United Methodist HealthMinistryFund

Toward a Maternal and Perinatal Health Action Agenda for Kansas: Landscape Analysis and Key Careholder Perspectives

Updated Draft Report May 2026

Contents

Executive Summary

Building on Progress with Maternal and Perinatal Health in Kansas

While Kansas faces many challenges, there has also been significant progress over the past decade. The following maternal and perinatal health milestones reflect the sustained leadership and collaborative efforts of partners across Kansas.

2016–2017: Building the data & systems foundation

- Strengthening of the Maternal Mortality Review Committee (MMRC)
- Expansion of Title V needs assessment and priority setting
- Increased focus on infant mortality, behavioral health, and rural access

2018-2019: Expanding care models

- Growth of team-based maternal care approaches
- Increased recognition of community health workers (CHWs), doulas, and lactation support
- Early investments in care coordination through KanCare managed care

2020: COVID-10 accelerates telehelath innovation

- Rapid expansion of telehealth for prenatal and postpartum care
- Increased attention to maternal mental health and social determinants of health
- Flexibility in Medicaid service delivery.

2021-2022: Postpartum coverage policy breakthrough

- 12-month postpartum Medicaid coverage extension (KanCare) implemented
- Reinbursment for maternal depression screenings during a child's wellchild visits.

2022-2023: Quality & workforce improvements

- Strengthening of the Kansas Perinatal Quality Collaborative (KPQC)
- Reimbursment for midwives CHWs and doulas.
- Increased reimbursement rates for lactation counselors and licensed mental health professionals.

2023-2024: Family economic supports & early childhood system integration

- Kansas Child Care Tax Credit enacted, helping offset cost of childcare for working families and supporting maternal workforce participation
- Expansion of "All In for Kansas Kids" strategic framework
- Growth of Help Me Grow Kansas
- Increased developmental screening and referral systems

2025-2026: Major transformation investments

- Launch of KanCare 3.0, with stronger maternal and child health requirements in managed care and expanded care coordination and support services
- Kansas awarded CMS Transforming Maternal Health (TMaH) Model: $17 million investment over 10 years which will focus on whole-person care, equity, and rural access
- Approved a Medicaid State Plan Amendment to expand DC:0-5-trained providers and infant mental health services supporting the parent-child dyad.
- Establishment of the Office of Early Childhood to strengthen coordination across early childhood programs and services
- Expansion of business child care tax credits to incentivize employer investment in child care access and support for working families

While there is progress to celebrate, Kansas faces significant and interrelated challenges in maternal and perinatal health, shaped by long-standing **structural**, **policy**, and **system-level** factors. Recent reports and strategic plans show declining overall health rankings, persistent racial and geographic inequities, workforce shortages, and widening gaps in access to maternity care—particularly in rural and underserved communities.

Findings from the Kansas Maternal Mortality Review Committee (KMMRC) highlight continued concern regarding maternal mortality and severe maternal morbidity (SMM) in the state. Consistent with national trends, maternal deaths in Kansas occur most often during the postpartum period and reflect the combined influence of clinical, social, and system-level factors.

KMMRC findings emphasize that **many maternal deaths are preventable**, underscoring opportunities for earlier intervention, stronger care coordination, and targeted system improvements. The *2024 Kansas Severe Maternal Morbidity and Maternal Mortality Report* documents persistent inequities, including:

- The **severe maternal morbidity rate for Black women was 75 percent higher** than for White women; and
- Women enrolled in **Medicaid** and women residing in **low-income** ZIP code areas were **more likely to experience severe maternal morbidity.**

Recognizing these urgent challenges, and the promise of collaborative action, the United Methodist Health Ministry Fund convened diverse careholders to develop a shared *Kansas Maternal and Perinatal Health Action Agenda***.** There is an ecology of assets in our state, with a diverse set of partners prepared to make complementary contributions to maternal and infant health in Kansas. A key challenge is integrating these many valuable resources into a coordinated and comprehensive system to advance health for all in Kansas.

Purpose and Approach

The United Methodist Health Mistry Fund, with assessment and facilitation support from the University of Kansas Center for Community Health and Development (KU CCHD), and in partnership with careholders across the state, is leading the development of a shared *Kansas Maternal and Perinatal Health Action Agenda***.** To inform this effort, KU CCHD conducted a statewide maternal and perinatal health landscape analysis and key leader interviews.

For the landscape analysis, KU CCHD staff gathered, reviewed, and synthesized existing information on maternal and perinatal health needs, priorities, and strategies in Kansas. Sources included recent assessments, reports, and strategic plans produced by state agencies, research organizations, and partners. These included recent findings from the Kansas Maternal Mortality Review Committee, the 2024 Kansas Severe Maternal Morbidity and Maternal Mortality Report, data from the Pregnancy Risk Assessment Monitoring System (PRAMS) and community-based assessments, the Kansas Health Institute's 2025 *What Happened to Health in Kansas?* report, recommendations from the Governor's Commission on Racial Equity and Justice, the draft *Maternal Health Innovation Program Strategic Plan*, the *Kansas Maternal Child Health Title V State Action Plan 2026-2030*, the University of Kansas Center for Public Partnerships and Research Kansas Primary Prevention Story Collection Framework Dataset, and the United Methodist Health Ministry Fund's commissioned report on *Access to Maternity Care in Kansas*. Additional details on data sources are provided in Appendix 2.

In addition, KU CCHD conducted semi-structured interviews with key leaders identified by the United Methodist Health Ministry Fund. Most participants were Kansas-based (n=15), with national partners also represented (n=3). Interviewees reflected a broad range of maternal and child health roles, including health care providers and administrators, advocates, nonprofit leaders, professional associations, funders, and government partners. Interviews were conducted virtually between November 2025 and January 2026 and were recorded for note-taking purposes. A general inductive analysis approach was used to identify cross-cutting themes and patterns, supported by illustrative quotes. Lived experiences are represented through quotes collected by the University of Kansas Center for Public Partnerships and Research through the Kansas Primary Prevention Story Collection Framework, an online survey designed to help community members, organizations, and state leaders center community narratives in service design, policy making, and action-planning. These stories were shared by participants between May 20, 2024 and January 6, 2026 and represent 81 out of 105 Kansas counties.

Key Highlights

Findings of an inductive analysis across the landscape assessment as well as key leader interviews revealed four opportunity areas with related recommendations:

1. Advance Equity in Maternal Health Outcomes

Address disparities by race, geography, and income through expanded access to health coverage, stronger partnerships with trusted community-based providers, use of technology to extend care in rural areas, and attention to social and economic conditions that shape health.

2. Build Connected and Accessible Systems to Support Families
Improve care coordination, regional collaboration, initiative alignment, and shared learning pathways to ensure access to appropriate levels of care.

3. Strengthen the Maternal Health Workforce
Expand and diversify the workforce, strengthen rural clinical readiness, enhance cultural competency, and expand access to perinatal support roles such as doulas, midwives, lactation consultants, and community health workers.

4. Finance Reform to Support Sustainable Maternal Infant Care
Reform payment models to reflect the cost of providing safe obstetric services, particularly in rural settings, improve reimbursement, unbundle payments, and advance value-based models that support coordinated, high-quality care.

Summary of Key Findings

Opportunity 1: Advance Equity in Maternal Health Outcomes

Kansas continues to experience persistent inequities in maternal health outcomes across race, geography, and income. Statewide data show that severe maternal morbidity (SMM) rates are substantially higher among non-Hispanic Black women, as well as among women enrolled in Medicaid and those living in low-income ZIP codes. Many maternal deaths occur during the postpartum period and are associated with cardiovascular conditions, mental health and substance use challenges, and gaps in continuity of care. These clinical risks are compounded by structural barriers such as inadequate insurance coverage, geographic isolation, and systemic discrimination within health care settings.[1,2]

Rural and frontier communities face particularly stark challenges. Ongoing closures of obstetric units, shrinking provider availability, and 24/7 on-call burdens for remaining family practice clinicians have created large maternity care deserts.[3] Families may travel hours for prenatal or specialty care, incurring added financial strain for lodging, transportation, and time away from work. One resident shared, "It's about a 2 and a half hour drive to the hospital, to and from. I've missed out on a lot of work, which resulted in me losing my job. It's been very difficult trying to keep up on necessities and food in my home. I'm a single mother, with two boys. I'm not sure where to begin or start when it comes to improving our situation."[4] Key leader interviewees emphasized that these long distances also elevate clinical risk and reduce the likelihood of timely, appropriate care.

