Florida 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
Women/Maternal Health					
Promote preventive, well-woman care	PO1: By June 30, 2030, increase the percentage of women ages 18 through 44 who have had a preventive medical visit in the past year from 69.1% (2023) to 76.0%. [Data Source: BRFSS] PO2: By June 30, 2030, increase the percentage Healthy Start women receiving interconception care services from 61.2% in 2024 to 67.3% [Data Source: Well Family System]	1. Contract with Florida's Healthy Start coalitions to assist women in obtaining comprehensive health care and support to reduce the risks for poor health outcomes and to promote the CONNECT system that refers women to health care and wrap around services. 2. Support the Florida Healthy Babies Program within county health departments to identify needs and to implement and evaluate programs to improve women's health in their community. 3. Collaborate with Tobacco Free Florida to provide resources, technical assistance, trainings, and referrals to assist and encourage women to quit using all tobacco products. 4. Promote and suggest enhancements to the Strong Florida Moms website to provide women and families with access to medical information and resources. 5. Contract with 2-1-1 Big Bend, Inc. to operate the Family Health line that offers short-term counseling, information, and referrals regarding women's health. 6. Collaborate with WIC clinics, Healthy Start and other home visiting agencies to provide education on the importance of the well-woman visit.	***Inactive -*** *SPM ESM 1.1 - The percentage of interconception (Show Your Love) services provided to Healthy Start clients.*	SPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	**Linked NOMs:** Women's Health Status Severe Maternal Morbidity
Promote early and adequate prenatal care	PO1: By June 30, 2030, increase the percentage of pregnant women who receive prenatal care beginning in the first trimester from 66.3% in 2023 to 69.6%. [Data Source: NVSS] PO2: By June 30, 2030, decrease	1. Support implementation of the Nurse Family Partnership model to improve prenatal health. 2. Support the state-funded Telehealth Maternity Care Program to assist pregnant women to obtain comprehensive prenatal health care and support services to reduce the risk for poor maternal health outcomes. 3. Support the Florida Healthy Babies Program within county health	No ESMs were created by the State. ESMs are optional for this measure.	SPM 2: Percent of pregnant women who receive prenatal care beginning in the first trimester	**Linked NOMs:** Severe Maternal Morbidity Neonatal Abstinence Syndrome

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	the rate of maternal mortality from 18.5 per 100,000 live births in 2023 to 15.7 maternal deaths per 100,000 live births. [Data source: FL-CHARTS] PO3: By June 30, 2030, decrease pregnancy-related mortality ratio- from 15.6 in 2022 to 14.0. [Data Source: FL MMRC] PO4: By June 30, 2030, increase the percentage of pregnant women who had a prenatal screen from 59.8% in 2024 to 65.8% [Data Source: DOH Health Management System] PO5: By June 30, 2030, increase the percentage of new mothers who received information from a health care provider on how to improve their health prior to pregnancy from 32.0% in 2023 to 35.1%. [Data Source: FL-PRAMS] PO6: By June 30, 2030, increase the percent of births with adequate prenatal care based on Kotelchuck Index from 64.4% in 2023 to 67.6%. [Data Source: FL-CHARTS]	departments to identify needs and to implement and evaluate programs to improve prenatal health care in their community. 4. Contract with Florida's Healthy Start coalitions to assist pregnant women to obtain comprehensive prenatal health care and support to reduce the risks for poor maternal health outcomes, and to promote the CONNECT system that connects pregnant women to health care and wrap around services. 5. Train providers, home visiting agencies, community-based organizations, and pregnant women to use Florida's Electronic Prenatal Screen to decrease the number of days from identification of risk to services. 6. Promote and suggest enhancements to the Strong Florida Moms website to provide pregnant women with access to medical information and resources. 7. Conduct quarterly meetings for the Maternal Mortality Review Committee (MMRC), (including MMRC Mental Health Subcommittee), to review maternal mortality and morbidity and make recommendations for clinical systems changes.			
Promote early and adequate prenatal care	PO1: By June 30, 2030, decrease the percentage of women who smoked during pregnancy from 1.8% in 2023 to 0.6%. [Data Source: NVSS]	1. Collaborate with Tobacco Free Florida to provide resources, technical assistance, trainings, and referrals to assist and encourage pregnant women to quit using all tobacco products. 2. 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. This includes the suite of Quit Your Way services	SPM ESM 5.1 - Percentage of Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) services provided to current	SPM 5: Percent of women who smoke during pregnancy	

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		that include phone quit, web coach, text and email quit support.	tobacco users.		
