Kentucky State Action Plan Table 2025 Application/2023 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					
Reduce maternal morbidity and mortality rates in Kentucky	Increase by 5% the number of women who are screened for well-women preventive health visits, immunizations, and referral to primary care provider by 2025.	• Utilize media outlets to promote preventative medical visits. • Develop educational modules focused on the Well-Woman Visit • Integrate well woman visit messaging in prenatal program evidence informed strategies • Provide education to women and track use of the Well-Woman Visit and referrals into evidence-based programs such as WIC, HANDS, and MIECHV/other home Visiting Programs. • Increase the number of educational presentations and materials regarding prevention and factors that significantly impact women's health (e.g., smoking, SUD, domestic violence, depression) to health care providers. • MCH remains committed to ongoing successful strategies/initiatives.	ESM WWV.1 - Number of women receiving assistance, education, or guidance for getting a well woman visit, immunizations, or referral to tobacco cessation programs, substance use programs or other referrals.	NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

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					NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression,

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					Formerly NOM 24) - PPD
Reduce maternal morbidity and mortality rates in Kentucky	Reduce by 10% the number of maternal deaths of Kentucky residents associated with substance use disorder by 2025	• Identify maternal deaths of any KY female resident between the ages of 15-55 years who was pregnant within one year prior to death regardless of the cause of death with drug overdose defined by ICD10 code of X40-X49 • Ensure review by Maternal Mortality Review Committee (MMRC) within 1 year of death • With guidance of MMRC develop recommendations from case findings for inclusion in the annual Maternal Mortality Review and Prevention report and provide information to KY Perinatal Quality Collaborative • Develop presentations of MMRC findings for stakeholders • Apply for AIM status and develop educational strategies for promotion and use of Maternal Safety Bundles		SPM 2: Number of maternal deaths of Kentucky residents associated with substance use disorder by 2025.	
Reduce maternal morbidity and mortality rates in Kentucky	A.) Increase the number of women who receive a postpartum checkup within 12 weeks after giving birth by 1% (or at rate TBD): B.) Increase the percent of women who attend a postpartum checkup and receive recommended care components by 1% (or at rate TBD).	From PRAMS or other data source(s) measure the number of women who have contacted their health care provider within 3 weeks of giving birth; those who are receiving ongoing medical care throughout the postpartum period; And/or, who have had a complete and full medical checkup no later than 12 weeks after giving birth; Establish training module in TRAIN or other course work/platform to assist doctors and providers on best practices to ensure a postpartum checkup	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Perinatal/Infant Health					
Reduce Infant Mortality Rate	Increase by 5% the number of infants exclusively breastfed through 6 months by 2025.	• Develop annual survey for birthing hospitals to measure progress on 10 steps for successful breastfeeding • Educate the general public and health care providers on the importance and benefits of breastfeeding (short-mid) • Partner with WIC, Kentucky Hospital Association and health promotion	ESM BF.1 - Number of hospitals receiving technical assistance, educational offerings. Policy review from public health (LHD or state program) about	NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly

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		programs at state and local health departments to assist birthing hospitals in implementing and increasing the number of hospitals who operationalizing the 10 steps for successful breast feeding (long) • Development of web-based parent materials, social media educational opportunities, linkage to virtual breastfeeding support (long) • Development and implementation of comprehensive breast feeding support and education training with local agency staff in WIC (long) • Offer Train the Trainer offerings to increase capacity of designated breastfeeding experts at all LHDs (mid) • Build work force capacity in the community for peer support counseling (long) • Develop education materials/offerings for employers regarding designing supportive policies for Mother-Friendly breastfeeding • Develop evidence based initiatives for nutrition education, breastfeeding, employer supports for breastfeeding, media campaigns	the 10 steps to successful breastfeeding	(Breastfeeding, Formerly NPM 4B) - BF	NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID
Reduce Infant Mortality Rate	Increase by 5% (current 79% for 2018 PRAMS data) the percent of PRAMS reporting mothers who place their infants in a back-to-sleep positioning by September 30, 2025.	• Distribute parent education materials (in other languages) to birthing hospitals and providers • Development of online modules for home visitation programs, CPS or other targeted providers. • Maintain 100% of infant deaths that are reviewed by a multi-disciplinary review team. • Development of educational materials at statewide literacy rate. • Implement targeted interventions at both the state and local level identified populations/areas at greatest risk of non-back sleep. • Include culturally sensitive education opportunities for addressing risk factors, smoking during pregnancies, environmental exposure, how to have conversation with parents on assessment of safe sleep	ESM SS.1 - PRAMS mothers who report placing their infants in a back-to-sleep positioning by September 30, 2025.	NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID

