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Practice Summary & Implementation Guidance

Becoming a Mom® Prenatal Education Program, Implemented through the Kansas Perinatal Community Collaborative Model

Becoming a Mom® (BaM) / Comenzando bien® (Cb) is a prenatal education program created by the March of Dimes, delivered through a community collaborative model in Kansas to improve knowledge, promote healthy behaviors, and enhance birth outcomes, particularly for pregnant persons at highest risk of adverse outcomes.

Location	Topic Area	Setting
Kansas	Birth Outcomes, Health Promotion & Communication, Reproductive Health	Community, Clinical

Population Focus	Date Added
Families & Caregivers, Infant, Women & Maternal	November 2024

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Section 1: Practice Summary

PRACTICE DESCRIPTION

The Kansas Blue Ribbon Panel on infant mortality, which was established in 2009, identified that infant mortality in the State of Kansas was driven largely by premature birth and low birth weight. To address these health concerns, the panel recommended the implementation of the March of Dimes Healthy Babies are Worth the Wait/Becoming a Mom® birth disparities program. In 2010, following the release of the Kansas Blue Ribbon Panel recommendations, coupled with cuts in state and local funding, a partnership between a local Title V funded Maternal Child Health program and the March of Dimes Greater Kansas Chapter created an innovative concept of a community collaborative prenatal education model, known as the Kansas Perinatal Community Collaborative (KPCC), utilizing the Becoming a Mom® (BaM) / Comenzando bien® (Cb) curriculum. This collaborative model aimed to address birth disparities primarily among low-income, minority women. Starting with a pilot program in Salina, Kansas (Saline County), the model has a three-fold focus of clinical services coupled with prenatal education and integrated support services. The collaborative model is driven by private and public partnerships across the state and local level that includes Title V, Medicaid, private foundations, public health departments, federally qualified health centers, clinical providers, birth facilities, employers, faith-based and community organizations. The community collaborative model brings permanent Maternal and Child Health infrastructure, leveraged and shared resources, change in the prenatal care delivery paradigm, a vehicle to identify community needs, a standardized evaluation system, and new funding opportunities for community collective impact and improvement of birth outcomes.

Through the collaborative model, the BaM/Cb program is implemented, providing education and support services in a group format, that leads to increased knowledge, behavior change, and improved birth outcomes. The program's objective is to enhance the well-being of pregnant individuals by welcoming all who wish to participate. However, it is tailored to prioritize education for those who are more susceptible to adverse pregnancy outcomes, such as those from lower socioeconomic backgrounds or racial and ethnic minorities. Through targeted efforts, the program aims to mitigate disparities within these under-resourced communities over time.

CORE COMPONENTS & PRACTICE ACTIVITES

BaM/Cb works to educate mothers about ways to improve their own health and steps to take to improve the health of their baby, reduce preterm births, and decrease risks of both infant and maternal mortality. While the goal of the program is to improve health of mothers in the program in general and will accept all mothers who wish to enroll in the program, the BaM/Cb program specifically aims to provide education to mothers that are more likely to be at risk (low socioeconomic status, racial/ethnic minorities), to reduce disparities among these populations through time. The core components of this program include in-person or virtual education provided by a nurse, health professional or other content expert in the community, provision of handouts that address items covered in each session and activities to help reinforce the information being provided, while creating group interaction and dialogue.

Core Components & Practice Activities

Core Component	Activities	Operational Details
Care	Assessment of access and barriers to prenatal care	Program participants are screened for access and barriers to care and assisted to navigate and overcome these barriers.
	Connection with prenatal clinical care providers.	Collaboration between prenatal clinical care providers and perinatal service providers across public health and other sectors is an integral component of the model, to ensure access to care is addressed. Encouraging communication with participant's care provider is an integral component of every session and is incorporated into multiple session activities to increase participant comfort with initiating and navigating these conversations.
Education	In-person and virtual meetings for pregnant persons and their partners where information on pregnancy and postpartum topics are shared.	Provide evidence-based education sessions and materials that are routinely updated to ensure the latest and most up-to-date information is provided to participants.
Support: Screening and Connecting	Screening tools	Substance Use, Social Determinants of Health, Risk Assessments and Perinatal Mood and Anxiety Disorder Screenings are integrated at specifically designated timeframes throughout the program.
	Guest presenters from community services	Content experts and guest presenters from community services and organizations put a "face with a name" and help reduce fear and stigma around accessing available services.
	Referrals and linkages to external community resources	Referrals and linkages to external community resources that are identified with program participants and/or support persons are facilitated by program staff.

