Indiana 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					
Access to high-quality, family-centered, trusted care is available to all Hoosiers..	To meet the CDC guidelines for weighted data by 2025. To obtain information not available from current data sources about maternal behaviors and experiences in pregnancy and early infancy Increase the percent of women receiving postpartum follow-up healthcare services. To increase the percent of mothers who receive a postpartum visit with a healthcare provider within 8 weeks of delivery To increase referrals of pregnant women to care. To reduce the incidence of poor maternal and infant health outcomes, related to chronic conditions. To increase the number of women receiving timely and appropriate preventive healthcare.	Increase awareness of PRAMS through marketing campaign and outreach. Conduct PRAMS steering committee meetings bi-annually to discuss marketing, data collection, and trends Partner with the Indiana Hospital Association to promote PRAMS in Hospital Labor and Delivery and OB clinics Increase the response rate for African American Women through focus groups Present PRAMS data annually to partners and stakeholders Conduct Quality Improvement projects to increase response rate. Promote adequate preconception, prenatal and postpartum health care services through marketing campaign and collaboration with partners. Increase the use of Group Prenatal Care for women before, during and after pregnancy Evaluate and implement Community Para-medicine home-based programs in multiple regions across the state to provide high-quality clinical care to women of childbearing age and their families. Analyze impact of implicit bias experienced by women in accessing care. Ensure that home visitors have access to training and education about postpartum care. Increase the home visiting program data represented as measured through	ESM WWV.1 - Number of women who responded to Pregnancy Risk Assessment Monitoring System (PRAMS). ESM WWV.2 - The percent of women receiving postpartum follow-up health care services within the first four to six weeks after delivery. ESM WWV.3 - Percentage of mothers enrolled in Home Visiting prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within 8 weeks (56 days) of delivery.	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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		MIECHV and OBN partnership. Utilize QI Tools Maintain or increase home visiting service capacity.			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
Reduce preventable deaths in the Maternal and Child Health population with a focus on reduction and elimination of inequities in mortality rates.	To reduce the number of maternal deaths by increasing the proportion of birthing hospitals that implement the AIM Patient Safety Bundles.	Increase the proportion of birthing hospitals that implement the use of AIM bundles. Annually collect and provide Maternal Mortality Review and Prevention report to stakeholders. Provide recommendations for new AIM bundles based upon review findings from the Maternal Mortality Review Committee (MMRC). Analyze impact of implicit bias experienced by women in pregnancy during MMRC case reviews.		SPM 2: Reduce Maternal Mortality Rates and Disparities by promoting best practices in clinical care.	
Prevent substance use including alcohol, tobacco and opioids among pregnant women and youth.	To increase the number of delivering Hospitals who participate in the perinatal substance use collaborative with the Indiana Perinatal Quality Improvement Collaborative.	Work with funded partner, IPQIC, to recruit and retain delivery hospitals to participate in the substance use collaborative. Offer evidence-based provider training to facilitate appropriate diagnosis and care of babies diagnosed with NAS. Maintain a comprehensive surveillance system for monitoring substance use in pregnant women and exposure in infants to inform program and policy development essential to reducing the number of infants exposed to substances. Provide technical assistance to prenatal care providers to conduct validated verbal screening for all pregnant women as required by Indiana code. Encourage all delivery hospitals to develop plans of safe care for all mother/baby dyads discharged from the hospital. Ensure plans include referrals to substance use treatment as appropriate. In conjunction with FSSA, determine feasibility of expanding Medicaid coverage for 12 months after delivery for women enrolled in treatment for substance use disorder. Support evidence-based programs to help pregnant women quit smoking. Partner with statewide organization to encourage providers conduct validated verbal screening for women of childbearing age for alcohol use.		SPM 1: Prevent substance use - including alcohol, tobacco, and other drugs - among pregnant women.	

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		Explore feasibility of adding ETOH to screening panel reported to ISDH-MCH.			
	Increase the percent of women receiving postpartum follow-up healthcare services. To increase the percent of mothers who receive a postpartum visit with a healthcare provider within 8 weeks of delivery	Promote adequate preconception, prenatal and postpartum health care services through marketing campaign and collaboration with partners. Increase the use of Group Prenatal Care for women before, during and after pregnancy. Evaluate and implement Community Para-medicine home-based programs in multiple regions across the state to provide high-quality clinical care to women of childbearing age and their families. Analyze impact of implicit bias experienced by women in accessing care. Ensure that home visitors have access to training and education about postpartum care.	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					
Reduce preventable deaths in the Maternal and Child Health population with a focus on reduction and elimination of inequities in mortality rates.	By 2025 all Indiana birthing hospitals will have completed their designation.	Increase number of hospitals surveyed by nurse surveyor team. Generate a report to examine data trends with regard to racial/ethnic disparities in VLBW births at Level I and Level II facilities.	ESM RAC.1 - Percent of hospitals surveyed to determine Obstetric and Neonatal Level 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
Reduce	Increase awareness of risk factors	Increase the percentage of women participating in group prenatal care.		SPM 3: Reduce disparities	

