State Action Plan Table (Massachusetts)						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Promote equitable access to preventive health care including sexual and reproductive health services.	1. By 2020, increase by 5% from baseline (74.3%, 95% CI [71.6 - 76.9] from BRFSS) the percent of women (ages 18-44) with a past year preventive visit. 2. By 2020, increase by 10% from baseline the percentage of women who receive contraception among MassHealth participants (baseline and increase to be determined from MassHealth data). 3. By 2020, increase by 10% from baseline the percentage of women who participate in MassHealth who receive a postpartum visit (baseline and increase to be determined from MassHealth data).	1a. Establish baseline measures with MassHealth (Medicaid) for the number of women who received a preventive visit within the past year. 1b. Work with MassHealth to increase preventive visits among MassHealth participants. 2. Work with MassHealth to increase Effective Contraceptive Counseling according to CDC guidelines. 3. Work with MassHealth to increase postpartum visits (MassHealth has several quality improvement projects underway to promote the postpartum visit including expanding	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks)	Percent of women with a past year preventive medical visit		

		outreach to participating women and improving billing systems for providers).	Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births			
Address substance use among women of reproductive age to improve individual and family functioning.	1. By 2020, increase by 3 per year the number of birth hospitals (out of 47 total) with consistently implemented maternal substance use / Substance Exposed Newborns (SEN) screening guidelines (baseline and change to be determined by surveying birth hospitals). 2. By 2020, increase by	1a. Convene an advisory group of MDPH and community partners to guide action on the maternal substance use priority. 1b. Survey hospitals about current substance use screening and breastfeeding policies for substance using mothers, and consistency of policy implementation in order to establish a baseline.				

	3 per year the number of birth hospitals (out of 47 total) that develop and implement a plan to improve services for women with substance exposed pregnancies (baseline and change to be determined by surveying birth hospitals). 3. By 2020, through increased use of non-pharmacologic interventions, decrease by 20% the number of infants in MA at risk for NAS needing pharmacologic therapy (baseline and change to be determined by surveying birth hospitals). 4. By 2020, increase by 50% the number of birth	1c. Disseminate Guidelines for Community Standard for Maternal / Newborn Screening (MDPH SEN Guidelines) to hospitals and community health centers. 1d. Identify strategies to implement the MDPH SEN Guidelines in pilot sites. 1e. Use lessons learned from pilot sites to develop best practices / tool kits and disseminate statewide. 1f. Collaborate with the MA Neonatal Quality Collaborative (NeoQIC) to identify Continuous Quality Improvement (CQI) initiatives related to screening.				

	hospitals (out of 47 total) that establish a referral system to Early Intervention (EI) for all SEN infants before or at the time of discharge (baseline and change to be determined by surveying birth hospitals).	2a. Establish a Maternal Substance Use Action Learning Collaborative that will use CQI strategies to improve the service system for women using substances in pregnancy, including screening, referral, and treatment. 2b. Identify and disseminate best practices for ensuring postpartum recovery and parenting support for mothers with substance use disorders, including methods for establishing services for mothers before hospital discharge. 3a. Partner with the Massachusetts Perinatal and Neonatal Quality Collaborative (MPNQC) on a CQI collaborative among birth hospitals to develop and disseminate best practice guidelines and				

		educational materials for SEN, based on toolkits of potentially better practices around the care of infants at risk for NAS. Toolkits have already been developed through partnership with the Vermont Oxford Network (VON), the Ohio Perinatal Quality Collaborative and the Northern New England Perinatal Quality Improvement Network. 3b. Partner with NeoQIC and MA Breastfeeding Coalition to develop Breastfeeding guidelines for mothers who use substances and disseminate these guidelines to all birthing hospitals. 3c. Conduct follow-up survey of hospitals after the implementation of breastfeeding for SEN guidelines to evaluate substance screening rates and breastfeeding practices, and provide				

		hospital support to increase guideline implementation. 4a. Survey hospitals about current Early Intervention referrals to establish a baseline. 4b. Partner with NeoQIC and EI on a quality improvement collaborative to establish a mechanism for referral to services including EI for all SEN infants before or at discharge at three pilot sites. Proposed sites are Beth Israel Deaconess Medical Center, Massachusetts General Hospital, and University of Massachusetts Memorial Hospital. 4c. Develop best practices / toolkits using lessons learned from these three pilot sites and replicate at all 47 birthing hospitals. 4d. Survey hospitals to determine change in referral systems to EI to				

		evaluate success of new referral mechanism for SEN infants.				

