

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>Enhance support services and improve coordination between community resources and clinical care throughout the perinatal period.</p>	<p>By 2030, 80% of postpartum women enrolled in PHP will complete a postpartum visit within 12 weeks of delivery.</p> <p>By 2030, 100% of all PHP patients (prenatal and postpartum) will receive targeted support (education, planning, and follow-up) to promote postpartum visit attendance.</p>	<p>Document requirements for education, case management, and interventions to increase completion of the postpartum visit in the Perinatal Health Partnership Policy and Procedure Manual.</p> <p>Align postpartum education delivered by home visitors with ACOG and SMFM recommendations to ensure consistency and reinforce key postpartum care messages.</p> <p>Assess for barriers or challenges that might impact the ability to keep appointments and provide interventions when possible (i.e., assistance with scheduling appointments and transportation).</p> <p>Quarterly review of records for all patients receiving home visiting services to assess continuous provision of education, case management, and interventions to assure compliance with policy manual and program compliance.</p>	<p>ESM PPV.1 - Percent of patients receiving home visiting services who completed the postpartum visit by 12 weeks postpartum</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>
<p>Enhance support services and improve coordination between community resources and clinical care throughout the perinatal period.</p>	<p>By 2030, 100% of postpartum patients enrolled in home visiting will receive an EPDS screening within the first 8 weeks postpartum.</p> <p>By 2030, 100% of home visiting staff will report knowledge gained from their initial EPDS training.</p> <p>By 2030, 100% of patients with positive EPDS results will receive a referral to a behavioral health service or provider.</p> <p>DPH and Postpartum Support</p>	<p>EPDS postpartum screening requirements will be documented in the Perinatal Home Visiting Policy and Procedure Manual.</p> <p>Provide initial EPDS training for new home visiting staff and annual training for all home visiting staff.</p> <p>Encourage public health districts to develop and expand partnerships with behavioral health service providers to establish a pathway for referral and follow-up of positive screening results.</p> <p>Provide perinatal psychiatry consultations to providers with prescriptive authority for patients who are pregnant and postpartum through PEACE for Moms.</p> <p>Educate clinical providers in FQHC's on postpartum mental health and</p>	<p>ESM MHS.1 - Percent of home visitors who reported knowledge gained from an EPDS training.</p> <p>ESM MHS.2 - Percent of postpartum patients who received timely and appropriate mental health interventions</p>	<p>NPM - Postpartum Mental Health Screening</p>	<p><b>Linked NOMs:</b>                      Maternal Mortality                      Infant Mortality                      SUID Mortality                      Neonatal Abstinence Syndrome                      Child Injury Hospitalization                      Women's Health Status                      Postpartum Depression                      Postpartum Anxiety</p>

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	<p>International, Georgia Chapter (PSI-GA) will work together to provide 250 Edinburgh screenings annually.</p> <p>By 2030, the Georgia Perinatal Quality Collaborative will provide 5 educational webinars on maternal mental health topics.</p>	<p>train providers to use a validated maternal mental health screening tool.</p> <p>Create tailored educational content for new parents on postpartum depression and anxiety.</p>			

