Youth Sexual Health Plan

District of Columbia 2016-2020

WE ARE WASHINGTON DC

GOVERNMENT OF THE DISTRICT OF COLUMBIA
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DEPARTMENT OF HEALTH
PROMOTE. PREVENT. PROTECT.

LETTER FROM THE DIRECTOR

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DEPARTMENT OF HEALTH
Promote. Prevent. Protect.

Office of the Director

Government of the District of Columbia
Department of Health

WE ARE WASHINGTON DC

June 16, 2016

Greetings:

I am pleased to present the 2016-2020 Youth Sexual Health Plan. This plan was prepared collaboratively by the HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA) and the Community Health Administration (CHA) within the District of Columbia Department of Health (DOH) and includes input and guidance from the department's Youth HIV/STD Prevention Working Group. I extend my appreciation and recognition to the DOH staff and the many health care providers, researchers, District government agencies staff, community organizations, and young people for their participation.

This is the third plan addressing this issue that was developed by DOH and community partners. What distinguishes it from previous plans is its multilevel focus, targeting all areas that shape young people's sexual and reproductive health. While HIV and sexually transmitted infection (STI) prevention remains a key objective, this plan combines health equity and youth development approaches while looking at the social determinants of youth sexual and reproductive health. It also includes the prevention of unplanned pregnancies, the support for contraceptive choice, the promotion of health literacy, and the integration of health in all relevant policies.

The plan sets three primary ambitious and achievable goals:

1. Provide accessible resources and pathways that support all District youth to make healthy decisions around relationships and sexual health.
2. Reduce unintended outcomes of unprotected sex (STI/HIV infections and unplanned pregnancies).
3. Enhance District coordination and collaboration to provide an equitable service continuum.

The plan brings together District government agencies to streamline data and language, align strategies, and share accountability for youth initiatives and success. While collaboration between government agencies and community partners is essential, the plan also calls for active participation from every individual or entity that works with District young people and from—most important—**youth**!

Sincerely,

LaQuandra S. Nesbitt

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Director

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ACKNOWLEDGMENTS

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A special thanks to the young people from the Young Women's Project, Promising Futures, Sasha Bruce Youthwork, and the Office of the State Superintendent of Education's Youth Advisory Committee, who provided the youth perspective.

To request additional information about the plan, please contact Veronica Urquilla or Andrea Augustine at HAHSTA, District of Columbia Department of Health, 899 N. Capitol St., NE, Fourth Floor, Washington, DC 20002 or at (202) 671-4900.

ABBREVIATIONS LIST

AAFP – American Academy of Family Physicians

AAP – American Academy of Pediatrics

ACOG – American Congress of Obstetricians and Gynecologists

CBO – community-based organization

CFSA – Child and Family Services Agency

CHA – Community Health Administration

DBH – Department of Behavioral Health

DC ICH – District of Columbia Interagency Council on Homelessness

DC-PEN – District of Columbia Peer Education Network

DCPL – District of Columbia Public Library

DCPS – District of Columbia Public Schools

DDS – Department on Disability Services

DHCD – Department of Housing and Community Development

DHCF – Department of Health Care Finance

DHS – Department of Human Services

DISB – Department of Insurance, Securities and Banking

DOC – Department of Corrections

DOES – Department of Employment Services

DOH – Department of Health

DPR – Department of Parks and Recreation

DYRS – Department of Youth Rehabilitation Services

GWU – George Washington University

HAHSTA – HIV/AIDS, Hepatitis, STD and TB Administration

HBX – Health Benefit Exchange Authority

LARC – long-acting reversible contraception

MPD – Metropolitan Police Department

NASW – National Association of Social Workers

NEP/LEP – non-English proficient/limited English proficient

OCP – Office of Contracting and Procurement

ODR – Office of Disability Rights

OHR – Office of Human Rights

OPGS – Office of Partnerships and Grant Services

OPM – Office of Performance Management

OSSE – Office of the State Superintendent of Education

PEP – post-exposure prophylaxis

PrEP – pre-exposure prophylaxis

RFA – request for application

SAHM – Society for Adolescent Health and Medicine

SBHC – school-based health centers

SRH – sexual and reproductive health

STICC – Sexually Transmitted Infection Community Coalition

TPP – Teen Pregnancy Prevention

YHSPWG – Youth HIV/STD Prevention Working Group

YMSM – young men who have sex with men

YSSP – Youth STI Screening Program

BACKGROUND

What is sexual health?

Sexual health is attained though the development of skills that support lifelong physical, emotional, mental, and social well-being. In addition to information about human anatomy and reproductive physiology, sexual health includes knowledge and skills related to decision making and goal setting about when and if to have a family; creating safe relationships; developing self-acceptance and a positive identity; and communicating with health professionals, partners, and families.

Sexual health requires a positive and respectful approach to sexuality and relationships and includes the possibility of having safe and wanted sexual experiences, free of coercion, discrimination, and violence.

— adapted from Youth Sexual Health in Colorado: A Call to Action, 2012

How do we define youth?

For the purpose of this plan, youth are typically ages 13-24. Some strategies also focus on younger youth ages 8-12.

Purpose of this plan

In 2007, the Department of Health's HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA) developed the first DC Youth and HIV Prevention Initiative Plan in an effort to define and coordinate needed resources to address the HIV epidemic in the District of Columbia. The Office of the Inspector General found that overall, the plan was successfully implemented. The subsequent plan, which continued this work and ended in 2015, resulted in a number of collaborations, initiatives, and programs that facilitated the expansion of HIV and STD education and services for youth in Washington, DC.

In the spring of 2015, the Youth HIV/STD Prevention Working Group (YHSPWG) began the process of developing the 2016-2020 plan. The working group consisted of members of community, education, healthcare, and government agencies that agreed to work collectively to ensure an HIV-free generation. Guided by the educational and clinical needs of in-school and disconnected youth, the working group began the process of developing a sexual health plan to serve a broad range of the DC youth population.

