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					
Strengthen the capacity of the health system to promote mental health and emotional well-being.	Increase to 92% from baseline (89.5%, PRAMS 2018) the percent of women who have moderate or high social support following the birth of their baby.	Provide training and technical assistance on perinatal mental health (including maternal mental health needs and co-morbidities including substance use and interpersonal violence) to health providers and other state agencies to increase awareness and reduce stigma. Develop and disseminate a perinatal mental health data analysis plan that outlines a process for collecting and reporting the MA postpartum depression screening rate, the identification of perinatal mental health diagnoses, and the incidence of postpartum psychosis. The plan will be used to inform program planning and policy development, including reduction of racial and ethnic inequities. (Complete) Leverage home visiting programs to screen for depression and social connectedness among pregnant and parenting people, including fathers, and facilitate connections to services. Collaborate with MassHealth to develop certification of doulas to enable a pathway for sustainable financing for doula services and to improve perinatal emotional and physical health, social support, and patient advocacy.	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.
Prevent the use of substances, including alcohol, tobacco, marijuana and opioids, among youth and pregnant people.	1. By 2025, reduce the percentage of women who report smoking during pregnancy from 4.3% (2018 NVSS) to 2.0%. 2. By 2022, improve measurement of marijuana use/consumption among pregnant women by adding specific questions related to marijuana use/consumption during pregnancy (from the current	1a. Add specific questions to PRAMS related to cigarette smoking/e-cigarette use/vaping during pregnancy (from the current question on smoking 3 months before, and last 3 months of pregnancy, and postpartum) to include all trimesters. 1b. Use PRAMS data to report on nicotine use during pregnancy and validate reporting of cigarette smoking on the birth certificate. 1c. Develop partnerships between the Tobacco Cessation program and other MDPH programs serving pregnant and postpartum people (e.g. home visiting, EI, WIC) to promote awareness of risks of nicotine use in all	ESM SMK-Pregnancy.1 - Percentage of women using the statewide smoking quitline who are pregnant	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 NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	question on any use which is asked during any prenatal visit to new questions which include all three trimesters and types of consumption) to the PRAMS survey. 3. By 2023, improve measurement of alcohol consumption among pregnant women by adding specific questions related to drinking during pregnancy (from the current question on pre-pregnancy drinking to include all three trimesters for both any alcohol use and binge drinking) to the PRAMS survey.	forms (e.g., cigarettes, e-cigarettes, vaping) during pregnancy, and promote resources for quitting, such as the quitline incentive program for pregnant people. 1d. Partner with the Tobacco Cessation program to conduct focus groups to consider questions for PRAMS that explore harm reduction messaging and perception that vaping is safer. 1e. Partner with PNQIN to provide training and technical assistance to OB providers as they implement quality improvement cycles to reduce nicotine use in all forms (e.g., cigarettes, e-cigarettes, vaping) during pregnancy. 2a. Use PRAMS data to report on marijuana use/consumption during pregnancy. 2b. Partner with the Bureau of Substance Addiction Services to expand funding for questions and to compare marijuana use data for trends with PRAMS data. 2c. Partner with BD-STEPS to share data on marijuana use during pregnancy. 2d. Raise awareness of PRAMS findings on marijuana use/consumption during pregnancy to people of reproductive age, other stakeholders, and PNQIN to inform their QI activities to reduce marijuana use/consumption during pregnancy. 3a. Use PRAMS data to report on alcohol consumption prior to pregnancy and analyze alcohol reporting on the birth certificate. 3b. Share findings with birthing hospitals to promote awareness. 3c. Partner with BD-STEPS to share data on alcohol use during pregnancy. 3d. Raise awareness of PRAMS findings on alcohol consumption before pregnancy and of birth certificate findings on alcohol consumption during pregnancy to people of reproductive age, other stakeholders, and the Perinatal-Neonatal Quality Improvement Network (PNQIN) to inform their			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 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 - Sudden Unexpected Infant

