DRAFT
TITLE V MATERNAL & CHILD HEALTH 5-YEAR STATE ACTION PLAN

PRIORITY 1: Women have access to and receive coordinated, comprehensive services before, during and after pregnancy. (Women/Maternal)

- *NPM 01: Well-woman visit (Percent of women with a past year preventive medical visit)*
- ***Impacts:*** *NPM 14-B: Smoking during Pregnancy and Household Smoking (B. Percent of children who live in households where someone smokes)*

OBJECTIVE 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.

Strategies	Outcomes
1.1.1 Obtain consensus among providers on standards of care and practice guidelines related to prenatal risk assessment • *Develop protocol and guidelines including utilization of progesterone to prevent preterm birth* • *Engage perinatal obstetricians to provide educational materials on recommended immunizations for women* • *Establish universal process for early access to care*	• Greater than 90% of at-risk women receive 17-P (previous preterm birth <37 weeks) • Reduced preterm birth rate by 10% through utilization of 17-P protocols Reduced NICU admissions due to prenatal or maternal use of substances (illegal or prescription drugs) (Neonatal Abstinence Syndrome - NAS) • Uniform Screening and monitoring for high-risk conditions for pre-term deliveries • High risk deliveries referred/performed in the facility that provides the appropriate level of care
1.1.2 Expand the *Becoming a Mom* (BAM) program model to at least ten new communities (from 10 to 20 total), targeting communities and regions with disparities and poor birth outcomes • *Replicate the model in at least five new communities* • *Integrate evidence-based tobacco cessation interventions, including the Quitline, into community-based service models* • *Link smoking during pregnancy/in the home to increased risk for infant mortality, especially SUID and SIDS* • *Decrease wait time for Medicaid coverage and access to prenatal care through referral to the outstation workers* • *Promote compliance with recommended immunizations for women and pregnant women*	• Increased utilization of the Quitline • Increased number of women reporting they quit and stay quit • Reduced rate of smoking in the household • Decreased preterm birth and low birth weight • Reduced infant mortality • Increased breastfeeding rates
1.1.3 Timely, reliable and effective screening, identification and prevention of pre-term birth to reduce prevalence of preterm and early term singleton births by 10 %* • *Universal practice protocol and tool to screen women for history of preterm birth and short cervix* • *Build capacity of and support for hospitals and providers to reduce EED (Driver 5)*	• 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

• *Standard forms for scheduling that collect gestational age and indication for delivery (to determine medically indicated)* • *Standard tool, process, reporting system for EED* • *Standard protocol and/or policies (hard stop, scheduling process/form, informed consent, flow charts, etc.*	
OBJECTIVE 1.2: Women are connected to the services and supports that they need to promote their emotional well-being through 100% screening and/or referral rates at every visit.	
Strategies	**Outcomes**
1.2.1 Integrate behavioral health education into community, clinic, and home settings • *Promote the ongoing participation in Medicaid Health Homes for serious mental illness or other chronic conditions chronic illness* • *Establish home visiting protocol that supports adequate referral and follow up for behavioral health screening and treatment*	• Increased access to and coordinated behavioral health services • Increased consumer knowledge of services, tools, resources, and community supports • More timely screenings • Reduced ER visits and hospital stays
1.2.2 Implement a standard screening protocol and utilization of standard tool for maternal risk and depression • *Local HDs utilize when appropriate* • *Coordinate among community partners*	•
OBJECTIVE 1.3: Communities have the capacity and resources to promote education, screening, referral, and treatment for women and families.	
Strategies	**Outcomes**
1.3.1 Promote and collaborate with family planning and Title X to improve women's health • *Well woman visits* • *promote and support reproductive health and planning* • *interconception care and spacing of children* • *cervical/breast cancer screening* • *methods of contraception including Long Acting Reversible Contraceptive (LARC)*	• By June 29, 2017, assist at least 10% of local agencies with increasing the number and effectiveness of contraceptive methods offered, including Long Acting Reversible Contraceptives (LARC). • Regular self-care and well woman visits • Uniform Screening and monitoring for high-risk conditions among Title X and Title V grantees • Improved, coordinated, comprehensive reproductive health/ life planning and MCH services for women • Joint/shared messages and updates re: progress, data, priorities, outcomes, etc. • Increased access to coverage appropriate • Earlier access to prenatal care • Increased compliance with prenatal and well visits
1.23.2 Increase community capacity through asset mapping and forging partnerships to address MCH population health needs • *Increase the number of public health departments with certified application counselors on site to support women in selecting appropriate health plans* • *Promote value-added services offered by KanCare Managed Care*	• Equitable MCH services/access in each public health region • Increased utilization of value added services by 10% • Increased number of contacts with each woman throughout pregnancy and post-partum period by 10%