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preventable deaths in the Maternal and Child Health population with a focus on reduction and elimination of inequities in mortality rates.	and circumstances contributing to preventable infant death in Indiana.	Continue to lead the Indiana Breastfeeding Alliance. Collaborate with internal and external partners to create and implement a new State Breastfeeding Plan. Host annual State Breastfeeding Conference. Increase provider engagement and education related to current infant safe sleep recommendations. Increase the number of communities addressing infant mortality through collaborative efforts and community action. Encourage data collection, review, and dissemination by child fatality review and FIMR teams to state and local prevention partners. Increase number of investigators trained in standardized infant death investigation. Increase number of death certifier and pathologists trained in proper death certificate completion.		in Infant Mortality.	
Child Health					
Reduce preventable deaths in the Maternal and Child Health population with a focus on reduction and elimination of inequities in mortality rates.	Increase the percentage of sites trained and operating mobile fitting and car seat inspection stations to ensure car seats are properly installed. Increase the percentage of child death reviews completed by the CFR teams.	Engage police and fire stations to expand statewide fitting stations. Partner with the Indiana Criminal Justice Institute to provide support for existing fitting stations and expand to new fitting stations. Analyze available trauma, hospitalization, child fatality review, and INVDRS data to determine trends associated with child injury and death and disseminate resulting data and recommendations. Identify risk factors for preventable child fatalities. Provide support and training to CFR teams to accurately report and classify child injuries and fatalities.	***Inactive -*** *ESM IH-Child.1 - Percent of sites operating mobile fitting and car seat inspection stations to ensure car seats are properly installed.* ESM IH-Child.2 - Percent of child deaths reviewed by Child Fatality Review teams.	NPM - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9 (Injury Hospitalization - Child, Formerly NPM 7.1) - IH-Child	NOM - Child Mortality rate, ages 1 through 9, per 100,000 (Child Mortality, Formerly NOM 15) - CM 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

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		Improve reliability of maltreatment related classifications (particularly those related to child neglect and negligence). Support evidence-based injury prevention programming. Increase resources available to Indiana families aimed at alleviating stressors and trauma that often lead to injury. Incorporate ACES education and awareness into Child Injury Prevention.	ESM IH-Child.3 - Percent of parents with children of car seat age reached through car seat distribution program in the past year.		NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide
Promote physical activity through policy improvements and changes to the build environment.	To increase the number of schools in Indiana implementing sustainable programming related to increased physical activity in children ages 6-11. To increase the percent of children whose access to engagement in physical activity is increased due to improvements in the built environment.	Gather baseline data for schools participating in physical activity programming. Provide professional development training to teachers, administrators, before and after school educators, and youth serving organizations. Provide technical assistant to Youth and Adolescent Physical Activity (YAPA) grantees around physical activity. Track the number of students in K-12 who participate in the Coordinated Approach To Child Health (CATCH) curriculum. Build partnership with the Department of Education and other educational leaders to collaborate on School Wellness Policy and develop tools on how to embed Physical Activity into the school day. Explore how to include Physical Activity in the Farm to School to ECE project. Explore a recognition program of Physical Activity and Paths to Quality. Create temporary changes to the built environment to promote Physical Activity through the Tactical Urban-ism Grant Program. Support changes in the built environment to promote Physical Activity. Collaborate with Purdue Extension community wellness coordinators to track their impact of their built environment initiatives.	ESM PA-Child.1 - Number of schools participating in an activity (training, professional development, policy development, technical assistance, PA in-school programming, PA before and after school programming) to improve physical activity among children, ages 6-11. ESM PA-Child.2 - Percent of children ages 6-11 impacted by improvements to the built environment.	NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day (Physical Activity, Formerly NPM 8.1) - PA-Child	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

