

Title V Maternal & Child Health Action Plan

Draft Revised March 30, 2016

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

OBJECTIVE 1.1: Increase the proportion of women receiving a well-woman visit annually.

- 1.1.1 Increase public health departments and Community Health Centers that have on-site assistance for accessing health care coverage such as certified application counselors or Medicaid eligibility workers, especially to ensure no gap in coverage beyond the post-partum period.
- 1.1.2 Utilize peer and social networks for women, including group education models, to promote and support access to preventive care.
- 1.1.3 Increase the number of programs promoting individuals' responsibility through documented health plans.
- 1.1.4 Promote consumer awareness of the importance of preconception care.
- 1.1.5 Promote the development of personal health plans during well woman visits.

OBJECTIVE 1.2: Increase the number of completed referrals for services in response to prenatal/postnatal risk screening at every visit by 2020.

- 1.2.1 Implement standard screening protocol and utilization of standard tools for smoking/tobacco, alcohol, substance use, and mental health, including maternal depression.
- 1.2.2 Define completed referral and develop protocol for documenting referrals and tracking follow-up.
- 1.2.3 Increase knowledge and promote utilization of health coverage benefits and community services related to improving health behaviors, such as tobacco cessation.

OBJECTIVE 1.3: Increase the number of established perinatal community collaboratives (e.g., Becoming a Mom (BAM) program) by at least 5 annually by 2020.

- 1.3.1 Develop new community collaborations and BAM programs, targeting cities, counties, and regions with disparities and poor birth outcomes.
- 1.3.2 Integrate evidence-based tobacco/smoking, safe sleep, and breastfeeding interventions into community based service models.
- 1.3.3 Engage FQHCs in more communities across the state with the goal of increasing coordination and access to a variety of services for those at greatest risk.
- 1.3.4 Develop regional models to implement or support rural expansion.
- 1.3.5 Integrate telehealth capabilities within the existing models.

OBJECTIVE 1.4: Increase the percent of pregnant women on Medicaid with a previous preterm birth who receive progesterone to 40% by 2017 and increase annually thereafter.

- 1.4.1 Increase patient, family and community understanding of progesterone and full-term births.
- 1.4.2 Universal practice protocol and tool to timely, reliably, and effectively screen women for history of preterm birth and short cervix.
- 1.4.3 Develop protocol and guidelines, including utilization of progesterone to prevent preterm birth and short cervix.
- 1.4.4 Use claims data and data linkages to increase the number of women prescribed progesterone.

OBJECTIVE 1.5: Decrease non-medically indicated births between 37 0/7 weeks of gestation through 38 6/7 weeks of gestation to less than 5% by 2020.

- 1.5.1 Integrate early elective delivery (EED) and preterm birth education and materials into community systems, including BAM programs.
- 1.5.2 Promote training and education for hospitals and OB providers to utilize or apply policies and practices contained in the 39 Weeks Toolkit.
- 1.5.3 Work with hospitals and providers to eliminate EED through partnership with the Kansas Healthcare Collaborative.

PRIORITY 2: Services and supports promote healthy family functioning (Domain: Cross-cutting/Life course)

OBJECTIVE 2.1: Increase opportunities to empower families and build strong MCH advocates by 2020.

- 2.1.1 Provide family and sibling peer supports for those interested in being connected to other families with similar experiences (e.g., Foster Care, Children and Youth with Special Health Care Needs, and others).
- 2.1.2 Conduct "Care Coordination: Empowering Families" trainings for parents of CYSHCN.
- 2.1.3 Increase the number of fathers that are engaged in family health activities.
- 2.1.4 Identify options to provide supports (e.g., making healthy choices, positive coping mechanisms, violence, substance abuse, and mental health issues) to parents of adolescents, such as home visiting and peer-to-peer networks.

OBJECTIVE 2.2: Increase the number of providers with capacity to provide trauma-informed care by 2020.

- 2.2.1 Increase MCH state staff and partner's capacity around trauma informed care.
- 2.2.2 Conduct an environmental scan to identify the types of trauma informed care occurring in the state and the providers offering it.
- 2.2.3 Provide training for MCH grantees including home visitors on trauma-informed care.

OBJECTIVE 2.3: Increase the number of families receiving home visiting services through coordination and referral services by 5% annually.

