Maternal and Child Health Services Title V Block Grant

New York

FY 2025 Application/ FY 2023 Annual Report

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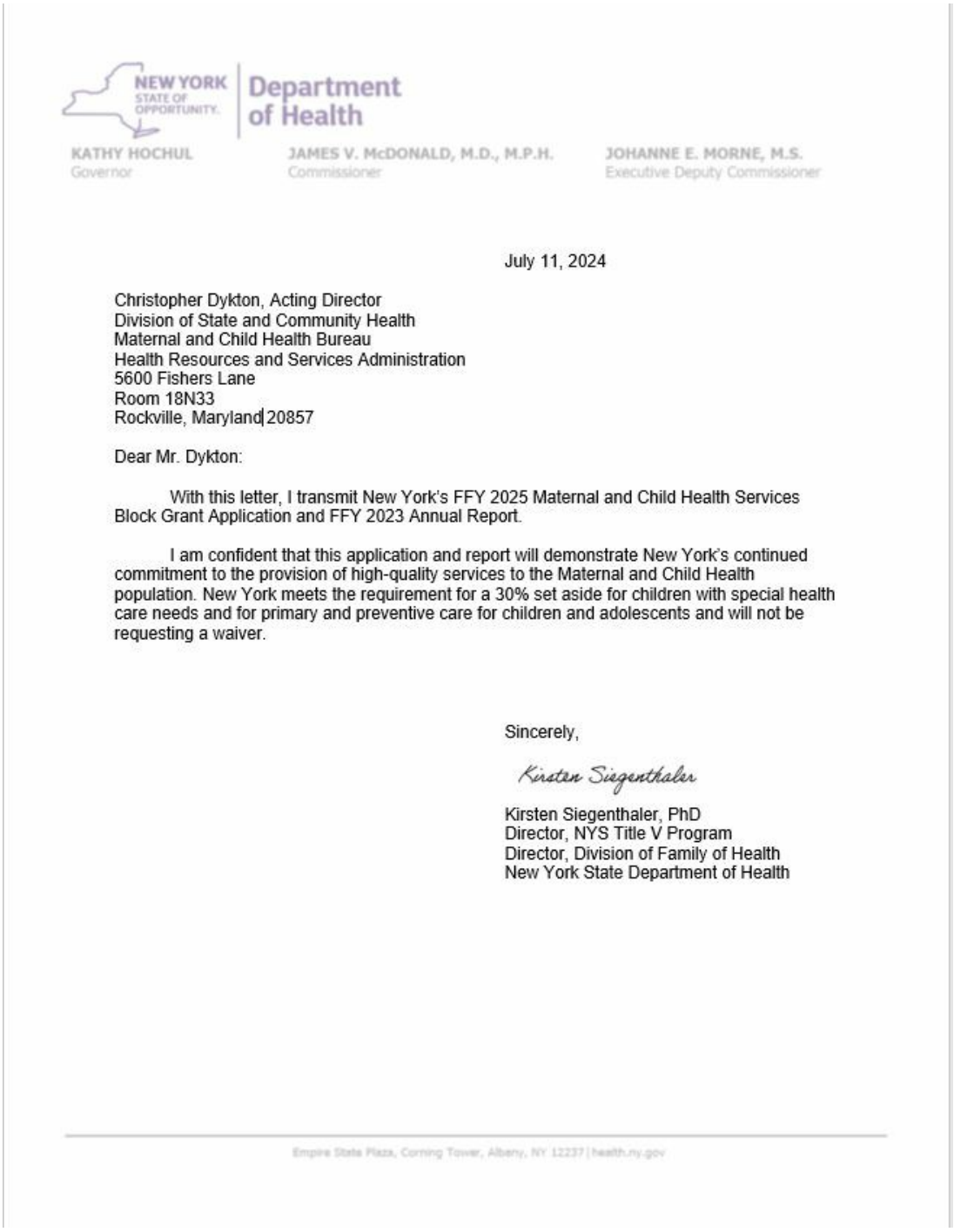
I. General Requirements

I.A. Letter of Transmittal



NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

JOHANNE E. MORNE, M.S.
Executive Deputy Commissioner

July 11, 2024

Christopher Dykton, Acting Director
Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane
Room 18N33
Rockville, Maryland 20857

Dear Mr. Dykton:

With this letter, I transmit New York's FFY 2025 Maternal and Child Health Services Block Grant Application and FFY 2023 Annual Report.

I am confident that this application and report will demonstrate New York's continued commitment to the provision of high-quality services to the Maternal and Child Health population. New York meets the requirement for a 30% set aside for children with special health care needs and for primary and preventive care for children and adolescents and will not be requesting a waiver.

Sincerely,

Kirsten Siegenthaler

Kirsten Siegenthaler, PhD
Director, NYS Title V Program
Director, Division of Family of Health
New York State Department of Health

Empire State Plaza, Corning Tower, Albany, NY 12237 | health.ny.gov

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix 2 of the 2026 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the 2021 Title V application/Annual Report guidance.

II. MCH Block Grant Workflow

Please refer to figure 3 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms", OMB NO: 0915-0172; Expires: December 31, 2026.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

The Title V Maternal and Child Health (MCH) Services Block Grant is the Nation's oldest Federal-State partnership to ensure the health of mothers, children, and youth, including Children and Youth with Special Health Care Needs and their families. Administered by the federal Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau, the Title V Maternal and Child Health Services Block Grant provides core funding to states for Maternal and Child Health public health activities.

Each year, states submit an annual report (for the previous year) and application (for the upcoming year) in accordance with Maternal and Child Health Bureau guidance. New York's Maternal and Child Health priorities and five-year State Action Plan for 2021-2025 were developed based on a comprehensive Needs Assessment designed to assess the state's Maternal and Child Health needs, strengths, capacity, and partnerships. The full Needs Assessment summary was submitted with our FY21 application. This Needs Assessment synthesized data and information from a wide range of sources including community listening forums, population health surveys and data systems, surveys of providers and the public, stakeholder meetings, and an inventory of MCH programs. The Needs Assessment identified ten cross-cutting themes voiced by families and community members. These themes related to social determinants of health including poverty, transportation, housing, biases in health care, environmental and neighborhood safety, family support, social cohesion, and more. Subsequent FY22, FY23, and FY24 Needs Assessment updates reinforced the initial ten priorities and highlighted the impact of the COVID-19 pandemic on NY's populations and service systems.

While this year's Needs Assessment update reflects the lingering impact of the pandemic alongside other persistent and emerging themes for Maternal and Child Health, it also highlights many areas in which we are restabilizing and enhancing programs, services, and the workforce. Moreover, it demonstrates our continued leadership and commitment to protect and promote the health of people of reproductive age, pregnant and birthing people, parents, infants, children, youth, and families, within the context of a changing health care landscape, the continued adoption of a life course perspective, a focus on data-driven, evidence-based public health interventions, and a dedication to centering the voices of people and communities we serve as an essential step toward health equity and justice. Building on last year's application, this year's application reflects the many ways in which the NYS Title V Program has continued to lead and meet its Maternal and Child Health commitments for the state.

Our action plan for the FY25 represents our ongoing commitment to address the objectives, strategies, and performance measures for our 2021-25 State Action Plan priorities across five MCH population health domains: women's and maternal health (WMH), perinatal and infant health (PIH), child health (CH), adolescent health (AH), and children and youth with special health care needs (CYSHCN). NY's application continues to reflect significant input from families, providers, and other key partners across the state, and remains centered on the issues voiced by communities that impact family and community health and well-being. It emphasizes understanding and addressing cross-cutting social determinants of health to reduce health disparities and promote health equity. It also reflects dedication to building a more comprehensive and inclusive system of supports for Children and Youth with Special Health Care Needs and their families, guided by the recent *Blueprint for Change* framework.

Within NYSDOH, the Division of Family Health leads the state's Title V MCH Services Block Grant activities. The Division of Family Health provides Department-wide leadership on Maternal and Child Health topics, directly oversees many Maternal and Child Health programs and initiatives, and collaborates with other key programs outside the Division and Department. In addition to directly funding programs, NY's Title V program plays a critical role in representing and ensuring that Maternal and Child Health needs are addressed through key policy initiatives both within and beyond the Division of Family Health, as reflected throughout this application.

Under Title V MCH Services Block Grant leadership, NYS continued to build on its previous work to supplement and further refine its 2021-25 Needs Assessment and State Action Plan. As detailed in our Needs Assessment Update for this year, this includes continued engagement of stakeholders to provide input and feedback on Maternal and Child Health outcomes in the state, ongoing data collection and analysis, and facilitating opportunities for community member input.

Recognizing the collaborative and cross-programmatic nature of our work, the Division of Family Health has continued to utilize an innovative structure and process to achieve our objectives throughout the year. Staff from across Division of Family Health as well as other areas of the Department of Health, including the Center for Environmental Health, Wadsworth Laboratories, and Division of Chronic Disease Prevention and from our Department's Regional Offices, are assigned to work on cross-disciplinary teams centered around each of the five Maternal and Child Health domains. Leaders for each team were identified based on their primary area of focus in their daily work, and then tasked with ensuring that work and activities for their respective domain, as outlined in the most recent Title V application, were completed. Despite the many unique and transformative challenges for the NYS Title V program over the past three years as we moved through the COVID-19 pandemic and transitioned to a new environment of hybrid work, domain teams have continued this approach through virtual meetings and expanded use of an online platform (Microsoft Teams). Domain teams share information, work on shared documents, and meet regularly. This platform and structure have helped to foster increased collaboration between team members, including team members who work outside of the Division and outside of the Capital District region.

Below are the NY National Performance Measures (NPM) and State Performance Measures (SPM) with the cross-cutting, community and data-informed Title V MCH Services Block Grant priorities.

Title V State Maternal and Child Health Priorities and National and State Performance Measures (NPM/SPM), 2021-2025

Population Domains and NPMs/SPMs		Community-Informed Priorities
Women's/Maternal Health • NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year Perinatal/Infant Health • NPM 3: Percent of very low birth weight (VLBW) infants born in a hospital with a		Health Care: Address equity, bias, quality of care, and barriers to access in health care services for women and families, especially for communities of color and low-income communities Community Services: Promote awareness of and enhance the availability, accessibility, and coordination of community services for families and youth, including children and youth with special health care needs and

Level III+ NICU • SPM1: Percent of samples received at the lab within 48 hours of collection Child Health • NPM 8.1: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day Adolescent Health • NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year Children and Youth with Special Health Care Needs (CYSHCN) • NPM 12: Percent of adolescents with and without special health care needs, ages 12-17, who received services necessary to make transitions to adult health care • SPM 2: Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months	**CROSS-CUTTING PRIORITIES ACROSS ALL DOMAINS**	their families, with a focus on communities most impacted by systemic barriers including racism. Parenting and Family Support: Enhance supports for parents and families, especially those with children with special health care needs, and inclusive of all family members and caregivers Social Support and Cohesion: Cultivate and enhance social support and social cohesion opportunities for individuals and families who experience isolation as a result of systemic barriers including racism, across the life course Healthy Food: Increase access to affordable fresh and healthy foods in communities. Community & Environmental Safety: Address community and environmental safety for children, youth, and families. Poverty: Acknowledge and address the fundamental challenges faces by families in poverty and near-poverty, including the "working poor" as a result of systemic barriers, including racism. Awareness of Resources: Increase awareness of resources and services in the community among families and the providers who serve them. Housing: Increase the availability and quality of affordable housing. Transportation: Address transportation barriers for individuals and families.

The FFY 21 Needs Assessment Summary and the five-year State Action Plan were developed based on community input and analysis of performance measures and investments. Below is a summary by domain of the key findings and priorities identified in our full five-year NA Summary.

Domain 1 – Women's and Maternal Health (WMH)

The preventive medical visit measure was selected for this domain because preventive medical visits for individuals of reproductive age are foundational to health throughout the life course; population health data demonstrate a need for its continued improvement; and it relates directly to priorities voiced by women and families through community listening forums - including awareness of community resources, transportation, social support, and health care access and quality.

In addition to preventive medical visits, strategies address a continuum of primary and preventive care and support that includes preconception, reproductive and sexual health, family planning, prenatal and postpartum care, and a full spectrum of medical care, mental/behavioral health, oral health, and other supports and services. NY's SAP reflects continued efforts to address access to comprehensive, high quality, and equitable health care services to people of reproductive age and a continued commitment to reduce maternal mortality and morbidity.

> *"We used to have a village and today it's gone."*

> *"Doctors don't respect us because they don't value us."*

Domain 2 – Perinatal and Infant Health (PIH)

Measuring appropriateness of perinatal care was selected for this domain because of its relevance to quality and systems of care for high-risk and vulnerable infants. While site of delivery for very low birth weight infants is one critical indicator of care, NY's Title V MCHSBG program views this indicator as part of a continuum of supports, services, and systems of care for infants, mothers, families, and service providers. This broader approach aligns with several priorities voiced by families in NY's Needs Assessment, including awareness of community resources and services, enhancing supports for families, improving people's health care experiences, ensuring access to transportation, and fostering community engagement and empowerment. Strategies include promoting early prenatal care and increasing awareness of community resources, supports, and services through Title V MCHSBG funded programs.

> *"I encourage people to enroll into whatever program is offered because through that you can be connected to other services that might be available in the community."*

Domain 3 – Child Health (CH)

The physical activity measure was selected for this domain, because it is responsive to concerns voiced directly by families in NY and reinforced by state-specific population health data. NY families identified the availability and accessibility of amenities that support children's safe, active play and access to healthy foods as top priority needs, alongside priorities for community and environmental safety for children and community transportation. Supporting healthy, active play and recreation for children and youth of all ages is critical to promoting healthy weight as well as general physical and mental health during childhood and throughout the life course. Strategies under the Child Health domain focus on promoting environments that support physical activity among children of all ages and abilities and support overall well-being.

> *"I had concerns with my daughter gaining weight and the doctor said it was fine. Then when her 4-year check-up came she said it was a concern. She didn't listen to me."*

> *"I want a community where they can grow up and know that they're safe and can go anywhere they want to go and trust the adults in their community. Right now, I am scared for my kids…"*

Domain 4 – Adolescent Health (AH)

Measuring adolescent well visits was selected for this domain because it aligns with both population health data indicators and concerns voiced directly by adolescents in NY. Preventive medical visits are one part of overall wellness, based on community input and population data, need to include social-emotional wellbeing and preparation for taking on the responsibilities of adulthood. Adolescence is often a very challenging stage in a person's life, during which there is immense physical, cognitive, social-emotional, and sexual development. Supporting adolescents' health and development and helping them prepare for their futures can have a lasting impact throughout the life course. Adolescent Health strategies focus on promoting routine care related to reproductive, oral, and behavioral health, and resources needed to successfully transition to adulthood.

“Everybody needs to talk even for one second or ten minutes. Even boys.”

"I feel like we should have more African American counselors. Because the counselors that are there, I feel like the students don't feel comfortable talking to them."

Domain 5 – Children and Youth with Special Health Care Needs (CYSHCN)

Measuring transitions to adult health care was selected because it was voiced as a key priority by youth with special health care needs and their families, reinforced by state-specific population health data. Families reported that only 15% of CYSHCN receive care in a well-functioning system, and less than 18% of youth age 12-17 with special health care needs received services necessary to make transitions to adult health care. This is consistent with experiences described by YSCHN and their families throughout the state. CYSHCN strategies include engaging youth with special health care needs and their families in our efforts to improve systems and practices supporting this population, including care coordination and transition support.

“[There should be] easier access to those resources so I do not have to be on a computer for 6 hours doing research.”

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

NYS is committed to ensuring the health and wellbeing of its population from birth through reproductive age and striving for equitable Maternal and Child Health outcomes. The state is fortunate to have comprehensive Medicaid benefits, insurance availability through the state's health insurance exchange, and significant state appropriations for Maternal and Child Health initiatives. The federal Title V Maternal and Child Health Services Block Grant funds infrastructure, including staff, within the NYS Department of Health.

As a result of this stable workforce, staff can apply for and implement other federal grants. The Department, through its bona fide agent Health Research, Inc., has been successful in its pursuit of federal grants to advance Maternal and Child Health. These grants are funded by HRSA and the Centers for Disease Control and Prevention (CDC) and include grants that support the state's Perinatal Quality Collaborative, Maternal Mortality Review Board, Early Hearing Detection and Intervention, Pediatric Mental Health Care Access, Rape Prevention Education, and a newly awarded State Maternal Health innovation grant, which will allow the Department over the next five years to implement universal virtual home visiting at two rural hospitals and evaluate Maternal and Infant health outcomes.

In addition, the Department with the Title V Director as Principal Investigator, received funding from the CDC under OT-21-2103 to address COVID-19 disparities. We funded 182 community-based organizations almost $50,000 each over the past 18 months. Eighty percent of the organizations had never worked with the Department of Health before. The funding was used to compensate them for their time and expertise as well as to allow them to implement the programs and activities that they know are needed in and by their specific communities. The funding was also used to support internal work on equitable procurement, so we not only funded non-traditional partners, but we worked to change the system so that funding was more accessible, supported by strong customer service, and funding was timely. The Department's work with community-based organizations is highlighted in our *Success Story*.

The Department also supports other federal grants that are administered directly by the Department. These grants include the Maternal, Infant, and Early Child Home Visiting (MIECHV) Program, Personal Responsibility Education Program, Sexual Risk Avoidance Education, Part C of Individuals with Disabilities Act, and Title X Family Planning. Title V funding supports staff in leadership positions to provide direction and ensure initiatives are aligned and integrated and in some instances funding to ensure Maternal and Child Health, including child preventive and children and youth with special health care needs are supported within these systems.

Title V funding also complements and supports state investments including 1) the state's Regional Perinatal Centers to implement quality improvement activities with NY's obstetrical hospitals and birthing centers to improve maternal and infant mortality and morbidity; 2) School Based Health Centers; and 3) a community health worker model of pregnancy and postpartum care. Staff work very closely with the state's Medicaid Program, also within the Department of Health. Title V and Medicaid staff meeting at a minimum monthly but usually more often. There is a strong collaboration on policy development and program development and implementation.

NY's Maternal and Child Health systems are complex. This application provides an overview that demonstrates Title V serves as a backbone and core to the Department's ability to advance the health and wellness of our population from birth through reproductive age.

III.A.3. MCH Success Story

The New York State Department of Health is committed to equity. To achieve equity, systems need to change. For our success story, we want to highlight work we have undertaken to advance equitable procurement.

The Department, with the Title V Director as Principal Investigator along with the Office of Minority Health and Health Disparities Prevention and the Office of Rural Health, applied for and was awarded a grant from the Centers for Disease Control and Prevention called *National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities*. This grant allowed the Department through its bona fide agent, Health Research, Inc., to invest in communities that had historic underinvestment and were negatively impacted by COVID-19.

There were multiple goals for this funding. The Department wanted to build trust with the community by engaging community partners with funding to compensate them for their expertise and time; they were paid to review materials and our trainings and provide feedback to the Department. We also shared power with them by allowing them to implement activities that were meaningful and needed by their communities. We established comprehensive, compassionate customer support. With grant funding we hired a diverse workforce to whom we provided training and support. Another key goal was making our grant process more user-friendly to applicants: changing the process of how we ask applicants to apply, how we award contracts, and how we reimburse them after award.

We funded 182 community-based organizations almost $50,000 each over two rounds of funding. Among the 182 organizations, 80% had never worked with the Department of Health previously. Their projects addressed mental health, health literacy, food security, physical activity, youth and community empowerment, social and community services, financial literacy, chronic disease prevention, financial literacy, and housing.

Some of the success has been captured in this quote: “I absolutely feel this is one project where we have been trusted [and] given the autonomy to lead the work the way that makes sense for our community. So in return, I feel I have trust in the funder.” The success was also seen in the ways we changed the processes of outreach, applying, awarding, and reimbursing organizations. Another success was that six awardees from the COVID grant were connected with, applied to, and were awarded a funding from another public health grant in chronic disease prevention. Community partners who may not have seen themselves as eligible for Department of Health funding have used the COVID grant as an entry point to new pots of government funding and are forming more stable, ongoing relationships as a result.

The Public Health Institute of Western Massachusetts was funded by the CDC to evaluate our equitable procurement initiative under a Novel and Emerging Practices Study. They identified areas of success as well as areas we can continue to improve. They produced a checklist for states to use to implement equitable procurement. We also performed our own evaluation by contracting with external Equitable Procurement experts within NYS, who provided us with more ideas about how to improve further. We plan to integrate this work into our Title V initiatives, since this CDC funding is one-time and ends in May 2026.

A compendium of all community-based organizations and a poster about both cohorts is included as *Supporting Document 3*. The compendium for the second cohort is being produced and is not available in time for this submission. We are awaiting release of the equitable procurement checklist from the CDC’s Novel and Emerging Practices Study.

III.B. Overview of the State

According to 5-Year population estimates from the 2022 American Community Survey, New York State is the fourth most populous state in the country, with just under 20 million people (19,994,379). Within the state, approximately 43% of the population (8,622,467) resides in New York City (NYC).

Density

Estimates from the 2020 Census indicate that there are 428.7 people per square mile in New York State. The most densely populated counties include New York County (74,782 persons per square mile), Kings County (39,438 persons per square mile), and Bronx County (34,920 persons per square mile). In addition to counties in NYC, Long Island, and the Hudson Valley region, other densely populated counties include Erie County, Monroe County, Onondaga County, Schenectady County, and Albany County.

According to Census estimates, New York State's population has grown between 2010 and 2020 at a rate of 4.2%. This statistic, however, masks significant variation observed at the regional level. While NYC, Long Island, Mid-Hudson, Capital District, Western New York, and Finger Lakes experienced population gains between 2010 and 2020, Central New York, Mohawk Valley, North Country, and Southern Tier experienced population losses between 1% to 3%.

Diversity

New York State is home to a highly diverse population. Across all states, New York ranks third in terms of having the highest percentage of foreign-born people. Compared to national estimates, New York State has a higher percentage of non-Hispanic Black, Asian, and Hispanic residents.

Of New York State's 19,994,379 residents, approximately 53.8% of individuals identify as White alone, 19.5% identify as Hispanic or Latino, 13.8% identify as Black or African American, 8.8% identify as Asian alone, 0.2% identify as American Indian or Alaska Native, and less than 0.1% identify as Native Hawaiian or Other Pacific Islander.

