# District of Columbia 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 |
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| **Women/Maternal Health** | | | | | |
| Improving women's reproductive health and promoting equitable access to care | Increase the percentage of women who are patients at a Federally Qualified Health Center (FQHC) that had their annual preventative medical visit from 58% to 63% by 2026 | Refer and track referral completion of women to preventive care services.<br><br>Utilize community-based education groups to promote annual preventive visits.<br><br>Prioritize gathering additional data to better understand barriers for reproductive age women in accessing care, particularly among women not traditionally engaged in care.<br><br>Enhance prenatal care including psychosocial support, education and health promotion.<br><br>Explore partnerships with local organizations and government agencies that serve low-income women and families with children (0-17).<br><br>Implement patient reminders and create outreach initiatives for women in the District to increase knowledge, and awareness, and build self-efficacy to attend their well women visits<br><br>Assess the quality of care received by women who are Medicaid beneficiaries and identify and address barriers to increasing the use of preventative services among reproductive-aged women in the District<br><br>Dissemination of mass media communications campaign to increase the rate of reproductive-aged women who attend their preventative well-woman visits | ***Inactive -*** *ESM WWV.1 - Number of women who responded and participated in PRAMS*<br><br>***Inactive -*** *ESM WWV.2 - Number of women referred for an annual well women visit by a perinatal program.*<br><br>***Inactive -*** *ESM WWV.3 - Percent of women that participated in PRAMS and reported attending a preventative medical visit in the past year.*<br><br>***Inactive -*** *ESM WWV.4 - Reduce the percent of women that reported experiencing implicit bias or discrimination in PRAMS* | NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV | NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM<br><br>NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM<br><br>NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW<br><br>NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB<br><br>NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB<br><br>NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM<br><br>NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM |

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| | | | ESM WWV.5 - Increase the percent of reproductive aged women receiving care at FQHCs who received preventive medical visits | | NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal<br><br>NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal<br><br>NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related<br><br>NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP<br><br>NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS<br><br>NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB<br><br>NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression, |

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| | | | | | Formerly NOM 24) - PPD |
| Improving women's reproductive health and promoting equitable access to care | Increase the percentage of women receiving a well-woman's visit at an FQHC who was screened for SDOH from 55% to 70% by 2026. | Administer the Protocol for Responding to & Assessing Patients' Assets, Risks, and Experiences (PRAPARE) screening tool to low-income women and refer them to services including food assistance, transportation, and lactation support.<br><br>Maintain partnerships with state programs such as WIC and Link U to coordinate successful referrals to services. | | SPM 1: Increase the percentage of women who are Medicaid beneficiaries that received a primary care visit within the past year | |
| Improving women's reproductive health and promoting equitable access to care | Reduce the percent of women who reported implicit bias and discrimination while receiving healthcare services from 12.6% to 11% by 2026 | Assess the quality of care received by women who are Medicaid beneficiaries and identify and address barriers to increasing the use of preventative services among reproductive aged women in the District<br><br>Create opportunities for implicit bias and racial equity training for providers. The strategy to improve the perceived treatment of women in the District while receiving medical services is to train those providing services, to provide an environment where their patients feel heard, appreciated, and empowered | | SPM 8: Reduce the percent of women that reported experiencing implicit bias or discrimination in PRAMS | |
| Improving women's reproductive health and promoting equitable access to care | Increase the percent of women who had a postpartum checkup from 89.2% to 92% by 2026 | Guidance during pregnancy and development of a postpartum care plan<br><br>Provide families with continued education on the importance of postpartum care | 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** | | | | | |
| Decreasing perinatal and infant health disparities | Increase rates of breastfeeding initiation among African American women from 63% to 75% by 2026 | Educate pregnant women about the benefits and management of breastfeeding, with priority given to subpopulations with lower rates of breastfeeding initiation and duration.<br><br>Refer and track referral completion of women to breastfeeding services.<br><br>Exploration of LinkU/FindHelp to increase referrals and counseling for | ***Inactive -*** *ESM BF.1 - Number of women provided with in-person or telephonic breastfeeding consults/support services* | NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months | NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM<br><br>NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM- |