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		QI activities. 3e. Collaborate with the FASD taskforce to include an explicit focus on prevention efforts and provider training, and to update existing educational materials.			Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Reduce rates of and eliminate inequities in maternal morbidity and mortality.	1. By 2025, the Massachusetts Maternal Mortality & Morbidity Review Committee (MMMRC) will increase the percent pregnancy-associated deaths that are reviewed within two years of occurrence from 0% to 50%. 2. By 2025, develop a structure for community input into the maternal mortality and morbidity review process that is authentic and addresses the power dynamics between medical providers and community stakeholders. 3. By 2025, leverage collaborative partnerships to inform practice and policy changes and disseminate findings including MMMRC recommendations. 4. By 2025, reduce inequities in rates of COVID-19 infection among birthing and lactating people of color by improving their vaccination coverage during pregnancy from 21.6% for Hispanic individuals, 21.5% for non-Hispanic Black individuals and	1a. Link birth and death files and other datasets (such as MassHealth) to identify pregnancy-associated and related deaths in a timely manner. 1b. Strengthen and increase the number of memoranda of understanding and data sharing agreements with key stakeholders to ensure timely access to data. 1c. Improve process and timing for data abstraction into the Maternal Mortality Review Information Application (MMRIA). 1d. Through participation in the MDPH-sponsored Lean Six Sigma quality improvement training, identify activities to improve the timeliness of identification and review. 1e. Establish and implement a process for prioritizing the abstraction and review of pregnancy associated deaths where COVID-19 is indicated. 2a. Establish a process/mechanism for community engagement. 2b. Improve the process for developing recommendations based on maternal death reviews that is informed by community and clinical partners. 2c. Through participation in the MDPH-sponsored Lean Six Sigma quality improvement training, identify activities to improve community contribution to the review process. 3a. Analyze data to a) understand burden, causes, and distribution of mortality and morbidity by selected characteristics, b) develop data briefs, and c) report trends in a timely manner.		SPM 1: Percent of cases identified for review by the Massachusetts Maternal Mortality and Morbidity Review Committee that were reviewed within two years of the date of death	

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	14.0% for non-Hispanic American Indian/Alaska Native/Other individuals to above 50.0% for these groups.	3b. Leverage multiple initiatives and partnerships to strengthen a maternal health system of care including implementing the ACOG Alliance for Innovation on Maternal Health (AIM) bundles and the CDC Levels of Care Assessment Tool (LOCATe) to establish maternal levels of care to improve maternal health outcomes and reduce maternal deaths. 4a. Conduct surveillance for SARS-CoV-2 infection among pregnant people and their infants by participating in the Surveillance for Emerging Threats to Mothers and Babies Network (SET-NET) and document any racial and ethnic inequities observed among pregnant people with SARS-CoV-2 infection. Analyze data on COVID-19 vaccine coverage among pregnant and recently pregnant people and explore racial and ethnic inequities in vaccine uptake. 4b. Leverage the PRAMS survey to understand people's experiences and needs during pregnancy and postpartum related to COVID-19 and provide state-level data to examine racial/ethnic inequities among pregnant people due to the pandemic. 4c. Train and support a cadre of Community Evaluators to improve the use of qualitative data to assess the needs of groups disproportionately affected by COVID-19, including pregnant and lactating people. 4d. Collaborate with the Perinatal-Neonatal Quality Improvement Network's COVID-19 Vaccination in Pregnancy Initiative (funded by CDC) to improve provider capacity to counsel birthing/postpartum people, increase the number of birth facilities with protocols to encourage vaccination, and improve community-clinical linkages. 4e. Disseminate public health messaging about COVID-19 vaccination for pregnant and lactating people (recommendations, safety, and access) through vendors, partners, and directly to families. 4f. Participate in the implementation of the Vaccine Equity Initiative as program managers, community liaisons, and vaccine ambassadors, to increase acceptance of and access to the COVID-19 vaccine among populations and communities hardest hit by COVID-19.			