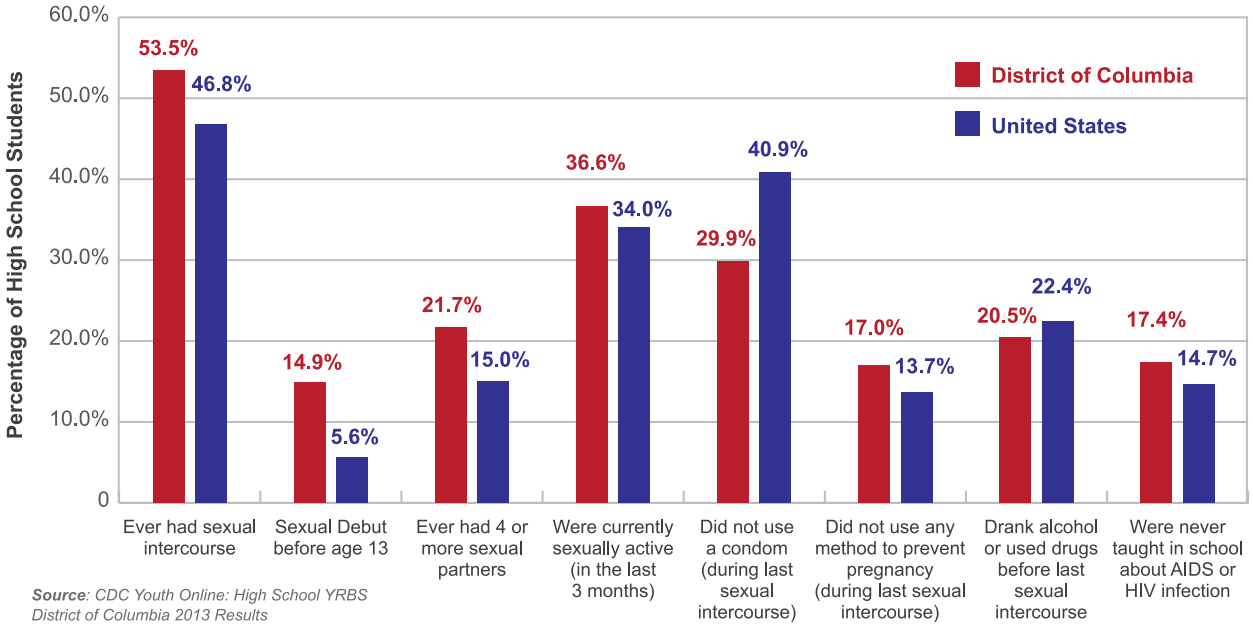
In developing this plan, the working group decided that the previous focus on HIV/STD prevention and lack of disease needed to be restructured to focus on the development and support of sexual health for young people. This would include the prevention of unintended pregnancies, the support for contraceptive choice, the promotion of health literacy, and the inclusion of health equity in all policies and approaches to the work.

The 2016-2020 DC Youth Sexual Health Plan is an effort to foster greater collaboration among youth-serving agencies to craft a shared vision, develop actionable items, and evaluate the impact of our work. It is an opportunity to connect outcomes related to sexual health to other aspects of a young person's life and recognizes the importance of meeting the needs of a variety of young people.

STATE OF YOUTH SEXUAL HEALTH IN DC

In the District of Columbia in 2013, youth ages 14–24 comprise 15.7% of the population (United States Census Bureau, 2015). As the table below illustrates, DC youth disproportionately engage in sexual behaviors that accelerate risk for sexually transmitted infections (STIs), including HIV, as well as unintended pregnancy. Across DC, in 2012, 16% of male students and 3% of female students reported initiation of sexual intercourse by age 11, while 25% of male students and 6% of female students reported initiation by age 13 (Ost & Maurizi, 2013). Additionally, 19% of high school students had a recent sexual partner that was three or more years older (Ost & Maurizi, 2013).

