TITLE V STATE ACTION PLAN
2021-2025

Prepared for:
Maryland Maternal Steering Committee
Maternal and Child Health Bureau
Maryland Department of Health

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STATE ACTION PLAN TABLE

DOMAIN
Maternal/Women's Health
STATE PRIORITY NEEDS
Optimize the health and well-being of women and mothers across the life course using preventive strategies and address racial disparities in health care access and outcomes.
OBJECTIVES
Increase the percentage of women accessing oral health services while pregnant and decrease disparities attributable to race or ethnicity.
Decrease the percentage of women who smoke while pregnant and reduce disparities attributable to race or ethnicity.
STRATEGIES
Outreach and Collaboration Strategies: ● Distribute the Maryland Oral Health Guide 2020 through local health departments and other strategic partners.
Counseling intervention: ● Continue to refer pregnant women who smoke to the Maryland Tobacco Quitline and other smoke cessation programs.
NATIONAL OUTCOME MEASURES
None.
NATIONAL PERFORMANCE MEASURES*
NPM 13.1: Percent of women who have had a preventive dental visit during pregnancy
NPM 14.1: Percent of women who smoke during pregnancy
EVIDENCE-BASED OR INFORMED STRATEGY MEASURES
Percentage of prenatal health providers promoting the importance of oral health during pregnancy.
Percent of prenatal health providers referring pregnant women who report smoking to smoke cessation programs.
STATE PERFORMANCE MEASURES
None.

DOMAIN
Perinatal/Infant Health
STATE PRIORITY NEEDS
Promote safe and healthy behaviors and environments for infants, including improving the percentage of infants who are breastfed or breastfed exclusively, addressing the conditions that make safe sleep practices challenging and addressing racial and ethnic disparities in these areas. Ensure higher risk mothers and newborns deliver at appropriate level hospitals.
OBJECTIVES
Increase the percent of infants who are breastfed and who are breastfed exclusively.
Increase public awareness through consistent safe sleep messages from trusted community partners.
Increase community stakeholder and partner involvement in the development of statewide strategies and policies to prevent Sudden Unexpected Infant Death (SUID).
Develop and promote messages about safe sleep that are culturally appropriate and effective in reaching African American families.
Increase the percentage of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU).
STRATEGIES
Provide training for providers and encourage hospitals to adopt policies that are conducive to breastfeeding.
Continue supporting the Morgan State University's Safe Sleep Project's development of appropriate messages for the African American community regarding safe sleep practices.
Continue supporting the Surveillance & Quality Improvement (SQI)Program to gather information from mothers who had a fetal or infant loss, the Fetal and Infant Mortality Review (FIMR).
Provide resources to the seven jurisdictions with the highest rates of infant mortality (Anne Arundel, Baltimore, Charles, Montgomery, Prince George's and Wicomico Counties and Baltimore City) through the Babies Born Healthy (BBH) Program.
Support the Office of Oral Health (OOH) in providing education to prenatal providers on the importance of oral health during pregnancy begun as part of the Perinatal and Infant Oral Health Quality Improvement (PIOHQI) Program.
NATIONAL OUTCOME MEASURES
9.2 - Neonatal mortality rate per 1,000 live births
9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
NATIONAL PERFORMANCE MEASURES*
NPM 4: A) Percent of infants ever breastfed Need to add in Risk Appropriate Perinatal Care
NPM 4: B) Percent of infants breastfed exclusively through six months
NPM 5: A) Percent of infants placed to sleep on their backs
NPM 5: B) Percent of infants placed to sleep on a separate approved sleep surface
NPM 5: C) Percent of infants placed to sleep without soft objects or loose bedding
EVIDENCE-BASED OR INFORMED STRATEGY MEASURES
Number of hospitals promoting breastfeeding
Number of providers educated on benefits of breastfeeding
Number of African American mothers reached through messaging on safe sleep practices
Percentage of mothers reporting that they most often place their baby to sleep on their back only

Percentage of mothers reporting that their baby always or often sleeps alone, usually in a crib, bassinet, or pack and play, and not usually in a standard bed, couch, sofa, armchair, car seat, or swing
Percentage of mothers reporting that their baby does not usually sleep with blankets, toys, cushions, pillows, or crib bumper pads
Percentage of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
STATE PERFORMANCE MEASURES
None.

DOMAIN
Child Health
STATE PRIORITY NEEDS
Improve access to preventive, primary, specialty and behavioral health services for Maryland Children including those with special health care needs.
OBJECTIVES
Increase the percent of children who receive a developmental screening.
Increase the percent of families who utilize home visiting programs for their children.
STRATEGIES
Leverage the reach that local health department home visiting programs have to Maryland families with children under the age of 5, thus, to provide developmental screenings.
Monitor, track and assess Medicaid data to determine how many children are receiving developmental screenings through their primary care providers.
NATIONAL OUTCOME MEASURES*
None.
NATIONAL PERFORMANCE MEASURES*
NPM 6: Child Developmental Screening
EVIDENCE-BASED OR INFORMED STRATEGY MEASURES
Number of children 10-71 months who receive a child developmental screening with a parent completed screening tool.
STATE PERFORMANCE MEASURES
Receipt of primary care in early childhood (5 or more visits by 15 months)

DOMAIN
CYSHCN
STATE PRIORITY NEEDS
Improve the health of children and youth with special health care needs through comprehensive and coordinated care, as well as support their transition to adult health care.
OBJECTIVES
Increase the number of pediatric providers in the state who identify with the medical home approach.
Increase the percentage of children with and without special healthcare needs who receive coordinated care using the medical home approach.
Identify and address racial disparities in care coordination.
By 2025, increase the percentage of children with special healthcare needs who successfully transition to adult care.
Reduce racial disparities among children with special healthcare needs in access to care and transitions to adult care.
STRATEGIES
Conduct outreach through medical schools.
Continue the Patient Centered Medical Home (PCMH) workgroup, working under the Maryland Health Care Commission (MHCC), to support initiatives to strengthen primary care and explore wider adoption of the medical home model.
Implement the Six Core Elements of Healthcare Transition 3.0
Promote Got Transition's "Six Core Elements" to transition and principles of successful transition.
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).
NATIONAL OUTCOME MEASURES*
NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system.
Healthy People 2020 Objective: Related to Maternal, Infant, and Child Health (MICH) Objectives 30.1 : Increase the proportion of children who have access to a medical home, (Baseline: 57.5%, Target: 63.3%) and 30.2: Increase the proportion of children with special health care needs who have access to a medical home. (Baseline: 49.8%, Target: 54.8%)
NATIONAL PERFORMANCE MEASURES*
NPM 11: Percent of children with and without special health care needs having a medical home.
NPM 12: Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
EVIDENCE-BASED OR INFORMED STRATEGY MEASURES
Number of adult and pediatric providers who have received training in transition services.
STATE PERFORMANCE MEASURES
None.

DOMAIN
Adolescent Health
STATE PRIORITY NEEDS
Increase the percent of adolescents who have a preventive medical visit.
OBJECTIVES
Increase the percentage of adolescents who receive an adolescent well-visit and reduce or eliminate disparities by race and ethnicity.
Decrease racial and ethnic disparities in adolescents receiving adolescent well-visits.
STRATEGIES
Continue the Healthy Kids Program, under the Early and Periodic Screening, Diagnostic and Treatment (ESPDT) Program to enhance the quality of health services delivered by Medicaid providers.
Continue the Sexual Risk Avoidance Education (SRAE) grant program to promote sexual risk avoidance based on the promotion of abstinence.
Continue the Personal Responsibility and Education Program (PREP) to promote positive youth development.
Implement the Maryland Optimal Adolescent Health Program
Track and monitor adolescent well visits through Medicaid data.
NATIONAL OUTCOME MEASURES*
None.
NATIONAL PERFORMANCE MEASURES*
NPM 10: Adolescent Well-Visit
EVIDENCE-BASED OR INFORMED STRATEGY MEASURES
Improve health literacy through the following activities: ● Monitor and track Adolescent well-visits through Medicaid data. ● PREP and SRAE grantees will continue to include health literacy and wellness in curriculum.
STATE PERFORMANCE MEASURES
Identification of mental/behavioral health needs in adolescents

STATE ACTION PLAN NARRATIVE BY DOMAIN

WOMEN'S/MATERNAL HEALTH

HRSA identifies three key strategic priority goals for women's and maternal health, to include: 1) improving women's health before, during and beyond pregnancy and across their life course; 2) improving the quality and safety of maternity care; and 3) improving systems of maternity care including both clinical and public health systems.

The state of Maryland identifies the objective for this population as optimizing the health and well-being of girls and women across the life course using preventive strategies.

Introduction

For the 2021-2025 Five-Year Action Plan, the Needs Assessment Steering Committee selected two NPMs related to women's and maternal health. They include preventive dental visit – pregnancy (NPM 13.1) and smoking – pregnancy (14.1).

Preventive Dental Visit – Pregnancy. In 2017, Maryland was above the national average for women who received a preventive dental visit during pregnancy (52.6% and 46.3%, respectively). The rate of pregnant women receiving preventive dental visits has remained somewhat consistent, despite the peak in 2014, and has increased slightly since 2015.

Smoking – Pregnancy. In 2018, Maryland was slightly below the national average for women who smoked during pregnancy (5.2% and 6.5%, respectively). Maryland has seen a downward trend in the percentage of women who smoke during pregnancy since at least 2010 (8.9%), while the national trend reached its peak in 2014 (7.9%) and has started decreasing since 2015.

Plan for the Application Year

Provided in this section are the selected national performance measures (NPMs), as well as the selected evidence-based strategy measures (ESMs). Furthermore, this section details the plan of action for this application year for each selected NPM.

NPM 13.1: Preventive Dental Visit – Pregnancy

HRSA states that the goal for this NPM is "to increase the number of pregnant women who have a dental visit during pregnancy." Furthermore, HRSA defines this NPM by the number of women who had a preventive visit during pregnancy divided by the total number of live births to determine the percent.

Evidence-Based Strategy Measure: Outreach and Collaboration

Percent of prenatal health providers promoting the importance of oral health during pregnancy.

