# District of Columbia State Action Plan Table 2026 Application/2024 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** | | | | | |
| Decrease maternal morbidity and mortality for postpartum women | Increase the percentage of pregnant women who reported attending a postpartum checkup and received recommended care components from 73% to 90% by 2030. | Increase access and promote utilization of home visiting services through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program Pilot use of DC Health care coordinator to support Postpartum women Increase utilization of 1-800-MOM-BABY Promote the Babies bill amendment and provide technical assistance to ensure that mothers have a Postpartum follow-up appointment before discharge Collaborate with the Maternal Health Taskforce and Maternal and Child Health Advisory Council to review and share data reports of Postpartum visits to identify trends and areas of opportunity | ESM PPV.1 - Percentage of mothers enrolled in home visiting programs who received a postpartum visit with a healthcare provider within 60 days of delivery and received recommended care components. | NPM - Postpartum Visit | **Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety |
| **Perinatal/Infant Health** | | | | | |
| Reduce adverse perinatal outcomes for infants in their first year of life. | By 2030, decrease the infant mortality rate for live births financed by Medicaid from 7.7 to 7.0 per 1,000 live births by increasing access to perinatal health care services. | Increase the number of infants enrolled in home visiting programs who are placed to sleep on their backs without bedsharing and soft bedding Increase the percentage of infants with abnormal newborn screening test result that receive appropriate follow-up testing Support early prenatal risk assessments to identify patients at high risk of delivering a very low birth weight infant | ESM RAC.1 - Number of pregnant women engaged through the implementation of early prenatal care with the Preterm Birth Reduction Initiative and assessed for high risk of preterm birth or having a very low birth weight (VLBW) infant. | NPM - Risk-Appropriate Perinatal Care | **Linked NOMs:** Stillbirth Perinatal Mortality Infant Mortality Neonatal Mortality Postneonatal Mortality Preterm-Related Mortality |
| Increase lactation support and education | Increase the percentage of infants ever breastfed from 82% to 85% by 2030 | Educate pregnant women about the benefits and management of breastfeeding Support mothers to initiate and sustain breastfeeding, particularly by integrating with prenatal counseling and early postpartum lactation support | ESM BF.1 - Increase the percentage of WIC infants who received breast milk | NPM - Breastfeeding | **Linked NOMs:** Infant Mortality Postneonatal Mortality SUID Mortality |

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| before, during, and after pregnancy | | | exclusively until at least 6 months of age ESM BF.2 - Increase the percentage of infants who received lactation support and ever breastfed until at least 6 months of age ***Inactive -*** *ESM BF.3 - Increase the percent of completed breastfeeding education training* ***Inactive -*** *ESM BF.4 - Percent of pregnant and postpartum WIC clients served by breastfeeding peer counselors (WIC)* ***Inactive -*** *ESM BF.5 - Percent of women provided with in-person or telephonic breastfeeding consults/support services* | | |
| Reduce adverse perinatal outcomes for infants in their first year of life. | Reduce the proportion of Medicaid beneficiaries in DC who deliver a low birth weight infant from 14% to 10% by 2030 through targeted interventions that improve access to high-quality, risk-appropriate prenatal and perinatal care | Support DC-PQCs initiatives for Respectful Care training for providers Improve access to comprehensive prenatal care Support investments in nutrition and food security | No ESMs were created by the State. ESMs are optional for this measure. | SPM 1: Risk appropriate perinatal care – Decrease the proportion of Medicaid beneficiaries who deliver a low-birth-weight infant | |
| **Child Health** | | | | | |
| Improving access to healthcare | Increase the percentage of children ages 0-17 who are connected to an identified medical | Introduce early connections to a medical home through care coordination and collaboration with non-clinical partners Link families that have children 0-5 and have concerns about their child's developmental and socio- | ESM MH.1 - Percent of adolescents without a medical home and | NPM - Medical Home | **Linked NOMs:** Children's Health Status CSHCN Systems of Care |