Figure 1: 2013 Youth Risk Behavior Surveillance (YRBS) Sexual Activity Data

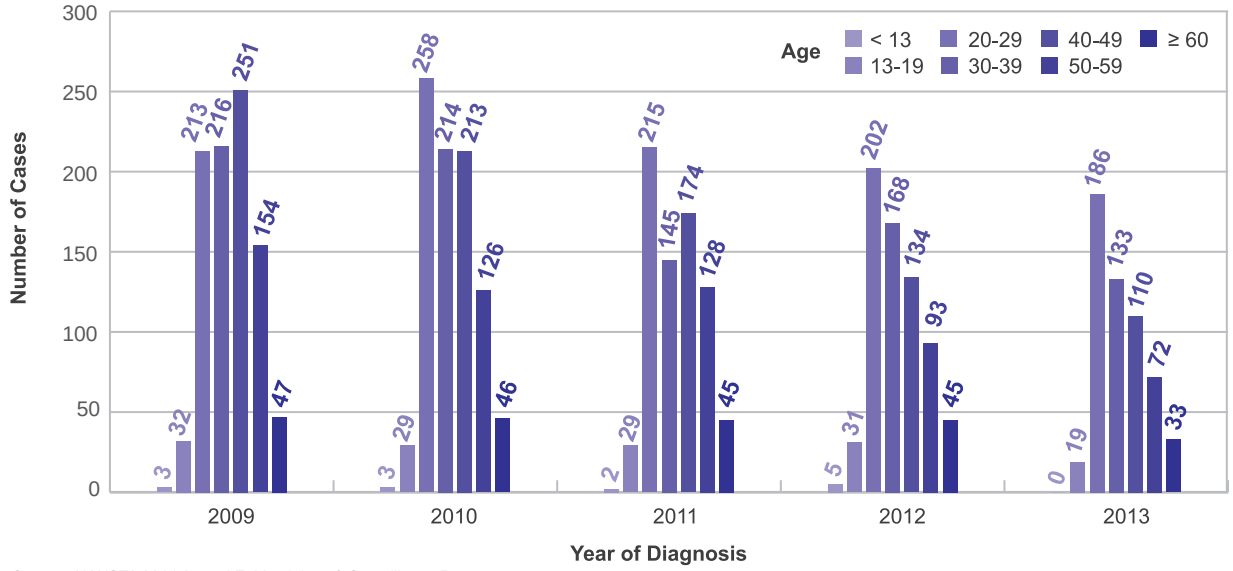


***Source**: CDC Youth Online: High School YRBS District of Columbia 2013 Results*

HIV

With a reported HIV prevalence rate of 2.5% in 2013, Washington, DC's numbers significantly exceed the World Health Organization's definition of an epidemic (1%) (Washington, DC: HIV/AIDS, Hepatitis, STD and TB Administration [HAHSTA], 2014). At the end of 2013, HIV prevalence among youth ages 13-24 according to the Strategic Information Division at HAHSTA was 0.6% (Washington, DC: HAHSTA, 2014), and young men who have sex with men (YMSM) and transgender youth are showing significant increases in HIV infection (Washington, DC: DC DOH, 2014).

Figure 2: Newly Diagnosed HIV Cases by Year or Diagnosis and Age at Diagnosis, District of Columbia

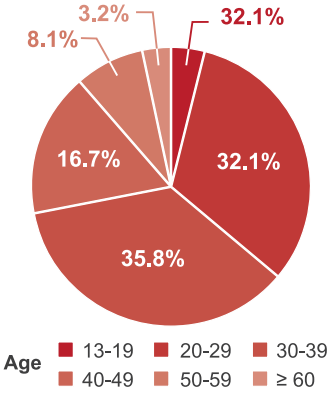


Source: HAHSTA 2014 Annual Epidemiology & Surveillance Report

Sexually Transmitted Infections

In the District of Columbia, STIs disproportionately affect youth compared with other age groups. Between 2009 and 2013, 23,367 cases of chlamydia and 7,702 cases of gonorrhea were diagnosed among youth ages 13–24 according to the Strategic Information Division at HAHSTA. More than half of all STIs occur in youth ages 15–24 (HAHSTA, 2014), with 30.8% of chlamydia cases among youth ages 15–19 and 34.0% among young adults ages 20–24 (HAHSTA, 2014). Similarly, 15- to 24-year-olds accounted for more than half of the gonorrhea cases in 2013 (HAHSTA, 2014). The incidence of both

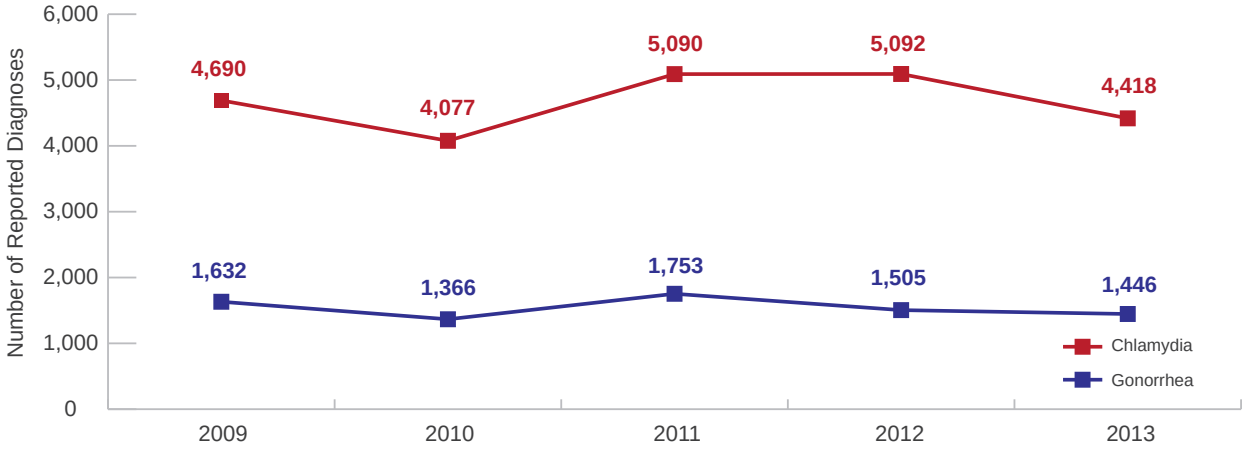
Figure 3: Transgender Persons Living with HIV by Age at Diagnosis, 2013, District of Columbia



Source: HAHSTA HIV Among Transgender Persons in the District of Columbia HIV/AIDS, Hepatitis, STD, and TB Data through 2014

infections in DC significantly outpaces that of Maryland and New York as well as the national rate (Centers for Disease Control and Prevention [CDC], 2015). Syphilis infection is not as prevalent compared with chlamydia and gonorrhea in DC and is less common in younger populations (ages 15–24).

Figure 4: Reported Chlamydia and Gonorrhea Cases Among Youth by Year, District of Columbia, 2009–2013



***Source**: Strategic Information Division at HAHSTA*

Figure 5: Cases and Rates per 100,000

	Maryland		New York		District of Columbia		U.S. *(excluding outlying areas)*	
	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate
Chlamydia	18,637	2329.1	60,648	2203.7	4,116	4170.9	949,270	2160.2
Gonorrhea	3,420	427.4	9,658	350.9	1,324	1341.7	185,127	421.3
Primary & Secondary Syphilis	148	18.5	289	10.5	29	29.4	4,542	10.3

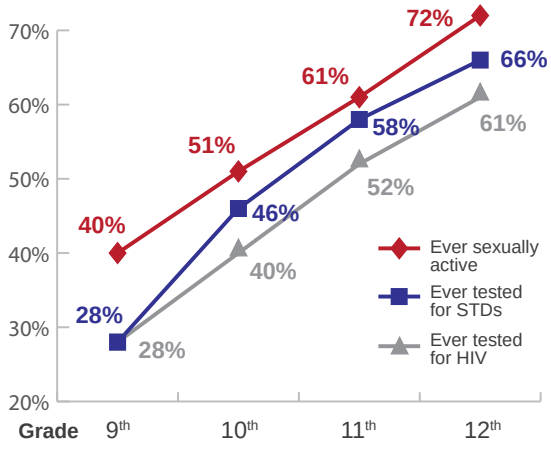
***Source**: Reportable STDs in Young People 15–24 Years of Age, by State, http://www.cdc.gov/std/stats/by-age/15-24-all-stds/default.htm.*

Despite high rates of chlamydia and gonorrhea among DC youth, many cases are asymptomatic and go undetected. In addition, only 70% of high school youth reported using a condom during most recent sexual intercourse (Ost & Maurizi, 2013). Taken together, these factors contribute to the spread of infection and heighten risk for long-term health complications.