The strategy selected for this NPM is to increase oral health awareness through outreach and collaboration. The outreach component consists of distributing educational materials on benefits of oral health in community-based settings and promoting preventive dental services for pregnant women as a no-cost preventive service. The collaboration component consists of forming interagency partnerships to improve coordination between services and building connections and strengthening opportunities for

collaborations with state programs, dental schools and dental hygiene programs, private practice and community-based programs.

Furthermore, collaboration can include partnerships with community partners to train staff to provide preventive oral health care to pregnant women as well as referrals to oral health professionals for dental visits. This strategy can also be used to provide oral health care to more children and adolescents. Potential areas of partnership for pregnant women include home visiting programs, prenatal care associations and WIC clinics, as well as Early Head Start and Head Start programs for children. Collaborating with community partners to provide oral health care is recommended by experts as an effective strategy for addressing NPM 13.1[1].

During the 2016-2020 application cycle, the strategies used in Maryland included the continuation of increasing the awareness among oral health and obstetric health care providers about the importance of health during pregnancy. This included the programs provided by the Office of Oral Health (OOH) in partnership with the University of Maryland, School of Public Health and Early Head Start.

AMCHP's Implementation Toolkit for National Performance Measure 13

The Association of Maternal and Child Health Programs (AMCHP) partnered with the National Maternal and Child Oral Health Resources Center (OHRC) on an Implementation Toolkit for NPM 13. AMCHP provides various relevant resources for the selected collaboration strategy[2], including:

- Bright Futures: Oral Health – Pocket Guide
- Oral Health Care During Pregnancy: A National Consensus Statement
- Children's Dental Services
- Improving Oral Health Outcomes for Pregnant Women and Infants by Educating Home Visitors
- Best Practices Approach: Perinatal Oral Health
- The Maternal and Child Health Bureau – Funded Perinatal and Infant Oral Health Quality Improvement (PIOHQI) Initiative 2013-2019: Final Report
- Title V MCH Services Block Grant Oral Health Toolkit
- Title V National Performance Measure 13 (Oral Health): Strategies for Success
- Pregnancy and Oral Health
- Improving the Oral Health of Pregnant Women, Children and Families

Maryland Oral Health Plan (MOHP) 2018 – 2023

The Maryland Dental Action Coalition (MDAC) created the Framework to Improve the Oral Health of all Marylanders. MDAC is a nonprofit organization, created in 2010, dedicated to increasing access to oral health care, preventing oral disease and improving oral health behaviors. MDAC works in collaboration with the MDH Office of Oral Health, the UMSOD, local health departments, federally qualified health centers (FQHCs), and other organizations to address oral health.

[1] Holt K, Kolo S, Louie R. 2020. Title V National Performance Measure 13 (Oral Health): Strategies for Success. Washington, DC: National Maternal and Child Oral Health Resource Center.

[2] https://create.piktochart.com/output/44460229-npm-13-1-collaborate-with-community-based-programs-pregnant

MDAC and its partners have made significant progress toward its goals and objectives, where many vulnerable populations, especially children, have seen an overall improvement in their oral health status.

The 2018-2023 MOHP is designed to serve as a guide for improving oral health of all Marylanders and takes a three-pronged approach, where it focuses on: 1) access to oral health care, 2) oral disease and injury prevention, and 3) oral health literacy and education. Access to oral health care includes five goals, oral disease and injury prevention includes three goals and oral health literacy and education has three goals, all of which include two to five actions.

2018 – 2023 MOHP		
Access to Oral Health Care Goals	**Oral Disease and Injury Prevention Goals**	**Oral Health Literacy and Education Goals**
1. All Maryland children have comprehensive dental insurance coverage through public (Medicaid/MCHP) or private insurance. 2. All Maryland Adults have comprehensive dental insurance coverage through Medicaid or private insurance. 3. All Maryland residents have a dental home. 4. Strengthen the oral health safety net provider system. 5. Integrate the oral health care system within the medical health care system	1. Use data to advance optimal oral health for all Marylanders. 2. Improve public awareness of oral disease and injury prevention. 3. Promote community-based oral disease and injury prevention programs	1. Increase understanding of the relationship between oral health and overall health, and promote good oral health practices and access to oral health care 2. Improve collaboration between oral health and other health and human services providers so that patients understand how to navigate the oral health care system and establish a dental home. 3. Educate medical professionals and students about the importance of the oral/systemic connection and foster collaboration between medical and dental disciplines and communities.

Maryland's Office of Oral Health (OOH)

The Office of Oral Health (OOH) was established in 1996 to address dental and oral diseases affecting the State's neediest children and adults. The mission of OOH is "to improve the oral health of Maryland residents through a variety of public oral health initiatives and interventions."

OOH oversees four programs: Community Water Fluoridation, Dental Sealants, Fluoride Varnish & Oral Health Screening Program, and Loan Assistance Repayment for Dentists. OOH partners with many organizations, including:

- American Academy for Oral Systemic Health
- American Academy for Pediatric Dentistry
- American Dental Association
- American Dental Hygienists Association
- Association of State & Territorial Dental Directors
- Center for Chronic Disease Prevention and Control (MDH)
- Centers for Disease Control and Prevention – Oral Health

- Centers for Medicare and Medicaid Services
- Children's Dental Health Project
- Deamonte Driver Dental Project
- Health Choice
- Dental Hygiene Programs in Maryland
  - Allegany College of Maryland
  - Baltimore City Community College
  - Community College of Baltimore County
  - FORTIS College-Landover
  - Hagerstown Community College
  - Howard Community College
  - University of Maryland
- Health Resources and Services Administration – Oral Health
- Healthy Teeth, Healthy Kids
- Horowitz Center for Health Literacy / University of Maryland School of Public Health
- Local Health Departments
- Maryland Academy of Family Physicians
- Maryland Area Health Education Centers (AHEC)
- Maryland Chapter American Academy of Pediatrics
- Maryland Dental Action Coalition
- Maryland Department of Aging
- Maryland Head Start Association
- Maryland Medical Assistance Program
- Maryland Rural Health Association
- Maryland State Board of Dental Examiners
- Maryland State Dental Association
- Maryland Tobacco Quitline, 1-800-QUIT-NOW
- Maternal and Child Health Bureau (MDH)
- Mid-Atlantic P.A.N.D.A.
- Mouth Healthy Kids (ADA)
- National Institute of Dental and Craniofacial Research
- National Maternal and Child Oral Health Resource Center
- National Museum of Dentistry
- Nurse Practitioners Association of Maryland
- Partnership for a Safer MD
- Prenatal Oral Health Program
- Scion Dental, Inc.
- The Oral Cancer Foundation
- University of Maryland School of Dentistry

Maryland Oral Health Resource Guide 2020

The Maryland Oral Health Resource Guide is produced annually by the Maryland Department of Health Office of Oral Health (OOH)[3]. The resource guide helps families, caregivers and advocates find affordable public health dental services in Maryland and surrounding regions. The directory lists, by county, dental health public programs or facilities that provide discounted, low-cost and/or special needs dental services. The director also lists information about other resources including the Maryland Health Smiles Program and programs in nearby Delaware and Washington, D.C.

Maryland's Practice Guidance for Prenatal and Dental Providers

MCHB collaborated with the Office of Oral Health (OOH) on a reference guide for dental care during pregnancy and infancy for prenatal care and oral health professionals. The guide was sent to all Maryland oral health and obstetric providers[4].

[3] https://phpa.health.maryland.gov/oralhealth/Documents/OralHealthResourceGuide.pdf

[4] https://phpa.health.maryland.gov/oralhealth/Documents/PregnancyGuidanceDocument.pdf

NPM 14.1: Smoking – Pregnancy

HRSA states that the goal for this NPM is "to decrease the number of women who smoke during pregnancy." Furthermore, HRSA defines this NPM by the number of women who report smoking during pregnancy divided by the total number of live births to determine the percent of women who smoke during pregnancy.

"Research has shown that women's smoking during pregnancy increase the risk of pregnancy complication, premature delivery, low birth weight infants, stillbirth, and sudden infant death syndrome."

-CDC

Evidence-Based Strategy Measure: Counseling Interventions

Percent of prenatal health providers referring pregnant women who report smoking to smoke cessation programs.

The strategy selected for this NPM is to provide enhanced counseling services that motivate pregnant women to quit smoking. Counseling interventions provide motivation to quit and support to increase problem solving skills. Counseling interventions may include motivational interviewing, cognitive behavior therapy (CBT), other psychotherapies, problem-solving and other approaches. Pregnant women are more likely to quit when cessation counseling is combined with motivational interviewing and is provided by a trained educator.

According to Fiore et al., this approach includes "the Five A's of Smoking Cessation," which are ask, advise, assess, assist and arrange. The Five A's are described as "the gold standard" and can be combined with motivational strategies in a step-by-step process[5].

Six studies, from 2015-2019, have shown a decrease in the number of women who smoke during pregnancy when they have access to one-on-one cessation counseling from a trained educator that includes motivational interviewing. The evidence is considered moderate, meaning that the strategy will likely work, but further research is needed to confirm effects.

During the 2016-2020 application cycle, the strategies used in Maryland included the continuation of the pregnancy incentive rewards program for participation in the Quitline, outreach materials to be used to publicize smoking cessation resources for pregnant women, and provider trainings about tobacco use and pregnancy, secondhand smoke exposure in the home and interventions.

Maryland Tobacco Quitline

The Maryland Tobacco Quitline, 1-800-QUIT-NOW, is provided by the Maryland Department of Health. The hotline operates 24 hours a day, seven days a week and provides free evidence-based counseling to assist Marylanders ages 13 years and older in quitting tobacco use.

From July 1, 2018 through June 30, 2019, 105 pregnant women enrolled in the Maryland Tobacco Quitline, where almost half (45%) resided in Baltimore City[6]. Comparatively, 3,713 pregnant women

[5] Fiore MC, Jaen CR, Baker TB, Bailey WC, Benowitz NL, Curry SJ, et al. Treating tobacco use and dependence: 2008 update. Clinical Practice Guideline. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service; 2008

[6] Optum Maryland Tobacco Quitline Data

reported smoking in Maryland in 2018[7]. Likewise, 49 women enrolled in the Maryland Tobacco Quitline reported planning to get pregnant, while 14 reported currently breastfeeding.