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Perinatal/Infant Health					
Foster healthy nutrition and physical activity through equitable system and policy improvements.	By 2025, increase the percent of infants who are ever breastfed from 84.3% (2016 NIS) to 86% and the percent of infants who are breastfed exclusively through 6 months from 23.2% (2016 NIS) to 29.5%.	Conduct a needs assessment to inform the development of a breastfeeding strategic plan. Collaborate with the MA Breastfeeding Coalition and the MA Baby Friendly Hospital Collaborative to support hospital policies that promote breastfeeding for all people giving birth, including those with disabilities. Increase access to lactation counseling services for WIC participants, including breastfeeding peer counselors who reflect the cultural and linguistic diversity of the communities in which they work.	ESM BF.1 - Percent of WIC participants receiving services from a Breastfeeding Peer Counselor who exclusively breastfed for at least three months	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
Child Health					
Foster healthy nutrition and physical activity through equitable system and policy improvements.	1. By 2025, increase the percent of families with children ages 0-5 years old who can always afford to eat good nutritious meals from 77.9% (2017-2018 NSCH) to 87%. 2. By 2025, increase from 103 to 150 the number of injury-related data, technical assistance, and press requests that are completed by Injury Prevention and Control Program staff.	1a. Maximize the access that families with young children have to food resources for which they are eligible by partnering with agencies such as MassHealth, Department of Transitional Assistance and Head Start through efforts such as enhanced data sharing about participant enrollment. 1b. Enhance the use of social media, digital marketing, and web-based tools to deliver targeted outreach to potentially eligible families and to facilitate enrollment in the WIC Program. 1c. Increase the availability of and access to fruits and vegetables through initiatives such as Healthy Incentives Program and the WIC Farmers Market Nutrition Program. 1d. Improve collaboration between WIC and Mass in Motion at the state and local levels to identify and implement upstream approaches to promoting food access and physical activity. 1e. Increase collaboration with the local food retailer community and with the national food retailer chains and EBT processors to maximize WIC	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.

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		access points and increase flexibilities for WIC benefit redemption through improvements in technology. 2a. Promote safe physical activity through injury prevention initiatives including roadway safety, water safety, built environment, and management of sports-related concussions. 2b. Increase representation of MCH stakeholders in work led by other state agencies and coalitions focused on improving the built environment, such as the Falls Prevention Coalition, MA Prevents Injuries Now Network, the State Highway Strategic Plan, and the Healthy Aging Collaborative. 2c. Ensure the IPCP stakeholder network is informed about injury prevention news and opportunities by circulating 48 newsletters annually. 2d. Provide 12 trainings annually based on stakeholder needs, including sports concussion management and prevention, safe sleep and other injury topics as requested.			
Strengthen the capacity of the health system to promote mental health and emotional well-being.	By 2025, increase to 60% from baseline (37.3%, 2017-2018 NSCH) the percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.	Increase the capacity of a cross-disciplinary workforce to screen for and promote social-emotional health in early childhood to ensure timely and effective supports and interventions. Leverage the Young Children's Council to align MDPH and state and community partners' work related to infant and early childhood social emotional wellness. Through Essentials for Childhood, co-create with families and community members a toolkit to promote community social connectedness. Implement the Learn the Signs Act Early Developmental Milestone Checklist Program in WIC clinics statewide to equip staff with tools and resources to identify and address developmental concerns. Collaborate with MassHealth, the Department of Mental Health, the MA Association for Infant Mental Health and the MA Child Psychiatry Access Project to promote understanding of infant and early childhood mental health, effective social emotional screening and follow-up in pediatrics, and services and referrals including use of the Diagnostic Classification of	ESM DS.1 - Percent of infants and children enrolled in WIC who are monitored using the Learn the Signs Act Early checklist	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

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		Mental Health and Developmental Disorders of Infancy and Early Childhood: DC:0–5 to assess infant and early childhood mental health.			
Adolescent Health					
Strengthen the capacity of the health system to promote mental health and emotional well-being.	1. By 2025, increase the percent of high school students who report having a teacher or other adult in school they could talk to about a problem to 77% from baseline (75%, 2017 YRBS). 2. By 2025, return to the pre-pandemic baseline the percentage of middle and high school students who report feeling so sad or hopeless almost daily for 2+ weeks in a row that they stopped doing some usual activities (high school: 33.8%, 2019 YRBS; middle school: 24.3%, 2019 YHS). 3. By 2025, return to the pre-pandemic baseline the percentage of middle and high school students who seriously considered attempting suicide in the past 12 months (high school: 17.5%, 2019 YRBS; middle school: 11.3%, 2019 YHS).	1a. Use positive youth development and racial justice principles in MDPH-funded programs to foster protective factors among youth. 2a. Provide three-tiered behavioral health services in Schools Based Health Centers: 1) promotion of positive mental health throughout the school community; 2) early identification of emerging mental health issues; and 3) response team approach for students with a mental health emergency. 2b. Implement a school-based tele-behavioral health pilot program to reduce barriers to access for critically needed behavioral health services for school-age children. 2c. Support school-based health staff and staff of adolescent health and youth development programs in 1) providing mental health assessment, brief intervention, and referrals to treatment for youth and 2) engaging in self-care and peer support to navigate the stressors they face due to the COVID-19 pandemic. 2d. Increase the capacity of the Sexual and Reproductive Health Program and school health programs to respond to the mental health needs of youth resulting from the COVID-19 pandemic (e.g., grief from the loss of a parent/caregiver) through staff training and the provision of individual and group services/supports. 3a. Provide suicide awareness and prevention training to school personnel. 3b. Improve Local Child Fatality Review teams' capacity to review suicide cases and generate applicable recommendations.	ESM AWV.1 - Percent of School Based Health Center clients who are male	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