Promote postpartum care	PO1: By June 30, 2030, increase the percentage of postpartum women who attend a postpartum visit within 12 weeks after delivery from 89.4% in 2023 to 93.9%. [Data Source: PRAMS] PO2: By June 30, 2030, increase the percentage of postpartum women who attend a postpartum checkup and receive recommended care components of the postpartum visit from 69.8% in 2023 to 76.8%. [Data Source: PRAMS] PO3: By June 30, 2030, decrease maternal mortality from 18.5 per 100,000 live births in 2023 to 15.7 maternal deaths per 100,000 live births. [Data source: FL-CHARTS] PO4: By June 30, 2030, decrease pregnancy-related mortality ratio- from 15.6 in 2022 to 14.0 [Data Source: FL MMRC] PO5: By June 30, 2030, attend 83% of AMCHP Big 6 Postpartum Visit whole group and subgroup meetings annually, sharing Florida's State Action Plan components related to Postpartum Visit with peers and providing feedback, as appropriate. [Data Source: DOH - MCH]	1. Contract with the Florida Perinatal Quality Collaborative (FPQC) to work with hospitals to implement quality improvement initiatives to improve clinical care for pregnant and postpartum women. 2. Support Florida's Telehealth Maternity Care Program to assist postpartum women in obtaining comprehensive health care and support services to reduce the risk for poor maternal health outcomes. 3. Support the Florida Healthy Babies Program within county health departments to identify and prioritize needs and to implement and evaluate programs to improve postpartum health care in their community. 4. Contract with Florida's Healthy Start coalitions to assist pregnant women to obtain comprehensive postpartum health care and supports to reduce the risks for poor maternal health outcomes and to promote the CONNECT system that connects postpartum women to health care and wrap around services. 5. Conduct quarterly meetings for the Maternal Mortality Review Committee (MMRC), (including MMRC Mental Health Subcommittee), to review maternal mortality and morbidity and make recommendations for clinical systems changes. 6. Support implementation of the Nurse Family Partnership model to improve postpartum health. 7. Promote digital health care services to expand capacity for improving maternal health outcomes and identifying/treating postpartum women who experience chronic illnesses, substance use, or mental health disorders (i.e., Telehealth Maternity Care Program, Behavioral Health IMPACT, Count the Kicks, MOMitor™). 8. Promote and suggest enhancements to the Strong Florida Moms website to provide pregnant women with access to medical information and resources. 9. Actively participate in AMCHP Big 6 Collaborative Peer Learning	ESM PPV.1 - Percent of Healthy Start clients who receive interconception care (ICC) services	NPM - Postpartum Visit	**Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety

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		Initiative and its Postpartum Visit subgroup.			
Promote postpartum care	PO1: By June 30, 2030, increase the percentage of postpartum women who attend a postpartum visit within 12 weeks after delivery from 89.4% in 2023 to 93.9%. [Data Source: PRAMS] PO2: By June 30, 2030, increase the percentage of postpartum women who attend a postpartum checkup and receive recommended care components of the postpartum visit from 69.8% in 2023 to 76.8%. [Data Source: PRAMS]	1. Contract with the Florida Perinatal Quality Collaborative to work with hospitals to implement quality improvement initiatives to improve clinical care for pregnant and postpartum women. 2. Support Florida's Telehealth Maternity Care Program to assist postpartum women in obtaining comprehensive health care and support services to reduce the risk for poor maternal health outcomes. 3. Support the Florida Healthy Babies Program within county health departments to identify and prioritize needs and to implement and evaluate programs to improve postpartum health care in their community. 4. Contract with Florida's Healthy Start coalitions to assist pregnant women to obtain comprehensive postpartum health care and supports to reduce the risks for poor maternal health outcomes and to promote the CONNECT system that connects postpartum women to health care and wrap around services. 5. Conduct quarterly meetings for the Maternal Mortality Review Committee (MMRC), (including MMRC Mental Health Subcommittee), to review maternal mortality and morbidity and make recommendations for clinical systems changes. 6. Support implementation of the Nurse Family Partnership model to improve postpartum health. 7. Promote digital health care services to expand capacity for identifying/treating postpartum women who experience chronic illnesses, substance use, or mental health disorders (i.e., Telehealth Maternity Care Program, Behavioral Health IMPACT, Count the Kicks, MOMitor™).	ESM MHS.1 - Percent of postpartum Healthy Start clients who receive a referral for mental health services	NPM - Postpartum Mental Health Screening	**Linked NOMs:** Maternal Mortality Infant Mortality SUID Mortality Neonatal Abstinence Syndrome Child Injury Hospitalization Women's Health Status Postpartum Depression Postpartum Anxiety
