressing identified health disparities and other gaps and incorporating activities outlined in the State Title V needs assessment.*
- *By September 29, 2024, annual maternal health data will be used to report on and implement culturally and linguistically appropriate and innovative approaches to address identified needs and disparities.*
- *By September 29, 2024, an annual report will be submitted to HRSA that documents and reports on maternal health indicators and outcomes disaggregated by maternal. race/ethnicity, age, level of education, health insurance coverage, and geographic location (urban/rural).*
- *By September 29, 2025, the established MHTF will update and finalize the Maternal Health Strategic Plan by increasing the number of actionable recommendations based on state-level maternal health data and will submit a final strategic plan to HRSA.*

- *By September 29, 2028, the number of innovative approaches for replication and scale-up to improve maternal health will be increased.*
- *By September 29, 2028, innovations focused on addressing existing maternal health disparities within the state will be evaluated and supported.*

Program staff recruited for a Maternal Health Task Force (MHTF) comprised of community and state-level partners from different sectors and fields relating to maternal health, to ensure that the scope of the MHSP was complete and representative of the needs of patients statewide. Task force members include representation from (but not limited to) University of Kansas Medical Center, KU School of Nursing, Kansas State University Research & Extension, United Methodist Health Ministry Fund, Stormont Vail Health, Kansas Birth Equity Network, Kansas Birth Justice Society, Topeka Doula Project, and other partnering organizations. Around 40 task force members were invited, and attendance sits at around 30 participants per meeting.
MHI objectives were broken down into four focus areas: continuum of care, supporting the maternal health workforce, enhancing maternal health data capacity, and promoting community and family engagement. As was highlighted in the MHSP, proposed grant activities included needs assessment and surveys, training, education, and outreach for providers regarding the continuum of maternal health services, and other activities deemed necessary by data from the KMMRC reviews and review of SMM data.

A Maternal Health Strategic Plan (MHSP) first draft was submitted to HRSA in September 2024. The MHSP presented identified strengths and gaps currently seen in the state and outlined planned activities.

Maternal Anti-Violence Information and Sharing (MAVIS): Despite staff turnover shortly following the Year 3, 1st quarter of our Maternal Anti-Violence Innovation and Sharing grant, we continued to see growth and development of this important work. Below is a list of trainings and activities made available to care providers across the state, with a focus on expanding opportunities to Home Visitors, Community Health Workers, and Birth Doulas.

Trainings, from January-September, hosted by our partners at Kansas Coalition Against Sexual and Domestic Violence:

Presentation Topics
Impact of Intimate Partner Violence (IPV) on Maternal Health and Pregnancy
The Intersection of Substance Use and Intimate Partner Violence for The Kansas Association of Addictions Professionals
Impact of IPV on Maternal Health and Pregnancy for the Johnson County Health Department
From ACES to Promoting Positive Experiences for Becoming a Mom Program Sites
The CUES Intervention for (Fourth Trimester Initiative) FTI Birth Facilities
From Screening to Supporting: Implementing Evidence Based IPV Strategies in Birth Facilities
Working with Pregnant and Postpartum Survivors at the Intersection: Trauma, Mental Health, and Substance Use
Maternal Anti-Violence Innovation and Sharing (MAVIS) Project
The CUES Intervention in Perinatal Health Settings

Each of these trainings was received with overwhelming positive feedback. Some of the feedback received included statements such as:

- “All the trainers were very knowledgeable and passionate about the subject. It made it easy to engage with them.”
- “I like the case scenarios, and the opportunities to meet others and hear about their experiences.”
- “I loved that it was focused on head, heart, AND hands learning and experiences.”
- “It was taught by someone with real life experience. It was emotional. It was empowering.”
- “The personal experiences from others helped me visualize that real people go through these issues. I enjoyed how personable the presenters were and also all of the activities that were done instead of sitting there and listening for hours on end it was nice to have activities.”