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
					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) - 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
Promote	1. By 2025, decrease the gap	1-2a. Maintain access to virtual and in-person sexuality education curricula		SPM 2: Rate of teen births	

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
equitable access to sexuality education and sexual and reproductive health services.	between the Latinx and White teen birth rates from 8 times higher among Latinx young women in 2016 to 5 times higher. 2. By 2025, decrease the gap between the Black and White teen birth rates to less than 2 times higher. 3. By 2025, provide training to 75% of Adolescent Sexuality Education and Sexual Reproductive Health Program grantees on the integration of reproductive justice principles into delivery of sexuality education and/or sexual and reproductive health services. 4. By 2025, 85% of females under age 25 are screened for chlamydia at clinics funded by the Sexual and Reproductive Health Program.	that reflects both evidence and emerging practice, and expand to communities with limited to no sexual health education available. 1-2b. Ensure clinical sexual and reproductive health services (in person and telehealth) are accessible to Latinx and Black youth via school-based health centers, sexual and reproductive health clinics, and other sources of clinical care, and reflect innovative and emerging best practices. 1-2c. Increase the capacity of Adolescent Sexuality Education, STRIVE and PREP organizations to reach and retain vulnerable youth populations such as BIPOC youth, youth with NDD, LGBTQ youth, homeless youth, unaccompanied minors, and others. 1-2d. Develop strategic partnerships with DESE, Elevatus, and other nontraditional stakeholders to address gaps in sexuality education across Massachusetts. For example, reaching rural and other communities that experience high rates of teen birth and/or sexually transmitted infections that may not have access to state resources to support sexuality education delivery. 1-2e. Use a positive youth development approach to address reproductive health inequities among youth ages 10-24 through virtual and in-person prevention/upstream programming, secondary/downstream programming, and the youth internships program. 3a. Provide technical assistance to program grantees as they adopt and implement a reproductive justice framework, including but not limited to training on addressing racial bias, understanding intersectionality, serving LGBTQ youth, and serving youth with special health care needs. 4a. Provide training and technical assistance to SRH providers to incorporate CDC's "Recommendations for Providing Quality Sexually Transmitted Diseases Clinical Services" and most recent "Sexually Transmitted Diseases Treatment Guidelines." 4b. Develop and disseminate the Protect Access to Confidential Healthcare (PATCH) Act materials to local stakeholders (e.g., clinics, schools, community-based agencies and patients) to ensure confidential access to		per 1,000 Latinx adolescents aged 15-19	

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		sexual and reproductive health services.			
Promote equitable access to sexuality education and sexual and reproductive health services.	By 2025, increase to 93% from baseline (90.9%, NSCH 2016-2017) the percent of adolescents with a preventive medical visit in the last year.	Increase preventive care visits at School-Based Health Centers (SBHC) by providing technical assistance and performance feedback to each SBHC and developing care practices that are welcoming for adolescents, particularly students with disabilities, young men, and LGBTQ youth. Ensure that clinical sexual and reproductive health providers are a source of primary care for adolescents directly or by referral by reviewing program standards in all Sexual and Reproductive Health Program agencies and ensuring alignment with the Quality Family Planning Guidelines.	ESM AWV.1 - Percent of School Based Health Center clients who are male	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

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
					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
Prevent the use of substances, including	By 2025, increase by 5% (from 65% in FY19) the percentage of schools with students in grades 7-12 implementing SBIRT	Update the SBIRT screening tool to the CRAFFT-2n to include additional questions and brief interventions for vaping and e-cigarette use among adolescents.			