- 2.3.1 Develop and utilize strategies for MCH home visitors to improve effective outreach and engagement of families in universal home visiting services.
- 2.3.2 Enhance and expand coordinated intake and referral systems across the state to support appropriate referrals and levels of services for families.

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

OBJECTIVE 3.1: Increase the proportion of children aged 1 month to kindergarten entry statewide who receive a parent completed developmental screening tool annually.

- 3.1.1 Conduct an environmental scan to identify the providers conducting developmental screening and determine which tools are being utilized.
- 3.1.2 Improve coordination of referral and services between early care and education, home visitors, medical homes, and intervention providers.
- 3.1.3 Build MCH capacity for screening and follow-up through complete referrals to providers and community based services.
- 3.1.4 Provide training to MCH grantees on developmental screening and use of Ages and Stages Questionnaires (ASQ-3; ASQ:SE2).

OBJECTIVE 3.2: Provide annual training to child care providers that increase knowledge and promote screening to support healthy social-emotional development of children.

- 3.2.1 Develop a standard and consistent message to communicate importance of developmental screening among child care programs.
- 3.2.2 Make available and provide training to child care providers on social-emotional development, milestones, and age appropriate activities using the Kansas Early Learning Standards.
- 3.2.3 Build childcare provider capacity to support coordination and referrals with other child care providers and community based services.
- 3.2.4 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 their needs.

OBJECTIVE 3.3: Increase by 10% the number of children through age 8 riding in age and size appropriate car seats per best practice recommendations by 2020.

- 3.3.1 Increase the number of MCH grantees, as a lead for or partner of local Safe Kids Coalitions, providing education and installation of car seats.
- 3.3.2 Increase number of trained car seat technicians; Support additional check lanes for MCH; Incorporate information and check lane locations into BAM site education/information.
- 3.3.3 Provide targeted training and technical assistance to child care providers related to regulatory and transportation requirements.
- 3.3.4 Assure appropriate motor vehicle safety education is provided for all individuals transporting infants and children.

OBJECTIVE 3.4: Increase the proportion of families receiving education and risk assessment regarding home safety and injury prevention by 2020.

- 3.4.1 Enhance information and education provided as part of prenatal and postnatal education related to home safety during infancy and early childhood (Safe Kids).
- 3.4.2 Provide education and support to assist parents with selecting a child care setting that meets health and safety requirements (CA, OIDS, checklists).
- 3.4.3 Develop a standard home visiting tool for MCH home visitors to assess environments for potential harm or injury in the home environment.
- 3.4.4 Track changes to the home environment between visits in response to education and consultation provided by MCH home visitors on the potential for harm or injury.

OBJECTIVE 3.5: Increase the percent of home-based child care facilities implementing daily routines involving at least 60 minutes of daily physical activity per CDC recommendations to decrease risk of obesity by 2020.

- 3.5.1 Provide training and resources to child care providers related to healthy practices and regulatory requirements.
- 3.5.2 Provide training to child care surveyors regarding the regulatory requirements related to daily routine and physical activity, including protocol for assessing and determining compliance.
- 3.5.3 Provide resources for facilitators to encourage and support children's participation in activities that raise their heart rate for a minimum of 60 minutes a day.

OBJECTIVE 3.6: Increase the percent of children and adolescents (K-12 students) participating in 60 minutes of daily physical activity.

- 3.6.1 Support schools and communities in promoting events and securing essential supplies for Bike to School and Walk to School events, including the walking school bus; non-competitive sports leagues; and intramural sports.
- 3.6.2 Partner with schools and communities to identify safe biking and walking routes between home and school.
- 3.6.3 Increase the number of community programs collaborating with MCH programs to promote whole-family participation in regular physical activity including engaging and educating businesses.
- 3.6.4 Support local health departments and or community centers in local initiatives to promote physical activity and utilization of walking and biking trails.

PRIORITY 4: Families are empowered to make educated choices about nutrition and physical activity (Domain: Perinatal & Infant)

OBJECTIVE 4.1: Increase the number of communities in Kansas that provide a multifaceted approach to breastfeeding support across community sectors by at least 10 by 2020.

- 4.1.1 Expand the number of communities that achieve the criteria for the Community Supporting Breastfeeding designation.
- 4.1.2 Partner with KBC and WIC in their efforts to promote and support breastfeeding with businesses through the Breastfeeding Friendly Business (welcome here) and Business Case for Breastfeeding.
- 4.1.3 Develop standard curriculum for infant feeding for use by local communities across the state; integrate into the Becoming a Mom prenatal education sessions.
- 4.1.4 Increase access to professional support through referrals and linkages between birthing facilities and community resources.
- 4.1.5 Partner with Medicaid and MCOs to increase awareness of and access to breastfeeding supportive benefits.

