Maryland State Action Plan Table 2025 Application/2023 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Ensure that all birthing people are in optimal health before, during, and after pregnancy	Increase the number of people receiving preventive dental visits from a baseline of 28% to 36% by 2025.	1. Distribute the 2024 Maryland Oral Health Resource Guide to Title V Partners 2. Disseminate the 2022 Pregnancy guidance document to provide 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.	ESM PDV-Pregnancy.1 - Percentage of pregnant individuals aged 21 and older on medical assistance in Maryland who receive a preventive dental visit	NPM - Percent of women who had a dental visit during pregnancy (Preventive Dental Visit - Pregnancy, Formerly NPM 13.1) - PDV-Pregnancy	NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC 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 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Ensure that all birthing people are in optimal health before, during, and after pregnancy	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.	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. 3. Collaborate with the Center for Tobacco Control and Prevention to update a tobacco cessation toolkit for OB/GYN providers.	ESM SMK-Pregnancy.1 - Number of pregnant individuals who use the statewide tobacco QuitLine	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 deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) -

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					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 Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly

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					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
Ensure that all birthing people are in optimal health before, during, and after pregnancy	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.	1. Improve linkages to care for substance use disorder treatment through implementing the electronic prenatal Risk Assessment with State Medicaid and the postpartum infant maternal referral form (PIMR) 2. Develop and start a Perinatal Mental Health Training Hub to increase the number of providers certified with Postpartum Support International. 3. Partner and fund with the Maryland MACS for MOM to provide training, ECHO learning cohorts, and a warm consultation line for providers. 4. Transition the programs under the Office of Gender Specific Services that includes funds for residential treatment providers and recovery houses to the Maternal and Child Health Bureau to further build upon Goal 3 of the Women's Health Action plan. 5. Monitor and understand opioid use trends through PRAMS Surveillance		SPM 1: Rate of overdose mortality for women ages 15-49	
Address the racial disparities in Severe Maternal Morbidity rates among Black NH and White NH	Decrease the excess rate of Black NH Severe Maternal Morbidity rate to White NH Severe Maternal Morbidity rate by 25% by 2026.	1. Address maternal health inequities through the Women's Health Action Plan that was released in May 2024. 2. Expand reproductive health services and protect reproductive health rights through increasing access and availability of on-demand contraceptive care and the Family Planning Program. 3. Advance birth equity through partnership with philanthropic funders in a newly formed Birth Equity Funders Collaborative 4. Partner with Maryland Medicaid to support the expansion of programs such as CenteringPregnancy, doulas reimbursement, home visiting expansion. 5. Implement the hemorrhage safety bundle to address the leading cause of Black Maternal mortality and morbidity, and partner with the Bloom Collective to center reproductive justice lens in bundle implementation. 6 Expand the Maternal, Infant, and Early Childhood Home visiting program from 10 jurisdictions to 16. 7. Develop a birthing hospital report card as required by the Maternal Health Act/SB 1059.		SPM 2: Excess rate between Black Non-Hispanic Severe Maternal Morbidity (SMM) events to White Non-Hispanic SMM events per 10,000 delivery hospitalizations	
Ensure that all birthing people are in optimal health before, during, and after pregnancy	Increase the proportion of birthing people who attend their postpartum appointment to over 95% by 2030.	1. Participate in the Health and Human Services Postpartum collaborative to address the leading causes of readmission with a healthcare system. 2. Expand the Maternal, Infant, and Early Childhood Home Visiting program from 10 jurisdictions to 16. 3. Increase completion of the Postpartum Infant Maternal Referral Forms to increase linkages to resources at the local health department and community-based resources. 4. Promote the	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	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.

