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

Domain: Women & Maternal Health

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

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

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

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

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

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

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

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

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

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

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

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

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

PRIORITY 2: All infants and families have support from strong community systems to optimize infant health and well-being.

Domain: Perinatal & Infant Health

NPM 5: 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

SPM 2: Breastfeeding (Percent of infants breastfed exclusively through 6 months)

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

OBJECTIVE 2.1: Promote and support cross-sector breastfeeding policies, practices, and environments to increase exclusive breastfeeding rates at 6 months by 2.5% annually through 2025.

Strategy	Description
2.1.1	Increase access to lactation support by African American providers such as breastfeeding peer counselors, doulas, International Board-Certified Lactation Consultants, and Certified Lactation Counselors that represent high-risk populations.
2.1.2	Support the implementation of community-centered, culturally relevant mother-to-mother, father, and grandparent breastfeeding support clubs for African Americans (e.g., Black Breastfeeding Clubs, Brown Baby Brigade, BSTARS, Reach our Brothers Everywhere (ROBE), Fathers Uplift, Grandmothers Tea Project).
2.1.3	Broaden the establishment of breastfeeding coalitions for African Americans that connect health care providers and the community to local information and resources, in partnership with the Kansas Breastfeeding Coalition (KBC) (e.g., African-American Breastfeeding Coalition of Wyandotte County).
2.1.4	Increase access for families to strong community breastfeeding education, supports and practices in cross-sector settings through collaboration with key community and state partners (e.g., Becoming a Mom, referrals to WIC and breastfeeding support and education, including the expansion of WIC Breastfeeding Peer Counseling, shared messaging through WIC and Home Visiting programs, hospitals, and provider offices, “Breastfeeding Welcome Here” initiatives, education about behavioral health and breastfeeding).

OBJECTIVE 2.2: Promote and support safe sleep practices and cross-sector initiatives to reduce the SUID rate by 10% by 2025.

Strategy	Description
2.2.1	Provide technical assistance to Safe Sleep Instructors to ensure consistent messaging across the state and continuity of supports in partnership with the Kansas Infant Death and SIDS (KIDS) Network of Kansas.
2.2.2	Align and strengthen safe sleep education in partnership with the KIDS Network of Kansas 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, and tobacco use prevention to provide direct education and referrals to families at high risk for adverse outcomes through Community Baby Showers.
2.2.4	Assist local MCH service providers in creating opportunities for real conversations with parents and caregivers identifying true barriers to implementing safe sleep practices.

OBJECTIVE 2.3: Implement 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 2025.

Strategy	Description
2.3.1	Promote consumer awareness of maternal morbidity and mortality risk factors and the importance of perinatal risk screenings (e.g., chronic disease, substance use, mental health, IPV, prior high-risk pregnancy, pregnancy intention) and health interventions through social media campaigns, public awareness events, and dedicated community engagement efforts in partnership with local MCH programs.
2.3.2	Increase provider knowledge of the importance of perinatal risk screening, brief interventions, and referrals for treatment through integration toolkits, action alerts, webinars, in-person grand rounds, lunch and learns, and other approaches.
2.3.3	Identify and/or develop resources for cross-sector implementation aimed at reduction of preventable causes of maternal mortality based on Kansas Maternal Mortality Review Committee findings and recommendations.
2.3.4	Enroll as a participating state in the national Alliance for Innovation on Maternal Health (AIM) initiative and adopt one or more patient safety bundles for statewide implementation in appropriate setting(s).
2.3.5	Include Neonatal Abstinence Syndrome (NAS) as a reportable birth defect and build surveillance protocols to supplement community prevention and referral activities.

OBJECTIVE 2.4: Increase the proportion of pregnant and postpartum women receiving MCH Universal Home Visiting services by 15% by 2025.

Strategy	Description
2.4.1	Conduct a complete review of the MCH Universal Home Visiting program model as part of Kansas home visiting network and implement enhancements as necessary to assure all families across the state have access to crucial assessment, screening, and referral services.
2.4.2	Establish and increase consumer/family and provider awareness about the importance of home visitation supports and impact on family and infant outcomes to increase referrals and number of families receiving support through MCH Universal Home Visiting programs.
2.4.3	Assure that MCH Universal Home Visiting programs can serve as an information source and connection point in communities to support safe, stable, nurturing relationships/environments and positive outcomes for infants and families, in alignment with All in for Kansas Kids initiative.
2.4.4	Incorporate family strengthening and parent training/support skills building sessions into MCH Universal Home Visiting standardized curriculum.

PRIORITY 3: Children and families have access to and utilize developmentally appropriate services and supports through collaborative and integrated communities.

