# Kansas | State Action Plan Table | 2026 Application/2024 Annual Report

| Priority Needs | Five-Year Objectives | Strategies | Evidence-Based or –Informed Strategy Measures | National and State Performance Measures | National and State Outcome Measures |
|---|---|---|---|---|---|
| **Women/Maternal Health** | | | | | |
| Women have access to and utilize integrated, holistic, and patient-centered care throughout the preconception, pregnancy, and postpartum periods. | Objective 1.1— By 2030, increase the postpartum visit attendance rate from 92.1% to 94.4%. Baseline: 92.1% Target: 94.4% Target setting method: 0.5% annual improvement Source: PRAMS | Strategy 1.1.1 Provide resources and tools to support local health agencies on education women about the importance of the postpartum visit and comprehensive medical services available to them throughout the postpartum period. Strategy 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. Strategy 1.1.3 Continue supporting hospitals and health care systems to ensure the postpartum visit is scheduled for every postpartum woman prior to discharge. | ESM PPV.1 - Percent of Title V program participants that report attending their postpartum visit. - attendance rate ESM PPV.2 - Percent of Title V program participants that report attending their postpartum visit. - pregnancy related deaths ESM PPV.3 - Percent of Title V program participants that report attending their postpartum visit. - illicit drugs | NPM - Postpartum Visit | **Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety |
| Women have access to and utilize integrated, holistic, and patient-centered care throughout the preconception, pregnancy, and postpartum periods. | Objective1.2—By 2030, reduce the number of pregnancy-related deaths from 18 per 100,000 live births to 14. Baseline: 18 Target: 14 (13.9) Target setting method: 5% annual improvement Source: KMMRC | Strategy 1.2.1 Explore and pilot/assess quality care improvement frameworks that address the core drivers of maternal mortality. Strategy 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. Strategy 1.2.3 Provide trainings, such as CUES, to providers, local health agencies, and community organizations to reduce maternal deaths due to violence. | ESM PPV.1 - Percent of Title V program participants that report attending their postpartum visit. - attendance rate ESM PPV.2 - Percent of Title V program participants that report attending their postpartum visit. - pregnancy related | NPM - Postpartum Visit | **Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety |

| Priority Needs | Five-Year Objectives | Strategies | Evidence-Based or –Informed Strategy Measures | National and State Performance Measures | National and State Outcome Measures |
|---|---|---|---|---|---|
| | | | deaths ESM PPV.3 - Percent of Title V program participants that report attending their postpartum visit. - illicit drugs | | |
| Women have access to and utilize integrated, holistic, and patient-centered care throughout the preconception, pregnancy, and postpartum periods. | 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% (2023 birth cohort data) to 88%. Baseline: 77.7% Target: 88% Target setting method: 2% annual improvement Source: PRAMS Phase 9- 2023 birth cohort data; DAISEY (as backup) | Strategy 1.3.1 Support recovery and care coordination models for pregnant and postpartum women and their families impacted by SUD. Strategy 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. Strategy 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 addressing the stigma associated with substance use during pregnancy. | No ESMs were created by the State. ESMs are optional for this measure. | SPM 1: Perinatal Behavioral Health | **Linked NOMs:** Postpartum Anxiety Postpartum Depression Maternal Mortality |

## Perinatal/Infant Health

| Priority Needs | Five-Year Objectives | Strategies | Evidence-Based or –Informed Strategy Measures | National and State Performance Measures | National and State Outcome Measures |
|---|---|---|---|---|---|
| All infants and families are supported by robust community systems that promote optimal infant health and well-being. | 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. Baseline: 18.6% 2024, 18.1% 2023 Target: 23% Target setting method: 1% annually Source: WIC, KBC | 2.1.1 Expand access to individually relevant breastfeeding support in under-served communities by increasing the number of peer counselors, doulas, Certified Lactation Counselors (CLCs), and International Board-Certified Lactation Consultants (IBCLCs), and by supporting the implementation of mother-to-mother, father, and grandparent-focused support groups and clubs. 2.1.2 Broaden the establishment of 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. | ESM BF.1 - Percent of WIC non-Hispanic black infants breastfed exclusively through six months. - breastfeeding policies, practices, programs | NPM - Breastfeeding | **Linked NOMs:** Infant Mortality Postneonatal Mortality SUID Mortality |
| All infants and families are supported by | Objective 2.2— Promote and support safe sleep practices and cross-sector initiatives to reduce | 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 | No ESMs were created by the State. ESMs are optional for | SPM 2: Safe Sleep | **Linked NOMs:** Infant Mortality |

