Florida 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 access to health care for women, specifically women who face significant barriers to better health, to improve preconception health.	1. By 2026, decrease the number of syphilis cases among women ages 15-44 years from 1,792 (2019: FLCHARTS) to 1,493. 2. By 2026, increase the percentage of interconception (Show Your Love) services provided to Healthy Start Clients from 72.4% (2021: Well Family System) to 80.0%. 3. By 2026, increase the percentage of pregnant women who had a prenatal screen from 65.6 percent (2020: Health Management System) to 70.3%. 4. By 2026, increase the number of women who received an interconceptional care service by 10% from 637 (2018-2019): Well Family System) to 701. 5. By 2026, increase percent of new mothers in Florida who received information about how to prepare for a healthy pregnancy and baby prior to pregnancy from 22.8%(FL-PRAMS: 2014) to 30.0% .	1. Coordinate with the Division of Disease Control and Health Protection/Bureau of Communicable Diseases to implement strategies to reduce the number of congenital syphilis cases. 2. Provide interconception services to Healthy Start clients on Medicaid from 60 days to 12 months as a result of Florida's extension of Medicaid postpartum coverage. 3. Develop and implement an electronic prenatal risk screening system to reduce barriers to the existing process and decrease the number of days from identification of risk to assessment. 3a. Educate stakeholders (e.g., providers, Healthy Start Coalitions, partnering agencies, pregnant woman) on the purpose and process for the electronic prenatal screening system. 4. Increase the number of referrals to the Coordinated Intake and Referral system that connects pregnant women, interconception women, and families of children under the age of three to services. 5. Contract with Healthy Start Coalitions to conduct perinatal screening to prenatal participants, interconception women, and mothers of infants and toddlers referred to Healthy Start.	***Inactive -*** *ESM WWV.1 - The number of interconception services provided to Healthy Start clients.* ESM WWV.2 - The percentage of interconception (Show Your Love) services provided to Healthy Start clients.	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 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

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					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 - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression,

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					Formerly NOM 24) - PPD
Promote tobacco cessation to reduce adverse birth outcomes and secondhand smoke exposure to children.	1. By 2026, increase the number of referrals to Tobacco Free Florida Quit Services from 20,533 (DOH-Tobacco-Free Florida Quit Line Providers: 2016) to 25,500. 2. By 2026, decrease the percentage of women who smoked cigarettes in the three months prior to becoming pregnant from 9.1 percent (2019: FL-PRAMS) to 7.1 percent. 3. By 2026, decrease the percentage of women who smoked during pregnancy from 4.1 percent (2020: FLCHARTS) to 2.7 percent.	1. Refer clients and their families in the Healthy Start program to free and proven effective services to help them quit using all tobacco products, including e-cigarettes in collaboration with the Bureau of Tobacco Free Florida. This includes the suite of Quit Your Way services that include phone quit, web coach, text and email quit support. 2. Provide free resources to educate families and teenagers about the health hazards of vaping by visiting EndTeenVapingFL.gov. 3. Train Healthy Start Coalitions skills that include motivational interviewing that can increase client utilization of cessation through partnership with the Bureau of Tobacco Free Florida and Area Health Education Centers (AHEC). 3a. Partner with Tobacco Free Florida community intervention providers in each county to educate Healthy Start clients on the dangers of secondhand smoke and assist in implementation of policies that protect all people, especially children, from exposure.	***Inactive -*** *ESM SMK-Pregnancy.1 - The number of Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) services provided to Healthy Start clients* ESM SMK-Pregnancy.2 - Percentage of Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) services provided to current tobacco users.	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 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal

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					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
Reduce maternal mortality and morbidity	1. By 2026, 50% of Florida's birthing hospitals will self-designate as a verified maternal level of care hospital. 2. By 2026, reduce the pregnancy-related mortality rate by 10% from 20.9 per 100,000 live births in 2020 to 18.8. 3. By 2026, decrease the pregnancy-related mortality ratio from 19.8 per 100,000 live births (2019: FL MMRC) to 15.0 per 100,000 live births. 4. By 2026, decrease the number of women who experience postpartum	1. Contract with the Florida Perinatal Quality Collaborative (FPQC) to implement the self-designated as a verified maternal level of care based on national standards. 2. Contract with the FPQC for a postpartum discharge planning initiative. 3. Continue quarterly pregnancy associated mortality review committee meetings to review maternal mortality and morbidity and make recommendations for system change. 3a. Conduct maternal mortality campaign for awareness and reduction. 3b. Provide fiscal support and technical assistance to the Florida Healthy Babies program to identify, evaluate, prioritize, and address health disparities through the provision of evidence-based interventions. 4. Contract for services for the Perinatal Mental Health Program, BH IMPACT, to improve the identification and treatment of pregnant and	***Inactive -*** *ESM SMK-Pregnancy.1 - The number of Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) services provided to Healthy Start clients* ESM SMK-Pregnancy.2 - Percentage of Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) services provided to current tobacco users.	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

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	depressive symptoms following a live birth from 13.0 percent (2019: FL-PRAMS) to 10.2 percent. 5. By 2026, telehealth minority maternity care programs will be available in all 67 counties in Florida. 6.. By 2026, decrease the number of infants diagnosed with neonatal abstinence syndrome from 1,375 (2018:FLCHARTS) to 1,181.	postpartum women who experience mental health and substance use disorders. 5. Establish telehealth minority maternity care programs to expand the capacity for positive maternal health outcomes in racial and ethnic minority populations in coordination with the Office of Minority Health and Health Equity. 6. Contract with the FPQC to work with providers, hospitals, and other stakeholders to improve identification, clinical care, and coordinated treatment/support for pregnant women with opioid use disorder and their infants.			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 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

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					Status, Formerly NOM 19) - CHS
Reduce maternal mortality and morbidity	1. By 2026, increase the percent of women who attended a postpartum checkup within 12 weeks after giving birth from 89.0% (PRAMS, 2021) to 93.0%. 2. By 2026, increase the percent of counties with a telehealth minority maternity care program from 25.4 to 100%. 3. By 2025, increase the percent of women who attended a postpartum checkup and received recommended care components from 77.1% (PRAMS, 2021) to 80.7%.	1. Establish telehealth minority maternity care programs to expand the capacity for positive maternal health outcomes in racial and ethnic minority populations in coordination with the Office of Minority Health and Health Equity. 2. Contract with FPQC to work with providers, hospitals, and other stakeholders through the Postpartum Access and Continuity of Care (PACC) Initiative to improve identification, clinical care and coordinated treatment/support for pregnant women by arranging timely and risk 3. Work with Florida Office of Communications to ensure a new pregnancy related website includes information on post-partum 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					
Promote breastfeeding to ensure better health for infants and children and reduce low food security.	1. By 2026, increase the number of Baby-Friendly Hospitals from 20 (2020) to 30. 2. By 2026, increase the percentage of women who initiate breastfeeding from 86.0 percent (2019: FL CHARTS) to 90.4 percent. 3. By 2026, increase the number of breastfeeding services to Healthy Start clients by 22% from 17,233 (2021:Well Family System) to 21,000. 4. By 2026, increase the percentage of women who	1. Continue to encourage hospitals to establish policies and protocols in support of breastfeeding and becoming a Baby Steps to Baby Friendly hospital or a Florida Breastfeeding Coalition's Quest for Quality Maternity Care Award recipient though the Florida Healthy Babies Initiative. 2. Support the Bureau of Chronic Disease in their efforts to provide technical assistance to hospitals, work places, and early care and education program to implement breastfeeding policies and programs by partnering with the Florida Breastfeeding Coalition and the Florida Child Care Food Program. 3. Contract with Healthy Start Coalitions to provide breastfeeding support and education to Healthy Start clients. 4. Partner with the Pacify program to increase access to professional lactation support through telelactation services.	***Inactive -*** *ESM BF.1 - The number of Florida hospitals achieving the Baby Steps to Baby Friendly hospital designation.* ESM BF.2 - Percentage of birthing hospitals that teach breastfeeding mothers how to recognize feeding cues, to breastfeed on-demand, and to understand the risks of artificial nipples/pacifiers.	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 NOM 9.5) - IM-SUID

