Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Women/Maternal Health					
Cardiovascular Disease including Diabetes, Obesity, and Hypertension	WM1a (1): Title V will conduct outreach and education on Heritage Health Adult (Nebraska Medicaid Expansion) enrollment and benefits, with a focus on disparate and disadvantaged women of childbearing age. WM1a (2): The DHHS Women's Health Initiatives Program will develop, implement, and evaluate a project collaboration with a community cultural organization to enhance local navigation and health services. WM1a (3): The DHHS Women's Health Initiatives Program will collaborate with partners to identify needs for updates and/or translations for existing educational materials for women on cardiovascular disease, and review use of social media, in order to assure cultural relevance and inclusion of disparate audiences.	WM1a: By 2025, increase access to preventive health care and address health disparities in order to reduce rates of obesity, diagnosed diabetes, and diagnosed hypertension in women age 18 to 44 years.	NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	ESM 1.1: Participation in the Women's Community Health Initiative for Preventing Cardio Vascular Disease.	NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations NOM 3: Maternal mortality rate per 100,000 live births NOM 4: Percent of low birth weight deliveries (<2,500 grams) NOM 5: Percent of preterm births (<37 weeks) NOM 6: Percent of early term births (37, 38 weeks) NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births

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					NOM 10: The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy NOM 11: The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth
Perinatal/Infant Health					
Premature Birth	PIN2a (1): The DHHS Maternal-Infant Health Program will convene and sustain a cross-sector multidisciplinary group to identify and make recommendations to Title V on actions to take to prevent premature birth and birth disparities. Strategy PIN2a(2): The DHHS Maternal-Infant Health Program will initiate a collaborative activity with Omaha Healthy Start on prematurity prevention. PIN2a(3): The Nebraska PRAMS program will develop, implement, and evaluate a Data-To-Action project related to prematurity during the period.	PIN2a: By 2025, decrease preterm birth by addressing disparities among women of childbearing age, increasing access to care, and providing education.	SPM 1: The percent of preterm births.		
Infant Safe Sleep	PIN3a(1): The DHHS Maternal Infant Health Program will continue expansion of NE Safe Babies campaign to include family practice, pediatric, and OB-GYN clinics across Nebraska. PIN3a(2): The DHHS Maternal Infant Health Program and MCH Epidemiology Office will review Omaha Fetal Infant Mortality Review data and identify actionable educational or policy recommendations. PIN3a(3): The MCASH Program will undertake a literature review of evidence regarding the impact of racial bias and other structural	PIN3a: By 2025, decrease Sudden Unexplained Infant Death rate by: promoting safe sleep practices particularly separate sleep surface; racial disparities; and protective factors such as breastfeeding.	NPM 5: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding	ESM 5.1: The number of birthing hospitals and pediatric clinics that become Champions of the "Nebraska Safe Babies Campaign".	NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.5: Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

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	determinants of health and equity influence how women are presented with educational information and resources regarding safe sleep. Identify and recommend change strategies where actionable. PIN3a(4): The DHHS Maternal Infant Health Program will undertake a review of available consumer education products regarding safe sleep and identify needs for health literate, culturally-diverse and inclusive, translated versions.				
Child Health					
Child Abuse Prevention	CH4a (1): The Nebraska MIECHV program will expand evidence-based home visiting services Nebraska families at-risk for child abuse and neglect in a collaboration with DHHS Division of Children and Family Services. CH4a (2): Title V staff will work with the Division of Children and Family Services to analyze data and describe any existing disparities among Child Welfare involved families.	CH4a: By 2025, reduce rate of substantiated child abuse or neglect by: supporting prevention, early identification, and early intervention strategies; and investigating disproportionality of children and families involved with the Child Welfare Agency.	SPM 2: The rate of substantiated reports of child abuse and neglect per 1,000 children (1-9).		
Access to Preventive Oral Health Care Services	CH5a(1): The DHHS Office of Oral Health will identify needs for translation of existing health literate oral health education materials. CH5a(2): Title V will assist the Office of Oral Health in acquiring and distributing Dental Health Starter Kits in the population. The DHHS Office of Oral Health will report evaluation measures of the project. CH5a(3): The DHHS School Health Program and the Office of MCH Epidemiology will participate in the planning and implementation of the statewide Oral Health Survey.	CH5a: By 2025, increase the percent of children ages 1 to 17 years who receive preventive oral health care services.	NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	ESM 13.2.1: The number of sites participating in the Nebraska Early Dental Health Starter Kits Educational program.	NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
Adolescent Health					
Motor Vehicle Crashes among Youth	AD6a(1): The DHHS Office of Injury Prevention will expand the scope of the Teens in the Drivers Seat survey to include non-participating schools, in order to enlarge the data and understanding of Nebraska youth driving behaviors. AD6a(2): The DHHS Office of Injury Prevention will assess and address the need for translations of health literate educational materials for	AD6a: By 2025 reduce the number of crashes among adolescent drivers age 14 to 19 years to prevent injury and death by addressing disparities in minority and rural populations.	NPM 7.2: Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19	ESM 7.2.1: The number of schools participating in the "Teens in the Driver Seat" program.	NOM 15: Child Mortality rate, ages 1 through 9, per 100,000 NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
	culturally-diverse audiences. AD6a(3): The DHHS Office of Injury Prevention will expand its distribution plan for safe driving materials including Graduated Drivers Licensing to community cultural centers and other non-school settings.				NOM 16.2: Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 NOM 16.3: Adolescent suicide rate, ages 15 through 19, per 100,000
Sexually Transmitted Diseases among Youth	AD7a(1): The DHHS STD Program will review and address needs for health literate, culturally and linguistically appropriate materials to educate the population, particularly disadvantaged groups. AD7a(2): The DHHS Adolescent Health Program will continue the development, testing, distribution, and evaluation of the Conversation Starters Project. AD7a(3): The DHHS Adolescent Health Program will continue the development, testing, distribution, and evaluation of Youth Friendly Clinic Recommendations. AD7a(4): With Title V support, the DHHS Adolescent Health Program will expand the evidence-based TOP positive youth development program to include at least one additional project site in a rural area or other area reflecting identified disparities. AD7a(5): The DHHS Reproductive Health Program will identify project opportunities to promote sexual health among underserved, disproportionately affected groups.	AD7a: by 2025, decrease the rates of chlamydia and gonorrhea among youth in Nebraska by addressing disparities among racial/ethnic and urban/rural groups.	SPM 3: The rate of chlamydia infections reported per 100,000 youth (age 15-19).		
Suicide among Youth	AD8a(1): The DHHS School Health Program will collaborate with partners and stakeholders involved in behavioral health in schools to identify gaps and assets in screening and referral of students; training of school personnel; needs for health literate and culturally- and linguistically-appropriate materials and communications for diverse consumers; referrals to community resources; school-family partnerships; and trauma-informed/restorative practices. AD8a(2): The MCASH Program will participate in the Nebraska Statewide Suicide Prevention Coalition and the Garret Lee Smith Suicide Prevention Grant project management team, in order to align Title V efforts with	AD8a: by 2025, reduce suicide rates among youth by: increasing access to early intervention services and education; addressing stigma; promoting protective factors (resilience, asset-building, family engagement) and reducing risk factors.	SPM 4: The death rate due to suicide per 100,000 youth (age 10-19).		