Teen Pregnancy

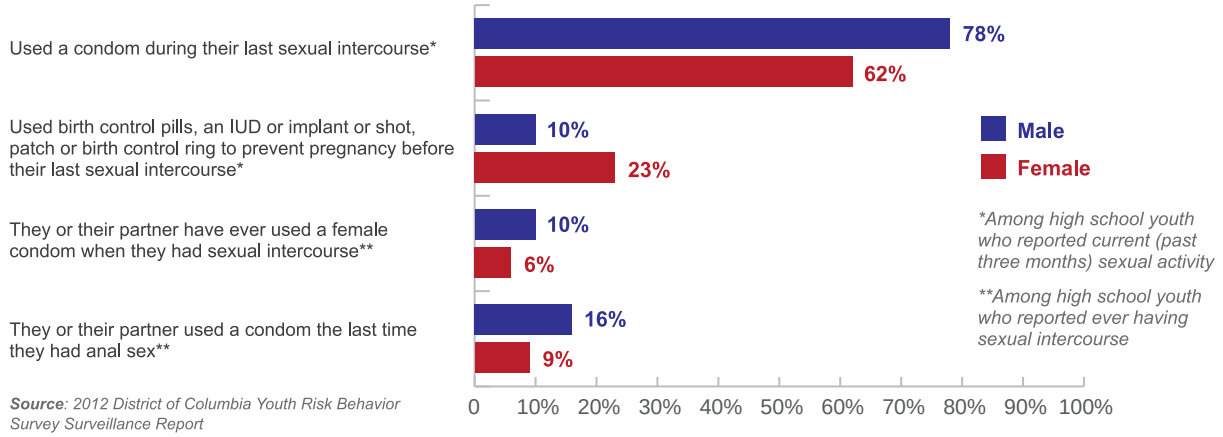
Both the national and DC teen pregnancy rates have decreased significantly since the 1990s. In DC, the teen birth rate (ages 15-19) dropped from 45.4 per 1,000 girls in 2010 to 28.4 births per 1,000 girls in 2014 (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2015). Despite this decline, DC outpaces the national average of 24.2 births per 1,000 girls, (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2015) and rates remain relatively steady in wards 7 and 8 (DC Campaign to Prevent Teen Pregnancy, 2013). In 2012, almost half of all teen births (790) in DC were in wards 7 (192) and 8 (265) (DC Campaign to Prevent Teen Pregnancy, 2013). High school youth report higher rates of condom use than the national average, but the reported use of contraception is significantly low (Centers for Disease Control, 2013).

Figure 6: DC 2012 YRBS Report: Sexual Activity and STD and HIV Testing Among High School-Aged Youth, by Grade



Source: 2012 District of Columbia Youth Risk Behavior Survey Surveillance Report

Figure 7: DC 2012 YRBS Reported Birth Control and Condom Use Among High School-Aged Youth, by Sex



Source: 2012 District of Columbia Youth Risk Behavior Survey Surveillance Report

NEXT STEPS

Many of the objectives in the DC Youth 2012-2015 HIV/STD Prevention Plan were accomplished. Highlights include:

- ☑ The ShowOff social marketing campaign, aimed at promoting positive attitudes and awareness around sexual health, was launched.
- ☑ Youth with historically low service utilization were reached through a variety of community-based organization and government initiatives to increase education, outreach, and testing.
- ☑ Pop-up STI screenings were successfully piloted at two DCPS high schools 2014-2015.
- ☑ The condom availability program was expanded to include all DCPS high schools and continues to expand at public charter schools.
- ☑ Prevention funding was secured to support youth peer education and capacity-building initiatives at various community-based organizations.

The 2016-2020 plan will build on these achievements while incorporating health equity and overall health into all policies. In 2015, the DC DOH established the Office of Health Equity to address the root causes of health disparities and create a better quality of life for all DC residents. As such, this plan shifts the focus away from disease and instead takes into account all the factors that shape youths' sexual and reproductive health.

Although DOH is the lead agency for this plan, the collaborating partners listed throughout the plan are critical to its successful implementation. The vision is to engage anyone working with youth in addition to youth themselves.

EVALUATION AND REVIEW

This plan will be reviewed on an annual basis by the Youth Sexual Health Working Group (formerly the Youth STD/HIV Working Group) to ensure continual assessment of plan activities and progress toward goals.

GOAL I

Provide accessible resources and pathways that support all DC youth in making healthy decisions around relationships and sexual health.

Objective I.A
Delay sexual debut

Strategy I.A.1

Implement best practices to target in-school and out-of-school youth.

Tactic I.A.1.a

Select best evidence-based, evidence-informed, promising, and emerging interventions for implementation.

Activity suggestions (short-term and mid-term)

- Conduct an environmental scan of ongoing/existing interventions.
- Identify other existing interventions not in use in DC.
- Select the best programs to utilize as a demonstration project.
- Conduct training.

Potential Collaborating Partners

- DBH
- DCPS
- DPR
- OSSE

Tactic I.A.1.b

Select at least three agencies/organizations where identified interventions will be implemented.

