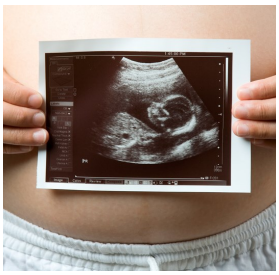



MCH 2020: Women & Maternal Health

Provide and assure women and mothers access to quality MCH services (women 15-44 years; pregnant women)

PRIORITY 1: Women have access to and receive coordinated, comprehensive care and services before, during, and after pregnancy.

1.1 All women of reproductive age who access Title V services receive prenatal risk assessments and education at least annually to improve birth outcomes.

1.2 Women are connected to the services and supports that they need to promote their emotional wellbeing through 100% screening and/or referral rates at every visit.

1.3 Communities have the capacity and resources to promote education, screening, referral, and treatment for women and families.

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^PRIORITY 2: Services and supports promote healthy family functioning.

2.1 Women and families show evidence of healthy relationships and life skills that support daily family functioning through improved outcomes on annual Becoming a Mom program evaluations.

2.2 Provide opportunities that promote and support informed, engaged, and empowered families as evidenced by increased referral and service delivery as collected in annual program data.

2.3 Align home visiting programs and expand services to ensure families are matched to services that meet their needs.

+PRIORITY 3: Developmentally appropriate care and services are provided across the lifespan.

3.4 Integrate oral health care and preventive services into programs and services for MCH populations in order to promote overall good health and desirable outcomes.

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

6.1 Build MCH capacity and support the development of a trained, qualified workforce serving Kansas children and families by providing professionals with up-to-date best practices and evidence-based services using a multi-faceted approach (referral network, mid-level training for home visitors, partnership support).

6.2 Deliver annual training and education to ensure that providers have the ability to promote diversity, inclusion, and integrate supports in the provision of services for the Special Health Care Needs population into adulthood.

***PRIORITY 7: Services are comprehensive and coordinated across systems and providers.**

7.1 Improve communication and outreach among service providers, individuals, and families for care coordination.

7.3 Assist and empower individuals and families to navigate systems for optimal health outcomes throughout the life course.

^PRIORITY 8: Information is available to support informed health decisions and choices.

8.1 Partner with existing programs (pediatricians, youth programs, local schools) to increase understanding of parents and teens as to the importance of and making informed decisions about healthy choices and regular self-care.

8.3 Assist individuals and families with navigating the health care system to locate, evaluate, access and utilize appropriate health care coverage and services.

#PRIORITY (Smoking Cessation): The rate of smoking in women in their reproductive years is reduced by 10%.
(Focus before, during, and after pregnancy.)

**Special Health Care Needs* *^Cross-cutting / Life course* *+Child* *#Infant Mortality CoIIN*

NATIONAL PERFORMANCE MEASURE(S): NPM 1 - Percent of women with a past year preventive medical visit

Kansas Department of Health and Environment

Vision: Title V envisions a nation where all mothers, children and youth, including CSHCN, and their families are healthy and thriving.

Mission: To improve the health and well-being of the nation's mothers, infants, children and youth, including children and youth with special health care needs, and their families.

KANSAS MATERNAL & CHILD HEALTH

PERFORMANCE MEASURE 1 Percent of women with a past year preventive medical visit

GOAL	To increase the number of women who have a preventive medical visit.
DEFINITION	**Numerator:** Number of women, ages 18 through 44, who had a preventive medical visit in the past year **Denominator:** Number of women, ages 18 through 44 **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Maternal, Infant, and Child Health (MICH) Developmental Objective 16.1: Increase the percentage of women delivering a live birth who discussed preconception health with a health care worker prior to pregnancy Related to Access to Health Services (AHS) Developmental Objective 7.0: Increase the proportion of persons who receive appropriate clinical preventive services
DATA SOURCES and DATA ISSUES	Behavioral Risk Factor Surveillance System (BRFSS)
MCH POPULATION DOMAIN	Women/Maternal Health
SIGNIFICANCE	A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit has been endorsed by the American College of Obstetrics and Gynecologists (ACOG) and was also identified among the women's preventive services required by the Affordable Care Act (ACA) to be covered by private insurance plans without cost-sharing.

INFANT MORTALITY COIIN: KANSAS LEARNING NETWORKS	
SMOKING CESSATION *Primary focus: Reduce smoking before, during and/or after pregnancy*	
Aim/Goals	By July 2016, we will reduce the rate of smoking in women in their reproductive years by 10% with emphasis on before, during, and after pregnancy. • Increase the percentage of women who stop smoking during pregnancy by 10% • Increase the percentage of women who maintain cessation after delivery by 10% • Increase the number of women enrolled in Quitline in reproductive years (15-44 years of age) by 10% • Increase the number of providers trained on the 5A's of tobacco cessation by 10%, implementing a provider reminder system and the KS Quitline fax referral system • In pilot sites: Increase the percentage of smoking women who are referred to smoking cessation counseling and programs like Quitline to 95% or higher