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
	existing approaches to reduce youth suicide. AD8a(3): The MCASH Program will collaborate with the Society of Care to identify opportunities for Title V to collaborate in this effort to support well-being of Native youth.				
Children with Special Health Care Needs					
Behavioral and Mental Health in School	CS9a(1): The Collaborative established will include families, and enhance availability of knowledge, services, and supports for families of CYSHCN. Included will be a website and information repository, formalized partnerships supported by memoranda of understanding or agreement; medical-community-legal partnerships; training and outreach for families and providers; and data collection and evaluation. CS9a(2): MHCP, in collaboration with the Munroe Meyer Institute (MMI) at the University of Nebraska Medical Center, will continue the Parent Resource Coordinator (PRC) project, supporting families with CYSHCN age birth to 21 years. This support includes mentorship with families and medical clinic providers to enhance the coordination between education, medical, and social supports for families. CS9b(1): The School Health Program will convene a cross-sector project team (or other means of continuous, collaborative communication) to promote the alignment and integration of approaches statewide to improving mental and behavioral well-being of students with and without special health care needs. CS9b(2): The School Health Program will develop, implement, and evaluate a project activities to promote trauma-informed schools and restorative discipline practices to disrupt racial and other disparities in school discipline practices.	CS9a: by 2025, the Medically Handicapped Children's Program (MHCP) will collaborate with stakeholders to implement a formalized, sustainable, statewide support structure to provide a continuum of supports to families with children and youth with special health care needs (CYSHCN). CS9b: The School Health Program will implement a collaborative, integrated project with schools and community partners to promote trauma-informed care and restorative discipline practices as approaches to address disparities in discipline and exclusion at school.	NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	ESM 11.1: The number of CYSCHN families who have contact with a Parent Resource Coordinator.	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 25: Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year
Cross-Cutting/Systems Building					
Improved Access to and Utilization of Mental Health	XC10a(1): The MCASH Program will continue consensus and inclusive Community Health Worker (CHW) Workforce Development by identifying strategies for statewide training and competencies for CHW in mental health first aid, motivational interviewing, suicide prevention, and trauma-	XC10a: By 2025, increase awareness and decrease stigma around mental and behavioral health issues by ensuring that	SPM 5: Percent of children, ages 0 through 17, who are continuously and adequately insured		

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Care Service	informed care. XC10a (2): The MCASH Program will provide a mechanism for continued consensus-building and policy development on financing and sustainability of the CHW workforce, by supporting a stakeholder group including CHW for the period of not more than two years. XC10a(3): The MCASH Program will train CHW to promote enrollment in Heritage Health Adult (Nebraska Medicaid Expansion) to improve access to care for diverse and disadvantaged parents and caregivers. XC10b(1): Title V will continue as lead agency in Nebraska Pediatric Mental Health Care Access Program, NEP-MAP. XC10c(1): The MCASH Program will undertake a collaboration with Medicaid to measure tele-behavioral health utilization trends in Nebraska	training, outreach, and provider tools reflect best practices in health literacy and are culturally- and linguistically- appropriate for underserved populations XC10b: By 2025, increase capacity of primary care providers to screen, refer, and treat mild-to-moderate mental and behavioral health issue in children, youth, and women of childbearing age. XC10c: By 2025, assess impact of tele-behavioral health on improving access and utilization of mental and behavioral health services by MCH populations in Medicaid.			