Maryland State Action Plan Table 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
Women/Maternal Health					
Ensure that all women are in optimal health before, during, and after pregnancy.	Objective 1. By 2030, increase the attendance rate for women at their postpartum visit to 97 percent. Objective 2. By 2030, increase the percentage of women who attend a postpartum checkup and receive a depression screening.	(1) Align state and local programs towards a standardized, systematic approach for perinatal care coordination; (2) Improve early identification of postpartum depression and other perinatal mood and anxiety disorders through increased screening and patient education; (3) Ensure that Perinatal home visiting and care coordination programs appropriately address and consider social and behavioral health needs in their services; (4) Partner with Maryland Medicaid to support MCH programming	ESM PPV.1 - Percent 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 - Postpartum Visit	**Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety
Address drivers for Severe Maternal Morbidity (SMM), with a focus on chronic conditions and comorbidities.	By 2030, maintain at least 95 percent participation of birthing hospitals to implement MDPQC AIM Bundle	Support clinical staff in addressing the drivers of SMM	No ESMs were created by the State. ESMs are optional for this measure.	SPM 3: Percent of birthing hospitals that report implementing 3 or more AIM bundle elements by the end of year 1 of the initiative	
Perinatal/Infant Health					
Ensure that all babies have the best possible start and thrive in their first year.	By 2030, increase the number of babies who are placed on their back to sleep as reported by PRAMS from a baseline of 83.7 percent to the Healthy People 2030 target of 88.9 percent.	Promote safe sleep practices among newborns to reduce sleep-related infant deaths.	***Inactive -*** *ESM SS.1 - Number of home visiting or care coordination clients, providers, and other Title V program participants that received infant safe*	NPM - Safe Sleep	**Linked NOMs:** Infant Mortality Postneonatal Mortality SUID Mortality

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			sleep counseling and information ESM SS.2 - Percent of birthing hospitals that give out safe sleep education per the Safe Sleep Act ESM SS.3 - Number of safe sleep materials disseminated by LHDs		
Ensure that all babies have the best possible start and thrive in their first year.	By 2030, increase the number of infants who are ever breastfed to 92 percent.	Cultivate a multifaceted community of professional lactation support through education and training opportunities across health care disciplines.	***Inactive -*** *ESM BF.1 - Number of birthing hospitals designated as breastfeeding friendly* ESM BF.2 - Percent of home visiting and care coordination LDH staff that report increased knowledge of breastfeeding best practices	NPM - Breastfeeding	**Linked NOMs:** Infant Mortality Postneonatal Mortality SUID Mortality
Ensure that all babies have the best possible start and thrive in their first year.	By 2030, ensure that all local health departments maintain a 90% review rate of cases received from the Office of the Chief Medical Examiner.	Coordinating a robust child and infant mortality review process to understand the drivers of deaths and develop and implement recommendations to prevent mortality and near fatality.			
Child Health					
Ensure that culturally congruent, comprehensive physical, social, and	By 2030, increase the percentage of children, ages 0 through 17, who have a medical home to 50 percent.	(1) Strengthen Childhood and Adolescent Immunization Coverage through School-Integrated and Family-Centered Approaches; (2) Strengthen Systems of Care through School-Health and Community-Health Integration and partnerships; (3) Strengthen systems for vision care follow-up and receipt of services.	ESM MH.1 - Number of CYSHCN receiving care coordination services via Title V programming	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN

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mental health services are available to every child in Maryland when they need them.			ESM MH.2 - Number of children served by MCH Programs who report having a medical home		Flourishing - Child Adolescent - All
Adolescent Health					
Ensure that adolescents age 12-17 receive developmentally appropriate, youth-centered, comprehensive health care that addresses holistic needs.	By 2030, increase the percentage of adolescents, ages 12 through 17, who have a medical home to 50 percent.	Expand Access to Preventive Care and Strengthen Integration of School-Based Health Centers	ESM MH.1 - Number of CYSHCN receiving care coordination services via Title V programming ESM MH.2 - Number of children served by MCH Programs who report having a medical home	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Ensure that adolescents age 12-17 receive developmentally appropriate, youth-centered, comprehensive health care that addresses holistic needs.	By 2030, increase the percentage of adolescents, ages 12 through 17, who receive needed mental health treatment from baseline 86.6 percent (2022-2023) to 88 percent.	Enhance Access to Integrated Behavioral Health and Support Positive Youth Development in School and Community Settings	ESM MHT.1 - Percent of students enrolled in SBHCs with a positive depression screening who have a documented plan of care	NPM - Mental Health Treatment	**Linked NOMs:** Adolescent Mortality Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Children's Health Status Adolescent Depression/Anxiety CSHCN Systems of Care Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Ensure that adolescents age 12-17 receive developmentally appropriate,	By 2030, decrease the rate of Asthma ED visits from a baseline of 7.5 per 1,000 visits for ages 2-17 to 6.5 per 1,000 visits.	Strengthen Systems of Care for School and Community-Based Asthma Management	No ESMs were created by the State. ESMs are optional for this measure.	SPM 1: Number of Asthma Emergency Room Visits per 1,000 for Children age 2-17 with a primary diagnosis of asthma	

