Texas 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					
Improve maternal and infant health outcomes through enhanced health and safety efforts.	By 2025, increase the proportion of women who had a health care visit in the 12 months before pregnancy to meet a target of 70.0% or higher (CDC PRAMS, 2017 baseline = 67.7%). By 2025, decrease the Non-Hispanic (NH) Black to NH White and Hispanic to NH White disparity gap in getting prenatal care as early as wanted. (Texas PRAMS 2018 baseline: % getting prenatal care as early as wanted: NH Black: 82.1%; Hispanic: 77.8%; NH White: 87.6%) By 2025, increase the proportion of women giving birth who attend a postpartum care visit with a health care worker to meet a target of 90% or higher (Texas PRAMS, 2018 baseline = 88.1%). By 2025, increase the proportion of birthing hospitals in Texas with one or more physicians participating at least annually in DSHS maternal health continuing medical education learning events to 70%.	Strategy 1: Assess needs, gaps, and opportunities to strengthen systems and expand initiatives to increase women's and maternal health awareness throughout the state. 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, infectious disease, mental health, behavioral health, preventive health and health promotion affecting women's, maternal and infant health. Strategy 3: Foster partnerships and promote best practices and to increase uptake of recommended maternal and women's health practices that reduce risk and prevent feto- infant and maternal harm. Strategy 4: Partner with health care organizations and provide technical assistance and support for maternal health care quality improvement.		SPM 5: Percent of women of childbearing age who self-rate their health status as excellent, very good, or good	

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	By 2025, reduce severe maternal complications (excluding blood transfusions) identified during delivery hospitalizations by 15% from baseline (HP3030 MICH-05).				
Support health education and resources for families and providers.	By 2025, increase abstinence from cigarette smoking among pregnant women by 1 percentage point. (CDC WONDER Online Database, Natality public-use data; 2017 baseline = 97%) By 2025, decrease any cigarette smoking during the three months before pregnancy by 10% (CDC PRAMS , 2017 baseline = 17.7) By 2025, decrease any cigarette smoking during the last three months of pregnancy by 10% (CDC PRAMS , 2017 baseline = 8.1) By 2025, decrease any cigarette smoking in the postpartum period by 10% (CDC PRAMS , 2017 baseline = 11.7%) By 2025, decrease any e-cigarette use during the three months before pregnancy by 10% (CDC PRAMS , 2017 baseline = 3.7%) By 2025, decrease any e-cigarette use during the last three months of pregnancy by 10% (CDC PRAMS , 2017 baseline = 1.1)	Strategy 1: Assess needs, gaps and opportunities to increase implementation of recommended smoking prevention and cessation best practices. Strategy 2: Foster partnerships with stakeholders to strengthen collaboration and increase synergy and collective impact of programmatic activities. Strategy 3: Develop, promote and disseminate materials, communications, and programmatic activities that reduce tobacco exposure among women, children and families.	ESM SMK-Pregnancy.1 - Number of health organizations engaged in a DSHS maternal or infant health improvement effort involving integration of tobacco/e-cigarette screening, education and referral.	NPM - Percent of women who smoke during pregnancy (Smoking - Pregnancy, Formerly NPM 14.1) - SMK-Pregnancy	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 NOM - Neonatal mortality rate per

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					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 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Implement health equity strategies across all maternal and child health populations.	By 2025, decrease the Black-White SMM disparity gap ratio from 1.9 (2019 baseline) to 1.4.	Strategy 1: Identify best and promising practices to increase maternal health equity and prioritize reduction and elimination of disparate outcomes in all DSHS maternal health programming. Strategy 2: Develop structures, processes, and a culture of equity to support health equity work. Strategy 3: Strengthen community engagement in health equity work. Strategy 4: Implement, and use continuous quality improvement and evaluation to assure, use of evidence based/evidence informed interventions to reduce disparities and increase health equity. Strategy 5: Develop and promote educational opportunities for health care		SPM 4: Maternal Morbidity Disparities: Ratio of Black to White severe maternal morbidity rate.	

