

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
<b>Women/Maternal Health</b>					
<p>Advance healthy birth outcomes by supporting mothers to thrive through pregnancy and the postpartum period.</p>	<p>By 2030, reduce the rate of pregnancy-related cardiovascular deaths from 3.3 per 100,000 live births (2019-2021 CA-PMSS) to 3.0 per 100,000 live births.</p> <p>By 2030, reduce the rate of pregnancy-related deaths among Black birthing women from 49.7 per 100,000 live births (2019-2021 CA-PMSS) to 42.3 per 100,000 live births.</p>	<p>Improve systems of risk-appropriate maternity care including (childbirth) regionalization and prenatal/postpartum access.</p> <p>Increase the proportion of facilities that evaluate the quality of their care using both patient experience and clinical measures.</p> <p>Increase maternal mortality/morbidity prevention by disseminating California Pregnancy Associated Review Committee (CA-PARC) recommendations and engaging potential implementation partners.</p> <p>Implement policy, systems and environmental change (PSE) activities to improve mental/behavioral health, including in the postpartum period.</p> <p>Improve primary prevention, early intervention and social supports across the perinatal period to improve mental/behavioral health.</p> <p>Promote community-aligned care and expand perinatal care teams (e.g., doulas, midwives) to include staff from the community, including during the postpartum period.</p> <p>Partner to improve neighborhood conditions, quality education, and economic opportunities and social supports.</p> <p>Promote policy, systems and environmental change (PSE) strategies for leading causes of morbidity before, during and after pregnancy.</p> <p>Partner on maternal anemia prevention across the perinatal period through policy, systems and environmental change (PSE) strategies.</p> <p>Expand the capacity of CA-PARC to review pregnancy related injury deaths.</p>	<p>ESM PPV.1 - Percentage of regular Big 6 state (California, Florida, Illinois, New York, Pennsylvania, Texas) peer learning meetings of the MCH Subgroup (postpartum visit) attended with active participation (e.g., presenting, responding to peer discussions).</p>	<p>NPM - Postpartum Visit</p>	<p><b>Linked NOMs:</b>                      Maternal Mortality                      Neonatal Abstinence Syndrome                      Women's Health Status                      Postpartum Depression                      Postpartum Anxiety</p>

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<b>Perinatal/Infant Health</b>					
<p>Advance healthy birth outcomes by supporting mothers and families to have thriving infants.</p>	<p>By 2030, reduce the rate of Black infant deaths from 8.81 per 1,000 live births (2023 CCMBF/CCMDF) to 8.37 per 1,000 live births.</p> <p>A) By 2030, increase the percentage of infants who are breastfed exclusively in-hospital from 68.8% to 73.8%. B) By 2030, increase the percentage of infants breastfed exclusively through three months from 30.8% to 35.8%.</p>	<p>Translate Fetal Infant Mortality Review (FIMR) findings and recommendations into action, including recommendations on the care experience.</p> <p>Partner to increase economic and social supports (e.g., transportation, childcare, parenting resources) to families.</p> <p>Promote community-aligned grief and bereavement and support services.</p> <p>Partner on maternal anemia prevention through policy, systems and environmental change (PSE) strategies to improve perinatal and infant outcomes.</p> <p>Promote breastfeeding initiation and duration through PSE and workforce strategies, including considerations of the care experience.</p> <p>Identify new partnerships to improve SIDS/SUID prevention.</p>	<p><i>Inactive - ESM BF.1 - Number of online views to the "Lactation Support for Low-Wage Workers" report</i></p> <p>ESM BF.2 - Number of trainings of Black Infant Health staff and their networks (e.g., doulas) to increase the knowledge, skills and abilities to provide community-aligned breastfeeding support.</p>	<p>NPM - Breastfeeding</p>	<p><b>Linked NOMs:</b>            Infant Mortality            Postneonatal Mortality            SUID Mortality</p>
<b>Child Health</b>					
<p>Improve the physical and mental health and development of all children so they flourish and thrive.</p>	<p>By 2030, increase the percentage of children who have received care within a medical home from 40.1% (NSCH 2021-2023) to 42%.</p>	<p>Promote the pediatric medical home through school-linked and school-based health prevention, education and services.</p> <p>Promote linkage and referrals to care and support services, especially those that target community health factors.</p> <p>Promote social connectedness.</p> <p>Collaborate to improve education and awareness of, and access to mental and behavioral health care.</p> <p>Increase child preventive health rates.</p> <p>Promote early childhood prevention, screening and intervention.</p> <p>Optimize nutrition and physical activity for children.</p>	<p>ESM MH.1 - Number of strategic planning, capacity building and education/outreach efforts completed by CDPH/MCAH to promote medical home for California children and families.</p>	<p>NPM - Medical Home</p>	<p><b>Linked NOMs:</b>            Children's Health Status            CSHCN Systems of Care            Flourishing - Young Child            Flourishing - Child Adolescent - CSHCN            Flourishing - Child Adolescent - All</p>