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youth-centered, comprehensive health care that addresses holistic needs.					
Children with Special Health Care Needs					
Maximize the health outcomes of children and youth with specific health care needs through family-centered, comprehensive and coordinated care (CYSHCN).	By 2030, increase the number of CYSHCN, ages 0-17, who receive care coordination services by 20 percent over baseline.	(1) Increase access to care coordination services. (2) Ensure care coordination services are standardized across the state	ESM MH.1 - Number of CYSHCN receiving care coordination services via Title V programming ESM MH.2 - Number of children served by MCH Programs who report having a medical home ESM MH_FCC.1 - Number of health care professionals participating in family-centered care education	NPM - Medical Home; Medical Home_Care Coordination; Medical Home_Family Centered Care	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Maximize the health outcomes of children and youth with specific health care needs through family-centered, comprehensive and coordinated care (CYSHCN).	By 2030, increase the percentage of CYSHCN, ages 0-17, who receive family-centered care by 11 percent over baseline.	(1) Educate providers about family centered care and the medical home; (2) Model the family centered care approach within the Title V CYSHCN office; (3) Increase access to information and services from the Title V CYSHCN office; (4) Collaborate with other organizations to improve services and supports that CYSHCN receive; (5) Collaborate with other organizations to improve services and supports that CYSHCN receive; (6) Collect data to inform future strategies addressing CYSHCN needs.	ESM MH.1 - Number of CYSHCN receiving care coordination services via Title V programming ESM MH.2 - Number of children served by MCH Programs who report having a medical home ESM MH_FCC.1 - Number of health care professionals	NPM - Medical Home; Medical Home_Care Coordination; Medical Home_Family Centered Care	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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			participating in family-centered care education		
Ensure a successful transition from pediatric health care to adult health care.	By 2030, increase the percentage of YSHCN, ages 12-17, who receive services to prepare for the transition to adult health care by 20% over baseline by 2030.	(1) Ascertain the state of health care transition needs within the state of Maryland; (2) Collaborate with other organizations to improve services and supports that YSHCN receive; (3) Collect data to inform future strategies addressing YSHCN needs.	***Inactive -*** *ESM TAHC.1 - Number of CYSCHN and their families who participate in health care transition planning activities* ESM TAHC.2 - Number of strategies developed to address issues for adolescents transitioning from pediatric to adult health care	NPM - Transition To Adult Health Care	**Linked NOMs:** CSHCN Systems of Care
Cross-Cutting/Systems Building					
Ensure that MCHB policies and processes are centered on data and experiences of Maryland's population to address differing health needs.	By 2030, increase the percentage of people with contextual and community expertise within MCHB committees, workgroups, and advisory boards by 75 percent.	(1) Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration; (2) MCHB Workforce Development; (3) Increase meaningful participation of people with contextual experience and community expertise within MCHB committees, program design, implementation, and evaluation.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 2: Percentage of MCHB committees/workgroups that include community members/persons with contextual experience and community expertise	
Support the integration of mental health and emotional well-being approaches for the MCH	By 2027, complete a landscape analysis on the state of mental health and emotional well-being integration within MCHB programs across the life course and develop 2-3 strategies.	(1) Develop a data-informed approach to mental health and emotional well-being within Title V and MCHB programs; (2) Conduct a landscape analysis of how mental health and emotional well-being are integrated into MCHB and Title V programs across the life course, to inform program decisions on integration support needs.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 4: Increase the integration of mental health and emotional well-being approaches across Title V and MCHB programs throughout the life course.	

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population across the life course.					