

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					
<p>Improve health outcomes and reduce injury risk and mortality through enhanced health and safety efforts for maternal and child health populations.</p>	<p>By August 31, 2030, increase the rate of women attending one or more postpartum follow up visit by 4% (Baseline 86.5%, 2023 Texas PRAMS)</p>	<p>Strategy 1: Assess needs, gaps, and opportunities to strengthen systems and expand initiatives to increase awareness about the importance of postpartum follow-up throughout the state.</p> <p>Strategy 2: Develop and promote educational opportunities, materials, communications, and programmatic activities to increase awareness and knowledge among women, their families, health care professionals, community health workers and other stakeholders on topics related to maternal medical and behavioral health, urgent maternal warning signs, and the importance of scheduling and attending postpartum visits.</p> <p>Strategy 3: Foster partnerships to develop systems of referral, counter referral and promote best practices to increase uptake of recommended maternal health practices that reduce risk and prevent maternal harm.</p> <p>Strategy 4: Provide technical assistance and support for maternal health care quality improvement.</p>	<p>ESM PPV.1 - Number of community health workers (CHWs) who complete a maternal health and postpartum care training course and demonstrate core competencies.</p>	<p>NPM - Postpartum Visit</p>	<p>Linked NOMs: Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety</p>
<p>Address health disparities across all maternal and child health populations.</p>	<p>By August 31, 2030, decrease the Black to White SMM disparity gap ratio from 2.0 to 1.8. (Baseline: 2023 Texas Hospital Inpatient Discharge Research Data File)</p>	<p>Strategy 1: Foster partnerships and identify best and promising practices to prioritize reduction and elimination of disparate outcomes in all DSHS maternal health programming.</p> <p>Strategy 2: Develop structures, processes, and strengthen community engagement to address non-medical drivers of health and mitigate health disparities.</p> <p>Strategy 3: Use continuous quality improvement and evaluation to develop and implement evidence-based interventions to reduce health disparities.</p> <p>Strategy 4: Develop and promote educational opportunities related to non-medical drivers of health for health care professionals and other stakeholders.</p>	<p>No ESMs were created by the State. ESMs are optional for this measure.</p>	<p>SPM 4: Maternal Morbidity Disparities: Ratio of Black to White severe maternal morbidity (SMM) rate.</p>	

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		<p>Strategy 5: Partner with health care organizations and provide support to mitigate health disparities, including technical assistance.</p>			
<p>Improve the cognitive and behavioral health and development of all maternal and child health populations.</p>	<p>By August 31, 2030, increase the percentage of women who had a health care visit in the 12 months before pregnancy by 6%. (Baseline: 80.1%, 2023 Texas PRAMS).</p> <p>By August 31, 2030, increase the percentage of women getting prenatal care as early as they wanted among Non-Hispanic (NH) Black, NH White, and Hispanic women by 10%, 5%, and 2%, respectively. (Texas PRAMS 2023 baseline: NH Black: 78.5%; Hispanic: 84.1%; NH White: 90.6%)</p> <p>By August 31, 2030, increase the number of health care professionals participating at least annually in DSHS maternal health continuing education (CE) opportunities by 2% (Baseline: Will established in FY 2025 (Data Source: programmatic CE data via would be DSHS Learning Management Systems (LMS) and other CE offerings)</p> <p>By August 31, 2030, reduce severe maternal complications (excluding blood transfusions) identified during delivery hospitalizations by 5% from</p>	<p>Strategy 1: Assess needs, gaps, and opportunities to strengthen systems and expand initiatives to increase women’s and maternal health awareness throughout the state.</p> <p>Strategy 2: Develop and promote educational opportunities for health care professionals and other stakeholders on women’s and maternal health topics related to pregnancy, birth outcomes, chronic disease, mental health, behavioral health, preventive health, and health promotion affecting women, maternal, and infant health.</p> <p>Strategy 3: Foster cross-cutting partnerships, promote/align best practices, and increase uptake of recommended maternal and women’s health practices that reduce risk and prevent fetoinfant and maternal harm.</p> <p>Strategy 4: Partner with health care organizations and provide support for maternal health care quality improvement, including technical assistance.</p>	<p>No ESMs were created by the State. ESMs are optional for this measure.</p>	<p>SPM 5: Percent of women of childbearing age who self-rate their health status as excellent, very good, or good.</p>	