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	breastfed exclusively through 6 months from 29.4 percent (2017:NIS) to 33.4 percent.				
Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of-school activities in a safe and healthy environment.	By 2026, increase the number of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU) from 78.9 percent (2017: FLCHARTS) to 82.1 percent.	1. Contract with the Florida Perinatal Quality Collaborative (FPQC) to implement the self-designated and verified maternal and newborn hospital level of care project. 1a. Contract with the FPQC for the monitoring maternal health care quality project. 1b. Promote the current regional perinatal intensive care centers program. 1c. Conduct maternal mortality campaign for awareness and reduction. 1d. Participate in the Agency for Healthcare Administration's Birth outcomes workgroup. 1e. Continue quarterly pregnancy associated mortality review committee meetings to review maternal mortality and morbidity and make recommendations for system change.	ESM RAC.1 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU). ESM RAC.2 - Percentage of birthing hospitals participating in perinatal quality collaborative projects.	NPM - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) (Risk-Appropriate Perinatal Care, Formerly NPM 3) - RAC	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 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related
Reduce infant mortality and morbidity.	1. By 2026, reduce percent of black mothers in Florida whose infant sleeps in bed with a parent or anyone else from 38.6 percent (2019: FL-PRAMS) to 35.3 percent. 2. By 2026, increase percent of black mothers in Florida who placed their infant on their back to sleep from 60.3 percent (2019) to 66.4 percent.	1. Promote safe sleep behaviors among families and infant caregivers with an emphasis on disparate populations through the Healthy Start program. 1a. Using the Florida Healthy Babies Initiative, inventory and evaluate safe sleep activities currently implemented statewide. 2. Partner with national organizations, such as the National Institute of Child Health Quality, to promote safe sleep initiatives and support local service providers (e.g. hospitals and social services) that interact with high risk populations. 2a. Provide infant safe sleep education through partnership with the Cribs for Kids organization. 2b. Implement Fetal and Infant Mortality Review Committees in all geographic areas of the state.	***Inactive -*** *ESM SS.1 - The number of birthing hospitals that are Safe Sleep Certified.* ESM SS.2 - The percentage of birthing hospitals that are Safe Sleep Certified.	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-sharing with an adult during sleep (Safe Sleep)	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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		2c. Partner with Count the Kicks for a statewide stillbirth prevention and awareness program that teaches expectant parents the method for, and importance of, tracking fetal movement daily during the third trimester of pregnancy.		- SS	
Child Health					
Improve dental care access for children and pregnant women	1. By June 30, 2024, increase the number of low-income children under age 21 receiving a preventive dental service from a school-based sealant program from 102,381 children (SFY 2022-2023) to 122,857 children, a percent increase of 20 percent. 2. By July 15, 2024, increase the number of school- based sealant programs (internal or external) completing annual reports in FLOSS from 48 programs to 52 programs, a percent increase of 8 percent. 3. By June 30, 2024, provide at least five trainings for dental and school personnel on implementing proven strategies to increase consent rate. 4. By June 30, 2024, provide technical assistance and site visits to at least five dental or school requestors.	1. Partner with community agencies and organizations to improve data completeness related to statewide school-based sealant program efforts. Encourage participation in the FLOSS database and offer technical assistance as needed. 2. Increase the number of children participating in existing school-based sealant programs by implementing proven strategies to increase consent rate, such as educating parents, attending community events, and routine distribution of forms. 3. Improve the quality and sustainability of existing CHD school-based sealant programs by providing continued technical assistance and training and in-person site visits and program evaluations related to financial sustainability as requested.		SPM 2: The percentage of low-income children under age 21 who access dental care.	
Address the social determinants of health that	1. By 2026, increase the number of partners and local county health departments participating in the Reach Out and Read program	1. Partner with local health departments in their childhood immunization, dental clinics, and well-child visits to encourage reading using the Reach Out and Read model, where a health professional distributes books to children at a well-child visit and emphasizes key reading strategies to		SPM 3: The percentage of parents who read to their young child age 0-5 years	

