California 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					
Ensure women in California are healthy before, during and after pregnancy.	Women/Maternal Objective 1: By 2025, reduce the rate of pregnancy-related deaths (up to one year after the end of pregnancy) from 18.6 deaths per 100,000 live births (2020 CA-PMSS) to 12.2 deaths per 100,000 live births. Women/Maternal Objective 2: By 2025, reduce the rate of severe maternal morbidity from 110.5 per 10,000 delivery hospitalizations (2021 PDD) to 88.8 per 10,000 delivery hospitalizations. Women/Maternal Objective 3: By 2025, increase the receipt of mental health services among women who reported needing help for emotional well-being or mental health concerns during the perinatal period from 54.2% (2021 MIHA) to 56.9%. Women/Maternal Objective 4: By 2025, increase the percent of women who had an optimal interpregnancy interval of at least 18 months from 73.1 (2021CCMBF) to 76.4%.	Women/Maternal Objective 1: Strategy 1: Lead surveillance and investigations of pregnancy-related deaths (up to one year after the end of pregnancy) in California. Women/Maternal Objective 1: Strategy 2: Partner to translate findings from pregnancy-related mortality investigations into recommendations for action to improve maternal health and perinatal clinical practices. Women/Maternal Objective 2: Strategy 1: Lead surveillance and research related to maternal morbidity in California. Women/Maternal Objective 2: Strategy 2: Lead statewide regionalization of maternal care to ensure women receive appropriate care for childbirth. Women/Maternal Objective 2: Strategy 3: Partner to strengthen knowledge and skill among health care providers and individuals on chronic conditions exacerbated during pregnancy. Women/Maternal Objective 3: Strategy 1: Partner with state and local programs to disseminate information and resources to reduce mental health conditions in the perinatal period. Women/Maternal Objective 3: Strategy 2: Partner to strengthen knowledge and skill among health care providers, individuals, and families to identify signs of maternal mental health-related needs. Women/Maternal Objective 3: Strategy 3: Partner to ensure pregnant and parenting women are screened and referred to mental health services during the perinatal period. Women/Maternal Objective 4: Strategy 1: Partner to increase provider and	ESM WWV.1 - Percent of local health jurisdictions that have adopted a protocol to ensure that all persons in MCAH Programs are referred for enrollment in health insurance and complete a preventive visit	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 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

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	Women/Maternal Objective 5: By 2025, reduce the rate of maternal substance use from 20.8 per 1,000 delivery hospitalizations (2021 PDD) to 19.7 per 1,000 delivery hospitalizations.	individual knowledge and skill to improve health and health care before and between pregnancies. Women/Maternal Objective 4: Strategy 2: Lead a population-based assessment of mothers in California, the Maternal and Infant Health Assessment Survey (MIHA), to provide data to guide programs and services. Women/Maternal Objective 4: Strategy 3: Lead efforts to improve local perinatal health systems utilizing morbidity and mortality data and implement evidence-based interventions to improve the health of pregnant individuals and their infants. Women/Maternal Objective 4: Strategy 4: Fund the DHCS Indian Health Program (IHP) to administer the American Indian Maternal Support Services (AIMSS) to provide case management and home visitation program services for American Indian women during and after pregnancy. Women/Maternal Objective 5: Strategy 1: Lead research and surveillance on maternal substance use in California. Women/Maternal Objective 5: Strategy 2: Partner at the state and local level to increase prevention and treatment of maternal opioid and other substance use.			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 symptoms following a recent live birth (Postpartum Depression,

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					Formerly NOM 24) - PPD
Ensure women in California are healthy before, during and after pregnancy.	This objective will be based on statewide and local needs assessments currently underway and will be updated as the new 5 year action plan is completed and reported on in FY 2025-26.	State strategies to support this NPM will be created after analysis of the statewide and local needs assessments and will be reported on in FY 2025-26.	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					
Ensure all infants are born healthy and thrive in their first year of life.	Perinatal/Infant Objective 1: By 2025, increase the percent of women who report exclusive in-hospital breastfeeding from 69.2% (2021 GDSP) to 72.5%.	Perinatal/Infant Objective 1: Strategy 1: Lead surveillance of breastfeeding practices and assessment of initiation and duration trends. Perinatal/Infant Objective 1: Strategy 2: Lead technical assistance and training to support breastfeeding initiation, including the implementation of the Model Hospital Policy or Baby Friendly in all California birthing hospitals by 2025. Perinatal/Infant Objective 1: Strategy 3: Partner to develop and disseminate information and resources about policies and best practices to promote breastfeeding duration, including lactation accommodation within all MCAH programs. Perinatal/Infant Objective 1: Strategy 4: Partner with birthing hospitals to support caregiver/infant bonding.	ESM BF.1 - Number of online views to the "Lactation Support for Low-Wage Workers" report	NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF	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
Reduce infant mortality with a focus on eliminating disparities.	Perinatal/Infant Objective 2: By 2025, reduce the rate of infant deaths from 4.1 per 1,000 live births (2021 BSMF/DSMF) to 4.0. Perinatal/Infant Objective 3: By 2025, reduce the percentage of preterm births from 9.1% (2021 BSMF) to 8.4%.	Perinatal/Infant Objective 2: Strategy 1: Lead research and surveillance related to fetal and infant mortality in California. Perinatal/Infant Objective 2: Strategy 2: Lead planning and development of evidence-based practices and lessons learned for reducing infant mortality rates. Perinatal/Infant Objective 2: Strategy 3: Lead the California SIDS Program to provide grief and bereavement support to parents, technical assistance,		SPM 1: Preterm birth rate among infants born to non-Hispanic Black women	