Selected counties in NYC have the highest percentage of Black or African American residents. According to the 2020 American Community Survey, 30 to 40% of residents living in both Kings County and Bronx County identify as Black or African American. Larger population centers including Rochester (Monroe County), Westchester County, Buffalo (Erie County), Albany (Albany County), and Rockland County also have higher percentages of Black or African American residents compared to the rest of the state.

For the state's Hispanic and Latino population, counties in NYC, Long Island, and Mid-Hudson have the highest percentages. Bronx County ranks highest across the state, with approximately 56% of the total county population identifying as Hispanic or Latino.

Immigration

Five-year Census estimates from 2022 indicate that 22.6% of New York State's population (4,508,936) is foreign born. Among this group, 59.6% (2,687,645) are naturalized citizens while 40.4% (1,821,291) are non-citizens. The largest percentage of foreign-born individuals migrated from Latin America (48.4%), Asia (29.7%), and Europe (15.4%). In addition to counties surrounding NYC, Long Island, and the Hudson Valley, counties with larger population centers, including Buffalo, Rochester, Syracuse, Utica, and Albany, have higher percentages of foreign-born residents.

Households and Families

According to five-year estimates from the 2022 American Community Survey, there are 7,604,523 households in New York State, with an average of 2.55 people per household. Of these households, 43.4% (3,299,986) are married couple families. Approximately 28.3% (12,150,793) of all households have at least one child under the age of 18.

Income and Poverty

Five-year estimates from the 2022 American Community Survey reveal that the median household income in New York State is $81,386. Counties with the highest income levels are heavily concentrated in NYC, Long Island, and Mid-Hudson. Nassau County on Long Island ranks highest in the state with a median household income level above $125,000.

Median household income has increased steadily since 2010 ($54,047). However, income levels vary significantly by race. According to the five-year estimates from the 2022 American Community Survey, the average median household income in 2022 inflation-adjusted dollars is $90,866 for White people, $91,254 for Asian people, $58,805 for Black or African American people, $61,135 for Hispanic or Latino people, and $59,483 for American Indian and Alaska Native people.
Income inequality has also increased over time in the state. The Gini coefficient has risen from 0.499 in 2010 to 0.51 in 2022. New York State ranks highest among all states in terms of income inequality.

According to 2022 estimates from the American Community Survey, 13.6% of New York State's population is living below the federal poverty line. Counties with the highest percentage of families falling below the threshold are concentrated in the NYC region, particularly in Bronx County (22.5%) and Kings County (15%).

Age Distribution

The median age in New York State is 39.3. Approximately 20.6% (4,128,443) of the population is under 18 years of age, and roughly 17% (3,402,284) of the population is 65 years or older. The median age has increased over the past decade, rising from 37.7 in 2007 to 39.3 in 2022.

Women of Childbearing Age

Estimates from the 2022 American Community Survey indicate that there are 228,348 women of childbearing age (15-50 years) who had a birth in the past 12 months, representing about 2% of the total female population.

Children

Of New York State's 19,994,379 residents, 5.6% of the population is under the age of 5 and 20.6% of the population is under the age of 18. According to 2022 American Community Survey 5-Year estimates, approximately 18.1% of all children in the state are living with families below the federal poverty line. Further, 8.3% of children are living with families where neither parent is in the labor force.

Children and Youth with Special Health Care Needs

Children and Youth with Special Health Care Needs (CYSHCN) are defined as those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. Based on data from the National Survey of Children's Health (NSCH) from 2020-2021, there are 743,518 children ages 0-17 years in New York State (18.6%) with a special health care need.

The sex of NYS CYSHCN was 57.6% Male, and 42.4% Female. The age distribution of NYS CYSHCN was 19.9% 0-5 years old, 34.2% 6-11 years old, and 45.9% 12-17 years old. The racial distribution of NYS CYSHCN was 45.6% non-Hispanic White, 26.1% Hispanic, 19.8% non-Hispanic Black, and 8.5% non-Hispanic Other/Multi-racial. 86.3 % of NYS CYSHCN lived

in a household where English was the primary language. 42.7% of NYS CYSHCN lived in a household with income between 0%-199% of the federal poverty level (FPL), 27.1% lived in a household between 200%-399% of FPL, and 30.2% lived in a household at 400% or greater of the FPL. Private insurance coverage was the most common, exclusively covering 46.6% of NYS CYSHCN, followed by 44.0% with public insurance including Medicaid and Child Health Plus, 7.7 % with both public and private insurance, and 1.7% uninsured.

Seventy percent of the NYS CYSHCN reported experiencing more than one health condition. Caregivers most commonly reported their child as being diagnosed with allergies (41.9%), followed by speech or language disorder (30.1%), anxiety (28.9%), learning difficulty (27.1%), asthma (27.0%) and attention deficit disorder (ADD) or attention-deficit/hyperactivity disorder (ADHD) (26.7%). While the presence of functional difficulty was less common than the presence of health conditions, over 58.7% of NYS CYSHCN experienced at least one functional difficulty. Among the 12 functional difficulties included in the 2020-2021 NSCH survey, difficulty concentrating (37.3%), breathing or other respiratory problems (18.4%), and coordination or moving around (12.1%) were the most frequently experienced by NYS CYSHCN.

Nearly one in nine NYS CYSHCN (11.5%) had their daily activities greatly affected by their health condition(s). One in ten NYS CYSHCN (10.1%) ages 6-17 missed 11 or more school days over the past year due to illness, compared to 1.8% of NYS children and youth without a special health care need. Nearly half of NYS CYSHCN (45.3%) ages 6-17 reported having trouble making or keeping friends, compared to 14.5% of NYS children and youth without a special health care need.

Families of CYSHCN face more financial strain and spend more time coordinating their child's care than families without a CYSHCN (Table 5). One in ten families with CYSHCN reported spending at least one hour per week coordinating their child's health care. Families of CYSHCN were more likely to reduce or stop working due to their child's health, have high out-of-pocket medical expenses, and have problems paying medical bills. Ninety-nine percent of the NYS CYSHCN have health insurance coverage all year; however, families of CYSHCN were less likely to have adequate health insurance and have insurance benefits that meet their child's needs.

Family-centered care is an approach to planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. Since the families are typically the decision makers and sources of support and information for children, a collaborative approach to health care is beneficial. NSCH data revealed that families of CYSHCN (85.9%) were less likely to receive family-centered care than families without a CYSHCN (87.0%). Individual components of family-centered care from the NSCH and from CYSHCN who received information and referral services from NYS local health departments (LHDs) were evaluated. The percent of NYS CYSHCN who reported always receiving each component ranged from 57% to 70% based on the NSCH.

Education

According to 2022-2023 school year data published by the New York State Department of Education, 2,422,494 children are enrolled in K-12 public schools. Approximately 40% (980,161) of public-school students are White, 29% (713,433) are Hispanic, and 16% (382,380) are Black or African American.

The high school graduation rate for all public-school students is 86%. However, graduation rates vary significantly by ethnicity. While 91% of white students graduate, only 81% of Black or African American and 81% of Hispanic or Latino students graduate from high school. Additionally, graduation rates differ based on migrant status. The graduation rate for migrants is 36%, compared to 86% for non-migrants.

In terms of educational attainment of adults (ages 25 and over), approximately 24.9% of the population has a high school diploma or GED, 21.6% of the population has a bachelor's degree, and 17.2% of the population has a graduate degree. The percentage of individuals with a bachelor's or graduate degree has increased over the past decade while the percentage of individuals with a high school diploma or less has decreased.

Language

According to five-year estimates from the 2022 American Community Survey, 69.4% of the population over the age of 5 (13,097,954) speaks only English. Of the 5,774,553 residents that speak a language other than English, 14.8% speak Spanish, 8.9% speak other Indo-European languages, and 5.2% speak Asian and Pacific Island languages. Approximately 13.1% of the population who speaks a language other than English report that they speak English less than “very well.”

Health Care

Approximately 5.7% of the non-elderly population (ages 0-64) in New York State has no health insurance. Estimates from the 2022 American Community Survey reveal that uninsured rates vary significantly by ethnicity. While only 3.1% of White people are uninsured, 9.6% of Hispanic people, 13.2% of American Indian or Alaska Native people, 5.1% of Asian people, 19.1% of Native Hawaiian and Pacific Islander people, and 5.0% of Black people have no health insurance coverage.

Ensuring access to health care by making affordable health insurance available is one of the critical accomplishments of the Governor’s health care agenda. As part of this agenda, NYS expanded access to Medicaid and created the NY State of Health (NYSOH), the state’s official health plan marketplace, to assist New Yorkers to gain access to quality affordable health care coverage.

Public Health Prevention Agenda

Further commitment to improving the health of all New Yorkers is evident in the NYS Prevention Agenda that was developed in conjunction with the Public Health Committee of the NYS Public Health and Health Planning Council (PHHPC), and in partnership with more than 140 organizations across the state. The Prevention Agenda focuses on eliminating the profound health disparities across all priority areas including preventing chronic diseases; promoting a healthy and safe environment; promoting healthy women, infants, and children; promoting wellbeing and preventing mental and substance use disorders; and preventing communicable diseases. Title V Maternal and Child Health Services Block Grant funded staff directed the update in the Prevention Agenda 2019-2024 related to Promoting Healthy Women, Infants and Children and worked to ensure the alignment with NYS’s Title V Maternal and Child Health Services Block Grant State Action Plan. The vision for the 2019-2024 Prevention highlights a Health in All Policies approach and a focus on healthy aging.

III.C. Needs Assessment
FY 2025 Application/FY 2023 Annual Report Update

III.C.1.a Needs Assessment Process Updates

NY's Title program combines structured needs assessment (NA) activities and ongoing communication with providers, families, and other partners to assess the needs of MCH populations and systems, as detailed below.

Statewide MCH Data Collection & Analysis

We review statewide data to assess status, trends, and disparities for key MCH indicators, and share results to inform program strategies and allocation of funds.

- Title V staff review national survey data including PRAMS, BRFSS, NSCH, and YRBSS annually. *[All]*
- In collaboration with the NYSDOH Office of Public Health Practice, DFH maintains a MCH data dashboard, updated in April 2024 *[All]*
- DFH collaborated with the NYSDOH Division of Chronic Disease Prevention to add Family Planning and Sexual Violence measures to BRFSS. *[WMH]*
- Title V leads a comprehensive maternal mortality and morbidity review process with the NYS Maternal Mortality Review Board (MMRB). This period we released a statewide report on pregnancy-associated deaths for 2018-20. A report on Severe Maternal Morbidity (SMM) is pending release. *[WMH]*
- A new report *Infant Mortality in New York State, 2016-2019* was published in June 2023. [*PIH*]
- Title V funded an over-sample of National Survey of Children's Health (NSCH) for NYS for Black, Hispanic, and CYSHCN. *[CH, AH, CYSHCN]*
- The Lead Poisoning Prevention Program manages a data system of children's blood lead levels and produces data reports on lead testing rates and lead poisoning.
- The *New York State Profile of CYSHCN* is updated annually and shared with partners. [*CYSHCN*].

Input from Local MCH Programs & Service Providers

Data collection and reporting are required for all Title V-funded programs. Local providers are required to engage with communities to assess community and client needs, which informs local and state work.

- All Title V-funded local programs submit quarterly reports on program activities, capacity, outcomes, and training and technical assistance (T&TA) needs.*[All]*
- Title V program staff convene quarterly calls with grantees to share information, review performance data, and discuss needs, challenges, and solutions. *[All]*
- DFH contracts with statewide and regional centers that provide additional information from local family planning, maternal/perinatal and infant health, adolescent health, and CYSHCN programs [*WMH, PIH, AH, CYSHCN*]
- The state's Growing up Health Hotline (GUHH) maintains data on information and resource needs based on calls received *[WMH, PIH, CH]*
- A new web-based data system for the SBHC and School-based Dental programs was rolled out in Fall 2023, with expanded race, ethnicity, and gender identity fields and enhanced data reporting functionality. *[CH, AH, CYSHCN*]
- The ACT Center for Community Action (CCA) communicates with local adolescent health (AH) grantees about their T&TA needs. AH programs conduct entry and exit surveys to monitor attendance, reach, and dosage of their curricula through the CCA's system. *[AH, CYSHCN]*
- A web-based data system for local health department (LHD) CYSHCN programs launched in 2021 is now fully

operational. LHD staff can review their own data in real time. Title V staff produce an annual report and are developing a new CYSHCN data dashboard. *[CYSHCN]*

- CYSHCN staff review Medicaid data to monitor enrollment in Health Home for Children. [*CYSHCN]*
- In 2023 CYSHCN staff collaborated with the NYS Association of County Officials (NYSACHO) to convene a statewide meeting and follow-up regional calls with local CSYCHN and Early Intervention programs.[*CYSHCN*]

Quality Improvement & Evaluation Initiatives

Title V staff lead a range of special projects to learn about specific service and system needs, capacity, and effectiveness.

- A Fall 2023 survey evaluated referrals between birthing hospitals and home visiting programs. Development of a statewide home visiting referral tracking tool is paused due to staffing vacancies. *[WMH, PIH]*
- NYSPQC led learning collaboratives with birthing hospitals on opioid use disorder and equity in birthing hospital and NICU care. These projects include discharge surveys to better understand birthing and NICU care experiences. *[WMH, PIH]*
- The Family Planning Program (FPP) surveyed local providers to assess partnerships with Syringe Exchange Programs (SEPS), which informed formation of regional partnerships. *[WMH]*
- A new QI project focused on language capacity in home visiting programs is underway. Title V staff also participated a national QI project on staff recruitment and retention. *[WMH, PIH]*
- The Newborn Screening Program continues a CQI initiative to improve lab collection and processing times, blood spot specimen quality, false positive screening results, timeliness in screening, and data completeness. Monthly reports to hospitals are used to prioritize targeted virtual TA site visits. Based on this work, the program has expanded its training to hospital IT staff, established a centralized hospital information portal, and offered a series of webinar trainings. *[PIH, CYSCHCN]*
- The Early Hearing Detection and Intervention (EHDI) program amended state regulations to improve newborn hearing screening and follow-up through a new two-tier inpatient newborn hearing screening protocol and companion standard for NICUs. [*PIH, CYSHCN*]
- DFH contracts with the Island Peer Review Organization (IPRO) to monitor FPP, Regional Perinatal Centers, SBHCs, and School-based Dental programs. In Fall 2023 Title V staff worked with IPRO to update monitoring tools, sampling methods, and review visits in response to provider feedback. [*All*]
- The CYSHCN Director is serving on the advisory group for a new study led by Cornell University and Bassett Health Care to compare health outcomes among students in district with and without SBHCs. [*CH, AH, CYSHCN*]
- A project to assess models and best practices for SBHCs is underway with support from an SPH student intern and FAPH physician fellow. [*CH, AH, CYSHCN*]
- Title V staff hosted and mentored two MPH interns to assess health equity in LHD CSYCHN programs and Sickle Cell program capacity statewide. [*CYSHCN*]

Advisory Groups

Title V staff convene and participate in many formal bodies that facilitate input from state and local partners including families and youth.

- DFH convenes the NYS Title V Advisory Council. With representation from LHDs, CBOs, parent groups, and advocates, the council meets three times each year on a range of MCH issues and initiatives *[All]*
- A new FPP Clinical Advisory Group will begin in 2024. *[WMH, AH]*
- DFH is working to establish a Midwifery Workgroup to better understand the needs, challenges, and opportunities for further engagement and partnership with midwives. *[WMH]*
- As part of our new HRSA Maternal Health Innovation grant, DFH is establishing a Maternal Health Task Force to develop

a strategic plan for improving maternal and pregnancy outcomes. *[WMH]*

- Title V staff are working to establish a statewide Home Visiting Parent Advisory Committee. Work on a formal procurement was paused due to staffing vacancies. *[WMH, PIH]*
- Perinatal Health and FPP staff are participating in a Congenital Syphilis Elimination Strategic Plan Workgroup led by the NYSDOH AIDS Institute. *[WMH, PIH]*
- The EHDI program convenes a state Advisory Group that meets quarterly with state partners including family members to provide guidance and feedback on relevant initiatives, including support for families of Deaf or Hard of Hearing children. *[PIH, CYSHCN*]
- Title V staff serve on the state Early Childhood Advisory Council (ECAC). Comprised of experts in education, health care, child welfare, and mental health from state agencies, CBOs, higher education, and others, the ECAC advises the Governor on early childhood issues. *[PIH, CH, CYSHCN*|
- Title V staff participate in an inter-agency workgroup on Adverse Childhood Experiences. *[CH, AH, CYSHCN]*
- NYSDOH convenes and staffs the Governor's NYS Advisory Council on Lead Poisoning Prevention to provide input on the prevention and elimination of childhood lead poisoning. [*CH, CYSHCN*]
- Title V staff serve on the Advisory Committee for the NYS Governor's Youth Council, a youth-run council comprised of youth from all 62 counties to facilitate ongoing communication with policymakers. [*AH*]
- In collaboration with Families Together in NYS-Youth Power, DFH is establishing a new Youth Advisory Group (YAG) to incorporate authentic youth voices and lived experiences into our program and policy work. Beginning in 2024, diverse youth from across the state will meet directly with Title V program staff to provide input and feedback on our youth-serving programs. [*AH, CYSHCN]*
- Title V staff participate in several interagency groups to support CYSHCN, including the NYS Council on Developmental Disabilities, the Deputy Commissioners' Cross-Systems Work Group, a new Pediatric & Obstetric Emergency Protocol Workgroup, and a new Pediatric Policy and Programs Cross-Agency Group**.** [*CYSHCN*]

Input from Families, Youth, & Community Members

Direct input from priority populations, especially families and youth, is a major emphasis for NY's Title V Program. Examples of how we integrate this across our programs include:

- In collaboration with the NYS Office of Health Insurance Programs, Title V staff are enhancing engagement with doula providers to inform expanded access to doula services, including new state Medicaid coverage for doula services effective April 2024. *[WMH, PIH]*
- With support from the ERASE Maternal Mortality grant, Title V staff are working with PICHC contractors and CBOs to host six listening sessions in Spring 2024 related to birthing experiences of communities disproportionately affected by maternal morbidity and mortality. *[WMH, PIH].*
- Under the same ERASE grant, in May 2024 DFH engaged IPRO to conduct key informant interviews with family members who have experienced a pregnancy-related death of a loved one, and to incorporate that information in the case summaries reviewed by the MMRB. *[WMH]*
- In conjunction with Hands & Voices NY, the EHDI program gathers input and feedback from parents through a survey administered in conjunction with family engagement and support events across the state. [*PIH, CYSHCN*]
- In addition to the Governor's Youth Council and new Youth Advisory Group mentioned above, local AH grantees engage youth in their programming and as paid advocates. [*AH*]
- DFH contracts with three Regional Support Centers (RSCs), which are required to employ parents of CYSYCN as Family Liaisons. The RSCs work with all LHDs to develop and implement tailored improvement plans to meet their community engagement goals. LHD CYSHCN programs are required to engage CYSHCN families in work groups and other local planning activities and their input informs local and statewide T&TA. *[CYSHCN]*
- A parent representative from *Parent to Parent of NYS* serves on the Title V Advisory Council. The OCFS-led Commissioner's Cross-Systems Work Group has begun holding periodic meetings with families. *[CH, AH, CYSHCN]*

III.C.1.b FINDINGS

III.C.1.b.i MCH Population Health and Wellbeing

Women's and Maternal Health. Maternal mortality improved steadily from 2018-2020, but provisional data for 2021 show a potential increase. The recently published statewide report confirmed that most cases of maternal mortality deaths are preventable. Moreover, stark racial disparities persist, and rural residents report poorer access to women's healthcare services.
The percentage of women with annual preventive visits continues to decline post COVID. However, the percentages of PICHC clients who have developed birth plans and of FPP clients with documented medical exams both increased, though the latter has not recovered from COVID losses. An increasing number of individuals seeking services indicate a primary language other than English.

Hemorrhage, embolism, and mental health conditions remain the leading causes of maternal mortality, and PICHC and MIECHV providers are requesting more training on suicide prevention, emergency response, and self-care. New York State has also experienced a significant increase in Severe Maternal Mortality (SMM) over the last 15 years that has disproportionately impacted racial and ethnic minorities.

Perinatal Health. Perinatal health outcomes have remained largely stable over the five-year cycle. The percentage of VLBW infants born in a level 3+ NICU has remained consistently high. The percentage of Newborn Bloodspot screenings received within 48 hours of collection has also started to recover from its COVID-19 pandemic related decrease. Infant mortality rates continue to improve overall, but racial disparities persist, with Black non-Hispanic children having nearly twice the rate of white non-Hispanic infants, driven by disparities in housing, employment, income, transportation, food security, stress, quality of medical care, social supports, insurance, and other factors.

Through the Growing Up Healthy Hotline (GUHH), individuals and families have requested information about ta multitude of services including Medicaid, the Food and Nutrition Program (FAN), and the Extended Syringe Exchange Program (ESAP).

Child Health. Outcome measures for children's health continue to recover from pandemic losses. SBHC providers report increased concerns about health care provider shortages, and the percentage of children enrolled in SBHCs who received anticipatory guidance on physical activity and nutrition has continued its negative trend.

Lifetime prevalence of asthma among children has decreased over the last year, but asthma-related ED visit rates for children have increased. The percentage of children who are obese continues to increase following a trend of fewer parents reporting that their children get 60 minutes of physical activity daily. Despite fewer children getting a preventive dental visit, the prevalence of tooth decay or cavities among children improved.

Adolescent Health. Indicators of adolescent health continue to reflect pandemic-related losses. Annual adolescent preventive health visit rates and HPV vaccination rates decreased throughout and after the pandemic. However, the percentage of youth programs that provide training on adult preparatory topics remaining consistently high, and the percentage of youth-serving programs that engage youth in program planning and implementation continues to increase to pre-pandemic levels.

Adolescent pregnancy rates continue to decrease, although providers have encountered emerging resistance to expanding sexual education topics in some school districts. Providers continue to report mental health as an area needing more resources to meet current demand. Despite this, suicide among adolescents continues to decrease. The percentage of adolescents who are obese has remained consistent. However, fewer adolescents are reported to be exercising 60 minutes or more daily.

