

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Women/Maternal Health					
Ensure that all birthing people are in optimal health before, during, and after pregnancy	1. Distribute the Maryland Oral Health Guide 2020 through local health departments and other strategic partners. 2. Support the Office of Oral Health in providing education to prenatal providers on the importance of oral health during pregnancy. 3. Link pregnant people who are referred to the Maternal and Child Health Care Coordination at the Local Health Department to Oral Health resources.	Increase the number of people receiving preventive dental visits from a baseline of 28% to 36% by 2025.	NPM 13.1: Percent of women who had a preventive dental visit during pregnancy	ESM 13.1.1: Percentage of pregnant individuals aged 21 and older on medical assistance in Maryland who receive a preventive dental visit	<p>NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year</p> <p>NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system</p> <p>NOM 19: Percent of children, ages 0 through 17, in excellent or very good health</p>
Ensure that all birthing people are in optimal health before, during, and after pregnancy	1. Title V programs (e.g., Care coordination, home visiting, and other programs) will continue to refer pregnant people who smoke to the Maryland Tobacco Quitline and other smoking cessation programs. 2. The Maryland Family Planning Program will implement SBIRT (Screening, Brief Intervention, Referral to Treatment) with their subrecipient sites.	To increase the number of women who abstain from smoking tobacco during pregnancy from a baseline of 95.3% to 96.3% or more by 2025.	NPM 14.1: Percent of women who smoke during pregnancy	ESM 14.1.1: Number of pregnant individuals who use the statewide tobacco QuitLine	<p>NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations</p> <p>NOM 3: Maternal mortality rate per 100,000 live births</p> <p>NOM 4: Percent of low birth weight deliveries (<2,500 grams)</p> <p>NOM 5: Percent of preterm births (<37 weeks)</p> <p>NOM 6: Percent of early term births (37, 38 weeks)</p> <p>NOM 8: Perinatal mortality rate</p>

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					<p>per 1,000 live births plus fetal deaths</p> <p>NOM 9.1: Infant mortality rate per 1,000 live births</p> <p>NOM 9.2: Neonatal mortality rate per 1,000 live births</p> <p>NOM 9.3: Post neonatal mortality rate per 1,000 live births</p> <p>NOM 9.4: Preterm-related mortality rate per 100,000 live births</p> <p>NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births</p> <p>NOM 19: Percent of children, ages 0 through 17, in excellent or very good health</p>
<p>Ensure that all birthing people are in optimal health before, during, and after pregnancy</p>	<p>1. Improve linkages to care for substance use disorder treatment through implementing the electronic prenatal Risk Assessment with State Medicaid, Overdose Data to Action partners and updating the postpartum infant maternal referral form (PIMR) 2. Partner with Medicaid to improve linkages with the Managed Care Organizations through the Maternal Opioid Misuse Model. 3. Develop appendices of a Linkages to Care toolkit for providers of birthing people. 4. Monitor and understand opioid use trends through PRAMS Surveillance</p>	<p>To decrease the overdose mortality rate for women, age 15-49 from 24.1 per 100,000 to 22.9 per 100,000 by 2025.</p>	<p>SPM 1: Rate of overdose mortality for women ages 15-49</p>		
<p>Address the racial disparities in Severe Maternal Morbidity rates among Black</p>	<p>1. Implement expansion of programs that improve maternal health through the Statewide Integrated Health Improvement Strategy. 2. Implement the severe maternal hypertension bundle developed by the Alliance for Innovation on Maternal Health (AIM) in the Maryland Perinatal Neonatal Quality Collaborative (MDPQC). 3. Develop and implement a maternal health strategic plan by the Maternal Health Improvement Taskforce as part of the Maternal Health Innovation Program (MDMOM) 4. Ensure access</p>	<p>Decrease the excess rate of Black NH Severe Maternal Morbidity rate to White NH Severe Maternal Morbidity rate by 25% by 2026.</p>	<p>SPM 2: Excess rate between Black Non-Hispanic Severe Maternal Morbidity (SMM) events to White Non-Hispanic SMM events per 10,000 delivery hospitalizations</p>		

