Alabama State Action Plan Table 2025 Application/2023 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					
Lack of preventive dental visits across all Title V populations, especially for those uninsured.	By 2025, increase the percentage of dental providers who receive education on the importance of preventive dental visits for expectant mothers by 10 percent. (Inactive) By 2025, increase the percentage of dental providers who are provided education and support on the provision/referral for HPV vaccine by 10 percent. (create a provider services survey and gather baseline data.(Inactive) By 2025 and forward, sustain the number of partnerships with oral health advocates who are providing educational materials specific to the pregnant population by 50. (Active)	Educate and reach out to oral health providers to improve understanding of preventive dental visits during pregnancy and through ads utilizing television, streaming, and social media platforms. Promote HPV education, and HPV vaccine education, promotion and referral using the #WATCHYOURMOUTH campaign developed through a partnership with the Mitchell Cancer Institute.	***Inactive -*** *ESM PDV-Pregnancy.1 - Percentage of dental providers receiving information/education regarding importance of preventive dental visits for expectant mothers* ***Inactive -*** *ESM PDV-Pregnancy.2 - Percentage of dental providers that received information/education regarding their perinatal patients about the FDA-approved HPV vaccine in order to reduce the risk of oropharyngeal, cervical, and other HPV-related cancers* ESM PDV-Pregnancy.3 - The number of providers including hygienists, nurses, social	NPM - Percent of women who had a dental visit during pregnancy (Preventive Dental Visit - Pregnancy, Formerly NPM 13.1) - PDV-Pregnancy	NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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			workers, physicians, pediatricians, nutritionists, and dentists who were provided oral health education and training tailored specifically to the MCH pregnant population		
High levels of maternal mortality.	Provide routine classes, to women participants, that promote health, breastfeeding, safe sleep, and make referrals to other programs that impact maternal mortality.	Offering more classes for women participants in WIC in counties with higher rates of maternal mortality than the state rate or in at least 5 counties. (Inactive) Offering more education about preventive screenings and referring eligible FP participants to WW in the counties where there are barriers in receiving health care such as rurality, lack of resources, or access to primary care. (Active)	***Inactive -*** *ESM WWV.1 - Proportion of women age 15-55 who report receiving a preventive medical visit in the past 12 months by increasing total enrollment percentage in the Well Woman Program by 2 points annually.* ESM WWV.2 - Increase the percentage of women receiving both FP services and WW services by two percent within active WW counties.	NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per

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					1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB NOM - Percent of women who experience postpartum depressive

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					symptoms following a recent live birth (Postpartum Depression, Formerly NOM 24) - PPD
	Partner with AMA and the ACHN to track how many Medicaid women completed their postpartum appointment.	Provide outreach on the importance of women to complete the postpartum checkup within 12 weeks after giving birth and to complete all the recommended care components required for a postpartum visit.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Perinatal/Infant Health					
High levels of infant mortality (and associated factors of preterm birth and low birth weight).	Increase the percent of delivering hospitals convened at a meeting to share data and discuss the Alabama Perinatal Regionalization System Guidelines (Complete). Ensure that at least 50 percent of the delivering hospitals would convene and complete the CDC LoMC tool so that all mothers can receive appropriate care for the delivery of their baby (Active).	Convene the delivering hospitals to share data and discuss the Alabama Perinatal Regionalization System Guidelines (Complete). Convene the delivering hospitals to share data and discuss the Alabama Maternal Regionalization System Guidelines (Active).	***Inactive -*** *ESM RAC.1 - Percent of delivering hospitals convened at a meeting to share data and discuss the Alabama Perinatal Regionalization System Guidelines* ***Inactive -*** *ESM RAC.2 - Number of steps of the CDC's LOCATe process completed in order to design and align the Alabama Perinatal Regionalization System Guidelines with the national criteria for the maternal levels of*	NPM - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) (Risk-Appropriate Perinatal Care, Formerly NPM 3) - RAC	NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related

