Alabama State Action Plan Table 2026 Application/2024 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Comprehensive Postpartum Care and Education	By 2030, at least 54 percent of all survey respondents reported not planning for pregnancy due to access of a trusted birth control method By 2030, an additional 5 percent of all WW enrollment resulted from participation from the REDCap survey. By 2030, attend at least 30 community outreach events and health fairs to promote WW and encourage completion of the REDCap survey	Share the QR link to REDCap survey on social media websites including the WW Facebook page. Coordinate WW outreach events with the MCH District coordinators to expand area of reach for the QR code. Aim to achieve at least a 10 percent REDCap survey response rate annually among eligible WW participants being seen at active WW CHDs to answer questions concerning their access to a trusted birth control method.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 1: Percent of survey respondents ages 15 to 55 eligible to enroll into WW who report having a trusted birth control method and are not planning for a pregnancy within the next 12 months.	
Comprehensive Postpartum Care and Education	By 2030, at least 54 percent of REDCap survey respondents reported attending at least one postpartum visit within 12 weeks of delivery. By 2030, attend 200 community outreach events statewide to distribute the postpartum bookmarks among the MCH pregnant population.	Coordinate ACHN maternity care case workers to provide postpartum educational materials statewide. Coordinate with FIMR nurses to distribute postpartum educational materials within their perinatal regions. Coordinate with various providers and hospitals to distribute postpartum educational materials statewide and emphasize the importance of postpartum care.	ESM PPV.1 - Percent of postpartum survey respondents who attend their postpartum visit appointment.	NPM - Postpartum Visit	**Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety
Perinatal/Infant Health					
Infant Mortality	By 2030, the Alabama Cribs for	Coordinate efforts with the ACHN maternity care workers to expand area of	ESM SS.1 - The	NPM - Safe Sleep	**Linked NOMs:**

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	Kids® Program aims to provide a crib (Pack-n-Play) to at least 4000 new mothers. By 2030, maintain SIDS as the third leading cause of death or lower for infants as presented in the 2023 CHS Infant Mortality Report. Prior CHS annual infant mortality reports listed SIDS as the second leading cause of death. By 2030, the out-based FIMR staff will attend 200 community outreach events to promote the Cribs for Kids® Program.	reach for the Alabama Cribs for Kids® Program. Coordinate efforts with the FIMR nurse coordinator to expand area of reach for the Alabama Cribs for Kids® Program. Coordinate efforts with FIMR nurse coordinators to implement bill boards on the importance of safe sleep within their regions. Coordinate efforts to promote the Alabama Cribs for Kids® program at community outreach events including Babypalooza. Coordinate efforts to encourage community participation with Clear the Crib Challenge statewide. Aim for at least a 10 percent survey response rate annually for Alabama Cribs for Kids® participants to answer questions concerning Pack-n-Play use for their infant at 2 to 3 weeks of age after it is delivered	proportion of mothers enrolled in the Alabama Cribs for Kids® Program who self-reported that their infants are using the cribs (Pack-n-Play) for all periods of sleep at the home setting		Infant Mortality Postneonatal Mortality SUID Mortality
Child Health					
Access to Comprehensive Health Care for Children	By 2030, at least 58 percent of survey respondents found the information concerning the medical homes useful. By 2030, at least 125 medical providers offering lead screenings have collaborated with ADPH to distribute the medical home bookmarks, with the initial focus serving those living in rural counties. By 2030, ACLPPP will attend at least 25 outreach events targeting medical doctors and families statewide for distribution of medical home bookmarks.	Coordinate efforts with MCH District Coordinators to expand the area of reach for distribution of the medical home bookmarks. Coordinate efforts with the ACLPPP to expand the area of reach for distribution of the medical home bookmarks among medical providers offering lead screenings. Coordinate efforts with CHDs to expand the area of reach for distribution of the medical home bookmarks.	ESM MH.1 - Percent of medical home bookmark survey respondents who find the educational material useful for finding a medical home for their child ESM MH.2 - Percent of CSHCN that have a comprehensive Plan of Care.	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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Adolescent Health					
Adolescent Safety and Wellness	By 2030, 58 percent of survey respondents ages 10 to 19 report an increase in knowledge after receiving positive youth development education that addresses bullying prevention. By 2030, 58 percent of survey respondents ages 10 to 19 report an increase in intention to change behavior, after receiving positive youth development education that addresses bullying prevention. By 2030, 58 percent of survey respondents ages 10 to 19 report an increase in confidence in abilities after receiving positive youth development education that addresses bullying prevention. By 2030, reach at least 7,500 youth through positive youth development education that addresses bullying prevention.	Determine bullying prevention topics to address through positive youth development education. Establish curriculum and/or program models that address selected bullying prevention topics. Incorporate bullying prevention topics, curriculum and/or program models into current positive youth development education. Coordinate with the evaluation team to develop survey questions that measure an increase in knowledge, intention to change behavior, and/or confidence in abilities related to bullying prevention. Provide training to staff delivering positive youth development education that addresses bullying prevention. Aim for at least a 10 percent annual survey response rate among youth ages 10 to 19 who initiated positive youth development education that addresses bullying prevention.	ESM BLY.1 - The percent of youth, ages 10-19 who report an increase in knowledge, intention to change behavior, and/or confidence in abilities after receiving positive youth development education that addresses bullying prevention.	NPM - Bullying	**Linked NOMs:** Adolescent Mortality Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Adolescent Depression/Anxiety Adverse Childhood Experiences
Children with Special Health Care Needs					
Insufficient or unequal assistance to help families navigate the system of care.	Increase the number of enrolled CSHCN who have a comprehensive Plan of Care by 10% annually.	MH 2.1. Train CRS staff on Medical Home and developing a comprehensive Plan of Care with a family and person-centered approach to increase quality service provision. MH 2.2. Continue to provide comprehensive care coordination to CSHCN through system navigation, education, resource identification, referral and follow up.	ESM MH.1 - Percent of medical home bookmark survey respondents who find the educational material useful for finding a medical home for their child	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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		MH 2.3. Partner with families to develop a plan of care that incorporates a psychosocial assessment of patient and family needs, therapy evaluations, and physician recommendations to meet the specific needs of the child and family. MH 2.4. Promote effective and efficient use of health care resources to increase connections, family and provider partnerships and provide information about Medical Home. MH 2.5 Foster communication among CRS staff, families, community and health care providers to strengthen relationships for improved system navigation.	ESM MH.2 - Percent of CSHCN that have a comprehensive Plan of Care.		