Domain: Child Health

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)

ESM: Percent of children who received a parent-completed developmental screen during an infant or child visit provided by a participating program

OBJECTIVE 3.1: Increase the proportion of children aged 1 month to kindergarten entry statewide who receive a parent-completed developmental screening by 5% annually through 2025.

Strategy	Description
3.1.1	Build MCH capacity to support coordination and two-way referrals with other providers offering community-based services through utilization of the statewide 1-800-CHILDREN helpline, including referrals to providers and services through local health agencies participating in an Integrated Referral and Intake System (IRIS) communities.
3.1.2	Provide guidance, training, and technical assistance to MCH local agencies and marketing and education to families on the importance of early/ongoing developmental screening, use of evidence-based screening tools (e.g., ASQ-3, ASQ SE-2, MCHAT), and follow up.
3.1.3	Partner in the development of an integrated, statewide developmental screening data-sharing platform to drive the implementation of an early childhood integrated data system (ECIDS).
3.1.4	Promote evidence-based programs and initiatives for community and health care providers regarding healthy child development and early learning (e.g., social-emotional development; developmental milestones/Learn the Signs, Act Early; early literacy/Turn a Page, Touch a Mind/Brush Book Bed/Imagination Library).

OBJECTIVE 3.2: Increase the proportion of children, 6 through 11 years, with access to activities and programs that support their interests, healthy development, and learning by 10% by 2025.

Strategy	Description
3.2.1	Partner with school-aged programs, local school districts and the Bureau of Health Promotion to align core messaging around child health initiatives (e.g., physical activity [Move Your Way and Let's Move], nutrition, literacy, screen-time, self-determination).
3.2.2	Provide resources and supports to partner with local officials to support safe, inclusive school and community playgrounds, including adapted play equipment for children with mobility and sensory needs.
3.2.3	Partner with community organizations leading efforts on social-emotional health and provide programs that support the encouragement and empowerment to build healthy relationships with parents/caregivers, teachers, mentors, health care providers, and peers.

OBJECTIVE 3.3: Increase the proportion MCH program participants, 1 through 11 years, receiving quality, comprehensive annual preventive services by 10% annually through 2025.

Strategy	Description
3.3.1	Engage partners to promote the importance of comprehensive preventive child well visits utilizing all elements of the Bright FuturesTM guidelines.
3.3.2	Assess need and capacity to increase access to care coordination services and supports in all settings where children receive preventive well-visits and support activities.
3.3.3	Provide technical assistance to MCH local agencies in existing IRIS communities using developed implementation toolkits to actively engage around the Help Me Grow core health care provider outreach components to provide coordinated services, supports, and connections.

PRIORITY 4: Adolescents and young adults have access to and utilize integrated, holistic, patient-centered care to support physical, social, and emotional health.

Domain: Adolescent Health

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

ESM: Percent of adolescent program participants, 12 through 17, that had a well-visit during the past 12 months

OBJECTIVE 4.1: Increase the proportion MCH program participants, 12 through 17 years, receiving quality, comprehensive annual preventive services by 5% annually through 2025.

Strategy	Description
4.1.1	Engage partners to promote a stronger cross-system recommendation to conduct complete annual well visits during adolescence utilizing all elements of the Bright FuturesTM guidelines.
4.1.2	Conduct annual provider educational efforts to support provider knowledge acquisition regarding the importance of comprehensive, quality adolescent well visits and the Bright FuturesTM Guidelines.
4.1.3	Support the development of a peer-to-peer awareness campaign, developed and delivered by adolescents and young adults, to express the importance of comprehensive, quality well visits and youth-inspired environments.
4.1.4	Engage local health agencies to implement youth-friendly care approaches from the Adolescent Health Institute in their facilities.

OBJECTIVE 4.2: Increase the proportion of adolescents and young adults that have knowledge of and access to quality health and positive lifestyle information, prevention resources, intervention services, and supports from peers and caring adults by 10% by 2025.

Strategy	Description
4.2.1	Partner with adolescents and young adults to identify, develop, and disseminate standardized guidance and educational materials focused on empowerment and health promotion (e.g., healthy living and eating, physical activity, mental health, substance use, social media, healthy relationships).
4.2.2	Increase awareness of adolescents and young adults about services and programs available to them in their community that are including and accessible to them through 2-1-1 and 1-800-CHILDREN resources and disseminate/share with youth-serving organizations and partners.
4.2.3	Distribute The Future is Now THINK BIG – Preparing for Transition Planning workbooks to schools for distribution during enrollment, orientation, and/or other appropriate events.
4.2.4	Partner with prevention initiatives to provide events/programs and develop community-based education classes, designed with adolescent and young adult input, to reduce risky behaviors and support youth in gaining important skills necessary for transition to adulthood (e.g., budgeting, independent living skills, furthering education, gaining employment, stress management, healthy relationships).