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			care ESM RAC.3 - Number of steps of the CDC's LoMC process completed in order to design and align the Alabama Maternal Regionalization System Guidelines with the national criteria for the maternal levels of care		
High levels of infant mortality (and associated factors of preterm birth and low birth weight).	Complete the steps of the CDC's LOCATe process in order to design and align the Alabama Perinatal Regionalization System Guidelines with the national criteria for the maternal levels of care (Complete). Ensure that at least 50 percent of the delivering hospitals would convene and complete the CDC's LoMC tool so that all mothers can receive appropriate care for the delivery of their baby (Active).	Implement the CDC's LOCATe process in order to align and implement the national criteria for the maternal levels of care (Complete). Implement the CDC's LoMC Assessment tool in order to align and implement the national criteria for the maternal levels of care (Active).	***Inactive -*** *ESM RAC.1 - Percent of delivering hospitals convened at a meeting to share data and discuss the Alabama Perinatal Regionalization System Guidelines* ***Inactive -*** *ESM RAC.2 - Number of steps of the CDC's LOCATe process completed in order to design and align the Alabama Perinatal Regionalization System Guidelines with the national criteria for the maternal levels of care*	NPM - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) (Risk-Appropriate Perinatal Care, Formerly NPM 3) - RAC	NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related

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			ESM RAC.3 - Number of steps of the CDC's LoMC process completed in order to design and align the Alabama Maternal Regionalization System Guidelines with the national criteria for the maternal levels of care		
High levels and worsening trends of sleep-related/SUID deaths.	Increase by 5 percent annually, the percentage of WIC prenatal participants placing their infants to sleep on their backs by providing safe infant sleep education (Inactive). Ensure that safe sleep practices is being utilized by increasing the proportion of Cribs for Kids respondents who have reported crib use for their infant for all periods of sleep at the home setting (Active).	Provide safe sleep education to WIC prenatal participants in order to increase the percent placing their infants to sleep on their backs (Inactive). Require completion of safe sleep education in order for participants to receive a crib from the Cribs for Kids Program (Active). Send out surveys about whether cribs are being used for all sleep periods at the home setting to Cribs for Kids participants when the infant is at two to three weeks of age (Active).	***Inactive -*** *ESM SS.1 - Number of sleep-related infant deaths* ***Inactive -*** *ESM SS.2 - Number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations* ESM SS.3 - The proportion of mothers enrolled in the Cribs for Kids Program who self-reported that their infants are using the cribs for all periods of sleep at the home	NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID

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			setting		
High levels and worsening trends of sleep-related/SUID deaths.	Decrease by 3 percent annually, the number of sleep-related infant deaths by implementing targeted consistent safe sleep education to caregivers, child health providers, health care providers, and hospital systems (Inactive). Ensure that safe sleep practices is being utilized by increasing the proportion of Cribs for Kids respondents who have reported crib use for their infant for all periods of sleep at the home setting (Active).	Implement targeted consistent safe sleep education to caregivers, child health providers, health care providers, and hospital systems (Inactive). Require completion of safe sleep education in order for participants to receive a crib from the Cribs for Kids program (Active). Send out surveys about whether cribs are being used for all sleep periods at the home setting to Cribs for Kids participants when the infant is at two to three weeks of age (Active).	***Inactive -*** *ESM SS.1 - Number of sleep-related infant deaths* ***Inactive -*** *ESM SS.2 - Number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations* ESM SS.3 - The proportion of mothers enrolled in the Cribs for Kids Program who self-reported that their infants are using the cribs for all periods of sleep at the home setting	NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID
High levels and worsening trends of sleep-related/SUID deaths.	Increase by 25 percent annually, the number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations (Inactive). Ensure that safe sleep practices is being utilized by increasing the proportion of Cribs for Kids respondents who have reported	Facilitate trainings to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations (Inactive). Require completion of safe sleep education in order for participants to receive a crib from the Cribs for Kids Program (Active). Send out surveys about whether cribs are being used for all sleep periods at the home setting to Cribs for Kids participants when the infant is at two to three weeks of age (Active).	***Inactive -*** *ESM SS.1 - Number of sleep-related infant deaths* ***Inactive -*** *ESM SS.2 - Number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new*	NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep,	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly

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	crib use for their infant for all periods of sleep at the home setting (Active).		*mothers, with being trained on safe sleep recommendations* ESM SS.3 - The proportion of mothers enrolled in the Cribs for Kids Program who self-reported that their infants are using the cribs for all periods of sleep at the home setting	Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS	NOM 9.5) - IM-SUID
Child Health					
Lack of preventive dental visits across all Title V populations, especially for those uninsured.	By 2025, increase the number of dental providers who receive education on the importance of preventive dental visits for children ages 1-17 years by 10 percent. (Inactive) By 2025, increase the percentage of dental providers who are provided education and support on the provision/referral for HPV vaccine by 10 percent. (create a provider services survey and gather baseline data.) (Inactive) By 2025 and forward, sustain the number of partnerships with oral health advocates who are providing educational materials specific to the child population by 50 (Active)	Provide educational preventive dental materials and oral health kits to patients and providers, and promotion of importance of preventive dental visits via the annual “Share Your Smile with Alabama” smile contest. Promote HPV education, and HPV vaccine education, promotion, and referral using the #WATCHYOURMOUTH campaign developed through a partnership with the Mitchell Cancer Institute.	***Inactive -*** *ESM PDV-Child.1 - Percentage of providers receiving information/education regarding importance of preventive dental visits for children ages 1-17 years of age* ***Inactive -*** *ESM PDV-Child.2 - Percentage of dental providers that received information/education regarding informing their families of patients at 9 years of age about the FDA-approved HPV vaccine in order to prevent future oropharyngeal,*	NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child	NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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			cervical, and other HPV-related cancers ESM PDV-Child.3 - The number of providers including hygienists, nurses, social workers, physicians, pediatricians, nutritionists, and dentists who were provided oral health education and training tailored specifically to the MCH child population		
Lack of timely, appropriate, and consistent health and developmental screenings.	Increase by 1 percent the total number of EPSDT screenings performed in CHDs annually.	Increase EPSDT sreenings in the CHDs.	***Inactive -*** *ESM DS.1 - Proportion of children birth to age 19 that received a well child appointment in the past year* ***Inactive -*** *ESM DS.2 - Proportion of children birth to age 19 that received a developmental screening in conjunction with a well-child appointment in the past year* ESM DS.3 - Proportion of children aged 12 & 24 months that have a reported	NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS	NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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			blood lead screening in the past year ESM DS.4 - Proportion of children birth to age 19 that received a well-child appointment in the past year		
Lack of timely, appropriate, and consistent health and developmental screenings.	Increase by 1 percent the total number of children birth to age 5 that receive the ASQ-3.	Partner with APC and Help Me Grow to monitor the number of developmental screenings.	***Inactive -*** *ESM DS.1 - Proportion of children birth to age 19 that received a well child appointment in the past year* ***Inactive -*** *ESM DS.2 - Proportion of children birth to age 19 that received a developmental screening in conjunction with a well-child appointment in the past year* ESM DS.3 - Proportion of children aged 12 & 24 months that have a reported blood lead screening in the past year ESM DS.4 - Proportion of children birth to age 19 that received a well-child appointment in the	NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS	NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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			past year		
Lack of timely, appropriate, and consistent health and developmental screenings.	Ensure that all WIC participants benefit from EPSDT.	Consistently referring children in health departments where EPSDT is provided or to their health care provider in counties that do not offer EPSDT.			
Lack of timely, appropriate, and consistent health and developmental screenings.	Intervene/refer patients identified as having mental health concerns/suicidal tendencies to appropriate health care professionals.	Due to the increasing number of suicides in children/adolescents and failure to identify mental health concerns in children and adolescents, proactively partner with Suicide Prevention to incorporate questions related to mental health in initial and updated medical history questionnaires in an effort to identify potential mental health concerns.			
Lack of timely, appropriate, and consistent health and developmental screenings.	Until more data is available, to maintain the percentage of 2 year old children who have received two blood lead tests at 12 and 24 months as recommended by the ACLPPP to at least 20 percent.	Increase the percentage of 2 year old children who were screened for lead poisoning at their 12 and 24 month follow-up visit.		SPM 9: Percent of 2 year old children who have received two blood lead tests at 12 and 24 months as recommended by the ACLPP Program	
	Increasing the number of families receiving educational materials on the importance of having access to early care among children 0-5 years old. Increasing the number of children between the ages of 1 and 14 to receive a school oral health screening so that educational materials on the importance of having access to a dental provider and a list of oral health providers can be shared to the parents when applicable.	Conducting promotional events and trainings tailored to discuss the importance of their children and adolescents having access to a personal doctor.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Adolescent Health					
Lack of	By 2025, increase the number of	Promote HPV education and HPV vaccine education, promotion, and	***Inactive -*** *ESM PDV-*	NPM - Percent of children,	NOM - Percent of children, ages 1