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NH and White NH	to the Maryland Family Planning Program. 5. Ensure access to Maternal, Infant, and Early Childhood Home Visiting. 6. Provide accessible patient centered family planning services through the Maryland Family Planning Program.				
Perinatal/Infant Health					
Ensure that all babies are born healthy and prosper in their first year	1. Continue with oversight of standardizing definitions for birthing hospitals levels of care through the Maryland Perinatal Standards of Care and with site visits for Level I, II, III, and IV birthing hospitals. 2. Provide maternal fetal medicine support and technical assistance through the Maryland Perinatal Support Program. 3. Continue to implement the maternal hypertension bundle and the neonatal antibiotic stewardship through the Maryland Perinatal-Neonatal Quality Collaborative. 4. Continue with The Maryland Health Innovation Program and Task Force to address maternal and perinatal health through data, policy, quality initiatives, training and telemedicine. 5. Continue with Surveillance Quality Initiatives such as Child Fatality Review and Fetal and Infant Mortality Review to identify systemic preventive factors.	Increase the percentage of very low birth weight babies delivered at an appropriate level hospital from 93.4% to greater than 95% by 2025.	NPM 3: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	ESM 3.1: Percentage of Level III & IV Perinatal Referral Centers who received their re-designations based on the 2019 MD Perinatal System Standards	NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births
Ensure that all babies are born healthy and prosper in their first year	1. Provide training for providers and encourage hospitals to adopt policies that are conducive to breastfeeding. 2. Provide breastfeeding education through home visiting, care coordination, and Babies Born Healthy.	Increase the number of infants who are ever breastfed from a baseline of 88.6% to 90% by 2025	NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	ESM 4.1: Number of birthing hospitals designated as breastfeeding friendly	NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
Ensure that all babies are born healthy and prosper in their first year	1. Assess the feasibility of implementing a Safe Sleep Communication Plan developed from Morgan State University's previous research, 2. Provide infant safe sleep education through Local Health Departments and Babies Born Healthy Sites. 3. Continue to support the Surveillance and Quality Improvement Program to gather information from mothers who had a fetal or infant loss through Fetal and Infant Mortality Review.	Increase the number of babies who are placed on their back to sleep as reported by PRAMS from 81.6% to 88.9% by 2025.	NPM 5: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding	<i>Inactive - ESM 5.1: Percentage of infants less than 6 months who are placed on their backs to sleep</i> ESM 5.2: Number of home visiting or care coordination clients, providers, and other	NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

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				Title V program participants that received infant safe sleep counseling and information	
Child Health					
Ensure that all children have an opportunity to develop and reach their full potential	1. Local health departments will educate parents on the importance of developmental screenings. 2. Track and monitor Medicaid data regarding developmental screenings.	Increase the percentage of children who receive a developmental screen from 40.9% to 46% by 2025.	NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	ESM 6.1: Number of parents who receive information/education on the importance of developmental screenings from Home Visiting and Care Coordination Title V providers	NOM 13: Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
Ensure that all children have an opportunity to develop and reach their full potential	1. Continue to monitor and track receipt of primary care in early childhood through Medicaid data. 2. Coordinate with local health departments to provide primary care services such as childhood vaccinations, and vision and hearing screenings. 3. Home visiting programs will continue to promote primary care. 4. Support school based health centers to deliver primary care to children.	Increase the percentage of children receiving at least five well visits by fifteen months from 67% to 73% by 2025.	SPM 3: Receipt of Primary Care During Early Childhood		
Ensure children with asthma and their families have the tools and supports necessary to manage their condition so that it does not impede their daily activities	1. Support asthma home visiting through the local health departments and in collaboration with the Environmental Health Bureau. 2. Support School Based Health Centers (transfer to MDH in 2022) 3. Support regional asthma collaborations to coordinate asthma related activities. 4. Partner with CRISP (HIE) to strengthen linkages amongst pediatric care teams including school health providers, EDs, primary care, and specialists.	Decrease the number of asthma ED visits per 1,000 for ages, 2-17 from 9.2 to 5.3 by 2026.	SPM 4: Number of Asthma Emergency Room Visits per 1,000 for Children age 2-17 with a primary diagnosis of asthma		
Adolescent Health					
Ensure that	1. Continue the Healthy Kids Program under the EPSDT Program to	Increase the percentage of	NPM 10: Percent of	ESM 10.1: Number of	NOM 16.1: Adolescent mortality

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<p>adolescents age 12-17 receive comprehensive well visits that address physical, reproductive, and behavioral health needs.</p>	<p>enhance the quality of health services delivered by Medicaid providers. 2. Continue the Sexual Risk Avoidance Education grant program to promote sexual risk avoidance. 3. Continue the Personal Responsibility and Education Program to promote positive youth development. 4. Implement the Maryland Optimal Adolescent Health Program to reduce teen pregnancy. 5. Continue to support local health departments school based health services. 6. Support the network of school based health centers across the state.</p>	<p>adolescents (12-17) who receive a preventive medical visit from a baseline of 81.4% to 85% by 2025.</p>	<p>adolescents, ages 12 through 17, with a preventive medical visit in the past year.</p>	<p>adolescent (12-17) who receive well visits through school health services and school-based health centers.</p>	<p>rate ages 10 through 19, per 100,000</p> <p>NOM 16.2: Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000</p> <p>NOM 16.3: Adolescent suicide rate, ages 15 through 19, per 100,000</p> <p>NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system</p> <p>NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling</p> <p>NOM 19: Percent of children, ages 0 through 17, in excellent or very good health</p> <p>NOM 20: Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)</p> <p>NOM 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza</p> <p>NOM 22.3: Percent of</p>