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		professionals and other stakeholders on maternal health equity. Strategy 6: Foster partnerships, promote best and promising practices, and increase uptake of recommended health and racial equity practices. Strategy 7: Partner with health care organizations and provide technical assistance and support for health and racial equity quality improvement.			
Improve maternal and infant health outcomes through enhanced health and safety efforts.	By August 31, 2030, increase the rate of women attending one or more postpartum follow up visit by 1% (Baseline 85.4%, 2020 Texas PRAMS)	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. 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. Strategy 3: Foster partnerships to develop systems of referral and counter referral and promote best practices to increase uptake of recommended maternal health practices that reduce risk and prevent maternal harm. Strategy 4: Provide technical assistance and support for maternal health care quality improvement.	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					
Improve nutrition across the life course.	By 2025, decrease the proportion of breastfed newborns who receive formula supplementation within the first 2 days of life from 22.5% to 21.5%. (National Immunization Survey, 2017 births). By 2025, increase the proportion of live births that occur in facilities that provide recommended care for lactating mothers and their babies (designated Baby-Friendly	Strategy 1: Assess needs, gaps and opportunities to strengthen systems for provision of recommended breastfeeding support practices using methods including surveys and qualitative research. Strategy 2: Foster coordination, collaboration, partnership, and collective impact with stakeholders across sectors --including birthing facilities, employers, state and local agencies, professional associations, insurers, coalitions, health care providers, service providers, community-based organizations, mothers, advocates, and other stakeholders— to address known barriers to breastfeeding through increased uptake and implementation of recommended practices in infant nutrition and care.	ESM BF.1 - 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. ESM BF.2 - Estimated	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

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	hospitals) from 20% to 25%. (CDC Breastfeeding Surveillance Sources, 2020 births). By 2025, increase the average Texas score on the CDC Maternity Practices in Infant Nutrition and Care (mPINC) Survey score from 79 (2020 baseline) to >81. (CDC Maternity Practices in Infant Nutrition and Care Survey (mPINC). By 2025, increase the number of Texas Mother-Friendly Worksites from 3200 (end of 2020) to > 3750. (Program data). By 2025, decrease the proportion of women who ever breastfed that reported they did not breastfeed for as long as they wanted to from 59.4%(2018) to 51.8% DSHS/ HHSC Texas WIC IFPS).	Strategy 3: Develop and disseminate materials, communications, outreach methods, and programmatic strategic plans for promoting breastfeeding support practices. Strategy 4: Facilitate educational opportunities, such as through online breastfeeding modules, to increase breastfeeding support and lactation management knowledge and skills of health care professionals who care for lactating mothers and their babies.	minimum 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 ESM BF.3 - Number of after-hours calls to Texas' lactation support hotline		NOM 9.5) - IM-SUID
Improve maternal and infant health outcomes through enhanced health and safety efforts.	By 2025, increase by 15% the percent of mothers who report they lay their babies down to sleep on their back only (Baseline= 74.1, 2018 Texas PRAMS)	Strategy 1: Assess needs, gaps and opportunities to strengthen systems for support of recommended sleep safety and SIDS risk reduction practices. Strategy 2: Partner to expand, coordinate, and integrate sleep safety and SIDS risk reduction programmatic efforts and outreach across health and human service programming. Strategy 3: Develop and disseminate materials, communications, outreach methods, and programmatic strategic plans for promotion of sleep safety and SIDS risk reduction. Strategy 4: Facilitate educational opportunities for health care professionals, health and social service providers, and other stakeholders	ESM SS.1 - Number of health professionals who received Texas HHS CE credits on SUID prevention or safe sleep practices in the past year	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-	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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		on topics related to promotion and assurance of recommended sleep safety and SIDS risk reduction practices, including through Texas Health Steps Online Provider Education.		sharing with an adult during sleep (Safe Sleep) - SS	
Implement health equity strategies across all maternal and child health populations.	By 2025, increase by 15% from baseline (baseline to be established) the percentage of live births among Black women that occur in facilities that provide recommended care for lactating mothers and their babies (Baby Friendly Hospitals). By 2025, increase by 15% from baseline (baseline to be established) the percentage of Black mothers reporting that a health care worker told them information about infant safe sleep practices. By 2025, decrease the Non-Hispanic (NH) Black to NH White disparity gap in getting prenatal care as early as wanted. (Texas PRAMS 2018 baseline: % getting prenatal care as early as wanted: NH Black: 82.1%; NH White: 87.6%)	Strategy 1: Carry out community-specific needs assessments and evidence-based strategic programming to address high fetal and infant mortality rates among Black infants. Strategy 2: Redesign DSHS preconception health and health care public awareness campaign and support local campaigns and outreach in counties with high Black infant mortality rates. Strategy 3: Improve the quality of perinatal care, education, and support provided to Black women through the work of the Healthy Texas Mothers and Babies Initiative and other projects, including the DSHS Infant Feeding Workgroup. Strategy 4: Collaborate with universities and community colleges with high rates of Black student enrollment to promote preconception health education and outreach. Strategy 5: Conduct targeted public health messaging in counties with high Black infant mortality rates in the PPOR for Maternal Health and Maternal Care through use of the Healthy Texas Babies' Public Awareness Campaign, Someday Starts Now, and in partnership with entities such as Healthy Start and WIC.		SPM 3: Infant Mortality Disparities: Ratio of Black to White infant mortality rate	
Child Health					
Promote safe, stable, nurturing environments to reduce violence and the risk of injury.	By 2025, decrease the rate of emergency room visits among children ages 0-19 years by 5% (Texas Hospital Outpatient Emergency Department Public Use Data 2019 baseline = 8,291 per 100,000).	Strategy 1: Assess and monitor injury prevention data and trends, factors that impact injury prevention, and community needs and assets for reducing injuries among children. Strategy 2: Lead state and national initiatives including the Child Safety Learning Collaborative and State Child Fatality Review Team Committee. Strategy 3: Lead, fund, and partner on dissemination of injury prevention	***Inactive -*** *ESM IH-Child.1 - Number of School Health Friday Beat newsletters per fiscal year with at least one injury prevention resource provided*	NPM - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9 (Injury Hospitalization - Child, Formerly NPM 7.1) - IH-Child	NOM - Child Mortality rate, ages 1 through 9, per 100,000 (Child Mortality, Formerly NOM 15) - CM NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM

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		information, trainings, and resources to providers, state and community partners, and regional staff. Strategy 4: Support Safe Riders and regional staff with existing child passenger safety seat distribution and education programming.	***Inactive -*** *ESM IH-Child.2 - Number of individuals trained on injury prevention through the Medical Child Abuse Resources and Education System (MEDCARES) grant* ESM IH-Child.3 - Percent of child deaths reviewed by Child Fatality Review Teams (CFRT) ESM IH-Child.4 - Number of stakeholders receiving trainings or technical assistance about preventable child injuries or death		NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide
Improve the cognitive, behavioral, physical, and mental health and development of all Maternal and Child Health populations.	Objective1: By 2025, increase the percentage of children, ages 9 through 35 months, who received a developmental screening in the past year to 60%. (NSCH 2018-2019 baseline = 46.4%)	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. Strategy 2: Lead, fund, and partner on activities and initiatives, such as Help Me Grow Texas and Learn the Signs. Act Early., to make developmental screening and monitoring tools and information accessible to families. Strategy 3: Lead and partner on the development, promotion, and dissemination of health information and resources about best practices to promote optimal early childhood health and development. Strategy 4: Partner with early childhood state agencies to establish and	ESM DS.1 - Number of Texas Health Steps Online Provider Education (THSteps) users completing developmental screening modules ***Inactive -*** *ESM DS.2 - Number of developmental screenings provided in the Healthy Child Care Texas Grant*	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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		improve statewide systems to increase access to resources and services that are supportive of optimal child development.	ESM DS.3 - Percent of families participating in Help Me Grow (HMG) Texas who receive a developmental screening		
Support health education and resources for families and providers.	By 2025, decrease number of children living in a household where someone smokes to 13.9% (NSCH 2019 baseline=14.6%)	Strategy 1: Assess needs, gaps, risk factors, and opportunities to strengthen systems and expand initiatives to increase implementation of recommended smoking prevention and cessation best practices. Strategy 2: Lead and partner on the development, promotion, and dissemination of educational materials, communications, and programming that reduce child exposure to secondhand smoke. Strategy 3: Partner with and support the Texas Tobacco Prevention and Control Program and the Texas Asthma Control Program, such as promoting the Texas Tobacco Quitline and supporting implementation of the Strategic Plan for Asthma Control in Texas, 2021-2024.	ESM SMK-Household.1 - Number of materials distributed to household members and caregivers intended to raise awareness about the risk of infant and child exposure to tobacco.	NPM - Percent of children, ages 0 through 17, who live in households where someone smokes (Smoking - Household, Formerly NPM 14.2) - SMK-Household	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,

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					Formerly NOM 9.1) - IM 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 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Improve nutrition across the life course.	By 2025, decrease the percent of children in 4th grade with a BMI in the overweight or obese range from 45.9% to 44.5% (SPAN 2019-2020).	Strategy 1: Assess needs, gaps, and opportunities to strengthen systems and expand initiatives to increase awareness of overweight and obesity in children. Strategy 2: Fund the implementation of the Texas School Physical Activity and Nutrition surveillance project to identify state and regional trends in health status of children in Texas. 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		SPM 2: Percent of overweight and obesity in Texas children ages 2-21.	