Primary Drivers & Change Ideas	**Providers and support personnel refer women to evidence-based programs like Quitline (Driver 2)**
	1. Screen for smoking at every visit and make referrals at the time of screening
	  o Cessation counseling
	  o Evidence-based interventions (Ex: Quitline, SCRIPT, Baby and Me Tobacco Free programs)
	2. Follow up with women referred to stop smoking; inquire and refer again with advice
	3. Refer adolescents and college age women to evidence-based support services like Quitline

	Women in child bearing years avoid smoking or stop and stay quit (Driver 4) 1. Leverage consistent, repeat messages about tobacco and nicotine across all systems 2. Use media, social media, texting, videos, peer to peer mentoring 3. Use of 5As and motivational interviewing techniques to help women commit to cessation
	Providers recognize role in coaching and supporting women to stop and stay quit (Driver 5) 1. Train providers in smoking interventions and aware of resources/interventions 2. Place toolkits (screening, referral, resources, programs) in the hands of providers 3. Enlist support of pediatricians to inquire about smoking, counseling, referrals postpartum
State Measures	*Outcome Measures* • Smoking Cessation Prior to Pregnancy • Smoking Cessation During Pregnancy

	• Percentage of women who report smoking during pregnancy • Number of enrolled women Quitline participants, in childbearing years, who report cessation at 7th month after enrollment (in States where Quitline collects this data) • Disparity reduction in all 5 outcome measures *Process Measures* • Number of enrolled Quitline participants in childbearing years
Pilot Measures	*Outcome Measures* • % Pregnant women referred to Quitline who report they quit smoking at clinic visit • % Women with continued cessation at post-partum visit *Process Measures* • % Quitline Referrals • % Pregnant Women Counseled by Pilot Site to Quit • % Engagement of Women who Smoke • % Home Visitation Referrals by Clinic
PRE/EARLY TERM BIRTH *Primary focus: Increase appropriate utilization of progesterone and/or reduce early elective deliveries*	
Aim/Goals	By July 2016, reduce prevalence of preterm and early term singleton births by 10 %. • Decrease non-medically indicated births between 37 0/7 weeks of gestation through 38 6/7 weeks of gestation to less than 5% • Increase the percent of pregnant women on Medicaid with a previous preterm birth who receive progesterone to 40% • Achieve or maintain equity in utilization of progesterone by race/ethnicity • Increase the number of *Healthy Babies are Worth the Wait/Becoming a Mom* (HBWW/BAM) sites by at least 5
Primary Drivers & Change Ideas	**Timely, reliable and effective screening, identification and prevention of pre-term birth (Driver 1)** 1. Universal practice protocol and tool to screen women for history of preterm birth and short cervix 2. Establish universal process for early access to care 3. Use claims data and data linkages to increase the number of women prescribed progesterone
	Increase patient, family and community understanding of progesterone and full term births (Driver 3)

	1. Integrate early elective delivery (EED) and progesterone education/materials into HBWW/BAM 2. Integrate screening and referral to BAM into WIC—intake, appointment interviews, data collected 3. Utilize existing blogs, websites and text messaging, such as Healthy Mom and Baby, March of Dimes Share Your Story and CineMama, and Text4Baby to provide information on progesterone
	Build capacity of and support for hospitals and providers to reduce EED (Driver 5) 1. Standard forms for scheduling that collect gestational age and indication for delivery (to determine medically indicated) 2. Standard tool, process, reporting system for EED 3. Standard protocol and/or policies (hard stop, scheduling process/form, informed consent, flow charts, etc.
State Measures	*Outcome Measures* • Initiation of Progesterone in Women with Prior Preterm Birth • Early Term Birth Rate • Non-medically indicated, early elective delivery • Stillbirth Rate (Balancing Measure)
Pilot Measures	*Process Measures* • Preterm Birth Risk Screening: Cervical Length • Preterm Birth Risk Screening: Prior Preterm Birth • Prescription for Progesterone • Progesterone and Home Visiting • Expected Delivery Date at Time Delivery is Scheduled

First Pilot Sites: Pre/Early Term Birth: Sedgwick County (Associates in Women's Health OBGYN); Geary County (Flint Hills OBGYN); Smoking Cessation: Sedgwick County HD WIC clinic; Saline County HD & collaborative partners; Crawford County HD & collaborative partners

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*The United States has one of the highest rates of infant mortality of all industrialized nations. On average, 6.15 out of every 1,000 babies born in the US die before their first birthday, based on 2010 statistics. This compares with an average of 5.0 for all other industrialized nations. Minority populations are disproportionately affected: the risk of infant death for babies born to non-Hispanic black women is more than two times greater than the risk of infant death for non-Hispanic white women. In 2013, US Department of Health and Human Services (HHS) Secretary, Kathleen Sebelius, announced the nation's first national strategy to reduce infant mortality. The Infant Mortality Collaborative Improvement and Innovation Network (CoIIN) Expansion is a key component of this strategy. A collaborative innovation network, or COIN, is a "cyberteam of self-motivated people with a collective vision, that innovatively collaborate by sharing ideas, information, and work enabled by technology." For more information, visit HRSA/MCHB website at: http://mchb.hrsa.gov/infantmortality/coiin/.