The Maryland Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program

Home visiting programs represent an important primary prevention strategy for adverse prenatal health behaviors, such as smoking cessation among pregnant women. The Maryland Maternal, Infant and Early Childhood Home Visiting (MIECHV) program is funded by the Health Resources and Services Administration (HRSA), in partnership with the Administration for Children and Families (ACF). The goal is to develop and implement evidence-based, voluntary family support programs to best meet the needs of their communities.

In 2010, the Affordable Care Act (ACA) established a new program under Title V-Section 511 called the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program. This outlines that MIECHV will serve at-risk communities and families by strengthening programs and activities carried out under Title V, improving coordination of services for at-risk communities and providing comprehensive services to improve outcomes for families residing in at-risk communities.

As of 2018 five evidence-based home visiting programs are in use in Maryland, which include Nurse-Family Partnership, Healthy Families America, Parents as Teachers, Home Instruction for Parents of Preschool Youngsters (HIPPY) and Early Head Start. Maryland MIECHV supports 15 home visiting sites that utilize two programs: Healthy Families America (14) and Nurse-Family Partnership (1).

Pregnancy and Tobacco Cessation Help (PATCH)

The PATCH Program mobilizes partnerships with existing local organizations to create portals of care to address smoking cessation, tobacco use screening, education, and prevention services offered to pregnant women and women of childbearing age. Five jurisdictions (Allegany, Calvert, Cecil, Dorchester, Garrett) were funded in FY 2019 to address higher smoking rates among pregnant women. These five jurisdictions incentivized eighteen community partners to be portals of care for the initiative.

In FY 2019, PATCH partners educated 2,790 women of childbearing age and 1,081 pregnant women on the dangers of using tobacco/nicotine during pregnancy and establishing smoke free homes policy, made 693 referrals to the Maryland Quitline and 572 referrals to LHD cessation programs.

The HABITS Lab at UMBC

The Health and Addictive Behaviors: Investigating Transtheoretical Solutions (HABITS) Lab at the University of Maryland, Baltimore County (UMBC) is currently working on a variety of projects relevant to smoking cessation, including MDQuit Resource Center and the Maternal Infant and Early Childhood Home Visiting (MIECHV) Program.

MDQuit Resource Center

The Maryland Resource Center for Quitting Use & Initiation of Tobacco (MDQuit) is funded by the Maryland Department of Health, within the Prevention and Health Promotion Administration's (PHPA) Center for Tobacco Prevention and Control and is located on the campus of the UMBC.

MDQUIT serves as Maryland's resource center with the goal of linking professionals and providers to state tobacco initiatives, providing evidence-based effective resources and tools, creating and

[7] Maryland Vital Statistics Administration

supporting an extensive and collaborative network of tobacco prevention and cessation professionals and offering a forum for sharing best practices.

Furthermore, MDQuit receives funding from the Maryland Behavioral Health Administration (BHA) to support a program for tobacco cessation and prevention among behavioral health agencies, providers and clients who use tobacco. MDQuit continues to provide support for the training of providers, staff and administration to implement the "Breaking the Habit in Behavioral Health (BH2)" tobacco curriculum.

Maternal Infant and Early Childhood Home Visiting (MIECHV) Program

UMBC's Home Visiting Training Center and Certificate Program is supported by funding from HRSA through the Maryland MIECHV (Maternal Infant and Early Childhood Home Visiting) program at MDH. UMBC's Psychology Department has developed a training curriculum and support systems to enhance current training and address the many demands and needs of home visitors. This project was implemented in two phases.

In the first phase of developing the Home Visitor Training Certificate Program, national best practices were reviewed and researched, input from local program administrators and staff were gathered and focus groups and interviews with home visitors and program supervisors were conducted. This information was combined to guide the development of the training curriculum in several areas including parent training and substance abuse. The second phase included implementing trainings with home visitors and evaluating the training to build an online video library to supplement the in-person trainings.

Revised Priority Needs and Strategies

In 2016-2020, reducing low-risk cesarean deliveries was identified as the NPM for the women's and maternal health population domain. The baseline in 2013, leading to its selection, was 35%. In 2017 the rate was 28.2%, down from previous years, but slightly higher than the national average of 26.0%. Maryland has continued to meet its objective since 2016. Task force members felt it was no longer necessary to prioritize low-risk cesarean deliveries for the 2021-2025 cycle. Instead, Needs Assessment Steering Committee members prioritized preventive dental visits during pregnancy and smoking during pregnancy.

Oral health was covered in 2016-2020 under the cross-cutting/life course domain. Because of the progress made with children, task force members felt that oral health should be prioritized specifically for pregnant women.

Maryland Priority Needs, 2021-2025	National Performance Measure(s)	Population Domains
1. Women's and Maternal Health: Optimize the health and well-being of women and mothers across the life course using preventive strategies.	**Preventive dental visit – pregnancy:** Percent of women who receive a preventive dental visit during pregnancy **Smoking – pregnancy:** Percent of women who smoke during pregnancy	Women's and Maternal Health

Maryland Priority Needs, 2016-2020	National Performance Measure(s)	Population Domains
1. Women's Wellness, Healthy Pregnancies: Optimize the health and well-being of girls and women across the life course using preventive strategies.	**Low-risk cesarean deliveries:** Percent of low-risk cesarean deliveries	Women's and Maternal Health

Likewise, smoking was also covered within substance use and misuse in 2016-2020 under the cross-cutting/life course domain. Task force members felt that smoking should be prioritized specifically for pregnant women. Children in households with smoking as decreased from the baseline at 20% to 12.1%

Challenges and Emerging Issues

In early 2020, a novel Coronavirus, COVID-19 (SARS-CoV-2) swept through the United States, including Maryland. The virus quickly became a global pandemic, affecting over 200 countries with over 7 million cases worldwide, as of June 2020. A second wave is suspected to hit the country later in 2020. As of June 2020, Maryland has seen over 50,000 confirmed cases and approximately 3,000 deaths from this virus. Maternal and women's health is among the many populations impacted by this novel virus.

Early data suggests that COVID-19 impacts maternal health in two main areas: 1) constrained access to reproductive and maternal healthcare and a subsequent increase in adverse health outcomes; and 2) rapid societal changes disproportionately and negatively affecting marginalized families and communities[8].

As COVID-19 overwhelms hospitals and resources are diverted to combat the virus, maternal health will consequently suffer. Tracking higher-risk pregnancies will become increasingly difficult as people opt for virtual prenatal checkups. Furthermore, women may not seek in-clinic checkups or hospital deliveries due to the fear of contracting the virus. Reports have indicated that some pregnant women are switching their birthing plan from a hospital setting to a home birth option, creating more of a strain on birthing centers and home birth providers. Due to the unknowns of how COVID-19 can impact a pregnancy, some women may want to delay their pregnancy, thus increasing the importance of access to contraceptives.

Systemic biases in the U.S. have resulted in higher rates of COVID-19 among Black communities. Initial research suggests that the pandemic may exacerbate existing barriers to care for women of color, women with low incomes, women with disabilities and women living in rural areas. Furthermore, the skyrocketing unemployment rate has created financial strain for millions, leading to low-income women and women of color potentially being less able to afford both COVID-19 related and general health care[9].

Women's health is impacted in additional ways. In a briefing released by the UN in April 2020, stress and domestic violence dangers may be instigated during stay-at-home orders. In the US, helplines are reporting COVID-19 related domestic violence calls. The UN reported that globally there has been in

[8] https://www.mhtf.org/2020/04/18/amidst-the-COVID-19-pandemic-we-must-remember-maternal-health/

[9] https://www.americanprogress.org/issues/women/reports/2020/04/23/483828/coronavirus-crisis-confirms-u-s-health-care-system-fails-women

increase in violence against women, with some countries reporting an increase in cases close to 25%. Stay at home orders may hinder some women from picking up the phone or seeking help.

Refuge's Chief Executive Sandra Horley told CNN "we know that ordinarily, the window of opportunity for women with abusive partners to make a call and seek help is often very limited… now, it is likely that window has become even smaller[10]."

COVID-19 poses unique challenges when it comes to alcohol drinkers. The anxiety about the virus together with isolation from a support system can lead to increased rates of alcohol use disorder (AUD), which is defined as a chronic, relapsing disease diagnosed based on an individual meeting a certain set of criteria over a 12-month duration[11]. In Maryland, liquor stores in Montgomery County saw a 46% spike during the week Governor Larry Hogan closed bars and restaurants, compared to the same period in 2019. Dr. Lauren Grawert, an addiction psychiatrist at Kaiser Permanente stated, "addiction is a disease of isolation, by definition and increased stress burden… when folks are more isolated, when they're more stressed, that is when relapses tend to happen[12]."

PERINATAL/INFANT'S HEALTH

HRSA identifies five key strategic priority goals for perinatal and infant's health, to include: 1) ensuring that higher risk mothers and newborns deliver at hospitals that are able to provide proper care; 2) increasing the number of infants who are breastfed and those who are exclusively breastfed through 6 months; 3) increasing the number of infants placed to sleep on their backs; 4) increasing the number of children who receive a developmental screening; and 5) increasing the number of children who are adequately ensured.

The state of Maryland identifies the objective for this population as improving perinatal and infant health in Maryland by reducing disparities.

Introduction

For the 2021-2025 Five-Year Action Plan, the task force selected three NPMs related to perinatal and infant's health. They include risk-appropriate perinatal care (NPM 3), breastfeeding (NPM 4) and safe sleep (NPM 5).

Risk-Appropriate Perinatal Care. In 2018, Maryland reported that 79.2% of very low birthweight (VLBW) infants were born in a level III or higher NICU, which represents an increase of approximately 1% since 2017. Maryland saw its highest percentage of VLBW infants with level III or higher NICU in 2013 (82.8%) and saw a negative trend until 2018. As of 2018, the percentage of VLBW infants born in a level III or higher NICU did not quite meet the Healthy People 2020 objective of 83.7%.