"If they need a specialized focus, then they end up needing to travel for hours or sometimes take a whole day, and there are costs associated with that – sometimes staying overnight, transportation, food, those things you take for granted when you live ten minutes from your provider."

"In rural and frontier areas of the state, access looks very different. People often have to travel long distances to receive care, there are fewer providers, and recruitment is extremely challenging. I've heard from family practice providers who used to deliver babies that it's hard to stay in practice when you're the only provider and essentially on

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[1] Kim, J., Nelson, J. (2024) *Kansas severe maternal morbidity and maternal mortality, 2016-2022.* Kansas Department of Health and Environment. https://kmmrc.kdhe.ks.gov/wp-content/uploads/2025/05/KHSR-Issue-99-KS-Severe-Maternal-Morbidity-Mortality-2016-2022_revision.pdf

[2] Kansas Department of Health and Environment. (2024). *Kansas Pregnancy Risk Assessment Monitoring System (PRAMS) Report, 2022.* https://www.kdhe.ks.gov/DocumentCenter/View/47094/Kansas-PRAMS-Report-2022-PDF KDHE Maternal and Child Health Section.

[3] Weis, K. & Alsup, A. (2025). *Access to maternity care in Kansas* (Issue Brief No. 1). University of Kansas School of Nursing, Kansas Nursing Workforce Center, and Kansas Center for Rural Health. https://healthfund.org/a/wp-content/uploads/2025-KU-SON-Access-to-Care-Report-FINAL.pdf

[4] University of Kansas Center for Public Partnerships and Research. (2026). *Kansas Primary Prevention Story Collection Framework* [Dataset]. Prepared for the Center for Community Health and Development.

call 24/7, which isn't sustainable. That's one reason we don't see as much family practice delivering in rural areas anymore—it's just not sustainable. So, the question becomes how we rethink the system."

Recommendation: Expand Coverage as a Foundation for Equity

Interviewees consistently identified health insurance coverage—before, during, and after pregnancy—as a foundational driver of maternal health and maternal equity. Lack of affordable care prior to pregnancy leads to unmanaged chronic conditions, such as hypertension and diabetes, that significantly increase pregnancy-related risks. Maternal health leaders described Medicaid expansion as essential for enabling preventive care and allowing "Black and Brown families to…enter into pregnancy healthier," noting that equity cannot be achieved without access to continuous, affordable health services.

"We can't have equity without access."

"[For equity] We need to cover moms. You cannot have healthcare just from the instant you have a positive pregnancy test until delivery. At a year, all of a sudden, the mom doesn't matter anymore and now my healthcare is nothing. Her health means nothing. That is not caring for people and for mothers, because they do not stop having needs when a baby turns 1.

In addition to Medicaid expansion, the 2021 Governor's Commission on Racial Equity and Justice recommends increasing the income eligibility for Medicaid and CHIP to 240% of the Federal Poverty Level and establishing universal health coverage for children from birth to age five.

"Kansas is one of the states with a growing number of uninsured children. In 2019, there were 9,000 fewer Kansas children who had health coverage than in 2016. Black, Indigenous, and children of color are nearly twice as likely to be uninsured than white children (7.8% vs 4.2%) in Kansas. Kansas can reduce the number of children who churn off Medicaid due to red tape/ administrative reasons by implementing a policy that ensures all Kansas children have continuous coverage for ages 0-5."[5]

Leaders stressed that increased coverage would also strengthen financial stability for rural providers by increasing reimbursable care volumes. However, they noted that current payment structures do not reflect how community-based providers—including doulas and midwives—actually deliver care. Documentation and billing requirements often prevent these providers from participating in Medicaid, despite their critical

[5] Governor's Commission on Racial Equity and Justice (2021). *Social Determinants of Health Final Report.* Kansas Office of the Governor. https://governor.kansas.gov/governors-commission-on-racial-equity-and-justice

role in supporting families. Low reimbursement rates similarly limit the viability of Medicaid-serving birth centers, reducing birthing options for families across the state.

"Systems need to align reimbursement mechanisms to support doulas, midwives, and community-based models—ensuring billing pathways reflect the services provided."

"We have birth centers in the state, but they're only accessible to private-pay individuals. We have had birth centers that have been accessible to Medicaid recipients in the past, and for a variety of reasons are not open currently, but one of the reasons…is low reimbursement rates…Moms should have an opportunity to choose, whether they're on Medicaid or not, whether they have a traditional hospital birth or a safe birth-center birth."

"Work requirements undermine progress by making access to [Medicaid] coverage harder."

"Everyone should have access to prenatal OB care and adequate healthcare coverage before, during, and after pregnancy."

Recommendation: Elevate Community-based Providers as Trusted Partners

Community-based organizations (CBO) and culturally concordant providers play a central role in advancing maternal health equity. These providers often share lived experience with the families they serve and are uniquely positioned to build trust, support engagement, and improve outcomes. Interviewees emphasized that Black women experience fewer disparities when cared for by providers who share cultural understanding.

"Black women have less disparate health outcomes when cared for by [community providers] that look like them."

Meaningful partnership with CBOs requires deliberate mechanisms for incorporating community expertise into policy and systems decisions. Many organizations regularly gather community feedback but lack structured avenues for ensuring those insights shape decision-making. Careholders stressed that people most affected by maternal health inequities are often those least represented at planning tables, underscoring the need for sustained, intentional engagement.

"There's always room for stronger relationships with community-based organizations. The people who know best what works in their communities are often the same people who don't have a seat at the table when decisions are being made. When I think about…people looking for food or housing support…those individuals don't always have a clear way to share what they're seeing or what they know about their communities…Making time—and creating intentional opportunities—for those voices to be heard is incredibly important."

Promising Efforts

The Kansas Birth Justice Society (https://ksbirthjusticesociety.org) is a Black- and Brown-led community-based organization dedicated to transforming how reproductive and maternal care is experienced in Kansas. The organization operates two specialized, family-centered spaces: Liberation Place, a mutual aid hub offering free reproductive and infant care supplies, and The Matrescence Center, a wellness and healing space that centers joy, connection, and holistic support for Black and Brown families. In addition, the Kansas Birth Justice Society leads bold, community-rooted advocacy efforts, including work that successfully advanced Medicaid reimbursement for community-based doulas.

Uzazi Village (https://uzazivillage.org) is a Kansas City-based community-based organization dedicated to centering Black and Brown families in advancing maternal health through culturally aligned care, advocacy, and education. Its holistic, community-centered approach strengthens family well-being and builds pathways to more equitable maternal health outcomes.

Recommendation: Utilize Technology to Reduce Access Barriers

Telehealth, remote monitoring, and digital tools offer promising strategies for expanding access and easing workforce shortages, especially in rural and underserved areas.[6,7] Careholders highlighted opportunities to use remote blood-pressure monitoring for hypertensive disorders—one of the leading contributors to maternal morbidity and mortality—and to extend access to maternal-fetal medicine specialists through virtual ultrasound review. Furthermore, maternal mental health care was identified as a critical area where telehealth could be substantially effective an help bridge the gap between access needs and availability.

However, leaders cautioned that technology must be implemented in ways that ensure quality and do not replace necessary in-person care. Effective telehealth requires broadband access, reimbursement parity, provider training, and clear workflows. Poorly implemented remote monitoring—such as distributing unconnected devices without training or follow-up—creates the illusion of access without improving outcomes.

"I don't see telehealth as a full replacement for in-person care, but…it can reduce unnecessary travel, especially for people with high-risk pregnancies who may need frequent monitoring."

"Telehealth offers us higher levels of care if it's used well."

Recommendation: Address Social and Economic Conditions That Shape Health

Interviewees emphasized that maternal health outcomes are shaped as much by social and economic conditions as by clinical care. Statewide assessments highlight transportation barriers, limited housing, food insecurity, childcare shortages, and income inequality as key contributors to poor maternal outcomes.[8,9] Participants described a vision of maternal health that includes paid family leave, living wages, worker protections, and investments in safe neighborhoods.