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		environment, substance use, teen births. • MCH remains committed to ongoing successful strategies/initiatives.			
Reduce outcomes related to substance use disorder for adolescents/pregnant women to reduce the number of Neonatal Abstinence Syndrome Cases or adolescents/children exposed to substances .	Decrease by 5% the number of new cases of neonatal abstinence syndrome (NAS) by 2025	• Provide technical support to reporting facilities. • Complete at least one report on the findings annually. • Continue collaborations with other state agencies to address the opioid epidemic. • Coordinate with KY Perinatal Quality Collaborative to develop ongoing educational opportunities to address early identification of substance use during pregnancy with referral and care coordination for pregnant woman. • Develop educational offerings for providers and birthing hospitals re: NAS		SPM 1: Rate of neonatal abstinence syndrome among Kentucky resident live births.	
Child Health					
Reduction of child injury rates with focus on preventable child injuries from child abuse and neglect, motor vehicle collisions, and other child injuries	Decrease by 5% the rate of emergency room visits among children ages 0-19 years by September 30, 2025.	• Adopt community educational opportunities, such as smoke alarm installations, water safety, etc. Provide injury prevention education for families participating in home visiting programs. • Increase the number of car seats that are installed and used appropriately and increase the number of CPS technicians in rural areas. Provide oversight and regulation of innovative programs such as comprehensive home safety assessments. Conduct outreach, education campaigns, and trainings in school-based settings.	ESM IH-Child.1 - Number of community members receiving training or technical assistance about preventable child injuries or death and promoting injury prevention activities including child maltreatment, child passenger, gun, water, fire, pedestrian, ATV, or more.	NPM - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9 (Injury Hospitalization - Child, Formerly NPM 7.1) - IH-Child	NOM - Child Mortality rate, ages 1 through 9, per 100,000 (Child Mortality, Formerly NOM 15) - CM NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly

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					NOM 16.3) - AM-Suicide
Reduce overweight and obesity among children, and adolescents	Reduce by 5% the percentage of 6-17 year olds reported in the National Survey of Children's Health (NSCH) who are obese by September 30, 2025.	• Develop support package and materials for technical assistance providers to increase capacity and consistency of TA provided. • Increase the number of collaborative partners for physical activity training within the school system. • Increase the number of schools with personnel trained in physical activity programs, such as Comprehensive School Physical Program (CSPAP), Integrating Classroom Physical Activity and recess trainings. • Infrastructure and Environmental Supports for Physical Activity: Promote the development and use of infrastructure that facilitates physical activity (e.g., walking trails, sidewalks, playgrounds, parks). • Maintain and develop additional online training modules that support ECE professionals in health best practices. • Promotion of nutrition and physical activity with Women, Infant and Children (WIC) recipients. • MCH remains committed to ongoing successful strategies/initiatives.	ESM PA-Child.1 - Number of early care and education professionals or providers completing training modules on nutrition, physical activity, or other obesity related opportunities.	NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day (Physical Activity, Formerly NPM 8.1) - PA-Child	NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS
Reduction of child injury rates with focus on preventable child injuries from child abuse and neglect, motor vehicle collisions, and other child injuries	Increase the percent of children with and without special health care needs, ages 0 through 17, who have a medical home by 1% (or at rate TBD).	Both MCH and OCSHCN may include one or more of the following Strategies: 1.) Work with Care Coordinators, Family-to-Family resources, and Family Liaison Consultant, and family members regarding increasing the number of personal doctor or nurse, or in-home providers and caregivers; 2.) Measure the percent of children who receive referrals annually; 3.) Establish training module in TRAIN or other course of study to train Primary Care providers (doctors, nurses, staff and other caregivers) regarding the benefits of a medical home and patient-centered care; 4.) Continued use of Telehealth and other resources that advance in-home patient care. Utilize findings from newly established Dashboard; 5.) Work with Primary Care providers regarding scheduling of appointments that are conducive to patient's needs, transportation issues, and other barriers to traditional office visits; 6.) Work on eliminating barriers to access.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.