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		<p>Identify and work to reduce negative child health outcomes for all children.</p> <p>Promote safe environments and communities and prevent unintentional injury for children and families.</p> <p>Uplift prevention efforts to reduce child abuse and neglect.</p>			
<b>Adolescent Health</b>					
<p>Enhance strengths, skills, and access to supports, ensuring all youth thrive.</p>	<p>By 2030, increase the percentage of adolescents, ages 12 through 17, with a preventive medical visit in the past year from 62.9% (NSCH 2021-2023) to 66%.</p>	<p>Improve awareness of and access to quality youth-friendly care.</p> <p>Support youth in valuing and prioritizing preventive care.</p> <p>Promote primary prevention and early intervention best practices for behavioral health.</p> <p>Support youth in enhancing their resilience and coping skills.</p> <p>Promote youth-friendly sexual and reproductive health services, information and education.</p> <p>Enhance skills for health and wellness and growth into adulthood.</p>	<p><i>Inactive - ESM AWW.1 - Percentage of adolescents 12-17 served in AFLP with a referral for preventive services.</i></p> <p>ESM AWW.2 - Percentage of Local MCAH programs that implement at least one Scope of Work (SOW) activity in Adolescent Focus Area 1: Access to Quality Care &amp; Services.</p>	<p>NPM - Adolescent Well-Visit</p>	<p><b>Linked NOMs:</b></p> <ul style="list-style-type: none"> <li>Teen Births</li> <li>Adolescent Mortality</li> <li>Adolescent Motor Vehicle Death</li> <li>Adolescent Suicide</li> <li>Adolescent Firearm Death</li> <li>Adolescent Injury Hospitalization</li> <li>Children's Health Status</li> <li>Child Obesity</li> <li>Adolescent Depression/Anxiety</li> <li>CSHCN Systems of Care</li> <li>Flourishing - Child Adolescent - CSHCN</li> <li>Flourishing - Child Adolescent - All</li> </ul>
<b>Children with Special Health Care Needs</b>					
<p>Improve access to supports and services for children and youth with special health care needs.</p>	<p>By 2030, increase the percentage of children with special health care needs, ages 0 through 17, who have a medical home from 34.3% (NSCH 2021-2023) to 35%.</p>	<p>Partner to improve access to quality, coordinated care and support services for CYSHCN and their families.</p> <p>Fund the Department of Health Care Services (DHCS) to provide necessary care coordination and case management for California Children's Services (CCS) program clients and improve systems to assist CYSHCN families in navigating services.</p> <p>Partner to develop programs and resources to enhance resilience and mental wellness support for CYSHCN and their families.</p> <p>Support LHJs to build workforce capacity in supporting CYSHCN and their</p>	<p>ESM MH.1 - Number of strategic planning, capacity building and education/outreach efforts completed by CDPH/MCAH to promote medical home for California children and families.</p>	<p>NPM - Medical Home</p>	<p><b>Linked NOMs:</b></p> <ul style="list-style-type: none"> <li>Children's Health Status</li> <li>CSHCN Systems of Care</li> <li>Flourishing - Young Child</li> <li>Flourishing - Child Adolescent - CSHCN</li> <li>Flourishing - Child Adolescent - All</li> </ul>

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		<p>families.</p> <p>Partner with various organizations to build workforce capacity to serve CYSHCN and their families.</p> <p>Lead development of informational platforms and tools for CYSHCN and their families.</p>			
<p>Improve access to supports and services for children and youth with special health care needs.</p>	<p>By 2030, increase the percentage of adolescents with special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care from 17% (NSCH 2021-2023) to 18%.</p>	<p>Partner to improve access to quality, coordinated care and support services for CYSHCN and their families.</p> <p>Fund the Department of Health Care Services (DHCS) to provide necessary care coordination and case management for California Children’s Services (CCS) program clients and improve systems to assist CYSHCN families in navigating services.</p> <p>Partner to develop programs and resources to enhance resilience and mental wellness support for CYSHCN and their families.</p> <p>Support LHJs to build workforce capacity in supporting CYSHCN and their families.</p> <p>Partner with various organizations to build workforce capacity to serve CYSHCN and their families.</p> <p>Lead development of informational platforms and tools for CYSHCN and their families.</p>	<p><i>Inactive - ESM TAHC.1 - Number of local MCAH programs that implement a Scope of Work objective focused on CYSHCN public health systems and services.</i></p> <p>ESM TAHC.2 - Number of identified key organizations engaged in at least one structured meeting or discussion with CDPH/MCAH on improving transition to adult care for CYSHCN in California.</p>	<p>NPM - Transition To Adult Health Care</p>	<p><b><u>Linked NOMs:</u></b> CSHCN Systems of Care</p>
<b>Cross-Cutting/Systems Building</b>					
<p>Increase knowledge and capacity of state and local MCAH workforce to improve maternal and child health</p>	<p>By 2030, implement at least two process improvements to increase state and local MCAH knowledge and capacity to advance healthy outcomes for all.</p>	<p>Build and streamline CDPH/MCAH infrastructure to increase workforce capacity to improve maternal and child health outcomes.</p>	<p>No ESMs were created by the State. ESMs are optional for this measure.</p>	<p>SPM 1: Number of state training opportunities implemented to increase workforce capacity.</p>	

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outcomes.					
Increase knowledge, skills and best practices regarding policy, systems, and environmental change (PSE) practices among state and local MCAH workforce.	By 2030, integrate at least two PSE practices into CDPH/MCAH programs or operational protocols.	Build CDPH/MCAH infrastructure and capacity for PSE.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 1: Number of state training opportunities implemented to increase workforce capacity.	