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[6] Weis, K. & Alsup, A. (2025). *Access to maternity Care in Kansas* (Issue Brief No. 1). University of Kansas School of Nursing, Kansas Nursing Workforce Center, and Kansas Center for Rural Health. https://healthfund.org/a/wp-content/uploads/2025-KU-SON-Access-to-Care-Report-FINAL.pdf

[7] Governor's Commission on Racial Equity and Justice. (2021). *Social Determinants of Health Final Report*. Kansas Office of the Governor. https://governor.kansas.gov/governors-commission-on-racial-equity-and-justice

[8] Kovach, K., Sterkhova, V., Uridge, E., Lin, W-C. (2025). *What happened to health in Kansas? Priorities for reversing a long-term decline in health ranking.* Kansas Health Institute. https://www.khi.org/wp-content/uploads/2025/09/What-Happened-to-Health-in-Kansas-Priorities-for-Reversing-a-Long-Term-Decline-in-Health-Ranking-WEB.pdf

[9] Kansas Department of Health and Environment. (2024). *Kansas Pregnancy Risk Assessment Monitoring System (PRAMS) Report, 2022.* https://www.kdhe.ks.gov/DocumentCenter/View/47094/Kansas-PRAMS-Report-2022-PDF KDHE Maternal and Child Health Section.

Brining this vision to reality requires a shift in expectations. A maternal health framework built on the assumption that resources such as paid family leave are the bare minimum—not optional supports—was emphasized as essential.

> *"I moved back…with a transitional housing voucher. It was a great blessing to myself and my son. While I was pregnant I was not sure I was going to have any housing at all for my son. I found a place to rent in Lawrence and thought it was great but quickly found out the opposite was true. The stress of the situation there and even contemplating having to move a third time in one year (once while 7 months pregnant, again with a four month old) was almost debilitating at times. I did not find much support in advocating for being able to stay there (which would have been my preference). Even agencies that are organized to help single parents like myself didn't seem to have the knowledge or motivation to help. It felt like I was being pressured from all sides, especially my landlord to just move. Well I did after much dragging my feet and trying other things. In the end, I did find a much better place. Now my son and I have a great place to call home, but I am just not sure why things continue to happen in this manner, that we don't have more choice, voice and less pressure, to just do what others want or see fit, especially for people that have experienced homelessness such as my self). It can feel as if we are being displaced over and over again."*[10]

[10] University of Kansas Center for Public Partnerships and Research. (2025, December 15). Douglas County Thrives [Community Sensemaking Session]. Lawrence, Kansas. https://www.dgcoks.gov/events/community-sensemaking-session

CBOs are positioned to help address these broader determinants through navigation support, connections to behavioral health services, assistance with transportation and childcare, and culturally grounded support. Leaders stressed that "health happens everywhere"—reflecting the importance of cross-sector solutions that extend beyond clinical systems.

> *"It spans beyond health care. A system that supports mothers and babies would look like a society where we have paid family leave, where we have a living wage, where we have protections for workers, people renting houses, and consumers."*

Promising Effort

Attane Health, https://attane-health.com, is a digital health company in Kansas City. They partner with healthcare providers, payers, and other organizations to offer patients and members nutritious high-quality foods, telehealth coaching, and valuable resources that reduce the cost of care, drive behavioral change, and improve health outcomes.

"I am a single mother doing my best to provide for my child, but these past months have been some of the hardest of my life. I had an emergency C-section that came with complications, and I had to stop working suddenly. I didn't have the luxury of taking proper time to recover – I went back to work only five weeks after giving birth, even though I was still in pain and struggling physically and emotionally. It wasn't because I was ready, but because I had no other choice. My bills, rent, and daily expenses kept piling up, and I didn't have anyone to depend on. Trying to recover from surgery, care for a newborn on my own, and return to work so soon has taken a huge toll on me. There are days when I barely sleep, and still have to push myself to keep going. I've reached out to different programs and organizations for help, but there seems to be little to no assistance [here] for single mothers like me. I've called around, filled out forms, and explained my situation repeatedly, but I often hear, 'we don't have funds right now,' or 'You don't qualify.' The stress of trying to keep a roof over our heads and food on the table has been overwhelming. Some months, I'm forced to choose between paying a bill or buying necessities for my baby. It's heartbreaking and exhausting to work so hard and still feel like I'm falling behind. I love my child more than anything, and I'm determined to provide a safe and stable home. But doing this completely alone, with no family help and very little community support, is breaking me down."[11]

[11]University of Kansas Center for Public Partnerships and Research. (2025, December 15). Douglas County Thrives [Community Sensemaking Session]. Lawrence, Kansas. https://www.dgcoks.gov/events/community-sensemaking-session

Opportunity 2: Build Connected and Accessible Systems to Support Families

Fragmentation across health care, public health, behavioral health, and community systems creates gaps in care during pregnancy, delivery, and the postpartum period.[12] Families often encounter confusing, disconnected services that require them to navigate complex systems on their own. Careholders consistently described the need for systems that are more coordinated, family-centered, and responsive to real-world needs.

> *"A coordinated, responsive system built around the reality of the family…I would love to see a system where families don't feel like they have to navigate us, but rather we have to navigate them."*

Interviewees emphasized that seamless communication and collaboration between providers—across hospitals, FQHCs, CBOs, and regional health systems—can improve the birthing experience, increase postpartum follow-up, and reduce missed opportunities for intervention. Strong relationships build trust and make it more likely that mothers feel seen and heard, supporting both maternal and infant health.

> *"There is fragmentation across systems - information does not transfer smoothly, and systems are not communicating with each other. This fragmentation negatively impacts outcomes and fails to keep mothers at the center."*

Recommendation: Support Families Navigating Pregnancy and Postpartum Care

Navigation support is essential for helping families coordinate appointments, understand care options, and access needed services.[13] Doulas, community health workers, and other perinatal support roles offer culturally grounded, relationship-centered assistance that improves engagement and reduces barriers.[14]

Interviewees underscored that navigation systems must center maternal autonomy—supporting mothers in choosing care settings and services that align with their needs and preferences.

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[12] Kovach, K., Sterkhova, V., Uridge, E., Lin, W-C. (2025). *What happened to health in Kansas? Priorities for reversing a long-term decline in health ranking.* Kansas Health Institute. https://www.khi.org/wp-content/uploads/2025/09/What-Happened-to-Health-in-Kansas-Priorities-for-Reversing-a-Long-Term-Decline-in-Health-Ranking-WEB.pdf

[13] Kansas Department of Health and Environment**.** (2024). *Kansas Pregnancy Risk Assessment Monitoring System (PRAMS) Report, 2022.* https://www.kdhe.ks.gov/DocumentCenter/View/47094/Kansas-PRAMS-Report-2022-PDF KDHE Maternal and Child Health Section. KDHE Maternal and Child Health Section.

[14] Governor's Commission on Racial Equity and Justice. (2021). *Social Determinants of Health Final Report*. Kansas Office of the Governor. https://governor.kansas.gov/governors-commission-on-racial-equity-and-justice

"Moms should be able to identify available supports through a clear, accessible system. A care navigation system should help mothers locate and obtain needed services [and] promote autonomy, allowing mothers to choose services that meet their needs."

Recommendation: Strengthen Coordination Across Systems

Effective maternity care requires collaborative networks that ensure the right level of care at the right time.[15] This includes clear referral pathways, coordinated transport, shared protocols, and strong relationships between local providers and higher-level care facilities. In rural western Kansas, some families rely on hospitals in neighboring states due to closer proximity and stronger referral relationships. Interviewees identified this as both a symptom of fragmentation and an opportunity to build stronger, Kansas-based regional networks.

"Maternal and child health systems are siloed, and communication is limited."

"I really believe that good collaboration reduces the chance of a bad experience, and bad experiences are one of the main reasons people don't return for care. If collaboration is strong, the mom feels seen and heard, care feels coordinated, and she's much more likely to continue care for herself and for her infant."

"States need to build a comprehensive network of care where all roles—doulas, midwives, CHWs, and perinatal workers—are recognized and accepted across settings. Workforce roles should function within a continuum of care that is coordinated and responsive across hospitals and community systems."

"That's really the key piece of all of this—collaboration and partnership…Every entity has a role to play within the system. We're not competing for clients or patients; instead, everyone has a piece to own. The goal is to stay in communication and work together, so the system functions seamlessly for the families."

[15] Weis, K. & Alsup, A. (2025). *Access to maternity care in Kansas* (Issue Brief No. 1). University of Kansas School of Nursing, Kansas Nursing Workforce Center, and Kansas Center for Rural Health. https://healthfund.org/a/wp-content/uploads/2025-KU-SON-Access-to-Care-Report-FINAL.pdf

Promising Effort

Coffey Health System (https://www.coffeyhealth.org/) in Burlington, Kansas has discontinued on-site labor and delivery services but has implemented a regional referral and care coordination strategy to preserve continuity of care. Prenatal and postnatal services are available locally, while births are supported through partnerships with surrounding hospitals.

