



KANSAS TITLE V MATERNAL & CHILD HEALTH (MCH)
FFY2021 State Priorities & Measures

State Priorities

States conduct a 5-year needs assessment to identify 7-10 state MCH priorities.

1. Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy. (W/M)
2. All infants and families have support from strong community systems to optimize infant health and well-being. (P/I)
3. Children and families have access to and utilize developmentally appropriate services and supports through collaborative and integrated communities. (C)
4. Adolescents and young adults have access to and utilize integrated, holistic, patient-centered care to support physical, social, and emotional health. (A)
5. Communities, families, and providers have the knowledge, skills, and comfort to support transitions and empowerment opportunities. (CSHCN)
6. Professionals have the knowledge, skills, and comfort to address the needs of maternal and child health populations. (CC)
7. Strengths-based supports and services are available to promote healthy families and relationships. (CC)

National Performance Measures (NPMs) & Evidence-Based or -Informed Strategy Measures (ESMs)

States select at least 5 of 15 NPMs that address the state priority needs; at least one for each population domain area.*

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

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

NPM 5: Safe Sleep (Percent of infants placed to sleep; (A) on their backs; (B) on separate sleep surface; and (C) without soft objects and loose bedding)

- o *ESM: Percent of Kansas Perinatal Community Collaboratives (KPCC) participants who placed their infants to sleep (A) on their backs; (B) in a crib/bassinet or portable crib*

NPM 6: Developmental screening (Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year)

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

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

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

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

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

State Performance Measures (SPMs)

States select measures to address state priorities not addressed by the National Performance Measures (no minimum or maximum).

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

- o *ESM: Percent of MCH program participants screened for depression and anxiety during pregnancy and/or the postpartum period using the Edinburgh Perinatal/Postnatal Depression Scale (EPDS)*
- o *ESM: Percent of pregnant/postpartum MCH program participants who received a referral in response to a positive screen for depression or anxiety through the Edinburgh Perinatal/Postnatal Depression Scale (EPDS)*

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

- o *ESM: Percent of WIC non-Hispanic black infants breastfed exclusively through six months.*

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

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

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

- o *ESM: Number of MCH participants receiving holistic care coordination*
- o *ESM: Percent of families enrolled in Special Health Care Needs Care Coordination Program that have increased their ability to independently navigate the systems of care*

MCH Population Domains*

1. Women & Maternal Health
2. Perinatal & Infant Health
3. Child Health
4. Adolescent Health
5. Children & Youth with Special Health Care Needs
6. Cross-cutting/Systems Building (Optional)