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		Coordinate Active Living Workshops to plan built environment improvements with community stakeholders.			
	• To increase the percent of families who received effective care coordination. • To increase the percent of children diagnosed with a condition identified through newborn screening who receive an annual assessment of services.	• Implement a standard process to review annual services received by newborns with a condition identified through newborn screening. • Collaborate with and educate home visiting programs and other state programs about newborn screening and follow up. • Within the clinic setting, increase the number of families who report receiving comprehensive care within a medical home while also addressing coordination and communication among doctors regarding the patient and making intentional referrals to community-based resources. • Enhance partnerships with family and parent organizations to assist with system navigation, education and referral to available community-based resources and ensure follow-up is conducted to address barriers to accessing needed services and supports. • Pilot an innovative payment model for place based coordination for children with medical complexity(ies) in collaboration with Indiana Medicaid. • Continue to provide statewide care coordination through system navigation, education, resource identification, referral and follow up.	ESM MH.1 - Percent of families who received effective care coordination. ESM MH.2 - Percent of children diagnosed with a condition identified through newborn screening who receive an annual assessment of services	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 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 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Adolescent Health					
Reduce preventable deaths in the Maternal and Child Health population with a focus on reduction and elimination of inequities in	Lower count of suicide-related hospitalizations.	Integrate youth suicide prevention into existing MCH programs and adolescent health clinics. Obtain weighted YRBS data to better understand the needs of teens in Indiana. Involve youth voices in work related suicide and injury prevention in teens. Develop guidance for healthcare facilities, including universal depression screenings and suicide risk assessments.	***Inactive -*** *ESM IH-Adolescent.1 - Reduce count of suicide-related hospitalizations in adolescents, ages 10 - 19.* ESM IH-Adolescent.2 - Reduce percent of	NPM - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 (Injury Hospitalization - Adolescent, Formerly NPM 7.2) - IH-Adolescent	NOM - Child Mortality rate, ages 1 through 9, per 100,000 (Child Mortality, Formerly NOM 15) - CM NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle

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mortality rates.		Continue involvement in the Adolescent and Young Adult Behavioral Health CoIIN. Increase the number of communities and agencies trained in ACEs and trauma-informed practices Explore using psychological autopsy to improve community and professional responses to pediatric suicide attempts and completions.	suicide-related hospitalizations in adolescents, ages 10 - 19		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
Promote physical activity through policy improvements and changes to the build environment.	To increase the number of schools in Indiana implementing sustainable programming to increase physical activity in children ages 12-17. To increase the percent of adolescents whose access to engagement in physical activity is increased due to improvements in the built environment.	Gather baseline data for schools participating in physical activity programming. Provide professional development training to teachers, administrators, before and after school educators, and youth serving organizations. Provide technical assistant to Youth and Adolescent Physical Activity (YAPA) grantees around physical activity. Track the number of students in k-12 who participate in the Coordinated Approach To Child Health (CATCH) curriculum. Build partnership with the Department of Education and other educational leaders to collaborate on School Wellness Policy and develop tools on how to embed Physical Activity into the school day. Create temporary changes to the built environment to promote Physical Activity through the Tactical Urbanism Grant Program. Support changes in the built environment to promote Physical Activity. Collaborate with Purdue Extension community wellness coordinators to track their impact of their built environment initiatives. Coordinate Active Living Workshops to plan built environment improvements with community stakeholders .	ESM PA-Adolescent.1 - Number of schools participating in an activity (training, professional development, policy development, technical assistance, PA in-school programming, PA before and after school programming) to improve physical activity among adolescents (12-17). ESM PA-Adolescent.2 - Percent of adolescents ages 12-17 impacted by improvements to the built environment.	NPM - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day (Physical Activity - Adolescent, Formerly NPM 8.2) - PA-Adolescent	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
Access to high-quality, family-	Increase knowledge, behavior, and confidence of providers caring for adolescents.	Increase the number of trained practices and clinicians using the Adolescent Champion Model.	ESM AWV.1 - The percent of health care providers who report	NPM - Percent of adolescents, ages 12 through 17, with a	NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly

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centered, trusted care is available to all Hoosiers..		Prioritize serving areas with high rates of teen pregnancy/STIs and at-risk youth populations. Promote the Adolescent Well Visit by Media campaign and other adolescent health programming.	knowledge, behavior, and confidence change in adolescent health care after Adolescent Champion Model training.	preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	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 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS

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					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
Strengthen mental health and emotional well-being through partnerships and programs that build	Increase the percentage of teens who are served using a Positive Youth Development Curriculum.	Understand current situation by increasing participation in the Youth Risk Behavior Survey and obtain consist, weighted data. Increase opportunities to engage youth voices as volunteers and/or paid staff and develop leadership skills. Increase opportunities for youth connectedness with family, school, and community through the Be Strong Families Parent Café and Teen Café		SPM 4: Number of youth served with a Positive Youth Development (PYD) curriculum, ages 10 - 18.	