State Action Plan Table (Massachusetts)						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Improve environments, systems, and policies to promote healthy weight, nutrition, and active living.	1. By 2020, increase by 5% from baseline (83.0% in 2013, NIS data) the percent of infants who are ever breastfed (to 87.0%). The HP2020 goal is 81.9%. 2. By 2020, increase to 75% from baseline [65.0% in 2013, Vermont Oxford Network (VON) data] the percentage of very low birth weight (VLBW) infants in the neonatal intensive care unit (NICU) receiving any breast milk at time of discharge or transfer. [Hospital specific data will also be collected.] 3. By 2020, increase by	1a. Continue to provide breastfeeding promotion and support education and training to all WIC staff and home visitors. 1b. Improve data quality about reporting of breastfeeding on the birth certificate at time of discharge by sharing birth certificate data with all 47 birthing hospitals and conducting a root-cause analysis of challenges to accurate reporting. 1c. Collaborate with Mass. Breastfeeding Coalition (MBFC) to support hospital policies that promote breastfeeding.	Post neonatal mortality rate per 1,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months		

	10% from baseline (20.6% in 2013, NIS data) the percentage of infants exclusively breastfed to 6 months (to 22.7%).	1d. Release updated WIC breastfeeding guidelines to all 47 birth hospitals to promote consistent messaging about breastfeeding.				
		1e. Engage hospitals to endorse MDPH's Breastfeeding guidelines.				
		2a. Establish baseline measures for the percentage of very low birth weight (VLBW) infants in the neonatal intensive care unit (NICU) receiving any breast milk at time of discharge or transfer.				
		2b. Review, share and promote existing toolkits developed by other Perinatal Quality Collaboratives to promote VLBW infants in NICU receiving any breast milk at time of discharge or transfer.				
		2c. Build data systems to support rapid data collection of breast milk metrics.				

		3a. Continue to provide breastfeeding promotion, support, education and training to all WIC staff and home visitors to promote breastfeeding continuation. 3b. Increase the percentage of WIC nutrition staff who have advanced credentials for breastfeeding [International Board Certified Lactation Consultant (IBCLC) / Certified Lactation Consultant (CLC)] 3c. Increase availability of IBCLCs / CLCs available within WIC offices to support breastfeeding mothers.				
Promote safe, stable, nurturing environments	1. By 2020, increase 5% above baseline	1a. Establish baseline measures for all NICU	Infant mortality rate per 1,000 live births	Percent of infants placed to sleep on their		

to reduce violence and the risk of injury.	(80.0% in 2012, PRAMS data), the percent of infants placed to sleep on their backs (supine). 2. By 2020, increase 5% above baseline the percent of infants who sleep in a safe space (crib, bassinette, pack n' play) among WIC participants (baseline and increase to be determined by PRAMS Phase 8 for WIC participants [PRAMS Phase 8, 2016-2018, will include this question]).	pilot sites for Safe Sleep initiatives. 1b. Train NICU staff and implement Safe Sleep practices in NICUs to replicate the model developed by South Shore Hospital. 1c. Train NICU staff about Safe Sleep practices: 1) develop curriculum with an emphasis on racial disparities 2) role model training 3) train-the-trainer 4) create webinar model with CME credits 1d. Increase the percentage of medically eligible preterm infants who engage in Safe Sleep practices in the NICU through increased staff training focusing on implementing Safe Sleep practices among medically eligible preterm infants (South Shore Hospital's baseline=17%). 1e. Increase the percentage of medically	Post neonatal mortality rate per 1,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	backs		

		eligible preterm infants who engage in Safe Sleep practices in the NICU among Black non-Hispanic infants, implementing existing toolkits and highlighting Safe Sleep practices among Black non-Hispanic infants. 1f. MDPH will develop a model Safe Sleep policy for the NICU and disseminate across Level III birthing hospitals. 1g. Increase the number of NICUs which have a Comprehensive Safe Sleep policy by sharing best practices. 1h. MDPH will develop a model Safe Sleep policy and disseminate across all 47 birthing hospitals 1i. Increase the number of birthing hospitals (47 total) that have a Safe Sleep policy. 2a. Establish baseline measures for Safe				

		Sleep practices (supine position, in a safe sleep environment) for WIC participants. 2b. Disseminate and promote WIC's Safe Sleep brochures, translated into 8 languages, though WIC offices 2c. WIC staff will provide safe sleep education to mothers.				