Activity suggestions (short-term and mid-term)

- Locate funding resources to support the intervention.
- Develop an application process to create access to the funding.
- Award and distribute funds to the most qualified agencies/organizations.
- Evaluate and share findings.

Potential Collaborating Partners

- DBH
- DCPS
- OSSE

Strategy I.A.2

Create a trusted adults model to support healthy decision making.

Tactic I.A.2.a

Partner with DCPS, OSSE, and the DC Public Charter School Board to identify optimal channels for caregiver engagement.

Activity suggestions (short-term and mid-term)

- Develop an informational SRH text message service for caregivers.
- Establish a mechanism to recruit and train champions of the trusted adult model.

Potential Collaborating Partners

- DC Public Charter School Board
- DCPS
- OSSE
- Parent Organizations

Tactic I.A.2.b

Collaborate with DCPS, OSSE, and the DC Public Charter School Board to implement professional development and informational support for school staff.

Activity suggestions (short-term and mid-term)

- Develop modules for training based on identified areas of need.
- Conduct trainings and provide technical assistance as needed.

- Connect trained staff with champions to engage adults at PTA meetings, back-to-school nights, and other opportunities for outreach and engagement.

Potential Collaborating Partners

- DBH
- DC Public Charter School Board
- DCPS
- OSSE

Tactic I.A.2.c

Develop training modules targeting pediatric and primary care clinicians to become champions of the trusted adult model.

Activity suggestions (short-term and mid-term)

- Host trainings and webinars that offer continuing education units.
- Collaborate with professional organizations to recruit and train clinicians.

Potential Collaborating Partners

- AAP (DC Chapter)
- AAFP
- ACOG
- NASW
- National Nursing Association
- SAHM

Tactic I.A.2.d

Devise and implement a communication plan to promote the trusted adult model.

Activity suggestions (short-term and mid-term)

- Develop consistent messaging around the trusted adult model.
- Integrate messaging into partner websites.
- Create social marketing and collateral materials to promote the campaign.

Potential Collaborating Partners

- AAP (DC Chapter)
- AAFP
- ACOG
- DC Public Charter School Board
- DCPS
- DC-PEN
- OSSE
- SAHM
- STICC

Objective I.B

Increase the visibility and availability of developmentally appropriate sexual health information

Strategy I.B.1

Create a communication plan with consistent, medically accurate messaging.

Tactic I.B.1.a

Develop a social media campaign.

Activity suggestions (short-term and mid-term)

- Identify a core set of messages and corresponding target populations.
- Ensure language accessibility for NEP/LEP as well as special needs populations.
- Engage social media subject matter experts.

Potential Collaborating Partners

- Community stakeholders
- OHR

Tactic I.B.1.b

Involve youth in the design and implementation of the campaign.

Activity suggestions (short-term and mid-term)

- Collaborate with youth-serving organizations to recruit youth advisors.
- Hold focus groups and other engagement activities to solicit youth input into the design and implementation.
- Create mechanisms to seek and apply youth feedback.

Potential Collaborating Partners

- DC-PEN
- DPR

Tactic I.B.1.c

Develop youth engagement activities to promote campaign efforts.

Activity suggestions (short-term and mid-term)

- Hold contests, fairs, and other events to promote awareness of the campaign.
- Develop training and materials for youth leaders.
- Create opportunities for youth to conduct street outreach.

Potential Collaborating Partners

- DC Government youth-serving agencies
- DC-PEN

Strategy I.B.2

Develop a cadre of peer educators and youth leaders.

Tactic I.B.2.a

Establish a peer health education program model.

Activity suggestions (short-term and mid-term)

- Identify an evidence-based or evidence-informed peer education model.
- Disseminate the model to youth-serving organizations.
- Provide funding and technical assistance to support the implementation of the model.
- Evaluate and share findings.

Potential Collaborating Partners

- DC Government youth-serving agencies
- DC-PEN

Tactic I.B.2.b

Create networking and educational opportunities for peer educators.

Activity suggestions (short-term and mid-term)

- Restructure the DC-PEN initiative.
- Identify intergovernmental funding to support learning opportunities.
- Develop and share a calendar of events.

Potential Collaborating Partners

- DC Government youth-serving agencies
- DC-PEN

Tactic I.B.2.c

Create street teams to conduct targeted outreach to populations with low SRH service utilization.

Activity suggestions (short-term and mid-term)

- Conduct an environmental scan to identify and map populations.
- Recruit and train peer educators from those populations (e.g., LGBTQ/YMSM, Latino/a, older youth, disconnected youth, and homeless youth).
- Engage experts to adapt peer education model to meet the needs of these populations.

Potential Collaborating Partners

- DC ICH
- DC-PEN
- DOES
- MPD

Tactic I.B.2.d

Develop a mechanism for peer educators to record and track referrals to SRH services.

Activity suggestions (short-term and mid-term)

- Identify non-governmental funding to support mobile technology.
- Enhance the capabilities of current SRH referral tools.
- Cross-reference and align information with OSSE's Healthy Youth Resource Guide.

Potential Collaborating Partners

- DBH
- OSSE
- Youth SRH service providers

Strategy I.B.3

Support the continued expansion of universal Districtwide sexual health education.

Tactic I.B.3.a

Collaborate with education agencies to assess the impact of the standards.

Activity suggestions (short-term and mid-term)

- Collaborate with education agencies to determine the appropriate data to collect.
- Partner with education agencies on data analysis.
- Disseminate findings and make recommendations for improvement.

Potential Collaborating Partners

- DC colleges and universities
- DCPS
- DC Public Charter School Board
- OSSE

Tactic I.B.3.b

Support activities to facilitate the implementation, monitoring, and enforcement of the standards.