CYSHCN. New York State families of CYSHCN continue to navigate recovery from the pandemic. The percentage of children identified as having special health care needs decreased over the last year, which we will monitor as a potential reflection of decreased screening. CYSHCN reported experiencing a higher rate of adverse childhood experiences. The percentage of NYS adolescents with special health care needs with a transition plan to adult care services has recovered from COVID and continues to increase. The percent of youth with sickle cell disease (SCD) served through our funded SCD program with transition plans has increased.

With the infusion of increased funding, LHDs are increasing their focus on CYSHCN and their families including through the promotion of accessible community spaces. Additionally, LHDs report that their ability to provide services continues to be limited by their inability to recruit and retain therapy providers.

III.C.1.b.ii Title V Program Capacity

III.C.1.b.ii.a. Organizational Structure

There have been no major changes to the Title V Program/ Division of Family Health organizational structure this year.

III.C.1.b.ii.b *Title V Agency Capacity*

As we continue the long recovery process from the COVID-19 pandemic, several changes this period positively affect state Title V capacity to provide and assure services for MCH populations:

- DFH contracts with statewide and regional centers that augment the agency's capacity to monitor, support, and learn from the work of local funded programs. [*WMH, PIH, AH, CYSHCN*]. Following mutual termination of a contract with the former PICHC T&TA provider, DFH requested approval to establish a new contract to ensure continuity of support, anticipated to start 7/1/24. During this transition period, DFH staff have engaged other subject matter experts to provide training on suicide prevention and promoted other resources and training opportunities. *[WMH, PIH*].
- As noted, a new monitoring contract with IPRO for selected programs began Fall 2023. [*All*]
- DFH was awarded a new HRSA State Maternal Health Innovation grant (2024-28, $2M annually), to conduct a maternal health-related needs assessment, establish a statewide maternal health taskforce, develop a preliminary strategic plan, conduct data system enhancements and innovations, and plan and implement innovative approaches to addressing maternal health issues. The innovation projects include a universal postpartum virtual home visiting model to provide birthing families with virtual visits and referrals for support services. [*WMH, PIH*]
- Through our collaboration with the Syringe Exchange Program, several FPPs are engaging in partnerships to support and provide referrals for individuals who use drugs. [*WMH*]
- Our recent assessment of FPP grantee reports, described in last year's NA Update, identified key themes related to staff retention and engagement, client experience, and reaching underserved populations. These inform QI/QA and T&TA for the program. [*WMH, AH*]
- New guidance for home visiting programs on best practices for referrals is in development, and information from the recent assessment of referral relationships with birthing hospitals has been shared with providers. Additional feedback from home visiting projects identified a common challenge in supporting families with a primary language other than English. We are exploring resources to help programs better support these families. [*WMH, PIH*]
- Resources on opioid use and neonatal abstinence syndrome have been developed through the NYSPQC learning collaboratives, including tools and resources for provider and patient education. Toolkits from the birth and NICU equity projects are in development. [*WMH, PIH*]
- Amendments to state regulations effective April 2024 have resulted in enhanced standards for newborn hearing screening and follow-up in the state. [*PIH, CYSHCN*].
- PICHC and MIECHV programs requested support for training staff on suicide prevention, emergency response, and self-care. From this, programs engaged with the NYS Office of Mental Health (OMH) to provide *Links to Hope* training planned for 2024. [*WMH, PIH]*

- 33 of our 37 FPPs participated in a project to enhance delivery of telehealth for sexual and reproductive health appointments, which we expect will increase telehealth visits and improve access to contraceptive and STI services, counseling, and preventive care. [*WMH, AH*]
- A procurement for new School-Based Dental Home grants was completed with new contracts starting July 2023, replacing the former school-based dental sealant program. The enacted state budget for 2024-25 includes additional funding for school-based dental services. *[CH]*
- The Pediatric Mental Health Care Access (PMHCA) grant from HRSA (2021-2026) is increasing youth access to mental health services by connecting SBHCs to children's mental health professionals through a partnership with the NYS Office of Mental Health's Project TEACH , which provides clinical consultation, telehealth mental health services, T&TA for SBHC. A key component is engaging youth and their families together in the provision of mental health telehealth services. [*CH, AH, CYSHCN*]
- New state legislation, adopted in 2023 with anticipated implementation in 2025, will establish a statewide Rental Registry program to require proactive lead inspections in rental units in multifamily dwellings built before 1980 in high risk areas of the state. [*CH, CYSHCN*]
- Several AH programs have reported resistance from school districts on delivering sexual health education, as part of wave of rising conservative advocacy with school boards. We are supporting providers to engage in relationship-building and education with school districts. [*AH*]
- As an outgrowth of our participation in a NYSDOH ACES workgroup, we continue to integrate work on trauma-informed practice and ACES across programs, trainings, and resources for local providers. [*CH, AH, CYSHCN]*
- There have been a series of CYSHCN program expansions. In 2022, we doubled grant funding for CYSHCN LHD programs, with a new requirement for minimum LHD CYSHCN staffing levels. In 2023 through a competitive procurement we increased the number of DOH-funded Sickle Cell programs from three to five, along with an increase in annual funding per program. Effective October 2024, a new statewide Center of Excellence for CYSHCN will replace the current three regional centers. This year the program also will conduct a competitive procurement to award a new state appropriation of $3 million for local CYSHCN work, with projects to begin in 2025. [*CYSHCN*]
- New state legislation signed by the Governor in December 2023 requires the state Health Equity Council to consider and issue recommendations to NYSDOH on promoting screening, education, and supportive services on sickle cell disease. [*CYSHCN*]
- The *Blueprint for Change* provides a framework to guide current and future work in support of CYSHCN and their families. All CYSHCN staff read the full Blueprint and each staff led a staff discussion of one article, including assessing how current work aligns with the Blueprint recommendations. We are developing a crosswalk between the Blueprint and current and planned CYSHCN domain action plan activities. [*CYSHCN].*

III.C.1.b.ii.c Workforce Capacity and Workforce Development

The MCH workforce at both state and local levels has been heavily impacted by the COVID-19 pandemic, retirements, inflation, stagnant wages, and shortages in specific professions (e.g., skilled nurses). Our Title V program is engaged in many approaches and initiatives to strengthen the capacity of the existing MCH workforce while continuing to invest in training the MCH workforce of tomorrow. We accomplish this through recruitment strategies, staff training and professional development, partnering with fellowship programs, and our innovative academic-practice partnership with the University at Albany School of Public Health's MCH Program. Please see section *III.E.2.b.i. MCH Workforce Development* for more detail on this critical work.

III.C.1.b.ii.d. State Systems Development Initiative (SSDI)

Please see *Systems Development Initiative* (SSDI) Update.

III.C.1.b.ii.e. Other data capacity

In addition to the SSDI-specific updates provided in *Section III.E.2.b.iii.b.*, we have strengthened our data capacity in other areas. Examples include:

- The new MHI grant funding, in conjunction with our NYSPQC AIM grant, will support capacity to conduct new data analyses, including deep dives in SMM, data matches between PRAMS and other administrative datasets, and deeper analysis of low-risk cesarean births. *[WMH, PIH]*
- The addition of CDC Family Planning and NYS-defined Sexual Violence measures to the BRFSS will provide additional insight to statewide health status and trends related to sexual health. *[WMH]*
- The regulatory changes for newborn hearing screening have improved documentation in the state EHDI Information System, which will help refine activities to promote timely screening and follow-up. [*PIH, CYSHCN*]
- The over-sample of National Survey of Children's Health for NYS will provide more robust information on a wide range of health & well-being indicators and potential disparities for NY's children and families, including CYSHCN. Title V data staff are traveling to CDC for additional training to facilitate analysis of the data. [*CH, AH, CYSHCN*]
- New web-based data systems for SBHC, SB Dental, and CYSHCN Programs will greatly increase capacity for data analysis and reporting to support statewide and local program activities. *[CH, AH, CYSHCN*].
- New state legislation requiring the establishment of a statewide Rental Registry program to require proactive lead inspections in rental units in multifamily dwellings built before 1980 in high risk areas of the state will enhance both data capacity and childhood lead poisoning prevention efforts. [*CH, CYSHCN*]

III.C.1.b.iii Title V Program Partnerships, Collaboration, and Coordination

Partnership and collaboration are core to our Title V work across all five domains and at every organizational level. We have selected a few examples to highlight the wide range of partnerships and collaborations our Title V program engaged in this year:

- The new federal Maternal Health Innovation (MHI) grant has led to new partnerships, with more expected as the project matures. NY Title V staff are engaging with other funded MHI programs to learn best practices from other states and have identified potential partner resources related to health equity. [*WMH*]
- Title V staff continue several key collaborations with the NYSDOH Division of Chronic Disease Prevention to promote children's health. Several additional SBHCs have joined the American Lung Association (ALA) asthma self-management program, DFH staff are expanding collaboration with the Bureau of Tobacco Control to promote vaping prevention initiatives and engage SBHCs in that area, and a previous effort to connect SBHCs with DOH-funded Creating Healthy Schools and Communities (CHSC) grantees in their districts has been revitalized. As one example of the latter collaboration, SBHC and CHSC grantees in Syracuse are working together with a local food pantry to expand access to healthy meals and food items for students and families. *[CH, AH, CYSCHN]*
- SBHC staff are partnering with the NYS Office of Mental Health (OMH) to update a crosswalk between OMH-approved Article 31 school-based mental health clinics and DOH-approved Article 28 SBHCs. DFH also partners with the OMH-funded Project TEACH to facilitate mental health consultation and referral support for SBHCs. *[CH, AH, CYSHCN*]
- Title V Adolescent Health staff have joined a NYSDOH Alcohol Surveillance Workgroup and an interagency Runaway Intervention Workgroup convened by the Division of Criminal Justice Services. [*AH*]
- The Lead Poisoning Prevention's partnership with the National Center for Healthy Housing provides access to a wide range of evaluation and technical assistance tools that are shared with local health departments. The program has also recently expanded its partnership with the Refugee Health Program, sharing data to better monitor health outcomes among refugee populations. [*CH, CYSHCN*]

- Title V CYSHCN staff continue to deepen and expand their collaboration with the NYS Office of Children and Family Services to support the OCFS-led HEARS Family Line, which provides families with resources and referrals to a variety of services and resources including food, clothing, housing, medical and behavioral health care services, parenting education, and child care, with messages available in 12 languages. As an outcome of the Deputy Commissioners Cross-Systems meetings in which CYSHCN staff participate, OCFS has expanded HEARS this year, and shares summary data on call volume and themes with us. [*CYSHCN*].

III.C.1.b.iv. Family and Community Partnerships

The preceding sections highlight many examples of how our Title V program partners with families and communities to support MCH. Please refer to the sub-section *Input from Families, Youth and Community Members* within *Section III.C.1.a Needs Assessment Process Updates*.

We would like to highlight one example of a recent family and community partnership from the CYSHYN program. As noted, every local CYSHCN program develops and implements a family engagement plan with support from the Regional Support Centers. This year the Erie County CYSHCN program planned and hosted a “Spring into CYSHCN” Family Resource Fair at the Explore & More Children’s Museum in Buffalo, NY. The museum space is customized with visual, social, communicative, sensory, and behavioral supports for families with different needs, including a universal changing table, elevators, wheelchair ramps, and sensory friendly rooms.

For this event, the Erie County CYSHCN program provided free admission to the museum, transportation assistance, and a nutritious meal for families. The Erie County Project Coordinator, Evanna Ramos, assembled a resource fair of community organizations based on needs identified through conversations with local families. Twenty-five community and government organizations engaged with attendees and enrolled and connected families with local services and programs. Featured vendors included Erie County Social Services, Parent Network of Western New York (WNY), Help Me Grow WNY, Mental Health Advocates of WNY, Lead716, and the Neurodiversity Network of WNY.

III.C.1.c. Identifying Priority Needs and Linking to Performance Measures

We are incorporating measures related to postpartum care and medical home consistent with the new universal National Performance Measures. look ahead to our next five-year Needs Assessment we will focus our attention to these measures and appropriate strategies and activities.

Click on the links below to view the previous years' needs assessment narrative content:

2024 Application/2022 Annual Report – Needs Assessment Update

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2021		2022	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$38,909,810	$39,701,635	$38,909,810	$37,088,652
State Funds	$29,285,355	$29,285,355	$29,285,355	$29,285,355
Local Funds	$55,602,278	$36,848,150	$35,897,127	$36,881,701
Other Funds	$0	$0	$0	$0
Program Funds	$16,735,967	$22,078,647	$21,713,525	$26,235,808
SubTotal	$140,533,410	$127,913,787	$125,805,817	$129,491,516
Other Federal Funds	$49,308,573	$44,826,458	$61,858,217	$49,502,087
Total	$189,841,983	$172,740,245	$187,664,034	$178,993,603

	2023		2024	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$38,909,810	$42,013,230	$38,909,810	
State Funds	$29,285,355	$29,285,355	$29,285,355	
Local Funds	$36,138,659	$47,689,009	$47,389,317	
Other Funds	$0	$0	$0	
Program Funds	$24,571,358	$17,789,263	$18,762,687	
SubTotal	$128,905,182	$136,776,857	$134,347,169	
Other Federal Funds	$62,282,555	$64,008,683	$66,910,483	
Total	$191,187,737	$200,785,540	$201,257,652	

	2025	
	Budgeted	Expended
Federal Allocation	$38,909,810	
State Funds	$0	
Local Funds	$71,957,219	
Other Funds	$0	
Program Funds	$21,296,337	
SubTotal	$132,163,366	
Other Federal Funds	$73,115,502	
Total	$205,278,868	

III.D.1. Expenditures

FY 23 Expenditures, including Title V MCHSBG, State appropriations, and other grant funding, demonstrate NYS's commitment to providing supports and services to NYS's women, children, and families. The State Allocation Plan is described in Section 504, Use of Allotment of Funds, and Section 505, Application for Block Grant Funds.

Expenditures, reflected in Form 2, confirm that NYS has continued to comply with the 30%-30%-10% requirements, as specified in Section 504(d) and Section 505(a)(3). The scope and comprehensiveness of services for NYS's MCH population are fully outlined and described in the FY 2023 report and FY 2025 application.

Title V MCHSBG funds supported primary and preventive health care services and infrastructure to continue to achieve the objectives for each State Priority in NYS's Title V State Action Plan. Initiatives. Programs, such as the Comprehensive Adolescent Pregnancy Prevention (CAPP), ACT Center for Community Action, and Family Planning and Reproductive Health Care Program, promote primary and preventive health care, preconception and interconception health, and physical, social, and emotional health and wellness for all individuals served. Programs such as the School-Based Health Center Program (SBHC) ensure access to health care for children and adolescents, also focusing on reproductive and behavioral health. The Lead Poisoning Prevention Program provides identification and follow-up for children at risk for or with high blood lead levels. The School-Based Dental Sealant Program promotes improved oral health for NYS's highest risk population. Programs that support specific populations, such as the American Indian Health Program, Perinatal and Infant Community Health Collaboratives (PICHC), and Migrant and Seasonal Farmworker Health, engage populations in health care across the life course. Title V MCHSBG funds supported monitoring of family planning, SBHC, and School-Based Dental Sealant programs to ensure services are provided in accordance with State and Federal requirements where applicable. Title V MCHSBG funds also support efforts to update NYS's standards for perinatal regionalization and efforts to identify and address those factors that result in maternal mortality and morbidity.

Title V MCHSBG funds, in conjunction with state and other federal funds, supports a rich tapestry of programs and initiatives developed to support NYS's Title V State Action Plan, and assist NYS to address the needs of women, children and families, including the overarching priority to promote health equity. NYS's Part C of the Individuals with Disabilities Education Action funding supports the administration of one of the largest Early Intervention Program in the nation. Grants such as HRSA's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program supports evidence-based home visiting and efforts to engage women and families into health insurance, interconception health, breastfeeding, parenting support, and a range of other supports and services. Funding provided through the Personal Responsibility Education Program (PREP) and Pregnancy Assistance Fund allows an expansion of adolescent programming to support the growth and development of children and adolescents. The HRSA Universal Newborn Hearing Screening and the CDC Early Hearing Detection and Intervention (EHDI) Surveillance grant augments the statewide newborn hearing screening program and supports enhanced efforts to track newborns lost to follow-up services. NYS leverages the Perinatal Quality Collaborative grant to support efforts to improve the quality of care provided to women and newborns in NYS's perinatal hospitals. The goal of NYS's Rape Prevention and Education (RPE) program is to decrease sexual violence and promoting healthy relationships among NYS's adolescents and young adults.

Supports and services to NYS's Children and Youth with Special Health Care Needs (CYSHCN) and their families are an essential component of NYS's Title V services. Through the Children and Youth with Special Health Care Needs Support Services (CYSHCN-SS) funding is provided for medical assessment of children with suspected health issues where there is no other source of financial support. Although all primary and preventive health care programs provide services to CYSHCN, NYS's Title V Program also oversees services specifically designed to serve CYSHCN. This funding supports staff in LHDs to respond to inquiries by families related to issues such as insurance coverage, assistance with services, family support and needed items for their CYSHCN. Support is provided to NYS's Wadsworth Center Laboratory that administers the statewide Newborn Metabolic Screening Program as well as specialty centers for individuals with genetic diseases and disabilities. NYS's Lead Poisoning Prevention Program focuses on environmental changes as well as identifying and supporting potentially lead poisoned children and their families. Programs such as NYS's SBHC provide

services to children, including CYSHCN that can result in decreased absenteeism, improved school performance, and better health outcomes. As stated in NYS's application, NYS's Title V MCHSBG program continues to focus improving supports and services for CYSHCN and their families. Information obtained from CYSHCN and their families will assist NYS's Title V Program to improve and enhance supports and services for CYSHCN in the coming years.

To calculate data on priority populations served by group (pregnant women, infants under 1 year of age, children ages 1-21 years, CYSHCNs and others) and by level of the MCH pyramid (direct health care services, enabling services, and population and infrastructure services), program managers provide information based on actual data collected from each program or provide an estimate for each of these categories. These data are compiled for Forms 3a and 3b. Expenditure reports are generated for the appropriate period and distributions by population and pyramid level are then calculated. NYS does not provide direct health care services using Title V funding except for limited funding through the Children and Youth with Special Health Care Needs Support Services. A rich health care coverage and service system in NYS results in very limited expenditures through CYSHCN-SS as NYS's direct care expenses remain less than 1%.

NYS's commitment to the MCH population is evidenced by the substantial State appropriation that is devoted to supports and services for NYS's women, children, including CYSHCN and families. Differences in state and local contributions from prior years are evident as NYS continues to promote enrollment into health insurance coverage for all New Yorkers, as well as to maximize the use of other state and federal fund sources to enhance services for the MCH population.

Overall, the actual expenditures for FY 23 appear more than originally projected. This is because multiple MCH grants are spent in the same time period due to the two-year spending period. Each award value remains fully obligated and will be fully dispersed by the liquidation deadline at the end of each year.

NYS's FY 23 application reflected a budget of over $24 million in Program Income, but actual expenditures were less than anticipated. This is likely related to the timing of the reporting by LHDs rather than an actual decrease in income.

NYS continues to be committed to identifying additional resources to serve NYS's MCH population. NYS's Title V Program has been very successful in accessing additional funding to develop the comprehensive system that currently exists in NYS, and a myriad of other grants support NYS's efforts to improve outcomes of all women, infants, and children, including CYSHCN and families across NYS.

III.D.2. Budget

This FY 2025 budget reflects NYS's commitment to Title V MCHSBG programs and services. NYS will continue to use FY 2025 Title V funds to support the implementation of NYS's Title V State Action Plan. Title V MCHSBG funds, in addition to State appropriation, Federal Medical Assistance Program (FMAP), and federal grant funds will continue to support programs and initiatives across all domains as described in the application section. This includes the development of substantial data analyses and reports to guide NYS's services for the MCH population. Support for efforts, such as maternal and infant mortality and morbidity surveillance and quality improvement efforts, to avoid these devastating outcomes is a priority. Enhancing NYS's efforts to identify those factors that result in maternal mortality and morbidity and addressing those factors will continue to be of importance in NYS's Title V MCHSBG program. NYS's Title V MCHSBG will continue interagency efforts to address maternal depression.

NYS will continue to move towards a greater understanding of comprehensive health, development, morbidity, and health disparities, social-emotional development in children and adolescents, and will promote and support efforts to ensure all NYS's children have the opportunity for healthy development. Information obtained through systems/care mapping has been used to develop enhanced systems for CYSHCN and their families. The Title V Program has increased its investment in the LHD CYSHCN program to provide more support to local staff who can connect with and support CYSHCN and their families. The Title V Program will also continue to invest in three regional technical assistance centers at the state's University Centers of Excellence in Developmental Disabilities (UCEDD). In NYS, the UCEDDs are the Westchester Institute for Human Development in Valhalla, Rose F. Kennedy Center at Montefiore Medical Center in New York City, and the Strong Center for Developmental Disabilities at the University of Rochester. These entities are federally designated by HRSA and established federally through a competitive application process to work with people with disabilities, family members, state and local government agencies, and community providers in projects that provide training, technical assistance, service, research, and information sharing. This investment will continue to assist NYS's Title V MCHSBG program to improve and enhance supports and services for CYSHCN and their families.

Overall efforts will continue to provide supports and services for children and adolescents, with a significant focus on physical activity and nutrition, social-emotional development, SBHCs and school-based dental programs, evidence-based home visiting services, oral health services, services for CYSHCN, and many other supports and services discussed throughout NYS's application. Paramount to the plan is the promotion of health equity for all across the life course.

Financially, the Title V Administrative budget of $2.6 million remains below the 10% limit for these costs. As in prior years, the NYS share for MCH services will continue to be considerable and will more than meet the requirements for state match. Expenditures for FY25 are expected to utilize the full allocation of $38,909,810. NYS continues to be fully committed to the health and wellness of all New Yorkers and will move forward in the comprehensive work as outlines in the Title V State Action Plan.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: New York

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

NYS's Title V Maternal and Child Health Services Block Grant program builds on years of leadership and public health investments. As a large state with well-developed health care, public health insurance, and public health systems, New York addresses Maternal and Child Health through a robust mix of public health programs, policy initiatives, and partnerships. One of the cornerstones and successes of the NYS Maternal and Child Health Block Grant is partnerships.