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		best practices in obesity prevention. Strategy 4: Support the promotion of best practices to increase uptake of recommended nutrition and other health behaviors that reduce risk of and prevent overweight and obesity in children.			
Support comprehensive, family-centered, coordinated care within a medical home model for all Maternal and Child Health populations.	By 2025, increase the percentage of CYSHCN and their families who are provided education and support about receiving care within a medical home by 2% above baseline (medical home services baseline FY15 = 5,754). By 2025, increase the percentage of providers of CYSHCN who are provided education about medical home by 5% above baseline (FY19 OPE participant baseline = 313).	Strategy 1: Lead and Fund development of educational resources, trainings, and initiatives to share evidence-informed and best practice approaches to medical home and care coordination with families, health care providers, case managers, and other professionals serving children and their families. Strategy 2: Partner and support state and national initiatives to promote family and provider education, and identify needs, gaps, and opportunities to strengthen systems to improve the quality of life and well-being of children. Strategy 3: Lead ongoing needs assessment and quality improvement activities to identify gaps and measure the experience of all children and adolescents, including CYSHCN, in accessing a medical home	ESM MH.1 - Percent of families receiving professional care coordination for their child ESM MH.2 - Increase percent of families who have a plan for an emergency and/or disaster	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
Adolescent Health					
Promote safe, stable, nurturing environments to reduce violence and the risk of	By 2025, increase the number of programs utilizing positive youth development in their programs by 55 organizations. (FY20 TYAN Baseline= 9 Community Partners)	Strategy 1: Assess and monitor injury prevention data and trends, factors that impact injury prevention, and community needs and assets for reducing injuries among youth and young adults. Strategy 2: Lead and fund efforts to strengthen, support, and mobilize organizations' capacity to build youth-adult partnerships and integrate	ESM IH-Adolescent.1 - Number of Texas Health Steps Online Provider Education (THSteps) users completing injury	NPM - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 (Injury Hospitalization -	NOM - Child Mortality rate, ages 1 through 9, per 100,000 (Child Mortality, Formerly NOM 15) - CM NOM - Adolescent mortality rate ages 10 through 19, per 100,000

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injury.	By 2025, decrease the rate of emergency room visits among children ages 0-19 years by 5% (Texas Hospital Outpatient Emergency Department Public Use Data 2019 baseline = 8,291 per 100,000). By 2025, increase the number of CFRT, educators and providers that are provided adolescent injury education, support and community resources from baseline by two percentage points. (MCH Section educational resources baseline FY21 = 38,367)	youth voices in decision-making. Strategy 3: Support providers, state and community partners, and regional 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 Public Health Regions. Strategy 4: 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. Strategy 5: Improve and innovate injury prevention efforts through ongoing evaluation, research, and continuous quality improvement of implementation efforts to reduce injury.	prevention modules. ***Inactive -*** *ESM IH-Adolescent.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19* ESM IH-Adolescent.3 - Percent of youth reporting "sometimes" or "often" to the presence of a caring adult in their lives ESM IH-Adolescent.4 - Percent of child deaths reviewed by Child Fatality Review Teams (CFRT)	Adolescent, Formerly NPM 7.2) - IH-Adolescent	(Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide
Improve nutrition across the life course.	By 2025, decrease the percent of adolescents in 11th grade with a BMI in the overweight or obese range from 42.1% to 41.5% (SPAN 2019 – 2020).	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. Strategy 2: Lead the development and dissemination of health information and resources about best practices to promote healthy behaviors across the life course related to improved nutrition and obesity prevention. Strategy 3: Fund the implementation of the Texas School Physical Activity and Nutrition surveillance project to identify state and regional trends in health status of youth and young adults in Texas. Strategy 4: 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.		SPM 2: Percent of overweight and obesity in Texas children ages 2-21.	