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Adolescent Health					
Reduce overweight and obesity among children, and adolescents	Increase by 20% the proportion of Kentucky schools that have implemented a school wellness policy and a comprehensive school physical activity program by 2025	• Develop support package and materials for technical assistance providers to increase capacity and consistency of TA provided. • Increase the number of collaborative partners for physical activity training within the school system. (long term) • Increase the number of schools with personnel trained in physical activity programs, such as Comprehensive School Physical Program (CSPAP), Integrating Classroom Physical Activity and recess trainings. • Infrastructure and Environmental Supports for Physical Activity: Promote the development and use of infrastructure that facilitates physical activity (e.g., walking trails, sidewalks, playgrounds, parks). • Maintain and develop additional online training modules that support ECE professionals in health best practices.	ESM PA-Adolescent.1 - Number of districts receiving training or technical assistance for strategies to create a healthy school nutrition environment, or evaluation of recess and multi-component education policies.	NPM - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day (Physical Activity - Adolescent, Formerly NPM 8.2) - PA-Adolescent	NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS
Reduce outcomes related to substance use disorder for adolescents/pregnant women to reduce the number of Neonatal Abstinence Syndrome Cases or adolescents/children exposed to substances .	Reduce by 2% the proportion of children and adolescents who live in a household with someone who smokes based on the National Survey of Children's Health by 2025. o Baseline: 32.7% (2017), 20.5% (2020), Target 19% (2025) Data Source: DPH and Kentucky Center for Smoke-Free Policy	• Support the 100% Tobacco-Free Schools Evidence Informed Strategy by assisting the schools with implementing this policy. • Collaborate with stakeholders to increase the number of local communities with smoke/vaping-free laws and ordinances. • Home Visits + Education Materials + Telephone Counseling: Provide in-person counseling via home visits + educational materials + telephone counseling to reduce child exposure to secondhand/vaping smoke in the home. • School-based Counseling + Education Materials: Provide in-person counseling in a school setting + educational materials to reduce child exposure to secondhand smoke/vaping in the home. • Smoking Policies/Bans/Legislation: Support policies/legislation to establish smoking/vaping bans in homes, cars, and other family spaces.	ESM SMK-Household.1 - Percentage of Kentuckians covered by comprehensive smoke-free policies by 2026. Baseline: 32.7% (2017) Data Source: DPH and Kentucky Center for Smoke-Free Policy	NPM - Percent of children, ages 0 through 17, who live in households where someone smokes (Smoking - Household, Formerly NPM 14.2) - SMK-Household	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term

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					births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Improve mental health	Reduce by 5% child and	• Develop data surveillance for emergency department visits including		SPM 6: Percentage of	

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and behavioral health outcomes among adolescents.	adolescent deaths categorized as suicide by 2025	self harm • Research process for implementation of Zero Suicide program • Identify clinical systems already implementing Zero Suicide • Align Zero Suicide implementation to health care quality standards Modify current evidence informed strategy (MCH Package) for inclusion of Zero Suicide Program guidelines Develop TRAIN Modules for mental/behavioral health of adolescents for distribution to school, social work, hospital, PCPs, nurses and others		child and adolescent deaths categorized as suicide by 2025.	
Improve mental health and behavioral health outcomes among adolescents.	By 2026, reduce by 1% the number of Kentucky residents children/adolescents reporting 5 or more adverse childhood experiences with the KYBRFSS	• Adopt community educational opportunities, such as webinars, presentations on ACES awareness and resilience strategies. • Partner with parent groups and KYSF work to improve outreach and education • School-Based Interventions: Conduct outreach, education campaigns, and trainings in school-based settings.			
Children with Special Health Care Needs					
Transition services for CYSHCN and transition education for all children	Increase the total number of CYSHCN population across the state who are completing a Health Care Transition survey by 5% yearly to assist in successful transition from a pediatric to an adult healthcare provider.	• Create and distribute updated transitions survey by FY24 using information from GotTransitions.org to evaluate preparation of young adults 18-21 years old transition to adult healthcare. • Based on survey results, develop, and provide education regarding successful transition process and use of HCT tool for evaluation of transition outcomes to pediatricians and providers who care for children and youth. Repeat survey evaluation. • Survey to pediatricians on their transitions awareness and processes to inform education efforts for pediatricians and CYSHCN. Participate in Regional Interagency Transition Teams (RITTs) to collaborate with community agencies and identify challenges for transition using the HCT tool by community providers. • Administer Transition Readiness Assessment Checklist for OCSHCN patients starting at age 12, to assist in development of age-appropriate skills to prepare for transition to adulthood.	ESM TR.1 - Percentage of improvement as guided by the Health Care Transitions (HCT) Process Measurement tool assessing progress on the implementation of Six Core Elements of Health Care Transitions statewide	NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