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	baseline (HP2030 MICH-05). (Baseline: 69.3 per 10,000 delivery hospitalizations, 2022. Data Source: Texas Health Data)				

Perinatal/Infant Health

<p>Improve mental health and chronic disease-related outcomes across the life course.</p>	<p>By August 31, 2030, decrease the percentage of breastfed newborns who receive formula supplementation within the first 2 days of life by 5%. (Baseline =17.8%, 2021 National Immunization Survey).</p> <p>By August 31, 2030, increase the percentage of livebirths that occur in facilities that provide recommended care for lactating mothers and their babies by 5%. (Baseline=59.7%, 2024 Texas Live Birth Files, Texas Center for Health Statistics)</p> <p>By August 31, 2030, increase the average Texas score on the CDC Maternity Practices in Infant Nutrition and Care (mPINC) Survey by 3.75%. (Baseline=80, 2022 CDC mPINC survey)</p> <p>By August 31, 2030, increase the number of Gold- and Silver- level designated Texas Mother-Friendly Worksites by 20%. (Baseline=54 Gold and 224 Silver, 2025 Texas Mother-Friendly Worksite Program)</p>	<p>Strategy 1: Assess needs, gaps and opportunities to strengthen systems for provision of recommended breastfeeding support practices using methods including surveys and qualitative research.</p> <p>Strategy 2: Foster coordination, collaboration, partnership, and collective impact with community partners to address known barriers to breastfeeding in the workplace, community, and healthcare environments through increased uptake and implementation of recommended practices in infant nutrition and care.</p> <p>Strategy 3: Develop, facilitate, and disseminate materials, and communications for health care professionals, health and social service providers, and other community partners for promoting breastfeeding support practices.</p>	<p>ESM BF.1 - Percent of births occurring in hospitals with policies consistent with the Ten Steps to Successful Breastfeeding as recognized through designation by the Texas Health and Human Services Commission (HHSC) Texas Ten Step (TTS) Program.</p> <p>ESM BF.2 - Percent of Texas Mother-Friendly Worksites (TMFW) that have gold- or silver- level designation status.</p> <p>ESM BF.3 - Number of after-hours calls to the Texas Lactation Support Hotline.</p> <p><i>Inactive - ESM BF.4 - Percent of births occurring in hospitals with policies consistent with the WHO/UNICEF Ten Steps to Successful Breastfeeding and recognized by the Texas Ten Step Designation.</i></p> <p><i>Inactive - ESM BF.5 - Estimated minimum</i></p>	<p>NPM - Breastfeeding</p>	<p>Linked NOMs: Infant Mortality Postneonatal Mortality SUID Mortality</p>
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			<p><i>number of Texas workers employed at a worksite with a written and communicated worksite lactation support policy and recognized by the Texas Mother-Friendly designation</i></p>		
<p>Improve health outcomes and reduce injury risk and mortality through enhanced health and safety efforts for maternal and child health populations.</p>	<p>By August 31, 2030, increase the percentage of mothers who report they lay their babies down to sleep on their back only by 15%. (Baseline= 76.1%, 2021-2022 Texas PRAMS)</p> <p>By August 31, 2030, increase the percentage of mothers who report placing their infant on a safe sleep surface by 15%. (Baseline= 34.8%, 2021-2022 Texas PRAMS)</p> <p>By August 31, 2030, increase the percentage of mothers who report placing their infant to sleep without soft objects by 15%. (Baseline= 50.3%, 2021-2022 Texas PRAMS)</p> <p>By August 31, 2030, increase the percentage of mothers who report their infant’s crib or bed was in the same room where they or another adult slept in the past two weeks by 10%. (Baseline= 85.2%, 2021-2022 Texas PRAMS)</p>	<p>Strategy 1: Assess needs, gaps, and opportunities to strengthen systems for recommended sleep safety support and SIDS risk reduction practices.</p> <p>Strategy 2: Partner to expand, coordinate, and integrate sleep safety and Sudden Unexpected Infant Death (SUID) risk reduction programmatic efforts and outreach across health and human service programming.</p> <p>Strategy 3: Develop, facilitate, and disseminate materials, communications for health care professionals, health and social service providers, and other community partners for sleep safety promotion and SUID risk reduction.</p>	<p>ESM SS.1 - Number of health professionals who received Texas Health and Human Services (HHS) continuing education (CE) credits on Sudden Unexpected Infant Death (SUID) prevention or safe sleep practices in the past year.</p>	<p>NPM - Safe Sleep</p>	<p><u>Linked NOMs:</u> Infant Mortality Postneonatal Mortality SUID Mortality</p>
<p>Address health disparities</p>	<p>By August 31, 2030, increase the percentage of non-Hispanic (NH)</p>	<p>Strategy 1: Carry out community-specific needs assessments and evidence-based strategic programming to address non-medical drivers</p>	<p>No ESMs were created by the State. ESMs are</p>	<p>SPM 3: Infant Mortality Disparities: Ratio of Black</p>	