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		expansion of Medicaid coverage postpartum from 60 days to 12 months as well as Healthy Babies Equity Act which provides Medicaid coverage for pregnant individuals regardless of their immigration status.		attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV	
Perinatal/Infant Health					
Ensure that all babies are born healthy and prosper in their first year	Increase the percentage of very low birth weight babies delivered at an appropriate level hospital from 93.4% to greater than 95% by 2025.	1. Finalize and disseminate the updated Maryland Perinatal Standards of Care for Level I, II, III, and IV birthing hospitals 2. Implement the maternal hemorrhage bundle and the neonatal hypoglycemic bundle through the Maryland Perinatal-Neonatal Quality Collaborative. 3. Center the reproductive justice lens and Black holistic care through partnership with the Bloom Collective to provide technical assistance and deliver trainings. 4. Participate in the HHS postpartum collaborative that will focus on addressing maternal hypertensive disorders of pregnancy with pilot hospital (s). 5. Prepare for the 2024-2025 RSV season through the development of toolkits and partnerships with prenatal providers, pediatricians, and pharmacies, and through participation of birthing hospitals with Vaccines for Children Program. 6. Update the Maryland Health Improvement Program TaskForce's Strategic Plan from 2021 through partnership with the Maternal Health Learning and Improvement Center and Task Force mem	ESM RAC.1 - Percentage of Level III & IV Perinatal Referral Centers who received their re-designations based on the 2019 MD Perinatal System Standards	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
Ensure that all babies are born healthy and prosper in their first year	Increase the number of infants who are ever breastfed from a baseline of 88.6% to 90% by 2025	1.Provide training for providers and encourage hospitals to adopt policies that are conducive to breastfeeding. 2. Disseminate pre-recorded trainings on the benefits of and ways to support breast feedings to home visitors, care coordinators, doulas, and other MCH workforce. 3. Disseminate resources for parents and families through Title V staff, home visitors and care coordinators.	ESM BF.1 - Number of birthing hospitals designated as breastfeeding friendly	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

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					NOM 9.5) - IM-SUID
Ensure that all babies are born healthy and prosper in their first year	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.	1. Provide infant safe sleep education and resources to birthing hospitals through Local Health Departments as newly required through Senate Bill 59, Hospitals: Care of Infants after Discharge 2. Identify an organization to provide further safe sleep communications and technical assistance and host a conference to discuss strategies to support infant safe sleep. 3. Continue to support the Surveillance and Quality Improvement Program to gather information from mothers who had a fetal or infant loss through the Fetal and Infant Mortality Review process.	***Inactive -*** *ESM SS.1 - Percentage of infants less than 6 months who are placed on their backs to sleep* ESM SS.2 - Number of home visiting or care coordination clients, providers, and other Title V program participants that received infant safe sleep counseling and information	NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS	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					
Ensure that all children have an opportunity to develop and reach their full potential	Increase the percentage of children who receive a developmental screen from 40.9% to 46% by 2025.	1.Provide education on the importance of developmental screenings through local health department care coordinators. 2. Partner with Maryland MIECHV to increase the number of developmental screens conducted. 3 Track and monitor Medicaid data regarding developmental screenings.	ESM DS.1 - Number of parents who receive information/education on the importance of developmental screenings from Home Visiting and Care Coordination Title V providers	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
Ensure that all children have an opportunity to develop and reach their full potential	Increase the percentage of children receiving at least five well visits by fifteen months from 67% to 73% by 2025.	1. Coordinate with local health departments to provide primary care services such as childhood vaccinations, and vision and hearing screenings. 2. Partner with perinatal care coordinators and home visiting programs to promote primary care. 3.Continue to monitor and track receipt of primary care in early childhood through Medicaid data.		SPM 3: Receipt of Primary Care During Early Childhood	