State Action Plan Table (Massachusetts)						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Promote safe, stable, nurturing environments to reduce violence and the risk of injury.	1. By 2020, decrease by 6% from baseline (144.6 per 100,000 in 2012) the rate of hospitalization for non-fatal injury per 100,000 children ages 0-9.	1a. Increase poisoning prevention program education sessions and collaborations with WIC, DCF, Early Intervention and Head Start Trainer staff. 1) Work with child serving agencies to promote injury prevention strategies in the home, community, and child care setting. 2) Provide education and outreach to parents and caregivers of children regarding poison prevention. 3) Actively pursue education efforts for families whose first language is not English. 1b. Support the MA / RI Regional Poison Control Call Center at Boston Children's Hospital. Use surveillance data to	Child Mortality rate, ages 1 through 9 per 100,000 Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000	Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19		

		identify emerging threats. 1c. Work with child serving agencies (MHVI, EIPP, MPPTI) to promote injury prevention strategies in the home, community, and child care setting. 1d. Promote drowning prevention efforts such as pool safety regulations, public education on supervising swim and bath time, swim lessons, etc. 1e. Use injury surveillance data to reassess injury prevention priorities and related program and policy interventions.				
Reduce the impact and burden of environmental contaminants on children and their families.	1. By 2020, increase 8% from baseline (80% in 2013, Childhood Lead Poisoning Prevention database) the blood lead level	1a. Use existing coalitions and collaborations to develop programs to target all children less than 6 years of age.				

	screening rates in high-risk communities (as defined by low socioeconomic status, percent of old housing stock, and other factors) 2. By 2020, provide 5,000 multi-trigger multi-component home interventions for children with asthma to reduce the state Emergency Department rates for pediatric asthma among Black non-Hispanic and Hispanic children.	1b. Reach out to Head Start program and others using new CDC guidance on reference values to convey renewed interest in education and screening. 1c. Work with clinicians and other health care providers to improve screening and provide culturally appropriate education about lead hazards to children, notably in high risk communities. 1d. Add questions about the presence of children under 5 at home in interviews with adults with elevated blood lead levels (reported to the Occupational Lead Poisoning Registry). Encourage adults with elevated levels to have their children screened. 1e. Work with CHWs who provide home visits for children with blood lead level>10µg / dL to				

		provide resources about work exposures to lead for parents and the risk of take-home lead. 1f. Work with the Department of Labor Standards and OSHA to ensure workers with elevated lead levels received information about take-home lead. 2a. Increase demand and reimbursement for CHW-led asthma home visits. 2b. Provide tools, such as standardized visits protocols and educational materials, and technical assistance for successful implementation of asthma home visits. 2c. Develop environmental scoring system for sites conducting home visits to allow comparison of environmental triggers for asthma across multiple environmental				

		assessment tools.				

State Action Plan Table (Massachusetts)						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Promote safe, stable, nurturing environments to reduce violence and the risk of injury.	1. By 2020, decrease the rate of hospitalization for non-fatal injury per 100,000 children ages 10-19 by 12% from baseline (203.1 per 100,000 in 2012).	1a. Develop and implement two-hour online suicide prevention programming for licensed professions required by gun law. 1b. Promote suicide prevention in public policy, workplaces, school, state agencies and other organizations. 1c. Through GLBTQ Safe Spaces, promote innovative promising approaches to serve hard-to-reach populations. 1d. Promote trauma-informed model policies and practices for screening and universal education in varied health and public health settings for suicidality and all forms of	Child Mortality rate, ages 1 through 9 per 100,000 Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000	Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19		