The Block Grant funding is critical to the NYS Department of Health ability to support the current needs and address the systemic issues that prevent people from birth through reproductive age from achieving equitable outcomes. Department staff serve as stewards for this funding to ensure that programs are located in the areas that have the least investment historically and that funds are utilized effectively, data are collected for accountability, and community feedback is continuously sought and incorporated. Department staff also serve as subject matter experts about issues, such as maternal health and mortality, infant health and mortality, child development, pediatric and adolescent physical health and mental health, oral health, reproductive and sexual health, and more. We are focused on individuals and on the population as we move upstream to address root causes of inequity.

To do the work to address root causes of inequity, we need to establish and maintain extensive partnerships, which requires human power and time. These partnerships include collaboration with other public health programs, other state agencies, and importantly with a broad array of external organizations ranging from large, sophisticated hospital and health care systems to small, grassroots community-based organizations. The Department is working towards more meaningful partnership with grassroots organizations, and part of this work includes moving toward sharing power.

In this application, NYS highlights efforts that have been undertaken to change the way we procure and build relationships and trust with grass roots community-based organizations. These are the organizations what know their communities and are trusted by their community. We funded 182 community-based organizations over the past 18 months. While the funding for these community-based organizations was not from the Block Grant, the infrastructure and staffing to apply for and provide leadership to this initiative was supported by the Block Grant. The funding was used to compensate them for their time and expertise as well as to allow them to implement the programs and activities that they know are needed in and by their specific communities. We are privileged that they would allow us to learn from them, and we worked hard to build and keep their trust. The Department's work with community-based organizations is highlighted in our *Success Story*.

Since NYS has such a robust system of care, benefits, and state funding, we do not utilize the Maternal and Child Health Block Grant to fund direct services. We prioritize funding to improve supports and services that help people know about and access health care as well as community-based services and to implement population health strategies. We accomplish this through contracts and community partnerships and through convening and policy. Block Grant funding supports internal state public health infrastructure and systems and, in combination with other state and federal funding sources, supports programs to maximize Maternal and Child Health outcomes. Key programs and partnerships are described in the *Title V Program Capacity* and *Title V Program Partnerships, Collaboration, and Coordination* sections of the five-year Needs Assessment Summary and the Needs Assessment Update in this year's application.

NYS's State Action Plan is driven by data, evidence, and input from stakeholders including families and youth. The life course model, drawn from HRSA's Maternal and Child Health (MCH) Bureau's seminal 2010 concept paper *Rethinking MCH: The Life Course Model as an Organizing Framework*, informed both the Needs Assessment and State Action Plan, and *The Blueprint for Change* informs its ongoing evolution. NYS's State Action Plan aims to translate life course and *Blueprint for Change* concepts into an integrated portfolio of actionable, effective, and measurable strategies to improve Maternal and Child Health outcomes and equity across the state. The State Action Plan flows directly from the state's five-year Needs Assessment and subsequent Needs Assessment updates and from the State Priorities and the National and

State Performance Measures selected in response to the Needs Assessment.

NYS's State Action Plan established quantitative five-year targets for objectives, based on analysis of data trends and projected impact of strategies; these targets are revisited annually. Initial five-year strategies and associated Evidence-Based/Informed Strategy Measures (ESM) are updated and refined annually to reflect evolving and emerging needs, progress, and lessons learned. In selecting and refining strategies, key considerations include evidence base, feasibility, and alignment with stakeholder priorities, with attention to advancing a balanced portfolio of population health surveillance and data analysis, policy and systems, workforce development, community-based prevention, and clinical quality improvement strategies. Across all of these, we continue to deepen our commitment to centering the voices and experiences of affected populations, and to advancing health equity.

Organizationally, this work continues to be led by cross-programmatic Maternal and Child Health Services Block Grant staff teams. These teams are especially effective for driving progress in domains and strategies that do not have a single 'home' within the Division of Family Health or a specific the NYS Department of Health. As evidenced in the Annual Report and Application section, NYS continues to make substantial progress implementing defined strategies, despite the significant challenges of the past four years. This is accomplished through direct oversight and administration of key Maternal and Child Health programs, as well as our role as convener and collaborator. We continuously seek to engage external partners at all levels to enrich the programs, while simultaneously seeking to bring the voice of our community, especially those who have been marginalized, to initiatives regardless of the source of funding.

The Department acknowledges that there are profound and long-lasting disparities in Maternal and Child Health outcomes. We have a lot of work to do. As we prepare for the next grant cycle and embark on our newest Needs Assessment, we will ensure that the community is at the center driving the work of the Block Grant, that we are held accountable through quantitative and qualitative evaluation, and that we push further upstream addressing root causes of inequity, even as that work requires us to move into newer, more unfamiliar areas of housing, transportation, and economic stability. The Department has taken a leading stance on the need to ensure equity; it created the Office of Health Equity and Human Rights. Department staff have received training so we can do the work we need to do to understand our own biases, as well as historical and institutional racism, sexism, ableism, and other conscious or unconscious beliefs that impact people's belonging, inclusion, and equity.

The importance of the Title V Maternal and Child Health Services Block Grant cannot be understated. This funding allows for the scaffolding and the infrastructure of the Maternal and Child Health work of the Department as well as the requirement to engage the community to lead the work, and the flexibility to evolve in the ways we know are needed based on our training and community voice.

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

A strong and diverse Maternal and Child Health workforce is needed to meet the needs of NY's population birth through reproductive age. The rapidly evolving U.S. health care and public health systems, mass retirements in the Maternal and Child Health workforce, persistent disparities in key Maternal and Child Health outcomes, and commitment to balancing equity-driven and evidence-based practice, all emphasize the need for a diverse, well-trained, and flexible MCH workforce that includes people with lived experience. Title V programs must continuously consider the needs of the current workforce while simultaneously investing in developing the workforce of tomorrow.

At the community level, most Maternal and Child Health services and programs are implemented by local partners including local health departments, universities and academic medical centers, hospitals and clinics, and community-based organizations. At the state level, Department staff, who are funded by the Title V Maternal and Child Health Services Block Grant, oversee and facilitate local programs through developing program models and guidelines, monitoring the responsible allocation and administration of available funding, and supporting effective implementation through training, technical assistance, data systems, and evaluation. Title V staff also play a key leadership role in convening partners; analyzing, developing, and implementing statewide Maternal and Child Health policy; and ensuring that the Maternal and Child Health perspective is represented in a wide range of program and policy initiatives within and beyond the NYS Department of Health.

The COVID-19 pandemic created unique workforce challenges as the focus of programs rapidly shifted to address new needs and barriers for Maternal and Child Health populations and staff adjusted to remote work environments and temporary redeployments. In the aftermath of the pandemic, we have faced many staff vacancies due to retirement and staff taking new positions, a loss of institutional memory and staffing capacity, and the challenge of adjusting to a hybrid work environment. While there have been challenges in rebuilding our workforce, this year we have filled many vacant positions and secured several new positions. Although the pandemic created many challenges, it also facilitated many unique professional development opportunities for staff to apply and expand their knowledge and leadership skills. We are exceptionally proud of how our staff have embraced and excelled in meeting these challenges to support the health of New Yorkers.

Our Title V program supports a continuum of strategic approaches to nurture the professional development and capacity of the state's Maternal and Child Health workforce for today and tomorrow:

Supporting professional development of the current Maternal and Child Health workforce. Within the Department of Health, we prioritize recruiting, retaining, and supporting the continuous professional development of a diverse and competent staff. All new Division of Family Health staff complete a series of virtual orientation modules, which are focused on the Title V program and role of each organizational unit within the Division as well as other competencies like health literacy and equity. Through their day-to-day work and involvement in collaborative cross-program domain teams, staff are engaged in planning and implementing all steps of our Title V process, from needs assessment to strategic plan development and implementation to monitoring and evaluating Maternal and Child Health programs. We encourage staff participation in a Department-wide mentoring initiative and notify staff of promotional opportunities including job postings and civil service test announcements. Title V funds support staff training and attendance at national and regional conferences, such as the Association of Maternal and Child Health Programs, City Match, and NYS Perinatal Association, as well as professional development activities offered by our partner Maternal and Child Health Program at the University at Albany (UAlbany) School of Public Health (SPH). We encourage Title V-funded local programs to include similar professional development activities in their grant budgets to support their staff.

As emphasized throughout this application, our Title V program is committed to supporting health equity and justice for all New Yorkers. To accomplish this, the Division of Family Health has pursued several key strategies to integrate awareness,

understanding, and practices to advance health equity across all staff, programs, and policies. In 2018 the Division established an internal Health Equity team, which compiled a comprehensive health equity curriculum with pre- and post-evaluation modules hosted on the Department's learning management system. All existing and incoming staff from entry level through top management are required to complete the series. In addition, Title V staff participate in an interagency Racial Justice Workgroup within the Center for Community Health. This workgroup is leading a multi-year effort to translate racial justice into action, including innovative training interventions to build the capacity of health and human services providers, health care facilities, and community-based organizations to employ a health equity framework. In July 2022, the Department of Health established a new Office of Health Equity and Human Rights. This office focuses on addressing health disparities and improving diversity, equity, and inclusion within the Department, and is a resource for programs across the entire Department to achieve common goals of equitable health for all New Yorkers.

NY HELPS Program. Recruiting qualified candidates to fill positions has been a challenge in the aftermath of the pandemic across state agencies. To help agencies fill the thousands of vacant positions under recruitment, the NYS Department of Civil Service developed the NY Hiring for Emergency Limited Placement Statewide (NY HELPS) Program. This program streamlines the appointment process to allow state agencies to hire diverse, qualified permanent employees quickly. Traditionally, the titles filled under the NY HELPS Program required job candidates to take competitive examinations to be considered for employment, but under HELPS these titles will be filled via non-competitive appointment for candidates that meet the minimum qualifications of the titles for which they apply.

Statewide Centers of Excellence. To augment state Title V staff support for local programs we have established statewide Centers of Excellence that provide training and technical assistance to local family planning, perinatal health, lead poisoning prevention, adolescent health, and Children and Youth with Special Health Care Needs (CYSHCN) programs. These centers support access to informational resources and practice support tools, facilitate ongoing access to experts in the field, provide training and technical assistance, lead structured quality improvement projects, and translate emerging research and best practices to support effective implementation of Maternal and Child Health programs and services. The Centers serve as invaluable resources to both local and state Maternal and Child Health staff. For example, the Regional Support Centers for CYSHCN have created a portal for program-specific trainings and other resources, and the centers work directly with Local Health Departments to develop and update their county-specific family engagement plans. The Centers of Excellence also have family members of CYSHCN on staff and serve as a resource for families and Local Health Departments. The ACT for Youth Center for Community Action provides training, technical assistance, and evaluation for adolescent health initiatives, including maintaining detailed evidence-based program implementation toolkits for Comprehensive Adolescent Pregnancy Prevention program and Personal Responsibility Education Program providers.

Partnerships and Collaborations. Working across programs and disciplines is critical to addressing the root causes and social determinants of health underlying health disparities and helps to build knowledge and resources for our current Title V staff and programs. In addition to the many formal and informal partnerships described in the preceding *Needs Assessment Update* section, we continue to operationalize this cross-sector approach through our Title V domain teams. For example, this year staff from lead poisoning prevention, newborn bloodspot screening, and asthma programs outside of the Division of Family Health have formally joined the Title V domain teams.

Working with Fellowship Programs. To augment our current state Maternal and Child Health workforce capacity we partner with several key fellowship programs described below. Fellows work side-by-side with Division of Family Health staff to enhance our capacity for assessing and addressing critical Maternal and Child Health needs and advancing priority projects.

NYS Public Health Corps Fellowship. The New York State Public Health Corps (NYSPHC) Fellowship Program was established in 2021 by Governor Hochul to build public health capacity and support during the pandemic and increase preparedness for future public health emergencies, both by increasing our workforce capacity today and by investing in the development of promising emerging public health professionals for the long term. Over 1,000 fellows were recruited and deployed to participate and use their talents and expertise to help advance the State's public health agenda while serving

their communities. Fellows work in specific assigned projects and participate in educational webinars, networking, mentorship, summits, and seminars as they grow as public health professionals.

In the first phase NYSPHC, the Division of Family Health hosted two fellows. Cecelia Guthrie worked on communication efforts for the New York State Perinatal Quality Collaborative, developing resources such as presentations, newsletters, and educational materials for pregnant people and their providers to further support positive health outcomes. She also contributed to projects focused on birth equity, opioid use disorder in pregnancy, and Neonatal Intensive Care Unit (NICU) equity. Avinash (Avi) Lekram was engaged as a Health Education Outreach Specialist to support the Bureau of Perinatal Reproductive Adolescent and Sexual Health, focusing on reproductive health and perinatal health to help advance equity. Some of their projects include updating a bill of rights for people who have experienced sexual assault and assisting with the planning of a first of its kind reproductive justice symposium. Both Cecelia and Avi entered the NYSPHC as recent graduates of the UAlbany SPH, where they both earned their Master of Public Health (MPH) degrees and Certificates of Graduate Study in Maternal and Child Health. Following their fellowship placement, Avi was hired in the Division of Family Health to support the new Pediatric Mental Health Care Access grant, through which they are leading the establishment of our new Youth Advisory Group among other priority activities.

In the second phase of NYSPHC, since July 2023 the Division of Family Health has hosted Isa Brackett, MPH as a Senior Health Program Coordinator. Isa is supporting work to produce a legislatively mandated report on Limited-Service pregnancy Centers (LSPCs) in New York State. They have conducted research to identify and compile a spreadsheet of over LSPCs in NYS based on affiliation and geographic locations, helped create a survey that was disseminated statewide to all identified LSPCs, completed a literature and policy review relating to LSPCs studies and legislation, and assisted in geo-mapping of the LSPCs locations. Additionally, Isa has contributed to the development of a family planning campaign to promote Title X Family Planning services and increase general knowledge of the services provide under Title X, and reviewed grant applications for the Sexual Risk Avoidance Education Program which includes program and budget evaluation reviews. Isa was hired in the Division of Family Health as a Health Program Administrator to support the Family Planning Program.

CDC Foundation State-Funded Project. The CDC Foundation is an independent not for profit organization that helps the Centers for Disease Control and Prevention (CDC) work more effectively with partners through philanthropic and private sector resources. In 2021, the Foundation established a State-Funded Projects program to assist health departments across the country in rapidly mobilizing state responses to address the ever-changing demands of emergency response. The Division of Family Health is fortunate to have secured one fellow, Cora Mann, through the program. Cora is assisting with maternal morbidity and mortality data collection and analysis to understand the scope, trends, causes, demographics, and geographical differences of maternal morbidity through sophisticated analysis of hospital discharge data in the Statewide Planning and Research Cooperative System (SPARCS) and birth data. She is leading the Division's efforts to examine the data and prepare reports and presentations that will be used to inform policy and program activities.

CDC MCH Epidemiology Program. Since 2022 Blair Berger, PhD, MSPH, a Senior Epidemiologist in the Maternal and Child Health Epidemiology Program at the CDC Division of Reproductive Health, Field Support Branch, has served as the CDC Maternal and Child Health Epidemiology Assignee to New York State. In her role, Dr. Berger advances and strengthens NYS Maternal and Child Health data, evaluation, and quality improvement initiatives through her subject-matter expertise in maternal, perinatal, and reproductive health and her methodological expertise in epidemiologic surveillance and evaluation, data linkage, advanced biostatistics, demography, mixed-methods and qualitative research, complex survey analyses, and measurement validation. She works extensively with large secondary state public health data systems, like vital statistics and hospital discharge records, as well as primary survey data collected by the NYS Perinatal Quality Collaborative, to support Maternal and Child Health policies and programs in NYS. Within the Division, Dr. Berger leads state surveillance and research activities on severe maternal morbidity to support the NYS State Maternal Health Innovation Program, and she has leadership roles guiding and implementing scientific approaches for the NYS Maternal Mortality Review Initiative and the NYS Perinatal Quality Collaborative projects focused on improving birth equity, family-centered neonatal intensive unit care, and opioid use disorder during pregnancy.

***NYS Fellowship in Applied Public Health*.** This year our Title V program continued to partner with the NYS Fellowship in Applied Public Health (FAPH), a leadership development initiative jointly sponsored by the NYS Department of Health and UAlbany SPH. Fellows are physicians and other advanced licensed health care professionals seeking to transition from clinical to public health practice and leadership roles. In addition to completing the Mater of Public Health (MPH) degree, fellows complete a year of full-time practicum placements within the NYS Department of Health and one Local Health Department. This year the Division of Family Health is hosting and mentoring two FAPH fellows. Dr. Ishani Choksi, a pediatric endocrinologist, is working with the Division's Bureau of Child Health to update guidelines for the School Based Health Centers Program and with the Family Planning Program to update guidelines for the Infertility Reimbursement Program. Tristan Sharratt, a Family Nurse Practitioner who recently completed his MPH degree through FAPH and previously completed a 3-month practicum in the Division's Family Planning Program to enhance services and supports for LGBTQ+ and people with disabilities, is rejoining the Division for a full year as an Advanced Fellow to support the upcoming five-year comprehensive Needs Assessment and other Title V projects. A third fellow Carrie Gordon-Stacey, who is a licensed midwife, is starting the fellowship in Fall 2024 and plans to complete at least one practicum rotation in the Division of Family Health.

Empire State Fellows Program. The Empire State Fellow Program is a full-time two-year leadership training program that prepares the next generation of talented professionals for careers as NYS policy makers. While taking part in the work of government, Empire Fellows participate in educational and professional development programs that will help them to serve as effective and ethical government leaders. The Division of Family Health currently hosts Kerline Destin, who is leading a project to chair a small working group and develop a communication guide for birthing people to improve their interactions with providers. Kerline will also be leading work on a state measure for our Title V action plan related to the communication guide. In addition, Kerline is an active member on the Division's Social and Emotional Workgroup and participates in ongoing work in the Division's Bureau of Health Equity and Community Engagement.

Academic-Practice Partnership with UAlbany School of Public Health. The UAlbany School of Public Health (SPH) was jointly founded by UAlbany and the NYS Department of Health nearly 40 years ago. In 2015, as an outgrowth of this foundational partnership, the SPH established an academic Maternal and Child Health training program with initial grant funding from the federal HRSA MCHB MCH Catalyst initiative. Rachel de Long, MD, MPH, a Clinical Professor at SPH and former NYS Title V Director, and Christine Bozlak, PhD, MPH, Associate Professor at SPH, serve as co-directors for the SPH MCH Program. Consistent with the federal MCH Catalyst Program goals, the SPH MCH program seeks to develop an increased focus on Maternal and Child Health within the university and to prepare students for Maternal and Child Health careers, with priority for students from diverse and underrepresented backgrounds. The program offers academic Maternal and Child Health courses, funds internships in the field of Maternal and Child Health for SPH graduate students, supports student and faculty travel to conferences, and facilitates a wide array of professional development opportunities for students, faculty, and practitioners. A certificate of graduate studies in Maternal and Child Health launched in the 2019-20 academic year has grown rapidly, with over 60 graduates to date and over 30 students enrolled as of June 2024.

From its inception, the partnership with the state's Title V program has been a distinguishing strength of the SPH MCH Program. Since Dr. de Long transitioned from her role as Title V Director to a full-time position at SPH, the MCH and Title V programs have continued to strengthen and expand the collaboration under Dr. Siegenthaler's leadership. In 2018 we established a Memorandum of Understanding (MOU) to implement a one-time Women's Health Initiative funded by the state legislature. That MOU was extended in 2019 to support faculty and student assistance with the Title V five-year Needs Assessment, and in 2021 we established the current five-year MOU detailed below. This academic-practice partnership was highlighted in a poster presentation at the 2023 AMCHP conference and in the National MCH Workforce Development Center's Winter 2024 Academic-Practice Partnership Newsletter.

The Academic-Practice Partnership between NYS Title V and SPH MCH Program encompasses several key approaches to support development of both the current and future MCH workforce:

- **Technical Assistance.** With support from our MOU, Dr. de Long dedicates a portion of her time to providing technical

assistance for the state's Title V grant. She participates in overall application framing and planning, works directly with the five Title V domain teams to gather and synthesize information for the five-year and annual Needs Assessments, and assists in writing other sections of the application. Throughout the year, both co-directors consult with the Division of Family Health on a variety of topics and facilitate connections with other faculty related to applied research and evaluation opportunities.

- **Teaching and professional development**. Title V staff engage regularly with SPH students both in and out of the classroom. The SPH MCH program co-directors incorporate options for student project topics related to state Title V priorities, and, with student permission, share the products with Title V staff to inform their work. In addition, Title V staff participate in seminars, networking events, community service projects, and other professional development activities hosted by the SPH MCH program, and in turn invite SPH MCH program staff to join relevant sessions convened by the NYS Department of Health. This approach creates an environment of shared learning and professional development, in which Title V staff, faculty, and students are engaged in professional development alongside one another, with different partners 'in the lead' for different activities and often functioning as both teachers and learners at the same time.
- **Student internships.** Applied field experience is a cornerstone of public health professional training. MPH and DrPH students at UAlbany are required to complete 720 hours of internships or practicums, providing a critical opportunity to expose them to state level Maternal and Child Health work and career opportunities. The Division of Family Health funds and hosts up to 18 graduate student interns annually (6 per semester). Through the MOU, students are hired by SPH and assigned to the Division staff as project mentors. This allows students to apply what they are learning in the classroom to real-world issues and settings, while developing essential public health skills and contributing to meaningful initiatives and products. It also expands the capacity of our Title V program to advance priority projects and provides Title V staff – many of whom are SPH graduates - with the opportunity to serve as mentors, which is critical to their own professional development. In addition to their core projects, students receive orientation to Title V and the Division, have opportunities to network with other students and staff, and benefit from direct guidance on how to pursue employment within the Division of Family Health and the Department of Health through both civil service and grant-funded opportunities.

  Since 2019 we have funded and mentored 48 graduate students within the Division of Family Health who supported over 30 distinct priority Maternal and Child Health projects across all five Title V domains. Several of the students we hosted are now employed in the Division or other organizational units at the Department, demonstrating the value of our investment in the future Title V workforce. We will host five students in Summer 2023, focusing on projects related to infant mortality, Maternal and Child Health disaster preparedness, CYSHCN, and Maternal and Child Health workforce development. See ***Supporting Document 5*** for a complete list of Title V-funded internships to date (2019-2024).