OBJECTIVE 4.2: Increase the number of Baby Friendly Hospitals in Kansas by 2020.

- 4.2.1 Partner with WIC and KBC to expand the High 5 for Mom and Baby program by increasing the number of hospitals trained and number implementing.
- 4.2.2 Promote and support the Empower Initiative in partnership with UMHMF, KBC and WIC.
- 4.2.3 Provide education to hospital and maternity care/OB staff related to support implementation of baby friendly hospital policies and practices.

OBJECTIVE 4.3: Increase the proportion of women and pregnant women receiving education related to the impact of prenatal and postpartum nutrition and exercise on optimal infant feeding by 2020.

- 4.3.1 Develop prenatal education content to support an accurate, consistent message for women and families.
- 4.3.2 Align and strengthen infant feeding education (breastfeeding and bottle feeding) and support through existing programs, including Becoming a Mom, home visiting, and WIC.
- 4.3.3 Increase the number of referrals to WIC and breastfeeding peer counselors for breastfeeding support and education, including the expansion of breastfeeding peer counseling sites.

PRIORITY 5: Communities and providers support physical, social and emotional health (Domain: Adolescent)

OBJECTIVE 5.1: Increase the number of schools that are implementing programs that decrease risk factors associated with bullying by 2020.

- 5.1.1 Identify evidence-based programs in partnership with the Bureau of Health Promotion that decrease risk factors associated with bullying through parental involvement, curriculum integration, and school staff-wide training.
- 5.1.2 Work with BHP to help schools improve school-based bullying policies to meet best practice.
- 5.1.3 Provide information to school nurses and counselors on how to respond to bullying.
- 5.1.4 Partner with school nurses and counselors to provide access to behavioral health services in schools.
- 5.1.5 Explore options for educating and reporting unsafe social media and digital content.

OBJECTIVE 5.2: Increase the number of adolescents aged 12 through 17 years accessing positive youth development, prevention, and intervention services and programs by 2020.

- 5.2.1 Provide annual training on Adverse Childhood Experiences (ACEs) and trauma informed responses and approaches for MCH staff and partners working with adolescents and their families.
- 5.2.2 Establish networks of skilled, supported adult mentors that are available to adolescents in safe, accessible environments to reduce risky behaviors and promote healthy relationships including abstinence.
- 5.2.3 Partner with communities to connect adolescents with supports that promote protective factors (Faith-based, pediatricians, schools).
- 5.2.4 Support public awareness campaigns to prevent adolescent self-injury.
- 5.2.5 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.
- 5.2.6 Identify methods to increase adolescent awareness of services and programs available to them in their community.

OBJECTIVE 5.3: Increase the number of providers serving adolescents that assess for and intervene with adolescents at risk for suicide.

- 5.3.1 Develop follow-up protocols for families to be referred for behavioral health services and offer additional support as needed to assure services are received.
- 5.3.2 Behavioral health awareness days with free screenings across the state.
- 5.3.3 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.
- 5.3.4 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.
- 5.3.5 Promote the yellow ribbon initiative and accessible crisis services through school and out-of-school activities.

OBJECTIVE 5.4: Develop a cross-system partnership and protocols to increase the proportion of adolescents receiving annual preventive services by 2020.

- 5.4.1 Engage health care providers, Medicaid and managed care organizations to promote annual well-child visits through adolescence into adulthood.
- 5.4.2 Engage school nurses to identify and refer children and adolescents with an Individualized Healthcare Plan who have not had a well visit in the past year.
- 5.4.3 Partner with schools to evaluate the capacity and infrastructure to provide school-based services for physical, social, and emotional health needs.

OBJECTIVE 5.5: Increase the number of adolescents receiving immunizations according to the recommended schedule (AIP) by 2020.

- 5.5.1 Increased awareness of, access to, and utilization of the Vaccines for Children (VFC) program.
- 5.5.2 Provide parent education on immunizations, including schedules, and the importance to child and adolescent health.
- 5.5.3 Identify and promote existing vaccination programs and campaigns.
- 5.5.4 Work with IKC to increase HPV vaccination completion for youth ages 13-17 years.