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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	Decrease the number of asthma ED visits per 1,000 for ages, 2-17 from 9.2 to 5.3 by 2026.	1. Support asthma home visiting through the local health departments and in collaboration with the Environmental Health Bureau. 2. Increase access to primary care through the School Based Health Center Program 3. Assist in the implementation of House Bill 86 that authorizes a stock bronchodilator program in Maryland schools by developing policies. 4. Support regional asthma collaborations to coordinate asthma related activities. 5. Partner with CRISP (HIE) to strengthen linkages amongst pediatric care teams including school health providers, EDs, primary care, and specialists.		SPM 4: Number of Asthma Emergency Room Visits per 1,000 for Children age 2-17 with a primary diagnosis of asthma	
Ensure that all children have an opportunity to develop and reach their full potential	Increase the percentage of children who have a medical home.	1. Support and expand the network of school-based health centers. 2. Develop partnerships between primary care providers (PCPs) and school-based health centers (SBHC) to create an expanded medical home model based on care coordination and increase access to care. 3. Collaborate with the FQHCs and the Mid-Atlantic Association of Community Health Centers to increase access to medical care for children.	ESM MH.1 - Number of CYSHCN who receive patient and family-centered care coordination 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

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Adolescent Health					
Ensure that adolescents age 12-17 receive comprehensive well visits that address physical, reproductive, and behavioral health needs.	Increase the percentage of adolescents (12-17) who receive a preventive medical visit from a baseline of 81.4% to 85% by 2025.	1. Support and expand the network of school-based health centers. 2. Continue the Healthy Kids Program under the EPSDT to enhance the quality of health services delivered by Medicaid providers. 3. Address the increase in adolescence suicide through partnership with the Office of Suicide Prevention and disseminating 988 Suicide Crisis and Lifeline toolkit. 4.Continue the Sexual Risk Avoidance Education grant program to promote sexual risk avoidance. 5. Continue the Personal Responsibility and Education Program to promote positive youth development. 6. Implement the Maryland Optimal Adolescent Health Program to reduce teen pregnancy.	ESM AWV.1 - Number of adolescent (12-17) who receive well visits through school health services and school-based health centers.	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

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					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

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Children with Special Health Care Needs					
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	Increase the proportion of children and adolescents with special health care needs who receive care in a family-centered, comprehensive, and coordinated system.	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 OCYSHCN 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.Work with AMCHP Family Delegate to provide feedback on work and improve enrollment in a FCMH. 10. Conduct provider trainings on FCMH.	ESM MH.1 - Number of CYSHCN who receive patient and family-centered care coordination 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
To improve the health of children and youth with special health care needs through early identification, comprehensive, and coordinated	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.	1. Ensure transition-age CYSHCN enrolled in OCYSHCN grant-funded care coordination services have a healthcare transition (HCT) plan. . Improve access to information about HCT resources and services for both families of CYSHCN and stakeholders through the OCYSHCN Newsletter. 3. Ensure input on OCYSHCN work from a diverse group of stakeholders and persons with lived experience through the Maryland CYSHCN Advisory Council. 4. Improve the health literacy of all public facing material for the OCYSHCN. 5. Provide HCT information to transition age youth with sickle cell disease. 6. Work with the AMCHP Family Delegate to provide feedback on OCYSHCN's work from a person with lived experience to solicit input on improving HCT. 7. Conduct provider training on HCT. 8.	ESM TR.1 - Number of CYSCHN and their families who participate in health care transition planning activities	NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

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care, and to support their successful transition to adult health		Conduct family trainings on HCT and related topics.			
Cross-Cutting/Systems Building					
Ensure that MCHB policies and processes are centered on equity and anti-racism principles	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.	1) Assess the various committees within the Bureau, review the authorizing statute, and determine ways within the State's procurement and contracting system to compensate members 2) Partner with the Department's Office of Appointments and Executive Nominations to share committee recruitments broadly 3) Facilitate a webinar and/or training related to disparities in maternal and child health, which will be open to internal and external stakeholders, 4) Assess and develop tools/guidance/templates that support the development of committees/workgroups that are diverse, 5) Partner with philanthropic organizations through the Birth Equity Funders Alliance to catalyze community engagement and solutions		SPM 5: Cross-Cutting Measure: Percentage of MCHB committees/workgroups that include community members/persons with lived experience	