Breastfeeding. In 2016, Maryland was slightly above the national average for infants ever breastfed (84.1% and 83.8%, respectively). Both nationally and in Maryland, there is an upward trend for infants ever breastfed, apart from 2015, where Maryland saw a spike of 91.0% infants breastfed before falling

[10] https://www.forbes.com/sites/alicebroster/2020/04/20/coronavirus-could-have-serious-consequences-for-womens-health-says-the-un/#3150d146e0ab

[11] https://www.alcohol.org/resources/coronavirus-and-alcoholism/

[12] https://www.wusa9.com/article/news/health/coronavirus/alcohol-sales-spike-during-coronavirus-stay-at-home-order/65-c8bccb33-39a1-4b5c-92a9-47be68aed859

slightly in 2016. As of 2016, infants ever breastfed in Maryland met the Healthy People 2020 objective of 81.9%.

Safe Sleep. In 2017, Maryland reported an increase in the percentage of infants placed to sleep on their backs (78.2%), which is slightly less than the national average (79.8%). As of 2017, safe sleep in Maryland met the Healthy People 2020 objective of 75.9%.

Plan for the Application Year

Provided in this section are the selected national performance measures (NPMs), as well as the selected evidence-based strategy measures (ESMs). Furthermore, this section details the plan of action for this application year for each selected NPM.

NPM 3: Risk Appropriate Perinatal Care

HRSA states that the goal for this NPM is "to ensure that higher risk mothers and newborns delivery at appropriate level hospitals," Furthermore, HRSA defines this NPM by the number of very low birthweight (VLBW) infants born in a hospital with a level III or higher NICU divided by the total number of VLBW infants to determine the percent

Evidence-Based Strategy Measure: Standardized Definitions for Hospital Level of Care

Percent of hospitals with a formal written plan for transport of complication obstetric/maternal patients to reduce infant mortality/morbidity.

The strategy selected for this NPM is to continue standardizing definitions for hospital levels of care. This entails defining hospital levels of neonatal care and levels of maternal care using AAP and ACOG/SMFM guidelines.

In 2019, ACOG/SMFM in collaboration with physicians and a CDC representative developed a revision of the original 2015 Levels of Maternal Care Obstetric Care Consensus. The revision was primarily to clarify terminology and present more recent data and literature. The standardized classification system establishes levels of maternal care, including basic care (level I), specialty care (level II), subspecialty care (level III) and regional perinatal health care centers (level IV)[13].

AMCHP's Implementation Toolkit for National Performance Measure 3

The Association of Maternal and Child Health Programs (AMCHP) partnered with the National Institute for Children's Health Quality (NICHQ) to create the Implementation Toolkit for NPM 3. NICHQ developed an Infant Mortality CoIIN Prevention Toolkit, which provides information on the classification of hospital care level based on AAP and ACOG/SMFM consensus reports and guidelines.

The Maryland Perinatal System Standards

Maryland has had a systematic approach focused on improving the perinatal care system and reducing infant mortality for over ten years. Indeed, since the mid-1990s, Maryland has had a systematic approach to improving the perinatal system of care and assuring delivery of very low birthweight (VLBW) infants at hospitals with the appropriate level of care. A Perinatal Clinical Advisory Committee

[13] https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2019/08/levels-of-maternal-care

within MCHB was formed to develop, review and update the Maryland Perinatal System Standards for all levels of perinatal and neonatal care. This multidisciplinary committee includes representatives from more than 15 Maryland State agencies and professional organizations, as well as from level II to IV delivery hospitals.

The Standards are updated (most recently in 2018) to maintain consistency with AAP and ACOG/SMFM's Guidelines for Perinatal Care and the AAP Policy Statement on Levels of Neonatal Care. The Standards specify that VLBW births should occur at level III and IV hospitals, which have the necessary subspecialty obstetrical care and neonatal intensive care.

Maryland Maternal Health Innovation Program, MDMOM

MDMOM, the Maryland Health Innovation Program, is a five-year HRSA funded program to improve maternal health across the state. MDMOM is a collaboration between Johns Hopkins University, Maryland Department of Health, Maryland Patient Safety Center and the University of Maryland, Baltimore County who work together to coordinate innovation in the areas of data, resource availability and hospital and community care.

The Maryland Maternal Health Task Force was convened by the MDH to address the needs of pregnant and postpartum women in Maryland. The Task Force is chaired by the Title V Manager and brings a diverse group of key stakeholders together. Task Force members are assigned to workgroups, which are formed around important focus areas in the 5-year Strategic Plan to improve maternal health in Maryland, including: 1) maternal health data, 2) telemedicine, 3) quality improvement, 4) training innovation, and 5) policy. Title V Manager, Colleen Wilburn, MPA, currently serves as the Project Coordinator for MDH. The purpose of the Task Force is to advice and make recommendations to the Maryland Department of Health on policies to improve maternal health throughout the state.

Perinatal and Infant Oral Health Quality Improvement (PIOHQI) Program

From 2014 through 2018, MCHB worked closely with OOH on a Perinatal and Infant Oral Health Quality Improvement (PIOHQI) Program. The project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (DHHS) with the goal "to reduce the prevalence of oral disease in pregnant women and infants at high risk for oral disease through improved access to and utilization of high-quality oral health care."

The OOH collaborated with the University of Maryland, School of Public Health to conduct a survey and focus groups of pregnant women, as well as survey medical and dental providers who service "hot spot" areas. The OOH also provided training to medical professionals on the importance of perinatal and infant oral health care. Additionally, the OOH developed and implemented an Early Head Start Oral Health Adoption program for accredited Dental Hygiene Programs to provide oral health education and referral resources to pregnant women and infants enrolled in Early Head Start. Specifically, this program helped pregnant women and parents understand the benefits of good oral health, the need to prevent oral disease and the importance of establishing a dental home.

In May 2020, the OOH submitted a proposal to collaborate with Maryland's Title V program to continue to provide education to prenatal providers on the importance of oral health during pregnancy by coordinating a 5-year outreach initiative that includes:

1. The promotion of "Smiles for Life: A National Oral Health Curriculum"
2. The dissemination of "Oral Health Care During Pregnancy: Practice Guidance for Maryland's Prenatal and Dental Providers" (MDH Document)

3. Oral Health During Pregnancy – Health Literacy/Social Marketing Campaign

NPM 4: Breastfeeding

HRSA states that the goal for this NPM is "to increase the percent of infants who are breastfed and who are breastfed exclusively through six months." Furthermore, HRSA defines this NPM in two ways: 1) by the number of infants who are ever breastfed divided by the total number of infants born in a calendar year to determine the percent; and 2) by the number of infants breastfed exclusively through 6 months divided by the total number of infants born in a calendar year to determine the percent.

Evidence-Based Strategy Measure: Lactation Consultants

Percent of postpartum mothers reporting that they received breastfeeding resources and reminders after delivery and before discharge.

The strategy selected for this NPM is to provide all postpartum mothers with breastfeeding information and providing appropriate referrals to lactation consultant services before discharge. This strategy entails informing pregnant women and new mothers about lactation consultant services and ensuring that lactation consultants have access to new mothers after birth. As part of this strategy, Title V may consider utilizing doulas in a similar role as lactation consultants to promote breastfeeding.

This strategy is considered to have moderate evidence, where "dedicated lactation specialists may play a role in providing education and support to pregnant women and new mothers wishing to breastfeed and to continue breastfeeding to improve breastfeeding outcomes" was shown in various systematic literature reviews[14].

AMCHP's Implementation Toolkit for National Performance Measure 4

The Association of Maternal and Child Health Programs (AMCHP) developed the Implementation Toolkit for NPM 4. The toolkit provides best practices to address NPM 4, which is guided by Title V Block Grant applications and recommended from the Surgeon General's Call to Action to Support Breastfeeding. The strategic approaches include:

- Policy and Systems Approaches
- Training and Education
- Community-Driven Resources
- Increasing Access to Services
- Culturally Tailored Resources
- Data and Metrics
- Safe Sleep and Breastfeeding

Maryland Hospital Breastfeeding Policy

The Maryland Department of Health (MDH) formed an 11-member committee, which includes the Title V Manager, to develop breastfeeding policy recommendations that will strengthen and improve current maternity care practices. The first finalized policy recommendations were completed in September 2012. These policy recommendations, based on WHO/UNICEF Ten Steps to Successful Breastfeeding, include evidence-based hospital practices to increase rates of breastfeeding initiation, duration and exclusivity for healthy, fully term infants whose mothers have chosen to breastfeed. The committee currently meets biannually and provides provider training and hospital policies for Baby-Friendly hospitals.

[14] https://www.mchevidence.org/documents/NPM-Webinar-3-04-22-20.pdf

In 2012, MDH launched a statewide initiative to help hospitals improve the support that hospitals give to breastfeeding mothers. All 32 birthing hospitals committed to this quality improvement process. In 2016, almost 85% of the birthing hospitals reaffirmed their commitments. Hospitals are encouraged to sign a letter of intent to become designated as Baby-Friendly through the Baby-Friendly Hospital initiative, or to follow the Maryland Hospital Breastfeeding Policy Recommendations. As of 2020, only 10 hospitals reaffirmed their commitments, representing approximately 31% of birthing hospitals.

Maternity Staff Training

Under the guidance of the Hospital Breastfeeding Policy Committee, and in a collaboration between International Board Certified Lactation Consultants (IBCLCs) at the Maryland Department of Health and the University of Maryland Upper Chesapeake Medical Center, a series of 15 maternity staff training modules were developed. The modules provide education and expertise needed to meet both the Maryland Hospital Breastfeeding Policy Recommendations and the Baby Friendly Hospital Initiative.

Technical Assistance Calls

The Maryland Hospital Breastfeeding Policy Committee offers technical assistance conference calls three to four times a year, on average, to help hospitals with implementation of the Maryland Breastfeeding Policy Recommendations and Baby Friendly Ten Steps. These calls include practical steps and information from IBCLCs, staff nurses, administrators and policy committee members from across Maryland. The experts on the call, professionals from hospitals achieving the topic at hand, lead the conversation about best-practices and ideas on how to best implement the topic being discussed. Past recordings on Auditing and Quality Improvement, Skin-to-Skin and Breastfeeding Training Resource Webinar are still available for listening.

Physician Webinar Series

In 2016, the Maryland Hospital Breastfeeding Policy Committee coordinated a six-lecture series of free webinars about breastfeeding-related topics[15]. These webinars provided continuing medical education (CME) credits, as well training sessions help fulfill the Baby Friendly USA and the Maryland Hospital Breastfeeding Policy Recommendations. CME credits were available at no cost until June 2019.