As we look forward, our Title V program will continue to prioritize development of the current and future Maternal and Child Health workforce development through our staff development activities and partnerships. As part of our academic-practice partnership with the UAlbany SPH MCH Program, we will be coordinating and sharing information about Maternal and Child Health workforce strengths, needs, and opportunities for our mutual Needs Assessments going into respective next five-year funding cycles.

III.E.2.b.ii. Family Partnership

The NYS Title V Maternal and Child Health Services Block Grant Program has a long history of partnering with consumers, including families and family organizations to ensure family voice across the state's Maternal and Child Health initiatives.

The NYS Title V Maternal and Child Health Services Block Grant Program ensures there is a family voice represented in the State's Maternal and Child Health services and programs, through our local partners including Local Health Departments, universities and academic medical centers, hospitals and clinics, and community-based organizations. When procuring services, the Division of Family Health requires local partners that receive contracts to ensure ongoing involvement and feedback is received from consumers who represent the diverse Maternal and Child Health population served in their community. Community involvement may take the form of membership on a board to guide services, workgroups to provide input regarding education materials or outreach strategies, or direct input from families served either from a survey or in-person listening forums. In a state the size of NYS, obtaining input through provider organizations or other organizations representative of the population is the most practical, meaningful way to obtain input from the state's large, diverse population.

The Division was recently awarded a federal grant from HRSA for Pediatric Mental Health Care Access. The grant is focused on enhancing mental health care access in the state's School Based Health Care Centers through a collaboration with the NYS Office of Mental Health's Project TEACH. One of the goals of this grant is to increase the use of and quality of telehealth to support mental and behavioral health services. The grant supports funding for the New York School Based Health Alliance which is going to School Based Health Centers to engage in person with families, students, and professionals in the school to understand their knowledge about and acceptance of accessing services through the School Based Health Center and by telehealth as a modality of care.

The NYS Children and Youth with Special Health Care Needs (CYSHCN) Program requires the three University Centers of Excellence in Developmental Disabilities (UCEDDs), which are the state's Resource Support Centers that provide technical support and assistance to counties, employ a parent/family member/caregiver of a child or youth with a special health care need to ensure that families can talk to a trusted messenger and that the programs' supports and services meet family's needs. The Local Health Departments' Children and Youth with Special Health Care Needs Program work plan requires that they provide program outreach and awareness regarding the local Children and Youth with Special Health Care Needs Program, gap-filling programs, and community resources. The goal of these activities is to empower families of Children and Youth with Special Health Care Needs and youth/young adults with special health care needs to navigate the systems of care. All 51 local contractors are required to report quarterly on their activities in this area.

The NYS Early Hearing Detection and Intervention Program engages families through their Advisory Council, which has multiple family members serving, and a contract with Hands and Voices. The Advisory Council meets quarterly and elicits input and feedback from family members. The contract with Hands and Voices is supporting opportunities for families and children who are deaf or hard of hearing together to come together for fun activities, to learn about resources, and to connect and support each other.

The NYS Early Intervention Program's ensures there is a family voice through its State Systemic Improvement Program quality improvement initiative. The goal of this quality improvement initiative is to improve family outcomes in the Early Intervention Program's service delivery system. The Early Intervention Program convenes an Advisory Group which includes family members who provide their feedback and ideas for improving the system. In addition to the quality improvement initiative, the Early Intervention Program funds the Family Initiatives Coordination Services Project that coordinates the development and implementation of a variety of family initiatives including training and support for parents involved in the Early Intervention Program to become advocates for special needs children at local, state, and national levels continues. The Family Initiatives Coordination Services Project includes a training for parents over two weekends to provide skills in advocacy and leadership as well as support to engage locally or at the state level as family voices. The Early Intervention Program has an Early Intervention Coordinating Council, required by federal and stat statute, that includes

family members, many of whom participated in the Family Initiatives Coordination Services Project training.

Division of Family Health staff participate in the Early Childhood Advisory Council, overseen by the NYS Council on Children and Families (CCF). This Council has recruited and is supporting parents/caregivers as members of the Council and to provide guidance and review of State-led Maternal and Child Health programs. The Council on Children and Families was awarded the Preschool Development Grant Birth to Five (PDGB5) and has established a Parent Advisory Council through Prevent Child Abuse NY. The Division has worked with the Council and Prevent Child Abuse NY to engage with parents on activities.

The Title V Children and Youth with Special Health Care Needs Director, Suzanne Swan, is a member of the Council on Developmental Disabilities (previously called the Developmental Disabilities Planning Council) which prioritizes engaging the family voice. Ms. Swan as a member shares information learned in that Council to support the Title V Children and Youth with Special Health Care Needs work.

The Maternal and Child Health Services Block Grant Advisory Council includes the family perspective. Michelle Juda, executive director of Parent to Parent of NYS, has been designated as a member of NYS's Maternal and Child Health Services Block Grant Advisory Council and NYS's family representation to the Association of Maternal and Child Health Programs. Ms. Juda provides valuable input to guide policy and practice and actively engages with her organization and parents to ensure their voices are included in the discussion and work to support families with Children and Youth with Special Health Care Needs. Ms. Juda has been a member for many years and is very active with the Advisory Council. She has also collaborated with Department staff on other special projects.

In the upcoming Needs Assessment, the Department is planning to engage families and people in the community with lived experience, including through the newly funded community-based organizations highlighted in the *Success Story* as we begin to assess and plan for the next five-year Title V grant cycle.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

Maternal and Child Health data are critical to the effective, efficient, and equitable implementation and improvement of Maternal and Child Health programs, services, and policies. Descriptions of the data systems and sources that inform NYS's Title V Maternal and Child Health Services Block Grant work are provided in the *Other MCH Data Capacity Efforts* Section.

The Division of Family Health relies on a strong workforce comprised of data analysts, epidemiologists, evaluation specialists, program research specialists, programmers, and research scientists to develop, maintain, and utilize our various Maternal and Child Health data systems, to evaluate and improve our programs and to monitor ongoing and emerging priorities.

This workforce includes both staff within the Division of Family Health and partners in other NYS Department of Health organizational units. While staff are funded by different funding sources, including Title V Maternal and Child Health Services Block Grant, State Systems Development Initiative, other federal grants, and state funds, data staff collaborate with other data staff as well as program staff to meet the needs of our Title V Maternal and Child Health Services Block Grant Program and the Department's Maternal and Child Health initiatives overall.

As of June 2024, NYS's Maternal and Child Health epidemiology workforce within the Division of Family Health included 45 staff with the titles and funding sources outlined in the table below.

The Division of Family Health has greatly expanded its capacity since the last reporting period. This is a result of filling vacancies, an additional state position allocated to the Division, and new federal grants, such as the Pediatric Mental Health Care Access and the State Maternal Innovation grants, that have been awarded.

Division of Family Health Staff with Maternal and Child Health Epidemiology-related Titles by Funding Source.

	Funding Source					
Maternal and Child Health Epidemiology-related Titles	Title V	State Systems Develop. Initiative	Other Federal Funding	Contractor	State Funded	Total
Epidemiologist	1					1
Evaluation Specialist			1			1
Program Research Specialist	3	1	7			11
Programmer				3		3
Project Manager				2		2
IT Specialist				3		3
Research Scientist	9		13	1	1	24
Total	13	1	21	9	1	45

Beyond the Division of Family Health, there are staff with similar titles throughout the NYS Department of Health that support programs receiving Title V Maternal and Child Health Services Block Grant funds, such as Newborn Bloodspot Screening in the Wadsworth Laboratory, Office for Public Health Practice which oversees the Maternal and Child Health Dashboard and the Prevention Agenda Dashboard (that includes the 'Promote Healthy Women, Infants, and Children' section, as well as data surveillance systems like the Pregnancy Risk Assessment Monitoring System, the Lead Poisoning Prevention Program in the Center for Environmental Health, and Comprehensive Services and Health Systems Approaches to Improve Asthma Control in Division of Community Chronic Disease Prevention.

Examples of Department staff outside of the Division of Family Health that support Maternal and Child Health efforts but are not Title V Maternal and Child Health Services Block Grant funded include data staff who are located organizationally in the Department's Office of Health Insurance Programs and the Office of Health Services Quality and Analysis (formerly the Office of Quality and Patient Safety) and who manage critical data sources, such as vital statistics, Medicaid claims, and hospital discharge data.

Other state agency partners outside of MYS Department of Health support Maternal and Child Health epidemiological efforts. The NYS Council on Children and Families developed the Kids' Well-being Indicators Clearinghouse (www.nyskwic.org), which aims to advance the use of children's health, education, and well-being indicators as a tool for policy development, planning, and accountability. The NYS Department of Health is a member agency of the Kids' Well-being Indicators Clearinghouse and provides data to the clearinghouse. Programmers contracting with NYS Office of Information Technology update, fix, and test NYS's Vital Records data systems.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

One of the main objectives of the State Systems Development Initiative (SSDI) is to build and expand NYS MCH data capacity to support Title V Maternal and Child Health Services Block Grant (MCHSBG) activities and contribute to data-supported decision making in MCH programs, including assessment, planning, implementation, and evaluation. The importance of New York State Department of Health (NYSDOH) data capacity is recognized as critical to identifying needs of the population, including the impact of structural racism. Improving data integration and utilization allows for greater ability to assess trends in outcomes, including health disparities.

The State's progress in completing its workplan that aligns with the four goals of the SSDI program

***Goal 1: Strengthen capacity to collect, analyze, and use reliable data for the Title V MCH Block Grant to assure data-driven programming*.**

The SSDI PI, SSDI coordinator, and other staff guide the collection and analysis of the data that forms the basis for the Five-Year Needs Assessment and the State Action Plan. Collectively these describe NYS's priority needs, key strategies and activities, and National Outcome Measures (NOMs), National Performance Measures (NPMs), State Performance Measures (SPMs), and Evidence-Based or -Informed Strategy Measures (ESM). Staff partner with stakeholders to review and discuss relevant MCH data and recommend structural and process measures used to monitor progress in all MCH population domains.

In 2024, Title V and SSDI data staff led the development, selection, refinement, and tracking of data and performance measures associated with the MCHSBG priorities to track progress towards achieving reported goals. SSDI and other Title V data staff assisted with the coordination of data collection of NOMs, NPMs, SPMs, and ESMs both within and outside the DFH; contributed to ad hoc data analyses; and wrote summaries of data analyses relevant to the MCH population for the MCHSBG Application/Annual Report. These activities support Title V MCHSBG analysis of the NPMs and related structural/process objectives as part of the MCHSBG Application/Annual Report.

Staff have been assisting with a plan to improve data linkages across the five-year SSDI funding cycle. During the reporting period, staff continued to perform a gap analysis based on amended or added Core/State Dataset (CDS) elements. New York State is currently reporting seven of the Core/National Dataset elements and six of the CDS elements as part of the MCHSBG.

Goal 2: Strengthen access to, and linkage of, key MCH datasets to inform MCH Block Grant programming and policy development, and assure and strengthen information exchange and data interoperability.

NYS has a strong commitment to data systems development and invests in infrastructure to promote data linkages and timely reporting. The following data sources are provided by partners to allow SSDI and other Title V staff to assess, monitor, and evaluate Title V programming in NYS: Newborn Screening Program data; Vital Records (births, deaths); New York City Vital Records; Statewide Perinatal Data System (SPDS); Children and Youth with Special Health Care Needs (CYSHCN) Program ; Early Intervention Program (EIP); Behavioral Risk Factor Surveillance System (BRFSS); Youth Behavioral Risk Factor Surveillance System (YBRFSS);Centers of Disease Control and Prevention (CDC) Pregnancy Risk Assessment Monitoring System (PRAMS) and Maternal Mortality Review Information Application (MMRIA); Immunization Information System; NYS Medicaid; NYS Quality Assurance Reporting Requirements (QARR); Statewide Planning and Research Cooperative System (SPARCS); National Survey of Children's Health (NSCH); Early Hearing Detection and Intervention (EHDI) Program; CDC Breastfeeding Report Card; National Immunization Survey; Sexually Transmitted Disease Surveillance; United States Current Population Survey; National Pediatric Nutrition Surveillance System; School-based Health Center (SBHC) Program; Statewide Health Information Network in New York (SHIN-NY); Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES); Project TEACH; American Community Survey (ACS); and United States Census data.

The SSDI Principal Investigator, the SSDI coordinator, and other DFH data staff have continued several efforts to increase data capacity and advance the development and utilization of linked information systems between key MCH datasets in NYS to improve access to electronic MCH health data. Below are data linkage projects:

- Birth and Infant Death Data
- Birth, Death and Hospital Discharge Data for Maternal Mortality and Morbidity
- All Payer Database (APD)
- NY Early Intervention Program and Children and Youth with Special Health Care Needs
- Early Hearing Detection and Intervention-Information System
- Pregnancy Risk Assessment Monitoring System (PRAMS) Data to NYS Birth Data
- Prevention Agenda Dashboard
- Maternal and Child Health Dashboard

Goal 3: Enhance the development, integration, and tracking of health equity and social determinants of health (SDoH) metrics to inform Title V programming.

The NYSPQC Birth Equity Improvement Project (BEIP) invites all birthing people to complete a Patient Reported Experience Measure (PREM) Survey during the birth hospitalization. This provides birthing facilities with feedback directly from patients. All of the measures are stratified by race/ethnicity, with a focus on Black birthing people.

The NYSPQC launched the NICU Equity Project in Fall 2023. Data collection for the project includes performance measures on screening for language/interpreter needs and for postpartum mood and anxiety disorder stratified by race/ethnicity. Data collection processes also validate NICU standardized processes to screen for SDoH and linkage of parents/families to needed community services/resources for SDoH needs. Additionally, the NYSPQC developed a NICU Parent Reported Experience Measure (NPREM) survey to be completed by parents with an infant in the NICU around time of discharge to provide feedback on their experience of care. The outcome measures from this survey are stratified by race/ethnicity and language. Staff prepare the data progress and lead discussions regularly on Coaching Call webinars and with the project's clinical advisory group and other stakeholders. Progress on data measures is used to guide the project's educational programming.

In 2024, the Title V Dashboard started development to assist users in visualizing data, determine groups that are not meeting state goals, highlight inequities, and inform staff for future decision making specific to Title V programs. Currently, data used in the Title V Dashboard that incorporates a comprehensive list of State Action Plan performance measures for the Title V's five domains. Various groups are highlighted to analyze SDoH, such as race/ethnicity, age, adverse childhood experiences, health insurance status, sex, location of residence (urban vs. rural), and income combined with zip code. Isolating these groups from the general data has allowed staff to easily see where improvements can be made in NYS communities experiencing health disparities. Future developments to the Title V Dashboard include a larger host of measures across various domains, allowing for users to not only understand selected measures of concern, but a large number of measures across multiple domains. These expanded objectives are expected to be completed and reported in more detail in the 2025 report.

Data linkages projects can be found under Goal 2 above, and resource materials developed are listed at the end of the report, under *Products or Resource Materials Developed*.

Goal 4: Develop and enhance capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats, such as COVID-19.

NYSDOH recently began offering full-time fellowships to new public health graduates and positioning them in every division within the Department. NYSDOH is recruiting individuals with various concentrations in public health¸ especially those with a

background in data science, as well as candidates from underrepresented racial and ethnic groups for these fellowship positions. NYSDOH fellowships serve as a pathway for leadership positions at NYSDOH, so strengthening the diversity of the fellows who are being hired now will lead to more inclusive public health leadership in the future.

The NYSDOH launched its own Data Modernization Initiative (DMI) in 2022 and held the first meeting of the Leadership Team in June 2022. Title V is represented on the Leadership Team and will continue to provide MCH expertise to the DMI.

Key SSDI program activities, including products and resource materials that were developed to support State Title V Program efforts.

NYS Perinatal Quality Collaborative (NYSPQC)
The NYSPQC works to address health inequities in perinatal outcomes. More information about the NYSPQC can be found in the Women and Maternal Health Annual Report.

The NYSPQC's NYS Birth Equity Improvement Project (BEIP) was launched to all NYS birthing hospitals and centers in January 2021. The project assists facilities to identify how individual and systemic racism impact birth outcomes at the facility level and identify actions to improve both the experience of care and perinatal outcomes for Black birthing people in the communities they serve. This project was implemented at the recommendation of the NYS Taskforce on Maternal Mortality and Disparate Racial Outcomes. To date, 69 NYS birthing facilities are participating in the project.

Title V staff created the Patient Reported Experience Measure (PREM) survey for the BEIP. NYSBEIP participating facilities are administering the PREM, which gives every birthing person at participating facilities the opportunity to provide feedback on their experience of care. The PREM is a self-directed, anonymous survey available in 12 languages. Facility-specific QR codes/links have been provided to all participating teams to access the survey, and answers go directly to NYSDOH for analysis. Survey questions were drawn from validated patient experience tools and developed with input from an advisory group. Questions focus on shared decision making, feeling treated differently due to race, ethnicity, or language spoken, and feeling treated with respect and compassion. Demographic information collected includes primary language, race/ethnicity, age, sexual orientation, and gender identity. All facilities participating in the project receive monthly trend reports stratified by race and ethnicity.
Participating facilities have reported the following:

- Facilities with written policies and procedures addressing equitable care increased 114%, from 36.2% in Q2 2021 to 77.3% in Q4 2023.
- Facilities with any type of anti-racism education program in place for staff increased 77% from 55.3% in Q2 2021 to 97.7% in Q4 2023.
- The percentage of facilities with the PREM survey implemented and offered to every birthing person more than doubled, from 27.7% in Q2 2021 to 90.9% in Q4 2023.
- Facilities that are reviewing perinatal data stratified by race and ethnicity to develop activities intended to address inequities in care increased 121%, from 29.8% in Q2 2021 to 65.9% in Q4 2023.

NYS Maternal Mortality Review Program

SSDI program staff, in partnership with the Maternal Mortality Review Board and other Title V program and analytic staff, aided in the completion of a comprehensive, statewide surveillance report of all pregnancy-associated deaths that occurred in 2018-2020, which included recommendations for the prevention of future deaths and related disparities. SSDI program staff are currently developing two fact sheets, highlighting some of the significant findings of the Report on Pregnancy-Associated Deaths in NYS, 2018-2020 - one focused on racial and ethnic disparities and the other focused on perinatal mental health and substance use disorder. Additionally, SSDI program staff aided in the development of the Maternal Mortality and Morbidity Advisory Council Report, 2024, the Spotlight on Perinatal Substance Use Disorder Issue Brief, and a

poster for the 2024 MMRIA User Meeting, by providing key findings and data.

New York State Maternal, Infant and Early Childhood Home Visiting Program

Starting in the Fall of 2021, the New York State Maternal, Infant, and Early Childhood Home Visiting grant program has been incorporating health equity and inclusion into their annual continuous quality improvement projects as an actionable step to eliminate disparities in health and wellness. Each local implementing agency has selected a topic for improvement, with an aim that is specific, measurable, attainable, relevant, time-bound, inclusive, and equitable (SMARTIE) to guide and plan their projects. Indicative of the importance and emphasis applied in deciding how to incorporate equity and inclusion, the agencies used a variety of methods within their projects, some using additional steps, and others embedding these elements within their change strategies. Specific methods included collecting verbal and written input from families to influence their projects, analyzing disaggregated data, and increasing accessibility and individualization for communication, care, and services within the scope of their projects. Inclusion practices have led to shared decision making within projects and allowed families to directly voice the barriers they face, rather than having staff rely on their own perceived barriers. Next steps include conducting qualitative analysis of the data to determine how effective these changes were in addressing equity and inclusion, and identifying other potential approaches, such as addressing the needs of families whose primary language is other than English.

Products or Resource Materials Developed:

1. Report on Pregnancy-Associated Deaths in NYS, 2018-2020
2. Maternal Mortality and Morbidity Advisory Council Report, 2024
3. Spotlight on Perinatal Substance Use Disorder Issue Brief
4. Palm Card for American Indian and Alaskan Native People who are Pregnant or Postpartum
5. Palm Card for Partners, Friends, and Family of American Indian and Alaskan Native People who are Pregnant or Postpartum
6. Hear Her Urgent Maternal Warning Signs poster (in English and Spanish) – co-branded with CDC
7. Hear Her Urgent Maternal Warning Signs poster (for American Indian/Alaskan Native people) – co-branded with CDC
8. Poster for the 2024 MMRIA User Meeting
9. New York State Birth Equity Improvement Project One-pager
10. New York State Birth Equity Improvement Project Toolkit
11. NYSPQC NICU Equity Project – Data Entry Instruction Guide
12. NYSPQC NICU Equity Project – NICU Parent Reported Experience Measure (NPREM) Survey

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

NYS's Title V Maternal and Child Health Services Block Grant (MCHSBG) program relies on a number of robust data and information systems to inform priority setting, monitor health outcomes and disparities, and assess programs and policies. These systems include population-level data (e.g., vital statistics), representative surveys (e.g., Behavioral Risk Factor Surveillance System, Pregnancy Risk Assessment Monitoring System), and program data systems. The various data sources augment the data provided in the Federally Available Dataset (FAD) during the Five-Year Needs Assessment to help set priorities and since then have been used monitor progress on improving the objectives and measures in the State Action Plan.

Data and information systems that inform Title V MCHSBG and MCH efforts overall are administered within the Division of Family Health (DFH) or are administered by other NYS Department of Health (NYSDOH) organizational units and DFH staff maintain strong partnerships and formal data use agreements to access needed data.

Within DFH, the following systems are maintained:

- DFH maintains specific data systems to support individual program needs. These programs include the Family Planning Program; Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program; Perinatal and Infant Community Health Collaborative (PICHC); School-Based Health Centers (SBHCs) and aligned with SBHCs the Pediatric Mental Health Care Access (PMHCA) initiative; Adolescent Pregnancy Prevention Programs; Sexual Violence Prevention Programs; the NYS Perinatal Quality Collaborative, Maternal Mortality Review Initiative, and the Children and Youth with Special Health Care Needs (CYSHCN) Program. Data particular to each program are collected for program monitoring and evaluation.
- For population surveillance for newborn hearing screening and follow-up, DFH developed and maintains the Early Hearing Detection and Intervention System (EHDI-IS 2.0), which is a front-end web application integrated with the New York State Immunization Information System (NYSIIS) in 2018. It allows hospitals, audiologists, and primary care practitioners to document all hearing screening, diagnoses, and referrals to early intervention for all infants who are born in NYS.
- In addition, the DFH oversees the NYS Early Intervention Program under Part C of Individuals with Disabilities Education Act (IDEA). Data from the NYS Early Intervention Program are linked with EHDI-IS to confirm referral of infants to the program when they have suspected and/or identified hearing loss. The NYS Early Intervention Program utilizes the New York Early Intervention System (NYEIS), which is a centralized, web-based system that electronically manages Early Intervention Program administrative tasks and provides for the exchange of information among municipalities, program providers and State administrators. NYEIS is going to be replaced by the EI-Hub, which is a new solution designed specifically for the New York State Early Intervention Program (EIP). The EI-Hub will allow users across New York State to seamlessly manage the work they do for children in the EIP. With a single sign-on through the Health Commerce System (HCS), EI-Hub users will be able to capture and report on child information from referral (intake) to transition, including managing provider data, provider management, claims creation, billing, and payments.