Organizations at the provider and community level	• Increased first trimester prenatal care utilization by 10% • Established service delivery collaborations at the community and regional levels Inventory of services and programs across the states • Identified assets as well as gaps and barriers • Targeted efforts in areas of the state where outcomes are poor and disparities (racial/ethnic and social/economic) persist • Strengthened partnerships • Expanded referral networks
1.3.3 Increase patient, family and community understanding of progesterone and full term births* • *Integrate early elective delivery (EED) and progesterone education/materials into BAM* • *Integrate screening and referral to BAM into WIC—intake, appointment interviews, data collected* • *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*	• 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
PRIORITY 2: Services and supports promote healthy family functioning. (Cross-cutting/Life course) • *NPM 14-B: Smoking during Pregnancy and Household Smoking (B. Percent of children who live in households where someone smokes)*	
OBJECTIVE 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.	
Strategies	**Outcomes**
2.1.1 Address family functioning in all MCH contacts • *Provide education to women and families on the importance of meal time and bedtime routines* • *Promote the importance of partners as active participants in health matters and provide opportunities for women to engage them in programs and services* (ties directly to NPM14-B partners/smoking in home, infant risk) • *Provide education on the importance of future planning as it relates to building strong relationships and health and family considerations (spacing of children)*	• Empowered, prepared adults and families • Increased potential for families to reach their financial, personal, and professional goals • Reduced risk of domestic violence, substance abuse, and poverty • Improved family functioning and communication • Reduced stress among family members
2.1.2 Utilize the Kansas Special Health Care Needs (KS-SHCN) "Family Caregiver Assessment" to identify needs and resources for family members of clients • *Provide education for families of children and youth with special health care needs as to how their role as a caregiver impacts the their own health and ability to care for their loved one*	• Family caregivers of children on the SHCN program will complete a family caregiver assessment to assist the SHCN Care Coordinator in identifying needs and resources.

2.1.3 Screen for smoking at every visit and make referrals at the time of screening to reduce the rate of smoking in women in their reproductive years by 10% with emphasis on before, during, and after pregnancy*
• *Providers and support personnel refer women to evidence-based programs like Quitline*
  ○ *Cessation counseling*
  ○ *Use of 5As and motivational interviewing techniques to help women commit to cessation*
  ○ *Evidence-based interventions (Ex: Quitline, SCRIPT, Baby and Me Tobacco Free programs)*
• *Leverage consistent, repeat messages about tobacco and nicotine across all systems*
• *Use media, social media, texting, videos, peer to peer mentoring*
• *Train providers in smoking interventions and aware of resources/interventions*
• *Place toolkits (screening, referral, resources, programs) in the hands of providers*
• *Enlist support of pediatricians to inquire about smoking, counseling, referrals postpartum*
	• 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