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across all maternal and child health populations.	<p>Black mothers who report placing their baby on their backs to sleep by 11.1%. (Baseline= 59.6%, Texas PRAMS 2020-2022)</p> <p>By August 31, 2030, increase the percent of live births among NH Black women that occur in facilities providing recommended care for lactating mothers and their babies (Texas Ten Step hospital designation) by 15% (Baseline=62.8%, 2024 Texas Live Birth Files, Texas Center for Health Statistics).</p>	<p>of health and mitigate health disparities in communities with high fetal and infant mortality rates.</p> <p>Strategy 2: Conduct targeted public health promotion, awareness, and education in counties with excess infant mortality through campaigns, partnerships, and community engagement.</p>	optional for this measure.	to White Infant Mortality Rate.	

Child Health

Improve the cognitive and behavioral health and development of all maternal and child health populations.	By August 31, 2030, increase the percentage of children, ages 9 through 15 months, who received a developmental screening in the past year to 70% (NSCH 2022-2023 baseline=68.3%)	<p>Strategy 1: Assess needs, gaps, risk factors, and opportunities to strengthen systems and expand initiatives to increase implementation of best practices related to optimal development.</p> <p>Strategy 2: Lead, fund, or partner on activities and initiatives, such as Help Me Grow Texas and Learn the Signs Act Early, to make developmental screenings and monitoring tools and information accessible to families.</p> <p>Strategy 3: Lead and partner on the development, promotion, and dissemination of health information and resources about best practices to optimal early childhood health and development.</p> <p>Strategy 4: Partner with early childhood state agencies to establish and improve statewide systems to increase access to resources and services that are supportive of optimal child development.</p>	<p>ESM DS.1 - Number of Texas Health Steps Online Provider Education (THSteps-OPE) users completing developmental screening modules.</p> <p>ESM DS.2 - Percent of families participating in Help Me Grow (HMG) Texas who receives a developmental screening.</p> <p>ESM DS.3 - Number of participants attending developmental screening Extension for Community Healthcare Outcomes (ECHO) educational sessions.</p>	NPM - Developmental Screening	Linked NOMs: School Readiness Children's Health Status
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Support	By August 31, 2030, increase the	Strategy 1: Assess needs, gaps, risk factors, and opportunities to	ESM MH.1 - Percent of	NPM - Medical Home	Linked NOMs:
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<p>comprehensive, family-centered, coordinated care within a medical home model for all maternal and child health populations.</p>	<p>percentage of children and their families who are provided education, support, and linkages about receiving care within a medical home by 3% above baseline (Total number of unique referrals by HMG Texas affiliates 2024 5,541).</p> <p>By August 31, 2030, increase the percentage of providers who completed education about medical home and case management by 2% above baseline (OPE 2024- 5,943).</p>	<p>strengthen systems and expand initiatives to increase implementations of best practices related to optimal development.</p> <p>Strategy 2: Lead, fund, and partner on activities and initiatives, such as Help Me Grow Texas and Healthy Paths for Strong Brains to make developmental screenings and monitoring tools and information accessible to families.</p> <p>Strategy 3: Lead and partner on the development, promotion, and dissemination of health information and resources about best practices to optimal early childhood health and development.</p>	<p>families receiving professional case management services for children with special health care needs (CYSHCN).</p> <p>ESM MH.2 - Percent of families who receive emergency preparedness assistance.</p> <p>ESM MH.3 - Percent of families receiving professional care coordination for their child.</p> <p>ESM MH.4 - Number of Community Health Workers (CHWs) trainings to increase Medical Home Initiatives and Child Case Management.</p> <p><i>Inactive - ESM MH.5 - Percent of families receiving professional care coordination for their child.</i></p> <p><i>Inactive - ESM MH.6 - Increase percent of families who have a plan for an emergency and/or disaster.</i></p>		<p>Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All</p>
<p>Improve mental health and chronic disease-related outcomes across the life</p>	<p>By August 31, 2030, decrease the percent of 4th graders with a BMI in the overweight or obese range from 39% to 37% (SPAN 2021-2023).</p>	<p>Strategy 1: Assess needs, gaps, and opportunities to strengthen systems and expand initiatives to increase awareness of overweight and obesity in children.</p> <p>Strategy 2: Fund the implementation of the Texas School Physical Activity and Nutrition (SPAN) surveillance project to identify state and regional</p>	<p>SPM ESM 2.1 - Percent change in number of Texas Health Steps Online Provider Education (THSteps-OPE) users completing</p>	<p>SPM 2: Percent of children in Texas, ages 6-17, who are obese.</p>	