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		resources and training on infant safe sleep to reduce infant mortality. Perinatal/Infant Objective 3: Strategy 1: Lead research and surveillance on disparities in preterm birth rates in California. Perinatal/Infant Objective 3: Strategy 2: Lead the implementation of the Black Infant Health (BIH) Program to reduce the impact of stress due to structural racism to improve Black birth outcomes. Perinatal/Infant Objective 3: Strategy 3: Lead the implementation of the state general fund effort, Perinatal Equity Initiative (PEI), to support local initiatives to support birthing populations of color. Perinatal/Infant Objective 3: Strategy 4: Lead the development and dissemination of preterm birth reduction strategies across California.			
Child Health					
Optimize the healthy development of all children so they can flourish and reach their full potential.	Child Objective 1: By 2025, increase the percentage of children (ages 9 through 35 months) who received a developmental screening from a health care provider using a parent-completed screening tool in the past year from 25.2% (NSCH 2022) to 32.4%. Child Objective 2: By 2025, increase the percentage of children (ages 0 -17 years) who live in a home where the family demonstrated qualities of resilience (i.e., met all four resilience items as identified in the NSCH survey) during difficult times from 85.1% (NSCH 2022) to 84.5%.	Child Objective 1: Strategy 1: Partner to build data capacity for public health surveillance and program monitoring and evaluation related to developmental screening in California. Child Objective 1: Strategy 2: Partner to improve early childhood systems to support early developmental health and family well-being. Child Objective 1: Strategy 3: Partner to educate and build capacity among providers and families to understand developmental milestones and implement best practices in developmental screening and monitoring within MCAH programs. Child Objective 1: Strategy 4: Support implementation of Department of Health Care Services (DHCS) policies regarding child health and wellbeing, including developmental screening. Child Objective 2: Strategy 1: Partner with CDPH Essentials for Childhood and other partners to build data capacity to track and understand experiences of adversity and resilience among children and families. Child Objective 2: Strategy 2: Partner to build capacity and expand	ESM DS.1 - Percent of children enrolled in CHVP with at least one developmental screen using a validated instrument within AAP-defined age range (10-months, 18-months, or 24-months timepoints) during the reporting period.	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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	Child Objective 3: By 2025, increase the percentage of children (ages 1 - 17 years) who had a preventive dental visit in the past year from 81.1% (NSCH 2022) to 82.6%. Child Objective 4: By 2025, decrease the percentage of fifth grade students who are overweight or obese from 41.3% (2019) to 39.3%.	programs and practices to build family resiliency by optimizing the parent-child relationship, enhancing parenting skills, and addressing child poverty through increasing access to safety net programs within MCAH-funded programs. Child Objective 2: Strategy 3: Support the California Office of the Surgeon General and DHCS ACEs Aware initiative to build capacity among communities, providers, and families to understand the impact of childhood adversity and the importance of trauma-informed care. Child Objective 3: Strategy 1: Support the CDPH Office of Oral Health (OOH) in their efforts to increase access to regular preventive dental visits for children by sharing information with MCAH programs. Child Objective 4: Strategy 1: Partner to enable the reporting of data on childhood overweight and obesity in California. Child Objective 4: Strategy 2: Partner with WIC and others to provide technical assistance to local MCAH programs to support healthy eating and physically active lifestyles for families.			
Optimize the healthy development of all children so they can flourish and reach their full potential.	Child Objective 5: By 2025, increase the percentage of children (ages 1 - 17 years) who had a preventive medical visit in the past year from 70.0 % (NSCH 2022) to a target to be determined by our upcoming needs assessment.	Child Objective 5: Strategy 1: Support local MCAH programs in ensuring children and their families have access to preventive and primary medical care. Child Objective 5: Strategy 2: Partner to build data capacity and program monitoring and evaluation to evaluate availability and access of regular, routine medical care for children and families in California.	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					
Enhance strengths, skills and supports to promote positive development and ensure	Adolescent Objective 1: By 2025, increase the proportion of sexually active adolescents who use condoms and/or hormonal or intrauterine contraception to prevent pregnancy and provide barrier protection against sexually transmitted diseases as measured	Adolescent Objective 1: Strategy 1: Lead surveillance and program monitoring and evaluation related to adolescent sexual and reproductive health. Adolescent Objective 1: Strategy 2: Lead to strengthen knowledge and skills to increase use of protective sexual health practices within CDPH/MCAH-funded programs.	ESM AWV.1 - Percentage of adolescents 12-17 served in AFLP with a referral for preventive services.	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