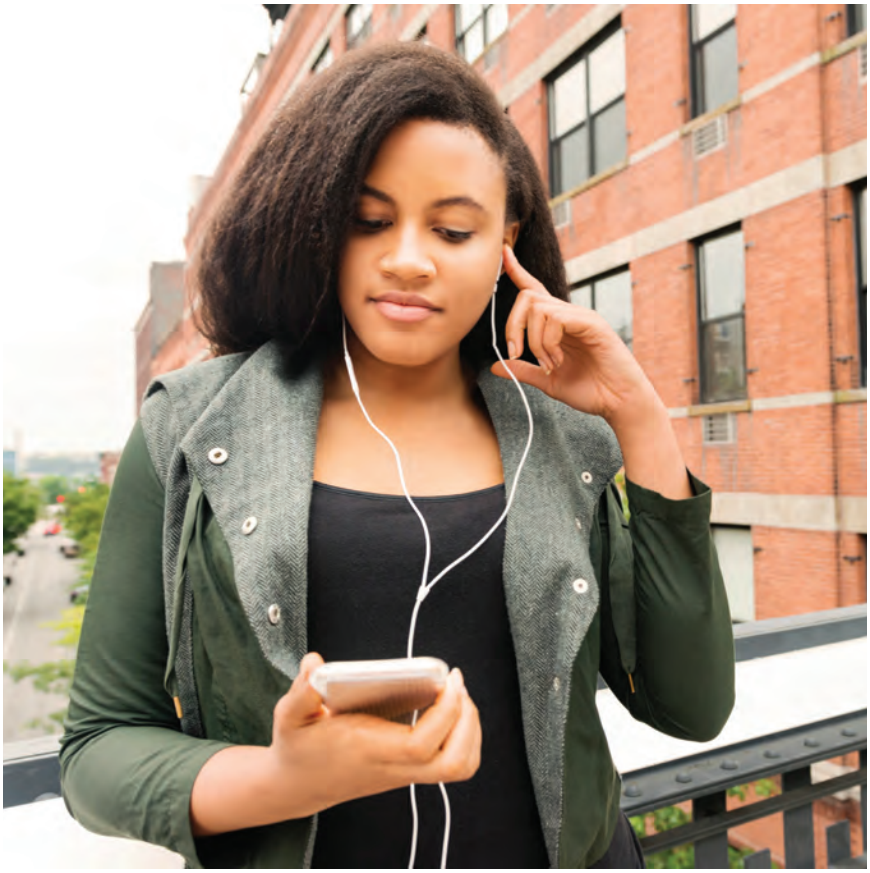
Activity suggestions (short-term and mid-term)

- Provide informational support to wellness policy teams in order to enhance student sexual and reproductive health.
- Develop educational tools to support the integration of SRH topics into various subjects.
- Identify tools and resources to support continuous sexual health education at the primary school level.

Potential Collaborating Partners

- DCPS
- DC Public Charter School Board
- OSSE


You Can't Hide
That Tiger Pride



GOAL II

Reduce unintended outcomes of unprotected sex (STI/HIV infections and unplanned pregnancies).

Objective II.A
Eliminate barriers to SRH services

Strategy II.A.1

Increase the utilization of school-based health centers (SBHCs).

Tactic II.A.1.a

Develop pathways and promoters to SBHCs.

Activity suggestions (short-term and mid-term)

- Increase the capacity of peer educators in the DC-PEN to support SBHCs.
- Promote SBHCs through Sexual Health Liaisons.
- Increase the knowledge of peer educators to enhance their role as referral sources.
- Establish relationships between peer education programs and SBHCs.

Potential Collaborating Partners

- DCPS
- DC-PEN
- SBHC operators

Tactic II.A.1.b

Provide community-level access to youth-focused health services.

Activity suggestions (short-term and mid-term)

- Promote youth-focused services within respective school communities.
- Leverage resources for free/low-cost services.
- Promote SBHCs within the school community.
- Expand YSSP sites.

Potential Collaborating Partners

- SBHC operators
- Youth service providers

Tactic II.A.1.c

Increase the cultural competency of clinical providers.

Activity suggestions (short-term and mid-term)

- Conduct a clinical assessment of the HAHSTA STD Clinic's accessibility to diverse populations.
- Develop and include criteria for cultural competency in all RFAs.
- Provide technical assistance for community partners to meet cultural competency criteria.
- Incorporate youth feedback into the cultural competency standards.

Potential Collaborating Partners

- DDS
- Federal funding agency technical assistance providers
- Mayor's Offices of Community Affairs: Office on Latino Affairs, District of Columbia Youth Advisory Council, Office on African Affairs, Office of LGBTQ Affairs, Office on Asian and Pacific Islander Affairs
- ODR
- OSSE/DCPS Youth Advisory Committees

Tactic II.A.1.d

Link HIV/STI and reproductive health services to provide comprehensive, youth-centric SRH services.

Activity suggestions (short-term and mid-term)

- Revise RFAs to include specific language requiring comprehensive sexual and reproductive health service delivery.
- Identify funding opportunities that can be created across DOH administrations.
- Create a recommended risk assessment for all providers.

- Support partnerships to facilitate referrals and linkages.

Potential Collaborating Partners

- AAP (DC Chapter)
- AAFP
- ACOG
- DC Government youth-serving agencies
- SAHM

Objective II.B

Increase self-efficacy to seek SRH services

Strategy II.B.1

Promote health literacy.

Tactic II.B.1.a

Define and promote a standard definition of health literacy.

Activity suggestions (short-term and mid-term)

- Establish a working definition of health literacy.
- Collaborate with educators and service providers to identify methods for health literacy education.
- Include standard definition in RFAs.
- Provide technical assistance and training on how to assess and educate clients on health literacy.

Potential Collaborating Partners

- DC Government and non-government youth-serving agencies
- DC Public Charter School Board
- DCHF
- DCPS
- HBX
- OSSE

Tactic II.B.1.b

Increase knowledge of accessible SRH services.