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influence the relationship between health status and biology, individual behavior, health services, social factors, and policies.	from 100 in 2017 to 130 total sites. 2. By 2026, increase the percentage of parents who read to their your child age 0-5 years from 27.4% (2020: NSCH) to 42.0%.	parents (example: the importance of reading aloud to a child daily).			
Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of-school activities in a safe and healthy environment.	By June 30, 2025, increase the number of Florida counties where registered school nurses are implementing Healthy Lifestyle Interventions based on the 5210 programs from eight counties to four. The 5210 program is based on five servings of fruits and vegetables, less than two hours of recreational screen time, one hour or more of physical activity and zero sweetened drinks per day. By June 30, 2025, increase the percentage of body mass index (BMI) intervention screening referrals for students at or above the 95th percentile that results in students receiving services from a healthcare provider from 31.6 percent (2016-17 baseline) to 36.6 percent. (This measure is the sum of completed referrals to healthcare providers and completed Healthy Lifestyle interventions by registered school nurses.)	Continue School Health Services Program involvement in the Florida Partnership for Healthy Schools (formerly the Florida Coordinated School Health Partnership), the Healthy District Collaborative, and the Interagency Collaborative by participating in meetings, conferences, and strategic planning. Promote the Center for Disease Control and Prevention's Whole School, Whole Community, Whole Child approach by educating county school health programs on strategies to expand school health advisory committee representation, including student/parent involvement, on at least one School Health Services Program statewide conference call and during county school health program on-site monitoring meetings conducted by school health liaisons during the 2022–23 school year.	ESM PA-Child.1 - The cumulative total of Florida school districts that have ever been awarded the evidence-based Florida Healthy School District recognition.	NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day (Physical Activity, Formerly NPM 8.1) - PA-Child	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 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS

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Increase access to medical homes and primary care for children with special health care needs.	Increase the percent of children age 0-17 years without special health care needs who have a medical home from 39.3% (2021-2022, NSCH) to 44.7% by December 31, 2025.	Promote services provided at county health departments. Home visiting programs will provide education to parents on what a medical home is and it's importance. Engage other state agencies (i.e., the Department of Children and Families child welfare, Department of Education) to promote the importance of a medical home for children. Partner with the Agency for Health Care Administration to share information about medical homes with their enrollees.	***Inactive -*** *ESM MH.1 - Number of partners serving CYSHCN in Florida receiving education or technical assistance about the patient-centered medical home model and related topics that impact CYSHCN .* ESM MH.2 - Percentage of caregivers of CYSHCN in Florida who always perceive themselves as a partner in their child's care. ***Inactive -*** *ESM MH.3 - Number of Adult Care Providers/Practices that report accepting CYSHCN transitioning to adult care.* ESM MH.4 - Percent of youth with special health care needs who report having successfully transitioned from pediatric to adult health care providers/practices.	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

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			Inactive - *ESM MH.5 - Percentage of providers in underserved geographic areas that received formal technical assistance through the UCF HealthARCH program that became designated patient-centered medical homes.* ESM MH.6 - Percent of PCMH pediatric providers located within the identified tracts of highest need, per the CMS Child Needs Index.		
Adolescent Health					
Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of-school activities in a safe and healthy	1. By 2026, decrease the number of Florida high school students who experienced bullying on school property from 14.3% (2017: BRFSS) to 13.3%. 2. By 2026, decrease the number of Florida high school students who experienced electronic bullying in the past 12 months from 11.5% (2017: BRFSS) to 10%. 3. By 2026, increase the percentage of adolescents and	1a. Partner with community agencies and organizations to promote bullying prevention initiatives. 1b. Coordinate with the Department of Education's Safe Schools Program to integrate additional anti-bullying and violence prevention messages. 2. Increase the number of youth with access to resources and hotlines related to violence and bullying prevention. 3a. Ensure that youth are receiving STD/HIV information and sexual risk avoidance strategies. 3b. Provide positive youth development education to encourage healthy behaviors and the reduction of risky behaviors.	***Inactive -*** *ESM BLY.1 - The number of students who participate in an evidence-based program that promotes positive youth development and non-violence intervention skills.* ESM BLY.2 - The percentage of adolescents and	NPM - Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others (Bullying, Formerly NPM 9) - BLY	NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide

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environment.	teens, ages 11 through 19, who reported satisfaction on the positive youth development and non-violence survey from 80% (2022) to 84%.		teens, ages 11 through 19, who reported satisfaction on the positive youth development and non-violence survey.		
Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of-school activities in a safe and healthy environment.	1. By 2026, increase the percent of adolescents (ages 12-17) who are physically active at least 60 minutes per day from 19.5 (2020: NSCH) to 26.9. 2. By June 30, 2024, increase the percentage of successful referrals for growth and development screening with body mass index (BMI) results at or above the 95th percentile resulting in students receiving services from a health care provider from 32.25 percent (2017-18 baseline) to 37.50 percent. This measure is the sum of completed referrals to healthcare providers and completed Healthy Lifestyle interventions by registered school nurses.	1. Educate county school health programs about the use of the Healthy Lifestyle Intervention Individualized Healthcare Plan and coding this service data in the Department's Health Management System. 2. Educate county school health programs on the requirements, application process, and benefits of becoming a Florida Healthy District.	ESM PA-Adolescent.1 - The cumulative total of Florida school districts that have ever been awarded the evidence-based Florida Healthy School District recognition.	NPM - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day (Physical Activity - Adolescent, Formerly NPM 8.2) - PA-Adolescent	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 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS
Children with Special Health Care Needs					
Increase access to medical homes and primary care for children with special health care needs.	11.1: By June 30, 2026, increase the number of DOH team members, providers (pediatric, family practice, and adult), families, family partners, and other partners serving CYSHCN in Florida who received education or technical assistance about the patient-centered medical home	11.1: Identify, evaluate, and enhance education and technical assistance provided to DOH team members, providers (pediatric, family medicine, and adult), families, family partners, and other partners serving children and youth with special health care needs (CYSHCN) regarding the patient-centered medical home model and related topics that impact the health and wellness of CYSHCN. 11.2.1: Create a cohort of caregivers of CYSHCN that are educated and equipped to be a partner in their child's care.	***Inactive -*** *ESM MH.1 - Number of partners serving CYSHCN in Florida receiving education or technical assistance about the patient-centered medical home model and related topics that*	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

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	model and related topics that impact the health and wellness of CYSHCN from 850 annually to 1050 annually. Data source: DAL: Reported Quarterly to MCH Block Grant. Baseline: 850 (7/1/21-6/30/22 target: (850) (7/1/22-6/30/23 target: (900) (7/1/23-6/30/24 target: (950) (7/1/24-6/30/25 target: (1000) (7/1/25-6/30/26 target (1050) 11.2: By June 30, 2025 increase the number caregivers of CYSHCN in Florida who perceive themselves as a partner in their child's care by 1% annually from identified baseline. (7/1/20-6/30/21 target: 67.8%) (7/1/21-6/30/22 target: 71%) (7/1/22-6/30/23 target: 72%) (7/1/23-6/30/24 target: 73%) (7/1/24-6/30/25 target: 74%) (7/1/25-6/30/26 target: 75%) 11.3: By June 30, 2025, increase the percentage of underserved geographic areas that have at least one pediatric practice that is designated as a PCMH by 20% (7/1/20-6/30/21 target: Xx1.03) (7/1/21-6/30/22 target: Xx1.05) (7/1/22-6/30/23 target: Xx1.1) (7/1/23-6/30/24 target: Xx1.15) (7/1/24-6/30/25 target: Xx1.2) 11.4: By June 30, 2026 Increase the percentage of youth with special health care needs that report	11.2.2: Leverage work with existing and potential partners to increase opportunities for families of CYSHCN to become family partners at the individual, community, and systems level. 11.3.1: Create a pipeline of providers that are engaged in enhancing their practice sites based on the foundational principles of patient-centered medical homes. 11.3.2: Leverage work with existing and potential partners to increase the spread of patient-centered medical homes. 11.4: Work with other Title V CYSHCN Programs and internal Department of Health colleagues to identify and implement activities that will increase the numbers of family practice and adult providers that serve young adults with special health care needs.	*impact CYSHCN .* ESM MH.2 - Percentage of caregivers of CYSHCN in Florida who always perceive themselves as a partner in their child's care. ***Inactive -*** *ESM MH.3 - Number of Adult Care Providers/Practices that report accepting CYSHCN transitioning to adult care.* ESM MH.4 - Percent of youth with special health care needs who report having successfully transitioned from pediatric to adult health care providers/practices. ***Inactive -*** *ESM MH.5 - Percentage of providers in underserved geographic areas that received formal technical assistance through the UCF*		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