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| | | pregnant women, children and adolescents with and without special health care needs, and families | ***Inactive -*** *ESM BF.2 - Number of women referred for breastfeeding peer counseling support.*<br><br>***Inactive -*** *ESM BF.3 - Number of staff that completed breastfeeding education training.*<br><br>ESM BF.4 - Percent of women referred for breastfeeding peer counseling support<br><br>ESM BF.5 - Increase the percent of completed breastfeeding education training<br><br>ESM BF.6 - Percent of women provided with in-person or telephonic breastfeeding consults/support services | (Breastfeeding, Formerly NPM 4B) - BF | Postneonatal<br><br>NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID |
| Decreasing perinatal and infant health disparities | Reduce the infant mortality disparity ratio among non-Hispanic Black infants from 3.5 to 2.6 by 2026 | Support home visiting programs, pre-term birth reduction programs, and case management for high-risk women.<br><br>Preconception and prenatal nutrition education to help lower the risk of congenital malformations.<br><br>Increase infants enrolled in home visiting that are always placed to sleep on | | SPM 6: Risk appropriate perinatal care – Decrease the proportion of Medicaid beneficiaries who deliver a low birth weight infant | |

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| | | their backs, without bedsharing and without soft bedding<br><br>Increase the percentage of infants with newborn screening test results outside normal limits for a newborn screening disorder that receive prompt and appropriate follow-up testing.<br><br>Increase early initiation of perinatal care by pregnant mothers in the first trimester | | | |
| Decreasing perinatal and infant health disparities | Decrease the percentage of low-birthweight infants with Medicaid insurance from 60% to 40% by 2025 | Enhance the capacity to provide a space for women to engage in early and continuous prenatal care to prevent maternal complications.<br><br>Enhance health information technology systems.<br><br>Increase identification of women at risk for preterm delivery and offer access to effective treatment to prevent preterm birth and referral to Maternal Fetal Medicine specialists.<br><br>Increase the identification of effective approaches for improving birth outcomes, such as group prenatal care (e.g., Centering Pregnancy) that provides a space to engage the target population through health education sessions to increase knowledge to encourage positive pregnancy health outcomes.<br><br>Improve access to preconception care services, including screening, health promotion, and interventions that enable individuals to achieve high levels of wellness, minimize risks, and enter pregnancy in optimal health.<br><br>Increase prenatal care within the first trimester | | SPM 6: Risk appropriate perinatal care – Decrease the proportion of Medicaid beneficiaries who deliver a low birth weight infant | |
| Decreasing perinatal and infant health disparities | Increase percent of pregnant women who initiate prenatal care in the first trimester from 68% to 75% by 2026 | Enhance capacity to provide a space for women to engage in early and continuous prenatal care to prevent maternal complications.<br><br>Enhance health information technology systems.<br><br>Increase identification of women at risk for preterm delivery and offer access to effective treatment to prevent preterm birth and referral to Maternal Fetal Medicine specialists.<br><br>Increase the identification of effective approaches for improving birth | | SPM 6: Risk appropriate perinatal care – Decrease the proportion of Medicaid beneficiaries who deliver a low birth weight infant | |