Recommendation: Align Existing Initiatives for Impact

Kansas has numerous ongoing maternal and child health initiatives, many with overlapping priorities. Without coordination, these efforts risk duplicating work or creating confusion among partners. Careholders noted the value of aligning goals, clarifying shared metrics, and improving visibility into each initiative's focus. Strengthening existing collaborative structures—rather than creating new ones—could maximize limited resources and reduce fatigue among partners.

"We have a lot of systems in place where we already collaborate…we don't need to create more. We have a lot of opportunity."

"It becomes overwhelming to keep track of all the efforts that are happening and to know where things overlap, where they're duplicative, or where there are still gaps. Even in my own work, talking to people across the state, I've had folks say, 'Wow, another maternal health effort?' That kind of stings, but it also makes me think how valuable it would be to get together, understand what everyone is working on, and figure out how it all fits together."

Recommendation: Invest in Shared Data Infrastructure

Shared data systems and coordinated learning platforms are essential for reducing fragmentation and informing evidence-based practice. Interviewees described challenges accessing timely, disaggregated data needed to evaluate programs, measure return on investment, and guide decision-making. They recommended universal data-sharing infrastructure, public dashboards, standardized screening protocols, and improved access to race- and income-stratified data. Strengthened data systems would support targeted interventions, continuous quality improvement, and coordinated statewide learning. However, barriers of fragmentation and affordability of shared systems were repeatedly identified by interviewees.

"You can get on a shared EMR with another facility, but it's very patchy and piecemeal. And those of us in rural areas don't have the resources to invest in systems like EPIC or other larger platforms, so our systems don't communicate as easily with others."

One careholder shared the challenge of measuring return on investment (ROI) of new technologies without accessible data.

"In our remote monitoring study, we saw a 24% decrease in ER utilization, but I can't tell you what that translated to in ROI because I don't have the claims data. We need to be able to quantify impact."

However, caution was also noted regarding data-sharing, especially for families without legal status.

Careholders additionally identified a list of maternal and child health research priorities (Appendix 3) that would be enhanced through shared data infrastructure and coordinated learning.

"If providers are using the same tools at the same times, we can aggregate data and better understand what's happening across the pregnant population."

Promising Effort

Kansas City Health Equity Learning and Action Network, https://kchealthequity.org, convenes and leads a regional, cross-sector coalition of more than 50 health systems, community-based organizations, clinicians, and public health partners dedicated to addressing structural racism and improving maternal health outcomes. A central focus of this work is a birth equity initiative that advances culturally grounded collaboration in four priority areas: implicit bias and beliefs, blood pressure screening and timely intervention, integration of doula support, and strengthened race and ethnicity data systems to drive action and accountability.

Opportunity 3: Strengthen the Maternal Health Workforce

Kansas faces workforce shortages that affect access to maternity care and the quality of patient experience. These shortages span obstetricians, family practice providers, certified nurse midwives, doulas, community health workers, lactation consultants, and nurses, contributing to expanding maternity care deserts, particularly in central and southwest Kansas.[16,17] Workforce challenges include issues of training, retention, and cultural concordance with the communities served.

[16] Weis, K. & Alsup, A. (2025). *Access to maternity care in Kansas* (Issue Brief No. 1). University of Kansas School of Nursing, Kansas Nursing Workforce Center, and Kansas Center for Rural Health. https://healthfund.org/a/wp-content/uploads/2025-KU-SON-Access-to-Care-Report-FINAL.pdf

[17] Kovach, K., Sterkhova, V., Uridge, E., Lin, W-C. (2025). *What happened to health in Kansas? Priorities for reversing a long-term decline in health ranking.* Kansas Health Institute. https://www.khi.org/wp-content/uploads/2025/09/What-Happened-to-Health-in-Kansas-Priorities-for-Reversing-a-Long-Term-Decline-in-Health-Ranking-WEB.pdf

One recommendation that emerged was expanding sub-contracts with existing community and statewide partners to provide priority services and supports, improving efficiency while helping sustain vital assets for maternal and child health.

> *"The workforce shortage…affects every type of provider involved in maternity care. There is a shortage of OB-GYNs. There are also shortages of family practice providers, certified nurse midwives, doulas, community health workers, and nurses. It's all of them."*

Recommendation: Grow a Diverse Maternal Health Workforce

Interviewees identified several strategies to strengthen workforce diversity, capacity, and accessibility. These include expanding career-ladder opportunities, improving the quality and reach of rural nursing programs, championing apprenticeship models, and creating early exposure pathways for young people interested in maternal health careers. Careholders emphasized that rural residents are willing and capable of serving in these roles when training pathways are made accessible.

> *"These are jobs that people in rural communities are absolutely capable of doing. The challenge is figuring out what role we can play in making those pathways accessible, so people can be trained and then provide really strong care in their own communities, for people they already know and serve."*

They also noted the need for integrated and accessible training opportunities for community health workers and doulas, who face inconsistent certification pathways and differing curriculum requirements across systems. Other states reduce entry barriers by covering certification costs or simplifying requirements.

Recruitment strategies emphasized diversifying the workforce, expanding loan-forgiveness and scholarship programs for rural service to enable those pursuing needed degrees to graduate without debt, raising compensation in underserved communities, and supporting providers with housing, childcare, and other socioeconomic stabilizers. Additionally, structural reforms—including flexible staffing models, reduced reliance on grant funding, and addressing hospital non-compete clauses—were identified as essential to maintaining a stable workforce. Careholders stressed that staffing innovation and strong compensation packages are necessary for recruitment and retention. Workforce leaders emphasized non-compete clauses continue to limit provider mobility despite policy efforts to remove them, hindering rural access when sole providers are restricted from practicing locally.

> *"Hospitals must leverage resources so they can recruit and retain their workforce. This means considering compensation, benefits, housing, childcare, loan forgiveness. We need flexibility and innovation to retain and recruit staff."*

“There was a policy to do away with non-compete clauses, but some still have them, and that can make it hard. If there’s only one OB provider in a region and they aren’t allowed to practice because of a non-compete, they either have to travel outside the region to practice or stop practicing altogether. It would really benefit our state to have a more concerted effort to recruit providers from rural areas and foster interest early so they can go through training and still be interested in practicing in those rural regions.”

“I think a lot of the issue with community health workers is that it’s often grant-based. Even when programs are initiated, there’s uncertainty—people wonder, what if I train someone but only have funding for a year, or I’m not able to retain them afterward? It’s not that it’s not worth it, but that uncertainty makes it challenging. I think this role needs to become a normal, expected part of for example, health departments, with dedicated funding budget not out of grants so sustainability isn’t a concern. Right now, the concern is whether there will be a job after training, but it’s such a smart role—a valuable use of people with an important skill set”

Recommendation: Workforce Training, Development and Retention

Two major maternal health training needs emerged: sustaining obstetric skills in low-volume settings and strengthening cultural humility and trauma-informed care across the workforce.

Sustaining Obstetric Skills in Rural or Low-volume Birth Settings

A skilled workforce is critical to reducing severe maternal morbidity and mortality.[18] Interviewees highlighted simulation training, rotations to higher-volume hospitals, and ongoing skill-building opportunities as essential strategies for reducing severe maternal morbidity and mortality in these settings. Providers noted that discomfort or loss of skill among nurses and clinicians is a core barrier to sustaining rural obstetric services.

> *"One of the main barriers to maintaining OB services in rural areas frequently is the providers, including nurses, being comfortable maintaining their skill set."*

Promising Efforts

The **Smoky Hill Family Medicine Residency Program** (https://smokyhillfmrp.org) in Salina, Kansas trains rural clinicians in Advanced Life Support in Obstetrics to strengthen clinical competence and confidence in providing obstetric care in low–birth-volume and rural practice settings.

A five-day obstetric nursing immersion at the **University of Kansas School of Nursing in Salina** provides rural nurses with focused didactic instruction, hands-on fetal monitoring training, and supervised clinical experience. In addition, the program trains physicians, nurses, and EMTs in Advanced Life Support in Obstetrics to strengthen emergency preparedness and team-based response capacity in low–birth-volume and rural care settings.