| Priority Needs | Five-Year Objectives | Strategies | Evidence-Based or –Informed Strategy Measures | National and State Performance Measures | National and State Outcome Measures |
|---|---|---|---|---|---|
| robust community systems that promote optimal infant health and well-being. | the SUID rate by 10% by 2030. Baseline: 92.2%(2024) Target: 95% Target setting method: Source: BaM (birth outcome card) | 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. | this measure. | | |
| All infants and families are supported by robust community systems that promote optimal infant health and well-being. | 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. Baseline: 2 Target: 2 Target setting method: 2 actively maintained over 5 years. Source: KPQC | 2.3.1 Increase community awareness of maternal health risks, including chronic conditions, behavioral health, pregnancy intention, and interpersonal violence, through locally tailored outreach and engagement led in partnership with local MCH programs, with support from KPQC and state-level public health communications. 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. | ESM SS.1 - Percent of infants of the BaM participants placed to sleep (A) on their backs; (B) in a crib/bassinet or portable crib. - reduce SUID<br>ESM SS.2 - Percent of Kansas Perinatal Community Collaboratives (KPCC) participants who placed their infants to sleep (B) in a crib/bassinet or portable crib after receiving caregiver education<br>ESM SS.3 - Percent of infants of the BaM participants placed to sleep (A) on their backs; (B) in a crib/bassinet or portable crib. - cross-sector initatives | NPM - Safe Sleep | <u>Linked NOMs:</u><br>Infant Mortality<br>Postneonatal Mortality<br>SUID Mortality |

| Priority Needs | Five-Year Objectives | Strategies | Evidence-Based or –Informed Strategy Measures | National and State Performance Measures | National and State Outcome Measures |
|---|---|---|---|---|---|
| **Child Health** | | | | | |
| Children and families' access and benefit from developmentally appropriate services within collaborative and integrated systems of health care and community supports. | 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. Baseline: 52.6% Target: 63% Target setting method: 2% per year annually Source: DAISEY | Strategy 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. Strategy 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. Strategy 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 | ESM MH.1 - Number of children served in Title V-funded programs that parents report their child has a medical home. - family participation ESM MH.2 - Number of children served in Title V-funded programs that parents report their child has a medical home. - family navigating services | NPM - Medical Home | **Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All |
| Children and families' access and benefit from developmentally appropriate services within collaborative and integrated systems of health care and community supports. | 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% Baseline: 34.7% Target: 45% Target setting method: 2% annually Source: NSCH for baseline, ASQ Enterprise (KSDE) when reports are available. | Strategy 3.2.1 Strengthen referral coordination through utilization of the Help Me Grow Centralized Access Point. Strategy 3.2.2 Promote evidence-based programs and initiatives for community and health care providers regarding healthy child development and early learning. Strategy 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 Zero to Three DC:0-5. | ESM DS.1 - Number of children served in Title V-funded programs that parents report their child has a medical home. - developmental screening | NPM - Developmental Screening | **Linked NOMs:** School Readiness Children's Health Status |
| Children and families' access and benefit from developmentally appropriate services within collaborative | 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%. Baseline: 78.2% (those reporting 'Never' being frustrated) Target: 83% Target setting | Strategy 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. Strategy 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. | ESM MH.1 - Number of children served in Title V-funded programs that parents report their child has a medical home. - family participation ESM MH.2 - Number | NPM - Medical Home | **Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All |