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| | | outcomes such as group prenatal care (e.g., Centering Pregnancy) that provides a space to engage the target population through health education sessions to increase knowledge to encourage positive pregnancy health outcomes.<br><br>Improve access to preconception care services, including screening, health promotion, and interventions that enable individuals to achieve high levels of wellness, minimize risks, and enter pregnancy in optimal health. | | | |
| **Child Health** | | | | | |
| Improving coordination to early intervention services and supporting healthy child development | Increase the percent of children ages 9 through 35 months, who received developmental screening using parent-completed screening tool in the past year from 32.2% to 36.9% by 2026<br><br>Increase the percent of children with up-to-date vaccinations at 2 years of age from 71% to 80% by 2026. | Link ASQ Enterprise between OSSE and DC Health to determine the scope of screening duplication.<br><br>Expand and utilize the Online ASQ Enterprise System to document screenings for early childhood development centers, early learning improvement networks, childcare, and medical providers.<br><br>Provide leadership for the State Early Childhood Development and Coordinating Council, a multi-sector body with the mission of supporting and advocating for policies and practices to improve collaboration and coordination among agencies and community partners, to ensure a comprehensive early childhood education and development system.<br><br>Screen, coordinate and connect families to services that promote optimal early childhood development to increase a child's chances of successful transition to school.<br><br>Implement resources to support families whose children have a positive developmental screening.<br><br>Expand awareness, knowledge, and provide support to home-visiting programs.<br><br>Promote timely immunization of DC children by working with medical providers and other stakeholders to increase the accessibility of immunizations; educating residents about the value of immunization; and tracking and reporting on vaccine administration and immunization coverage | ***Inactive -*** *ESM DS.1 - Number of children who received a developmental screening*<br><br>***Inactive -*** *ESM DS.2 - Operationalize the use of a centralized registry (ASQ HUB) to track data on developmental screening.*<br><br>ESM DS.3 - Percent of children who received a developmental screening through MIECHV<br><br>ESM DS.4 - Percent of children aged 24 to 35 months who received vaccinations on time to support health development | 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<br><br>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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| Improving access to healthcare and healthful foods among children | Increase the percent of children ages 0-17 who have a medical home from 46.8% to 47.9% by 2026 | Introduce early connections to a medical home through care coordination and collaboration with non-clinical partners (e.g. home visiting, CBOs).<br><br>Provide practice-based navigation services to families of children in accessing and coordinating medical care and community resources.<br><br>Work with SBHCs to implement child-friendly approaches including confidential services; a safe, non-judgmental clinic environment; and the availability of services that address adolescents' most prevalent needs (reproductive and mental health services) in the school.<br><br>Link families (including partners) who have children 0-5 and have concerns about their child's developmental and or socio-emotional health to a medical home.<br><br>Increase awareness in schools about the importance of identifying a medical home provider.<br><br>Provision of referral assistance with students and families.<br><br>Support place-based initiatives to reach children and families where they live and play. | ***Inactive -*** *ESM MH.1 - Number of children and adolescents with and without special health care needs referred to a medical home*<br><br>***Inactive -*** *ESM MH.2 - Percent of children and adolescents with and without special health care needs referred to a medical home*<br><br>ESM MH.3 - Percent of adolescents who elected School-based Health Centers (SBHCs) as their medical home | 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<br><br>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<br><br>NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS<br><br>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 |
| Reducing grief and trauma-related symptoms among children and adolescents. | Increase the percent of children with mental health needs who received counseling from 59.1% to 65% by 2026 | Provide training and consultation/crisis support on trauma and bereavement to key partner staff (i.e. teachers, administrators, social workers).<br><br>Provide individual or group therapy to District residents, ages 6-21, who have been exposed to trauma and/or traumatic loss.<br><br>Engage in service coordination with the DC Department of Behavioral Health and other clinical service providers in partner schools and community organizations.<br><br>Refer participants to appropriate mental health and other community services as needed and follow-up with parents/legal guardians to verify completion. | | SPM 3: Mental Health-Increase the percent of children and adolescents, ages 3-17 with mental health needs who received counseling | |