Culturally Competent, Respectful, and Trauma-informed Care

High-quality maternal health care requires clinicians who are trained in cultural humility and trauma-informed practices, particularly for communities that experience discrimination or implicit bias within health systems.[19] Interviewees described a vision of maternity care where families can give birth

[18] Kansas Perinatal Quality Collaborative. (2025). *Maternal Health Innovation Program Strategic Plan*. https://kansaspqc.kdhe.ks.gov/initiatives/maternal-health-innovation

[19] Kansas Department of Health and Environment. (2024). *Kansas Pregnancy Risk Assessment Monitoring System (PRAMS) Report, 2022*. https://www.kdhe.ks.gov/DocumentCenter/View/47094/Kansas-PRAMS-Report-2022-PDF

without fear of discrimination and where birth is centered in dignity, respect, and joy. One recommendation that emerged was provider training in understanding the patient's experience of care (e.g., what they received, how responsive to their needs) to strengthen accountability, learning, and quality improvement.

Careholders also emphasized the need for linguistically appropriate care for Kansas' diverse communities. One Kansas resident shared, "my best friend is bilingual and we do not have enough translators in our community and language barrier is a huge issue."[20]

"[Our vision is] a world where mothers and families enter a birth space—home, hospital, or birth center—without fear of discrimination, obstetric violence, trauma, or fear that they won't leave the birthing experience. A world where women are heard and listened to, where people are seen as their own experts, and lived experience is valued as expertise."

"There needs to be a strong emphasis on education for health professionals. Harmful myths—like teaching that Black women have higher pain tolerance—must be dismantled. Health equity matters, even when it is politically uncomfortable to say so."

"Services must be culturally and linguistically competent, including for rural and urban African American, Latino, and other diverse communities. The system should ensure mothers can speak and understand the language used in services."

Careholders highlighted several priority areas for training enhancement, including active listening, motivational interviewing, mental health and substance use screening, cultural humility and implicit bias, and reflective team-based supervision to reduce burnout.

It was additionally noted that as clients attempt to contact health providers, those who answer the phone (or text) play a critical role in creating a sense of welcoming that helps clients feel that they are valued.

[20] University of Kansas Center for Public Partnerships and Research. (2026). *Kansas Primary Prevention Story Collection Framework* [Dataset]. Prepared for the Center for Community Health and Development.

Promising Efforts

1. The **Kansas Birth Equity Network's (KBEN) Birth Equity Curriculum** (https://www.kumc.edu/school-of-medicine/academics/departments/population-health/research/kansas-birth-equity-network/our-work.html) was co-created with parents and community members to equip learners with an understanding of the Black maternal health crisis. It addresses both implicit and explicit bias in maternal and paternal health care and equips learners to advance respectful, culturally responsive, and equity-centered maternity care.
2. **Kansas Birth Justice Society's Catalyst Doula Training** (https://ksbirthjusticesociety.org) is preparing 200 community-based doulas across Kansas. Rooted in a reproductive justice framework, this evidence-based training equips doulas to serve Black, Indigenous, and People of Color (BIPOC) populations, help improve birth outcomes and advance equity for birthing people and babies across Kansas.

Recommendation: Expand and Support Community-based Providers

There is strong support for expanding the role of community-based providers across the state.[21] This includes expanding the role of community-based providers—including home-birth midwives, doulas, lactation consultants and community health workers—who provide social, emotional, and culturally grounded care not typically offered in medical settings. Evidence from Kansas' first pilot of community-based doulas of color showed dramatically improved outcomes for Black mothers, including C-section rates under 5% and zero NICU admissions.[22] Careholders emphasized that these outcomes stem from "adjacent care" that centers listening, trust, navigation, and advocacy—especially within systems not originally designed for Black and Brown families.

> *"Community-based providers, like home birth midwives and doulas, are providing a type of care that the current system is not providing. They're providing care for the aspects of that person's needs that are not clinical. They're providing the social and emotional care. They're providing the culturally based care. They're ensuring that somebody walks through their experience of pregnancy with the support that they need. And the numbers don't lie on that either. We know that improves outcomes."*

To expand community-based models statewide, leaders identified the need for legislative recognition of midwives, clear licensure pathways, safe-transfer laws, adequate Medicaid reimbursement, and provider willingness to integrate these roles into care teams. In some regions, limited Medicaid-registered doulas—

[21] Governor's Commission on Racial Equity and Justice (2021). *Social Determinants of Health Final Report*. Kansas Office of the Governor. https://governor.kansas.gov/governors-commission-on-racial-equity-and-justice

[22] Key leader interview. December 5, 2025.

sometimes only one provider across entire multi-county areas—highlight the urgency of building this workforce.

Interviewees also noted the need to improve relationships and role clarity between physicians, hospitals, doulas, and CHWs to prevent misconceptions about reimbursement and scope of practice. Strengthening statewide networks that recognize and integrate all maternal-health roles was identified as a core priority.

"There is a sense of 'turfism' within the healthcare industry creating resistance to including other professionals such as doulas and home visitors."

"States need to build a comprehensive network of care where all roles—doulas, midwives, CHWs, perinatal workers—are recognized and accepted across settings."

Promising Efforts

Nurture KC's Healthy Start Program (https://nurturekc.org/about-us/programs) leverages community health workers (CHWs) to provide trusted, relationship-centered pregnancy support, education, and advocacy for expectant and parenting families.

Kansas Birth Justice Society's Catalyst Doula Training (https://ksbirthjusticesociety.org) supports community-based providers through a comprehensive, hybrid, and culturally relevant curriculum. The program supports providers with capacity-building scholarships, training for Medicaid registration, and ongoing professional development.

Opportunity 4: Finance Reform to Support Sustainable Maternal Care

Sustainable maternal health services depend on financing models that reflect the realities of care delivery, particularly in rural and low-volume settings. Workforce stability, service availability, and hospital viability are all shaped by reimbursement structures.

Recommendation: Align Reimbursement with the Cost of Readiness

Safe obstetric care requires high fixed costs—such as maintaining on-call anesthesia, surgical capability, and trained staff—regardless of the number of deliveries. Current Medicaid reimbursement rates have not kept pace with these costs. Leaders noted that Kansas has not increased obstetric Medicaid reimbursement in more than 30 years, creating unsustainable conditions for providers.

Critical-access hospitals reported that without updated reimbursement models that reflect readiness costs, they cannot maintain OB-GYN services—even when committed to doing so. Low reimbursement has also contributed to the closure of birth centers serving Medicaid patients, leaving only private-pay options in many areas. Rural hospitals underscored that extremely low delivery volume paired with high overhead costs makes the current model untenable.

"Until reimbursement models change, critical access hospitals cannot sustain OB GYN services, even if they are committed and capable."

"Critical access hospitals…need a reimbursement model that covers the very high costs of having a team available to provide the highest level of care—anesthesia, surgery, and physicians. When you have very low volume but very high costs, it's never going to work."

Recommendation: Unbundle Payments

Kansas currently uses global maternity payments, bundling prenatal care, delivery, and postpartum care into a single reimbursement. This model undermines sustainability in rural settings because only the delivering facility is reimbursed—even when another provider delivers the majority of prenatal care. As interviewees noted, this suppresses collaboration across FQHCs, birth centers, and hospitals, and leaves some providers unpaid for substantial portions of care. One example involved birth centers receiving no reimbursement when a patient labored there but transferred for delivery.

Unbundling or implementing interprofessional billing would support team-based care and improve sustainability for low-volume providers.

"If a mother labored mostly at a birth center but transferred to a hospital for delivery, the birth center received no reimbursement, even if it provided most of the care. Addressing policies like this is important."

Recommendation: Explore Value-based Payment Models

Kansas Medicaid (KanCare) primarily reimburses maternal health services through fee-for-service, which incentivizes volume over coordination. Interviewees pointed to value-based models—such as Transforming Maternal Health—as more promising approaches because they reward quality outcomes, collaboration, and whole-person care. Careholders emphasized the need for payment structures that support healthy, low-intervention pregnancies rather than activities tied only to service volume.

"We need to really look at how we prioritize payment structures for healthy outcomes and low intervention when it comes to healthy pregnancy and birth."

The **Healthy Moms, Healthy Babies Act** was announced by Governor Sarah Huckabee Sanders in 2025 to improve maternal health in Arkansas.

"The Healthy Moms, Healthy Babies Act strengthens maternal care in Arkansas by unbundling the global payment, increasing provider reimbursements, and expanding access to telemedicine. This bill also improves pregnancy outcomes by empowering community health workers and ensuring Medicaid coverage for expectant mothers." - Representative Aaron Pilkington.

