# Colorado 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 |
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| **Women/Maternal Health** | | | | | |
| Increase social emotional well-being | Objective1B: By September 30, 2025, increase enrollment in the Baby and Me Tobacco Free and QuitLine smoking cessation programs for those who are pregnant and postpartum by 5%. | Strategy 1: Ensure comprehensive screening, referral, and connection to intervention for behavioral health issues, including mental health and substance use disorders, among the MCH population for parent, caregiver and child with consideration for systemic equity issues and individual implicit biases. | ESM SMK-Pregnancy.1 - Percent of pregnant people insured by Medicaid who smoke during the last three months of pregnancy | NPM - Percent of women who smoke during pregnancy (Smoking - Pregnancy, Formerly NPM 14.1) - SMK-Pregnancy | NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM<br><br>NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM<br><br>NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW<br><br>NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB<br><br>NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB<br><br>NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM<br><br>NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM |

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| | | | | | NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal<br><br>NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal<br><br>NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related<br><br>NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID<br><br>NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS |
| Increase social emotional well-being | Objective 2A: By September 30, 2025, increase the number of people reached with behavioral health messages in community, clinical and educational settings by 15%.<br><br>Objective 2B: By September 30, 2025, increase by 10%, the # of school/districts implementing Second Chance and integrating it as an alternative to suspension | Strategy 2: Support universal prevention, early intervention, and treatment of behavioral health among MCH populations. | | SPM 4: Percent of women of reproductive age (18-44 years) who report good mental health | |

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| | program (increase from from 160 to 176 schools).<br><br>Objective 2C: By September 30, 2025, implement at least 2 practice or policy changes to improve coordination between systems that support the social emotional wellness of MCH population. | | | | |
| Increase social emotional well-being | Objective 1A: By September 30, 2025, increase the percentage of mothers who were able to get mental health care or counseling services when needed or wanted in the year since their baby was born from 62.7% to 65%.<br><br>Objective 1C: By September 30, 2025 increase # of pediatric and family practices implementing Healthy Steps in Colorado from 32 to 36.<br><br>Objective 3A: By September 30, 2025, increase the number of data products or tools that expand our understanding of racism as a root cause of behavioral health outcomes by 1.<br><br>Objective 3B: By September 30 2025, increase the participation of those with lived experience in the implementation of public health and behavioral health initiatives. | Strategy 1: Ensure comprehensive screening, referral, and connection to intervention for behavioral health issues, including mental health and substance use disorders, among the MCH population for parent, caregiver and child with consideration for systemic equity issues and individual implicit biases<br><br>Strategy 3: Increase state investment in addressing inequities and population disparities related to social emotional wellbeing. | 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** | | | | | |
| Promote | Objective 1A: By September 30, | Strategy 1: Build nutrition security through increased access to | ESM BF.1 - Percent | NPM - A) Percent of | NOM - Infant mortality rate per |

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| positive child and youth development | 2025, the percent of births at Baby-Friendly designated hospitals is maintained at approximately 37%.<br><br>Objective 1B: By September 30, 2025, monitor the impact of breastfeeding-supportive policies and practices (to include training and resources) by implementing at least one survey.<br><br>Objective 2A: By Sept 30, 2025, support at least ten institutions or programs that integrate at least one "farm to" component (nutrition/agricultural education, local food procurement, gardens).<br><br>Objective 2B: By September 30, 2025, develop at least one resource connecting food and mood and inclusive nutrition and feeding practices for CYSHCN.<br><br>Objective 2C: By September 30, 2025, increase participation or redemption rates for at least one fruit and vegetable incentive | breastfeeding supportive environments in communities facing the greatest racial/ethnic disparities.<br><br>Strategy 2: Build nutrition security through increased access to nutrient-rich locally grown food in communities facing the greatest racial/ethnic disparities | of births insured by Medicaid at Baby-Friendly hospitals | infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF | 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM<br><br>NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal<br><br>NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID |
| **Child Health** | | | | | |
| Improve access to supports | Objective 1: By Sept 30, 2025, provide consultation and active implementation support for at least 3 projects where state or local MCH-related digital health modernization efforts are identified, including a focus on referrals. | Strategy 1: Invest in people, process & technology (information systems integration) that increase access to supports.<br><br>Strategy 2: Identify and address access inequities. | ESM DS.1 - Percent of children referred to early intervention who do not complete an evaluation | 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 | NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR<br><br>NOM - Percent of children, ages 0 through 17, in excellent or very |

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| | Objective 2: By September 30, 2025, increase availability of data sources that illuminate outcome inequities to support state and local partner decision making by 1. | | | 6) - DS | good health (Children's Health Status, Formerly NOM 19) - CHS |
| Improve access to supports | Objective 1B: By September 30, 2025, advance at least four recommendations through the stakeholder engagement process that ensure a more comprehensive, integrated system of care for all children including CYSHCN. | Strategy 1: Invest in people, process & technology (information systems integration) that increase access to supports | ESM MH.1 - Percent of children with special health care needs ages 0-17 years who receive family-centered care | 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 | 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<br><br>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<br><br>NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS<br><br>NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC |
| **Adolescent Health** | | | | | |
| Increase prosocial connection | Objective 1A: By September 30, 2025, engage with community-based organizations and similar agencies to implement a minimum of one prosocial connection policy or process to reduce barriers to | Strategy 1: Work with community to address structural and systemic barriers to community connectedness.<br><br>Strategy 2: Create supportive environments for youth facing the greatest racial disparities. | ESM BLY.1 - Percent of youth who identify as transgender who have a trusted adult to go to for help with a serious problem | NPM - Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others (Bullying, | NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM<br><br>NOM - Adolescent suicide rate, |