PRIORITY 6: Professionals have the knowledge and skills to address the needs of maternal and child health populations
(Domain: Cross-cutting/Life course)

OBJECTIVE 6.1: Increase the proportion of smoking women referred to evidence-based cessation services to 95% or higher by 2020.

- 6.1.1 Provider training on tobacco use and smoking with focus on pregnancy, and identify resources and interventions available.
- 6.1.2 Expand education and utilization of the Quitline (including reminder and fax referral system).
- 6.1.3 Promote referral to the Baby & Me Tobacco Free Program as an intervention where available.
- 6.1.4 Increase the number of communities implementing the Baby & Me Tobacco Free program.
- 6.1.5 Increase the number of providers trained on evidence-based tobacco cessation techniques, including motivational interviewing.

OBJECTIVE 6.2: Increase abstinence from cigarette smoking among pregnant women to 90% by 2020.

- 6.2.1 Place toolkits (screening, referral, resources, and programs) in the hands of providers.
- 6.2.2 Facilitate referrals to Baby & Me Tobacco Free for smoking cessation counseling and support based on family risk and need.
- 6.2.3 Standardize smoking history and screening forms.
- 6.2.4 Enlist support of pediatricians to inquire about smoking, counseling, and referrals postpartum.
- 6.2.5 Leverage consistent, repeat messages about tobacco and nicotine across all systems, using media, social media, texting, videos, peer-to-peer mentoring.
- 6.2.6 Engage women and families to collect input on additional interventions to support cessation including SCRIPT.

OBJECTIVE 6.3: Implement collaborative oral health initiatives, identify baseline measures, and expand oral health screening, education, and referral by 2020.

- 6.3.1 Integrate oral health education and referral into prenatal and infant health education through BAM programs, well visits, dental visits, home visits.
- 6.3.2 Promote oral health in all programs targeted towards CYSHCN through care coordination activities.
- 6.3.3 Repeat screenings at child care facilities in three years.
- 6.3.4 Continue offering the existing training and develop level 2 and 3 courses (additional 4 hours) to build on what has been offered.
- 6.3.5 Educate health care professionals regarding the child care home population for ongoing screenings and oral health education.

OBJECTIVE 6.4: Build MCH capacity and support the development of a trained, qualified workforce by providing professional development events at least four times each year through 2020.

- 6.4.1 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.
- 6.4.2 Develop a system to capture increases in MCH staff and grantees completing trainings, such as the MCH navigator self-assessment by 2017.
- 6.4.3 Incorporate MCH competencies more intentionally into position descriptions.
- 6.4.4 Providers/social workers/professionals trained in ACEs and trauma-informed care.
- 6.4.5 Train paraprofessionals working with families on strategies to address risk of immediate harm to support safe, stable and nurturing environments.

OBJECTIVE 6.5: 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.

- 6.5.1 Offer information and training to child care and education providers to support inclusion within those settings and assure higher quality care for CYSHCN.
- 6.5.2 Host webinars and online trainings for health providers on caring for CYSHCN, adapting from the Caring for People with Disabilities course.
- 6.5.3 Partner with the National Alliance on Mental Illness (NAMI) to offer youth and adult education programs to KS-SHCN clients.

OBJECTIVE 6.6: Implement a multi-sector (community, hospitals, maternal and infant clinics) safe sleep promotion model by 2018.

- 6.6.1 Enhance the safe sleep instructors skill sets to include training home visitors and facilitating community baby showers.
- 6.6.2 Provide essential supplies including sleep sacks and pack and plays to families and caregivers identified as at risk and in need.
- 6.6.3 Expand promotion of the AAPs Safe Sleep guidelines by activating the Safe Sleep Instructors to roll out the Hospital Safe Sleep Bundle Intervention and the Safe Sleep Toolkit for outpatient clinics.
- 6.6.4 Increase the number of Safe Sleep instructors by approximately 5 per year through targeted recruitment in areas with identified need for instructors, high rates of sleep-related injury or mortality, and low levels of related resources.

PRIORITY 7: Services are comprehensive and coordinated across systems and providers
(Domain: Children & Youth with Special Health Care Needs - CYSHCN)

OBJECTIVE 7.1: Increase family satisfaction with the communication among their child's doctors and other health providers to 75% by 2020.