	Activities to promote group interaction	Activities are integrated into every session to promote group interaction and connection building between participants.
Assessment and Evaluation	Assessment of pregnancy, postpartum, and infant care knowledge and behavior change.	Assess and reassess the knowledge and behaviors of participants regarding pregnancy, the postpartum period, and infant care, as well as evaluating birth outcomes. Pre/Post Completion Surveys as well as Birth Outcome Surveys are collected. Surveys are updated on an annual basis.

HEALTH EQUITY

The KPCC model utilizes a Collective Impact framework. Collective Impact is premised on the belief that no single policy, government entity, organization, or program can tackle or solve the increasingly complex social problems we face as a society. The approach calls for multiple organizations or entities from different sectors to abandon their own agenda in favor of a common agenda, shared measurement, and alignment of effort. Primary components include a common agenda, common progress measures, mutually reinforcing activities, collaborative communication, and a backbone organization to coordinate and monitor activities. Collaborative strategy is implemented, bringing together individuals, agencies, organizations, and community members to systematically solve existing and emerging problems that could not easily be solved by one group alone. The KPCC model focuses on increasing capacity, strengthening communications and efficiencies while improving outcomes. Each community collaborative becomes a partner-supported and sustained initiative. Coordinating existing services, sharing resources, and leveraging available funds helps ensure the long-term sustainability of local efforts. Duplication is minimized and service capacity increased. Funding is a finite resource however it is not a barrier. Many Kansas community collaboratives have launched initiatives without new funding by capitalizing on existing resources. Understanding what resources are available among partners has helped KPCC's collectively design a model that leverages systems, services, and resources more effectively.

The BaM curriculum was developed by the March of Dimes and supplemental materials were developed by the Kansas team, which includes a local curriculum review committee, to better meet the needs of Kansas residents and Title V priorities. The social ecological model serves as the basis upon which the curriculum is built and revised. The curriculum and implementation resources were developed by reviewing best practices, evidence-based research and recommendations from accredited entities such as the AAP, ACOG, AFP, etc. The curriculum is reviewed and updated each year with the most up-to-date information. If a significant shift in evidence-based practice occurs, changes to the curriculum are made immediately rather than waiting to make the changes during the regularly scheduled timeframe. Participant feedback is gathered through post-completion surveys and program adaptations are made in response to common themes that are identified.

The program is intentionally designed to promote health equity by making services available to all pregnant individuals while prioritizing outreach and support for communities that experience significant disparities in maternal health.

In summary, the program's health equity component is deeply embedded in its design, from ensuring universal access and cost-free participation to actively targeting and engaging underserved populations. By leveraging community partnerships, adapting content to diverse needs, and addressing practical barriers like transportation and childcare, the program aims to create a more equitable environment for all pregnant individuals, especially those from historically marginalized communities. These efforts reflect a strong commitment to reducing health disparities and improving maternal health outcomes for everyone, particularly those who are most at risk.

EVIDENCE OF EFFECTIVENESS

While the below description depicts the most recent evaluation period, KDHE has been completing a similar process for program evaluation since 2015. See 2022 Program Reports and Infographics here.

Initial Survey (Pre-Survey)
For the pre-survey, records from the BaM/Cb Initial Survey form were extracted from DAISEY (Kansas MCH Data System) for the calendar year prior to the evaluation year, as well as the current evaluation year (January 2021 through December 2022). This allows for any participants that may have started the BaM/Cb program before the evaluation period, or fell out and returned to complete the program, to be captured for analysis. After evaluation, cleaning, and deduplication of records, 1,627 Pre-Survey records were available for potential linkage to post-survey records for the calendar year 2022, with 883 of these having been completed in 2022 specifically (including transfers).

Completion Survey (Post-Survey)
For the post-survey, records from the BaM/Cb Completion Survey form were extracted from DAISEY for the 2022 calendar year. After evaluation, cleaning, deduplication of records, there were 608 records from 2022.

Birth Outcome Card
Data from Birth Outcome Cards completed from Jan. 1, 2021 to present, Aug. 16, 2023, were extracted from DAISEY. Extending the timeframe for capturing the outcome data allowed more birth outcomes to be included. After evaluation, cleaning, and deduplication of records, there were 526 Birth Outcome Cards completed in 2022.