OBJECTIVE 4.3: Increase the number of local health agencies and providers serving adolescents and young adults that screen, provide brief intervention and refer to treatment for those at risk for behavioral health conditions by 5% by 2025.

Strategy	Description
4.3.1	Develop protocols for MCH local agencies to identify when an adolescent or young adult might need behavioral health services, make referrals to treatment when needed, assure timely access to care, and offer support to families throughout the process.
4.3.2	Partner with other state agencies and community-based organizations to promote resources that reduce the stigma and embarrassment often perceived as associated with mental illness, emotional disturbances, and seeking treatment.
4.3.3	Promote evidence-based suicide prevention initiatives and accessible crisis services through school and out-of-school activities.

PRIORITY 5: Communities, families, and providers have the knowledge, skills, and comfort to support transitions and empowerment opportunities.

Domain: Children with Special Health Care Needs

NPM 12: Transition (Percent of adolescents with and without special health care needs, ages 12-17, who received services necessary to make transition to adult health care)

ESM: Percent of youth with special health care needs, ages 12 to 21, who have one or more transition goals achieved on their action plan by the target completion date

OBJECTIVE 5.1: Increase the proportion of adolescents and young adults who actively participate with their medical home provider to assess needs and develop a plan to transition into the adult health care system by 5% by 2025.

Strategy	Description
5.1.1	Provide technical assistance and support to local health agencies and medical home providers of families served through the Kansas Special Health Care Needs Program (KS-SHCN) to incorporate transition readiness education and resources for youth ages 12 and older.
5.1.2	Promote the implementation of evidence-based practices and policies with providers serving adolescents and young adults to support transition from pediatric to adult health systems.
5.1.3	Partner with health care professional organizations to engage with insurers to support adequate reimbursement for transition care services.

OBJECTIVE 5.2: Increase the proportion of families of children with special health care needs who report their child received care in a well-functioning system by 5% by 2025.

Strategy	Description
5.2.1	Implement national standards through a collaborative network of programs, providers, partners, and families dedicated to advancing the Kansas State Plan for Systems of Care for Children with Special Health Care Needs (CSHCN).
5.2.2	Expand the partnership between Title V and Medicaid to strengthen coordinated services and supports for CSHCN in managed care and home and community-based services programs.
5.2.3	Assess gaps in insurance coverage, adequacy, and affordability for families of CSHCN and engage with key partners to support modification of policies and practices to advance and increase access and coverage of necessary medical and social services.
5.2.4	Partner with Medicaid and the behavioral health agency to implement policy change to allow family caregivers the opportunity to serve as nursing caregivers through waivers when appropriate.
5.2.5	Assess statewide barriers to accessing primary and specialty care services for families of CSHCN, including palliative care, multi-disciplinary specialty care teams, telehealth, and primary care medical homes.

OBJECTIVE 5.3 Increase the proportion of families who receive care coordination supports through cross-system collaboration by 25% by 2025.

Strategy	Description
5.3.1	Provide technical assistance and support to child welfare agencies working with family foster homes to improve coordination across systems and align services for CSHCN in foster care.
5.3.2	Expand KS-SHCN Care Coordination eligibility to support families transitioning out of early intervention services, assuring they are connected to appropriate community-based services and resources.
5.3.3	Provide quarterly Systems Navigation Trainings for parents of CSHCN.

PRIORITY 6: Professionals have the knowledge, skills, and comfort to address the needs of maternal and child health populations.

Domain: Cross Cutting - Workforce Development

SPM 3: Workforce Development (Percent of participants reporting increased self-efficacy in translating knowledge into practice after attending a state sponsored workforce development event)

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

OBJECTIVE 6.1: Increase the proportion of providers with increased comfort to address the behavioral health needs of MCH populations by 5% by 2025.

Strategy	Description
6.1.1	Provide skills-building training and case consultation opportunities for the MCH workforce to increase knowledge, skill, and comfort to identify behavioral health conditions and risks, facilitate effective brief interventions, and complete referrals to treatment/further assessment following best practice guidelines.
6.1.2	Partner with organizations interested in reducing the number of children exposed to adverse childhood experience to assure knowledge, skills, and comfort among MCH programs to support parental and child resilience through the strengthening families approach.
6.1.3	Develop guidance on developing effective community partnerships to identify and address behavioral health needs within the community using a streamlined, collaborative approach.