		violence. 1e. Promote strategies that address young drivers including improvements to the Graduated Driver's License program and social marketing campaigns on safe driving (speed, texting, seat belts) aimed at young drivers.				
Promote equitable access to preventive health care including sexual and reproductive health services.	1. By 2020, increase by 2% from baseline the percent of adolescents with a preventive medical visit in the last year (91% in 2011 / 12). 2. By 2020, increase by 10% from baseline the number of SBHC clients age 12-18 years seen by the medical provider who are assessed at least once during the school year for substance use using the CRAFFT tool. (2% increase per school year from 63% in 2014 to 73% in 2020).	1a. Increase provider self-efficacy with adolescent males within School-Based Health Centers (SHBCs). 1b. Implement Quality Family Planning Guidelines in all Sexual and Reproductive Health Program agencies. 1c. Implement surveillance of referrals to preventive care visits and follow-up from home-visiting programs serving adolescents. 2. Improve SBHC clinician self-efficacy to conduct the CRAFFT	Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000 Percent of children with a mental/behavioral condition who receive treatment or counseling Percent of children in excellent or very good health Percent of children and adolescents who are	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.		

		screen and respond to disclosures through Observed Structured Clinical Exams (OSCE) and Motivational Interviewing training.	overweight or obese (BMI at or above the 85th percentile) Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine			

State Action Plan Table (Massachusetts)						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Increase connections to Medical Home for all children, including those with special health needs.	1. By 2020, increase the % of CYSHCN having a medical home from 47.1% (2009 / 10) to 56.5% by 2017* and to 58.2% by 2020. *to align with MCHB D70 Systems Integration Grant (SIG) objective.	1a. Align Title V strategies with to-be-determined strategies from the MA CYSHCN Systems Integration Project State Plan (D70 SIG). 1b. Work collaboratively with key partners and stakeholders to develop a plan for securing payment for comprehensive care coordination in the medical home for CYSHCN. 1c. Develop / enhance a “shared resource” that serves as a “one stop shop” for professionals and families of CYSHCN to access reliable resources and a variety of services supporting the social, emotional, mental,	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system Percent of children in excellent or very good health Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	Percent of children with and without special health care needs having a medical home		

		physical and education health of CYSHCN (This is a D70 SIG strategy – specifics to be determined). 1d. Collaborate with the MA Chapter American Academy of Pediatrics (MCAAP) to promote PCMH and educate and train providers on providing medical home approach to care. 1e. Engage with the MA Health Policy Commission (HPC) as it rolls out the MA PCMH Certification Program; provide support by offering resources and technical assistance to physicians on provision of medical home approach to care. 1f. Incorporate medical home concepts in all trainings provided by Family TIES, Care Coordination, and Community Support Line staff. 1g. Provide training,	Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine			

		technical assistance and resources related to medical home to providers. 1h. Provide resources and information related to medical home to families.				
Support effective health-related transition to adulthood for adolescents with special health care needs.	By 2020, increase the % of CYSHCN who received services necessary to transition to adult health care from 47% (2010 / 11 NS-CSHCN) to 52%.	1a. Provide information and resources to youth, families and providers via the MDPH transition website, including “A Bridge to Adult Health Coverage and Financial Benefits” brochure; tip sheets for families; links to resources; and training materials for providers. 1b. Seek opportunities to present health-related transition information, including information on public benefits, at conferences and other venues attended by youth and families. 1c. Use the Community Support Line and Family TIES to respond	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system Percent of children in excellent or very good health	Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care		

		to phone inquiries about health-related transition. 1d. Collaborate with EOHHS sister agencies (MA Rehab Commission; MA Dept. of Developmental Services; MA Dept. of Mental Health, MA Commission for the Deaf and Hard of Hearing; MA Commission for the Blind) and community organizations (e.g. Arc, Institute for Community Inclusion) serving transition-age youth to share health related transition issues and resources. 1e. Represent YSHCN on the Transitional Advisory Committee convened by the EOHHS Bureau of Transitional Planning. 1f. Expand use of the Care Coordination Program's "guardianship pathway" to selected schools in Worcester, Holyoke, Lawrence and New				

		Bedford.				