While education of BaM/Cb participants is a critical element of the program, it is also important to understand the impact of the education and support on maternal and infant outcomes through time. Most BaM/Cb participants who provided information on their postpartum behaviors reported breastfeeding, following safe infant sleep practices, and taking steps toward family planning:

- More than nine in ten BaM/Cb babies (96.5%) were reported as sleeping only on their backs, and not on their sides or stomachs. 90.2% among babies for whom the participant had reported in the Pre-Survey that they would put them to sleep *in other positions* besides only on their backs.
- More than nine in ten BaM/Cb babies (95.8%) were reported as being put down to sleep in a crib/bassinet or portable crib, and not in an adult bed, couch or recliner with the participant, or in a car seat/carrier, bouncer or swing. 91.4% among babies for whom the participant had reported in the Pre-Survey that they *would not only* sleep in a crib/bassinet or portable crib.
- More than nine in ten BaM/Cb babies (94.6%) were ever fed breast milk, vs. 87.1% of all Kansas births. Only 51.7% of BaM/Cb babies were exclusively breastfeeding at the time the Birth Outcome Card was completed.
- About three in four participants (75.1%) had talked to their doctors about options for preventing pregnancy.

- While not statistically significant in the most recent evaluation period, the preterm birth rate was lower at 9.9% for BaM/Cb participant births than 10.5% of other births to Kansas residents. In all years prior to 2020, preterm birth rates were statistically significantly lower for BaM/Cb participants than for other Kansas residents.

Other key findings worth noting:

- BaM/Cb participants reported they had connected, or had planned to connect, to multiple services including breastfeeding support (78.8%), car seat installation by a certified car seat technician (74.9%), parenting/early childhood services (63.0%), and WIC (60.8%).
- Participants reported being referred to the program by collaborative partners such as a clinic (44.2%), WIC (17.9%), or a hospital (11.7%), reinforcing the significance of the Kansas Perinatal Community Collaborative (KPCC) model.

Consistently over the duration of the BaM/Cb program in Kansas, it has reached a younger and more racially and ethnically diverse population than among Kansas births overall. Despite the impact of the COVID-19 pandemic on site operations, program data compared to births occurring to Kansas residents in 2022, shows pregnant persons who completed the BaM/Cb program in 2022 were:

- Significantly more likely to be of a minority racial or ethnic group
  - Non-Hispanic Black: BaM/Cb, 8.7%; Kansas Births, 6.4%
  - Hispanic: BaM/Cb, 25.1%; Kansas Births, 18.4%
- Significantly more likely to be younger
  - Under 17 years old: BaM/Cb, 2.5%; Kansas Births, 1.2%
  - 20 to 24 years old: BaM/Cb, 23.4%; Kansas Births, 20.2%
  - 25 to 29 years old: BaM/Cb, 35.4%; Kansas Births, 30.8%
- Significantly more likely to use the WIC program
  - 48.7% of BaM/Cb participants reported WIC enrollment, whereas 21.8% of Kansas births in 2022 were to WIC recipients.

Program Feedback

Of the BaM/Cb participants who completed the Post-Survey in 2022:

- 78.3% rated their experience as excellent, whereas an additional 21.2% rated it as "good".
- Most participants "agreed" (30.6%) or "strongly agreed" (33.7%) that they felt a connection to and supported by other participants.
- When asked about feeling a connection to and supported by the teacher/instructor or group leader, more than eight in ten participants expressed agreement (33.4%) or strong agreement (56.8%).
- Participants also favorably rated the ease of understanding the information, with 37.6% reporting that it was "very easy," 25.1% reporting that it was "easy," and 32.9% reporting that it was "just right".
- Most participants reported they had learned "a lot" from the program (74.3%).
- All six sessions were helpful; for each session, more than three in four participants who reported attending the session rated it as "very" or "extremely" helpful.

COLLABORATORS AND PARTNERS

Despite turnover at the MoD, the Kansas BaM Program Coordinator continues to maintain contact with key individuals at the MoD. This is done through routine emails, phone calls, and meetings. The BaM program administrators are asked to provide feedback on the program annually at a minimum. They are also encouraged to reach out to the stated BaM Program Coordinator as questions or concerns arise, as well as with any input gathered at the local level, whether it be from program participants or collaborative partners. Furthermore, when it comes time for curriculum updates, these individuals are asked to review changes prior to implementation for feedback. Finally, the state BaM Program Coordinator conducts site visits at least every other year, if not every year, to provide additional in-person support. The BaM program participants are surveyed at the end of their participation regarding the program strengths and opportunities for improvement. This feedback is reviewed on a yearly basis to address common issues that may arise or to increase information on a particular topic if it is being requested. Local collaboratives meet on a regular basis through which they engage their collaborative partners and invite input. Many of these collaboratives include participant voice in their meetings, by inviting program participants to be part of the collaborative effort (i.e. Delivering Change in Geary County).