Maryland WIC Program

The Maryland WIC Program is committed to helping families have positive, successful breastfeeding experiences. WIC provides resources, such as a FAQ sheet, handouts and a breastfeeding checklist available in both English and Spanish, as well as videos that provide information on various breastfeeding-related topics.

NPM 5: Safe Sleep

HRSA states that the goal for this NPM is “to increase the percent of infants placed to sleep on their backs, on a separate approved sleep surface, without soft objects or loose bedding.” Furthermore, HRSA defines this NPM in three ways: 1) the number of mothers reporting that they most often place their baby to sleep on their back only divided by the total number of live births to find the percent; 2) the number of mothers reporting that their baby always or often sleeps alone, usually in a crib, bassinet, or pack and play, and not usually in a standard bed, couch, sofa, armchair, car seat or swing divided by the

[15] https://phpa.health.maryland.gov/mch/Pages/Hospital_Breastfeeding_Physician_Training.aspx

total number of live births to find the percent; and 3) the number of mothers reporting that their baby does not usually sleep with blankets, toys, cushions, pillows or crib bumper pads divided by the total number of live births to find the percent.

Evidence-Based Strategy Measure: Build on Safe Sleep Campaigns

Percent of postpartum mothers reporting that they received information about safe sleep practices and received appropriate referrals to safe sleep resources before discharge.

The strategy selected for this NPM is to build on safe sleep campaigns by engaging Title V programs and community partners. This strategy entails a professional training made available to Home Visitors, Healthy Start providers and other direct service providers in the community who work directly with expecting and new mothers and families to emphasize a nuanced approach to take family needs, beliefs and context into account when talking about safe sleep.

This strategy is a new approach and is supported by the "Building on Campaigns with Conversations" series of modules developed by the National Center for Education in Maternal and Child Health (NCEMCH). The modules received extensive input from the National Action Partnership to Promote Safe Sleep (NAPPSS) coalition of more than 70 national organizations. Furthermore, this approach is based on Ajzen's Theory of Planned Behavior and follows current American Academy for Pediatrics (AAP) recommendations for safe sleep.

AMCHP's Implementation Toolkit for National Performance Measure 5

The Association of Maternal and Child Health Programs (AMCHP) partnered with the National Institute for Children's Health Quality (NICHQ) to create the Implementation Toolkit for NPM 5. Furthermore, NICHQ developed an Infant Mortality CoIIN Prevention Toolkit, which provides information on safe sleep practices.

Morgan State University (MSU) Safe Sleep Project

The Morgan State University (MSU) Safe Sleep Project is funded by MCH with Title V funds. The Project was started in 2019 and aims to provide safe sleep messaging in African American communities through the development of a social marketing campaign. Focus groups were conducted in two Baltimore City communities to understand why African American communities are not using safe sleep practices. Currently, the Program is working on a video that speaks to myths about safe sleep practices in communities of color. This video will be distributed to local health departments and home visiting programs throughout the state

Surveillance & Quality Improvement Program

The Surveillance & Quality Improvement Program works with mothers who had a fetal or infant loss to gain information about their experience. The Program is funded with Title V funds, where money goes to support the Fetal and Infant Mortality Review (FIMR).

Maryland's FIMR Program

The Maternal and Child Health Bureau, housed within the Maryland Department of Health, serves as the lead agency for Maryland's FIMR Program. There are 18 FIMR projects in Maryland which represent all 24 jurisdictions, of those 16 are jurisdiction level programs and two are regional FIMR programs.

FIMR teams work to identify various findings, recommendations and action steps for improving systems of care for pregnant women and infants. Recent recommendations include improving access to prenatal

care, family planning, bereavement and other mental health services and substance abuse services. Additionally, they recommend increased screening for domestic violence, safe infant sleep practices and improved case management.

Babies Born Healthy (BBH) Grantees

The Babies Born Healthy (BBH) Program provides resources to the seven jurisdictions with the highest counts or rates of infant mortality, to include Anne Arundel, Baltimore, Charles, Montgomery, Prince George's and Wicomico Counties and Baltimore City. Community Health Workers work with nurses to coordinate care and navigate services to high-risk communities to link at-risk pregnant women to services associated with improved birth outcomes.

Local Health Departments Participating in BBH

Anne Arundel County

The Anne Arundel County Department of Health provides various services, information and resources for perinatal health, including Healthy Start. Healthy Start provides case management, home visiting, outreach and other services to prevent injuries and deaths to high-risk pregnant women, infants and toddlers up to the age of 2. These services are provided by community health nurses and social workers.

The Anne Arundel County Department of Health is working on an initiative for Healthy Moms and Babies, where the aim is to increase the number of healthy pregnancies and healthy babies by promoting awareness and improving access to County health resources. The goal is "for all babies in Anne Arundel County to be born healthy and thrive." As part of this initiative, various information on safe sleep is provided, including a new "Safe Sleeping for Babies flier," safe sleep videos and a safe sleep information card, as well as the ABCs of safe sleep.

Baltimore City

The Baltimore City Health Department operates under the vision of "an equitable, just, and well Baltimore where everyone has the opportunity to be healthy and to thrive" and the mission "to protect health, eliminate disparities and enhance the wellbeing of everyone in our community through education, coordination, advocacy and direct service delivery." The Baltimore City Health Department covers various areas of responsibility, including maternal and child health.

The Baltimore Infants and Toddlers Program (BITP) serves infants and toddlers up to the age of 2 who may be experiencing a delay in development, as well as their families. Services include special instruction, speech pathology and audiology, occupational therapy, physical therapy, psychological services, case management, medical services for diagnosis, health services related to other early intervention services and family education, counseling and support.

ABCDs for Sale Sleep

Alone. Babies should never sleep with anyone else. Share a room, but not a bed with your baby.
Back. Babies should always sleep on their backs. Babies are less likely to choke when on their backs.
Crib. Babies should always sleep in a crib – every night and every nap. The crib should be clean and clear. There should be no toys or blankets in the crib.
Don't Smoke. Never smoke cigarettes or marijuana in a home with babies, young children, or pregnant women. Smoke in the home makes it harder for babies to breathe well.
http://healthybabiesbaltimore.com/our-initiatives/safe-sleep

Baltimore City currently has two BBH initiatives in place, B'more for Healthy Babies (BHB) and Baltimore Healthy Start. B'more for Healthy Babies (BHB) is a Baltimore City initiative led by the Baltimore City Health Department with support from Family League of Baltimore and HealthCare Access Maryland. BHB coordinates and connects communities, organizations and resources to give every baby the best possible start. BHB provides pertinent information on the ABCD's of safe sleep, as well as provide a safe sleep toolkit.

Baltimore Healthy Start Inc. started in 1991 as a 501(c)3 nonprofit corporation by the Baltimore City Health Department to implement the original federal Healthy Start informant mortality reduction initiative, Baltimore Healthy Start, Inc. promoted health and wellness by investing in the health and well-being of Baltimore's families. Baltimore Healthy Start Inc. aims to reduce perinatal health disparities by providing expecting and new mothers and families with necessary health care and resources.

Baltimore County

The Baltimore County Department of Health offers a variety of health services, information and resources for children's health, including the Infants and Toddlers Program. The Infants and Toddlers Program is a joint effort of the Baltimore County Department of Health, Baltimore County Public Schools, Department of Social Services and other private agencies. Services may include assistive technology (equipment), developmental monitoring, individual and family counseling, nursing, occupational therapy, physical therapy, service coordination (case management), social work, speech and language therapy and transportation.

Charles County

The Charles County Department of Health operates with the mission "to promote, protect and improve the health of our community" and the vision statement of "a healthier Charles County," and offer various infant and child services, information and resources. The Charles County Infants and Toddlers Program provides a family centered approach to assist infants and toddlers who may be delayed in

development or have disabilities. The Infant and Toddler services may include service coordination, audiology, physical therapy, occupational therapy, speech language pathology, family training, counseling, home visits, assistive technology services and special instruction.

Montgomery County

The Montgomery County Government provides information and resources for maternal and infant health, including Babies Born Healthy (BBH), improved pregnancy outcomes, case management for infants at risk, nurse case management for maternal and child and the teen parent support program. Furthermore, the Department of Health and Human Services houses the Montgomery County Head Start/Prekindergarten Program and the Montgomery County Infants and Toddlers Program (MCITP), both of which provide services, resources and support to infants, toddlers and young children who may have developmental delays and disabilities.

The Montgomery County Babies Born Healthy (BBH) program eligibility requirements include African American women who are pregnant, being a Montgomery County resident living in specific zip codes and being a Medicaid recipient.

The Maternal/Child Nurse Case Management Program provides on-site and in-home Community Health Nurse Case Management services to uninsured pregnant women and children up to age 2. Case management services include education, assessment and referral, and assistance to clients in accessing health, economic and self-sufficiency services and programs.

The Teen Parent Support program provides peer group education on raising children, healthy relationships and prevention of repeat teenage pregnancy. The support groups are made up of Montgomery County Public School (MCPS) students who are pregnant or parenting and are led by school nurses and assisted by MCPS staff and community partners. The groups take place during the school day.

Prince George's County

Prince George's County provides Maternal and Infant Health Programs which offer services and education information designed to promote healthy outcomes, as well as provide education for the community about important pregnancy and infant topics. Programs and services include the Healthy Beginnings Program, the Safe Sleep Campaign and the Community Action Team.

The Healthy Beginnings Program provides services that promote healthy pregnancy outcomes and early health care practices for Prince George's infants and children up to age 2. Nurses and support staff provide case management through assessments, interventions and referrals for psychosocial and behavioral risk factors associated with both poor health and developmental outcomes.

Prince George's Safe Sleep Campaign provides safe sleep training for organizations, childcare centers and community groups that interact with pregnant women, mothers with infants, or care for infants. The Safe Sleep Campaign also provides individual education and outreach through various materials and resources, including informational PDFs, websites and information on organizations and initiatives like Charlie's Kids Foundation and Cribs for Kids.

The Prince George's County Community Action Team (CAT) brings together key stakeholders from the community, including key community leaders, public health agencies and providers, human service providers, health care providers and advocacy groups to create public health interventions that address trends in infant mortality. Prince George's CAT currently oversees the infant Safe Sleep Campaign, prenatal education and bereavement.