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course.		<p>trends in health status of children in Texas.</p> <p>Strategy 3: Lead, partner, and support efforts to educate and build capacity among providers and health professionals to understand healthy weight status, promote healthy behaviors across the life course, and implement best practices in obesity prevention.</p> <p>Strategy 4: Support the promotion of best practices to increase uptake of recommended nutrition and other health behavior that reduce risk of an prevent overweight and obesity of children.</p>	obesity related modules. SPM ESM 2.2 - Percent change in number of Texas Health Steps Online Provider Education (THSteps–OPE) users completing mental health related modules.		
Improve health outcomes and reduce injury risk and mortality through enhanced health and safety efforts for maternal and child health populations.	By August 31, 2030, the number of online provider education users completing mental health related modules will increase by 5%. (THSteps 2024 baseline 11,176 injury prevention modules)	<p>Strategy 1: Assess and monitor injury prevention data, trends, and factors that impact injury prevention, community needs, and assets for reducing injuries among children.</p> <p>Strategy 2: Partner and collaborate on state and national initiatives including the Child Safety Learning Collaborative (CSLC) and State Child Fatality Review Committee.</p> <p>Strategy 3: Lead, fund, and partner on dissemination of injury prevention information, trainings, resources to providers, community partners, and public health regional staff.</p> <p>Strategy 4: Support Safe Riders and public health regional staff with existing child passenger safety seat distribution and education programming.</p>	SPM ESM 6.1 - Percent change in number of Texas Health Steps Online Provider Education (THSteps–OPE) users completing injury prevention modules. SPM ESM 6.2 - Percent change in number of programs or organizations utilizing positive youth development. SPM ESM 6.3 - Percent of child deaths reviewed by Child Fatality Review Teams (CFRTs). SPM ESM 6.4 - Percent of youth reporting “sometimes” or “often” the presence of a caring adult in their lives.	SPM 6: Rate of emergency department (ED) visits for non-fatal injury per 100,000 children, ages 0 through 19.	