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| | | Provide mental health screenings to children in the District.<br><br>Support Care Coordination efforts to increase access to community-based organizations in the District.<br><br>Improve maternal and child health, prevent child abuse and neglect, encourage positive parenting and promote child development and school readiness.<br><br>Exploration of LinkU/FindHelp to increase referrals and counseling for pregnant women, children and adolescents with and without special health care needs, and families | | | |
| Improving the oral health of Pregnant Women, children and adolescents. | Increase the percent of children aged 1-17 who are <200% FPL (Medicaid proxy) that had a dental visit from 75% to 80% by 2026 | Continue to administer the School-Based Oral Health Program (SBOHP) to increase access to preventive dental services for students ages 0 - 17 enrolled at the District's LCDCs, public schools, and public charter schools, who may not otherwise be using the dental care system.<br><br>Provide accessible dental homes and oral health education to the DC population<br><br>Provide annual preventive oral health services (i.e., education and treatment in every DC school)<br><br>Use public-and-private partnerships to ensure every DC resident has equitable access to oral health services<br><br>Recruit and retain dental workforce to practice in shortage areas through the State Loan Repayment Program<br><br>Research, compile and publish an oral health utilization brief in conjunction with the Primary Care Office (PCO)<br><br>Implement a grant program to address workforce challenges following the pandemic and share resources, evaluation findings, and lessons learned<br><br>Implement a grant program to redirect preventable oral health utilization in emergency departments and share resources, evaluation findings, and learnings | ***Inactive -*** *ESM PDV-Child.1 - Number of children and youth provided with preventive oral health services through a SBHC.*<br><br>***Inactive -*** *ESM PDV-Child.2 - Number of children ages 1-17 years receiving preventive dental care from a dentist.*<br><br>***Inactive -*** *ESM PDV-Child.3 - Percent of women enrolled in Medicaid that received oral health education services*<br><br>ESM PDV-Child.4 - Percent of Medicaid enrolled children ages 1-17 years | NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child | NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC<br><br>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<br><br>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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| | | | receiving preventive dental care through the School-based Oral Health Program | | |
| **Adolescent Health** | | | | | |
| Reducing grief and trauma-related symptoms among children and adolescents. | Increase the percent of adolescents ages 12 to 17 with mental health needs who received counseling from 59.1% to 65% by 2026 | Provide training and consultation/crisis support on trauma and bereavement to key partner staff (i.e. teachers, administrators, social workers).<br><br>Provide individual or group therapy to District residents, ages 6-21, who have been exposed to trauma and/or traumatic loss.<br><br>Engage in service coordination with the DC Department of Behavioral Health and other clinical service providers in partner schools and community organizations.<br><br>Refer participants to appropriate mental health and other community services as needed and follow-up with parents/legal guardians to verify completion.<br><br>Provide mental health screenings to adolescents in the District.<br><br>Provide accessible mental health programs in school-based health centers and community-based organizations.<br><br>Provide training for behavioral health professionals. | | SPM 3: Mental Health- Increase the percent of children and adolescents, ages 3-17 with mental health needs who received counseling | |
| Enhancing positive youth development for adolescents to decrease high-risk behaviors. | Reduce births to teens ages 15 to 19 from 15.6% to 10.4% by 2026 | Provide oversight for DC Health's Teen Pregnancy Prevention (TPP) Program to increase enhanced knowledge regarding access to and increasing the use of contraception methods including long-acting reversible contraceptives (LARCs) among adolescents.<br><br>Implement One Key Question (OKQ) and develop reproductive health plans for students who visit in SBHCs or participate in the TPP program.<br><br>Increase the availability of adolescent-friendly health services.<br><br>Create sustainable community-clinical linkages for adolescent health services. | | SPM 4: Teen Pregnancy Prevention- Decrease the percentage of live births to teenagers ages 15 to 19 | |