OBJECTIVE 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.	
Strategies	**Outcomes**
2.2.1 Utilize peer and social networks for women to promote and support access to preventive health care • *Promote building relationships with women in education class* • *Facebook group* • *Circles as model (Heather Morgan)* • *Public awareness/community norms re: behaviors*	• Increased well woman preventive medical visits • Fewer pre-term births • Increased awareness of women's health needs and importance of preventive care.
2.2.2 Develop a progressive family leadership program to empower families and build strong MCH advocates	• Family members of CYSHCN will be prepared to advocate for quality of care for their child.
2.2.3 Provide family and sibling peer supports for those interested in being connected to other families with similar experiences (Foster Care, Special health care needs, other)	
OBJECTIVE 2.3: Align home visiting programs and expand services to ensure families are matched to services that meet their needs.	
Strategies	**Outcomes**
2.3.1 Using an evidence-based model, provide parenting resources and mentors for adolescent caregivers • *Home visiting approach* • *Parent to Parent (mentors, coaches, lived experience)* • *Referral to evidence-based smoking intervention*	• Provide support to parents who experience problems, such as relationship, violence, substance abuse and mental health issues, to enable enhanced relationships with their adolescents.

2.3.2 Redesign the universal MCH Home Visiting program to serve more families and target those most appropriate for the program	• HSHV increase number of families served
2.3.3 Replicate Maternal, Infant, and Early Childhood (MIECHV) central intake model across the state to support appropriate referral and level of service/intervention	• Improved practice and standard/approach • Services targeted and aligned with the need (intensity, duration)

PRIORITY 3: Developmentally appropriate care and services are provided across the lifespan. (Child)

- *NPM 06: Developmental screening (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)*
- *NPM 07: Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9*

OBJECTIVE 3.1 Infants, children and adolescents are in environments where there are safeguards against preventable injury and harm.

Strategies	**Outcomes**
3.1.1 Assure appropriate motor vehicle safety education is provided for all individuals transporting infants and children • *Training/class targeted to child care providers* • *Increase number of trained car seat technicians/support additional check lanes for MCH* • *Incorporate information and check lane locations into BAM site education/information*	• Decrease the rate of motor vehicle occupant injuries among child passengers under age 8, 80 lbs or 4 ft 9 inches increase by 3% • Increase the number of children riding in age and size appropriate seats until at least age 8, 80 lbs or 4 ft 9 inches in Kansas by 10% by 2016 (Bureau of Health Promotion)
3.1.2 Establish prevention activities focused on reducing motor vehicle crash injuries and deaths to adolescents due to distracted or impaired driving (SAFE initiative)	• Decrease the rate of motor vehicle occupant injuries among those 14 years and older by 5% in Kansas by 2016 • Increase the percent of Kansans over 14 years of age using a seatbelt by 10% by 2016 • Increase the percent of Kansans under age 14 using a bike helmet by 10% (Bureau of Health Promotion)
3.1.3 Engage home visiting in evaluating safety concerns in the home and provide education regarding prevention and risk • *Hospital rounds/prior to discharge (checklist)* • *On-site visits, check ins and review of environment* • *Tracking of discussion/environment risks and rechecking on follow up*	• Increase the number of MCH grantees that serve as lead agency for local safe kids coalitions
3.1.4 Increase the number of MCH grantees that serve as the home agency for local Safe Kids Coalitions	• Increase the number of MCH grantees that serve as lead agency for local safe kids coalitions
3.1.5 Provide education and support to assist parents with selecting a child care setting that meets health and safety requirements • *Promote and educate providers, media, public on online compliance and open records information* • *Provide education and information regarding child care requirements and access through BAM programs*	• Increased utilization of resources and tools available (e.g. Child Care Aware and other referral networks/providers) • Increased access and utilization of the online child care information dissemination system (compliance history and license verification) • Increased awareness and safety for children in out of home care