Wicomico County

The Wicomico County Health Department houses the Maternal & Child Health division which is comprised of various programs dedicated to the mission of protecting, promoting and improving the health and well-being of women, children and families. This is achieved through education, prevention and case management, as well as providing access to prenatal and health care services to those in need.

Healthy Families Wicomico County is a voluntary, evidence-based home visiting program modeled after the national initiative Healthy Families America (HFA). Healthy Families Wicomico has been accredited and meets the standards for Home Visitation Services as established by HFA. This program serves pregnant or parenting families until the age of 5, with enrollment preference of no later than the first three months after birth.

Revised Priority Needs and Strategies

In 2016-2020, safe sleep was identified as the only NPM for the perinatal and infant health population domain. Task force members decided to keep safe sleep for the 2021-2025 action plan, with the addition of two other NPMs: Risk Appropriate Perinatal Care and Breastfeeding.

Maryland Priority Needs, 2021-2025	National Performance Measure(s)	Population Domains
2. Healthy Pregnancy Outcomes and Infants: Improve perinatal and infant health in Maryland by reducing disparities.	**Risk Appropriate Perinatal Care:** Percent of very low birthweight (VLBW) infants born in a hospital with a level III or higher NICU **Breastfeeding:** Percent of infants ever breastfed **Safe Sleep:** Percent of infants placed on back to sleep Percent of infants who always or often sleep alone, usually in a crib, bassinet, or pack and play, and not usually in a standard bed, couch, sofa, armchair, car seat or swing Percent of infants who sleep without blankets, toys, cushions, pillows or crib bumper pads.	Perinatal and Infant Health

Maryland Priority Needs, 2016-2020	National Performance Measure(s)	Population Domains
2. Healthy Pregnancy Outcomes and Infants: Improve perinatal and infant health in Maryland by reducing disparities.	**Safe Sleep:** Percent of infants placed on back to sleep	Perinatal and Infant Health

Challenges and Emerging Issues

The COVID-19 pandemic presents challenges for perinatal and infant health as well. Perinatal health is adversely impacted in virtually the same ways as was discussed in the women's and maternal health section. Programs, such as Infants and Toddlers (ITP), are implementing virtual models, which are still in the learning curve phases and therefore may not provide as comprehensive of a service.

Labor and delivery during the pandemic may look very different. Delivery restrictions, including some hospitals no longer admitting spouses, close family members or doulas and other hospitals forcing expecting mothers to choose between their spouse or doula, can potentially lead to increased stress, anxiety and depression for the mother.

Much is still unknown about the risk of COVID-19 to newborns and infants. However, for mothers suspected or confirmed to have COVID-19, it is recommended that a temporary separation of the newborn from a mother be considered to reduce the risk of spreading the virus to the newborn. The CDC recommends, for mothers who do not choose temporary separation, that the hospital and mother take precautions to avoid spreading the virus to the newborn, such as social distancing, mask wearing and washing hands. For mothers who are discharged before meeting the criteria to discontinue isolation, these precautions should continue to be implemented.

Breastfeeding is also made more challenging when separation is implemented. During separation it is recommended that hand expression or pumping be done every 2-3 hours, at least 8-10 times in 24 hours, especially in the first few days. If a mother chooses to breastfeed, the CDC recommends that a cloth face covering be work and hands be washed with soap and water for at least 20 seconds prior to each feeding. Breast milk is still recommended because it provides protection against illnesses.

CHILD HEALTH

HRSA identifies four key strategic priority goals for child's health, to include: 1) increasing the number of children who receive a developmental screening; 2) decreasing the number of hospital admissions for non-faulty injury among children ages zero through nine; 3) increasing the number of children adequately insured; and 4) increasing access to comprehensive oral health for MCH populations most at risk for oral disease.

The state of Maryland identifies the objective for this population as improving access to preventive, primary and behavioral health services as well as medical homes for Maryland children including those with special health care needs.

Introduction

For the 2021-2025 Five-Year Action Plan, the Project Steering Committee selected Developmental Screening (NPM 6) as the NPM for child health.

Developmental Screening. In 2018, 34.7% of parent's completed the developmental screening questionnaire, compared to 33.5% nationally.

Plan for the Application Year

Provided in this section is the selected national performance measure (NPM), as well as the selected evidence-based strategy measure (ESM). Furthermore, this section details the plan of action for this application year for each selected NPM.

NPM 6: Developmental Screening

HRSA states that the goal for this NPM is "to increase the percent of children who receive a developmental screening." Furthermore, HRSA defines this NPM by the number of children, ages 9 through 35 months (2 years), whose parents completed a Standardized Developmental Screening tool in the past year divided by the total number of children, ages 9 through 35 months, to determine the percent.

Evidence-Based Strategy Measure: Local Health Department Home Visiting Programs

Percent of families who utilized local home visiting programs for their children.

The strategy selected for this NPM is to leverage the reach that local health department home visiting programs have to Maryland families with children under the age of five to educate parents on the importance of developmental screenings and to provide opportunities to complete a developmental screening. Additionally, Medicaid data will be monitored, tracked and assessed to determine how many children are receiving developmental screenings through their primary care providers

AMCHP's Implementation Toolkit for National Performance Measure 6

The Association of Maternal and Child Health Programs (AMCHP) partnered with Innovation Station to develop AMCHP's Implementation Toolkit for National Performance Measure 6. The toolkit provides an issue brief *Early Childhood Developmental Screening and Title V: Building Better Systems.* The toolkit also explores six strategic approaches, which include: 1) data collection, measurement, and existing landscape, 2) technical assistance and training, 3) policy research development and implementation, 4)

education, engagement, and resource development, 5) systems coordination, and 6) other program strategies.

Local Health Department Home Visiting Programs

Currently, six of the twenty-four local health departments in Maryland use Title V funds to provide home visiting services to prenatal and postpartum women and infants. During FY 2019, a total of 4,178 families were enrolled in a local health department home visiting program. Public health nurses provide prenatal and postpartum women and infants with social support, education on safe sleep practices, breastfeeding, child development, parenting and health education, linkages to community resources, medical homes, and dental care, and risks associated with second-hand smoke.

Maryland's CFR

The Maryland Child Fatality Review (CFR) is made up of a 25-member team with the purpose of preventing child deaths by: 1) understanding the causes and incidences of child deaths; 2) implementing changes within the agencies represented on the State CFR Team to prevent child deaths; and 3) advising the State leadership on child death prevention. The State CFR Team also sponsors an all-day training for local CFR team members on select topics related to child fatality issues.

Local Infants and Toddlers Program

Infants and Toddlers programs direct a family-centered system of early intervention services for infants, toddlers and young children with developmental delays and disabilities, as well as their families.

Infants and Toddlers programs are available in all 24 jurisdictions in Maryland. Local programs are a collaborative partnership through public schools, health departments, and departments of social service. The lead agency varies from jurisdiction to jurisdiction and in larger jurisdictions services are provided through community-based organizations. Services are designed to enhance a child's potential before they reach school age and may include audiology, physical therapy, occupational therapy, transportation, speech-language pathology, family training, special instruction, assistive technology, health services and home visits. Title V funds are used by four local health departments to provide Infants and Toddlers services including care coordination and case management.

Revised Priority Needs and Strategies

In 2016-2020, developmental screening was identified as the NPM for the child health domain. Developmental screenings remained the selected NPM for the 2021-2025 action plan for this population domain.

Maryland Priority Needs, 2021-2025	National Performance Measure(s)	Population Domains
3. Access to Health Care for Children: Improve access to preventive, primary, specialty and behavioral health services as for Maryland Children including those with special health care needs.	**Developmental Screening:** Percent of children, ages 9-71 months, receiving a developmental screening using a parent completed screening tool.	Child Health
Maryland Priority Needs, 2016-2020	**National Performance Measure(s)**	**Population Domains**
3. Access to Health Care for Children: Improve access to preventive, primary, specialty and behavioral health services as well as medical homes for Maryland children including those with special health care needs.	**Developmental Screening:** Percent of children, ages 9-71 months, receiving a developmental screening using a parent completed screening tool	Child Health

Challenges and Emerging Issues

Despite children not appearing to be at higher risk for COVID-19, there are still implications for children's health, including constrained access to health care, schools, extracurricular activities and other supports. The CDC recommends that during these challenging and unprecedented times, children need to be kept healthy[16]. They recommend:

- Teaching and reinforcing everyday preventive actions
- Helping your child stay active
- Helping your child stay socially active
- Helping your child cope with stress.

The pandemic may be especially stressful for school-aged children who are struggling with a "new normal" of being socially isolated from their peers, friends and loved ones, while also dealing with home-schooling. With public schools closed, most extracurriculars are cancelled and referrals to services are extremely hindered. Children who already have mental health conditions like anxiety disorder or depression may struggle with a magnified emotional impact. A recent survey, conducted among children from Hubei province in China and published in JAMA Pediatrics, revealed that children confined to their homes during the pandemic present above normal symptoms of anxiety and depression[17].

"[COVID-19 has] definitely made me a lot sadder. I feel more depressed all the time and it's hard for me to find joy in little moments."

-9th Grade Student

https://www.npr.org/2020/05/21/859991352/coronavirus-crisis-may-worsen-symptoms-in-children-with-anxiety-depression

[16] https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/children.html

[17] https://www.psypost.org/2020/05/home-confinement-during-COVID-19-puts-children-at-risk-for-symptoms-of-anxiety-and-depression-study-suggests-56726

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN)

HRSA identifies its key strategic goal for children and youth with special health care needs as creating an effective system of care to allow for optimal health and quality of life for all CYSHCN and their families. An effective system of care ensures:

- Families are partners in care
- Screening occurs early and continuously
- Families can easily use community-based services
- Children and youth have access to an accessible family-centered, comprehensive medical home
- There is adequate insurance and funding to cover services
- Families and providers plan for transition to adult care and services.

The State of Maryland identifies the objective for this population as improved health through comprehensive, coordinated care for CYSHCN and support for successful transition to adult health care.

Introduction

For the 2021-2025 Five-Year Action Plan, the task force selected Medical Home (NPM 11) and Health Care Transition (NPM 12) as the NPMs for children and youth with special health care needs. This NPM includes children and youth with and without special health care needs crossing both CSHCN and Child Health population domains.