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
alcohol, tobacco, marijuana and opioids, among youth and pregnant people.	(Screening, Brief Intervention and Referral to Treatment).	Partner with schools, school districts, and school-based health centers to promote the CRAFFT-2n screening tool through updated SBIRT training and technical assistance. Partner with BSAS to obtain data from BSAS-funded coalitions on adolescent surveys which include questions on adolescents' perceptions of risk, parental attitudes, and peer attitudes when adolescents use marijuana, drugs, and alcohol.			
Children with Special Health Care Needs					
Strengthen the capacity of the health system to promote mental health and emotional well-being.	By 2025, increase the percent of children with special health needs ages 3-17 who receive mental health treatment or counseling when needed to 85% from baseline (76.9%, NSCH 2017-2018). 2. By 2025, increase the number of infants and toddlers enrolled in Early Intervention who demonstrate improved positive social-emotional skills to 57.2% from baseline (49.3% in FY21).	1a. Collaborate with community-based organizations such as the Parent Professional Advocacy League and the Federation for Children with Special Needs to raise awareness of mental health concerns and resources for treatment among children and youth with special health needs and their families. 1b. Through DCYSHN programs, provide services and supports beyond traditional mental health treatment that address basic needs that may lead to mental health concerns in this population (e.g., lack of respite care, food/housing insecurity). 1c. Establish partnerships in the Haitian, Cambodian, and Vietnamese communities to better understand cultural differences for families of children with special health needs (both physical and behavioral) and develop strategies to increase awareness of services and reduce stigma. 2a. Implement the evidence-based practice Parents Interacting with Infants (PIWI), into Early Intervention programs, including mandatory PIWI training for new staff entering the EI system. PIWI is an approach to working with families and their young children focused on promoting social-emotional development.	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.
Support effective health-related transition to adulthood for adolescents with special	By 2025, increase the percent of youth with special health needs who received services necessary to transition to adult health care from 17.9% (NSCH 2016-2017) to 40.3%.	Increase access to health transition resources and information for families, youth, and providers. Provide culturally and linguistically appropriate services and supports to youth and their families based on individual needs prior to and throughout the transition process.	ESM TR.1 - Percent of youth ages 14 and older receiving services from the DPH Care Coordination Program who receive	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	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

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
health needs.		Engage youth and young adults with special health needs and their families to ensure youth voice in efforts to strengthen the system and aligns services around health transition. Engage internal (MDPH programs serving transition age youth) and external partners (clinicians, non-medical providers, sister agencies) to strengthen the system and align services around health transition for young adults.	health transition information and support from their Care Coordinator	(Transition, Formerly NPM 12) - TR	
Cross-Cutting/Systems Building					
Eliminate institutional and structural racism in internal Department of Public Health programs, policies, and practices to improve maternal and child health.	1. By 2025, increase to 95% from baseline (64% in 2019) the percent of BFHN and BCHAP staff who have used any racial equity tool or resource in their work. 2. By 2025, increase the percent of BFHN staff of color from 36.8% to 42.6%.	1a. Embed into MDPH opportunities for staff to engage in ongoing learning and dialogue, such as workshops, affinity groups, and town hall meetings, to promote common language, shared understanding, and authentic support for a public health framework centered on racial equity. 1b. Develop tools and resources to identify and address institutional racism within core elements of public health work – such as program planning, community engagement, procurement, and data collection and analysis – and build staff capacity to use them in the implementation and monitoring of MDPH-funded programs. 1c. Participate in the Cross-Department Racial Equity Collaborative, which aims to share best and promising practices for eliminating institutional racism and align related activities happening across MDPH. 2a. Foster a workplace culture that acknowledges and addresses the impact of systems of oppression on staff, including microaggressions, to improve staff retention. 2b. Implement changes to the hiring and recruitment process to increase employment of staff with intersectional identities, including those with disabilities, of diverse genders, and people of color.		SPM 3: Percent of Bureau staff who have used any racial equity tool or resource in their work	
Engage families, fathers and youth with diverse life experiences	By 2025, increase to 50% from baseline (38.1% in FY19) the percent of Title V programs that offer compensated family engagement and leadership opportunities.	Understand and better coordinate current efforts across MDPH bureaus and offices to partner with and engage communities, families, fathers, and youth at the systems and program level. Implement at MDPH the statewide Family Engagement framework developed in partnership with the Department of Early Education and Care		SPM 4: Percent of Title V programs that offer compensated family engagement and leadership opportunities	