OBJECTIVE 3.2: Children receive immunizations according to the recommended schedule.	
Strategies	**Outcomes**
3.2.1 Improve access to childhood immunizations for families by reducing barriers and improving delivery processes	• Increased compliance with recommended immunizations • Increased awareness of, access to, and utilization of the Vaccines for Children (VFC) program
3.2.2 Support medical and early intervention providers through appropriate tools and resources to encourage parents resistant of immunizing their child(ren)	• Increased compliance with recommended immunizations • Increased awareness of risks and health benefits (individual and public) of immunizations • Increased utilization of the Vaccines for Children (VFC) program
3.2.3 Provide parent education on immunizations, including schedules, and the importance to child health • *Utilize screening tools in practices for parents to identify if child is on time or needs to catch up on the recommended schedule* • *Promote the "Immunize, Bee Wise" campaign through WIC and MCH clinics*	• Increased compliance with recommended immunizations • Increased awareness of risks and health benefits (individual and public) of immunizations • Increased awareness of, access to, and utilization of the Vaccines for Children (VFC) program
OBJECTIVE 3.3: Multi-sector (individual, health care/social service provider, community, organization) approaches are in place to reduce SIDS and Sudden Unexplained Infant Death (SUID) rates.	
Strategies	**Outcomes**
3.3.1 Provide essential supplies including sleep sacks and pack and plays to families and caregivers identified as at risk and in need	•
3.3.2 Launch a campaign on safe sleep practices targeted to relative caregivers and those providing family-friend-and neighbor care • *Establish safe sleep standard of care for clinical providers, birthing facilities, and home visitors*	• Coordinated Safe Sleep Public Service Announcements • Knowledge of infant safe sleep will increase • Sharing of information with clients/patients will increase • Increased awareness and compliance with safe sleep practices • Safe sleep toolkits integrated into the BAM curriculum
3.3.3 Inventory existing safe sleep initiatives and activities to determine what services are needed and areas to target education, training, and materials • *Identify a safe sleep expert in every region of the state and ensure availability of core health and safety training related to safe sleep policies and practices*	• Safe sleep service gaps will be identified • Layered GIS map of existing services provided by community programs (HSHV, PAT, Safe Kids, BAM, Early Head Start, clinics, birthing hospitals, etc.) • Diverse statewide representation to embed safe sleep messages
OBJECTIVE 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.	
Strategies	**Outcomes**
3.4.1 Integrate oral health education into prenatal and infant health education • *Through BAM programs* • *Providers/pediatricians* • *Well woman/prenatal clinic visits – dental screening* • *PRAMS*	• Perinatal health / infant mortality reduction- relationship between poor oral health and negative birth outcomes • Relationship between breastfeeding and reduced caries risk • Improved oral health behaviors such as proper tooth brushing with fluoride toothpaste

• *Promote oral health integration into state Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) by providing oral health training, education, and resources to home visiting programs*	• Appropriate feeding and eating practices • Healthier food choices • Using mouth guards and helmets during sports and recreational activities • Cessation of tobacco use
3.4.2 Promote oral health in all programs targeted towards CYSHCN through care coordination activities • *Conduct a statewide needs assessment for oral health services for CYSHCN*	• Improved identification of oral diseases, injuries, and craniofacial disorders leading to timely referral for care and coordination of services • KS-SHCN clients will experience fewer oral health problems
3.4.3 Implement collaborative oral health initiatives to expand oral health screening and education to targeted to infants and children • *Healthy Smiles*	• Increased tooth brushing in homes and child care facilities • Increased number of providers trained in oral health • Increased number of children screened for dental decay • Reduced number of children with a cavity before age 5 • Increased access to preventive oral health services, especially for families with low incomes or those with inadequate or no insurance
OBJECTIVE 3.5: All children receive an age-appropriate developmental screening at least annually with a valid and reliable tool.	
Strategies	**Outcomes**
3.5.1 Build MCH capacity for screening follow-up through complete referrals to providers and community-based services • *KIDOS: Increased ASQ screenings and referrals for at-risk children 0-3 statewide*	•
3.5.2 Conduct statewide campaign to coordinate among providers who screen for developmental delays, including recommended protocols for information sharing • *KIDOS: Improved coordination of referral and services between early care and education, medical homes, and intervention providers* • *Conduct comprehensive analysis to identify the various types of providers who are conducting developmental screening and determine which tools are being utilized* • *Provide developmental screening assessments across the state through outreach and telehealth*	• SHCN clients receive a developmental screening or assessment, which is shared among all service providers working with the family
3.5.3 Develop a standard and consistent message to communicate importance of developmental screening among home visiting and child care programs	• Consistent shared/aligned message • Increased number of children screened • Reduced time from screening to identification and receiving early intervention services
PRIORITY 4: Families are empowered to make educated choices about nutrition and physical activity. (Perinatal/Infant) • *NPM 4: Breastfeeding (A. Percent of infants who are ever breastfed and B. Percent of infants breastfed exclusively through 6 months)*	
OBJECTIVE 4.1: Infants, children, and adolescents ages 0-17 years of age and older have access to healthy foods and increased knowledge of opportunities for	