Improve dental care access for women and children	PO1: By June 30, 2030, increase the percentage of women, ages 18-44 years, who received oral health care at a county health department in the past 12 months from 36.4% in 2024 to 38.2%. [Data Source: HMS]	1. Support the Florida Healthy Babies Program within county health departments to identify and prioritize oral health care needs and to implement and evaluate oral health programs to improve women's oral health in their community. 2. Collaborate with Early Head Start programs, home visiting programs, and/or Special Supplemental Nutrition Program for Women, Infants, and	ESM PDV-Pregnancy.1 - Percent of trained health providers providing women with referrals to oral health professionals for	NPM - Preventive Dental Visit - Pregnancy	**Linked NOMs:** Women's Health Status Children's Health Status

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	PO2: By June 30, 2030, increase the percentage of women, ages 18-44 years, who received a teledentistry exam through a county health department dental program in the past 12 months from 0.14% in 2024 to 0.24%. [Data Source: HMS] PO3: By June 30, 2030, increase the percentage of pregnant women who receive preventive dental visits from 40.0% in 2023 to 50.5%. [Data Source: PRAMS] PO4: By June 30, 2030, increase the percentage of trained health providers providing oral health care to women ages 18-44 years in the past 12 months from 0% in 2024 to 50%. [Data Source: HMS]	Children (WIC) clinics to train staff to conduct oral health risk assessments, provide preventive oral health care, and refer pregnant women for dental visits. 3. Develop an electronic oral health record and train oral health professionals in county health departments to provide teledentistry for women of childbearing age through remote programs. 4. Develop and disseminate public service announcements on oral health education and provide an online resource link for additional information. 5. Develop oral health educational materials that can be shared with health providers and clients through an online resource link and printed.	dental visits in the past 12 months		
Perinatal/Infant Health					
Ensure risk-appropriate perinatal care	PO1: By June 30, 2030, decrease the rate of Severe Maternal Morbidity from 103.0 per 10,000 delivery hospitalizations in 2023 to 92.7 per 10,000 delivery hospitalizations. [Data source: FL-CHARTS] PO2: By June 30, 2030, reduce the perinatal mortality rate from 6.1 per 1,000 live births and fetal deaths in 2022 to 5.5 per 1,000 live births and fetal deaths. [Data source: NVSS]	1. Promote Florida's prenatal screen to home visiting agencies, clinical providers, and community-based organizations for all pregnant women to complete. 2. Support implementation of the Nurse Family Partnership model. 3. Contract with the Florida Perinatal Quality Collaborative to work with hospitals to implement quality improvement initiatives to improve perinatal care for women. 4. Conduct quarterly technical assistance meetings for the Fetal and Infant Mortality Review Committee (FIMR) who review fetal and infant deaths to improve birth outcomes.	ESM RAC.1 - Percent of maternity hospitals that have achieved Levels of Maternal Care verification through the FPQC initiative ESM RAC.2 - Percent of referrals made to doulas and other perinatal professionals among Telehealth Maternity Care Program	NPM - Risk-Appropriate Perinatal Care	**Linked NOMs:** Stillbirth Perinatal Mortality Infant Mortality Neonatal Mortality Postneonatal Mortality Preterm-Related Mortality

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	PO3: By June 30, 2030, increase the percentage of Very Low Birth Weight (VLBW) infants born in hospitals with a Level III or higher Neonatal Intensive Care Unit (NICU) from 84.2% in 2023 to 92.6%. [Data source: FL-CHARTS] PO4: By June 30, 2030, decrease the percentage of low-risk cesarean deliveries among low-risk first births from 29.9% in 2023 to 23.6% [Data Source: NVSS]	5. Conduct quarterly Maternal Mortality Review Committee meetings (including Mental Health Subcommittee) to review maternal mortality and morbidity and make recommendations for clinical systems changes. 6. Support state-funded Telehealth Maternity Care Program to assist perinatal women to obtain comprehensive health care and support services to reduce the risk for poor maternal and infant health outcomes	enrollees who receive services from those professionals ***Inactive -*** *ESM RAC.3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)* ***Inactive -*** *ESM RAC.4 - Percentage of birthing hospitals participating in perinatal quality collaborative projects.*		