State Action Plan Table (Massachusetts)						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Promote equitable access to dental care and preventive measures for pregnant women and children.	1. By 2020, increase by 10% from baseline the percent of women who had a dental visit during pregnancy (2011 baseline = 49.9% MA PRAMS). 2. By 2020, increase by 10% from baseline the percent of children, ages 1 through 17, who had a dental visit in the past year (baseline= 83.3% NSCH 2011 / 12).	1a. Promote Implementation of Oral Health Guidelines in 3 pilot Community Health Centers (CHCs) for both NPM 13 A & B. 1b. Support CHCs to develop baseline measures for pilot sites (South Cove, Kennedy and Holyoke CHCs have baseline). 1c. Promote Oral Health Guidelines through professional organizations (OB, Dental, Pediatric) for both NPM 13 A & B. 2a. Promote Oral Health Guidelines through professional organizations (OB, Dental, Pediatric) for both NPM 13 A & B. 2b. Promote establishment of Dental	Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months Percent of children in excellent or very good health	A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year		

		Home for children at pilot and additional CHCs (if they receive grant).				
Promote health and racial equity across all MCH domains by addressing racial justice and reducing disparities.	1a. By 2020, 100% of new MDPH hires will be trained in health and racial equity principles and approaches. 1b. By 2020, 100% of MDPH Title V leadership will be trained in health and racial equity principles and approaches.	a. Align Title V with MDPH Commissioner-level strategies to promote health and racial equity. b. Work with MDPH Training Director and the Office of Health Equity to incorporate the principles of health equity, racial justice, and the social determinants of health into staff orientation. c. Collaborate with the Office of Health Equity to hold trainings for BCHAP and BFHN staff to improve a) awareness and understanding of the factors behind health inequities, and b) use of data to inform programmatic strategies, interventions, and procedural guidance to				

		address inequities. d. Use internal team meetings, brown bags lunches, and expert speakers to hold ongoing discussions on health equity and racial justice. e. Improve consistency of collection and analysis of demographic data and identify data elements that should be integrated or updated within existing data collection methods. (E.g. race, ethnicity, primary language, disability status, sexual orientation, and gender identity).				
Promote emotional wellness and social connectedness across the lifespan.	1. By 2020, increase by 10% from baseline (82% in FY14) the number of expected screenings using the social connectedness tool that are completed in MA Home Visiting (MHVI).	1a. Train home visitors on the use of standardized and evidence-based screening tools to assess for social connectedness among pregnant and parenting women, including data				

	2. By 2020, increase by 5% from baseline (70% in 2014) the number of children aged 0-6 years on Medicaid who receive screening for social-emotional heath during pediatric / well child visits.	collection and documentation.				
		1b. Increase the number of social connectedness support groups and resources within MHVI that are available to mothers with an identified need.				
	3. By 2020, increase by 0.40% from baseline (56.7% in FY14) the number of infants and toddlers enrolled in EI who demonstrate improved positive social-emotional skills.	1c. Expand Moving Beyond Depression to additional MHVI communities to serve more mothers experiencing postpartum depression.				
	4a. By 2020, increase by 10% from baseline (63.9% in FY14) the number of SBHC clients age 11 years and older seen by the medical provider who are assessed at least once during the school year for the presence of a trusted adult.	2a. With support from the MCH Workforce Development Center, leverage MHVI to promote integration of behavioral health into pediatric primary care.				
		2b. Develop multi-system capacity for implementing best practices for mitigating toxic stress in infancy and early childhood, including embedding a two-generational approach to care.				
	4b. By 2020, increase by 10% from baseline (59.7% in FY14) the number of SBHC clients					

	age 11 years and older seen by the medical provider who are assessed at least once during the school year for school connectedness.	2c. Improve MCH workforce capacity to effectively address social-emotional health in early childhood. 2d. Raise awareness among early childhood providers of the importance of emotional health and the link between physical and emotional health. 3a. Expand the infrastructure necessary to promote positive social-emotional skills for infants and toddlers enrolled in EI, such as sharing / implementing evidence-based best practices across programs, fidelity of administration of the BDI-2, supervision guidelines, consistent definitions of parent engagement, and data management protocols. 3b. Continue universal screening of EI enrolled infants and toddlers (0-3 years of age) for early				

		social-emotional delays using a validated tool (ASQ-3:SE or Greenspan) and provide interventions to promote social connectedness. 4a. Screen for resiliency, social, and school connectedness among students accessing care through one of MA's 33 School-Based Health Centers (SBHCs). 4b. Develop strategies and interventions across all SBHCs to improve school connectedness and link students to a trusted adult in instances where such resiliencies are not identified. 4c. Train SBHC clinical staff on the importance of school connectedness and a trusted adult in a young person's life, as well as strategies to foster those resiliencies among students.				