- 7.1.1 Support family-centered medical homes through increased awareness among families, including communicating with their doctors and effective health advocacy skills.
- 7.1.2 Provide professional development opportunities to health care providers to increase family-centered medical home supports.
- 7.1.3 Implement communication and referral protocols for SHCN Care Coordinators and providers.

OBJECTIVE 7.2: By 2020, increase the proportion of families who received care coordination supports through cross-system collaboration by 25%.

- 7.2.1 Explore new and existing partnerships that promote collaboration between primary care and behavioral health providers (KAIMH, KDADS, schools).
- 7.2.2 Expand KS-SHCN to have care coordinators located in all six Kansas public health regions.
- 7.2.3 Engage MCO's and primary care providers in collaborative coordination for SHCN clients.
- 7.2.4 Provide support to agencies working with foster homes and the foster care system in serving CYSHCN in foster care.
- 7.2.5 Develop, monitor and evaluate a patient-centered care coordination action plan for all SHCN clients and BAM participants.

OBJECTIVE 7.3: Develop an outreach plan to engage partners, providers, and families in the utilization of a shared resource to empower, equip, and assist families to navigate systems for optimal health outcomes by 2020.

- 7.3.1 Complete the online navigational tool kit to provide resources and services, including expansion to Help Me Grow.
- 7.3.2 Increase access to primary and specialty care in underserved areas.
- 7.3.3 Increase utilization of Medicaid, CHIP, and Health Insurance Exchange services through education and referrals.
- 7.3.4 Connect SHCN care coordinators with foster care and MCO case managers to provide technical assistance and support for SHCN clients.
- 7.3.5 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 (Domain: Cross-cutting/Life course)

OBJECTIVE 8.1: Increase the proportion of MCH grantee providers who provide health information education to clients to improve health decision making among women, pregnant women, children, adolescents, and children and youth with special health care needs annually.

- 8.1.1 Identify a baseline proportion of MCH grantee providers using DAISEY who are providing health information education.
- 8.1.2 Provide resources to increase education/knowledge of healthy decision making.
- 8.1.3 Work with partners to ensure that wellness visits incorporate best practices.

OBJECTIVE 8.2: Partner with Health Literacy Kansas (HLK) to provide training to improve the knowledge of parents and teens as to the importance of making informed health decisions by 2020.

- 8.2.1 Emphasize the importance of health insurance literacy with HLK.
- 8.2.2 Identify target populations and/or regions that require increased health literacy support.
- 8.2.3 Promote distribution and use of "What to do when your child gets sick."

OBJECTIVE 8.3: By 2020, create and disseminate a toolkit for preschool through school-aged providers with a curriculum and activities designed to teach children and adolescents about healthy habits and choices.

8.3.1 Identify effective age-appropriate approaches to assist children ages 6 to 11 years with making informed decisions about health and wellness.

8.3.2 Work with schools to incorporate information about healthy choices into school enrollment and orientation materials.

8.3.3 Work with child and youth programs (Child Care, Girl Scouts, Boy Scouts, Boys and Girls Club, YMCA, etc.) to provide health and wellness information.

8.3.4 Distribute *The Future is Now THINK BIG – Preparing for Transition Planning* workbooks to schools for distribution to children and adolescents as part of orientation.

OBJECTIVE 8.4: Increase youth-focused and youth-driven initiatives to support successful transition, self-determination, and advocacy by 2020.

8.4.1 Implement the youth leadership program, *Faces of Change*.

8.4.2 Implement Plan It Live It to support effective transition planning.

8.4.3 Explore opportunities for increased youth leadership.

8.4.4 Provide opportunities for parents to improve their skills in seeking out quality health-related information.

OBJECTIVE 8.5: Incorporate information regarding changes to the health care system into existing trainings and technical assistance by 2020.

8.5.1 Educate MCH staff regarding changes to the health care system.

8.5.2 Identify opportunities to optimize changes in the health care system in maximizing service delivery to families.

8.5.3 Sponsor/host regional training on health transformation.

8.5.4 Provide training and technical assistance to local health departments (LHDs) on Title V service planning and delivery.

8.5.5 Support connection between LHDs and Navigators to increase families' access.

8.5.6 Review and identify steps to incorporate information from the *Peer-to-Peer Technical Assistance for State Title V MCH Programs on Implementation of the ACA*.

8.5.7 Review and incorporate *Standards for Systems of Care for CYSHCN*.