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preventive dental visits across all Title V populations, especially for those uninsured.	dental providers who receive education on the importance of preventive dental visits for children ages 1-17 years by 10 percent. By 2025, increase the percentage of dental providers who are provided education and support on the provision/referral for HPV vaccine by 10 percent. (create a provider services survey and gather baseline data.)	referral using the #WATCHYOURMOUTH campaign developed through a partnership with the Mitchell Cancer Institute.	*Child.1 - Percentage of providers receiving information/education regarding importance of preventive dental visits for children ages 1-17 years of age* ***Inactive -*** *ESM PDV-Child.2 - Percentage of dental providers that received information/education regarding informing their families of patients at 9 years of age about the FDA-approved HPV vaccine in order to prevent future oropharyngeal, cervical, and other HPV-related cancers* ESM PDV-Child.3 - The number of providers including hygienists, nurses, social workers, physicians, pediatricians, nutritionists, and dentists who were provided oral health education and training tailored specifically to the MCH child	ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child	through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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			population		
Lack of timely, appropriate, and consistent health and developmental screenings.	Increase by 1 percent the total number of EPSDT screenings performed in CHDs annually.	Increase EPSDT screenings in the CHDs.	***Inactive -*** *ESM AWV.1 - Proportion of adolescents, aged 12 to 19, that received an adolescent well visit in the past year* ESM AWV.2 - Proportion of adolescents, aged 12 to 19, that received an adolescent well-visit in the past year	NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 2 through 4, and adolescents, ages

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					10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB
Children with Special Health Care Needs					
Lack of or inadequate	By 2025, increase the total score on the Six Core Elements of Health	The state CSHCN Program staff, including the Parent Consultant, will conduct a transition readiness assessment at age 14 using a standardized	ESM TR.1 - Percent of YSHCN enrolled in	NPM - Percent of adolescents with and	NOM - Percent of children with special health care needs