Practice Collaborators and Partners			
Partner/ Collaborator	**How are they involved in decision-making throughout practice processes?**	**How are you partnering with this group?**	**Does this stakeholder have lived experience/come from a community impacted by the practice?**
March of Dimes	The MoD is contacted to find out when updates will be released and to provide updates on what supplemental curriculum Kansas is including.	The Kansas BaM Program Coordinator works to maintain a relationship with the MoD staff for information on their updates as well as any updates Kansas is planning. Partnership between KDHE and MOD was established from the beginning, to assure adherence to copyright restrictions and protect program (Kansas model) fidelity.	The MoD is a long-standing nonprofit organization that is committed to ending preventable maternal health risks and death, ending preventable preterm birth and infant death and closing the health equity gap for all families. March of Dimes involves community members in designing and implementing programs aimed at improving maternal and child health outcomes. This ensures that the

			programs meet the specific needs and challenges faced by local communities.
BaM Program Administrators	Local program administrators are engaged to share their experiences with implementing the BaM program. Their input is used to adjust curriculum, activities and evaluation tools as needed.	The Kansas BaM Program Coordinator regularly corresponds with BaM program administrators about their experiences and conducts site visits to further support and engage the programs. Input is gleaned during these site visits as well as throughout the year related to annual curriculum and evaluation updates; special projects; TA opportunities; etc. A "Curriculum Review Committee" composed of local clinical providers (OB/GYNs, Nurse Midwives, Pediatricians, mental health, etc.), public health and other service providers (WIC dietician, Title X family planning nurse, early childhood partners, Kansas University - local program evaluators) review the curriculum and provide recommendations on a regular and as requested basis.	Yes, each of these individuals has direct experience administering the program either in-person, online, or both. Participant voice is relayed through the local program administrators.
BaM Program Participants	Participants are surveyed on their experiences in the BaM program and their feedback is used to adjust curriculum and activities as needed.	Participants are engaged through their feedback on surveys and as provided to program administrators throughout their engagement with the program.	Yes, each of these individuals has completed the BaM program and is providing direct feedback on their experience. Special projects have also included local workgroups to gather input from

		Specific feedback gathered through program surveys includes overall experience; feeling of connection and support; level of ease/difficulty of understanding; level of information learned; level of helpfulness/ valuableness. In addition, program surveys request participant feedback on program facilitators as well as any additional feedback they would like to provide on the program in general. Throughout the years, specific content has been added or supplemented based on participant feedback.	underrepresented communities and related to specific focus areas.

REPLICATION

The BaM/Cb program was initially launched in Salina, Kansas in 2010. The model was replicated in Junction City, Kansas in 2012. Both sites saw preliminary success, marked by improvements in both knowledge and behavior, as well as birth outcomes. As such, program evaluation tools were refined and standardized in 2013. From there, additional BaM sites were added on a yearly basis. In 2022, there were a total of 17 sites operating a BaM program (following a loss of 3 hospital-based program sites during the COVID-19 pandemic). Each of these programs demonstrates improvements in pre to post knowledge and behavior, as well as birth outcomes, as demonstrated through the annual BaM State Aggregate Report, as well as individual site reports for each local program. As mentioned previously, through reviewing evaluation data and obtaining feedback from program administrators and participants, KDHE has continued to improve and adapt the curriculum to changing best practices and changing needs of the residents of Kansas.

Replication with underrepresented communities has also been a focus of the program and its collaborative back-bone structure. An example of this has been replication of the program through partnerships between our Sedgwick County program, locally branded as "Baby Talk", and the Wichita Black Nurses Association and KanCare (State of Kansas Medicaid program). Each of these program partnerships focuses on supporting a specific at-risk community, with adjustments made to address their unique needs.

As mentioned previously in this application, we are currently funding Health Equity Opportunity Projects in two local communities, one in the southwest corner of the state, and one in the northeast. These programs have committed to participate in a bi-weekly workgroup, working to adapt the curriculum for low-literacy and English Language Learner populations.