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capacity and reduce stigma.		Model.			
Children with Special Health Care Needs					
Access to high-quality, family-centered, trusted care is available to all Hoosiers..	To increase the percent of families who received effective care coordination. To increase the percent of children diagnosed with a condition identified through newborn screening who receive an annual assessment of services.	Implement a standard process to review annual services received by newborns with a condition identified through newborn screening. Collaborate with and educate home visiting programs and other state programs about newborn screening and follow up. Within the clinic setting, increase the number of families who report receiving comprehensive care within a medical home while also addressing coordination and communication among doctors regarding the patient and making intentional referrals to community-based resources. Enhance partnerships with family and parent organizations to assist with system navigation, education and referral to available community-based resources and ensure follow-up is conducted to address barriers to accessing needed services and supports. Pilot an innovative payment model for place based coordination for children with medical complexity (ies) in collaboration with Indiana Medicaid. Continue to provide statewide care coordination through system navigation, education, resource identification, referral and follow up.	ESM MH.1 - Percent of families who received effective care coordination. ESM MH.2 - Percent of children diagnosed with a condition identified through newborn screening who receive an annual assessment of services	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 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 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Access to high-quality, family-centered, trusted care is available to all Hoosiers..	To increase the percent of adolescents with and without special health care needs who have received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.	Collaborate with Center for Youth and Adults of Childhood (CYACC) to train IU School of Medicine residents on transition to adulthood and caring for individuals with special needs. Work with current primary care and sub-specialty providers (including referring physicians) of patients regarding transition. Develop and conduct trainings for families on transition.	ESM TR.1 - Number of participants in Center for Youth and Adults with Conditions of Childhood (CYACC) clinical services. ESM TR.2 - Number	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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		Collaborate with school-based clinics to address transition for individuals with and without special healthcare needs through initiatives that educate on a variety of topics, including post-secondary education, workforce readiness, and activities of daily living.	of adult and pediatric providers who have received training in transition services and caring for CYSHCN.		
Strengthen mental health and emotional well-being through partnerships and programs that build capacity and reduce stigma.	To enhance and expand the promotion of optimal health, development, and well-being of children and their caregivers through education, training, etc.	Increase marketing and education materials through awareness, common language, and use in multiple platforms. Collaborate with other state entities to develop NBS and genetic training and materials. Increase the utilization of systems building through education, and collaboration and partnership. Partner with Oral Health division to develop strategies to improve access to oral health care.		SPM 5: Promotion of optimal health development and well-being.	
Cross-Cutting/Systems Building					
Reduce health disparities and inequities in internal MCH programs, policies and practices to improve maternal and child health.	Reduce health disparities and inequities in internal programs, policies, and practices.	Continue engagement with Anti-Racism training with internal staff and external partners . Using data driven methods, MCH will distribute funding based on priority populations to reduce health inequities. Inclusion of health disparities language in all MCH grant agreements. Ensure that data reports produced by Title V describe relevant disparities and discuss potential root causes, implications, and recommendations for moving towards equity. Provide effective, equitable, understandable, and culturally responsive services.		SPM 7: Reduce health disparities and inequities in internal programs, policies, and practices to improve maternal and child health.	
Engage Families and Youth with diverse life experiences to	Increase the percentage of families and youth with diverse life experiences engaged in our work to improve MCH services.	Identity current programs that involve parents and opportunities for expanding family representation throughout Title V programs. Identify already existing family and youth groups and councils and survey them on best ways to partner and increase family representation.		SPM 8: Engage families and youth with diverse life experiences to improve MCH services.	

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inform and improve MCH services.		Explore the development of an MCH Family/Consumer Advisory Board. Explore the development of a Youth Advisory Board.			
Ensure Frequent Surveillance, Assessment and Evaluation of data drives funding, programming, and system change.	To improve statewide surveillance, data collection, and evaluation capacity.	Develop and disseminate basic health information that is accurate and clearly understandable. Offer training to MCH staff to improve data literacy. Collaborate with MCH Epi team for data exploration and visualization tools.		SPM 9: MCH Data are analyzed and disseminated and used to inform Title V programming and funding allocations.	
Strengthen mental health and emotional well-being through partnerships and programs that build capacity and reduce stigma.	To increase partnerships to collectively assess and identify resources and gaps in mental health services.	Conduct an internal and external gap analysis to assess what work around mental, social and emotional well-being current partners and grantees are doing to see where ISDH can support efforts. Collaborate with internal and external partners to increase a 2 gen approach awareness. Collaborate with state, local, and non-traditional partners as well as consumers to inform mental health needs. Use data from statewide and national surveys to better understand self-reported mental health.		SPM 6: Strengthen mental, social and emotional health and well-being through partnerships and programs that build capacity and reduce stigma.	