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| | | Provide accessible pregnancy prevention programs within schools. | | | |
| Improving access to healthcare among adolescents. | Increase the proportion of adolescents 0 to 17 who have a medical home from 46.8% to 47.9% by 2026 | Work with SBHCs to implement adolescent-friendly approaches including confidential services; a safe, non-judgmental clinic environment; and the availability of services that address adolescents' most prevalent needs (sexual and mental health services) in the school.<br><br>Encourage and empower students to utilize school-based health centers as their medical home. | ***Inactive -*** *ESM MH.1 - Number of children and adolescents with and without special health care needs referred to a medical home*<br><br>***Inactive -*** *ESM MH.2 - Percent of children and adolescents with and without special health care needs referred to a medical home*<br><br>ESM MH.3 - Percent of adolescents who elected School-based Health Centers (SBHCs) as their medical home | 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<br><br>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<br><br>NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS<br><br>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 |
| Improving access to healthcare among adolescents. | Increase the percentage of adolescents ages 12 to 17 who use transition planning services from 19.4% to 25% by 2026 | Assist students with finding an adult therapist and checking eligibility to enroll in Medicaid (transition).<br><br>Train pediatric/adult providers around transition.<br><br>Work with school health services (school nurses and SBHCs) to provide transition planning to seniors.<br><br>Build communications/media to promote transition.<br><br>Exploration of LinkU/FindHelp to increase referrals and counseling for pregnant women, children and adolescents with and without special health | ***Inactive -*** *ESM TR.1 - Number of CSHCN provided with transition services*<br><br>ESM TR.2 - Percent of CSHCN provided with transition services | NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR | 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 |

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| | | care needs, and families | | | |
| Improving the oral health of Pregnant Women, children and adolescents. | Increase the percent of children aged 1-17 who are <200% FPL (Medicaid proxy) that had a dental visit from 75% to 80% by 2026 | Continue to administer the School-Based Oral Health Program (SBOHP) to increase access to preventive dental services for students ages 0 - 17 enrolled at the District's LCDCs, public schools, and public charter schools, who may not otherwise be using the dental care system.<br><br>Provide accessible dental homes and oral health education to the DC population<br><br>Provide annual preventive oral health services (i.e., education and treatment in every DC school)<br><br>Use public-and-private partnerships to ensure every DC resident has equitable access to oral health services<br><br>Recruit and retain dental workforce to practice in shortage areas through the State Loan Repayment Program<br><br>Research, compile and publish an oral health utilization brief in conjunction with the Primary Care Office (PCO)<br><br>Implement a grant program to address workforce challenges following the pandemic and share resources, evaluation findings, and lessons learned<br><br>Implement a grant program to redirect preventable oral health utilization in emergency departments and share resources, evaluation findings, and learnings | ***Inactive -*** *ESM PDV-Child.1 - Number of children and youth provided with preventive oral health services through a SBHC.*<br><br>***Inactive -*** *ESM PDV-Child.2 - Number of children ages 1-17 years receiving preventive dental care from a dentist.*<br><br>***Inactive -*** *ESM PDV-Child.3 - Percent of women enrolled in Medicaid that received oral health education services*<br><br>ESM PDV-Child.4 - Percent of Medicaid enrolled children ages 1-17 years receiving preventive dental care through the School-based Oral Health Program | NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child | NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC<br><br>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<br><br>NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS |
| Enhancing positive youth development for adolescents to decrease high-risk | Retain at least 85% of youths (aged 14-21) engaged in tailored adolescent health programming, including the Youth Advisory Council and PYD curriculum. | Increase participation in YAC across all DC public, private, and charter schools.<br><br>Promote peer health education and survey implementation within youth-focused curriculum.<br><br>Facilitate in-person engagement within the partner schools to promote | | SPM 7: Promote the retention of youth participating in tailored adolescent health programming, including the Youth Advisory Council and positive youth | |