physical activity in order to adhere to and achieve optimum lifelong health.	
Strategies	**Outcomes**
4.1.1 Increase the availability of healthy food and beverages in sufficient supply in schools • *Develop or improve school policies related to allowing water and food in elementary, middle, and high school classrooms to support health and school performance* • *Consider time to access water and snacks in between academic classes/during transition* • *Incorporate healthy snacks as rewards/incentives*	• BHP: Walk and bike to school initiatives
4.1.2 Increase opportunities for students to participate in regular physical activity both in and out of school (e.g., non-competitive sports leagues, intramural) • *Promote and support the Bike to School and Walk to school events; support with resources like reflectors, tape, etc.* • *Partner with schools and communities to identify safe biking and walking routes between home and school* • *Expand the "walking school bus" program (Marion Co)*	•
4.1.3 Promote and implement "brain breaks" in schools including recess and designated time between classes and activities	•
OBJECTIVE 4.2: Parents have access to information and resources on infant nutrition and feeding education in a multi-faceted way using existing programs starting in the prenatal period, initiated during the first trimester.	
Strategies	**Outcomes**
4.2.1 Align and strengthen infant feeding education (breastfeeding and bottle feeding) and support through existing programs, including *Becoming a Mom*, home visiting, and WIC	•
4.2.2 Support breastfeeding mothers and babies by creating communities in Kansas that provide a multifaceted approach to breastfeeding support across community sectors • *Expand the Communities Supporting Breastfeeding model to at least ten new Kansas communities*	•
4.2.3 Develop prenatal education content to support an accurate, consistent message for women related to optimal infant feeding • *Develop standard curriculum for infant feeding for use by local communities across the state; integrate into the Becoming a Mom prenatal education sessions*	•
OBJECTIVE 4.3: Increased opportunities for regular physical activity for families are provided through structured environments and improved accessibility to facilities that support physical activity.	
Strategies	**Outcomes**
4.3.1 Explore opportunities to engage local businesses in health and wellness activities	•
4.3.2 Provide resources and educational materials to child care and home visiting	•

programs focused on healthy eating and physical activity in early childhood to decrease risk of obesity in childhood and adolescence	
4.3.3 Support local health departments and/or community centers in local initiatives to promote physical activity and utilization of walking and biking trails	•

PRIORITY 5: Communities and providers support physical, social and emotional health. (Adolescents)

- *NPM 09: Bullying (Percent of adolescents, 12 through 17, who are bullied or who bully others)*
- *NPM 10: Adolescent well-visit (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year)*

OBJECTIVE 5.1: All children and adolescents receive comprehensive preventive health care that addresses social and emotional aspects of health at annual child and adolescent well visits, promoted through a developed cross-system partnership (schools, community, partners, health care providers).