Promote breastfeeding for infants up to 6 months	PO1: By June 30, 2030, increase the percentage of infants who are ever breastfed from 86.4% in 2023 to 90.7%. [Data Source: NVSS] PO2: By June 30, 2030, increase the percentage of infants exclusively breastfed for the first six months from 29.9% in 2022-2023 to 32.9%. [Data Source: NSCH]	1. Conduct quarterly technical assistance meetings for the Fetal and Infant Mortality Review Committee who review fetal and infant deaths to improve birth outcomes. 2. Contract with 2-1-1 Big Bend, Inc. to operate the Family Health line that offers education and referrals regarding breastfeeding. 3. Collaborate with home visiting agencies to assist women and families to obtain education and training on breastfeeding. 4. Support the Florida Healthy Babies Program within county health departments to identify and prioritize needs and to implement and evaluate breastfeeding programs to improve infant health in their community. 5. Contract with the Ounce of Prevention Fund to develop and implement statewide public awareness campaigns (newborn screenings, Sudden Unexpected Infant Death prevention, positive birth outcomes, and healthy living).	ESM BF.1 - Percent 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 - Breastfeeding	**Linked NOMs:** Infant Mortality Postneonatal Mortality SUID Mortality
Promote safe sleep strategies	PO1: By June 30, 2030, increase the percentage of infants placed to sleep on their backs from 63.9% in	1. Conduct quarterly technical assistance meetings for the Fetal and Infant Mortality Review Committee who review fetal and infant deaths to improve birth outcomes.	ESM SS.1 - Percent of birthing hospitals that are Safe Sleep	NPM - Safe Sleep	**Linked NOMs:** Infant Mortality Postneonatal Mortality

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	2023 to 70.3%. [Data Source: PRAMS] PO2: By June 30, 2030, increase the percentage of infants placed to sleep on a separate, approved sleep surface from 27.7% in 2023 to 30.5%. [Data Source: PRAMS] PO3: By June 30, 2030, increase the percentage of infants placed to sleep without soft objects or loose bedding from 67.7% in 2023 to 74.5%. [Data Source: PRAMS] PO4: By June 30, 2030, decrease the rate of infant mortality from 6.0 per 1,000 live births in 2023 to 5.4 per 1,000 live births [Data Source: FL-CHARTS]	2. Contract with 2-1-1 Big Bend, Inc. to operate the Family Health line that offers education and referrals regarding safe sleep 3. Collaborate with home visiting agencies to assist women and families to obtain education and training on safe sleep. 4. Support the Florida Healthy Babies Program within county health departments to identify and prioritize needs and to implement and evaluate safe sleep programs to improve infant health in their community. 5. Contract with the Ounce of Prevention Fund to develop and implement statewide public awareness campaigns (newborn screenings, Sudden Unexpected Infant Death prevention, positive birth outcomes, and healthy living).	Certified		SUID Mortality
Child Health					
Prevent child and adolescent injuries and reduce hospitalizations	PO1: By June 30, 2030, reduce the rate of hospitalization for non-fatal injury among children, ages 0 through 9, from 128.3 per 100,000 population in 2022 to 100.1 per 100,000. [Data source: HCUP]	1. Contract with the Ounce of Prevention Fund to develop and implement statewide public awareness water safety campaigns (bath time safety, swimming pool rules, boating safety, drowning prevention). 2. Provide Youth Mental Health First Aid twice/year to adults who work with children. 3. Contract with Florida's Healthy Start coalitions to assist families to obtain comprehensive health care and support to reduce the risk for childhood injuries or hospitalizations and to promote the CONNECT system that connects families of children under the age of three to health care and wrap around services. 4. Support implementation of the Nurse Family Partnership model. 5. Partner with county health departments, SafeKids Coordinators, and	No ESMs were created by the State. ESMs are optional for this measure.	SPM 4: Rate of emergency department visits for non-fatal injury per 100,000 adolescents, ages 10 through 19	**Linked NOMs:** Adolescent Motor Vehicle Death Adolescent Firearm Death Adolescent Injury Hospitalization Adolescent Mortality Adolescent Suicide Child Injury Hospitalization Child Mortality

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		Healthy Start coalitions for injury prevention activities, including offering car seats, bicycle helmets, fire prevention education, poison control, and home safety kits to families. 6. Promote water safety for children ages 0-4 through the Department's Swimming Lesson Voucher Program. 7. Ensure at least one staff member is trained on safe car seat installation and use within each county health department.			