| Priority Needs | Five-Year Objectives | Strategies | Evidence-Based or –Informed Strategy Measures | National and State Performance Measures | National and State Outcome Measures |
|---|---|---|---|---|---|
| and integrated systems of health care and community supports. | method: 1% per year annually Source: NSCH (4.20: During the past 12 months, how often were you frustrated in your efforts to get services for this child?) | | of children served in Title V-funded programs that parents report their child has a medical home. - family navigating services | | |
| **Adolescent Health** | | | | | |
| Ensure adolescents & young adults have consistent access to & actively engage with comprehensive, patient-centered care & community supports that strengthen physical, social, and emotional well-being. | 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%. Baseline: 9.0% Target: 60% Target setting method: 10% per year annually Source: Medicaid Claims Data (Preventive Medicine Office Visit HCPCS codes: 99381, 99382, 99383, 99384, 99385, 99201, 99203, 99391, 99392, 99393, 99394, 99395*, 99202, 99204; Emotional/Behavioral Assessment: 96127) | Strategy 4.1.1 Engage adolescent-serving programs and partners to promote the importance of an annual adolescent well visit to parents and adolescents. Strategy 4.1.2 Conduct annual provider education and technical assistance on Bright Futures guidelines for comprehensive adolescent care. Strategy 4.1.3 Develop protocols to identify behavioral health needs, support timely referrals and care coordination for adolescents/young adults and their families. | ESM AWV.1 - Percent of local MCH grantees who have been trained or have received educational materials on how to increase awareness of adolescent well-visits ESM AWV.2 - Percent of adolescents and young adults (ages 12-17) enrolled in KanCare with a well-visit in the last year. - visit with behavioral screen ESM AWV.3 - Percent of adolescents and young adults (ages 12-17) enrolled in KanCare with a well-visit in the last year. - engaged Title V | NPM - Adolescent Well-Visit | **Linked NOMs:** Teen Births Adolescent Mortality Adolescent Motor Vehicle Death Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Children's Health Status Child Obesity Adolescent Depression/Anxiety CSHCN Systems of Care Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All |
| Ensure adolescents & young adults have consistent access to & | Objective 4.2 — By 2030, increase the number of adolescents and young adults engaged in Title V funded programs and initiatives by 10%. Baseline: 0 % Target: 10% | Strategy 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 | ESM AWV.1 - Percent of local MCH grantees who have been trained or have received educational | NPM - Adolescent Well-Visit | **Linked NOMs:** Teen Births Adolescent Mortality Adolescent Motor Vehicle Death Adolescent Suicide |

| Priority Needs | Five-Year Objectives | Strategies | Evidence-Based or –Informed Strategy Measures | National and State Performance Measures | National and State Outcome Measures |
|---|---|---|---|---|---|
| actively engage with comprehensive, patient-centered care & community supports that strengthen physical, social, and emotional well-being. | Target setting method: 2% per year Source: Internal Tracking | adulthood, such as budgeting, independent living, continuing education, securing employment, stress management, and building healthy relationships. Strategy 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. | materials on how to increase awareness of adolescent well-visits ESM AWV.2 - Percent of adolescents and young adults (ages 12-17) enrolled in KanCare with a well-visit in the last year. - visit with behavioral screen ESM AWV.3 - Percent of adolescents and young adults (ages 12-17) enrolled in KanCare with a well-visit in the last year. - engaged Title V | | Adolescent Firearm Death Adolescent Injury Hospitalization Children's Health Status Child Obesity Adolescent Depression/Anxiety CSHCN Systems of Care Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All |

## Children with Special Health Care Needs

| Priority Needs | Five-Year Objectives | Strategies | Evidence-Based or –Informed Strategy Measures | National and State Performance Measures | National and State Outcome Measures |
|---|---|---|---|---|---|
| Individuals with SHCN, their families, communities, and providers have the knowledge, skills, and support to access to coordinated care and community supports that aid transition. | 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. Baseline: 69.5% Target: 75% Target setting method: 1% per year annually Source: NSCH (4.15, part B) Welligent (optional) | Strategy 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. Strategy 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. Strategy 5.2.3 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. | ESM TAHC.1 - 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 ESM TAHC.2 - Percent of youth with special health care needs, ages 12 to 21, who have one or more transition goals included on their action plan. - engage | NPM - Transition To Adult Health Care | **Linked NOMs:** CSHCN Systems of Care |

| Priority Needs | Five-Year Objectives | Strategies | Evidence-Based or –Informed Strategy Measures | National and State Performance Measures | National and State Outcome Measures |
|---|---|---|---|---|---|
| | | | with provider ESM TAHC.3 - Percent of youth with special health care needs, ages 12 to 21, who have one or more transition goals included on their action plan. - SHCN care coordination | | |
| | 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. Baseline: 34.9% Target: 45% Target setting method: 2% per year annually Source: NSCH (4.12e – received needed care coordination); Welligent (optional) | Strategy 5.2.1 Assess current system functionality through surveys or focus groups. Strategy 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. Strategy 5.2.3. Provide training for professionals on family centered, cross sector coordination and continuous quality improvement | ESM MH.1 - Number of children served in Title V-funded programs that parents report their child has a medical home. - family participation ESM MH.2 - Number of children served in Title V-funded programs that parents report their child has a medical home. - family navigating services | NPM - Medical Home; Medical Home_Care Coordination | **Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All |