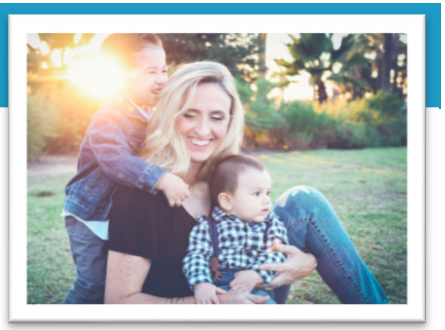
OBJECTIVE 6.2: Increase the proportion of MCH local agencies implementing trauma-informed approaches that support increased staff satisfaction and healthier work environments by 5% annually through 2025.

Strategy	Description
6.2.1	Incorporate state and local MCH agency training to build efficacy in translating knowledge into practice for trauma-informed and hope-infused approaches.
6.2.2	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.
6.2.3	Partner with MCH local agencies to conduct a self-assessment to help them find improvement opportunities, clarify current practices, and develop a work plan to provide services through trauma informed approaches.

OBJECTIVE 6.3: Increase the proportion of MCH-led activities that address social determinants of health (SDOH) to reduce disparities and improve health outcomes for MCH populations by 15% annually through 2025.

Strategy	Description
6.3.1	Develop guidance and trainings for local health agencies and providers to ensure that providers can promote and address diversity and inclusion, integrate supports in the provision of services for high-risk populations in Kansas, and reduce health disparities through responsive policy change initiatives.
6.3.2	Integrate chronic disease education and prevention activities into existing community collaboratives to engage in system and environmental changes to address locally identified disparities.
6.3.3	Implement annual community awareness campaign for the prevention of birth defects, targeting messages to address disparities due to social determinants of health in local communities.

PRIORITY 7: Strengths-based supports and services are available to promote healthy families and relationships.



Domain: Cross Cutting - Family and Consumer Partnership

SPM 4: Family Strengths (Percent of children whose family members know all of the time they have strengths to draw on when the family faces problems)

ESM: Number of MCH participants receiving holistic care coordination

ESM: Percent of families enrolled in Special Health Care Needs Care Coordination Program that have increased their ability to independently navigate the systems of care

OBJECTIVE 7.1: Increase the proportion of MCH-led activities with a defined program plan for family and consumer partnership (FCP) to 75% by 2025.

Strategy	Description
7.1.1	Develop the Title V Family and Consumer Partnership (FCP) Program, including a resource toolkit for engaging and partnering with families across MCH domains.
7.1.2	Provide training to MCH programs on the importance of family-centered services and supports to: strengthen families; promote strong, healthy, and safe family environments; address diverse needs of families; and build supportive communities.
7.1.3	Align the FCP guidance and evaluation activities with the Standards for Quality for Family Strengthening and Support as a model of quality and evaluation.

OBJECTIVE 7.2: Increase the number of individuals receiving peer supports through Title V-sponsored programs by 5% annually through 2025.

Strategy	Description
7.2.1	Expand the Supporting You Network through programmatic partnerships, adding at least two new programs a year and providing expanded trainings, resources, and technical assistance to the provision of a peer-to-peer support program.
7.2.2	Identify and implement evidence-based peer support models for intentional engagement of non-traditional MCH populations (e.g. fathers, siblings of CSHCN, relative caregivers) across MCH programs.
7.2.3	Develop and offer a marketing package, inclusive of printable flyers, mailers, business cards, and social media messages, tailored to the target populations of the participating programs and providing an opportunity to engage in audio and video promotional activities as a network.

OBJECTIVE 7.3: Increase the number of families and consumers engaging as leadership partners with the MCH workforce through the FCP Program by 5% annually through 2025.

Strategy	Description
7.3.1	Expand the Title V Family Delegate Program to support a personalized leadership plan based upon the interests of the family leaders, such as core MCH learning curriculums and skills-building opportunities.
7.3.2	Create MCH learning pathways to support engagement and leadership at all levels, based upon individual goals and interests, as part of the partnership and engagement toolkit.
7.3.3	Expand opportunities across all MCH programs to engage families and consumers with lived experiences as program evaluators, co-trainers, interns, paid staff or consultants, mentors, grant reviewers, active participants in assessment processes, and more.
7.3.4	Expand the existing Family Advisory Council model to engage families across all MCH domains, including integration of Title V activities with the All in for Kansas Kids strategic plan activities associated with family advisory and leadership teams.

OBJECTIVE 7.4: Increase the number of MCH-affiliated programs providing holistic care coordination through cross-system collaboration by three through 2025.

Strategy	Description
7.4.1	Develop an implementation toolkit to spread and scale holistic care coordination services across MCH programming.
7.4.2	Expand existing partnerships among public health, primary care, behavioral health providers, and managed care organizations to support the behavioral health needs of the family.
7.4.3	Implement a robust continuing education curriculum for ongoing learning for case managers, care coordinators, and community health workers on the provision of holistic care coordination services.