

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					
Improving Mental and Behavioral Health for Women	<p>W1. Increase mental health screenings and referrals to treatment/support</p> <p>W2. Increase openness to mental health resources and support</p>	<p>W1a. Promote universal screening for depression and anxiety at clinics (for every well-check, prenatal and postpartum care, and pediatrician visit) and community organizations (such as those that provide lactation support, WIC, doula services)</p> <p>W1b. Promote a referral pathway for positively screened women in clinics and community-based settings that includes a range of support</p> <p>W2a. Reduce stigma around mental health for women by promoting available resources/support that are culturally-appropriate through social media and community-based conversations</p>	ESM MHS.1 - Percent of WIC staff trained on postpartum mental health, screening protocols, and referral processes.	NPM - Postpartum Mental Health Screening	<p>Linked NOMs:</p> <p>Maternal Mortality</p> <p>Infant Mortality</p> <p>SUID Mortality</p> <p>Neonatal Abstinence Syndrome</p> <p>Child Injury Hospitalization</p> <p>Women's Health Status</p> <p>Postpartum Depression</p> <p>Postpartum Anxiety</p>
Reducing Maternal Mortality and Morbidity	W3. Improve maternal health outcomes in areas with gaps	<p>W3a. Map maternity care services and providers in Nebraska to understand gaps and capabilities of the perinatal health care system and identify needs in areas with longer distances to care</p> <p>W3b. Explore and use alternative delivery methods to improve access to prenatal and postpartum care services</p> <p>W3c. Pilot universal home visiting to identify women who need support and services</p>	ESM PPV.1 - Number of families served by federally or state funded home visitation programs in the previous calendar year	NPM - Postpartum Visit	<p>Linked NOMs:</p> <p>Maternal Mortality</p> <p>Neonatal Abstinence Syndrome</p> <p>Women's Health Status</p> <p>Postpartum Depression</p> <p>Postpartum Anxiety</p>
Promoting Women's Preventive Care	W4. Increase the percent of women who have an annual preventive visit	<p>W4a. Improve coordination for preventive screening at every point-of-access for families</p> <p>W4b. Working through organizations, promote preventive screenings through medical homes by promoting organizational health literacy</p>	<i>Inactive - SPM ESM 1.1 - Percent of women participating in Women's Community Health Initiative who have had a well check according to the US Preventive Services Task Force (USPSTF) guidelines</i>	SPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	<p>Linked NOMs:</p> <p>Women's Health Status</p>

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			<i>based on age and history.</i>		
Perinatal/Infant Health					
Reducing Preterm Births	<p>PI1. Increase percent of birthing hospitals with a maternal level of care designation</p> <p>PI2. Educate providers and the public about preterm birth and ways to support pregnant women to prevent preterm birth</p>	<p>PI1a. Define maternal/prenatal levels of care through perinatal regionalization to ensure facilities are equipped to deliver care appropriate for individual medical needs</p> <p>PI2a. Develop and promote an education campaign for providers to increase awareness of need for risk-appropriate prenatal care, how to address risk factors for preterm birth, and to promote awareness of Medicaid’s Presumptive Eligibility Policy and the Prenatal Plus program</p> <p>PI2b. Develop and promote an education campaign for the public on how to address risk factors for preterm birth and to promote awareness of presumptive eligibility</p> <p>PI2c. Tie the education campaign from Strategy PI2b to the Women’s/Maternal Health domain Strategy W3b to address perinatal health via alternative delivery method</p>	ESM RAC.1 - Percent of birthing hospitals with a maternal level of care designation.	NPM - Risk-Appropriate Perinatal Care	Linked NOMs: Stillbirth Perinatal Mortality Infant Mortality Neonatal Mortality Postneonatal Mortality Preterm-Related Mortality
Child Health					
Increasing Access to Preventive Health Services for Infants and Children through Screening and Referrals	C1: Increase percent of children who have an annual preventive health visit and medical home	<p>C1a: Promote awareness of developmental screenings, resources, and preventive services to families</p> <p>C1b: Improve coordination for preventive services at every point-of-access for families</p> <p>C1c: Identify and address barriers to accessing preventive health visit</p>	<i>Inactive - ESM MH.1 - The percentage of families who are satisfied with supports provided by the Parent Resource Coordinator</i> ESM MH.2 - Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participant Ratio, Ages 0-5.	NPM - Medical Home	Linked NOMs: Children’s Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Increasing	C2: Increase percentage of	C2a: Support local capacity to provide dental services through LHDs	<i>Inactive - ESM PDV-</i>	NPM - Preventive Dental	Linked NOMs:

