Georgia State Action Plan Table 2025 Application/2023 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or – Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Prevent Maternal Mortality	1.1a Annually provide ≥ 8,005 federally funded breast cancer screening or diagnostic services to Breast and Cervical Cancer Program (BCCP) eligible women. 1.1b Annually meet or exceed the CDC guidelines of providing ≥ 35% of initial program cervical cancer screening to women, aged 30 and older, who have never been screened or not screened with the last 10 years. 1.2 Complete a Levels of Maternal Center designation for at least 10 hospitals annually. 1.3 Conduct one site visit annually at each RPC to verify RPC compliance with Level III+ care. 1.4 Review 75% of pregnancy-associated deaths identified for Maternal Mortality Review Committee review within 2 years of the date of death. 1.5 Annually increase the number of providers registered with PEACE for Moms by 15%.	1.1a Collaborate with Breast and Cervical Cancer Program (BCCP) providers (i.e., district and contracted providers) to improve preventative care for women by meeting or exceeding the CDC Guidelines for breast and cervical cancer prevention services annually. 1.1b BCCP implement at least two evidence-based interventions (EBIs) in each public health system (e.g., patient reminders, community-based group education, patient navigation, provider education, extended hours, reduction of structural barriers, provider assessment and feedback, one-on-one education, and small media). 1.2 Increase participation in the Levels of Maternal Care designation program by outreaching to hospitals and providing technical support in completing the application.	ESM WWV.1 - Percent of women (30 years or older) who have never been screened or not screened within the last 10 years, who received an initial program cervical screening test ***Inactive -*** *ESM WWV.2 - Percent of women (ages 15-44) served in Georgia Family Planning Program who use long-acting reversible contraceptives (LARCs)*	NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

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	1.6 Enroll 28 of Georgia birthing facilities into the Cardiac Conditions in Obstetrical Care AIM patient safety bundle in the first two years after launch.				NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression,

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					Formerly NOM 24) - PPD
Promote oral health among MCH populations	13.1 By 2025, increase the percent of women who had a preventive dental visit during pregnancy by 5% (Baseline: 31.5%, PRAMS, 2019).	13.1a Support state supplemental PRAMS questions regarding pregnancy and oral health to create a more comprehensive understanding of oral health status and access to care in pregnant women in Georgia. 13.1b Partner with Georgia OBGYN Society (GOGS), Healthy Mothers Healthy Babies Coalition of Georgia (HMHBGA), and Georgia Academy of Family Physicians (GAFP) to coordinate trainings on oral health and the medical provider role. 13.1c Partner with the state Home Visiting program to provide resources and trainings on oral health and pregnant women. 13.1d Create a multi-tiered varied platform approach by developing a campaign that uses radio ads, physical resource bags, videos and social media clips to increase oral health literacy in pregnant women. 13.1e Provide trainings to local water plant operators on the value of community water fluoridation and technical assistance to improve monthly reporting from local community water systems.	***Inactive -*** *ESM PDV-Pregnancy.1 - Percent of medical providers who reported an increase of oral health knowledge from trainings and presentations* ESM PDV-Pregnancy.2 - Number of oral health resource bags distributed to pregnant women and caregivers of young children through internal and external partners	NPM - Percent of women who had a dental visit during pregnancy (Preventive Dental Visit - Pregnancy, Formerly NPM 13.1) - PDV-Pregnancy	NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Prevent Maternal Mortality	Implement the home visiting program in 51 counties.	Implement home visiting program in rural counties among high-risk populations	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Perinatal/Infant Health					
Prevent Infant Mortality	3.1 Complete a Levels of Neonatal Center designation for at least 10 hospitals annually. 3.2 Conduct one site visit annually	3.1 Increase participation in the Levels of Neonatal Care designation program by outreaching to hospitals and providing technical support in completing the application.	ESM RAC.1 - Number of hospitals verified annually through the Levels of Neonatal Care Designation	NPM - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit	NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM

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	at each RPC to verify RPC compliance with Level III+ care.		Program	(NICU) (Risk-Appropriate Perinatal Care, Formerly NPM 3) - RAC	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related
Prevent Infant Mortality	4.2 Annually increase the number of home visitors that take a breastfeeding best practice course. 4.3 By 2025, increase the number of referrals made from MIECHV and Healthy Start women to the Georgia WIC Special Supplemental Nutrition Program by 25%. 4.4a By the end of 2025, 50% of Georgia hospitals will be actively implementing the Optimizing Nutrition for Georgia Newborns. 4.4b Enroll 28 of Georgia hospitals into the Optimizing Nutrition for Georgia Newborns quality improvement initiative in the first two years after launch (GaPQC).	4.2a Provide training and coaching to MIECHV and Healthy Start Home Visiting Staff to promote breastfeeding best practices. 4.2b Educate Home Visitors about PACIFY, a 24/7 perinatal and infant feeding support virtual platform, that can be utilized by clients who are new/expectant parents. 4.2c In partnership with Georgia AAP, will make breastfeeding recommendations and share nutrition education materials with Home Visitors and other programs. 4.3a Develop a one-pager on how to successfully collaborate between Georgia Home Visiting and Georgia WIC. 4.3b Develop and implement a referral process between Georgia Home Visiting and WIC Peer Counseling Program. 4.3c Increase the awareness of eligibility processes (i,e., Gateway Program). 4.4 Develop an active recruitment plan to enroll Georgia hospitals in the Optimizing Nutrition for Georgia Newborns initiative.	***Inactive -*** *ESM BF.1 - Percent of the 10-Steps to Successful Breastfeeding training slots utilized by staff and providers from the state's birthing hospitals* ESM BF.2 - Number of home visitors who report increased knowledge of breastfeeding best practices ESM BF.3 - Number of MIECHV and Healthy Start women who are referred to WIC services ESM BF.4 - Percent of Georgia hospitals	NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID

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			actively implementing the Optimizing Nutrition for Georgia Newborns		
Prevent Infant Mortality	5.1 Implement a multicomponent strategy that engages childcare providers, health care providers (i.e., pediatricians and obstetricians), hospital systems, public health programs, faith-based organizations, and others to increase parental education of safe infant sleep and reduce Sudden Unexpected Infant Death (SUID) by 2025.	5.1a Facilitate safe infant sleep trainings to assist healthcare professionals and those who interact with expecting families and caregivers (including home visitors, first responders, shelters) with providing accurate and up-to-date information on the AAP recommendations on safe infant sleep. 5.1b Collaborate with hospitals (i.e., well-baby, NICU, Pediatric Units) to provide consistent and accurate parent/caregiver education, conduct crib audits, update policy as needed and actively endorse, and model safe infant sleep practices. 5.1c Work with multi-sector organizations to reach all families, including those at higher risk for SUID, to specifically address disparities in the rates of infant mortality due to SUID. 5.1d Promote safe and healthy infant sleep behaviors and environments including access to smoking cessation programs and improving support systems that address Social Determinants of Health for populations/areas of greatest risk of SUID.	***Inactive -*** *ESM SS.1 - Percent of hospitals and birthing facilities providing education and modeling safe infant sleep to parents with newborns or infants* ESM SS.2 - Number of professionals trained to education on, identify, and model safe infant sleep environments ESM SS.3 - Number of safe infant sleep educational materials distributed by the Program	NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID
Prevent Infant Mortality	1.1 By 2025, increase the percentage of congenital syphilis cases averted from 80.3% to 85%.	1.1a Ensure investigations prioritized for females of reproductive age 15-45 and reactive serology, including provider follow-up to confirm age, treatment and pregnancy status. 1.1b Ensure timely and adequate treatment (30 days prior to delivery) for pregnant females with syphilis. 1.1c Ensure interviews are conducted on all syphilis cases for females of reproductive age 15-45. 1.1d Ensure treatment for partners of syphilis positive pregnant females. 1.1e Identify pregnancy status of all females identified as a new syphilis		SPM 1: Percent of congenital syphilis cases averted	