Medical Home. In 2018, Maryland saw a reduction in the percentage of children with and without special health care needs, ages 0 through 17, who met the criteria for having a medical home. With both populations, Maryland's percentage was higher than the national average (50.6% vs. 42.7% and 49.7% vs. 49.4%, respectively).

Transition. In 2017, 15.3% of children in Maryland received services necessary to transition to adult health care, compared with 14.2% nationally. 21.6% of children and youth with special health care needs received services necessary for transition to adult health care, compared to the national average of 18.9%.

Plan for the Application Year

Provided in this section is the selected national performance measure (NPM), as well as the selected evidence-based strategy measure (ESM). Furthermore, this section details the plan of action for this application year for each selected NPM.

NPM 11: Medical Home

HRSA states that the goal for this NPM is "to increase the percent of children with and without special health care needs who have a medical home." Furthermore, HRSA defines this NPM by the number of children with and without special health care needs, ages 0 through 17, who meet the criteria for having a medical home (personal doctor or nurse, usual source for care and family-centered care; referrals or care coordination if needed) divided by the total number of children, ages 0 through 17 to determine the percent.

Evidence-Based Strategy Measure: Outreach

Percent of families who received effective care coordination for their children.

The strategy selected for this NPM is to provide outreach to communities and families about the availability and benefits of the pediatric medical home model of care. Title V Agencies can support this strategy through various approaches including relationship building and engaging with the community, implementing community health workers, proactively seeking family and community feedback and focusing on cultural competency. This strategy may also entail involving medical students and changing the curriculum to emphasize the importance of coordinated care through a medical home model.

Key informants and strategic planning session participants both supported a medical school curriculum change to emphasize both medical home and transition.

AMCHP's Implementation Toolkit for National Performance Measure 11

The Association of Maternal and Child Health Programs (AMCHP) will provide resources and a toolkit for the implementation of the medical home approach. An estimated launch date is not available at this time.

The Maryland Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program

MIECHV staff work closely with the Title V child and adolescent health staff on various childhood issues including home visiting, early childhood mental health, child abuse and neglect, developmental screenings and access to medical homes. MIECHV serves as one of the best practice standards associated with ensuring that children have a medical home.

In September 2019, HRSA awarded approximately $351 million in funding to 56 states, territories and nonprofit organizations to support evidence-based home visiting through the MIECHV Program, of which Maryland received $7,782,513. Nationwide, this funding resulted in MIECHV programs serving over 154,000 parents and children with more than 1,000,000 home visits.

In Maryland, formula funding is allocated to six jurisdiction with communities that demonstrated the highest need for maternal and child intervention, which make up the Tier 1 communities, including Baltimore City and Dorchester, Prince George's, Somerset, Washington and Wicomico Counties. Competitive funds further expand home visiting in Maryland to at-risk communities within Allegany, Baltimore, Caroline and Hartford Counties, which make up the Tier 2 communities, while also providing additional funds to five of the six Tier 1 jurisdictions[18].

Perinatal and Infant Oral Health Quality Improvement Expansion Grant Program

The goal of this grant program is to reduce the prevalence of oral disease in both pregnant women and infants most at risk for disease through improved access to quality oral health care. Specifically, the project aims to reduce prevalence of oral disease in pregnant women and infants; increase preventive care utilization for pregnant women; establish a dental home for infants by age one and reduce dental expenditures.

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18 https://phpa.health.maryland.gov/mch/Pages/home_visiting.aspx#:~:text=Maternal%2C%20Infant%20and%20Early%20Childhood,Children%20and%20Families%20(ACF).

The OOH plans to employ multiple strategies to improve the oral health literacy and awareness of low-income pregnant women and the oral health behaviors of health care practitioner groups to increase oral health care utilization for the mother and her child throughout their lifespan. This is important because, currently, pregnant women in Maryland are underutilizing their Medicaid Dental Benefit. Ultimately, by linking the delivery of oral health with primary care, the overall well-being of pregnant women and infants will be improved.

The Office of Oral Health used the Perinatal and Infant Oral Health Quality Improvement (PIOHQ)I grant funds to improve project infrastructure by recruiting and hiring a Project Manager and part-time Evaluation Specialist, as well as convening a Project Advisory Board composed of representatives from various health professional groups throughout the State. Key partners include the Maternal and Child Health Bureau's Office of Quality Initiatives, WIC, and the Office for Genetics and People with Special Health Care Needs, the Office of Women's Health within the Office of Surveillance and Quality Initiatives, which has close ties to the Maryland Chapter of the American College of Obstetricians and Gynecologists, and the Office of Minority Health and Health Disparities. External partners include the Maryland Dental Action Coalition, the State Head Start Collaboration Office, and the University of Maryland, School of Dentistry.

The grant supported the development of collaborative partnerships with the University of Maryland, School of Public Health to conduct a survey and focus group of pregnant women, a survey of medical and dental providers who reside and/or practice in state "hot spots", and training to medical professionals on the importance of perinatal and infant oral health care. The OOH has also implemented an Early Head Start Oral Health Adoption program for accredited Dental Hygiene Programs to provide oral health education and referral resources to Early Head Start enrolled pregnant women and infants.

With further support, the OOH will be able to continue to plan, develop, and evaluate evidence-based statewide interventions targeting perinatal women and infants[19].

NPM 12: Transition

HRSA states that the goal for this NPM is "to increase the percent of adolescents with and without special health care needs who have received the services necessary to make transitions to adult health care." Furthermore, HRSA defines this NPM by the number of children with and without special health care needs, ages 12 through 17, whose families report that they received the services necessary to transition to adult health care, by the total number of adolescents, ages 12 through 17 to determine the percent.

Evidence-Based Strategy Measure: Six Core Elements of HCT 3.0

Number of adult and pediatric providers who have received training in transition services.

The strategy selected for this NPM is to encourage through increased education and training opportunities, the use of Got Transition's Six Core Elements of HCT 3.0 in pediatric family medicine, internal medicine practices, specialty clinics, care coordination programs, school-based health centers and mental health programs, and health plans/ACOs. Maryland may also consider providing a 1-hour free Continuing Education course on HCT for MDs, PAs, NPs, nurses, social workers, mental health

[19] https://www.mchoralhealth.org/PDFs/PIOHQI_Expansion_Abstracts_MD.pdf

counselors and allied health. 10 peer-reviewed articles have documented progress in this strategy, making the evidence moderate.

AMCHP's Implementation Toolkit for National Performance Measure 12

The Association of Maternal and Child Health Programs (AMCHP) partnered with Got Transition to develop AMCHP's Implementation Toolkit for National Performance Measure 12. The toolkit provides various relevant resources and tools Title V programs and public health professionals can use to address NPM 12 and encourage successful youth transitions to adult health care. The toolkit explores five strategic approaches, which include: 1) youth and family education and leadership development, 2) health care professional workforce development, 3) care coordination, 4) communications and social media, and 5) measurement and assessment.

Office for Genetics and People with Special Health Care Needs (OGPSHCN)

The Office for Genetics and People with Special Health Care Needs (OGPSHCN) provides information and resources for youth to young adult health care transition. Various fact sheets and videos about health care transition can be found on the OGPSHCN website, including Got Transition's "Six Core Elements" of Health Care Transition and the American Academy of Pediatrics (AAP) Clinical Report.

Updated in 2013, OGPSHCN developed the Maryland Youth to Young Adult Care Notebook[20]. The care notebook has been designed for parents and caregivers of a child with special health care needs and provides a helpful central tool to store all a child's health care information. The care notebook allows parents and caregivers to provide any health information about their child, including reports from recent doctor's visits, recent summary of a hospital stay, current school plan, test results and informational pamphlets. Additionally, parents and caregivers can also provide pertinent information about their child that they feel people caring for their child may need.

OGPSHCN has administered health care transition focused grants using Title V funds to grantees from academic clinical centers and community-based organizations for the last several years. These include:

The Johns Hopkins Transition Independence Network: J-TraIN:
This project implemented the customized evidence-based best practice model for health care transition (HCT). J-TraIN is a collaborative within the Johns Hopkins Health System that seeks to improve transition between pediatric and adult medicine for youth with special care needs through direct patient care and provider training using the Project ECHO model.

The Coordinating Center-Transition Connection Initiative:
The Coordinating Center developed this initiative as a pilot project to improve HCT from pediatric to adult health care systems for youth with special health care needs and their families. The pilot focused on participants in the Rare and Expensive Case Management program ages 12-15 in Baltimore City or Baltimore County and used a customized transition readiness tool to help youth identify their needs, create an individualized plan of care, and maximize their independence in all aspects of adult life.

[20] https://phpa.health.maryland.gov/genetics/docs/HCTL/Notebook_log_071017.pdf

Children's National Medical Center-Complex Care and Parent Navigator Program:
This parent navigation program led a pilot effort to provide transition related services, identify appropriate adult providers, and facilitate transition training workshops for families.

OGPSHCN also administered grants to local health departments that provided HCT services in concert with their primary projects that focused on care coordination and case management services. Building upon this substantial experience with grant projects focused on HCT and medical home implementation, OGPSHCN is initiating a competitive grant process during the Title V application year.

Got Transition

Got Transition/Center for Health Care Transition Improvement[21] is a cooperative agreement between the Maternal and Child Health Bureau and The National Alliance to Advance Adolescent Health. They operate under the aim of improving transition from pediatric to adult health care through the use of modern and innovative strategies. Through various partners, Got Transition is working to:

- Expand the use of the Six Core Elements of Health Care Transition™ in pediatric, family medicine and internal medicine practices;
- Partner with health professional training programs to improve knowledge and competencies in providing effective health care transition supports to youth, young adults and families;
- Develop youth and partner leadership in advocating for needed transition supports and participating in transition quality improvement efforts;
- Promote health systems measurement, performance and payment policies aligned with the Six Core Elements of Health Care Transition; and
- Serve as a clearinghouse for current transition information, tools and resources.

Six Core Elements of Health Care Transition (HCT) 3.0

1. Transition and Care Policy/Guide
2. Tracking and Monitoring
3. Transition Readiness/Orientation to Adult Practice
4. Transition Planning/Integration into Adult Practice
5. Transfer of Care/Transition to Adult Approach to Care/Initial Visit
6. Transfer Completion/Ongoing Care

Additionally, Got Transition has developed two toolkits relevant to transition from pediatrics to adult healthcare: A Family Toolkit: Pediatric-to-Adult Health Care Transition and Young Adult Health Care Transition Social Media Toolkit[22].