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	satisfaction with their ability to access community-based resources needed in order to transition to adult health care by 2% annually from identified 28% baseline. Data Source: Satisfaction Survey for Young Adults Transitioning to Adult Health Care. (7/1/2022-6/30/2023 Target: (30%) (7/1/2023-6/30/2024 Target: (32%) (7/1/2024-6/30/2025 Target :(34%) (7/1/2025-6/30/2026 Target: (36%)		*HealthARCH program that became designated patient-centered medical homes.* ESM MH.6 - Percent of PCMH pediatric providers located within the identified tracts of highest need, per the CMS Child Needs Index.		
Improve access to appropriate mental health services to all children.	1.1: By June 30, 2026, increase the number of DOH team members, providers, (pediatric, family practice, and adult), families, family partners, and community service providers in Florida who received education or technical assistance about accessing or providing access to behavioral health services from 335 annually to 735 annually. Data source: DAL for MCH Block Grant quarterly reporting. Baseline: 335 (7/1/21-6/30/22 target:(335) (7/1/22-6/30/23 target: (435) (7/1/23-6/30/24 target: (535) (7/1/24-6/30/25 target: (635) 7/1/25-6/30/26 target: (735) 1.2: By June 30, 2025, increase the number of traditional and non-traditional providers that have initiated integrating behavioral health services, by 3% annually from identified baseline. (data	1.1.1: Identify, evaluate, and enhance education and technical assistance provided to DOH team members, providers (pediatric, family medicine, and adult), families, family partners, and community service providers regarding accessing or providing access to behavioral health services and related topics that impact behavioral health and wellness 1.1.2: Collaborate with organizations on existing or developing Public Awareness Campaigns to increase awareness of mental health and reduce stigma 1.1.3: Leverage work with existing and potential partners to increase awareness, prevention identification, treatment activities, and treatment resources 1.2.1: Identify, develop, and disseminate resources for change management for traditional and non-traditional providers to begin behavioral health integration 1.2.2: Leverage work with existing and potential partners to increase the accessibility and utilization of needed behavioral health services 1.2.3: Create a pipeline of providers that are engaged in enhancing their practice sites by improving behavioral health awareness, prevention, identification and treatment		SPM 1: The percentage of children that need mental health services that actually receive mental health services.	

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	source: CMS Public Health Detailing activity tracker) (baseline: X) (7/1/20-6/30/21 target: X + 3%) (7/1/21-6/30/22 target: X) (7/1/22-6/30/23 target: X) (7/1/23-6/30/24 target: X) (7/1/24-6/30/25 target: X) 1.3: By June 30, 2025, increase the number of activities identified that support families in enhancing mental health protective factors and build resilience by 3 annually (data source: Public Health Detailing Activity Tracker) (baseline: 0) (7/1/20-6/30/21 target: 3) (7/1/21-6/30/22 target: 6) (7/1/22-6/30/23 target: 9) (7/1/23-6/30/24 target: 12) (7/1/24-6/30/25 target: 15)	1.3.1: Identify, develop, and disseminate resources for traditional and non-traditional providers, as well as community partners, on available activities and resources that enhance mental health protective factors and build resilience in the families they are serving 1.3.2: Leverage work with existing and potential partners to increase activities for families that enhance mental health protective factors and build resilience			
Increase access to medical homes and primary care for children with special health care needs.	11.1: By June 30, 2026, increase the number of DOH team members, providers (pediatric, family practice, and adult), families, family partners, and other partners serving CYSHCN in Florida who received education or technical assistance about the patient-centered medical home model and related topics that impact the health and wellness of CYSHCN from 850 annually to 1050 annually. Data source: DAL: Reported Quarterly to MCH Block Grant. Baseline: 850 (7/1/21-6/30/22 target: (850) (7/1/22-6/30/23 target: (900) (7/1/23-6/30/24 target: (950) (7/1/24-	11.1: Identify, evaluate, and enhance education and technical assistance provided to DOH team members, providers (pediatric, family medicine, and adult), families, family partners, and other partners serving children and youth with special health care needs (CYSHCN) regarding the patient-centered medical home model and related topics that impact the health and wellness of CYSHCN. 11.2.1: Create a cohort of caregivers of CYSHCN that are educated and equipped to be a partner in their child's care. 11.2.2: Leverage work with existing and potential partners to increase opportunities for families of CYSHCN to become family partners at the individual, community, and systems level. 11.3.1: Create a pipeline of providers that are engaged in enhancing their practice sites based on the foundational principles of patient-centered medical homes.			SOM 1: Percent of families reporting not being frustrated in their efforts to obtain services for their child with special health care needs