Adolescent Health

Support families and providers	By August 31, 2030, increase the number of programs utilizing positive youth development in their	Strategy 1: Lead and fund the implementation of Texas Youth Action Network (TYAN) to develop a statewide infrastructure to spread positive youth (PYD) development and youth-adult partnerships (YAP) and	ESM ADM.1 - Percent of youth reporting the presence of a caring	NPM - Adult Mentor	Linked NOMs: Adolescent Depression/Anxiety Flourishing - Child Adolescent -
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through education, resources, and strategic programming.	programs by 50 organizations (FY24 TYAN Baseline=90).	integrate youth voices in decision making.	adult after participating in a youth-adult partnership (YAP).		CSHCN Flourishing - Child Adolescent - All
Improve mental health and chronic disease-related outcomes across the life course.	By 2030, decrease the percentage of adolescents in 11th grade with a BMI in the overweight or obese range from 45.8% to 44% (SPAN 2021-2023).	<p>Strategy 1: Assess needs, gaps, and opportunities to strengthen systems and expand initiatives to increase awareness of overweight and obesity in youth and young adults.</p> <p>Strategy 2: Fund the implementation of the Texas School Physical Activity and Nutrition (SPAN) surveillance project to identify state and regional trends in health status of children in Texas.</p> <p>Strategy 3: Lead, partner, and support efforts to educate and build capacity among providers and health professionals to understand healthy weight status, promote healthy behaviors across the life course, and implement best practices in obesity prevention.</p> <p>Strategy 4: Support the promotion of best practices to increase uptake of recommended nutrition and other health behaviors that reduce risk of an prevent overweight and obesity of youth and young adult in Texas.</p>	SPM ESM 2.1 - Percent change in number of Texas Health Steps Online Provider Education (THSteps-OPE) users completing obesity related modules. SPM ESM 2.2 - Percent change in number of Texas Health Steps Online Provider Education (THSteps-OPE) users completing mental health related modules.	SPM 2: Percent of children in Texas, ages 6-17, who are obese.	
Improve health outcomes and reduce injury risk and mortality through enhanced health and safety efforts for maternal and child health populations.	<p>By August 31, 2030, decrease the rate of emergency room visits among children ages 0-19 years by 3% (Texas Hospital Department Public Use 2019 baseline- 8,291 per 100,000).</p> <p>By August 31, 2030, increase the number of CFRT, educators and providers that are provided adolescent injury education, support and community resources from baseline by 3% (OPE FY24= 36,125).</p>	<p>Strategy 1: Support providers, state, community, and public health regional (PHR) staff's injury prevention efforts by providing injury prevention information, trainings, and resources such as the Texas Health Steps Online Provider Education and supporting efforts in the PHR's.</p> <p>Strategy 2: Lead and partner on the development, promotion, and dissemination of educational materials, communications, and programmatic activities that effectively inform and educate Texans about injury prevention, factors that influence it, and how to reduce injuries among youth and young adults.</p> <p>Strategy 3: Assess and monitor injury prevention data and trends, factors impacting injury prevention, and community needs and assets for reducing injuries among children, youth, and young adults.</p>	SPM ESM 6.1 - Percent change in number of Texas Health Steps Online Provider Education (THSteps-OPE) users completing injury prevention modules. SPM ESM 6.2 - Percent change in number of programs or organizations utilizing positive youth development. SPM ESM 6.3 - Percent of child deaths reviewed by Child Fatality	SPM 6: Rate of emergency department (ED) visits for non-fatal injury per 100,000 children, ages 0 through 19.	

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			Review Teams (CFRTs). SPM ESM 6.4 - Percent of youth reporting “sometimes” or “often” the presence of a caring adult in their lives.		
Improve mental health and chronic disease-related outcomes across the life course.	<p>By 2030, increase the number of youth educated on the dangers of tobacco products, including e-cigarettes and other emerging products by 500,000. (Texas Tobacco Prevention and Control Program Records, FY24 Baseline = 156,858).</p> <p>By 2030, increase the number of trusted adults who influence youth educated on the dangers of tobacco products and the rapidly evolving tobacco product landscape by 50,000. (Texas Tobacco Prevention and Control Program Records, FY24 Baseline = 34,824).</p>	<p>Strategy 1: Educate and engage stakeholders and decision makers on evidence-based strategies to prevent initiation of tobacco use, including e-cigarettes.</p> <p>Strategy 2: Educate and engage stakeholders, such as parents, schools, and community-based organizations, and decision makers on evidence-based strategies to reduce youth use of emerging tobacco products, including e-cigarettes.</p>	No ESMs were created by the State. ESMs are optional for this measure.	SPM 7: Percent of youth in grades 6 to 12 who reported current tobacco product use, including electronic cigarettes (e-cigarettes).	