Revised Priority Needs and Strategies

In 2016-2020, medical home and transition were identified as the NPMs for the children and youth with special health care needs domain. For the 2021-2025 action plan, both medical home and transition remained as the NPMs selected for the Children with Special Health Care Needs population domain.

[21] https://www.gottransition.org/

[22] https://phpa.health.maryland.gov/genetics/docs/HCTL/Social%20Media%20Toolkit%20-%20FINAL%206-7-18.pdf

Maryland Priority Needs, 2021-2025	National Performance Measure(s)	Population Domains
4. Healthy Children with Special Needs: Improve the health of children and youth with special health care needs through comprehensive and coordinated care, as well as support their transition to adult health care.	**Medical Home:** Percent of children with and without special health care needs having a medical home. **Transition:** Percent of children with and without special health care needs who received services necessary to make transitions to adult health care.	Children with Special Health Care Needs
Maryland Priority Needs, 2016-2020	**National Performance Measure(s)**	**Population Domains**
4. Healthy Children with Special Needs: Improve the health of children and youth with special health care needs.	**Medical Home:** Percent of children with and without special health care needs having a medical home. **Transition:** Percent of children with and without special health care needs who received services necessary to make transitions to adult health care.	Children with Special Health Care Needs

Challenges and Emerging Issues

Children and youth with special health care needs (CYSHCN) represent a population that may be at increased risk for complications of the COVID-19 illness. CYSHCN may be especially vulnerable to secondary impacts of the COVID-19 pandemic.

School and business closings can adversely affect the availability of services, therapies and supports for children with special health care needs. Home health care and in-home therapy needs may switch to virtual platforms to allow the child to stay in touch with their therapists and direct support team[23]. Furthermore, these changes can be especially stressful to CYSHCN who Benefit from predictability in daily routines.

[23] https://www.healthychildren.org/English/health-issues/conditions/chest-lungs/Pages/COVID-19-Information-for-Families-of-Children-and-Youth-with-Special-Health-Care-Needs.aspx

ADOLESCENT HEALTH

HRSA identifies six key strategic goal for adolescents to improve their health and safety, as well as increase access to comprehensive coordinated health care. These six goals are to: 1) decrease the number of hospital admissions for non-fatal injury among adolescents age 10 through 19; 2) increase the number of adolescents who are physically active; 3) reduce the number of adolescents who are bullied or who bully others; 4) increase the number of adolescents who have a preventive medical visit; 5) increase the number of adolescents, with and without special health care needs, who receive necessary services to make transitions to all aspects of adult life, including health care, work and independence; and 5) increase the number of children who are adequately insured.

Introduction

For the 2021-2025 Five-Year Action Plan, the Needs Assessment Steering Committee selected one NPM related to adolescent health, adolescent well visit (NPM 10.

Adolescent Well-Visit. In 2018, according to the National Survey of Children's Health (NSCH), 68.8% of adolescents, ages 12 through 17, received a preventive medical visit within the last year, above the national average of 64.8%. Non-Hispanic Black adolescents reported having a preventive medical visit more than their non-Hispanic White peers (80% and 74.6%, respectively).

Plan for the Application Year

Provided in this section is the selected national performance measure (NPM), as well as the selected evidence-based strategy measure (ESM). Furthermore, this section details the plan of action for this application year for each selected NPM.

NPM 10: Adolescent Well-Visit

HRSA states that the goal for this NPM is "to increase the percent of adolescents who have a preventive medical visit". Furthermore, HRSA defines this NPM by the number of adolescents, ages 12 through 17, with a preventive medical visit in the past year divided by the total number of adolescents, ages 12 through 17 to find the percent.

Evidence-Based Strategy Measure: Improve Access and Uptake of Adolescent Well-Visits

% of Adolescents ages 12-17 at MCH-contracted health centers who have at least one comprehensive well-care visit with a PCP or an OB/Gyn practitioner.

In partnership with Maryland Medicaid, Title V will track Adolescent Well Visits by CPT codes from Medicaid data. Maryland Medicaid, like several other states, has added Adolescent Well Visits to the protocols for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits.

Title V will also continue to provide existing prevention programming, sexual health services and risk-reduction to promote comprehensive services for adolescents.

AMCHP's Implementation Toolkit for National Performance Measure 12

The Association of Maternal and Child Health Programs (AMCHP) partnered with the Adolescent & Young Adult Health National Resource Center to develop AMCHP's Implementation Toolkit for National Performance Measure 10. The toolkit provides various relevant resources and strategies Title V

programs can use to encourage adolescent well-visits, which include: 1) improving access and uptake of preventive services; 2) improving quality of preventive services; 3) improving State/systems-level policies and practices; and 4) positive youth development.

Maryland Healthy Kids Program

In Maryland, the prevention care component of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program is known as the Healthy Kids Program. The Program provides appropriate practice-based performance improvement assessments and targeted interventions to enhance the quality of health services delivered by Medicaid providers. The Maryland Healthy Kids Program Schedule of Preventive Health Care summarizes the minimum standards of preventive care for all children and adolescents up to 21 years of age, which are developed through a collaboration with key stakeholders. The Preventive Health Schedule closely correlates with the American Academy of Pediatrics' periodicity schedule.

Title V Partnerships

Title V staff have active and productive partnerships with the Office of School Health and other organizations with the goal of improving screening and referral for emotional/behavioral health concerns in adolescents, improving successful transition to adult health care and encouraging reproductive life planning. Adolescent well-visits and school-based health services are vital components of advancing these objectives.

SRAE and PREP

The Sexual Risk Avoidance Education (SRAE) grant program funding is administered by the OFCHS and uses a multi-dimensional approach to promote sexual risk avoidance based on the promotion of abstinence as the best risk reduction strategy for adolescents. In addition, the Personal Responsibility and Education Program (PREP) program funds made available under the Affordable Care Act are also administered under the OFCHS. Both SRAE and PREP provide support to local community agencies and health departments to implement evidence-based programming to prevent teen pregnancy and promote positive youth development. Additionally, both grantees continue to include health literacy and wellness in their curriculum.

Maryland Optimal Adolescent Health Program (MOAHP)

In July 2020, the Maternal and Child Health Bureau, Office of Family and Community Health Services (OFCHS) was awarded a three-year federal teen pregnancy prevention grant. Project funds will be distributed to grantees (e.g., Healthy Teen Network, Johns Hopkins University Center for Adolescent Health, local health departments, school, and community-based programs) located throughout the state. Grantees will offer sexual education programming to teens age 14-19 living in areas of the state with high rates of teen birth and sexually transmitted infections.

The teen pregnancy prevention initiative, formally named Maryland Optimal Adolescent Health Program (MOAHP), promotes equity in reaching optimal health by preventing teen pregnancy and sexually transmitted infections in rural counties of the state by creating an infrastructure to develop and support highly effective health education and parent/caregiver programs. MOAHP will increase the capacity of health education programs to develop students' positive attitudes and values towards sexual and reproductive health and increase opportunities to reinforce skills and positive behaviors. Parent/caregiver programs will increase healthy communication between adults and youth. Healthy

Teen Network (HTN) will lead this effort by providing instruction and guidance to health educators and administrators to improve program outcomes and promote the sustainability of highly effective health education programming in Maryland.

The MOAHP consortium will use the Positive Prevention Plus curriculum, which has seen a statistically significant delay in the onset of sexual activity and statistically significant increases in student-parent communication around sexual health issues. HTN will model and enforce behaviors that create an environment in which students feel valued and emphasize individual and group norms that support optimal health-enhancing behaviors as well as demonstrate effective instructional and behavior management strategies that support social-emotional learning.

OFCHS will create networks of support for health educators and students to effectively engage youth, parents/caregivers, and the community in MOAHP. OFCHS and HTN will partner with the Maryland State Department of Education (MSDE) and community stakeholders to replicate, with fidelity, effective programs, and supportive services that are culturally and age appropriate, medically accurate, and trauma-informed. Johns Hopkins University Center for Adolescent Health will evaluate and inform the program throughout the project period.

Revised Priority Needs and Strategies

The NPM and priority need selected by task force members for 2021-2025 remains the same as the 2016-2020 selection, Adolescent well-visits.

Maryland Priority Needs, 2021-2025	National Performance Measure(s)	Population Domains
5. Healthy Adolescents: Improve the health and well-being of adolescents and young adults in Maryland including those with special health care needs by addressing risky behaviors.	**Adolescent well-visits:** Percent of adolescents with a preventive service within the past year	Adolescent
Maryland Priority Needs, 2016-2020	**National Performance Measure(s)**	**Population Domains**
5. Healthy Adolescents: Improve the health and well-being of adolescents and young adults in Maryland including those with special health care needs by addressing risky behaviors.	**Adolescent well-visits:** Percent of adolescents with a preventive service within the past year	Adolescent

Challenges and Emerging Issues

COVID-19 has challenges and adverse impacts on the adolescent population. Like the effects on child health, school closures represent one of the largest impacts felt by adolescents. Adolescents have developmental needs that call for social connections and separation from their parents, which both help to develop social skills and empathy as well as gain a sense of identity. Disconnection not only takes an emotional toll on adolescents and can lead to both educational setbacks and decreased

social and emotional skills[24]. School closure has implications for both adverse mental health and physical health, resulting in poorer health outcomes for this population.

Adolescent well-visits are still recommended by the American Academy of Pediatrics (AAP) during COVID-19, however in Maryland adolescent well-visits made up the largest gaps due to misunderstanding the importance. Therefore, COVID-19 may result in an even larger gap. Regarding sexual and reproductive health, the reallocation of resources and priorities may result in increased rates of adolescent pregnancies, HIV and sexually transmitted diseases[25].

[24] https://hub.jhu.edu/2020/05/11/COVID-19-and-adolescents/

[25] Coronavirus Disease (COVID-19) Preparedness and Response - UNFPA Technical Briefs V March 23_2020 at https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_Preparedness_and_Response_-_UNFPA_Interim_Technical_Briefs_Contraceptices_and_Medical_Supplies_23_March.pdf