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access to services necessary for CSHCN to transition to all aspects of adult life.	Care Transition™ 3.0 Current Assessment of Health Care Transition Activities for Transitioning Youth to an Adult Health Care Clinician from baseline to 90 percent (Baseline = FY 2020 total score of 68.75 percent). By 2025, increase the number of attendees at CRS Teen Transition clinic by 25 percent (Baseline = FY 2020 total attendees of 54).	tool, administered periodically, and discuss needed self-care skills and changes in adult-centered care. The state CSHCN Program staff, including the Parent Consultant, will incorporate transition planning into their existing plan of care, starting at age 14 partnering with youth and families in developing transition goals and preparing and updating a medical summary and emergency care plan. Provide education to families about Teen Transition clinic and the benefits of attending. Provide education to staff to guide implementation of transition strategies. The state CSHCN Program staff will identify adult providers to accept program clients, complete a transfer package for youth leaving the program and follow-up with the provider regarding the YSHCN's transfer status. Obtain feedback on transition experience of young adults.	state CSHCN Program who report satisfaction with their transition experience to adulthood.	without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR	(CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC
Lack of or inadequate access to health and related services, especially in rural areas and for services identified as difficult to obtain.	By 2025, increase by 10 percent the number of families of CYSHCN in the program who report receiving comprehensive care coordination.	Develop and implement a survey for families to assess the comprehensiveness of and satisfaction with CRS Care Coordination services and connection to community resources. Utilize information from the surveys to improve the quality of care coordination for CYSHCN. Educate families on the importance of care coordination and its value in improving health care outcomes for CYSHCN through developing a Care Coordination Program fact sheet. Train CRS care coordinators to use a family and person-centered approach to care plan development. Ensure that families of CYSHCN have access to and are educated about the importance of connection to a medical home. Expand outreach activities to promote public awareness of CRS Care Coordination Services within the medical community and among families of CYSHCN. Develop an internal tracking mechanism for referrals to community resources for CYSHCN not enrolled with CRS.		SPM 3: Increase the capacity of families to connect CYSHCN to the health and human services they require for optimal behavioral, developmental, health, and wellness outcomes through our Care Coordination Program.	
Increase family and youth involvement and participation in advisory groups, program development, policy-making, and system	By 2025, increase the Engagement Score on the FESAT by 10 percent above the baseline (baseline to be established in FY 2021). By 2025, the first cohort of participants will have completed the Family Leadership Training Institute.	Administer the FESAT to assess progress on strengthening family/youth engagement within CRS. Incorporate the four domains of Family Engagement into staff development activities through the development of a Family Engagement Quality Improvement Initiative action plan within each CRS District. Conduct ongoing monitoring of District action plans to ensure incorporation of the four domains of Family Engagement. Utilize alternative methods to increase parent and youth involvement in advisory groups and program development i.e. Zoom meetings, Facebook Live meetings, and conference calls. Develop and conduct a Family Leadership Training Institute. Develop or modify a Family/Youth Partnership outreach campaign aimed at healthcare providers and related professionals to teach about the importance of engaging families/youth in the decision-making		SPM 2: Strengthen and enhance family/youth partnerships, involvement and engagement in advisory groups, program development, policymaking, and system-building activities to support shared decision making between families and health-related professionals.	

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
building activities.		process. Utilize the Family/Youth Partnership outreach campaign materials at professional conferences and other community events.			
	By 2025, increase by 10 percent the number of families of CYSHCN in the program who report having a medical home.	To ensure that all CSHCN have access to a medical home.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Cross-Cutting/Systems Building					
Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.	Increase the number of WW visits performed at the local CHDs; Increase public awareness of program via social media & marketing materials.	Increase the proportion of WW preventative visits in all program specific counties for women ages 15-55 and educating the public in all program specific counties of available WW services.			
Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.	Each county participating in WW Program will establish a particular day of the week to offer WW services at CHDs; WW staff will continue to assist identified at-risk women in having healthy pregnancies to avoid poor birth outcomes.	Recruit women ages 15-55 to the WW Program for CVD risk factor screenings, healthy life/reproductive health planning (interconception and preconception care), health coaching and nutritional counseling.			

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Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.	WW Program will continue to offer monthly support group meetings coordinated by social workers; nutritional classes per registered dietitian; and physical activity incentives, such as YMCA memberships, and through partnership with ADPH Nutrition and Physical Activity Division.	WW Program will provide risk reduction counseling to help clients understand their risks, health coaching to set goals for behavioral change, and offer nutritional counseling and support to WW participants to help discover healthy lifestyle behaviors.			
Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.	Continue to partner with community partners in selected counties for referrals into the WW Program; increase the number of community partners in all counties participating in WW Program to increase enrollment and broaden ethnicity of participants.	WW Program will recruit all women aged 15-55 residing in counties participating in the WW Program via marketing materials and social media.			
Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn,	Increase and continue distribution of Spanish marketing materials to recruit Spanish speaking women aged 15-55.	WW Program will continue to use Spanish speaking marketing materials to recruit population and offer Spanish literature for education and healthy lifestyle behaviors.			

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
work, and play.					
Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.	Encourage/provide wellness visits to women, ages 15-55, who report not having a preventative visit in the last year regardless of insurance status.	Target underinsured and/or uninsured women, ages 15-55, to enroll in WW Program.			
Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.	Increase the number of early head start programs that accept children with disabilities by one provider per year.	Increase the number of early head start programs that accept children with disabilities.		SPM 5: Increase the proportion of EHS programs participating in the EHSCCP grant program that maintain ten percent of their population with children with special needs.	