The legislation includes reforms recommended by the Governor's Strategic Committee on Maternal Health. This includes:

- Establishing Presumptive Medicaid eligibility for pregnant women, meaning pregnant women can receive prenatal care while they complete their Medicaid application;
- Offering reimbursement pathways for doulas and community health workers;
- Establishing pregnancy-related Medicaid coverage for remote ultrasounds, remote blood pressure monitoring, and continuous glucose monitoring;
- Unbundling Medicaid payments for pregnancy care, paying for up to 14 prenatal and postnatal care visits, encouraging providers to work with pregnant women so they attend more appointments, and increasing Medicaid's investment in pregnant ;
- Increasing reimbursements for traditional deliveries and c-sections by 70%; and
- Investing additional funding in care for pregnant women and encouraging more providers to participate in the Medicaid program.

The Governor's commitment for funding for these investments allows the state to access additional federal Medicaid funding.

https://governor.arkansas.gov/news_post/governor-sanders-announces-healthy-moms-healthy-babies-act

Georgia Health Initiative

The **Maternal Health Vitality Think Tank (MHVTT)** is a collaborative initiative convened by the Georgia Health Initiative to align leaders and organizations working to improve maternal health outcomes in Georgia. It was created in response to a recognition that many dedicated stakeholders—including health care providers, public health leaders, community organizations, academic institutions, policymakers, and funders—were pursuing important work but often in parallel rather than through coordinated, systems-level strategies. The Think Tank aims to bring these actors together to foster dialogue, shared understanding, and collective accountability around improving maternal health across the state.

Rather than developing entirely new programs or solutions, the MHVTT focuses on aligning existing efforts and translating known recommendations into coordinated action. Through a co-created Strategic Alignment Plan, the collaborative prioritizes strengthening care coordination across the maternal health continuum, building a sustainable and equitable maternal health workforce, and aligning funding and resources to support lasting systems change. The initiative complements ongoing direct-service work by addressing the underlying systems, policies, and structures that shape maternal health outcomes.

In this effort, the Georgia Health Initiative serves as a convener and facilitator, helping to bring together diverse stakeholders, steward shared resources, and support the translation of strategy into practice. The Think Tank also helps generate evidence and shared learning—such as commissioning research to assess progress on maternal health recommendations in Georgia—to ensure that collective action is grounded in data and responsive to real needs. Ultimately, the MHVTT seeks to advance a vision of "maternal health vitality," where families experience healthy pregnancies, safe births, and dignified recovery through more coordinated, equitable systems of care.

https://georgiahealthinitiative.org/news/convening-with-intention-georgia-health-initiative-and-the-maternal-health-vitality-think-tank/

Alignment of Findings, Opportunities, and Action Agenda Directions

Landscape Findings	Implications for Kansas	Potential Action Agenda Directions	Example Strategies
Declining health rankings driven by structural and policy factors	Improvements in maternal and perinatal health require system-level solutions, not isolated programs	Advance policy and financing strategies that address Medicaid coverage, public health investment, and system coordination	Support Medicaid expansion; extend postpartum coverage; align state and philanthropic funding toward shared priorities; elevate maternal health within broader health system reforms
Growing maternity care deserts and rural hospital closures	Geographic inequities limit timely access to prenatal, delivery, and postpartum care	Strengthen regional maternity care networks, increase workforce training and recruitment, expand telehealth, support innovative care delivery models, and payment reform	Invest in hub-and-spoke networks; expand tele-maternity and remote monitoring; develop alternative birthing sites; strengthening rural nursing/OB training; align reimbursement with cost of care
Persistent racial and socioeconomic inequities in outcomes	Without intentional focus, inequities will continue or worsen	Embed birth equity frameworks, disaggregated data, and accountability measures across all initiatives; increase access to continuous affordable coverage; promote CBOs as trusted partners	Require race/ethnicity data reporting; support equity-focused quality improvement; expand Medicaid; fund community-led initiatives; strengthen culturally concordant provider pipelines
Workforce shortages across clinical and community settings	Capacity constraints undermine quality, continuity, and access to care	Invest in recruitment, retention, and training of a diverse maternal health workforce, including community-based providers	Expand reimbursement for doulas, CHWs, and home visitors; fund loan repayment; create rural pipelines; adopt flexible staffing; eliminate non-compete clauses; integrate community-based doulas & midwives statewide
Fragmented systems across health, public health, and community sectors	Families experience gaps in care and inconsistent support	Promote cross-sector collaboration and integrated, patient-centered care across the perinatal continuum	Develop shared referral and care coordination platforms; expand two-generation care; fund backbone organizations; use CHWs as care navigators; implement shared learning and data infrastructure; develop and make available an inventory of Kansas assets for implementing

			promising strategies for promoting maternal and infant health
Multiple plans and initiatives with overlapping priorities	Efforts risk duplication without coordination	Align goals, metrics, and investments through a shared Kansas Maternal and Perinatal Health Action Agenda	Convene cross-sector partners; create an implementation roadmap; use the Action Agenda to guide funding and policy decisions
Inadequate reimbursement & outdated financing models	Current Medicaid and global maternity payments undermine sustainability—especially in rural and low-volume settings—and disincentivize collaboration	Reform payment structures to reflect readiness costs, unbundle maternity care, and advance value-based maternal health models	Increase OB Medicaid reimbursement; reimburse birth centers; adopt interprofessional billing; implement value-based models such as Transforming Maternal Health
Limited behavioral health & SUD integration in perinatal care	Mental health and substance use are major contributors to maternal morbidity and mortality; screening and treatment access remain inconsistent	Integrate behavioral health into prenatal and postpartum care; expand tele-behavioral health; strengthen cross-system referral pathways	Standardize mental health/SUD screening; link mothers to community-based behavioral health supports; increase tele-BH in rural regions
Cultural and linguistic barriers & experiences of discrimination	Implicit bias, language barriers, and lack of culturally grounded care contribute to inequitable outcomes and negative birth experiences	Advance culturally and linguistically responsive care; expand community-based, culturally concordant workforce roles	Implement cultural humility & trauma-informed training; expand CHW/doula models; improve interpreter access; support trusted community-provider partnerships
Weak maternal health data systems and limited access to disaggregated data	Providers and policymakers lack timely, race- and geography-stratified data needed to monitor trends, guide QI, and evaluate ROI	Invest in shared learning systems, statewide data infrastructure, and public dashboards to support accountability and continuous improvement	Develop universal data-sharing platforms; standardize screening and reporting; strengthen statewide analytics capacity; align data tools across initiatives

Using this Report

This is designed as a practical resource for individuals, communities, organizations, and cross-sector partners committed to improving maternal and perinatal health in Kansas. It brings together a comprehensive landscape analysis, careholder perspectives, and actionable strategies to support informed dialogue and collective decision-making. Careholders can use the findings and recommendations to guide community conversations, strengthen engagement, and support coordinated planning efforts to advance equitable, high-quality care for mothers, infants, and families across the state.

"Beyond survival, we want families to thrive. The first five years of life are so important."

Conclusion

This assessment identifies multiple opportunities to build on Kansas' existing strengths and advance maternal and perinatal health statewide. The findings point to a shared commitment to improving equity in outcomes, expanding access across rural and urban communities, strengthening and sustaining the maternal health workforce, and aligning financing with the realities of maternity care delivery.

Careholders consistently emphasized the need for coordinated systems that ensure continuity of care from pregnancy through the postpartum period and highlighted the critical role of community-based providers and trusted partnerships in meeting both clinical and non-clinical needs. Across interviews and the landscape review, careholders surfaced promising practices, emerging innovations, and shared priorities that—when aligned—can more effectively support mothers, infants, and families across Kansas.

With strategic policy action and intentional coordination, these efforts can reinforce one another and help create a more equitable, accessible, and sustainable system of maternal and perinatal care.

"When single mothers aren't thriving, children aren't thriving either, and that is when poverty and trauma become generational. Financial support for single mothers isn't about luxury. It's about stability, dignity, and the ability to continue showing up for our children, our work, and our communities. When we invest in single mothers, we're not just helping a single individual. We're strengthening the very people who hold our communities together and ending generational cycles."[23]

[23] University of Kansas Center for Public Partnerships and Research. (2025, December 15). Douglas County Thrives [Community Sensemaking Session]. Lawrence, Kansas. https://www.dgcoks.gov/events/community-sensemaking-session

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Appendix 1

UMHMF MCH Careholder Interview Questions (Kansas Partners)

1. **Opening Question: Vision**

Imagine a future where all mothers and babies achieve the highest level of health and well-being. What does your vision of a system that fully supports mothers and babies look like?