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		case. 1.1f Review & disseminate data on congenital syphilis cases with missed opportunities to all health districts. 1.1g Educate providers and general public on the law regarding 1st prenatal visit and 3rd trimester testing for Syphilis and HIV.			
Prevent Infant Mortality	2.1 By 2030, reduce the rate of infant mortality (per 1,000 live births) in the Black population by 10% (Baseline: 9.6, OASIS, 2020).	2.1 Work with birthing hospitals individually to support the development and/or implementation of a hospital specific health equity action plan.		SPM 2: Rate of infant mortality (per 1,000 live births) in the Black Population	
Child Health					
Promote developmental screenings among children	6.1 By 2025, engage 15 physician practices to promote developmental screenings and submit referrals to public health. 6.2 By 2025, identify and collaborate with 25 community-based organizations to initiate or increase developmental screenings.	6.1a Develop a Physician Outreach campaign to increase the number of providers utilizing standardized developmental screenings and supportive services available through Public Health (e.g., BCW, C1st, CMS, EHDI, Home Visiting, Help Me Grow). 6.1b Provide feedback on referrals to all referral sources to encourage care coordination and future referrals. 6.2a Provide 10 total trainings annually via the state office to community partners and provider practices through collaborative partnerships with medical and maternal and child health agencies. 6.2b Make the ASQs available to parents online. 6.2c Work with the Home Visiting program to produce a protocol to increase the number of de-duplicated developmental screenings.	ESM DS.1 - Number of providers that receive developmental screening education and training who report promoting developmental screenings with parents in their practices ESM DS.2 - Percent of children that screen with concern that are referred to appropriate intervention services by providers ***Inactive -*** *ESM DS.3 - Number of community partners who promote developmental screenings and make referrals to their local public health district*	NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS	NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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			Inactive - *ESM DS.4 - Percent of children, ages 0 through 5, who receive a developmental screening from DeKalb Board of Health Refugee Clinic* ESM DS.5 - Percent of children participating in Home Visiting with at least one developmental screening using a validated instrument.		
Increase the number of children, both with and without special health care needs, who have a medical home	11.1 By 2025, increase the number of families who receive linkage to appropriate care through a cross-agency referral system, Help Me Grow (HMG).	11.1a Expand the use of telehealth technology to improve access to audiological and early intervention services for children and youth with special health care needs. 11.1b Facilitate efforts to educate families about telehealth as an option for care. 11.1c Provide ongoing evaluation of the Department's telehealth network to ensure pediatric specialty services meet the needs of families and patients. 11.1d Develop and implement a quality improvement plan for Title V's Children and Youth with Special Health Care Needs program to identify opportunities in which telehealth technology may be used to improve medical home access. 11.1e Expand the capacity of HMG liaisons to help families navigate/ access comprehensive services. 11.1f Improve access to information and resources for CYSHCN. 11.1g Develop an outreach plan to engage partners, providers, and families	***Inactive -*** *ESM MH.1 - Number of telehealth/telemedicine patient encounters* ESM MH.2 - Number of telehealth/telemedicine providers in the network ESM MH.3 - Number of callers connected to resources through Help Me Grow (HMG) ESM MH.4 - Percent of families that receive a follow-up call from HMG that report they were linked to a	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to

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		in the utilization of HMG, a shared resource to assist families to navigate the early childhood system.	medical home, or any other service to meet their needs		obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Promote oral health among MCH populations	13.2 By 2025, increase the percent of children, ages 1 through 17, who had a preventive dental visit in the past year by 5% (Baseline: 79.7%, NSCH, 2018-2019).	13.2a Create and update a State Oral Health Surveillance Plan that functions to identify data sources, collection strategies, collection timeframes, and dissemination approaches. 13.2b Coordinate and provide district coordinator meetings periodically where resources are shared, updates are provided from states and district programs, continuing education or presentations are offered, and technical assistance is offered as needed. 13.2c Work with Healthy Mothers Healthy Babies (HMHB) and other external partners by providing subject matter expertise and strategic feedback. 13.2d Support district programs partnering with local schools to promote school-based/school-linked sealant and oral health prevention programs that target schools where 50% or more of the student population are eligible for free and reduced lunch. 13.2e Support district program staff going to local schools and providing oral health education programs. 13.2f Provide trainings to local water plant operators on the value of community water fluoridation and technical assistance to improve monthly reporting from local community water systems.	ESM PDV-Child.1 - Number of children screened at school-based/ school-linked programs ***Inactive -*** *ESM PDV-Child.2 - Number of Hispanic children who are provided with oral health education*	NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child	NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Adolescent Health					
Increase bullying and suicide prevention	9.1 By September 2021, identify the prevalence and existing prevention programs and GA State policy and legislation on bullying. 9.2 By 2025, observe improvements in bullying prevention efforts by schools that service the target population (ages 12-17).	9.1 Conduct an environmental scan and needs assessment to determine the status of bullying in Georgia. 9.2 Provide guidance and/or recommendations to DOE and individuals schools on evidence-based strategies to prevent bullying. 9.3 DPH IPP will engage in events hosted by agencies or organizations that include bullying prevention in their strategic plans and that align overall activities and policy contributions within a framework of shared risk	ESM BLY.1 - Number of schools, individuals, and organizations that receive guidance on evidence-based strategies to prevent bullying	NPM - Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others (Bullying, Formerly NPM 9) - BLY	NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide

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	9.3 By 2025, increase use in clear and consistent use of language across organizations working on bullying and suicide prevention and other relevant stakeholder groups.	and protective factors and/or social determinants of health, in order to support efforts to display and encourage the use of consistent language and communications around the public health issue of bullying. 9.4 Increase awareness of shared risk and protective factors between violence and suicide among partners, including those working on ACEs prevention, bullying prevention, child abuse and neglect, and interpersonal violence prevention.			
Children with Special Health Care Needs					
Improve systems of care for CYSHCN	12.1 By 2025, increase the percentage of youth/young adults enrolled in the state's Title V Children and Youth with Special Health Care Needs program that report successful transfer to an adult provider by 40% 12.2 By 2025, increase the number of community stakeholders that partner with the state's Title V Children and Youth with Special Health Care Needs program to implement health care transition processes and procedures for youth/young adults with or without special health care needs by 25.	12.1a Develop and implement a health care transition quality improvement and evaluation plan to assess the effectiveness and efficiencies of the Department's health care transition program activities that impact youth and families. 12.1b Provide technical assistance and guidance on health care transition planning for care coordinators supporting the Title V Children and Youth with Special Health Care Needs program. 12.1c Implement condition specific transition planning protocols for adolescents enrolled in the Title V Children and Youth with Special Health Care Needs program. 12.1d Provide educational opportunities for youth and families to increase their knowledge on health care transition planning services and resources. 12.2a Establish an advisory group to include youth, families, and providers to support practice improvement efforts for health care transition. 12.2b Partner with adolescent health programs within the Department to implement best practices that support health care transition planning for youth and young adults with or without special health care needs. 12.2c Develop and implement a health care transition communication plan to share targeted messaging for transitioning youth/young adults with and without special health care needs from pediatric to adult care for audiences to include youth/young adults, families, health plans, medical providers, state agencies and community partners.	ESM TR.1 - Percent of youth/young adults enrolled in the Department's Title V program for Children and Youth with Special Health Care Needs (CYSHCN) that transfer to an adult provider. ESM TR.2 - Number of stakeholders, state agencies, and community partners that collaborate with the Department to improve health care transition for youth/young adults with or without special health care needs.	NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

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		12.2d Provide continuing education opportunities on the six core elements of health care transition for medical and nursing students, pediatric and adult providers.			
Increase the number of children, both with and without special health care needs, who have a medical home	11.1 By 2025, increase the number of families who receive linkage to appropriate care through a cross-agency referral system, Help Me Grow (HMG).	11.1a Expand the use of telehealth technology to improve access to audiological and early intervention services for children and youth with special health care needs. 11.1b Facilitate efforts to educate families about telehealth as an option for care. 11.1c Provide ongoing evaluation of the Department's telehealth network to ensure pediatric specialty services meet the needs of families and patients. 11.1d Develop and implement a quality improvement plan for Title V's Children and Youth with Special Health Care Needs program to identify opportunities in which telehealth technology may be used to improve medial home access. 11.1e Expand the capacity of HMG liaisons to help families navigate/ access comprehensive services. 11.1f Improve access to information and resources for CYSHCN. 11.1g Develop an outreach plan to engage partners, providers, and families in the utilization of HMG, a shared resource to assist families to navigate the early childhood system.	***Inactive -*** *ESM MH.1 - Number of telehealth/telemedicine patient encounters* ESM MH.2 - Number of telehealth/telemedicine providers in the network ESM MH.3 - Number of callers connected to resources through Help Me Grow (HMG) ESM MH.4 - Percent of families that receive a follow-up call from HMG that report they were linked to a medical home, or any other service to meet their needs	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Cross-Cutting/Systems Building					
Increase father involvement among MCH populations	3.1 By 2025, increase the number of fathers that are recruited and enrolled into Georgia Healthy Start sites fatherhood programs by 5% annually. 3.2 By 2025, increase the number of fathers that are retained and	3.1 Educate Georgia Healthy Start sites on evidence-based and best practice models to recruit and retain fathers in fatherhood programming. 3.2 Increase Georgia Healthy Start sites access to training on Fatherhood Involvement. 3.3 Increase fatherhood collective impact activities that include meetings, trainings, and other events among the Georgia Healthy Start sites.		SPM 3: Percent of fathers (ages 18-55) whose knowledge increased using a Father Involvement curriculum in Georgia Healthy Start sites.	

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	complete the fatherhood programs using a Father Involvement curriculum by 5% annually.	3.4 Provide fatherhood curriculum tools and resources to the Georgia Healthy Start sites (i.e. marketing materials, needs assessments, forms and templates, etc.). 3.5 Establish a media campaign to increase agency and community awareness of fatherhood programming available through the Fatherhood Initiative.			