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| among children | home from 44% to 48% by 2030. | emotional health to a medical home Increase awareness in schools about the importance of identifying a medical home provider | elected School-based Health Centers (SBHCs) as their medical home<br>ESM MH.2 - Percent of District Medicaid-enrolled Children ages 10-17 who have had a well-child visit within the last year | | Flourishing - Young Child<br>Flourishing - Child Adolescent - CSHCN<br>Flourishing - Child Adolescent - All |
| Promote access to resources and services that allow all children to develop and reach their full potential | Increase the percentage of children ages 9 through 35 months who received developmental screening using a parent-completed screening tool and are flourishing in the past year from 41% to 45% by 2030. | Utilize early childhood development programs to provide the appropriate developmental screening tool to clients Provide resources to support families whose children have positive developmental screening Expand and utilize identified online systems to document screenings for early childhood development centers, early learning improvement networks, childcare, and medical providers Collaborate with Healthcare provider networks to assess current use of a validated screening tool and bring awareness to standardized screening | ESM DS.1 - Percent of children who received a developmental screening through home visiting programs<br>ESM DS.2 - Percent of children who receive early intervention for developmental support services after being screened with the Ages and Stages tool<br>***Inactive -*** *ESM DS.3 - Percent of children aged 24 to 35 months who received vaccinations on time to support health development* | NPM - Developmental Screening | **Linked NOMs:**<br>School Readiness<br>Children's Health Status |
| **Adolescent Health** | | | | | |
| Improve access to mental healthcare | Increase the percentage of adolescents ages 12-17 with mental health needs who received counseling or treatment from 71% | Engage adolescents through the Youth Advisory Council mental health initiatives and build on peer support programs for adolescents facing mental health challenges Provide training and crisis support on trauma and bereavement to the DC School Health Services program staff | ESM MHT.1 - Reduce the percentage of high school students who | NPM - Mental Health Treatment | **Linked NOMs:**<br>Adolescent Mortality<br>Adolescent Suicide<br>Adolescent Firearm Death |

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| services among adolescents | to 76% by 2030. | | reported that their mental health was most of the time or always not good, by implementing mental health promotion initiatives embedded within adolescents communities<br>ESM MHT.2 - Percent of youth engaged in mental health initiatives and peer support programs that report a high level of engagement, defined by consistent participation, sense of belonging, and program satisfaction. | | Adolescent Injury Hospitalization<br>Children's Health Status<br>Adolescent Depression/Anxiety<br>CSHCN Systems of Care<br>Flourishing - Child Adolescent - CSHCN<br>Flourishing - Child Adolescent - All |
| **Children with Special Health Care Needs** | | | | | |
| Improve access to a family-centered, community-based, coordinated system of healthcare for Children with Special Health Care Needs (CSCHN) | By 2030, increase the percentage of children and youth with special health care needs who have a medical home from 35.4% to 39.5% through enhanced care coordination, referral, and family-centered care | Increase the network of available Parent Navigators that are able to provide guidance and support to families about accessing services and provide comprehensive care coordination. Increase the capacity for Help Me Grow care coordinators and home visiting staff to provide developmental screenings and refer families of CYSHCN to early intervention services and medical home Build capacity for newborn screening referrals and specialty care follow-up. Increase engagement of families in the healthcare systems and ensure parents are at the table for decision-making Increase access to mental health and behavioral health interventions to address barriers faced by the CYSHCN population | ESM MH.1 - Percent of adolescents without a medical home and elected School-based Health Centers (SBHCs) as their medical home<br>ESM MH.2 - Percent of District Medicaid-enrolled Children ages 10-17 who have had a well-child visit within the last year | NPM - Medical Home | **Linked NOMs:**<br>Children's Health Status<br>CSHCN Systems of Care<br>Flourishing - Young Child<br>Flourishing - Child Adolescent - CSHCN<br>Flourishing - Child Adolescent - All |