Activity suggestions (short-term and mid-term)

- Collaborate with HAHSTA-funded YSSP and CHA-funded TPP sites to develop appropriate messaging.
- Facilitate the integration of messaging into YSSP and TPP sites' existing marketing materials.
- Create digital tools to map SRH providers.
- Host awareness month events and health fairs to promote SRH service providers.
- Increase engagement of youth around new models of prevention including PrEP, PEP, LARC, and non-genital STI screening.

Potential Collaborating Partners

- DC Public Charter School Board
- DCPL
- DCPS
- DCPR
- OSSE
- YSSP and TPP sites

Strategy II.B.2

Improve the user experience of SRH services.

Tactic II.B.2.a

Implement modalities for assessment and improvement.

Activity suggestions (short-term and mid-term)

- Create report cards for providers and offer technical assistance on youth competency.
- Make clinic/space assessments a requirement in RFAs.
- Develop client satisfaction surveys and secret shopper programs.

Potential Collaborating Partners

- AAP (DC Chapter)
- AAFP
- ACOG
- SAHM
- Youth-funding agencies
- Youth leaders
- Youth-serving organizations

Objective II.C

Increase facilitators of SRH services

Strategy II.C.1

Increase the number of providers who have knowledge of adolescent sexual health.

Tactic II.C.1.a

Assess and enhance the knowledge of clinical youth service providers.

Activity suggestions (short-term and mid-term)

- Create and distribute a DC SRH Morbidity and Mortality Report to clinicians and CBOs.
- Collaborate with implementing partners to identify providers and to develop and conduct trainings.
- Survey providers to assess current knowledge of adolescent sexual health.

Potential Collaborating Partners

- AAP (DC Chapter)
- AAFP
- ACOG
- Professional clinical organizations
- SAHM
- STICC

Strategy II.C.2

Create more SRH entry points.

Tactic II.C.1.b

Expand low-barrier access.

Activity suggestions (short-term and mid-term)

- Explore options to introduce low-barrier SRH services into schools without SBHCs.
- Identify funding to support these efforts.
- Equip existing mobile units to offer expanded health screenings and assessments.
- Identify funding to support the establishment of flexible payment options.

Potential Collaborating Partners

- DHCF
- School health vendor
- Youth-serving organizations (with mobile units)

GOAL III

Enhance District coordination and collaboration to provide an equitable service continuum.

Objective III.A
Create policies to facilitate access to SRH care

Strategy III.A.1

Collaborate with insurance providers to ensure youth-friendly practices/policies.

Tactic III.A.1.a

Adjust requirements to allow for easier access to care.

Activity suggestions (short-term and mid-term)

- Eliminate the "Explanation of Benefits" for youth seeking SRH services without parental consent.
- Identify and implement changes to create options for reimbursement of same-day LARC insertion.
- Identify options for insurance for those under age 26 without parental coverage or in need of insurance outside of their parents' policy.

Potential Collaborating Partners

- DBH
- DC health insurance providers
- DHCF
- DISB
- HBX

Strategy III.A.2

Identify the platform for interagency collaboration.

Tactic III.A.2.a

Establish mechanisms for interagency collaboration.

Activity suggestions (short-term and mid-term)

- Develop memoranda of agreement between DOH and other DC Government youth-serving agencies.
- Establish common language, definitions, and measures.
- Align agency strategies regarding youth.

Potential Collaborating Partners

- CFSA
- DBH
- DC Public Charter School Board
- DCPL
- DCPS
- DHCD
- DOC
- DOES
- DPR
- DYRS
- MPD
- OSSE

Objective III.B
Develop and implement an SRH funding plan

Strategy III.B.1

Secure and distribute funding to finance local initiatives and programs.

Tactic III.B.1.a

Secure federal dollars to support SRH initiatives.

Activity suggestions (short-term and mid-term)

- Identify and map current federal and local dollars in the District used for SRH.
- Identify gaps in services and communities.
- Identify and apply for federal funding opportunities to support SRH.
- Develop RFAs using common language and measures.

Potential Collaborating Partners

- Academic partner
- Interagency task group
- OPGS

Tactic III.B.1.b

Engage private funders and decision makers to align funding strategies.

Activity suggestions (short-term and mid-term)

- Scan the funding landscape to identify current and potential funders of SRH.
- Collaborate internally to develop a needs statement.
- Hold a funders' fair to educate prospective funders on existing needs, collaborations, and programs.
- Submit formal requests for funding.

Potential Collaborating Partners

- DC Government youth-serving agencies
- OSSE/DCPS Youth Advisory Committees
- DC youth-serving agencies
- Mayor's Youth Advisory Council
- Washington Regional Association of Grantmakers

Strategy III.B.2

Align SRH programming with community needs.

Tactic III.B.2.a

Develop a DOH Youth Sexual Health Community Advisory Board.

Activity suggestions (short-term and mid-term)

- Meet regularly.
- Solicit feedback.
- Use as a mechanism to align RFAs to support best practices and meet community needs.

Potential Collaborating Partners

- DC Government youth-serving agencies
- Washington Regional Association of Grantmakers

Objective III.C

Coordinate and align data management processes

Strategy III.C.1

Establish uniform data collection measures and sharing guidelines.

Tactic III.C.1.a

Appoint a data committee, facilitated by DOH, that includes relevant government agencies.

Activity suggestions (short-term and mid-term)

- Reach out to youth-serving agencies to identify dedicated data ambassadors.
- Develop a common data dictionary.
- Share current data collection efforts and data points.
- Develop a data collection template.

Potential Collaborating Partners

- DC Government youth-serving agencies
- DOH-GWU academic partnership

Tactic III.C.1.b

Maintain agency-level dissemination and monitoring of standards compliance.

Activity suggestions (short-term and mid-term)

- Develop and distribute common data points to be collected by all DC Government youth-serving agencies.
- Use common language, as defined in the data dictionary, in all materials.
- Require grantees and vendors of youth services to collect common data points.
- Develop a semiannual data reporting schedule.
- Engage the Office of Performance Management to facilitate cooperation.
- Conduct an annual review of use of standards.