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		• Incorporate Transfer of Care planning to identify adult health care providers able to provide care for CYSHCN.			
Data Capacity for CSHCN	Increase Data Capacity for CYSHCN using the Data Action Plan as a measurement. Increase yearly score by 20% to achieve a maximum allowable score of 36 points by the end of the 5-year needs assessment cycle. Goals are focused on internal growth and external collaboration.	Internal: 1. Increase internal data sharing and reporting. 2. Creating a formal process for developing informational tools and IT capabilities. 3. Establish a data utilization team that meets quarterly and provides meaningful assessments of enhancement requests. 4. Create a more formal process for application development and system enhancement requests. 5. Increase OCSHCN staff knowledge and use of internal OCSHCN information technology resources. 6. Disaggregate EHDI data by race and other factors such as language spoken, geographic region, etc. to determine disparities in newborn hearing screening, diagnosis, and intervention. Implement change if required. External: 1. Enter into data sharing agreement within the cabinet. 2. Work with KIDS Count data on children with disabilities or CYSHCN. 3. Work to integrate new data into KY Health Information Exchange (KHIE). 4. Find and use more external sources for data analysis. 5. Use contacts at universities and other partners for data analysis. 6. Develop surveys to measure external stakeholders (physicians, schools, and medical facilities) on matters related to CYSHCN such as transition services, access to care, and ECHO. 7. Increase access to state systems like kynect and with other agencies of the cabinet through technology integration.		SPM 9: Percent of OCSHCN 2022-25 Data Action Plan Components Completed.	
Adequate Insurance for CSHCN	Increase by 5% the number of families of CYSHCN reporting that they have access to adequate health insurance to cover needed services (CYSHCN Outcome #3) as measured by the National Survey of Children's Health (supplemented internally with OCSHCN data to capture subset of OCSHCN affiliated CYSHCN families).	• Educate and improve awareness among CYSHCN and their families regarding obtaining adequate insurance. • Increase the number of trained OCSHCN social workers and F2F HIC staff to serve as certified application counselors for KY Health Benefits Exchange (Kynect). • Collaborate with advisory committees and community partners to inform transition-aged youth about insurance options as they prepare to move to adult healthcare. • Monitor OCSHCN patients who have recently lost insurance coverage and follow-up on alternative options.		SPM 5: Percent of children ages 0 through 17 who are adequately insured.	
Access to Care and Services for CSHCN	Increase access to care to the CYSCHN population by addressing the barriers to	1. Provide resources to assist CYSHCN and their families to bet interact with first responders. Likewise, provide resources to assist first responders in working with CYSHCN. 2. Establish new partnerships		SPM 10: Percent of OCSHCN 2022-25 Access to Care Plan	

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	obtaining equitable health care. The goal will be measured using the OCSHCN Access to Care Plan, outlined by 10 strategies. The Access to Care plan will be scored yearly with a maximum score of 30 points to be achieved by the end of the 5-year needs assessment cycle.	that offer services closer to where patients and families live, with OCSHCN providing care-coordination. Expand reach to serve the population more efficiently. 3. Offer resources for CYSHCN and their families around resiliency by providing tools, resources, and positive parenting information. 4. Collaborate with neonatal providers, newborn nurseries, NICU staff, and other stakeholders to facilitate early intervention, treatment, and follow-up for NSA. 5. Educate pediatricians on healthcare transitions to increase number of CYSHCN and non-CYSHCN with a successful transition. 6. Utilize the ECHO model to educate providers. Initiate ECHO Autism and other topics based on system need. 7. Increase and tailor existing care-coordination services for children with medical complexities. 8. Track return rate of OCSHCN clinic applications based on race, language, and other available demographics to assess potential trends. Assess if there is a correlation between race and rate of return for applications. Implement change if required. 9. Find CHFS approved resource which outlines how racial equity, diversity, inclusion and access should be considered in agency materials/communications. 10. Engage with immigrant/ refugee centers to explain OCSHCN services to ensure access to health care/insurance coverage. Identify and establish an ongoing contact point for each center serving immigrants in Kentucky.		Components Completed.	
	Increase the percent of children with and without special health care needs, ages 0 through 17, who have a medical home by 1% (or rate TBD).	Both MCH and OCSHCN: Work with Care Coordinators, Family-to-Family resources, and Family Laison Consultant, and family members regarding increasing the number of personal doctor or nurse, or in-home providers and caregivers; Measure the percent of children who receive referrals annually; Establish training module in TRAIN or other course to train Primary Care providers (doctors, nurses, and other caregivers) regarding training staff about the benefits of a medical home and patient-centered care; Continued use of Telehealth and other resources that advance in-home patient care. Utilize findings from newly established Dashboard; Work with Primary Care providers regarding scheduling of appointments that are conducive to patient's needs, transportation issues, and other barriers to traditional office visits; Work on eliminating barriers to access.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.

Cross-Cutting/Systems Building

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Improve mental health and behavioral health outcomes among adolescents.	By 2026, reduce by 1% the number of Kentucky residents children/adolescents reporting 5 or more adverse childhood experiences (ACEs) with the KY Behavioral Risk Factor Survey System (KYBRFSS).	Adopt community educational opportunities, such as webinars, presentations on ACES awareness and resilience strategies. Partner with parent groups and KYSF to work to improve outreach and education. School-Based Interventions: Conduct outreach, education campaigns, and trainings in school-based settings.		SPM 8: Adverse Childhood Experiences: Percentage of KY respondents who report five or more ACEs.	