## Perinatal/Infant Health

Strengthen regionalized perinatal care through quality improvement initiatives that promote evidence-based practices for mothers and infants.	<p>By 2030, increase the number of birthing facilities that have undergone AAP levels of care designation (neonatal verification) from 3 to 6.</p> <p>By 2030, increase the number of birthing facilities that have undergone ACOG levels of care designation (maternal verification) from 20 to 30.</p>	<p>Recruit facilities to complete the AAP and/or ACOG levels of care designation by directly contacting facilities, and promoting at leadership and partnership meetings (e.g., AWHOON, GA OBYN Society) and during webinars (e.g., hosted by AAP and TJC).</p> <p>Create an online continuing education module (CME) teaching clinicians best practices and guidelines on patient transfers to appropriate levels of care.</p>	<p>ESM RAC.1 - Percent of hospitals that incorporated the CME module into their staff education requirements <i>Inactive - ESM RAC.2 - Number of hospitals verified annually through the Levels of Neonatal Care Designation Program</i></p>	NPM - Risk-Appropriate Perinatal Care	<p><b><u>Linked NOMs:</u></b> Stillbirth Perinatal Mortality Infant Mortality Neonatal Mortality Postneonatal Mortality Preterm-Related Mortality</p>
Strengthen regionalized perinatal care through quality improvement initiatives that promote evidence-based practices for mothers and infants.	<p>By 2030, increase the percentage of births breastfed (live births reported to be breastfed upon discharge) from 80.7% to 83% (OASIS).</p> <p>By 2030, increase the percentage of infants exclusively breastfeeding at 6 months from 18.7% to 21% (USBC Ga Breastfeeding Report Card).</p> <p>By 2030, decrease the percentage of formula supplementation at two</p>	<p>Increase clinical provider knowledge on breastfeeding through tailored curriculum provided through webinars, conferences and asynchronous learning platforms.</p> <p>Increase home visitors' knowledge on breastfeeding through in-person training and tailored resources.</p> <p>Develop a toolkit for clinicians to use when providing prenatal breastfeeding education.</p>	<p>ESM BF.1 - Percent of providers and health educators who reported having increased knowledge after receiving evidence-based breastfeeding education <i>Inactive - ESM BF.2 - Number of home visitors who report increased knowledge of breastfeeding best</i></p>	NPM - Breastfeeding	<p><b><u>Linked NOMs:</u></b> Infant Mortality Postneonatal Mortality SUID Mortality</p>

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	days from 24.2% to 21% (USBC Ga Breastfeeding Report Card).		<p><i>practices</i></p> <p><b>Inactive - ESM BF.3 -</b> Number of MIECHV and Healthy Start women who are referred to WIC services</p> <p><b>Inactive - ESM BF.4 -</b> Percent of Georgia hospitals actively implementing the Optimizing Nutrition for Georgia Newborns</p>		
Increase safe sleep practices by strengthening professional and caregiver education and community outreach.	Implement a multicomponent strategy that engages childcare providers, health care providers (e.i., pediatricians and obstetricians), hospital systems, public health programs, faith-based organizations, and others to increase caregiver and provider education on safe infant sleep and reduce Sudden Unexpected Infant Death (SUID) by 2030.	<p>Ensure health care professionals understand, actively endorse, and model safe sleep practices.</p> <p>Ensure infant caregivers have the knowledge, skills, and self-efficacy to practice safe sleep for every sleep.</p> <p>Engage and activate infant caregivers and communities to support safe sleep.</p> <p>Implement policies that support/facilitate safe sleep practices.</p>	<p>ESM SS.1 - Percent of professionals trained to educate on safe infant sleep and model safe infant sleep environments who report an increase in knowledge on the subject.</p> <p>ESM SS.2 - Number of safe infant sleep educational materials distributed by the Program</p> <p><b>Inactive - ESM SS.3 -</b> Number of professionals trained to education on, identify, and model safe infant sleep environments</p>	NPM - Safe Sleep	<b>Linked NOMs:</b> Infant Mortality Postneonatal Mortality SUID Mortality