Improve dental care access for women and children	PO1: By June 30, 2030, increase the percentage of schools visited by a school-based dental program that submits data in FLOSS from 9% in SFY 2023-2024 to 15%. [Data source: FLOSS] PO2: By June 30, 2030, increase the percent of children aged 1 to 17 who receive a preventive dental visit from 72.2% in 2022-2023 to 79.4%. [Data source: NSCH] PO3: By June 30, 2030, decrease the percent of children aged 1 to 17 who have decayed teeth or cavities from 11.8% in 2022-2023 to 10.2%. [Data source: NSCH] PO4: By June 30, 2030, increase the percent of children ages 1 to 17 who receive a teledentistry exam from a county health department from 1.19% to 2.24%.	1. Facilitate partnerships between county health departments and pediatric oral health services. 2. Collaborate with Early Head Start, Head Start, daycares, home visiting programs, Healthy Start, primary care, and WIC clinics to train staff to provide preventive oral health services, education, and referrals to oral health dental visits. 3. Utilize school-based dental screenings to improve children's oral health status and use of dental services. 4. Encourage Florida Healthy Babies to include oral health care in annual work plans and to distribute oral health resource kits to families. 5. Encourage federally qualified health centers, non-profit community programs, university dental schools, and school-based sealant programs to report their program data in FLOSS. 6. Develop an electronic oral health record and train county health department oral health care providers to increase teledentistry examinations for children ages 1-17 in rural areas. 7. Develop and disseminate public service announcements on oral health education and provide an online resource link for additional information.	ESM PDV-Child.1 - Percent of schools visited by a school-based dental program	NPM - Preventive Dental Visit - Child	**Linked NOMs:** Tooth decay or cavities Children's Health Status CSHCN Systems of Care **Linked SOMs:** SOM 1 - The percentage of low-income children under age 21 who access dental care.
Increase access to medical homes and primary care for all	PO1: By June 30, 2030, increase the percent of children, ages 0 through 17, who have a medical home from 39.8% in 2022-2023 to 43.8%. [Data source: NSCH]	1. Distribute and promote patient-centered medical home educational resources for children through county health departments. 2. Support the Florida Healthy Babies Program within county health departments to identify and prioritize medical home needs and to ensure	ESM MH.1 - Increase the PCMH recognized provider-based measure of change by 2% yearly	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent -

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children, including children and youth with special health care needs.		children have access to a medical home.	through use of the CMS Child Need Index Maps & Performance Dashboard to increase access to PCMHs in or near FL that are identified areas with moderate/high health care needs ***Inactive -*** *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 - Percent of youth with special health care needs who report having successfully transitioned from pediatric to adult health care providers/practices.* ***Inactive -*** *ESM MH.4 - Percent of PCMH pediatric providers located within the identified tracts of highest need, per the CMS Child Needs Index.*		CSHCN Flourishing - Child Adolescent - All

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Adolescent Health					