The systems outside of DFH that DFH staff access via partnership or formal agreements are:

- Vital Records (VR), two separate systems for NYC and Rest of State (ROS)
    - Core Electronic Birth Certificate (EBC): The Statewide Perinatal Data System (SPDS) is an electronic maternal and newborn data collection system which was established and is currently maintained by NYSDOH with the purpose of improving prenatal, obstetric, and newborn care for mothers and infants in NYS. The SPDS was developed to make data available for NYSDOH and hospitals for monitoring and quality improvement. Web-based and modular in design, SPDS includes the Core EBC that captures birth data in hospitals outside of NYC, and the NICU module (see below). The EBC provides near-real-time data for use in vital records birth registration, rapid enrollment of eligible newborns in Medicaid, and maternal/child public

health surveillance of hospitals and communities. In addition to meeting National Center for Health Statistics (NCHS) standards for collection of electronic birth data, the Core EBC Module also includes quality improvement (QI) variables.
    - NYS Electronic Death Registration System (EDRS) is a secure web-based system for electronically registering deaths for NYS hospitals, excluding NYC. EDRS simplifies the data collection process and enhances communication between health care providers and medical certifiers, medical examiners/coroners, funeral directors, and local registrars as they work together to register deaths.
    - Fetal death records used to identify pregnancy-related deaths.
    - NYC vital records system, eVital, allows all NYC hospitals to electronically submit birth and death registrations using mobile devices and facial recognition security. The eVital birth module captures the same birth data as the SPDS, using NCHS standards supplemented by the set of QI variables, but does not as yet provide NYC hospitals with access to the same statistical summary reports and data extraction capabilities as are available for upstate hospitals.
    - NYS Office of Mental Health Project TEACH and Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) data.
- Neonatal Intensive Care Unit (NICU) Module is a module of the SPDS that captures detailed clinical information from all hospitals, including NYC, certified to provide specialty or intensive care to high-risk neonates, i.e., those designated as Level II, III or Regional Perinatal Center. The NICU Module captures data for all neonates admitted to special and intensive care nurseries for longer than four hours and includes information on newborns who die in the delivery room, or in transit to or within the neonatal special or intensive care units. Data include demographics for the infant and birthing person and diagnoses and treatments for the infant.
- Statewide Planning and Research Cooperative System (SPARCS) is a comprehensive all payer data reporting system established in 1979. It collects patient level detail on patient characteristics, diagnoses and treatments, services, and charges for each hospital inpatient stay and outpatient (ambulatory surgery, emergency department, and outpatient services) visit; and each ambulatory surgery and outpatient services visit to a hospital extension clinic and diagnostic and treatment center licensed to provide ambulatory surgery services.
- All Payor Database (APD) is a comprehensive health claims and clinical database aimed at improving quality of care, efficiency, cost of care and patient satisfaction available in a self-sustainable, non-duplicative, interactive, and interoperable manner that ensures safeguards for privacy, confidentiality, and security. Currently the APD includes SPARCS hospital discharge data, VR death data, and Medicaid claims and encounter data. Going forward, VR birth data, commercial claims data, and other public health registries and electronic health records will be integrated.
- Newborn Screening Laboratory Information Management System (LIMS) is maintained by the Wadsworth Laboratory to record bloodspot samples received, demographics, results for the 50 different disorders tested, and follow-up.
- New York State Immunization Information System (NYSIIS) is the system where health care providers report all immunizations administered to persons less than 19 years of age and their immunization histories. It aims to establish a complete, accurate, secure, real-time immunization medical record that is easily accessible and promotes public health by fully immunizing all individuals appropriate to age and risk.
- Statewide Health Information Network for New York (SHIN-NY) facilitates the electronic exchange of clinical information and connects healthcare professionals statewide to improve patient outcomes, reduce unnecessary and avoidable tests and procedures, and lower costs. It ensures access to a patient's electronic medical records wherever and whenever they need it. Health records are not publicly accessible. Only a patient decides who can see their records and may opt out at any time.
- Electronic Clinical Laboratory Reporting System (ECLRS) provides laboratories that serve NYS with a single electronic system for secure and rapid transmission of reportable disease information to NYSDOH, local health departments (LHD), and the New York City Department of Health and Mental Hygiene. It enhances public health surveillance by providing timely reporting; improving completeness and accuracy of reports; and generally facilitating the identification of emergent public health problems by monitoring communicable diseases, lead poisoning, HIV/AIDS, and cancer. ECLRS was particularly critical during the COVID-19 pandemic to record test results; public

health law was changed to mandate reporting of SARS-CoV-2.

- LeadWeb is a NYSDOH-maintained system used by LHDs to carry out the required case management and follow-up activities for children with elevated blood lead levels (BLL). All BLL test results for children younger than 18 are reported to LeadWeb by laboratories, and LHDs are notified of new cases identified in their county. LeadWeb also collects information on housing-related hazards and environmental follow-up for each child. LHD staff are required to document when follow-up services are provided for each case, which they input directly into LeadWeb. As such, the system provides a real-time database of blood lead tests and follow-up activities.
- Pregnancy Risk Assessment Monitoring System (PRAMS) is an ongoing mail/telephone survey of mothers who have recently given birth to a live born infant, designed by the CDC. It collects information from mothers about behaviors and experiences before, during, and after pregnancy that are not available from other data sources. The goal of the PRAMS project is to make data available to inform policy and program investments to improve the health of mothers and infants by reducing adverse outcomes such as low birth weight, infant mortality and morbidity, and maternal morbidity. PRAMS provides state-specific data for planning and assessing health programs and for describing maternal experiences that may contribute to maternal and infant health.
- Behavioral Risk Factor Surveillance System (BRFSS) is an annual statewide random telephone and cellular surveillance survey designed by the CDC. The survey monitors modifiable risk behaviors and other factors contributing to the leading causes of morbidity and mortality in the population. Data from the BRFSS are useful for planning, initiating, and supporting health promotion and disease prevention programs at the state and federal level, and monitoring progress toward achieving health objectives for the state and nation. NYS's BRFSS sample is representative of the non-institutionalized civilian adult population, aged 18 years and older.
- The Youth Risk Behavior Survey (YRBS), coordinated by the CDC, monitors students' health risks and behaviors in several categories, including weight and diet, physical activity, injury and violence, tobacco use, alcohol, and other drug use, and sexual behaviors. The YRBS is conducted every two years among a representative group of NYS students in grades 9–12. The NYS Center for School Health conducts the YRBS in NYS on behalf of the NYS Education Department.

Systems outside of DFH that DFH staff access through publicly available sources include: the National Survey of Children's Health (NSCH), the American Community Survey (ACS), NYS Quality Assurance Reporting Requirements (QARR), CDC Breastfeeding Report Card, National Immunization Survey, Sexually Transmitted Disease Surveillance, United States Current Population Survey, National Pediatric Nutrition Surveillance System, and United States Census data.

DFH has partnered with NYSDOH's Public Health Information Group to build the MCH Dashboard (https://www.health.ny.gov/MCHdashboard), which is comprised of select national and state performance measures related to the NYS's Title V MCHSBG application. It was built to support the assessment of needs, monitor progress towards improving the health of NYS MCH populations, and reducing health disparities. It provides an interactive visual presentation of state and county data and for select measures, socio-demographic data. Where available, the most current data are compared to previous year data to monitor performance at both state and county levels. Trend graphs, tables, maps, and bar charts are available from the state and county homepage dashboard views. The Dashboard was updated every year in February 2023 and April 2024.

DFH has a strong commitment to data systems development and utilizes Title V and SSDI funding to invest in infrastructure to promote data linkages and timely reporting.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

The NYS written Emergency Operations Plan is called the Comprehensive Emergency Management Plan and is coordinated by the Office of Emergency Management and involves participation from other state agencies, including the NYS Department of Health and the Office of Children and Family Services. The Comprehensive Emergency Management Plan is reviewed annually.

The NYS Department of Health written Emergency Operations Plan is called the Health Emergency Preparedness and Response Plan and is coordinated through the NYS Department of Health's Office of Health Emergency Preparedness. It includes input from major NYS Department of Health Programs, including the Center for Community Health and Division of Family Health's Title V Maternal and Child Health Services Block Grant. The Health Emergency Preparedness and Response Plan is reviewed every three years or as needed after major events or identified changes.

Both the NYS Comprehensive Emergency Management Plan and the NYS Department of Health's Health Emergency Preparedness and Response Plan includes annexes which specifically look at the needs of the populations birth through reproductive age. Under the NYS Comprehensive Emergency Management Plan, the NYS Department of Health participates in the Emergency Support Function 6 with the Office of Children and Family Services and other human service agencies, and in other Emergency Support Functions, to identify methods of serving various populations, including the population birth through reproductive age, when responding to an emergency impacting NYS.

Under the NYS Department of Health's Health Emergency Preparedness and Response Plan, populations from birth through reproductive age are considered as part of overall access and functional needs populations, as well as specifically planned for under the Pediatric Surge annex. This annex focuses on large scale events and the impacts to the healthcare system with large number of pediatric patients.

The NYS Department of Health's Office of Health Emergency Preparedness staff participate in the Emergency Support Function meetings where the NYS Department of Health is a member agency and other NYS Comprehensive Emergency Management Plan meetings, and coordinate with Department of Health program subject matter experts, including Title V Maternal and Child Health Services Block Grant staff, as needed for specific questions about program area activities or populations which are served to inform State level and Department level emergency response plans, including the Comprehensive Emergency Management Plan and Health Emergency Preparedness and Response Plan.

Title V Maternal and Child Health Services Block Grant staff, specifically Dr. Marilyn Kacica, who is the Medical Director, was a key expert in providing information and identifying pediatric resources for the Health Emergency Preparedness and Response Plan Pediatric Surge annex.

NYS Department of Health staff at the state Emergency Operation Center or within the NYS Department of Health will review current state or department level plans and current situational assessments at the time of a disaster to modify and develop plans specific to an incident. This includes engagement and coordination with identified program subject matter experts, including Title V Maternal and Child Health Services Block Grant staff, as needed for any Maternal and Child Health planning before or during a disaster.

The NYS Department of Health Incident Management System is a flexible and scalable structure based on the needs of the incident. In an incident where Maternal and Child Health concerns are identified, Title V Maternal and Child Health Services Block Grant leadership would be activated within the Incident Management System as a key response group. This activation would include participation on key leadership coordination calls, as well as focused groups dealing with specific aspects of response operations. Title V Maternal and Child Health Services Block Grant leadership will also be included for situational awareness on any department wide Incident Management System activations to share information with appropriate program areas and NYS Department of Health leadership as identified.

Title V Program staff helped identify key resources for training as part of the Health Emergency Preparedness and Response Plan Pediatric Surge plan. Additionally, Title V Maternal and Child Health Services Block Grant staff were part of the development group that created the NYS Department of Health Pediatric and Obstetric Emergency Preparedness Toolkit, a guide for emergency preparedness planning, training, and practice, including clinical and operational information for emergencies.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

Working collaboratively to improve health outcomes for the NYS' population from birth through reproductive age is an essential part of the NYS Title V Maternal and Child Health Services Block Grant program. Title V Maternal and Child Health Services Block Grant programs and staff engage with a wide range of partners, both internal and external, to collaborate on a range of projects and activities aimed at ensuring our population has access to high quality health care services. These collaborations are highlighted throughout the Needs Assessment, Title V Maternal and Child Health Services Block Grant application and report, and include partnerships with other public health programs, state and local agencies, private sector partnerships, families, and consumers. A summary of major partnerships is included in *Supporting Document 1*.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

As required by HRSA, the NYS Title V Maternal and Child Health Services Block Grant program has an active intra-agency agreement with the NYS Title XIX Medicaid program. The NYS Title V Program has and continues to be housed within the NYS Department of Health, as is the NYS Medicaid Program. Operated by the NYS Department of Health's Office of Health Insurance Programs (OHIP), the NYS Medicaid program is part of the larger organizational structure of the Department of Health along with the NYS Title V Maternal and Child Health Services Block Grant program, which is administered by the Division of Family Health which is within the Office of Public Health's Center for Community Health.

Among the many advantages of being part of the same agency, the Title V Maternal and Child Health Services Block Grant and the state's Medicaid programs have an established and strong relationship designed to enhance the services for the population from birth through reproductive age within NYS.

This intra-agency relationship enables Title V staff to support the state's Medicaid programs whenever possible, ensuring that the Title V Maternal and Child Health Services Block Grant program is the payer of last resort.

The strong collaborative relationship between these programs is outlined in detail in the attached Intra-Agency Agreement (IAA). In addition to the formal outlined scope of services, the Office of Health Insurance's Medicaid staff and the state's Title V Maternal and Child Health Services Block Grant funded staff have bimonthly calls about Reproductive, Maternal, and Perinatal Health topics and quarterly calls about Pediatric and Adolescent Health topics. In addition, we convene meetings as needed about specific topics or emerging issues. Staff from Medicaid routinely participate on work groups and initiatives to address maternal mortality, School Based Health Centers, and reproductive health. There is a shared vision, frequently shared data to support Maternal and Child Health outcomes, and ongoing collaboration to improve systems of care for NYS residents.

Success activities, such as the updating of the State Plan Amendment to make sickle cell a singular qualifying condition for the Medicaid Children's Health Home which expanded care coordination services for thousands of individuals, are highlighted in the annual report and application.

III.E.2.c State Action Plan Narrative by Domain

State Action Plan Introduction

As described in the five-year Needs Assessment summary, New York's state priorities for the current five-year grant cycle were driven by this fundamental question: *how can we be responsive to the themes voiced by families and communities, within the context of the program infrastructure and resources we have, and with consideration for the national priorities, and specific performance measures established by HRSA?*

From this question, we endorsed ten crosscutting priorities for NY's Title V State Action Plan. These priorities align directly with the ten crosscutting themes identified from family and community members through the Needs Assessment process described in our Needs Assessment summary. In turn, we selected five National Performance Measures (NPMs) and developed two additional State Performance Measures (SPMs) as focal points for action. These NPMs and SPMs align with both the priorities voiced by families and community members and the capacity and mission of our Title V Maternal and Child Health Services Block Grant programs.

This approach continued to develop New York's five-year State Action Plan. The plan is anchored by the 10 broad crosscutting priorities and the seven specific performance measures. The action plan responds to this question: *what strategic public health approaches and specific program activities can New York's Title V program lead or meaningfully support over the next five years to make measurable progress in the specific areas encompassed by these seven performance measures, in ways that are responsive to the crosscutting priorities voiced by families and community members?*

The resulting State Action Plan serves to link the broad, crosscutting priorities identified by families and community members with the specific outcomes encompassed in the selected national and state performance measures. The State Action Plan table presents the strategic public health approaches identified to address each of the national or state performance measures, highlights selected activities and action steps to carry out that strategic approach, and shows how each strategic approach aligns with the crosscutting priorities.

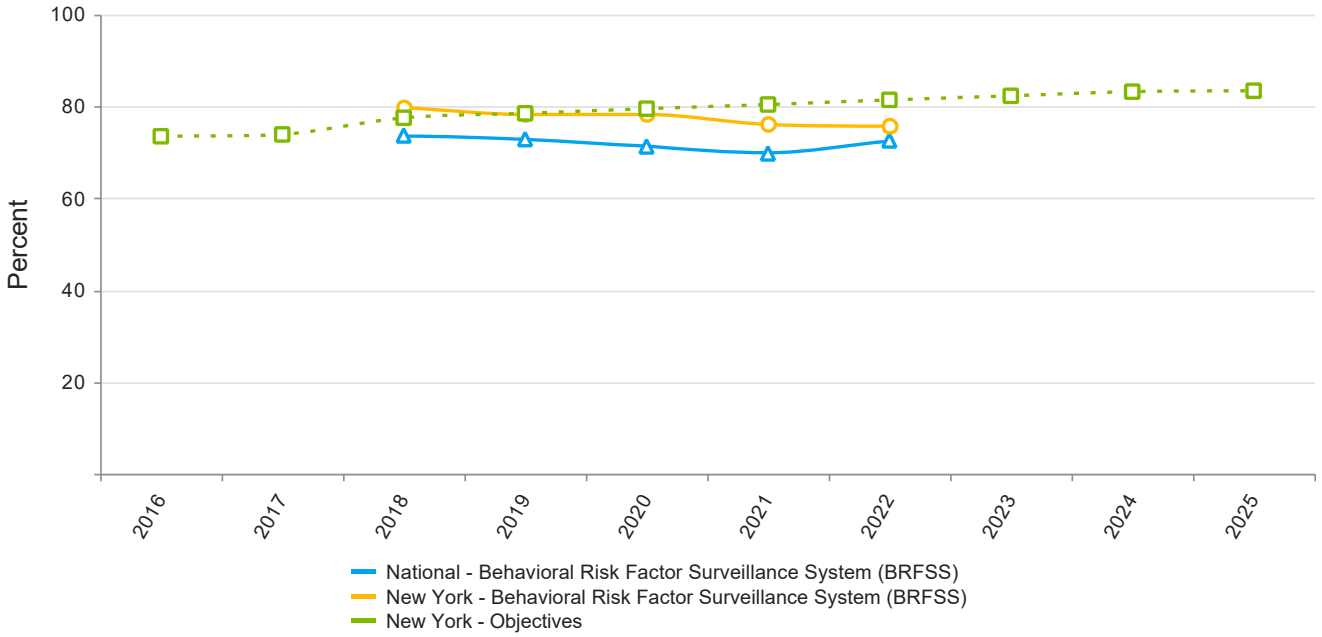
Evidence-based strategy measures (ESMs) were developed for each domain to capture the reach and effectiveness of these strategies for the relevant populations directly served through the Title V Maternal and Child Health Services Block Grant programs. Specific objectives with measurable improvement targets were developed for each domain to further operationalize the strategies and measures. Wherever possible, these objectives and measures were aligned with the NYS Prevention Agenda to reinforce consistency and synergy with the Title V State Action Plan.

Further detail on specific program and policy activities associated with each of these strategic approaches is described in the narrative by domain below.

Women/Maternal Health

National Performance Measures

NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV
Indicators and Annual Objectives



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective		79.4	80.3	81.3	82.2
Annual Indicator	79.6	78.3	78.3	75.9	75.5
Numerator	2,826,660	2,737,695	2,703,220	2,698,183	2,643,832
Denominator	3,550,054	3,498,639	3,451,509	3,553,627	3,503,858
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2018	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	83.1	83.3

Evidence-Based or –Informed Strategy Measures

ESM WWV.1 - Percent of Maternal and Infant Community Health Collaboratives (MICHC) program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker (CHW)

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			55.3	58.1	61
Annual Indicator	52.7	63.4	40.1	53.9	62.4
Numerator		2,068	573	1,299	1,668
Denominator		3,260	1,430	2,412	2,675
Data Source	MICHC Program Data	MICHC Program Data	MICHC Program Data	MICHC Program Data	MICHC Program Data
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	64.1	67.3

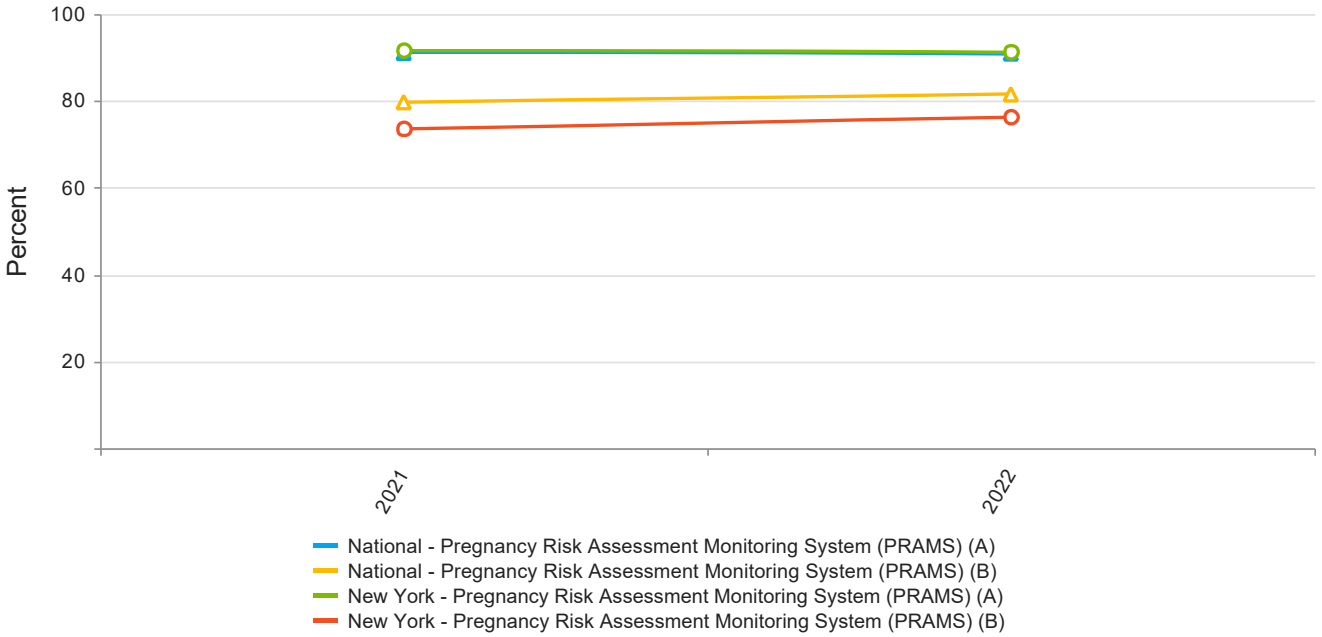
ESM WWV.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			37.5	37.7	37.9
Annual Indicator	37.3	36.2	29.7	32.9	33.5
Numerator		92,136	58,264	66,886	64,392
Denominator		254,718	195,847	203,468	191,962
Data Source	Family Planning Program Client Visit Record data	Family Planning Program Client Visit Record data	Family Planning Program Client Visit Record data	Family Planning Program Client Visit Record data	Family Planning Program Client Visit Record data
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	38.2	38.2

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
Indicators and Annual Objectives



NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	91.2
Numerator	166,888
Denominator	182,980
Data Source	PRAMS
Data Source Year	2022

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	76.2
Numerator	124,429
Denominator	163,344
Data Source	PRAMS
Data Source Year	2022

Evidence-Based or –Informed Strategy Measures

None

State Action Plan Table

State Action Plan Table (New York) - Women/Maternal Health - Entry 1
Priority Need
Address equity, bias, quality of care, and barriers to access in health care services for women and families, especially for communities of color and low-income communities
NPM
NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV
Five-Year Objectives
Objective WMH-1: Increase the percent of women, ages 18 through 44, with a preventive medical visit in the past year by 5%, from 79.6% in 2018 to 84.6% in 2022. (BRFSS)
Objective WMH-2: Reduce the maternal mortality rate by 10%, from 17.8 deaths per 100,000 live births in 2014-2018 to 16 deaths per 100,000 live births in 2018-2022. (NVSS)
Objective WMH-3: Reduce the rate of severe maternal morbidity per 10,000 delivery hospitalizations by 5%, from 83.5 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2017 to 79.3 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2021. (HCUP-SID)
Objective WMH-4: Reduce the percent of women who have depressive symptoms after birth by 5%, from 13% in 2017 to 12.4% in 2021. (PRAMS)

Strategies
Strategy WMH-1: Integrate specific activities across all relevant Title V programs to promote the health and wellness of people of child-bearing age, including enrollment in health insurance, routine well visits, pregnancy planning and prevention, prenatal, and postpartum care through coordination and linkages across systems of care (hospital to community). Please see Supporting Document 2 “State Action Plan Table” and domain narrative sections for specific activities related to each strategy.
Strategy WMH-2: Strengthen coordination between birthing hospitals, outpatient health care providers, and other community services to make support for birthing parents and their families more comprehensive and continuous. Please see Supporting Document 2“ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.
Strategy WMH-3: Apply public health surveillance and data analysis findings to improve services and systems related to maternal and women’s health care. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.
Strategy WMH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact women’s health and use of health care across the life course. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

ESMs	Status
ESM WWV.1 - Percent of Maternal and Infant Community Health Collaboratives (MICHC) program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker (CHW)	Active
ESM WWV.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year	Active

NOMs

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

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, Formerly NOM 24) - PPD

State Action Plan Table (New York) - Women/Maternal Health - Entry 2

Priority Need

Acknowledge and address the fundamental challenges faced by families in poverty and near-poverty, including the “working poor” as a result of systemic barriers, including racism.