**Child Health**

Create and support	By 2030, increase the proportion of children who receive a	Improve provider capacity to administer, interpret, and communicate results from validated developmental screening tools (e.g. ASQ, MCHAT R/F),	ESM DS.1 - Percent of providers who	NPM - Developmental Screening	<b>Linked NOMs:</b> School Readiness
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<p>systems that provide timely, appropriate, and consistent health and developmental screenings to children in Georgia.</p>	<p>developmental screening to 35.8%.</p>	<p>and make appropriate, timely referrals to DPH programs through training and outreach.</p> <p>Leverage Georgia’s 18 Children 1st District Coordinators to strengthen local screening, triage, and education efforts—building on their existing responsibilities for developmental screening completion, family communication, and outreach to partners.</p> <p>Enhance caregiver understanding of screening results and follow-up steps by embedding brief family feedback and education mechanisms into the Children 1st developmental screening process.</p>	<p>demonstrate increased self-efficacy to interpret results, communicate findings to families, and refer appropriately to DPH child health programs after participating in developmental screening-related trainings.</p> <p><i>Inactive - ESM DS.2</i>  <i>- Number of providers that receive developmental screening education and training who report promoting developmental screenings with parents in their practices</i></p> <p><i>Inactive - ESM DS.3</i>  <i>- Percent of children that screen with concern that are referred to appropriate intervention services by providers</i></p> <p><i>Inactive - ESM DS.4</i>  <i>- Percent of children participating in Home Visiting with at least one developmental screening using a validated instrument.</i></p>		<p>Children's Health Status</p>
<p>Strengthen access to a</p>	<p>By 2030, ensure that ≥80% of children referred to Children 1st</p>	<p>Confirm medical home linkage: Children 1st coordinators verify medical home linkage during intake and MCH assessments.</p>	<p><i>Inactive - ESM MH.1</i>  <i>- Number of</i></p>	<p>NPM - Medical Home; Medical Home_Care</p>	<p><b>Linked NOMs:</b>  Children's Health Status</p>

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<p>more integrated community-based continuum of high-quality family centered clinical care and coordinated services for children and CYSHCN and their families</p>	<p>who are not immediately triaged to other Child Health programs complete a Maternal &amp; Child Health (MCH) assessment and are linked to a primary care provider.</p> <p>By 2030, ensure that 100% of Children 1st coordinators are trained and equipped to assist families in identifying and establishing a connection with a primary care provider, in order to support timely medical home linkage for children referred to public health.</p> <p>By 2030, increase the percentage of youth, ages 0 through 17, who have had a preventative dental visit in the past year to 89% (baseline value 87%, Georgia Basic Screening Survey 2016-17).</p>	<p>Train Children 1st staff to support medical home linkage by developing and implementing training on how to identify when a child lacks a primary care provider (PCP), how to help families find one, and how to communicate the importance of a medical home.</p> <p>Provide funding allocations to public health districts to support oral health staff positions, dental clinics, teledentistry, and school-based education and services.</p> <p>Conduct quarterly district dental coordinator meetings for statewide planning, sharing best practices, continuing education, and technical assistance.</p> <p>Provide resources and support for districts' school-based preventive oral health services targeting schools where 50% or more of the student population are eligible for free and reduced lunch.</p> <p>Provide Oral Health resources to districts that support partnerships and referral strategies to increase the number of children with access to dental care.</p>	<p><i>telehealth/telemedicine providers in the network</i>  <b>Inactive - ESM MH.2</b>  <i>- Number of callers connected to resources through Help Me Grow (HMG)</i>  <b>Inactive - ESM MH.3</b>  <i>- 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</i>  ESM MH_CC.1 - Percent of Children 1st staff who demonstrate knowledge on how to assist families in identifying and connecting to a primary care provider  ESM MH_CC.2 - Percent of Title V partners who complete the workforce trainings offered by the Department's CYSHCN Program  ESM MH_CC.3 - Number of stakeholders, state agencies, and</p>	<p>Coordination</p>	<p>CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All</p>

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			community partners that collaborate with the Department to improve access to family centered clinical care and coordinated support services.		