- What supports, or infrastructure would need to be in place to bring that future to life?

2. **Strengthening Maternal Care Delivery**

From your perspective, what policy or system-level changes are needed to strengthen the delivery of maternal care?

- What barriers currently limit high-quality care?

3. **Cross-System Collaboration**

What role does collaboration across health systems play in strengthening care delivery?

- Are there any particular areas for collaboration you would recommend (e.g., governance models, shared accountability structures, or funding mechanisms)?

4. **Maternal Health Workforce**

How can we strengthen the workforce to improve access to care, the quality of care, and the patent's experience?

- Where are the biggest opportunities to expand or better support doulas, midwives, community health workers, and perinatal support roles?

5. **Role of Community-Based Providers**

How can community-based providers/ care improve maternal health care? What needs to be done to integrate community-based care (providers or delivery models) into the system?

6. **Advancing Maternal Health Equity**

To advance maternal health equity, what policies and systems need to be prioritized?

- Are there particular populations or communities where change is most urgent?

7. **Role of Technology and Innovation**

What role should digital tools like telehealth and remote monitoring play in improving maternal care?

- *Are there specific policy considerations to ensure equitable access?*
- *What are the main barriers for more widespread implementation?*

8. **Data and Research Needs**

What research is needed to improve maternal health care? Are there gaps in existing data systems that need to be strengthened?

9. Community and Careholder Engagement

What ongoing community and careholder engagement is needed to guide improvements in maternal health?

10. Promising Efforts:

Are there programs, policies, or community efforts, here in Kansas or elsewhere, that have made a positive impact for mothers and babies and could be expanded or replicated?

11. Final Thoughts

Is there anything else you'd like to share as we work together to ensure all Kansas mothers and babies have what they need to thrive?

UMHMF MCH Careholder Interviews (National Partners)

1. **Opening Question: Vision**

Imagine a future where all mothers and babies achieve the highest level of health and well-being. What does your vision of a system that fully supports mothers and babies look like?

- *What supports, or infrastructure would need to be in place to bring that future to life?*

2. **Strengthening Maternal Care Delivery**

From your perspective, what national policy or system-level changes are needed to strengthen the delivery of maternal care across states?

- *What barriers currently limit high-quality care?*
- *Are there federal, multi-state or other policy-level or system-level changes that have been most effective in strengthening maternal care delivery in other states/nationally?*

3. **Cross-System Collaboration**

What role does collaboration across health systems play in strengthening care delivery?

- *Are there any particular areas for collaboration you would recommend (e.g., governance models, shared accountability structures, or funding mechanisms)?*
- *Are there any examples from other states/nationally that have been effective in supporting collaboration across health systems?*

4. **Maternal Health Workforce**

How can we strengthen the workforce to improve access to care, the quality of care, and the patient's experience?

- *How can states better support doulas, midwives, community health workers, and perinatal support roles?*
- *Are there promising approaches nationally or from other states, particularly those serving rural or underserved populations that could inform Kansas's efforts?*

5. **Role of Community-Based Providers**

How can community-based providers/ care improve maternal health care? What needs to be done to integrate community-based care (providers or delivery models) into the system?

- *Are there examples of models nationally/ from other states that have effectively integrated community-based providers into maternal care?*
- *What structures or policies help ensure community-based providers can partner sustainably with clinical systems?*

6. **Advancing Maternal Health Equity**

What national policies or system changes are most essential for advancing maternal health equity?

- *Are there populations or settings across the United States where you see the most urgent need for action?*
- *Are there national strategies that have reduced maternal health equity gaps, that Kansas should consider?*

7. Role of Technology and Innovation

What role should digital tools like telehealth and remote monitoring play in improving maternal care?

- *What policy considerations are needed to ensure equitable access?*
- *Where do you see barriers to scaling these innovations across states?*
- *Are there national or other state-level examples that show how technology can expand access or equity, especially in rural or underserved communities?*

8. Data and Research Needs

What research is needed to improve maternal health care? Are there gaps in existing data systems that need to be strengthened?

9. Community and Careholder Engagement

Across various states, what approaches to community and careholder engagement have been most successful in guiding maternal health improvements?

10. Promising Efforts:

Are there programs, policies, or initiatives, nationally or in specific states, that have made a positive impact for mothers and babies and could be expanded or replicated in Kansas?

11. Final Thoughts

Is there anything else you'd like to share as we work together to ensure all Kansas mothers and babies have what they need to thrive?

Appendix 2

Maternal and Perinatal Health Landscape in Kansas: Data Synthesis

Maternal Mortality and Severe Maternal Morbidity

Recent findings from the Kansas Maternal Mortality Review Committee (KMMRC) underscore ongoing concerns related to maternal mortality and severe maternal morbidity (SMM) in the state. Consistent with national trends, maternal deaths in Kansas disproportionately occur during the postpartum period and are driven by both clinical and non-clinical factors, including cardiovascular conditions, mental health and substance use, and gaps in continuity of care.

KMMRC findings emphasize that many maternal deaths are **preventable**, highlighting opportunities for earlier intervention, improved care coordination, and system-level improvements. Racial and geographic disparities persist, reinforcing the need for equity-focused strategies, expanded postpartum coverage, and sustained investment in community-based supports. For example, the 2024 Kansas Severe Maternal Morbidity and Maternal Mortality Report found that the SMM rate for non-Hispanic Black women was **75% higher** than the rate for non-Hispanic White women, **35.5% higher** than the rate for the Hispanic population, and **32.8% higher** than the rate for non-Hispanic Asian/Pacific Islanders. Women enrolled in Medicaid or residing in low-income zip code areas were more likely to experience SMM. KMMRC investigations identified contributing circumstances including obesity, mental health conditions, substance use disorder, and experiences of discrimination.

Lived Experience of Mothers and Families

Data from the Pregnancy Risk Assessment Monitoring System (PRAMS) and community-based assessments provide important insight into the lived experiences of Kansas mothers and families. These sources highlight barriers related to transportation, affordability, workforce shortages, and limited access to respectful, culturally responsive care—particularly in rural and underserved communities.

The 2022 PRAMS report highlights socioeconomic disparities across indicators including unintended pregnancy, timing of prenatal care initiation, cigarette smoking, stress, breastfeeding, and postpartum depression. The PRAMS report also shows persistence of racial disparities, with a higher percentage of non-Hispanic Black mothers reporting unintended pregnancy, lack of prenatal care in the first trimester, experiencing partner-related and financial stress in the year before the birth, and other negative outcomes compared to non-Hispanic White mothers.

Mothers consistently report challenges navigating care transitions during pregnancy and the postpartum period, as well as unmet needs related to mental health, breastfeeding support, and social services. Incorporating the voices of families into planning and implementation efforts is critical to ensuring that maternal and perinatal health strategies are responsive, equitable, and aligned with community priorities.

Quality and Safety in Maternity Care

Improving quality and safety in maternity care remains a key opportunity for reducing preventable maternal morbidity and mortality in Kansas. Participation in initiatives such as the Alliance for Innovation on Maternal Health (AIM) and other perinatal quality improvement efforts has supported adoption of evidence-based practices related to obstetric emergencies, including hemorrhage and hypertension.

However, variation in implementation and sustainability across facilities—particularly in rural and resource-limited settings—continues to pose challenges. Strengthening statewide coordination, data sharing, and technical assistance can help ensure consistent application of proven safety practices and support continuous quality improvement across the maternity care system.

Perinatal Behavioral Health and Substance Use

Perinatal mental health and substance use disorders represent growing contributors to maternal morbidity and mortality in Kansas. Available data indicate gaps in screening, referral, and access to treatment during pregnancy and the postpartum period, particularly outside urban areas.

Integrating behavioral health into prenatal and postpartum care, expanding tele-behavioral health services, and supporting provider training are important strategies for addressing these needs. Aligning maternal health, behavioral health, and substance use systems will be essential to improving outcomes for mothers, infants, and families.

Statewide Health Context

What Happened to Health in Kansas? Priorities for Reversing a Long-Term Decline in Health Ranking

Kansas Health Institute, September 2025

This report examines factors contributing to Kansas' long-term decline in overall health rankings—from **8th in 1991 to 28th in 2024**. Findings were informed by input from **100 health experts and leaders across Kansas**, 69% of whom hold advanced degrees.