NPM

NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV

Five-Year Objectives

Objective WMH-1: Increase the percent of women, ages 18 through 44, with a preventive medical visit in the past year by 5%, from 79.6% in 2018 to 84.6% in 2022. (BRFSS)

Objective WMH-2: Reduce the maternal mortality rate by 10%, from 17.8 deaths per 100,000 live births in 2014-2018 to 16 deaths per 100,000 live births in 2018-2022. (NVSS)

Objective WMH-3: Reduce the rate of severe maternal morbidity per 10,000 delivery hospitalizations by 5%, from 83.5 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2017 to 79.3 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2021. (HCUP-SID)

Objective WMH-4: Reduce the percent of women who have depressive symptoms after birth by 5%, from 13% in 2017 to 12.4% in 2021. (PRAMS)

Strategies

Strategy WMH-1: Integrate specific activities across all relevant Title V programs to promote the health and wellness of people of child-bearing age, including enrollment in health insurance, routine well visits, pregnancy planning and prevention, prenatal, and postpartum care through coordination and linkages across systems of care (hospitals to community). Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy WMH-2: Strengthen coordination between birthing hospitals, outpatient health care providers, and other community services to make support for birthing parents and their families more comprehensive and continuous. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy WMH-3: Apply public health surveillance and data analysis findings to improve services and systems related to maternal and women’s health care.Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy WMH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact women’s health and use of health care across the life course. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

ESMs	Status
ESM WWV.1 - Percent of Maternal and Infant Community Health Collaboratives (MICHC) program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker (CHW)	Active
ESM WWV.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year	Active

NOMs
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
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, Formerly NOM 24) - PPD

State Action Plan Table (New York) - Women/Maternal Health - Entry 3

Priority Need

Address equity, bias, quality of care, and barriers to access in health care services for women and families, especially for communities of color and low-income communities

NPM

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

Five-Year Objectives

Increase the percentage of individuals receiving postpartum visits: a) establish baseline percentage and propose a percentage increase for individuals who attended a postpartum checkup within 12 weeks after giving birth; and b) similarly for individuals who attended a postpartum checkup and received recommended care components.

Strategies

The NYS Title V Program is working to ensure postpartum visits through a number of our current strategies and activities. The work to review current initiatives, identify gaps, and develop strategies and activities to improve postpartum visits is just beginning in the current grant. We will report on more robust strategies and activities in next year's application.

ESMs | Status

No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.

NOMs

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.

Women/Maternal Health - Annual Report

For Women's and Maternal Health (WMH), New York's Title V Program selected **National Performance Measure (NPM) 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year.** New York select this NPM because 1) preventive medical visits for individuals of reproductive age are foundational to health throughout the life course, 2) population health data demonstrate a need for continued improvement in this area, and 3) it relates directly to priorities voiced by women and families at community listening forums held across New York State (NYS). During the community listening sessions, women and families expressed priority needs that include increased awareness of and access to community resources, quality health care, transportation, and social support. This NPM also aligns directly with the NYS Prevention Agenda goal to increase the use of primary and preventive health care services among women of all ages, especially women of reproductive age.

While NPM 1 directly measures annual preventive medical visits, it should be viewed as part of a continuum of primary and preventive care that includes preconception, reproductive and sexual health, family planning, prenatal, and postpartum care, as well as encompassing a full spectrum of medical, mental/behavioral health, oral health, dietary/nutritional, and other supports and services.

The New York State Maternal Mortality Review Board has identified increasing access to comprehensive, high quality, and equitable health care services as a key element of efforts to eliminate the striking racial and ethnic disparities in mortality and morbidity outcomes. NYS is ranked 15th in the nation for the rate of maternal mortality. While NYS's overall maternal mortality rate has declined from its peak, racial disparities in maternal deaths persist, with maternal deaths being over 4 times more likely for Black women compared to White women during the 2018-2020 timeframe. Severe maternal morbidity also affects the lives of people who give birth, as well as their newborns, families, and health care provider teams, in profound and sometimes life-altering ways. Severe maternal morbidity can result in prolonged hospital stays, substantial medical costs, higher life-long burden of health problems, physical and emotional stress, and interference with maternal-newborn bonding. Additionally, severe maternal morbidity is associated with an increased risk for maternal death. Perinatal depression is among the most common morbidities during pregnancy and the postpartum period, with significant implications for the health and well-being of the entire family. During listening sessions, NYS women and families consistently highlighted maternal depression as a challenge requiring more attention and supports.

The following specific objectives were established to align with this national performance measure:

Objective WMH-1: Increase the percent of women, ages 18 through 44, with a preventive medical visit in the past year by 5%, from 79.6% in 2018 to 84.6% in 2022. (Behavioral Risk Factor Surveillance System)

Objective WMH-2: Reduce the maternal mortality rate by 10%, from 17.8 deaths per 100,000 live births in 2014-2018 to 16 deaths per 100,000 live births in 2018-2022. (National Vital Statistics System)

Objective WMH-3: Reduce the rate of severe maternal morbidity per 10,000 delivery hospitalizations by 5%, from 80 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2017 to 76 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2021. (Healthcare Cost and Utilization project-State Inpatient Database)

Objective WMH-4: Reduce the percent of women who have depressive symptoms after birth by 5%, from 13% in 2017 to 12.4% in 2021 (Pregnancy Risk Assessment Monitoring System)

Four strategic public health approaches were identified to accomplish these objectives. These strategies are presented in the State Action Plan Table, and each is described in more detail with specific program and policy activities that will be implemented to advance the broader strategic approach in the upcoming year.

Strategy WMH-1: Integrate specific activities across all relevant Title V programs to promote the health and wellness of people of child-bearing age, including enrollment in health insurance, routine well visits, pregnancy planning and prevention, and prenatal and postpartum care.

Improving the health of individuals of reproductive age requires a life course approach to be most effective. Preventive medical visits are a key opportunity for delivering health education and reinforcing health-promoting behaviors. Preventive visits for individuals of reproductive age help identify chronic conditions, such as hypertension and diabetes, which may contribute to maternal morbidity and mortality. Family planning and reproductive health visits ensure that individuals of reproductive age have access to contraception for pregnancy prevention, as well as counseling for reproductive life planning, appropriate birth spacing, and preconception health. Title V programs also provide enabling services, such as social support and referrals/linkages to a wide range of community services, to holistically address health and wellness, including mental health and social determinants of health for reproductive age individuals. Incorporating specific activities across programs leverages the public health infrastructure and capacity supported through previous and ongoing Title V investments.

Through the Perinatal and Infant Community Health Collaboratives (PICHC), community health workers conduct basic health and well-being assessments in the prenatal and postpartum periods using standardized evidence-based and/or validated screening tools to identify and prioritize the needs of the individuals and families they serve. Assessments are completed at enrollment and updated throughout clients' service periods and individualized care plans are developed based on the needs identified. Community Health Workers receive annual training on 1) Communicating with families on difficult and sensitive topics such as mental health and depression, 2) Using a trauma-informed care approach, and 3) Managing emergency situations. Community Health Workers also connect clients and families to needed services and provide enhanced social support. Community Health Workers help ensure early and consistent participation in preventive and primary health care services, including early prenatal care, particularly for those individuals not engaged in care and other supportive services. Community Health Workers also provide health information to increase clients' knowledge and their ability to self-advocate and make informed health care decisions with the goal of helping families achieve optimal health, self-sufficiency, and overall well-being.

PICHC programs coordinated outreach and engagement activities work with other home visiting programs serving the same communities including programs supported by New York's funding from the Health Resources and Services Administration for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative. The MIECHV initiative provides funds to promote and improve the health, development and well-being of children and families, who are most impacted by systemic barriers and at risk for not receiving services, through evidence-based home visiting programs. The PICHC and MIECHV programs coordinated outreach, referral, assessment, and intake processes help identify and engage pregnant and parenting families to ensure they connect with home visiting programs and supportive services responsive to their needs.

The goal of the PICHC initiative is to improve perinatal health outcomes and eliminate racial, ethnic, and economic disparities in those outcomes. 26 programs state-wide implement strategies to improve the health and well-being of individuals of reproductive age and their families with a focus on individuals in the prenatal, postpartum, and interconception periods. PICHC programs are required to implement individual-level strategies to address perinatal health behaviors, and community-level strategies to address the social determinants which impact health outcomes. The core individual-level strategy is the use of Community Health Workers to outreach and provide supports to high-need, low income, Medicaid-eligible individuals at risk for, or with a previous history of, adverse birth outcomes. Community-level strategies will involve collaboration with diverse community partners, including community residents, to mobilize community action to address the social determinants impacting perinatal health outcomes.

The Family Planning Program supports 37 health facilities that are regulated by the NYSDOH under Article 28 of NYS Public Health Law (these include hospitals, clinics, health departments, federal qualified health centers) that operate 164 family planning clinic sites across the state.

Services provided include contraceptive services; preconception planning and counseling services; pregnancy testing and related counseling; preventive services such as basic health screening, screening for sexually transmitted diseases, HIV counseling and testing, and breast and cervical cancer screening; appropriate referrals; and health education. To address barriers to receiving reproductive health care, the NYS Family Planning Program applied for and was awarded a one-year Telehealth grant (7/15/22-5/31/23) from the Office of Population Affairs to provide funds to rural Family Planning Program providers to support telehealth infrastructure, improve access to telehealth services, and support training and technical assistance for the Family Planning Program providers. Ensuring continued access to these core primary and preventive services is essential. The Family Planning Program submitted and was awarded a 12 month no cost extension (6/1/23-5/31/24) to finish the telehealth project, as well as approval for a change in scope for the project. The change in scope was to include downstate providers, as needs assessments showed that our non-rural providers were also in need of financial assistance to enhance their telehealth capabilities to reach those members who located in healthcare desserts.

Funding from this grant was also set aside to support the NYS Family Planning Training Center, managed by John Snow Research and Training Institute, Inc. With this funding they held one webinar for providers, developed a telehealth sustainability toolkit and a telehealth billing and coding guide to ensure providers have access to the latest telehealth best practices to ensure community members can access telehealth services during this reporting period. The Training Center during this reporting period also provided mini grants to 10 Family Planning Providers to support training and TA identified by the organization to assist them in providing high quality, patient centered care via telehealth.

As reinforced by the Needs Assessment community forums, increasing awareness of available resources among both consumers and providers is critical. Home visiting programs are encouraged to promote use of the state's Growing Up Healthy Hotline service which, in turn, provides callers with linkages to local community resources, supports, and services including Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC), Medicaid, Family Planning, prenatal care, and the NYS Early Intervention Program. Social media and other emerging communication platforms increase the potential to reach large and diverse populations. Title V staff incorporate a science-based health messaging approach when developing social media campaigns, with the goal of educating New Yorkers to positively influence their health care decision-making capabilities and improving overall health outcomes.

The NYS Title V Program led the following specific program and policy activities to advance this strategy during the 2021-22 reporting period:

WMH-1.1 Across all Title V programs, enhance promotion of the NYS Growing up Health Hotline to increase awareness of available community resources, supports, and services including the Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC), Medicaid, family planning, and prenatal care.

Staff promoted the Growing up Health Hotline across all these programs as well as the NYS Early Intervention Program. During FFY23, the Growing up Health Hotline handled nearly 13,000 calls, most of which resulted in a referral to local agencies that oversee the Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC). Other callers were referred to the NYS Marketplace for health insurance coverage or local departments of health for early intervention services. The Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC) continues to promote the Growing up Health Hotline in brochures and via the online chat service "Wanda" when respondents are Spanish speaking.

For the 2023-2026 contract cycle, Growing Up Health Hotline services will include texting service that will provide the same information offered by the telephone service, and will be available 24 hours a day, seven days a week, 365 days per year. In consultation with Goodwill Vision Enterprises and other stakeholders, text message decision trees were developed for four of the top call categories received by the hotline: NYS Early Intervention Program, WIC, health insurance, and home visiting and parent support programs.

WMH-1.2 Through the Regional Perinatal Centers and networks of affiliate birthing hospitals, support and enhance capacity

to provide high quality perinatal telehealth services and perinatal subspecialty providers, particularly to rural communities and communities with disproportionate access to such services.

Telehealth services are tailored based on regional assessments of provider and affiliate hospital needs, including routine prenatal and postpartum care and/or specialty care such as maternal-fetal medicine, radiology, and genetic counseling. Each of the five upstate Regional Perinatal Centers that serve a significant rural population identified needs and capacity. Several of the Regional Perinatal Centers developed or expanded telehealth services to increase local access to maternal-fetal medicine specialists, including real-time video consultation and store-and-forward ultrasound reading with accompanied supplemental training for local ultrasonographers. Data are not yet available to assess outcomes or delivery of services, as there were significant delays in project implementation due to COVID-19 and nationwide microchip and equipment shortages. Title V funding for these programs ended during the program year, and staff are working to summarize the processes and lessons learned from this program *(See Strategy PIH-1.5 for more detail on Telehealth Services for Neonatal Services).*

For the 22-23 grant year, the Department has collected information from the Regional Perinatal Centers regarding consultations to affiliate birth facilities via telemedicine regarding patient transfers and clinical management. The hospitals provide quarterly report submissions that include details on Obstetrical and Neonatal/Pediatric consultations and transfers and back transfers. Conversations with Regional Perinatal Centers and the Department regarding perinatal telehealth are ongoing.

WMH-1.3 Through the PICHC and MIECHV programs, integrate virtual home visiting services to increase acceptance and support of services for hard-to-reach families.

Virtual home visits conducted in the context of the response to COVID-19 have helped to maintain communication and allow for essential Community Health Worker and home visiting services to continue including providing health information, support and referral and follow-up for preventive and prenatal care visits. The use of virtual tools for home visiting, outreach, education, and further social supports continued to be integrated as a supplement to safe, in-person services during the on-going COVID-19 pandemic. During the reporting period, PICHC programs conducted 26,517 visits with clients, of which 52% (13,909) were virtual visits. Community Health Workers and home visitors continuously disseminated guidance from reputable sources, such as the NYSDOH, on COVID-19 and perinatal health as it became available.

WMH-1.4 Through the PICHC program, continue to support Community Health Workers to conduct outreach to find and engage high-risk pregnant and postpartum families in consistent, comprehensive preventive and primary care services, including prenatal, interconception, and postpartum care.

The PICHC programs supported Community Health Workers to conduct outreach to find and engage high-risk pregnant and postpartum families in consistent and comprehensive preventive and primary care services, including preconception, prenatal, and postpartum care. From October 1, 2022, to September 30, 2023, a total of 5,210 clients were enrolled in the PICHC programs. Community Health Workers routinely screened clients for health insurance enrollment and health care engagement, assisted them in getting care through referrals as needed, and provided ongoing social support and reinforcement for health care utilization. They also provided clients with health information and social support to increase their knowledge and ability to self-advocate and make informed health care decisions, including help developing birth plans. During this period from October 1, 2022, to September 30, 2023, Community Health Workers engaged 1,643 prenatal clients to create a birth plan. Community Health Workers also issued a total of 22,203 referrals, with the top five referral categories overall being clothing/baby care items, referrals to food pantry, Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC), transportation, and housing assistance.

WMH-1.5 Continue to provide training to Train PICHC and MIECHV programs on the Centers for Disease Control and Prevention's (CDC) *Learn the Signs Act Early* campaign and collaborate with the NYS Council on Children and Families on the Early Childhood Comprehensive Systems grant, which supports dissemination of *Learn the Signs Act Early* materials.

In January 2022, Maternal and Infant Community Health Collaboratives and MIECHV-funded home visiting staff attended a webinar presented by NYS Early Intervention staff on what families can expect following a referral to their services. Related, in a February 2022 webinar for Maternal and Infant Community Health Collaboratives and Maternal, Infant, and Early Childhood Home Visiting-funded home visiting staff, developmental pediatrician and *Learn the Signs Act Early* ambassador, Dr. Romina Barros, provided updates on developmental monitoring materials which can be obtained without cost and provided to families.

WMH-1.6 Through the MIECHV Initiative, direct American Rescue Plan Act (ARPA) Act funds to MIECHV funded programs.

Staff allocated ARPA funds to Healthy Families New York programs via a new Memorandum of Understanding with the NYS Office for Children and Family Services, which oversees Healthy Families New York programs, and new contracts with Nurse Family Partnership programs, which are overseen by the New York State Department of Health (NYSDOH). In FFY22, contracts were created between the NYSDOH and Nurse Family Partnership programs, and the NYS Office of Children and Family Services' Healthy Families New York programs, to allocate the ARPA funds to support families participating in home visiting by provision of internet-connected technology and met the emergency needs of clients by supplying prepaid grocery cards, diapers, and other infant supplies. Programs have also used funds to provide technology for home visitors to conduct virtual home visits and bolstered recruitment or retention of home visiting staff with incentive payments.

In January 2023, the monthly call with local implementing agencies (LIAs) centered around innovative uses for American Rescue Plan (ARP) funds. Two LIAs shared their experiences. Subsequently more LIAs began to spend the funds. Service delivery expanded in one county with an additional Nurse Home Visitor, and a mental health therapist was added to the staff at another LIA providing one-to-one therapy to all clients with a demonstrated need. Throughout the year, there was spending in all 7 categories. A wide variety of emergency supplies were provided to approximately 350 families each quarter including, essential baby care items, cleaning products, first aid supplies, and bus passes for transportation to medical appointments. Cell phones and tablets were provided to more than 150 families to facilitate virtual visits and staying connected to their family visitor. Hazard pay was used to supplement staff income at 10 LIAs to provide more competitive salaries and to reduce turnover. Nearly 500 families experiencing food insecurities were provided grocery gift cards. One LIA partnered with a diaper bank to provide over 3,000 diapers for families.

NYSDOH recently surveyed LIAs for their projected ARP expenditures, and to assess if they needed a no cost time extension (NCTE) to allow more time to spend the funds. Four LIAs requested a NCTE, with three extending to 12/31/23 and one extending to 9/30/24.

WMH-1.7 Through the Family Planning Program, continue to support the delivery of comprehensive, confidential reproductive health services for low-income people of reproductive age who are uninsured or underinsured.

Addressing barriers to accessing reproductive health services continues to be a priority of all Family Planning Program work. An example of this is an additional one-time federal grant award which has now been extended through May 2024 to continue supporting telehealth services in rural service and downstate in healthcare desserts and those that serve a high volume of low income and underinsured individuals.as the NYS Family Planning Program continues to support dispensing 12-month supplies of contraceptives when appropriate. NYS Family Planning Program requires providers to submit a Schedule of Discounts (SOD) that aligns with the most current Federal Poverty Level (FPL) Guidelines and must ensure that Schedule of Discounts is reasonable, attainable, and fair with the goal of prioritizing services for low-income individuals who may be uninsured or underinsured. Cost should not be a barrier to any individual wishing to access family planning services. The Schedule of Discounts ensure that no fees are charged for family planning clients at or below 100% of the FPL, and the sliding fee scale charges for the other FPL levels must be applied progressively, such that individuals with lower income levels pay a smaller portion of the total cost. There are no charges for patients at or below 250% FPL for chlamydia testing, HIV testing and counseling, pregnancy testing and counseling, emergency contraception and condoms for patients, all common reasons why patients visit the family planning clinics. Family Planning Providers continue to assist

uninsured clients in enrolling in the most appropriate health insurance plans including Medicaid, Family Planning Benefit Program, and Family Planning Extension Program.