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Access to Preventive Health Services for Infants and Children through Screening and Referrals	children with lead and dental screenings, including follow-up for high blood lead levels and dental needs that require treatment	<p>C2b: Link families with positive screens for dental treatment with providers</p> <p>C2c: Link families with high blood lead levels to key services through referral and outreach</p>	<p><i>Child.1 - The percentage of children participating in the Open Mouth Survey from underserved communities</i></p> <p>ESM PDV-Child.2 - Number of children reached through Title V funded outreach and fluoride treatments</p>	Visit - Child	Tooth decay or cavities Children's Health Status CSHCN Systems of Care
Adolescent Health					
Supporting Youth Mental Health	Y1. Leverage social and community networks to support youth mental health	<p>Y1a. Improve youth mental health using peer-to-peer support programs with a positive youth development framework</p> <p>Y1b. Promote mental health in schools by promoting NDE initiatives</p>	ESM MHT.1 - Number of community partnerships with Title V that support peer-to-peer support programs	NPM - Mental Health Treatment	<p>Linked NOMs:</p> <p>Adolescent Mortality Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Children's Health Status Adolescent Depression/Anxiety CSHCN Systems of Care Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All</p>
Supporting Reproductive Health and Well-Being in Youth	<p>Y2. Improve utilization of reproductive health and well-being services</p> <p>Y3. Build youth capacity to have conversations with adults about reproductive health and well-being</p>	<p>Y2a. Promote reproductive health through outreach and education with youth-serving professionals</p> <p>Y2b. Promote positive youth development through peer-to-peer support programs</p> <p>Y3a. Support parent-child communication</p> <p>Y3b. Incorporate reproductive health interventions into mentorship programs</p> <p>Y3c. Build statewide capacity for mentorship</p>	No ESMs were created by the State. ESMs are optional for this measure.	SPM 2: Adolescent preventive medical visit	

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Children with Special Health Care Needs					
Increasing Access to Early Screening and Identification for CYSHCN	<p>SHC1. Increase the percentage of families who have a medical home</p> <p>SHC2. Increase the percentage of families who receive developmental screenings between 9 and 35 months</p>	<p>SHC1a. Increase Educational Service Units (ESUs) awareness of patient-centered medical homes and capacity to refer families to potential medical homes in their community</p> <p>SHC1b. Continue the Family Care Enhancement Project (FCEP) through UNMC MMI that uses a parent resource coordinator to support CYSHCN families through a medical home</p> <p>SHC1c. Support CYSHCN families through the MHCP and DCP</p> <p>SHC2a. Promote screening tools and early intervention materials to health care providers, ESUs, maternal health care provider clinics, and community-based organizations to increase timely developmental screenings</p> <p>SHC2b. Address family barriers to receiving developmental screenings</p>	<p><i>Inactive - ESM MH.1 - The percentage of families who are satisfied with supports provided by the Parent Resource Coordinator</i></p> <p>ESM MH.2 - Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participant Ratio, Ages 0-5.</p>	NPM - Medical Home	<p>Linked NOMs:</p> <p>Children's Health Status</p> <p>CSHCN Systems of Care Flourishing - Young Child</p> <p>Flourishing - Child Adolescent - CSHCN</p> <p>Flourishing - Child Adolescent - All</p>
Increasing Access to Mental and Behavioral Health Services for CYSHCN	SHC3. Increase the percentage of CYSHCN with mental and behavioral health needs who are receiving services	<p>SHC3a. Use community health workers, parent resource coordinators, and patient navigators to provide care coordination services for mental and behavioral health</p> <p>SHC3b. Bridge existing resources with expertise in triage, screening, referral, and support services for CYSHCN experiencing mental health crises, as part of a five-year plan</p> <p>SHC3c. Build family awareness and knowledge of existing programs and support by hosting sessions at family-centered conferences in Nebraska</p>	No ESMs were created by the State. ESMs are optional for this measure.	SPM 3: CYSHCN mental health care	