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	6/30/25 target: (1000) (7/1/25-6/30/26 target (1050) 11.2: By June 30, 2025, increase the number caregivers of CYSHCN in Florida who perceive themselves as a partner in their child's care by 5% annually from identified baseline. (7/1/20-6/30/21 target: X) (7/1/21-6/30/22 target: X+ 5%) (7/1/22-6/30/23 target: X+10%) (7/1/23-6/30/24 target: X+15%) (7/1/24-6/30/25 target: X+20%) 11.3: By June 30, 2025, increase the percentage of underserved geographic areas that have at least one pediatric practice that is designated as a PCMH by 20% (7/1/20-6/30/21 target: Xx1.03) (7/1/21-6/30/22 target: Xx1.05) (7/1/22-6/30/23 target: Xx1.1) (7/1/23-6/30/24 target: Xx1.15) (7/1/24-6/30/25 target: Xx1.2)	11.3.2: Leverage work with existing and potential partners to increase the spread of patient-centered medical homes. 11.4: Work with other Title V CYSHCN Programs and internal Department of Health colleagues to identify and implement activities that will increase the numbers of family practice and adult providers that serve young adults with special health care needs.			
Improve access to appropriate mental health services to all children.	1.1: By June 30, 2026, increase the number of DOH team members, providers, (pediatric, family practice, and adult), families, family partners, and community service providers in Florida who received education or technical assistance about accessing or providing access to behavioral health services from 335 annually to 735 annually. Data source: DAL for MCH Block Grant quarterly reporting. Baseline: 335 (7/1/21-	1.1.1: Identify, evaluate, and enhance education and technical assistance provided to DOH team members, providers (pediatric, family medicine, and adult), families, family partners, and community service providers regarding accessing or providing access to behavioral health services and related topics that impact behavioral health and wellness 1.1.2: Collaborate with organizations on existing or developing Public Awareness Campaigns to increase awareness of mental health and reduce stigma 1.1.3: Leverage work with existing and potential partners to increase awareness, prevention identification, treatment activities, and treatment resources			SOM 1: Percent of families reporting not being frustrated in their efforts to obtain services for their child with special health care needs

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	6/30/22 target:(335) (7/1/22-6/30/23 target: (435) (7/1/23-6/30/24 target: (535) (7/1/24-6/30/25 target: (635) 7/1/25-6/30/26 target: (735) 1.2: By June 30, 2025, increase the number of traditional and non traditional providers that have initiated integrating behavioral health services, by 3% annually from identified baseline. (data source: CMS Public Health Detailing activity tracker) (baseline: X) (7/1/20-6/30/21 target: X + 3%) (7/1/21-6/30/22 target: X) (7/1/22-6/30/23 target: X) (7/1/23-6/30/24 target: X) (7/1/24-6/30/25 target: X) 1.3: By June 30, 2025, increase the number of activities identified that support families in enhancing mental health protective factors and build resilience by 3 annually (data source: Public Health Detailing Activity Tracker) (baseline: 0) (7/1/20-6/30/21 target: 3) (7/1/21-6/30/22 target: 6) (7/1/22-6/30/23 target: 9) (7/1/23-6/30/24 target: 12) (7/1/24-6/30/25 target: 15)	1.2.1: Identify, develop, and disseminate resources for change management for traditional and non-traditional providers to begin behavioral health integration 1.2.2: Leverage work with existing and potential partners to increase the accessibility and utilization of needed behavioral health services 1.2.3: Create a pipeline of providers that are engaged in enhancing their practice sites by improving behavioral health awareness, prevention, identification and treatment 1.3.1: Identify, develop, and disseminate resources for traditional and nontraditional providers, as well as community partners, on available activities and resources that enhance mental health protective factors and build resilience in the families they are serving 1.3.2: Leverage work with existing and potential partners to increase activities for families that enhance mental health protective factors and build resilience			