Children with Special Health Care Needs

Support comprehensive, family-centered, coordinated care within a medical home model for all maternal and child health populations.	<p>By 2030, increase the percentage of CYSHCN and their families who receive care coordination resources and support by 2% above baseline. (MH services baseline = FY23 168).</p> <p>By 2030, increase the percentage of CYSHCN providers who receive education about medical home by 5% above baseline (OPE participant baseline = FY24 661).</p>	<p>Strategy 1: Assess needs, gaps, and opportunities to strengthen systems and expand initiatives to increase CYSHCN accessing a medical home.</p> <p>Strategy 2: Lead or fund care coordination activities, develop and distribute evidence-informed resources and medical home best practices.</p> <p>Strategy 3: Fund and partner with community-based organizations and DSHS regional staff to help families find primary and specialty care providers, connect with needed resources/services, and develop emergency preparedness plans.</p> <p>Strategy 4: Fund the CSHCN Services Program’s health care benefit</p>	<p>ESM MH.1 - Percent of families receiving professional case management services for children with special health care needs (CYSHCN).</p> <p>ESM MH.2 - Percent of families who receive emergency preparedness assistance.</p> <p>ESM MH.3 - Percent of</p>	NPM - Medical Home	<p>Linked NOMs:</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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		<p>administered through the Texas Health and Human Services Commission to provide medically necessary services to eligible CYSHCN up to age 21.</p> <p>Strategy 5: Foster partnerships and support state and national initiatives to strengthen systems to improve the quality of life and wellbeing of CYSHCN and their families.</p> <p>Strategy 6: Lead, fund, and partner to address non-medical drivers of health and health disparities that CYSHCN and their families experience in accessing a medical home.</p>	<p>families receiving professional care coordination for their child.</p> <p>ESM MH.4 - Number of Community Health Workers (CHWs) trainings to increase Medical Home Initiatives and Child Case Management.</p> <p><i>Inactive - ESM MH.5 - Percent of families receiving professional care coordination for their child.</i></p> <p><i>Inactive - ESM MH.6 - Increase percent of families who have a plan for an emergency and/or disaster.</i></p>		
<p>Improve transition planning and support services for children, adolescents, and young adults, including those with special health care needs.</p>	<p>By 2030, increase the percentage of CYSHCN and their families who receive resources and support to plan for transitioning from pediatric to adulthood by 2% above baseline. (Transition Services Baseline = FY24 1,725).</p> <p>By 2030, increase the percentage of pediatric and adult providers who receive resources on transition to adult health care by 2% above baseline. (OPE Participants Baseline = FY24 1,048).</p>	<p>Strategy 1: Assess needs, gaps, and opportunities to strengthen systems and expand initiatives to improve transition planning for CYSHCN.</p> <p>Strategy 2: Lead the statewide Transition to Adulthood Learning Collaborative and development of health care transition to adulthood resources including presentations for families and professionals.</p> <p>Strategy 3: Lead education and outreach efforts to assist transition-age youth to learn about the importance of strategies and planning for transition to adulthood.</p> <p>Strategy 4: Fund and partner with community-based organizations and DSHS regional staff to help CYSHCN and their families to learn about and actively plan for the transition to adulthood.</p>	<p>ESM TAHC.1 - Percent of transition-age children and youth with special health care needs (CYSHCN) families receiving professional help with health care transition.</p> <p><i>Inactive - ESM TAHC.2 - Decrease percent of families of transition-age youth who have not prepared for medical transition to adulthood</i></p> <p><i>Inactive - ESM TAHC.3 - Percent of families of transition age youth with</i></p>	<p>NPM - Transition To Adult Health Care</p>	<p>Linked NOMs: CASHCN Systems of Care</p>

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			<i>special health care needs receiving professional help with their child's transition to adulthood</i>		
Support families and providers through education, resources, and strategic programming.	<p>By 2030, increase the percentage of CYSHCN and their families who are provided family supports and community resources services by 2%. (FSCR Services Baseline = FY24 5,416).</p> <p>By 2030, increase the percentage of providers of CYSHCN who receive education and support on the provision of family supports and community resources by 2%. (FSCR Provider Services baseline = FY24 3,872).</p>	<p>Strategy 1: Assess needs, gaps, and opportunities to strengthen systems and expand involvement for CYSHCN in their communities.</p> <p>Strategy 2: Lead development of educational resources and projects aimed at removing systemic barriers to improve the involvement of CYSHCN and their families in community life and strategically advance family engagement.</p> <p>Strategy 3: Lead advancement of family engagement efforts to promote involvement of the CYSHCN family perspective, awareness of the importance of meaningful family engagement at all levels, a family-centered approach to services, and development of family leaders.</p> <p>Strategy 4: Fund community-based organizations and DSHS regional staff to support CYSHCN and their family's involvement in community life.</p>	No ESMs were created by the State. ESMs are optional for this measure.	SPM 1: Percent of children and youth with special health care needs (CYSHCN) and their families who participate in social or recreational activities with families who have children with or without disabilities.	