Strategies	Outcomes
5.1.1 Promote annual well-child visits through adolescence into adulthood • *Engage Medicaid and MCOs to develop a cross-system partnership and develop protocols for follow up on children and adolescents not receiving annual preventive services*	•
5.1.2 Engage school nurses to identify and refer children with an Individualized Healthcare Plan who have not had a well-child visit in the past year	•
5.1.3 Promote incorporation of behavioral health screening into annual child and adolescent well visits • *Develop follow-up protocols for families to be referred for behavioral health services and offer additional support as needed to assure services are received.* • *Behavioral health awareness days with free screenings across the state.* • *Provide school-based access to confidential mental health screening, referral and treatment that reduces the stigma and embarrassment often associated with mental illness, emotional disturbances and seeking treatment.* • *Increase access to substance abuse screening, treatment and prevention services through co-locating screening, treatment and prevention services in schools and/or facilities easily accessible to adolescents in out of school time.*	•

OBJECTIVE 5.2: Adults, children, and adolescents are aware of and have access to prevention and intervention programs that educate, empower, and equip them to practice protective factors to reduce the impact of bullying through MCH community and school trainings provided annually.

Strategies	Outcomes
5.2.1 Increase awareness of options for educating and reporting unsafe digital content	•
5.2.2 Partner with school nurses and counselors to provide access to behavioral health services in schools as well as develop bullying and cyberbullying prevention and intervention programs • *Steps to Respect* • *Committee for children* • *School events, assemblies, speakers, champions*	•

5.2.3 Establish networks of skilled, supported adult mentors that are available to adolescents in safe, accessible environments • *Make connections among schools, families, communities, and school trainings provided annually* • *Communities in Schools (CIS) and school-based clinics* • *Equip parents/caregivers/home to deal with the impact on family of bullying*	•
OBJECTIVE 5.3: All youth are provided with the support, relationships, and resources they need in order to build and improve coping skills and manage stress though measureable, positive youth development interventions and the implementation of evidence-based practices to prevent suicide.	
Strategies	**Outcomes**
5.3.1 Partner with communities to connect children and adolescents with supports that promote protective factors • *Faith-based* • *Schools* • *Encourage the implementation of policies, procedures, and the evaluation of programs in health care settings to assess for and intervene with adolescents at risk for suicide* • *Encourage the implementation of policies, procedures, and the evaluation of programs in health care settings to assess for and intervene with adolescents at risk for suicide*	•
5.3.2 Implement evidence-based/evidence-informed practices to support healthy behaviors and choices and the development of positive coping mechanisms among adolescents • *Support public awareness campaigns to prevent adolescent self-injury* • *Promote the yellow ribbon initiative and accessible crisis services through school and out-of-school activities* • *Promote the yellow ribbon initiative and accessible crisis services through school and out-of-school activities*	•
5.3.3 Provide services that support reducing the impact of Adverse Childhood Experiences (ACEs) on children and adolescents • *Training for MCH staff, grantees and community partners*	• Provide services that support reducing the impact of Adverse Childhood Experiences (ACEs) on children and adolescents
PRIORITY 6: Professionals have the knowledge and skills to address the needs of maternal and child health populations. (Cross-cutting/Life course)	
OBJECTIVE 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 multi-faceted approach (referral network, mid-level training for home visitors, partnership support).	
Strategies	**Outcomes**
6.1.1 Increase knowledge of providers, partners, and consumers, including families as it relates to Kansas Maternal and Child Health: purpose, scope, target populations,	•