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| | community connectedness.<br><br>Objective 2A: By September 30, 2025, increase the number of policy, practices and or system changes that increase equity in supportive environments for youth by at least 3.<br><br>Objective 2B: By September 30, 2025, provide a minimum of 10 trainings or technical assistance sessions/ resources/supports for LPHAs and CBOs (or communities) to implement evidence-based, equity-driven prosocial strategies. | | ESM BLY.2 - Percent of youth of color who have a trusted adult to go to for help with a serious problem | Formerly NPM 9) - BLY | ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide |
| **Children with Special Health Care Needs** | | | | | |
| Improve access to supports | Objective 1A: By September 30, 2025, together with partners implement 3 activities per year that ensure a more comprehensive, integrated system of care for school-aged children with behavioral health needs. | Strategy 1: Invest in people, process & technology (information systems integration) that increase access to supports. | ESM MH.1 - Percent of children with special health care needs ages 0-17 years who receive family-centered care | 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 | 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<br><br>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<br><br>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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| | | | | | NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC |
| **Cross-Cutting/Systems Building** | | | | | |
| Reduce racial inequities | Objective 1A: By September 30, 2025, implement at least two racial equity best practices or policies per year into MCH program infrastructure<br><br>Objective 1B: By September 30, 2025, integrate at least 3 trauma-informed practices into MCH infrastructure (state or local). Practices will be related to influencing state and local staff behaviors and advancing a culture of care and belonging.<br><br>Objective 1C: By September 30, 2025, continue to pilot test the implementation of Community Storytelling Ambassadors to promote a race equity culture and value lived experience.<br><br>Objective 2A: By September 30, 2025, collaborate with national and statewide partners to provide at least 50 coaching, consultation, and training opportunities to state and local MCH staff and partners regarding racial equity<br><br>Objective 3A: By September 30, | Strategy 1: Build program infrastructure and capacity for racial equity efforts.<br><br>Strategy 2: Develop and strengthen workforce competencies related to racial equity.<br><br>Strategy 3: Coordinate and align racial equity efforts between the MCH program and workforce development section (WDS), branch (CYFB), division (PSD), and department (CDPHE). | | SPM 3: Number of points for racial equity related policy, practices and systems changes implemented at the program, division and department level | |

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| | 2025, strengthen collaboration and sustain at least 3 partnerships and 3 shared activities across the branch, division, and department. | | | | |
| Create safe and connected built environments | Objective 1A: By September 30, 2025, provide influence on a minimum of six new or enhanced built environment policies or initiatives for state implementation to increase safe and connected communities that will have a positive impact on equity and connectedness.<br><br>Objective 2A: By September 30, 2025, engage with community based organizations and similar agencies to implement a minimum of one built environment policy or process to increase youth engagement, inclusion, and influence in creating safe and connected built environments.<br><br>Objective 2B: By September 30, 2025, provide consistent and ongoing technical assistance to support five communities who are prioritizing safe and connected built environment. The technical assistance provided will support the communities as they move through the continuum of policy, system, and environmental change. | Strategy 1: Build cross-sector partnerships to increase capacity for implementing place-based policy strategies to increase equity, community safety, activity friendly routes.<br><br>Strategy 2: Provide technical assistance for the implementation of equity-driven, evidence-based, policy strategies to increase activity-friendly routes, community safety, and opportunities for social interaction. | | SPM 1: Percent of children ages 0-17 years who live in a supportive neighborhood | |
| Increase economic mobility | Objective 1A: By September 30, 2025, Increase traffic on the Get Ahead Colorado/Hacia Adelante website by at least 10% through | Strategy 1: Identify and implement policy/systems changes that support increased tax credit claims.<br><br>Strategy 2: Engage community partners to strengthen and expand common | | SPM 5: Percent of children in poverty according to the supplemental poverty measure | |

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| | outreach partnerships.<br><br>Objective 2A: By September 30, 2025, increase the number of practice, policy, or systems changes implemented in state or local governments that support economic mobility by at least 30.<br><br>Objective 2B: By September 30, 2025, share information about referral to and utilization of FAMLI paid family and medical leave with at least 10 partners.<br><br>Objective 3A: By September 30, 2025,implement at least two process improvements to data/messaging products (EM resource hub/other benefits page on Get Ahead Colorado / Hacia Adelante Colorado website, messaging documents, data dashboard, maps) based on feedback from partners. | eligibility and enrollment in services that support economic mobility.<br><br>Strategy 3: Gather and share data, research and policies related to improved access to economic mobility and the benefits of improved economic mobility among Coloradans. | | | |