## Adolescent Health

<p>Ensure youth &amp; young adults, w/ and w/o SHCN, and their families have access to a coordinated system of services that support an informed and smooth transition from pediatric to adulthood</p>	<p>By 2030, increase the percent of youth with special health care needs, ages 12 through 17, who received services necessary to transition to adult health care from 28.8% (NSCH 2022-2023) to 33.8%.</p> <p>By 2030, increase the percent of adolescents, ages 12 through 17, who received services to prepare for the transition to adult health care from 19.3% (NSCH 2022-2023) to 24.3%.</p> <p>By 2030, increase the percent of adolescents, ages 12 through 17 years, with a preventive medical visit in the past year from 75.1% to 80.1% (NSCH 2022-2023).</p> <p>By 2030, increase the percent of children with special health care needs, ages 12 through 17, who receive needed care coordination from 62.3% to 67.3% (NSCH 2022-2023).</p>	<p>Engage with youth leaders to co-create health care transition communication, resources, digital self-management tools and peer to peer programming.</p> <p>Collaborate with parent-led and youth-serving organizations to provide support and disseminate consistent and accurate information on health care transition care planning, services and resources as well as creating smoother transitions between systems.</p> <p>Provide workforce development opportunities for pediatric and adult providers, care coordinators, patient navigators, community health workers and transition specialists focused on adolescent health and well-being, youth engagement and communication, health care transition fundamentals and managing transition for youth with medical complexities.</p> <p>Build cross-sector partnerships with administrators, providers and individuals with lived experience to reduce the barriers families experience while accessing health care transition services and resources.</p> <p>Collaborate with partners to explore opportunities for tracking continuity of care and identifying key metrics to monitor successful transitions for the adolescent population.</p>	<p>ESM TAHC.1 - Percent of YSHCN enrolled in the Department's CYSHCN Program who have a transition plan in place after completing a transition readiness assessment.</p> <p>ESM TAHC.2 - Percent of youth/young adults enrolled in the Department's Title V Program for Children and Youth with Special Health Care Needs (CYSHCN) who transfer to an adult provider.</p> <p>ESM TAHC.3 - Number of youth and young adults who access HCT information co-created by youth leaders.</p> <p><i>Inactive - ESM TAHC.4 - Number of</i></p>	<p>NPM - Transition To Adult Health Care</p>	<p><b><u>Linked NOMs:</u></b> CSHCN Systems of Care</p>
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			<p><i>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.</i></p> <p><b>Inactive - ESM</b> TAHC.5 - 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.</p>		
<p>Foster adolescent development by providing programs that increase protective factors and promote health behaviors</p>	<p>By 2030, observe improvements in bullying prevention efforts by elementary and/or middle schools to increase protections for the population of interest (age 12-17).</p> <p>By 2030, increase the use of clear and consistent language across organizations working in bullying and other relevant stakeholder groups.</p> <p>By 2030, increase the parent knowledge of bullying and involvement in prevention.</p>	<p>Engage with agencies, organizations, and schools to increase awareness of bullying through the use of clear and consistent language within education and policy through educational webinars.</p> <p>Increase awareness of shared risk and protective factors between violence and bullying among partners, including those working on Adverse Childhood Experiences (ACEs) prevention, bullying prevention, child abuse and neglect and interpersonal violence prevention.</p> <p>Pilot parent education session and community events to expand their understanding of bullying in order to support their children prevent bullying from occurring.</p>	<p>ESM BLY.1 - Percent of parents who reported an increase in knowledge and/or skill from the parent education sessions conducted on supporting children involved in bullying situations.</p> <p><b>Inactive - ESM BLY.2</b> - Number of schools, individuals, and organizations that receive guidance on evidence-based strategies to prevent</p>	<p>NPM - Bullying</p>	<p><b>Linked NOMs:</b> Adolescent Mortality Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Adolescent Depression/Anxiety Adverse Childhood Experiences</p>