INTERNAL CAPACITY

As has been mentioned previously, the BaM/Cb program is best implemented through a collaborative infrastructure consisting of organizations, services and providers who's currently existing roles and mission are to serve and support the perinatal population. Examples include:

- State Level: Title V Maternal Child Health (MCH) Program (recommended lead); State Breastfeeding Coalition; Safe Kids and other related organizations such as the Kansas Infant Death and SIDS Network; State Medicaid and MCOs; Health Foundations; Philanthropic Organizations.

- Local Level: Public Health Departments - Title V supported MCH programs, WIC; birthing facilities; FQHCs; private clinical providers; doulas; Community Health Worker (CHW) networks; community mental health centers; early childhood programs and coordinating councils; home visiting programs; early intervention programs; breastfeeding coalitions; Safe Kids coalitions; businesses and major employers; faith-based organizations; Research and Extension (K-State Research and Extension); Health Foundations; Philanthropic Organizations; service/civic organizations.

By partnering and building off existing infrastructure, rarely are new personnel required. Collaborative and creative allocation of roles and responsibilities among existing staff, as well as resource contribution (i.e. classroom space, childcare, transportation, snacks, incentives, etc.) increase capacity and sustainability, while decreasing cost and burden to any one entity. Required personnel supports and partner roles include:

- State Level: *Title V Support is not required but makes good sense. Recommended building into existing Title V infrastructure to support program implementation at state and local level.*
  - Statewide Program Coordinator – Creates and coordinates state infrastructure for supporting local implementation, which includes program fidelity and trademark protection; implementation training; ongoing technical assistance; updating and maintaining implementation resources; data system and evaluation; marketing and promotion; solicitation of local program sites.
  - Epidemiologist – Cleans and interprets program data; creates annual state aggregate and local site reports.
- Local Level:
  - Champions/Promoters - Promote initiative in community and recruit collaborative partners as well as BaM participants.
  - Program Coordinator - Coordinates and oversees overall function of collaborative and implementation of BaM/Cb program; communicates with all collaborative partners.
  - Site Coordinators - Coordinate communication and responsibilities as partnering/referring organization.
  - Facilitators/Instructors - Facilitate/teach BaM/Cb sessions.
  - Guest Presenters - Present as a "content expert" or as a representative of a community resource/agency/organization.
  - Support Staff - Program support during sessions - i.e. check-in process, collection of evaluation data, etc.

- Support Staff - Program support between sessions- i.e. scheduling, enrollment, reminder phone calls, texts or postcards, gather session supplies, monitoring of participant completion status, etc.
- Data Entry - Transcription of evaluation data from paper to electronic format when necessary; oversees data collection via electronic sending/receiving of enrollment and evaluation forms in online data collection system.
- Other Partner Roles/Contributions: - childcare; transportation; snacks; incentives.

PRACTICE TIMELINE

Implementation is at a community's own pace. Implementation and training resources have been created in an online format to support local communities in preparing for implementation on their own timeline. Planning should include reasonable time for collaborative building as well as training completion for BaM/Cb program implementation.

PRACTICE COST

Costs of implementation vary from site to site and largely depend on local resource availability and in-kind donations. The intention of the collaborative approach is that resources are shared by collaborative partners, thus decreasing the cost burden on any one entity and supporting long term sustainability. The following are elements to consider and plan for related to implementation costs:

- Printing
    - May include curriculum handouts and promotional materials
        - Currently, printed curriculum handouts are provided to all Kansas program sites at no cost to the local program, through state partnerships and shared investments. This funding is not guaranteed and is dependent upon the availability of funds year to year, therefore program sites should plan for this potential cost in the future.
- 3-Ring Binders (1 inch) and Clear Page Protectors
    - Program sites are encouraged to provide each participant with a 3-ring binder filled with all session curriculum handouts and associated resources (inserted in a clear page protector for each of the six sessions). Provision of printed curriculum has continued since program inception, even for virtual participants, based on evaluation data that indicated 60.9% of virtual participants used their cellular phone for participation. Check with local retailers about a partnership that would provide binders at-cost.
- Snacks
    - Beings the sessions are two hours in length, most program sites provide a light healthy snack during the session. Snacks are often donated by local retailers, restaurants, service/civic or other organizations, but otherwise should be budgeted for.
- Incentives
    - Incentives range in cost and are dependent upon local resources and the type of incentives provided (see information on incentive if FAQ linked in resources below). Incentives are often donated (or provided at-cost) by local retailers, or other charitable organizations. A ballpark figure for incentives per participant is $50-100 without receipt of donations.
- Staff time