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		Strategy 5: Support the promotion of best practices to increase uptake of recommended nutrition and other health behaviors that reduce risk of and prevent overweight and obesity in youth and young adults.			
Children with Special Health Care Needs					
Support comprehensive, family-centered, coordinated care within a medical home model for all Maternal and Child Health populations.	By 2025, increase the percentage of CYSHCN and their families who are provided education and support about receiving care within a medical home by 2% above baseline (medical home services baseline FY15 = 5,754). By 2025, increase the percentage of providers of CYSHCN who are provided education about medical home by 5% above baseline (FY19 OPE participant baseline = 313).	Strategy 1: Lead and Fund development of educational resources, trainings, and initiatives to share evidence-informed and best practice approaches to medical home and care coordination with families, health care providers, case managers, and other professionals serving CYSHCN and their families. Strategy 2: Fund community-based organizations and DSHS regional staff to assist CYSHCN and their families to learn about medical home services, and access primary care providers, develop emergency preparedness plans, and connect with needed resources/services. Strategy 3: Fund the CSHCN Services Program's health care benefit administered through HHSC to provide medically necessary services to eligible CYSHCN up to age 21. Strategy 4: Lead ongoing needs assessment and quality improvement activities to identify gaps and measure the experience of CYSHCN in accessing a medical home. Strategy 5: Partner and support state and national initiatives to promote family and provider education, and identify needs, gaps, and opportunities to strengthen systems to improve the quality of life and well-being of CYSHCN and their families. Strategy 6: Lead and partner on efforts to address non-medical drivers of health and health disparities that CYSHCN and their families experience in accessing a medical home.	ESM MH.1 - Percent of families receiving professional care coordination for their child ESM MH.2 - Increase percent of families who have a plan for an emergency and/or disaster	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
Improve transition planning and support services for	By 2025, increase the percentage of CYSHCN and their families who are provided education and support about transition from pediatric to adult health care by 2% above	Strategy 1: Lead development of educational resources, trainings, and initiatives such as the statewide Transition to Adulthood Learning Collaborative to share evidence-informed and best practices on transitioning to adulthood with families, youth and young adults, health care clinicians, case managers, educators, and other professionals serving	ESM TR.1 - Percent of families of transition age youth with special health care needs receiving	NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
children, adolescents, and young adults, including those with special health care needs.	baseline. FY15 Transition Services Baseline = 3,809). By 2025, increase the percentage of pediatric and adult providers who are provided education on transition from pediatric to adult health care by 2% above baseline. (FY19 OPE Participants Baseline = 1,084).	CYSHCN and their families. Strategy 2: Lead education and outreach efforts to help youth and young adults, families, health care clinicians, case managers, educators, and other professionals serving transition-age youth learn about the importance of implementation strategies and proactive planning for health care transition. Strategy 3: Fund community-based organizations and DSHS regional staff to assist CYSHCN and their families to learn about and actively plan for the transition to adulthood. Strategy 4: Lead ongoing needs assessment and quality improvement activities to identify gaps and measure the experience of YSHCN in planning for the transition to adulthood. Strategy 5: Partner and support state and national initiatives to promote family and provider education, and identify needs, gaps, and opportunities to strengthen systems to improve the transition of CYSHCN to adult health care. Strategy 6: Lead and partner on efforts to address non-medical drivers of health and health disparities that CYSHCN and their families experience in transitioning to adulthood.	professional help with their child's transition to adulthood ESM TR.2 - Decrease percent of families of transition-age youth who have not prepared for medical transition to adulthood	to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR	Systems of Care, Formerly NOM 17.2) - SOC
Increase family support and ensure integration of family engagement across all Maternal and Child Health programming.	By 2025, increase the percentage of CYSHCN and their families who are provided family supports and community resources by 2%. (FY19 FSCR Services Baseline= 3,529). By 2025, increase the percentage of providers of CYSHCN who are provided education and support on the provision of family supports and community resources by 2%. (FY17 FSCR Provider Services baseline = 1,777).	Strategy 1: Lead development of educational resources and projects aimed at removing systemic barriers to improve the inclusion of CYSHCN and their families in community life and strategically advance family engagement. Strategy 2: Lead advancement of family engagement efforts to promote inclusion of the family perspective in all MCH programs, awareness of the importance of meaningful family engagement at all levels, a family-centered approach to services, and development of family leaders. Strategy 3: Fund community-based contractors and DSHS regional staff to help strengthen CYSHCN and their families and support their inclusion in community life by providing linkages for basic needs, facilitating parent to parent networking, hosting social and recreational activities, and offering		SPM 1: Percent of CYSHCN and their families who participate in social or recreational activities with families who have children with or without disabilities	

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		respite for parents and caregivers. Strategy 4: Lead needs assessment and quality improvement activities to identify gaps and measure the experience of CYSHCN and their families in being included in their communities. Strategy 5: Partner and support state and national initiatives aimed at helping to ensure CYSHCN grow up in their families in the community, and identifying needs, gaps, and opportunities to strengthen systems to advance community inclusion. Strategy 6: Lead and partner on efforts to address non-medical drivers of health and health disparities that CYSHCN and their families experience in being included in their communities.			