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| behaviors. | | youth-serving programs, increase participation, and maintain retention.<br><br>Increase the availability of adolescent-friendly health services.<br><br>Create sustainable community-clinical linkages for adolescent health services.<br><br>Provide the youth with opportunities to become leaders and advocates within their community. | | development (PYD) curriculum | |
| **Children with Special Health Care Needs** | | | | | |
| Improving access to healthcare among children with special health care needs | Increase the percentage of CSHCN 0 to 17 who have a medical home from 36.2% to 42.2% by 2026 | Introduce early connections to a medical home through care coordination and collaboration (e.g. home visiting, CBOs).<br><br>Provide practice-based navigation services to families of CSHCN in accessing and coordinating medical care and community resources.<br><br>Employ and empower Parent Navigators to provide guidance and support to families about how to access services, work with providers, and other aspects of care coordination for CSHCN | ***Inactive -*** *ESM MH.1 - Number of children and adolescents with and without special health care needs referred to a medical home*<br><br>***Inactive -*** *ESM MH.2 - Percent of children and adolescents with and without special health care needs referred to a medical home*<br><br>ESM MH.3 - Percent of adolescents who elected School-based Health Centers (SBHCs) as their medical home | 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<br><br>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<br><br>NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS<br><br>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 |
| Improving access to healthcare | Increase the percentage of CSHCN ages 12 to 17 who use transition planning services from | Work with School health services (school nurses and school based health centers (SBHCs)) to provide transition planning to seniors. | ***Inactive -*** *ESM TR.1 - Number of CSHCN provided with* | NPM - Percent of adolescents with and without special health care | NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who |

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| among children with special health care needs | 12.2% to 22.5% by 2026 | Build communications/media to promote transition.<br><br>Employ and empower Parent Navigators to provide guidance and support to families to encourage adolescents with SHCN to transition into adult care<br><br>Assist students with finding an adult therapist and checking eligibility to enroll in Medicaid (transition).<br><br>Train pediatric/adult providers around transition | *transition services*<br><br>ESM TR.2 - Percent of CSHCN provided with transition services | needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR | receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC |
| **Cross-Cutting/Systems Building** | | | | | |
| Improving the oral health of Pregnant Women, children and adolescents. | Increase the percent of children aged 1-17 who are <200% FPL (Medicaid proxy) that had a dental visit from 75% to 80% by 2026 | Continue to administer the School-Based Oral Health Program (SBOHP) to increase access to preventive dental services for students ages 0 - 17 enrolled at the District's LCDCs, public schools, and public charter schools, who may not otherwise be using the dental care system.<br><br>Provide accessible dental homes and oral health education to the DC population<br><br>Provide annual preventive oral health services (I.e., education and treatment in every DC school)<br><br>Use public-and-private partnerships to ensure every DC resident has equitable access to oral health services<br><br>Recruit and retain dental workforce to practice in shortage areas through the State Loan Repayment Program<br><br>Research, compile and publish an oral health utilization brief in conjunction with the Primary Care Office (PCO)<br><br>Implement a grant program to address workforce challenges following the pandemic and share resources, evaluation findings, and lessons learned<br><br>Implement a grant program to redirect preventable oral health utilization in emergency departments and share resources, evaluation findings, and learnings | | | |
| Improving | Reducing the percent of children | Provide free healthy foods to children and their families through pop up | | SPM 2: Healthy Food | |

| Priority Needs | Five-Year Objectives | Strategies | Evidence-Based or –Informed Strategy Measures | National and State Performance Measures | National and State Outcome Measures |
|---|---|---|---|---|---|
| access to healthcare and healthful foods among children | living in households that were food insecure at some point during the year from 7.5% to 4.2% by 2026 | markets located in food insecure areas of the District.<br><br>Build capacity among corner store managers to increase inclusion of healthy foods in their stores.<br><br>Collaborate with the DC Department of Small and Local Business Development to explore sustainability strategies, such as cooperative produce purchases among Healthy Corners vendors.<br><br>Increase access to fruits and vegetables for low-income DC residents, improve the viability of farmers' markets operating in communities with high poverty rates, and improve attitudes and understanding of healthy eating through education.<br><br>Set up mobile farmers' markets in low-income neighborhoods.<br><br>Provide nutrition education and healthy food demonstrations.<br><br>Build public-and-private partnerships with the DC Community to provide affordable and healthy food<br><br>Enhance data sharing agreements and capacity among DC Health and partners to increase enrollment and participation in food access programs<br><br>Increase access to healthy food at DCPS schools | | Access- Percent of children living in households that were food insecure at some point during the year | |