Maryland State Action Plan Table 2023 Application/2021 Annual Report

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	NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
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	NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations NOM 3: Maternal mortality rate per 100,000 live births NOM 4: Percent of low birth weight deliveries (<2,500 grams) NOM 5: Percent of preterm births (<37 weeks) NOM 6: Percent of early term births (37, 38 weeks) NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths

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					NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
Ensure that all birthing people are in optimal health before, during, and after pregnancy	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 lnkages 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	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.	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	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 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	Decrease the excess rate of Black NH Severe Maternal Morbidity rate to White NH Severe Maternal Morbidity rate by 25% by 2026.	SPM 2: Excess rate between Black Non-Hispanic Severe Maternal Morbidity (SMM) events to White Non-Hispanic SMM events per 10,000 delivery hospitalizations		

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	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 feasability of implementing a Safe Sleep Communication Plan developed from Morgan State University's previous research, 2. Provide infant safe sleep eductation 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	***Inactive -** ESM 5.1: Percentage of infants less than 6 months who are placed on their backs to sleep* ESM 5.2: Number of home visiting or care coordination clients, providers, and other Title V program participants that received infant safe sleep counseling and	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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				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 adolescents age 12-17 receive comprehensive	1. Continue the Healthy Kids Program under the EPSDT Program to 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	Increase the percentage of adolescents (12-17) who receive a preventive medical visit from a baseline of 81.4% to 85% by 2025.	NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.	ESM 10.1: Number of adolescent (12-17) who receive well visits through school based health centers	NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000 NOM 16.2: Adolescent motor

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well visits that address physical, reproductive, and behavioral health needs.	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.				vehicle mortality rate, ages 15 through 19, per 100,000 NOM 16.3: Adolescent suicide rate, ages 15 through 19, per 100,000 NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling NOM 19: Percent of children, ages 0 through 17, in excellent or very good health 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) NOM 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza NOM 22.3: Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine NOM 22.4: Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine NOM 22.5: Percent of adolescents, ages 13 through 17, who have

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					received at least one dose of the meningococcal conjugate vaccine NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
Children with Special Health Care Needs					
Ensure optimal health and quality of life for all CYSHCN and their families by providing all services within an effective system of care in alignment with the Six Core Outcomes	1) Encourage implementation of the Medical Home model in pediatric primary care practices through education and training opportunities, particularly with providers-in-training and early career providers to inform and educate about the medical home, and to provide some practical tips on how to implement a medical home in their practice. 2) Discuss expansion, replication, and sustainability of medical home-focused initiatives currently underway by current OGPSHCN grantees who were awarded under the 2020 competitive request for applications. 3) Educate family members on factors of the medical home they can control: recognizing good medical care; engaging in clear and respectful communication, and effective advocacy for their CYSHCN 4) Conduct trainings for families on resource , identification and advocacy, 5) Continue to seek opportunities to provide family sensitivity trainings to internal and external partners who serve CYSHCN 6) Implement a schedule to review and edit all public-facin	Increase the proportion of children and adolescents with special health care needs who receive care in a family-centered, comprehensive, and coordinated system.	NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	ESM 11.1: Number of CYSHCN who receive patient and family-centered care coordination services	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 25: Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year
Ensure optimal health and quality of life for all CYSHCN and their families	1) Increase and enhance parent/family education and training around HCT, 2) Implement the Six Core Elements of Healthcare Transition 3.0, 3) Promote Got Transition's "Six Core Elements" to transition and principles of successful transition, 4) Continue to provide information and resources for youth to young adult health care transition through the Office of Genetics and People with Special Health Care Needs (OGPSHCN), 5)	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.	NPM 12: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition	ESM 12.1: Number of CYSCHN and their families who participate in health care transition planning activities	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

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by providing all services within an effective system of care in alignment with the Six Core Outcomes	Establish a collaborative relationship with the Governor's Transitioning Youth Initiative (GTYI), coordinated through the Maryland Developmental Disabilities Administration (DDA), 6) Explore strategies to engage families in the transition process for their youth with special health care needs, 7) explore how information from the National Resource Center for Supported Decision Making and other organizations, as well as feedback from self-advocates, can be incorporated into HCT materials, 8) review resources related to sex education for CYSHCN, 9) Establish training prot		to adult health care		
Cross-Cutting/Systems Building					
Ensure that MCHB policies and processes are centered on equity and anti-racism principles	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.	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.	SPM 5: Cross-Cutting Measure: Percentage of MCHB committees/workgroups that include community members/persons with lived experience		