Inadequate supports for transition to all aspects of adulthood.	Increase the percent of YSHCN enrolled in State CSHCN program who report increased preparedness to transition to adulthood by 10% annually.	TAHC 2.1. Continue to administer the CRS Transition Program and conduct outreach to promote the program to YSHCN across the state. TAHC 2.2. Provide families with individualized skills and tools to prepare for transition to adulthood and lifelong care. TAHC 2.3. Develop and implement a health care transition quality improvement and evaluation plan to assess the effectiveness of the CRS Transition Program. TAHC 2.4. Utilize CRS staff including the Parent and Youth Consultants to provide support and increase awareness of the importance of preparing for transition to adulthood. TAHC 2.5. Provide technical assistance and guidance on planning for transitioning to an adult health care provider for CRS staff.	***Inactive -*** *ESM TAHC.1 - Percent of YSHCN enrolled in state CSHCN program who report satisfaction with their transition experience to adulthood.* ESM TAHC.2 - Percent of YSHCN enrolled in state CSHCN program who report increased preparedness to transition to adulthood.	NPM - Transition To Adult Health Care	**Linked NOMs:** CSHCN Systems of Care
Lack of peer support and opportunities to create community for families, caregivers, and youth.	Increase family and youth peer support for CYSHCN using the Family and Youth Support Measurement tool as a measurement. Increase yearly score by 30% to achieve a maximum allowable score of 28 (100%) points by the end of the 5-year needs assessment cycle.	SPM 2.1 Enhance the CRS Parent and Youth Connection programs to build community for individuals to share their experiences. SPM 2.2 Utilize OCI to create marketing materials and a social media campaign to promote and encourage utilization of the Parent and Youth Connection programs. SPM 2.3 Engage with community stakeholders and families to identify existing community support groups and other peer support opportunities for families of CSHCN and YSHCN.	SPM ESM 2.1 - Percent of progress made in achieving strategies to increase peer support for parents and caregivers of CSHCN and YSHCN.	SPM 2: Percent of children with special health care needs, ages 0-17, whose parent receives emotional support with parenting.	**Linked NOMs:** CSHCN Systems of Care

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		SPM 2.4 Create peer support resource list for parents and caregivers of CSHCN and YSHCN and share via social media and Parent Connection e-newsletter. SPM 2.5 Facilitate access to the identified peer support resources through CRS clinics. SPM 2.6 Create an ongoing Family and Youth Peer Support Column for the Parent Connection e-newsletter that highlights coping techniques, mental health topics, and emotional support information. SPM 2.7 Collaborate with FVA to promote Parent-to-Parent mentoring to assist parents with navigating complex medical systems.			
Cross-Cutting/Systems Building					
Access to Comprehensive Oral Health Education and Services for all MCH Populations	By 2030, at least 58 percent of all dental health kit recipients who completed the REDCap survey plans to use the dental health kit. OHO and its partners attend at least 50 community outreach events annually to increase distribution of dental health kits. By 2030, at least 75 percent of schools visited for oral health screenings and receiving dental health kits had more than 50 percent of the students eligible to receive food assistance.	Expand the area of reach for the distribution of the dental health kits distributed throughout the MCH populations at outreach events. Coordinate with CRS for dental health kits to be distributed at clinics and any outreach events. Coordinate with the Alabama Cribs for Kids® Program for distribution of dental health kits and the educational materials tailored specifically for infants Coordinate with the Healthy Childcare of Alabama for distribution of dental health kits and the educational materials tailored specifically for children ages 3 to 5. Aim for at least an annual 10 percent REDCap survey response rate for dental health kit recipients to answer questions concerning plans to use the contents of the dental health kit and what their current oral health practices are in preventing tooth decay.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 3: Percent of dental health kit survey respondents who plans to use the dental health kit, which includes age-appropriate toothbrush, educational materials, dental floss, timer, and toothpaste	