- Staff time can be somewhat difficult to separate out, as it just becomes part of the everyday work staff are doing in their role to provide care/services to pregnant persons. It will also vary based on staff position and rate per hour, as well as program size (number of participants; number/frequency of group sessions provided). Staff time will be increased at the beginning of collaborative building and program implementation but should decrease as partnerships are built and the program gets underway. Ongoing staff time should include:
  - Program Coordinator (approx. 4-8 hours per month)
  - Site Coordinators (approx. 4 hours per month)
  - Facilitators/Instructors (approx. 3 hours per session).
  - Support Staff during sessions (approx. 3 hours per session)
  - Support Staff between sessions (approx. 4-8 hours per week)
  - Data Entry (approx. 1 hour per participant per program completion of all six sessions)

LESSONS LEARNED

The community collaborative model is essential to long term sustainability. There have been a few organizations who have implemented the BaM/Cb program on their own without really having the collaborative backbone component built. While not impossible, it has certainly created greater burden on the single organization, jeopardizing long term sustainability of the program, while also limiting growth and reach of the program.

Having clinical prenatal care providers actively engaged in the collaborative efforts, and actively engaged in scheduling their patients for classes (through an EMR or other scheduling system) as "part of prenatal care" leads to the greatest participation rates and success. Passive referral systems, such as providing a program brochure in the new OB packet, is least successful.

Having a state program coordinator and Title V support is important for initial infrastructure development, updating of implementation resources and ongoing technical assistance.

The COVID-19 pandemic was a particularly trying time. Being able to quickly adapt to a virtual delivery model enabled most programs to stay in operation. Programs who's lead organization was the birth center, had to shut down and a couple have struggled to restart following significant staffing loss and leadership change. Programs who had a strong collaborative backbone, were able to shift responsibilities to other organizations and partners during these difficult times. Unintended consequences were a desire for continued virtual participation (negative) and reaching populations that were not previously being reached through in-person only offerings (positive). As a result, TA efforts have been focused on reengaging participants in the in-person environment, while strengthening and improving the virtual mode of implementation to assure active participation and equally improved outcomes by virtual participants.

In hindsight, we should have documented each quality improvement cycle using a model such as Plan, Do, Study, Act. While we have conducted these cycles on an annual basis, we have never officially documented it as such. With limited staff capacity, the focus has been on getting the work done and not on documenting it.

Once fully underway, state Title V infrastructure support should budget for at least 1 FTE Program Coordinator and 1 FTE Program Assistant to properly implement, scale and spread the BaM/Cb program and KPCC model across a state.

NEXT STEPS

One way we are hoping to expand BaM/Cb classes is with virtual platforms. Kansas has a variety of county types from urban to frontier. As such, we have some counties that simply do not have the capacity to offer BaM/Cb classes in person. Therefore, we are looking at the potential of having some of our seasoned program sites who already offer virtual classes to expand this offering to counties that do not have the capacity to fully implement the program themselves.

Other enhancement dreams include: looking for a tech product/company to provide additional online/text support and community building with the BaM participants through their pregnancy and postpartum period; partnering with state and local organizations to provide ongoing engagement and support for behavior modification of BaM participants identified with conditions of pregnancy that increase risk of subsequent chronic disease (i.e. hypertensive disorder of pregnancy, gestational diabetes, obesity, perinatal mood and anxiety disorder, etc.).

Currently, we are revising the course curriculum to make the material more accessible for individuals with varying levels of health literacy and those for whom English is not their primary language. We are also exploring ways to adapt the curriculum and activities to better engage participants in online courses. To effectively reach our target populations, it is essential to make the material more accessible and engaging for all participants Additionally, we intend to continually partner with the March of Dimes and our local program sites to ensure we have the most accurate information and that we are responsive to the changing needs of our population.

Future long-term goals include achieving *best practice* designation; Medicaid reimbursement of services for support of long-term sustainability; BaM/Cb program access in every community across the state of Kansas.

RESOURCES PROVIDED

- Collective Impact and the KPCC Model
    - Take Action to begin the development of a Perinatal Community Collaborative
- Kansas Becoming a Mom® Public-Facing Website
- Becoming a Mom® Implementation FAQ
- Program Impact
- Curriculum and Implementation Overview
- For program replication inquiry, contact Stephanie.Wolf@ks.gov
- Access to training webinars, curriculum and related implementation resources is available via a login and password protected user account issued upon signing of the program replication MOU.