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youth are healthy and thrive.	by: • percent of sexually active adolescents who used a condom at last sexual intercourse from 55% to 58% • percent of sexually active adolescents who used the most effective or moderately effective methods of FDA-approved contraception from 23% to 25%. Adolescent Objective 2: By 2025, increase the percent of adolescents aged 12-17 with a preventive medical visit in the past year from 62.0% (NSCH 2022) to 83.8%. Adolescent Objective 3: By 2025, increase the percentage of adolescents aged 12-17 who have an adult in their lives with whom they can talk about serious problems from 76.7% (NSDUH 2018-2019) to 79.7%.	Adolescent Objective 1: Strategy 3: Partner across state and local health and education systems to implement effective comprehensive sexual health education in California. Adolescent Objective 2: Strategy 1: Lead to develop and implement best practices in CDPH/MCAH-funded programs to support youth with accessing youth-friendly preventive care, sexual and reproductive health care, and mental health care. Adolescent Objective 2: Strategy 2: Partner to increase access to and the quality of preventive care for adolescents in California. Adolescent Objective 3: Strategy 1: Lead to strengthen resilience among expectant and parenting adolescents to improve health, social, and educational outcomes. Adolescent Objective 3: Strategy 2: Partner to identify opportunities to build protective factors for adolescents at the individual, community, and systems levels. Adolescent Objective 3: Strategy 3: Partner to strengthen knowledge and skills among providers, individuals, and families to identify signs of distress and mental health-related needs among adolescents.			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 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) -

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					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					
Make systems of care easier to navigate for CYSHCN and their families.	CYSHCN Objective 1: By 2025, maintain the number of Local MCAH programs (44) that chose during FY 21-22 to implement a Scope of Work activity focused on CYSHCN public health systems and services. CYSHCN Objective 2: By 2025, increase the percentage of adolescents with special health	CYSHCN Objective 1: Strategy 1: Lead state and local MCAH capacity-building efforts to improve and expand public health systems and services for CYSHCN. CYSHCN Objective 1: Strategy 2: Lead program outreach and assessment within State MCAH to ensure best practices for serving CYSHCN are integrated into all MCAH programs. CYSHCN Objective 1: Strategy 3: Partner to build data capacity to understand needs and health disparities in the CYSHCN population.	ESM TR.1 - Number of local MCAH programs that implement a Scope of Work objective focused on CYSHCN public health systems and services.	NPM - Percent of adolescents with and 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	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

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	care needs (ages 12-17) who received services necessary to make transitions to adult health care from 18.4% to 20.2% (NSCH 2016-2020).	CYSHCN Objective 2: Strategy 1: Partner on identifying and incorporating best practices to ensure that CYSHCN and their families receive support for a successful transition to adult health care. CYSHCN Objective 2: Strategy 2: Fund DHCS/ISCD to assist CCS counties in providing necessary care coordination and case management to CCS clients to facilitate timely and effective access to care and appropriate community resources. CYSHCN Objective 2: Strategy 3: Fund DHCS/ISCD to increase timely access to qualified providers for CCS clients to facilitate coordinated care.			
Increase engagement and build resilience among CYSHCN and their families.	CYSHCN Objective 3: By 2025, maintain the number of local MCAH programs (17) that chose to implement a Scope of Work objective focused on family engagement, social/community inclusion, and/or family strengthening for CYSHCN.	CYSHCN Objective 3: Strategy 1: Partner to train and engage CYSHCN and families to improve CYSHCN-serving systems through input and involvement in state and local MCAH program design, implementation, and evaluation. CYSHCN Objective 3: Strategy 2: Fund DHCS/ISCD to support continued family engagement in CCS program improvement, including the Whole Child Model, to assist families of CYSHCN in navigating services. CYSHCN Objective 3: Strategy 3: Support statewide and local efforts to increase resilience among CYSHCN and their families.	ESM TR.1 - Number of local MCAH programs that implement a Scope of Work objective focused on CYSHCN public health systems and services.	NPM - Percent of adolescents with and 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	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
Make systems of care easier to navigate for CYSHCN and their families.	This objective will be based on statewide and local needs assessments currently underway and will be updated as the new 5 year action plan is completed and reported on in FY 2025-26.	State strategies to support this NPM will be created after analysis of the statewide and local needs assessments and will be reported on in FY 2025-26.	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.