programs, services, and more • *Utilize MCH Navigator and MCH Competency Assessment (state and local levels)* • *Incorporate MCH competencies more intentionally into position descriptions*	
6.1.2 Professionals are up to date on best practices and evidence-based interventions and services • *Mid-level training for home visitors* • *Providers/social workers/professionals trained in ACEs* • *Referral network, coordination, partnerships* • *Train mid-level professionals working with families on strategies to address risk of immediate harm to support safe, stable and nurturing environments*	• Immediate recognition of and response to crisis situations • Interim solution during wait for appointment post referral • Increase awareness of ACEs and impact across the life span • Increased number of professionals trained on Lemonade for Life
6.1.3 Improve coordination with the Center for Population Health specific to workforce development for primary care	•
OBJECTIVE 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 (SHCN) population into adulthood.	
Strategies	**Outcomes**
6.2.1 Offer information and training to child care and education providers to support inclusion within those settings and assure higher quality care for CYSHCN	• Parents will experience fewer issues finding qualified child care providers to care for children who are not of school age
6.2.2 Host webinars and online trainings for health providers on caring for CYSHCN, adapting from the Caring for People with Disabilities course • *Promote through conferences, grand rounds, webinars, etc.*	• **UNDER DEVELOPMENT –** Will adapt from course syllabus from previous Caring for People with Disabilities class, including a pre/post test to determine level of understanding and capacity for change
6.2.3 Partner with NAMI to offer youth and adult education programs to KS-SHCN clients • *Reduce stigma through community awareness and education, including parent and client education materials about behavioral health.*	• **UNDER DEVELOPMENT** – looking at valuable behavioral health data sources and working with partners to identify existing data rather than creating new data sources or data points
OBJECTIVE 6.3: Ensure availability of ongoing, up to date education and training opportunities that promote consistent messages and curriculums aimed at the social-emotional development of children for child care providers.	
Strategies	**Outcomes**
6.3.1 Make available and provide training to child care providers on social-emotional development, milestones, and age-appropriate activities (e.g. Second Step)	•
6.3.2 Develop and disseminate consistent messages across all entities working with early childhood (coordination)	•
6.3.3 Partner with statewide networks such as Child Care Aware and Kansas Child Care Training Opportunities to assess the training needs of providers and develop training to meet the needs	•
PRIORITY 7: Services are comprehensive and coordinated across systems and providers. (CYSHCN) • *NPM 11: Medical home (Percent of children with and without special health care needs having a medical home)*	

OBJECTIVE 7.1: Improve communication and outreach among services providers, individuals, and families for care coordination.	
Strategies	**Outcomes**
7.1.1 Support implementation of family-centered medical homes through increased awareness, professional development, and collaboration • *Support partners (Tele-med, AAP, family practice) in improving access to medical homes*	• Better outcomes for women and children, reduced infant mortality; fewer pre-term births, increased physician visits
7.1.2 Implement communication and referral protocols for SHCN Care Coordinators and providers • *Provide support to agencies working with foster homes and system partners serving CYSHCN in foster care.* • *Engage MCO's and primary care providers in collaborative coordination for SHCN clients.*	• Medical home (% of children with and without special needs having a medical home)
7.1.3 Expand KS-SHCN to have care coordinators located in all regions	• SHCN staff can assure effective communication to support care coordination and document patient outcomes
OBJECTIVE 7.2: Systems that support age and developmentally appropriate, universal behavioral health are integrated, increasing collaboration among systems of care.	
Strategies	**Outcomes**
7.2.1 Explore partnerships with and support existing structures that promote behavioral health services • *KAIMH, KDADS, Schools* • *Provide school-based access to confidential mental health screening, referral and treatment that reduces the stigma and embarrassment often associated with mental illness, emotional disturbances and seeking treatment* • *Increase access to substance abuse screening, treatment and prevention services through co-locating screening, treatment and prevention services in schools and/or facilities easily accessible to adolescents in out of school time*	•
7.2.2 Promote collaboration between primary care and behavioral health providers	•
7.2.3 Integrate behavioral health assessment results in the KS-SHCN action plan resources/referrals	• SHCN clients receive a behavioral health screening or assessment, which is shared among all service providers working with the family.
OBJECTIVE 7.3: Assist and equip individuals and families to navigate systems for optimal health outcomes throughout the life course.	
Strategies	**Outcomes**
7.3.1 Develop, monitor and evaluate a patient-centered care coordination action plan for all SHCN clients • *Provide support to agencies working with foster homes and system partners serving CYSHCN in foster care*	• **UNDER DEVELOPMENT**: Telehealth outcomes are being developed through the AMCHP Workforce Development Center Cohort 2 Project • SHCN families will be supported and feel comfortable coordinating care and navigating systems
7.3.2 Complete the online navigational tool kit to provide resources and services	• Families will experience a decreased need of care coordination support