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
through shared power and leadership to improve maternal, child, and family health services.		and the Department of Elementary and Secondary Education. Build and sustain relationships and trust with families of diverse demographic backgrounds and life experiences – including but not limited to fathers, youth, Black, Indigenous, and people of color, people with disabilities, and people who identify as LGBTQ – to share voice and power in the design and delivery of services. Address institutional barriers (e.g. allowable grant costs, income tax documentation, established organizational culture, institutional racism) to authentic engagement and power sharing with families and youth and to ensuring they receive fair and consistent financial compensation for their partnership and leadership roles. Ensure communications tools, such as marketing materials and intake forms, for “maternal and child health” programs are inclusive and representative of fathers. Develop best practices for virtual engagement of families, fathers, and youth beyond the COVID-19 pandemic that maintain quality of engagement and equity of opportunity.			
Eliminate health inequities caused by unjust social, economic, and environmental systems, policies and practices.	By 2025, decrease to 9.5% from baseline (12%, 2018-2019 NSCH) the percent of families who have had difficulty since their child was born covering basics, like food or housing, on their income.	Increase families’ access to and assess the impact of public benefits and programs that promote economic stability, including Paid Family and Medical Leave, the Earned Income Tax Credit, and Supplemental Security Income benefits. Improve access for youth and adults, including those with disabilities to employment that is safe, accessible, stable and well compensated. Support and advise external coalitions and agencies (e.g., the Statewide Special Education Advisory Panel, Coalition for Social Justice, Department of Early Education and Care) to promote equitable access to childcare services and educational opportunities for all children. Promote access to safe and affordable housing and reduce environmental exposures through initiatives such as the Childhood Lead Poisoning Prevention Program.		SPM 5: Percent of families who have had difficulty since their child was born covering basics, like food or housing, on their income	

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		Through Essentials for Childhood, develop a Community Connectedness Toolkit to strengthen community support for families and promote strong community social connectedness. Using a family and community engagement approach, support families in accessing concrete supports such as housing, childcare, education & job training, public benefits, and financial resources through programs including home visiting programs for pregnant and parenting families and the Catastrophic Illness in Children Relief Fund. Build reciprocal partnerships with external stakeholders – such as families, MassHealth, the Department of Transitional Assistance, Department of Transportation, Executive Office of Public Safety and Security, Child Fatality Review program, the MA Chapter of the American Academy of Pediatrics, and the Community Action Lead Project – to address systems-level inequities and align efforts and resources. Collaborate with partners to promote and implement best practices for family access to and engagement in virtual health and social services that mitigate potential inequitable outcomes and help bridge the digital and economic divide.			
Support equitable healing centered systems and approaches to mitigate the effects of trauma, including racial, historical, structural, community, family, and childhood trauma.	1. By 2025, increase by 10% above baseline (to be established) the percent of BFHN and BCHAP staff who report a workplace culture that reflects a safe and supportive environment to mitigate primary and secondary trauma. 2. By 2025, use surveillance data from multiple sources to develop a data dashboard that measures Adverse and Positive Childhood Experiences (ACEs and PCEs) to inform program and policy strategies that promote healing centered engagement at community, family, and individual	1a. Design trauma-informed and healing centered organizational assessment questions as part of a Department-wide Racial Equity Survey to inform a strategic plan that promotes racial equity and healing centered approaches within programs and divisions within BFHN and BCHAP. 1b. Offer trainings and workshops on Healing Centered Organizations to develop a shared understanding of and support for a public health framework that builds capacity for promoting trauma-informed and healing centered approaches in programs, policies and practices within BFHN and BCHAP (including acknowledging and addressing the impact of structural racism and other systems of oppression on staff). 1c. Provide opportunities for ongoing dialogue, learning communities, and group reflection in internal BFHN and BCHAP meetings ensuring that principles and practices of healing-centered and restorative justice approaches are embedded in these meetings.		SPM 6: Percent of BFHN and BCHAP Title V staff that report a workplace culture that reflects a safe and supportive environment to mitigate primary and secondary trauma	

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	levels.	2a. Use existing surveillance data from NSCH, YHS, YRBS and PRAMS to analyze indicators of resilience and healing among the MCH population. 2b. Identify indicators of community factors that promote safe, stable, nurturing environments within communities to measure community capacity to support healing systems and approaches. 2c. Support communities in using data that reflects healing centered practices to inform community strategies that promote resilience and mitigate trauma. 2d. Ensure principles and practices of healing centered and trauma-informed engagement are embedded within program practices, data collection and reporting among DPH-funded programs within BFHN and BCHAP.			