Between January 2024-September 2024, our partners at Kansas Connecting Communities completed several activities and trainings. They completed SUD screening implementation with one Fourth Trimester Initiative (FTI) site and two TA sessions with the KPQC FTI facilities/centers focused on screening and referral. Also, MAVIS supported consultant time to prepare perinatal mental health screening and intervention training content for the KCC 1-day in-person perinatal behavioral health trainings and updated the screening implementation checklist based on a pilot with FTI sites during TA and feedback from KDHE. Additionally, KCC offered other TA sessions, conference presentations, hosted a Maternal Depression Screening Policy Training, and promoted and distributed MAVIS patient-facing resources.

Count the Kicks® (CTK) Stillbirth Prevention Initiative: Kansas Title V maintained its partnership with Healthy Birth Day to give communities access to Count the Kicks resources, including but not limited to materials for order, a Count the Kicks webinar, and an Oral Health/Stillbirth Prevention education partnership to increase the touch points people receive during pregnancy. We experienced two Baby Saves thanks to our partnership with Count the Kicks; one seen here, and the other press release shared below.

KANSAS MOM USES COUNT THE KICKS, SAVES HER BABY'S LIFE

LAWRENCE, Kan. *--- (Jan. 25, 2024) --- A free and easy-to-use pregnancy app available to expectant parents in Kansas is credited with saving the life of a Lawrence baby. When Lawrence mom Jenna Sheldon-Sherman reached the third trimester of pregnancy with her baby, she began using the Count the Kicks app every day to monitor her baby's well-being. During her 38th week of pregnancy, Jenna noticed a change in baby Sophia's normal movement patterns, which she brought up at her ultrasound appointment.*

"They then did a Biophysical Profile (BPP) ultrasound, and the baby failed the practice breathing portion. A non-stress test showed the baby's heart was not fluctuating as much as they would like," Jenna said.

Jenna was admitted to the hospital for monitoring, and while everything looked fine at first, Jenna kept telling her providers that something was wrong because she knew how much her baby normally moved. "They performed another BPP, and the baby again failed the practice breathing portion. Because of the failed BPPs and my insistence that the baby was moving less than usual, they induced me immediately," she said.

Jenna and her doctor credit the Count the Kicks app with helping her be in tune with her body and her baby. "After delivery, the doctor discovered a true knot in her umbilical cord. She said this is likely what caused the decreased movement. I am beyond thankful to the Count the Kicks app for helping me stay attuned to my baby's movements. I know that my knowledge and advocacy helped to get her here safely," Jenna said.

Because Jenna had a son who was stillborn in 2021, her provider knew counting kicks would be an especially important part of her pregnancy with Sophia, which is why Jenna's doctor recommended she use the Count the Kicks app. Count the Kicks helps expectant parents get to know their baby's normal movement patterns in the third trimester of pregnancy and empowers them to speak up if their baby's normal movement ever changes. Regular use of the app is proven to improve birth outcomes for moms and babies. In addition, 77% of app users report using the app daily helped to decrease their anxiety about the well-being of their baby.

The CDC lists a change in baby's movements as one of its 15 urgent maternal warning signs, and research proves the importance of monitoring fetal movement. The free Count the Kicks app provides a simple way for expectant parents to track how long it takes their baby to move 10 times each day and rate the strength of their baby's movements. When the strength of movement or the amount of time it takes to get to 10 movements changes, this could be a sign of potential problems and is an indication to call their provider.

The Count the Kicks program is made possible by funds from the Kansas Department of Health and Environment, which launched the program in Kansas in 2018. Through the partnership, maternal health providers, birthing hospitals, social service agencies, childbirth educators and other providers in Kansas can order FREE Count the Kicks educational materials (available at CountTheKicks.org) to help them have a conversation about getting to know their baby's normal movement patterns in the third trimester of pregnancy.

"The Kansas Department of Health and Environment is committed to improving birth outcomes for families in our state, especially those who have been historically and traditionally marginalized and disproportionately affected by stillbirth," said Secretary Janet Stanek. "We encourage anyone who works with expectant parents to order Count the Kicks educational materials to share with the communities you serve. Through our collective and inclusive efforts, together we can help more families have healthy birth outcomes."

Every year in the U.S. an average of 21,745 babies are stillborn according to the CDC. The CDC also reports an average of 190 babies are stillborn each year in Kansas. Through this collaboration, the organizations hope to reduce the stillbirth rate in Kansas by 30% as they have seen in Iowa, which would save approximately 61 babies in the state each year.