Improve access to appropriate mental health treatment for all children, including children and youth with special health care needs.	PO1: By June 30, 2030, increase the percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling from 69.0% in 2022-2023 to 75.9%. [Data source: NSCH] PO2: By June 30, 2030, decrease suicide attempts among middle school and high school students from 7.3 per 100 population in 2024 to 6.6 per 100 population [Data Source: Florida Youth Substance Abuse Survey]	1. Provide Youth Mental Health First Aid twice/year to adults who work with adolescents. 2. Provide Question-Persuade-Refer (QPR) suicide prevention gatekeeper training for adults likely to interact with adolescents (e.g., parents, caregivers, school related professionals, faith based organizational staff) 3. Collaborate with organizations on existing or developing Public Awareness Campaigns to increase awareness of mental health and reduce stigma 4. Leverage work with existing and potential partners to increase awareness, prevention identification, and treatment for adolescent behavioral health services	ESM MHT.1 - Number of QPR suicide prevention trainings for adults who interact with youth	NPM - Mental Health Treatment	**Linked NOMs:** Adolescent Mortality Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Children's Health Status Adolescent Depression/Anxiety CSHCN Systems of Care Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Prevent child and adolescent injuries and reduce hospitalizations	PO1: By June 30, 2030, reduce the rate of hospitalization for non-fatal injury among adolescents, ages 12 through 19, from 241.1 per 100,000 population in 2022 to 235.7 per 100,000 population. [Data source: HCUP] PO2: By June 30, 2030, decrease the mortality rate among adolescents, ages 12 through 17, from 29.7 per 100,000 in 2023 to 26.7 per 100,000 [Data Source: FL-CHARTS]	1. Contract with the Ounce of Prevention Fund to develop and implement statewide public awareness water safety campaigns aimed at adolescents (swimming pool rules, boating safety, drowning prevention). 2. Provide Youth Mental Health First Aid twice/year to adults who work with adolescents. 3. Partner with county health departments and Safe Kids Coalitions for injury prevention activities designed for adolescents, including offering bicycle helmets, fire prevention education, poison control strategies, and counseling on the dangers of alcohol and drug use. 4. Partner with Safe Kids Coalitions to implement “Impact Teen Driver” programs, an evidence-based model to promote seat belt usage and to prevent reckless and distracted driving throughout the state. 5. Offer bystander training for bullying intervention for adolescents and communities.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 4: Rate of emergency department visits for non-fatal injury per 100,000 adolescents, ages 10 through 19	**Linked NOMs:** Adolescent Motor Vehicle Death Adolescent Firearm Death Adolescent Injury Hospitalization Adolescent Mortality Adolescent Suicide Child Injury Hospitalization Child Mortality
Increase access to medical homes	By June 30, 2030, increase the percent of children, ages 0 through 17, who have a medical	Distribute and promote patient-centered medical home educational resources for adolescents through county health departments.	ESM MH.1 - Increase the PCMH recognized provider-	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care

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and primary care for all children, including children and youth with special health care needs.	home from 39.8% in 2022-23 to 43.8% [Data source: NSCH]. By June 30, 2030, increase the percent of adolescents, ages 12-17, with a preventive medical visit in the past year from 67.0% in 2022-23 to 73.7% [Data source: NSCH].		based measure of change by 2% yearly through use of the CMS Child Need Index Maps & Performance Dashboard to increase access to PCMHs in or near FL that are identified areas with moderate/high health care needs ***Inactive -*** *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 - Percent of youth with special health care needs who report having successfully transitioned from pediatric to adult health care providers/practices.* ***Inactive -*** *ESM MH.4 - Percent of PCMH pediatric providers located within the identified tracts of highest need, per the CMS Child Needs*		Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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			Index.		