Highest-priority challenges identified:

- Closure of rural hospitals and loss of health care services
- Lack of Medicaid expansion
- Limited availability of mental health services
- Low public health funding

Additional high-priority concerns:

- Chronic disease and obesity
- Income and wealth inequality
- Rural workforce shortages
- Housing access
- Lack of a statewide culture of health
- System fragmentation

Participants emphasized that **structural and system-level drivers**, rather than individual behaviors, are the primary contributors to Kansas' declining health outcomes. The report highlights the role of policy decisions, underinvestment, and infrastructure gaps as key determinants of population health.

As noted by the authors, the findings provide practical guidance for leaders allocating limited resources and offer a data-informed set of priorities to support coordinated, system-level transformation across Kansas' health landscape (Kovach et al., 2025).

Racial Equity and Maternal Health

Governor's Commission on Racial Equity and Justice

The Governor's Commission on Racial Equity and Justice examined inequities across economic systems, education, and health care. Released in 2021, recommendations related to **Maternal and Child Health** emphasized advancing racial equity through policy, financing, data, and community-based approaches. Key recommendations included:

- Expand Medicaid and offer comprehensive maternal benefits
- Extend Medicaid coverage for mothers to **12 months postpartum**
- Increase income eligibility for Medicaid, CHIP, and pregnant women to **240% of the Federal Poverty Level (FPL)**
- Improve health of children by reducing the number of uninsured children through enabling continuous coverage for children ages 0-5
    - "Kansas is one of the states with a growing number of uninsured children. In 2019, there were 9,000 fewer Kansas children who had health coverage than in 2016. Black, Indigenous, and children of color are nearly twice as likely to be uninsured than white children (7.8% vs 4.2%) in Kansas. Kansas can reduce the number of children who churn off Medicaid due to red tape/ administrative reasons by implementing a policy that ensures all Kansas children have continuous coverage for ages 0-5. Increased access to coverage will result in more consistent access to pediatrician-recommended well-child visits. Such regular check-ups, as recommended by the American Academy of Pediatrics, are more frequent during early years of development to ensure delays or health problems are addressed as early as possible. This can help to put a child on the path for success in kindergarten and well beyond into adulthood."
- Publicly report child health measures by race, ethnicity, and service location
- Develop payment policies that support the child–caregiver relationship using a **two-generation care** model (including comprehensive home visiting)
- Develop payment policies to reimburse community-based providers such as community health workers, home visitors, doulas, and lactation consultants.
- Utilize quality programs as part of Managed Care Organization (MCO) contracts to improve quality of care
- Train partners to utilize a **birth equity framework**
- Establish **First 1,000 day "health homes"** for mothers and children ages 0–3.

    - "Kansas should establish health homes for the first 1,000 days of a child's life and utilize comprehensive care coordination services to better connect new mothers and children to needed physical and behavioral health care. KDHE should explore how to leverage the pediatric visit to pay for care coordination services as well as utilize community-based providers, like Community Health Workers, to provide care and critical wrap-around services to ensure mothers and children's physical, behavioral, social, and emotional needs are met during the child's first 1,000 days."
- Support telehealth policies to improve access and outcomes and sustain telehealth beyond COVID-19
- Partner with state and community organizations to offer best practices and education for mothers and families during and after pregnancy

Maternal Health Strategy and Systems Improvement

Kansas Maternal Health Innovation Program Draft Maternal Health Strategic Plan

The Kansas Maternal Health Innovation (MHI) Program focuses on improving maternal health outcomes by reducing **severe maternal morbidity** and **maternal mortality**. The draft strategic plan, released in March 2025, identifies four core strategies:

- Quality services
- A skilled workforce
- Enhanced data quality and capacity
- Innovative programming

Maternal and Child Health Priorities

Kansas Maternal Child Health Title V State Action Plan 2026-2030

The Kansas Department of Health and Environment Title V State Action Plan outlines seven priority areas:

1. Ensure women have access to and utilize integrated, holistic, and patient-centered care across preconception, pregnancy, and postpartum periods
2. Support infants and families through strong community systems that promote optimal infant health and well-being
3. Ensure children and families benefit from developmentally appropriate services within integrated health and collaborative community systems
4. Promote consistent access to comprehensive, patient-centered care for adolescents and young adults that supports their physical, social, and emotional well-being
5. Ensure individuals with special health care needs (SHCN), their families, communities, and providers have the knowledge, skills, and comfort to offer coordinated care and support transition.

6. Strengthen workforce capacity and public health systems through investment in training, infrastructure, and cross-sector collaboration ensuring a skilled, adaptable workforce and resilient systems capable of addressing current and emerging maternal and child health needs
7. Expand access to resources and services that build on family strengths and promote healthy relationships and family well-being

Access to Maternity Care in Kansas

This 2025 report by the University of Kansas School of Nursing and Kansas Center for Rural Health, commissioned by the United Methodist Health Ministry Fund, documents significant gaps in access to maternity care across Kansas. Findings indicate a growing **maternity care desert**, particularly in central and southwest regions of the state.

Key findings include:

- Many Kansans must travel **up to 60 miles** for low-risk prenatal, postpartum, and labor and delivery care
- **59% of Kansans lack local access** to inpatient maternity care services
- Nearly **30% of Kansas ZIP codes** are more than **100 miles from tertiary, high-risk maternity services**

The report offers several recommendations to address these access challenges:

- Expand and optimize maternity care delivery through telehealth
- Promote collaborative regional networks to support coordinated maternity care systems
- Develop innovative reimbursement and payment models for maternity services
- Engage careholders continuously to inform policy development and system improvement (Weis, 2025)

Landscape Takeaways

- **Structural and policy drivers matter most.** Careholders emphasize that Kansas' maternal and perinatal health challenges are driven by system-level factors—such as Medicaid policy, public health investment, workforce capacity, and infrastructure.
- **Access to maternity care is increasingly fragile.** Hospital closures, maternity unit shutdowns, and workforce shortages have created expanding maternity care deserts, requiring many Kansans to travel long distances for both routine and high-risk care.
- **Equity must be central to action.** Racial, geographic, and socioeconomic inequities persist in maternal and child health outcomes. Advancing birth equity will require targeted policy reforms, transparent data reporting, and sustained investment in community-based providers and supports.
- **Workforce development is critical.** Strengthening and diversifying the maternal health workforce—including clinicians and community-based providers such as doulas, community health workers, and home visitors—is a consistent priority across plans and recommendations.
- **Care must be integrated across the life course.** Effective strategies emphasize coordinated, patient-centered care spanning preconception through postpartum, as well as two-generation approaches that support both caregivers and children.
- **Alignment creates opportunity.** Kansas has multiple complementary initiatives underway. Aligning priorities, funding, and partnerships through a shared Action Agenda offers an opportunity to accelerate progress, reduce fragmentation, and improve outcomes for mothers, infants, and families statewide.

Appendix 3

Careholder-identified Research Priorities

Technology & Innovation	• ROI and impact of emerging maternal health technologies • Effect of remote monitoring on maternal outcomes, access, and quality of care
Rural Health Systems & Regional Models	• How rural Kansas communities (e.g., Gove County, Kearny County) developed maternal health hubs and regional models of care • Capacity/readiness of rural health centers • Collaboration among health centers, hospitals, and CBOs
Research Ethics & Evidence Gaps	• Ethical and methodological considerations when conducting research with pregnant women (a protected population)
Maternal Mortality & Morbidity	• Drivers of maternal mortality among patients of color • Links between mental health and maternal mortality/morbidity • Causes of maternal deaths and disparities • Experiences of women with severe maternal morbidity to identify prevention pathways
Community-Based & Non-Clinical Interventions	• Effectiveness of community-based, non-clinical supports • Outcomes of community birth models • Strategies for narrative change around community birth • Barriers contributing to hesitation in accessing community-based care
Models of Care & Workforce Integration	• Safety, quality, and efficacy of out-of-hospital midwifery • Integrating midwives into FQHC-based maternal care
Trauma, Safety & Patient Experience	• Obstetric violence, birth trauma, and provider communication during crises
Population-Specific Needs	• Maternal healthcare needs of migrant and immigrant populations • Prevalence and impacts of substance use disorders among women, including during pregnancy
Policy & Systems Research	• Effective maternal health policy and systems-level reforms • Impact of hospital ownership changes on referral patterns, insurance alignment, reimbursement structures, and patient routing