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			<i>bullying</i>		
Children with Special Health Care Needs					
<p>Strengthen access to a more integrated community-based continuum of high-quality family centered clinical care and coordinated services for children and CYSHCN and their families</p>	<p>By 2030, increase the percent of children with special health care needs who receive care in a medical home from 41.2% (NSCH 2022-2023) to 46.2%.</p> <p>By 2030, increase the percent of children with special health care needs, ages 0 through 17, who receive needed care coordination from 54.9% (NSCH 2022 -2023) to 59.9%.</p> <p>By 2030, increase the percent of children with special health care needs, ages 0 through 17, who have family centered care from 80.5% (NSCH 2022-2023) to 85.5%.</p>	<p>Engage with family leaders to co-create low health literacy roadmaps to navigate various developmental and medically complex conditions, family centered care training, decision making and goal setting tools and digital life plan and care planning resources.</p> <p>Collaborate with parent-led organizations to strengthen peer-to-peer support and family networking opportunities, as well as disseminate consistent and accurate information on accessing medical home and care coordination services.</p> <p>Provide workforce development opportunities for therapeutic, pediatric and adult providers, care coordinators, patient navigators, and community health workers focused on family centered principles, cultural competence, protective factors, team-based approach to care, family engagement and feasible models of family centered care.</p> <p>Build cross-sector partnerships with administrators, providers, bilingual professionals and providers, and individuals with lived experience to reduce the barriers families experience while accessing family centered approach to care and exploring opportunities to streamline care coordination services and utilizing integrated care plans.</p> <p>Collaborate with partners to explore opportunities for value-based care models and monitoring access to care coordination services.</p>	<p><i>Inactive - ESM MH.1 - Number of telehealth/telemedicine providers in the network</i></p> <p><i>Inactive - ESM MH.2 - Number of callers connected to resources through Help Me Grow (HMG)</i></p> <p><i>Inactive - ESM MH.3 - 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</i></p> <p>ESM MH_CC.1 - Percent of Children 1st staff who demonstrate knowledge on how to assist families in identifying and connecting to a primary care provider</p> <p>ESM MH_CC.2 - Percent of Title V partners who complete the workforce trainings offered by the Department's</p>	<p>NPM - Medical Home; Medical Home_Care Coordination</p>	<p><b>Linked NOMs:</b></p> <p>Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All</p>

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			CYSHCN Program ESM MH_CC.3 - Number of stakeholders, state agencies, and community partners that collaborate with the Department to improve access to family centered clinical care and coordinated support services.		
Ensure youth & young adults, w/ and w/o SHCN, and their families have access to a coordinated system of services that support an informed and smooth transition from pediatric to adulthood	<p>By 2030, increase the percent of youth with special health care needs, ages 12 through 17, who received services necessary to transition to adult health care from 28.8% (NSCH 2022-2023) to 33.8%.</p> <p>By 2030, increase the percent of adolescents, ages 12 through 17, who received services to prepare for the transition to adult health care from 19.3% (NSCH 2022-2023) to 24.3%.</p> <p>By 2030, increase the percent of adolescents, ages 12 through 17 years, with a preventive medical visit in the past year from 75.1% to 80.1% (NSCH 2022-2023).</p> <p>By 2030, increase the percent of children with special health care needs, ages 12 through 17, who receive needed care coordination</p>	<p>Engage with youth leaders to co-create health care transition communication, resources, digital self-management tools and peer to peer programming.</p> <p>Collaborate with parent-led and youth-serving organizations to provide support and disseminate consistent and accurate information on health care transition care planning, services and resources as well as creating smoother transitions between systems.</p> <p>Provide workforce development opportunities for pediatric and adult providers, care coordinators, patient navigators, community health workers and transition specialists focused on adolescent health and well-being, youth engagement and communication, health care transition fundamentals and managing transition for youth with medical complexities.</p> <p>Build cross-sector partnerships with administrators, providers and individuals with lived experience to reduce the barriers families experience while accessing health care transition services and resources.</p> <p>Collaborate with partners to explore opportunities for tracking continuity of care and identifying key metrics to monitor successful transitions for the adolescent population.</p>	ESM TAHC.1 - Percent of YSHCN enrolled in the Department's CYSHCN Program who have a transition plan in place after completing a transition readiness assessment. ESM TAHC.2 - Percent of youth/young adults enrolled in the Department's Title V Program for Children and Youth with Special Health Care Needs (CYSHCN) who transfer to an adult provider. ESM TAHC.3 - Number of youth and young adults who access HCT information co-created	NPM - Transition To Adult Health Care	<b><u>Linked NOMs:</u></b> CSHCN Systems of Care

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	from 62.3% to 67.3% (NSCH 2022-2023).		<p>by youth leaders.</p> <p><i>Inactive - ESM TAHC.4 - 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.</i></p> <p><i>Inactive - ESM TAHC.5 - 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.</i></p>		