Children with Special Health Care Needs					
Increase access to medical homes and primary care for all children, including children and youth with special health care needs.	PO1: By 2030, increase the percent of children with special health care needs in Florida, ages 0 through 17, who have a medical home from 28.7% to 30.1% (baseline: 28.7% from 2022-2023 NSCH, NPM: Medical home, children with special health care needs).	1.1 Support Patient Centered Medical Home practice transformation for primary care, inclusive of coaching and facilitation services. 1.2 Develop, implement, or facilitate best practices to promote the medical home models for children and youth with special health care needs. 1.3 Leverage work with existing and potential partners to increase the access to medical homes and primary care, inclusive of children and youth with special health care needs. 1.4 Utilize data in meaningful ways to enhance evidenced-based shared decision-making. 1.5 Support workforce development and skill-based training in identified areas impacting families of CYSHCN. 1.6 Engage families and include parents (or youth) with CYSHCN as partners in identifying needs and developing services and supports designed for their benefit. 1.7 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. 1.8 Establish consumer participation on clinic or hospital healthcare governances related to quality improvement initiatives.	ESM MH.1 - Increase the PCMH recognized provider-based measure of change by 2% yearly through use of the CMS Child Need Index Maps & Performance Dashboard to increase access to PCMHs in or near FL that are identified areas with moderate/high health care needs ***Inactive -*** *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 - Percent of youth with special health care needs who report having successfully transitioned from pediatric to adult health care providers/practices.* ***Inactive -*** *ESM MH.4*	NPM - Medical Home; Medical Home_Personal Doctor; Medical Home_Family Centered Care	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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			- Percent of PCMH pediatric providers located within the identified tracts of highest need, per the CMS Child Needs Index. ESM MH_PDOC.1 - Increase the percent of children and youth with special healthcare needs in Florida, ages 0 through 17, who report having a personal doctor or nurse, by 5% yearly ESM MH_FCC.1 - Increase the percent of caregivers of children and youth with special healthcare needs in Florida, ages 0 through 17, who report their doctors or health care providers make them feel like a partner in their child's care, by 2% yearly		
Increase access to medical homes and primary care for all children, including children and	PO1: By June 30, 2030, increase 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 from 15.1% in 2022-2023 to 16.6%.	1.9 Implement Six Core Elements Adaptation with Quality Improvement (QI): Incorporate the evidence-driven youth-to-adult health care transition (HCT) Six Core Elements™ in a medical center/hospital system or learning collaborative with built-in QI activities. 1.10 Incorporate evidence-driven youth-to-adult transition strategies, including health care transition (HCT) strategies, into medical home and other condition specific systems serving CYSHCN.	ESM TAHC.1 - Increase the percent of children and youth with special health care needs, ages 12-17 years, who report that their doctor or other health care	NPM - Transition To Adult Health Care	**Linked NOMs:** CSHCN Systems of Care

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
youth with special health care needs.		1.11 Partner with youth, families and organizations to promote awareness and encourage adoption of evidence-driven youth-to-adult health care transition (HCT) practices and policies.	provider actively worked with them to gain skills to manage their health and health care, by 10% yearly ESM TAHC.2 - Increase the percent of youth who are 18 years or older with special health care needs and served by the Statewide Networks for Access and Quality, who report successful transition from pediatric to adult health care providers/practices, by 5% yearly		
Improve access to appropriate mental health treatment for all children, including children and youth with special health care needs.	PO1: By 2030, increase the percent of children and youth with special health care needs in Florida, ages 3 through 17, who need mental health treatment or counseling and received it, from 23.8% to 24.9% (baseline: 23.8% from 2022-2023 NSCH, Child & Family Health Measure, Health Care Access and Quality Indicator 4.4, SHCN status-expanded, Response YES).	2.1 Support the implementation and sustainability of integrated and collaborative care models of primary care and behavioral health (BH) care to ensure that all children, including children and youth with special health care needs, receive comprehensive care in a medical home model. 2.2 Support the coordination of integrated or collaborative care between primary care providers, pediatricians, and mental health providers to improve screening rates for common behavioral health diagnoses, such as ADHD, anxiety, depression. 2.3 Develop focused primary care behavioral health integration campaigns. 2.4 Leverage work with existing and potential partners to increase the accessibility and utilization of needed behavioral health services. 2.5 Support workforce development and skill-based training for healthcare providers or families, including pediatricians, nurses, and behavioral health professionals to better meet the behavioral health need of all children and	SPM ESM 3.1 - Increase the percentage of primary care providers who report improved self-efficacy in integrating behavioral health services as part of the Florida Pediatric Behavioral Health Collaborative, by 10% yearly SPM ESM 3.2 - Increase the percent of all children and youth served through the Florida Pediatric Behavioral Health	SPM 3: Percent of children with special health care needs (expanded criteria) in Florida, ages 3 through 17, who express some degree of difficulty in access to mental health treatment or counseling that is needed	

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		youth, inclusive of those with special health care needs. 2.6 Engage families and include parents (or youth) with CYSHCN as partners in identifying needs and developing services and supports designed for their benefit.	Collaborative, who screen positive for a behavioral health need and receive treatment recommendations, by 5% yearly		