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					<p>adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine</p> <p>NOM 22.4: Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine</p> <p>NOM 22.5: Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine</p> <p>NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females</p>

Children with Special Health Care Needs

<p>To improve the health of children and youth with special health care needs through early identification, comprehensive, and coordinated care, and to support their successful transition to adult health</p>	<p>1. Increase access to care coordination services. 2. Identify opportunities with MD's health information exchange to collect utilization data and analyze it to identify family centered medical home (FCMH) needs. 3. Improve access to information about FCMH resources and services through OGPSHCN newsletter. 4. Ensure care coordination service providers emphasize the benefits of a FCMH. 5. Ensure input on work from diverse stakeholders and persons with lived experience through family professional partnership grants and Maryland CYSHCN Advisory Council. 6. Improve the health literacy of all public facing materials. 7. Collaborate with Genetic Centers who serve Maryland families. 8. Ensure that children with sickle cell disease (SCD) are enrolled in a FCMH through the SCD Follow up Program and in collaboration with the SCD Steering Committee Members. 9. Identify an AMCHP Family Delegate to provide feedback on work and improve enrollment in a FCMH. 10. Conduct provider trainings on FCMH.</p>	<p>Increase the proportion of children and adolescents with special health care needs who receive care in a family-centered, comprehensive, and coordinated system.</p>	<p>NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home</p>	<p>ESM 11.1: Number of CYSHCN who receive patient and family-centered care coordination services</p>	<p>NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system</p> <p>NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling</p> <p>NOM 19: Percent of children, ages 0 through 17, in excellent or very good health</p> <p>NOM 25: Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year</p>
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<p>To improve the health of children and youth with special health care needs through early identification, comprehensive, and coordinated care, and to support their successful transition to adult health</p>	<p>1. Ensure transition-age CYSHCN enrolled in the OGPSHCN care coordination services have a healthcare transition (HCT) plan. 2. Identify potential partnership opportunities with MD’s health information exchange to collect HCT data on CYSHCN and analyze it to identify needs regarding HCT. 3. Improve access to information about HCT resources and services for both families of CYSHCN and stakeholders through the OGPSHCN Newsletter. 4. Ensure input on OGPSHCN work from a diverse group of stakeholders and persons with lived experience through Family Professional Partnership request for applications and the Maryland CYSHCN Advisory Council. 5. Improve the health literacy of all public facing material for the OGPSHCN. 6. Provide HCT information to transition age youth with sickle cell disease. 7. Identify an AMCHP Family Delegate to provide feedback on OGPSHCN’s work from a person with lived experience to solicit input on improving HCT. 8. Conduct provider training on HCT.</p>	<p>Increase the proportion of adolescents with and without special health care needs who have received the services necessary to make transitions to adult health care.</p>	<p>NPM 12: 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</p>	<p>ESM 12.1: Number of CYSCHN and their families who participate in health care transition planning activities</p>	<p>NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system</p>
Cross-Cutting/Systems Building					
<p>Ensure that MCHB policies and processes are centered on equity and anti-racism principles</p>	<p>1) Continue to convene the MCHB Equity Work Group, 2) Facilitate a webinar and/or training related to disparities in maternal and child health, which will be open to internal and external stakeholders, 3) Conduct an internal assessment of family engagement using an evaluation tool, 4) Work towards stakeholders of committees/workgroups represent racially, ethnically, and geographically diverse communities (ex. FIMR Teams) through assessment and creation of tools/guidance/templates that support the development of committees/workgroups that are diverse , 5) Recruitment and onboarding of an Advanced Health Policy Analyst and Outreach Manager. A part of this person’s role will convene the MCHB Equity workgroup to help implement a plan to help Title V further focus on equity, 6) request grantees to disaggregate data by race and ethnicity to better understand health disparities, 7) Participate in the Root Causes of Health Initiative (ROCHI), an initiative led by the Institute for Healthcare.</p>	<p>To increase the percentage of MCHB committees/workgroups that include community members/persons with lived experiences from a baseline of 18% to at least 50% by 2025.</p>	<p>SPM 5: Cross-Cutting Measure: Percentage of MCHB committees/workgroups that include community members/persons with lived experience</p>		