## Cross-Cutting/Systems Building

| Priority Needs | Five-Year Objectives | Strategies | Evidence-Based or –Informed Strategy Measures | National and State Performance Measures | National and State Outcome Measures |
|---|---|---|---|---|---|
| Strengthen workforce capacity & enhance public health systems by investing in training, infrastructure, & cross-sector collaboration, ensuring a | 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. Baseline: 48% Target: 58% Target setting method: Increase by 2% annually Source: MCH Sponsored Workforce Post-Event Surveys (Third Thursday Webinar, | Strategy 6.1.1 Develop and deliver training programs that build core competencies, such as data literacy, health justice, cultural competency, and systems thinking. Strategy 6.1.2 Explore career pathways and mentorship opportunities to support professional growth and workforce retention. Strategy 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. | No ESMs were created by the State. ESMs are optional for this measure. | SPM 3: Workforce Development | |

| Priority Needs | Five-Year Objectives | Strategies | Evidence-Based or –Informed Strategy Measures | National and State Performance Measures | National and State Outcome Measures |
|---|---|---|---|---|---|
| skilled, adaptable workforce and resilient systems. | measuring change in pre/post survey) | | | | |
| Strengthen workforce capacity & enhance public health systems by investing in training, infrastructure, & cross-sector collaboration, ensuring a skilled, adaptable workforce and resilient systems. | 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. Baseline: 0% of agencies utilizing state public dashboard with metrics of datasets freely available Target: 50% of agencies utilizing state public dashboard with metrics of datasets freely available Target setting method: Increase of agency utilization by 10% of agencies per year Source: Internal data (MCH dashboard) | Strategy 6.2.1 Explore opportunities to increase data collection and sharing at the state-level. Strategy 6.2.2 Investigate integrated platforms for cross-sector data analysis to identify disparities, guide resource allocation, and inform evidence-based interventions. Strategy 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. | No ESMs were created by the State. ESMs are optional for this measure. | SPM 3: Workforce Development | |
| Resources and services that recognize and build upon existing family strengths and community services are accessible to support healthy relationships and family well-being. | Objective 7.1—Increase the percentage of state Title V activities and programs that engage with families and consumers to 10% by 2030. Baseline: 4.6% Target: 10% Target setting method: 1% per year annually Source: Internal Tracking (Community Check Box- % of programs within Family Health led the activity? -indicated by FCP) | Strategy 7.1.1 Expand peer support networks for families and consumers. Strategy 7.1.2 Continue supporting the Family Advisory Council and integrate their individual experiences more robustly across Title V activities and programs. Strategy 7.1.3 Revise and relaunch the Family Delegate program. Strategy 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. | No ESMs were created by the State. ESMs are optional for this measure. | SPM 4: Parenting Support | |
| Resources and services that recognize and build upon | Objective 7.2—Increase the number of non-traditional MCH populations participating in Title V funded initiatives by 10% by 2030. | Strategy 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. Strategy 7.2.2 Increase participating of fathers and other non-traditional MCH populations on the Family | No ESMs were created by the State. ESMs are optional for this measure. | SPM 4: Parenting Support | |

| Priority Needs | Five-Year Objectives | Strategies | Evidence-Based or –Informed Strategy Measures | National and State Performance Measures | National and State Outcome Measures |
|---|---|---|---|---|---|
| existing family strengths and community services are accessible to support healthy relationships and family well-being. | Baseline: 0 Target: 10% Target setting method: 2% annually Source: Tracking FAC membership and number of contracts with agencies providing services to fathers, grandparents, kin, etc. | Advisory Council. Strategy 7.2.3 Partner with father-serving organizations across the state to address the unmet needs of fathers. | | | |