7.3.3 Increase access to primary and specialty care in underserved areas • *Expand KS-SHCN Specialty Clinics through rural outreach and telemedicine* • *Increase utilization of Medicaid, CHIP, and Health Insurance Exchange services through education and referrals*	• SHCN care coordinators will be connected with foster care and MCO case managers to provide technical assistance and support for SHCN clients SHCN providers will have access to care coordinators for support and assistance in their community. *NOTE: This could be in-person or remote access*
PRIORITY 8: Information is available to support informed health decisions and choices. (Cross-cutting/Life course)	
OBJECTIVE 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.	
Strategies	**Outcomes**
8.1.1 Determine age-appropriate avenues for reaching children in middle childhood (ages 6-11 years) to assist them with making informed decisions about health and wellness • *In partnership with pediatric partners, ensure that well-child visits incorporate best practices in building* • *Work with schools to incorporate information about healthy choices into school enrollment and orientation materials* • *Work with youth programs (Girl Scouts, Boys Scouts, Boys & Girls Clubs, YMCA, etc.) to encourage badges related to health and wellness*	•
8.1.2 Provide resources to increase education and knowledge of health decision-making for women, pregnant women, children, adolescents, and children and youth with special health care needs • *Provide Resource Libraries (R&Rs) with kits for child care and for school age with activities/curriculum around healthy habits/choices* • *Increase the availability of information to parents and family members about normative child and adolescent development, and risk and protective factors for youth.*	•
8.1.3 Make accurate, age appropriate information on reproductive health and healthy relationships, including the benefits of abstinence and avoiding risky behaviors more easily available to youth and their families	•
OBJECTIVE 8.2: Collaborate with local school districts to implement and provide youth-focused initiatives and curriculums that include progress measures to families are better equipped to advocate for all needed services, supports, and family/professional partnerships to achieve successful and healthy transitions.	
Strategies	**Outcomes**
8.2.1 Distribute *The Future is Now THINK BIG – Preparing for Transition Planning* workbooks to schools for distribution to children and adolescents as part of orientation; incorporate into assemblies, school counseling sessions, etc. • *School class where the child learns about health care (can take information home to parents)*	•

8.2.2 Provide youth-focused and youth-driven initiatives to support successful transition, self-determination, and advocacy • *Implement Faces of Change* • *Implement Plan It Live It* • *Explore opportunities for increased youth leadership (Youth Advisory Council, DCF)*	• Youth participating in the Faces of Change will self-report improvements in self-efficacy in five core areas of development (learning, connecting, thriving, working, and leading)
8.2.3 Provide opportunities for parents to improve their skills in seeking out quality health-related information and services • *Conduct "Care Coordination: Empowering Families" trainings for parents of CYSHCN* • *Promote distribution and use of "What to do when your child gets sick"*	• Parents are empowered to engage a variety of valued members of their child's care team
OBJECTIVE 8.3*:* Assist individuals and families with navigating the health care system to locate, evaluate, access, and utilize appropriate health care coverage and services.	
Strategies	**Outcomes**
8.3.1 Provide support to local health departments and other community-based organizations with in providing services in alignment with health transformation, including insurance enrollment and outreach • *Sponsor/host regional training on health transformation* • *Support connection between LHDs and Navigators to increase families' access* • *Provide training/TA to LHDs around Title V service planning and delivery*	•
8.3.2 Identify opportunities to optimize health transformation in maximizing service delivery to families • *Review and identify steps to incorporate from the Title V state toolkit – ACA* • *Review and incorporate Standards of Care for CYSHCN*	•
8.3.3 Educate MCH staff to increase competencies and skills necessary to guide and support local agencies developing and delivering MCH services and programs • *Training MCH staff on resources that are available* • *Connect LHDs with resources that are available to support their work – MCH toolkit*	•

*Infant Mortality CoIIN Action Plan (Focus Areas: Smoking Cessation and Pre and Early Term Birth)