Potential Collaborating Partners

- DC Government youth-serving agencies
- OCP
- OPGS
- OPM

Tactic III.C.1.c

Develop a mechanism to match, share, and compare data at the agency level.

Activity suggestions (short-term and mid-term)

- Identify internal capabilities to house data.
- Identify a mechanism for data collection.

Potential Collaborating Partners

- DHS
- OPM

Strategy III.C.2

Align agency-level data management standards.

Tactic III.C.2.a

Maintain dissemination and monitor compliance at the community provider level.

Activity suggestions (short-term and mid-term)

- Include common language and data reporting as a requirement of all grant awards.
- Develop a quarterly reporting schedule for all grantees.
- Include data collection review as part of the grants monitoring process.

Potential Collaborating Partners

- DC Government youth serving agencies
- Interagency task group
- OPGS

Objective III.D

Perform continuous quality improvement

Strategy III.D.1

Incorporate youth feedback into SRH service delivery and policymaking.

Tactic III.D.1.a

Establish a quarterly youth review panel.

Activity suggestions (short-term and mid-term)

- Engage youth advisory committees in data and implementation review.
- Develop a mechanism for peer educators to review and comment on plan implementation and progress.
- Develop and implement a mechanism for youth feedback at the program level to determine funding renewal and program changes.

Potential Collaborating Partners

- DC Peer Educators
- DC Youth Advisory Committee
- OSSE Youth Advisory Committee

Strategy III.D.2

Use data for decision making.

Tactic III.D.2.a

Annually assess and update the DC Youth Sexual Health Plan.

Activity suggestions (short-term and mid-term)

- Develop an evaluation plan that includes process and outcome measures.
- Create agency-level performance reports with respect to this plan.
- Identify performance gaps and make recommendations for improvement.

Potential Collaborating Partners

- Academic partner
- Clinical Quality Improvement Team (HAHSTA)
- DC Youth Sexual Health Plan Working Group
- OPM

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YOUTH SEXUAL HEALTH PLAN LOGIC MODEL

GOALS	OBJECTIVES	STRATEGIES
Provide accessible resources and pathways that support all DC Youth in making healthy decisions around relationships and sexual health	Delay sexual debut Increase the visibility and availability of developmentally appropriate sexual health information	- Implement best practices to target in-school and out-of-school youth - Create a trusted adults model to support healthy decision making - Create a communication plan with consistent messaging - Develop a cadre of peer educators and youth leaders - Support the continued expansion of Districtwide sexual health education
Reduce unintended outcomes of unprotected sex (STI/HIV infections and unplanned pregnancies)	Eliminate barriers to SRH services Increase self-efficacy to seek SRH services Increase the number of facilitators of SRH services	- Increase the utilization of school-based health centers (SBHCs) - Promote health literacy - Improve the user experience of SRH services - Increase the number of providers who have knowledge of adolescent sexual health - Create more SRH entry points
Enhance District coordination and collaboration to provide an equitable service continuum	Create policies to facilitate access to SRH care Develop and implement an SRH funding plan Coordinate and align data management processes Perform continuous quality improvement	- Collaborate with insurance providers to ensure youth-friendly practices/policies - Identify the platform for interagency collaboration - Secure and distribute funding to finance local initiatives and programs - Align SRH programming with community needs - Establish uniform data collection measures and sharing guidelines - Align agency-level data management standards - Incorporate youth feedback into SRH service delivery and policymaking - Use data for decision making
EVALUATION		

TACTICS	OUTCOMES
- Select best evidence-based, evidence-informed, promising, and emerging interventions for implementation. - Select at least three agencies/organizations where identified interventions will be implemented. - Partner with DCPS, OSSE, and the DC Public Charter School Board to identify optimal channels for caregiver engagement. - Collaborate with DCPS, OSSE, and the DC Public Charter School Board to implement professional development and informational support for school staff. - Develop training modules targeting pediatric and primary care clinicians to become champions of the trusted adult model. - Devise and implement a communication plan to promote the trusted adult model. - Develop a social media campaign. - Involve youth in the design and implementation of the campaign. - Develop youth engagement activities to promote campaign efforts. - Establish a peer health education program model. - Create networking and educational opportunities for peer educators. - Create street teams to conduct targeted outreach to populations with low SRH service utilization. - Develop a mechanism for peer educators to record and track referrals to SRH services. - Collaborate with education agencies to assess the impact of the standards. - Support activities to facilitate the implementation, monitoring, and enforcement of the standards.	**Reduced sexual and reproductive health disparities** **Strengthened infrastructure to promote sexual and reproductive health** **Increased use of sexual and reproductive health services** **Enhanced responsiveness of SRH programming and policy making** **Decreased incidence and prevalence of STIs/HIV** **Ongoing engagement of youth in SRH programming and policy making** **Decreased rates of unplanned pregnancy**
- Develop pathways and promoters to SBHCs. - Provide community-level access to youth-focused health services. - Increase the cultural competency of clinical providers. - Link HIV/STI and reproductive health services to provide comprehensive, youth-centric SRH services. - Define and promote a standard definition of health literacy. - Increase knowledge of accessible SRH services. - Implement modalities for assessment and improvement. - Assess and enhance the knowledge of clinical youth service providers. - Expand low-barrier access.	
- Adjust requirements to allow for easier access to care. - Establish mechanisms for interagency collaboration. - Secure federal dollars to support SRH initiatives. - Engage private funders and decision makers to align funding strategies. - Develop a DOH Youth Sexual Health Community Advisory Board. - Appoint a data committee, facilitated by DOH, that includes relevant government agencies. - Maintain agency-level dissemination and monitoring of standards compliance. - Develop a mechanism to match, share, and compare data at the agency level. - Maintain dissemination and monitor compliance at the community provider level. - Establish a quarterly youth review panel. - Annually assess and update the DC Youth Sexual Health Plan.	

EVALUATION

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DEPARTMENT OF HEALTH
PROMOTE. PREVENT. PROTECT.