WMH-1.8: Through public awareness campaigns, the NYSDOH promotes messages about maternal warning signs to educate pregnant and postpartum women on when to seek help for untoward conditions associated with perinatal complications.

NYSDOH conducted two statewide social media campaigns, utilizing the Centers for Disease Control and Prevention's Hear Her Campaign, to build public awareness of the importance of recognizing early urgent maternal warning signs for pregnant and recently pregnant people. The simple message is that listening and acting quickly could save a life. The goals of the Hear Her Campaign are to raise awareness of potentially life-threatening warning signs during and after pregnancy and to improve communication between patients and their healthcare providers. The NYSDOH utilized social media platforms (Facebook, Instagram, and Snapchat) to convey information to pregnant people and their partners, friends, and family about pregnancy-related complications. The NYSDOH also employed two palm cards developed by CDC – one for pregnant and recently pregnant people and one for partners, friends, and family. These palm cards were co-branded, printed, and distributed to hospitals and home visiting programs in NYS to disseminate to their clients. The palm cards were translated into the ten languages most commonly-spoken in NYS and are available on the NYSDOH's website at www.health.ny.gov/HearHer for downloading and printing, or they can be ordered from the Department's distribution warehouse free of charge. In 2023, the NYSDOH added two new palm cards to the stockpile of Hear Her materials, which were specifically designed for American Indian and Alaskan Native pregnant people, as well as for their partners, friends, and family. These two new palm cards are available on the NYSDOH's website.

In the fall of 2021, the NYSDOH conducted a public awareness campaign about Perinatal Mood and Anxiety Disorders to educate birthing people about this condition and to highlight the resources available for help. Following the campaign, the Department continued to make resources available through the Department's website at Perinatal Mood and Anxiety Disorders (ny.gov).

In response to the Maternal Mortality Review's recommendation for COVID-19 vaccination of pregnant women, NYSDOH issued a Health Advisory in December 2021 to facilities, providers, and stakeholders on the importance of COVID-19 vaccination for people who are pregnant, postpartum, breastfeeding, or who may become pregnant. Additionally, NYSDOH produced a brochure and a poster explaining the importance of COVID-19 vaccinations and affirming their safety. The brochure was translated into the 10 most common non-English languages spoken in NYS, and the poster was translated into Spanish. All birthing hospitals in NYS were notified of these materials, which were made available for downloading and printing on the NYSDOH website at Pregnancy & COVID-19.

WMH-1.9: Continue to support prevention and response services for sexual violence through the Sexual Violence Prevention Unit.

Women's health and reproductive health are significantly interconnected with sexual violence. Women between the ages of 12 and 34 are at the highest risk for sexual violence. In the short term, sexual assault can lead to unintended pregnancies, sexually transmitted diseases, and injuries. However, there are many more long-term health consequences from sexual assault that range from depression, anxiety, and suicide to obesity, cancer, high-blood pressure, fibromyalgia, fibroids, preterm labor, miscarriages, fetal growth issues, placental abruption, and frequent c-section (The Sexual Abuse to Maternal Mortality Pipeline, Black Women's Blueprint). New York State's Rape Prevention and Education program consists of six Regional Centers for Sexual Violence Prevention to implement evidence-based/informed primary prevention strategies in 17 counties across NYS with the highest average number of reported forcible rapes. To support survivors of sexual violence, 55 NYSDOH approved Rape Crisis Programs provide support and advocacy services. Finally, the Sexual Assault Forensic Examiners (SAFE) Program consists of hospital programs, training programs, and examiners to respond to survivors of sexual assault and collect forensic evidence.

Strategy WMH-2: Strengthen coordination between birthing hospitals, outpatient health care providers, and other community services to make support for birthing parents and their families more comprehensive and continuous.

Coordination between birthing hospitals, community providers, and community-based organizations that provide essential support to birthing persons and their families is critical to maintaining optimal health and well-being and ensuring continuity of care during this period in a person's life. PICHC programs routinely coordinated with a wide variety of community-based organizations that provide health and social support services to address needs related to both physical and mental health, and social determinants of health such as safe housing, transportation, poverty, and nutrition. Birthing hospitals in NYS are required to provide similar referral services through support and social services. As noted above, telehealth services have emerged as a promising approach to delivering clinical care that can be tailored to the needs of each region and community, both urban and rural. Strengthening the connection between the PICHC providers and individual birthing hospitals ensures that pregnant New Yorkers, including those with high-risk pregnancies and chronic conditions, are connected to the highest quality of birthing services and support services, including timely postpartum care.

The Title V Program led the following specific program and policy activities to advance this strategy during the 2020-21 reporting period:

WMH-2.1 Establish regulations to require birthing hospitals to provide referral and support for ancillary services, including mental health, alcohol and substance use treatment, and other services.

Submitted regulations for internal review prior to publication that require birthing hospitals to provide referral and support for ancillary services, including mental health, alcohol and substance use treatment, and other services, and collaborated with NYSDOH partners in response to pending legislation for midwifery-led birth centers. The Department continues to work on regulations to update and modernize the statewide perinatal regionalization system. This includes requirements for perinatal services within birthing hospitals, as well as freestanding and midwifery birth centers. In May 2021, the Midwifery Birth Center Accreditation bill (S1414-A/A259-A) was passed by both houses of the legislature and was ultimately signed by Governor Kathy Hochul in December 2021. A chapter amendment was passed and signed, making technical revisions to the Midwifery Birth Center Accreditation bill (now an Act) in February 2022. During this timeframe, the regulations package was paused until the final act language was available. To comply with the Act, the Department engaged with midwifery stakeholders and advocates representing state and national chapters of the American Association of Birth Centers and the Commission for the Accreditation of Birth Centers, as well as key stakeholders from midwifery practices across the state. This input received was incorporated into the draft regulations and were published for public comment on May 31, 2023.

The public comment period was closed at the end of July 2023. Around 100 comments were received from hospitals, community organizations, midwifery birth centers and individuals. The Department has been organizing comments into subtopics and drafting responses to be provided. At this time, no significant changes to the regulations are required and a second public comment period is anticipated.

WMH-2.2 Implement a Vaccine Hesitancy Media Campaign.

Staff from the Division of Family Health worked with the NYSDOH's Bureau of Marketing and Creative Communications to launch Phase 1 of the COVID-19 and Pregnancy Media Campaign in October 2022. A workgroup consisting of staff from these areas met bi-weekly to develop promotional materials including Facebook posts and other social media to increase vaccination uptake for pregnant and postpartum women/people. The group also developed Phase 2 of the campaign which launched in December and focused on sharing testimonials from perinatal providers on their experience with receiving COVID-19 vaccination. The NYS Perinatal Quality Collaborative identified two perinatal providers who were recently pregnant and interested in promoting vaccination to the perinatal population. One of the providers is from University of Rochester Medical Center and the other from Northwell Health. The providers reported their testimonials on receiving the COVID-19 vaccination during pregnancy and the benefits of the vaccine.

WMH-2.3 To improve coordination and increase bilateral referrals between birthing hospitals and home visiting programs, Title V staff will assist in connecting PICHC programs with their local birthing hospitals and support formal meetings. Additionally, Title V staff will share promising and best practices from established home visiting-birthing hospital partnerships across the state to encourage collaboration.

As part of the effort to increase referrals to PICHC and MIECHV-funded home visiting programs, MIECHVstaff collaborated with the NYS Office of Children and Family Services and the NYS Council on Children and Families to update language on the *NYS Parent Portal* from “home visiting” to “parenting support.” This change was supported by focus studies conducted in 2018 which found that home visiting-eligible parents tied the term “home visiting” to Child Protective Services and preferred terms like “parenting support.” The update was also prompted by plans for a Title V-funded media campaign to direct pregnant and newly parenting New Yorkers in counties with low home visiting program enrollment to the *NYS Parent Portal* for resources like daycare, home visiting, and afterschool programs in their county. The media campaign ran August-October 2022 and led to over 100,000 clicks to the *NYS Parent Portal*. An evaluation to determine the impact on home visiting program enrollment is pending as of December 2022.

Title V staff previously mentored two master’s in public health student interns, one each in the Spring 2022 and Fall 2022 semesters. These interns examined existing relationships between home visiting programs and birthing hospitals via Survey Monkey questionnaires and evaluation of responses. The Spring 2022 intern used Maternal and Infant Community Health Collaboratives, Nurse Family Partnership programs, and Healthy Families New York referral data and created a referral monitoring tool in Excel to track trends in referrals made. With guidance from Title V staff, the intern ascertained best practices for improving referral relationships by survey analysis and evaluation of current data trends, and she presented on her findings to Maternal and Infant Community Health Collaboratives and Maternal, Infant, and Early Childhood Home Visiting-funded programs in April 2022. The Fall 2022 intern developed a survey for birthing hospitals, based on the previous questionnaire. The survey conducted in Fall of 2022 had a very low response rate which led to the proposal for a third master’s in public health student intern to recreate the birthing hospital survey and send out again.

The third student joined the Department in the Fall of 2023. She created a new survey for birthing hospitals that was informed by Home Visiting program responses in Spring 2022 and the work done on the survey from Fall 2022. The intern made the new survey more user-friendly and cut down completion time. Due to these updates, the response rate was much higher, and the intern was able to present these findings to the Regional Perinatal Centers on their first quarterly call of the year. The intern also created a promising practices tip sheet to be distributed to home visiting and birthing hospital staff.

Strategy WMH-3: Apply public health surveillance and data analysis findings to improve services and systems related to maternal and women’s health care.

Data-driven, evidence-based practice is essential to achieving public health goals for the Title V program. Across all Title V programs, continuous effort is needed to enhance the collection, analysis, and sharing of data to inform the planning and implementation of Title V-funded programs and related policy work. Sharing data with stakeholders, including providers and community members, is critical to raise awareness, empower community action, and facilitate quality improvement efforts at all levels.

Title V staff have implemented a comprehensive review process with the multidisciplinary NYS Maternal Mortality Review Board for the purpose of reviewing maternal deaths and maternal morbidity. NYS has an established public health surveillance process in place to identify and review cases of maternal death through multiple sources of data and chart reviews. The cases are identified within one year of the date of death and the case reviews are completed within two years of the date of death. The 2019 maternal death cohort review was completed by the end of calendar year 2021. The 2020 maternal death cohort review was completed by the end of calendar year 2022. The 2021 maternal death cohort review is expected to be completed by the end of calendar year 2023, except for one remaining case due to the availability of autopsy report.

Analysis of NYS Perinatal Quality Collaborative project data provided by participating birthing hospitals helps to improve services and systems related to maternal health care. The NYS Perinatal Quality Collaborative, American College of Obstetricians and Gynecologists District II of NY, Healthcare Association of New York State (HANYS) and Greater New York Hospital Association (GNYHA), with support from the National Institute for Children's Health Quality (NICHQ), has led specific improvement projects related to opioid use disorder in pregnancy and birth equity, two important areas related to maternal mortality and morbidity.

The NYS Opioid Use Disorder (OUD) in Pregnancy & Neonatal Abstinence Syndrome (NAS) Project aimed to improve care for both birthing persons with OUD and infants with NAS. The project's pilot phase began in September 2018 with 15 participating birthing hospitals. In October 2020, the project was expanded to include an additional 26 NYS birthing hospitals. By the close of the project in June 2023, the 41 participating hospitals increased the percentage of pregnant people screened for substance use disorder with a standardized questionnaire on admission to labor and delivery 77% (from 35.8% first three months of the expansion phase to 63.5% last three months of the project); and increased the percentage of pregnant people with OUD referred to Medication-Assisted Treatment by nearly five times higher (from 2.9% to 13.7%).

Based on analysis of qualitative data obtained from the 2018 listening sessions that engaged over 200 women statewide, the Department has developed and implemented a comprehensive interdisciplinary hospital quality improvement project focused on birth equity and implicit bias. This learning collaborative, which launched in January 2020, has engaged birthing hospital and center staff from clinical, administrative, and executive levels to analyze hospital policies and procedures that may contribute to bias and develop strategies to improve outcomes. This project has included the development a comprehensive training curriculum that can be replicated at facilities to enable staff to better understand and mitigate bias. As with all NYS Perinatal Quality Collaborative projects, Title V staff have been collecting and performing analysis of project data throughout the project period.

The Title V Program led the following specific program and policy activities to advance this strategy during the 2022-23 reporting period:

WMH-3.1 Summarize, share, and discuss findings of the Maternal Mortality Review Board with key partners, including the Maternal Mortality and Morbidity Advisory Council, to inform statewide prevention strategies.

NYSDOH staff developed a fact sheet based on the *New York State Report on Pregnancy-Associated Deaths in 2018* that summarized the main findings and recommendations for the 2018 maternal death cohort that was published in November 2022. The Maternal Mortality Review Board published an issue brief in November 2022: "Spotlight on Perinatal Mental Health." An additional issue brief, "Spotlight on Perinatal Substance Use Disorder," was nearing release at the close of the reporting period. Those publications can be found on the dedicated Maternal Mortality pages on the NYSDOH website developed by Title V staff: Maternal Mortality

The Maternal Mortality and Morbidity Advisory Council met seven times during the reporting period (10/22, 1/23, 2/23, 3/23, 5/23, 6/23, 10/23) and has written a report with their own recommendations for improving outcomes and reducing disparities, which is currently in the executive review process for release in the next reporting period.

WMH-3.2: Issue a maternal mortality report to provide data and information that can be used to improve maternal outcomes.

During the reporting period, the Maternal Mortality Review met six times (11/22, 1/23, 3/23, 5/23, 7/23, and 9/23) to perform the maternal death case reviews. The Maternal Mortality Review assessed the causes of death, factors leading to the death, and preventability for each maternal death reviewed.

A statewide report on pregnancy-associated mortality for 2018-2020 deaths with data and recommendations to improve maternal outcomes has been developed and is currently in the executive review process. The 2018-2020 report is expected

to be released in the next reporting period (See Strategy PIH- 2.6 for more detail on NYS Perinatal Quality Collaborative and equitable care.) A two-page factsheet presenting the highlights of the NYS Report on Pregnancy-Associated Deaths in 2018-2020 has also been developed during the reporting period and is expected to be released in the next reporting period.

The NYC Maternal Mortality and Morbidity Review Committee (M3RC) released the 2022 City Council annual report in January 2023, presented their findings internally to NYC DOHMH Bureau of Alcohol and Drug Use Prevention, Care and Treatment, Bureau of Maternal Health on Maternal Mental Health MMRC data, and Birth Equity workgroup on pregnancy-related deaths by cause of death & race/ethnicity, and provided data for external presentation at CAMBA event.

WMH-3.3: Identify cases of severe maternal morbidity through hospital discharge data and conduct an analysis using linked birth data and hospital discharge data to define the major causes of maternal morbidity.

Analytic staff examined 15 years of hospital discharge data (2008-2022) to monitor statewide and regional levels, trends, and disparities in severe maternal morbidity, with a primary focus on the surveillance period 2017-2022. Through these efforts, staff identified the top indicators of severe maternal morbidity, analyzed trends over time statewide and by key sub-populations, and examined severe maternal morbidity rates by maternal characteristics, geographic patterns, and facility context to identify priority areas for action to monitor, reduce, and eliminate inequities in severe maternal morbidity. Findings from this analysis have been summarized in a comprehensive statewide surveillance report on severe maternal morbidity. The report has been written and is currently undergoing internal review, with anticipated release in the next reporting period.

WMH-3.4: Through the New York State Perinatal Quality Collaborative, NYS birthing hospitals and centers have been engaged in a comprehensive interdisciplinary hospital quality improvement project focused on implicit bias through the NYS Birth Equity Improvement Project

The NYS Birth Equity Improvement Project launched in January 2020. The project seeks to assist birthing hospitals and centers in identifying how individual and systemic racism impacts birth outcomes and in taking action to improve both the experience of care and perinatal outcomes for Black women/birthing people in the communities they serve. (See Strategy WMH-4 below for further detail)

WMH-3.5: Collaborate with NYSDOH AIDS Institute and the New York City Department of Health and Mental Hygiene on efforts to address significant increases in the number and rate of infectious (primary, secondary, and early latent) syphilis among NYS females of childbearing age.

Strategy WMH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact women's health and use of health care across the life course.

Women and Maternal Health outcomes are impacted by the social determinants of health, or the conditions in which people are born, live, work, play, learn, and age. The social determinants of health include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of power and resources due to racism and other biases are root causes of inequities in access, availability of services, and quality of clinical care. All ten priorities that emerged from community members' input during the needs assessment revolve around the social determinants of health and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities.

The NYS Title V Program strives to contribute to broad-based efforts to address inequality and the social determinants of health. Strategies focus on improving outreach to find and engage high-need women and their families in health insurance and health care; increasing knowledge of available community resources and supports; working with community stakeholders to improve delivery of care and services; developing supports, opportunities and social norms that promote and facilitate healthy behaviors across the lifespan; involving community members in program implementation and policy

development; and promoting community engagement and mobilization to proactively address bias and racism and other community and systems-level factors impacting racial and ethnic disparities.

The PICHC program incorporates a multi-faceted approach to ensuring health equity principles are embedded in the framework. The overall intended outcomes of PICHC programs are to help families achieve an optimal level of health, self-sufficiency, and overall well-being. The program activities are responsive to feedback received from community members during the Department's 2018 statewide Commissioner's listening sessions, and reflected in the Voice Your Vision Report: listening_session_report.pdf (ny.gov). The program also incorporated a recommendation from the Governor's task force on maternal mortality to expand Community Health Worker services statewide: maternal_mortality_report.pdf (ny.gov), and also recommendations from the NYS Postpartum Workgroup to implement a stress free zone model of care: 2021-01_expert_panel_on_postpartum_care_final_report.pdf (ny.gov).

As part of the PICHC contractual agreement, Title V staff worked to ensure Community Health Workers are compensated with a living wage and afforded promotional opportunities. With additional funding from the state's Reducing Maternal Mortality appropriation, not only have Community Health Workers' salaries increased, but the requirements for the Community Health Worker Supervisor position have been updated to allow for a pathway for experienced Community Health Workers to advance to a Community Health Worker supervisory role. To achieve this, PICHC programs that have identified a potential candidate must submit a staff development plan that includes the Community Health Workers resume, a one-year probation period and additional training on Mental Health First-Aid, Case Management, Identification of Child Abuse and Maltreatment, Crisis Intervention, and Identification of Intimate Partner and Domestic Violence.

Community Health Workers conduct enhanced outreach, perform intake screening assessments using evidence-based tools, issue referrals and follow-up for needed services, work with clients to develop birth and postpartum plans, and connect or provide support groups for clients on topics related to breast/chest feeding, parenting/childbirth classes, Doula support, financial and health literacy resources, translation services and referral to English as a New Language (ENL) classes and grief support groups for families who have lost a parent or infant/child.

On a community-level, PICHC programs are required to conduct community mobilization, engagement and advocacy activities which include:

1. Start a new community action board if none exist in the catchment area (with 25% of the board consisting of community members) or participate in an existing community action board whose focus is improving perinatal and infant health.
    a. Identify gaps and barriers in the community and develop strategies for addressing social determinants impacting perinatal health outcomes.
    b. Develop a mechanism to include community input and report actions back to the community at large.
2. Promote civic engagement by training community members to participate on community action boards and other advocacy groups, and train 10-20 community members annually to develop leadership and advocacy skills.

The Title V Program led the following specific program and policy activities to advance this strategy during the 2021-22 reporting period:

WMH-4.1 Through the PICHC programs, contracted staff, including Community Health Workers, routinely worked with diverse community stakeholders, including community residents, to identify and collaboratively address issues and barriers impacting maternal and infant health outcomes at the community level, including:

- Actively participated in local community advisory boards, consortiums, or coalitions to address issues impacting perinatal and infant health and identify effective strategies for addressing the social determinants impacting those outcomes.
- Engaged and partnered with diverse stakeholders from a wide array of community sectors including community residents, grassroots organizations, community-based service organizations, health care providers, local

government, local foundations, and local businesses. This included working with over 4,227 community partners at more than 1,057 coordinated outreach events.

- Worked collaboratively with community partners to address relevant community issues such as safe housing, availability and accessibility of resources and services (e.g., health care, mental health, substance abuse services, home visiting, family support resources), social norms (e.g., related to use of preventive care services, breastfeeding, or personal health behaviors), and community mobilization to effectively identify and address community problems. Community Health Workers issued more than 19,215 health care and social support referrals to PICHC clients. The top five social support referrals are clothing and baby care items, the Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC); food pantry; housing assistance; and food stamps.

WMH-4.2 Through the PICHC programs, Community Health Workers were provided professional development, including annual training on how to talk with families about difficult topics like mental health and depression using a trauma-informed care approach; how to manage emergency situations; and cultural humility, anti-racism, and equity in perinatal care, and Community Health Workers provided supports to individual clients and their families to address behavioral and social determinants of health outcomes including:

- Information on available community resources for needs related to housing, food, employment and job training, transportation, and other basic needs, and guidance on how to access these resources, including remotely, as needed.
- Helping families connect and use/enroll in enhanced social support resources and programs including parenting classes, peer support groups, childbirth education and resources, breastfeeding education, and directly supported clients to develop birth plans.

WMH-4.3 Collaborate with partners, including but not limited to, the Office of Mental Health's Project TEACH, American College of Obstetricians and Gynecologists District II NY, home visiting programs and other community-based organizations, to address mental health in pregnant and postpartum people by increasing screening and follow-up support.

- Project TEACH, American College of Obstetricians and Gynecologists District II NY, and NYSDOH's NYS Perinatal Quality Collaborative have been hosting webinars on the integration of maternal mental health into obstetric practices, including the private practice perspective, and a focus on maternal mental health disparities and steps for achieving equity.
- Integrating parent engagement and leadership into state-level home visiting programs.

Title V staff continued to collaborate with partners, including the NYS Office of Mental Health's Project TEACH, the American College of Obstetricians and Gynecologists NY, home visiting programs, and other community-based organizations to address mental health in pregnant and postpartum people by increasing screening and follow-up support. A webinar was conducted on January 11, 2023, which focused on providing an overview of perinatal mood and anxiety disorders (PMADs) and understanding how Project TEACH can help NYS' providers with caring for perinatal patients with PMADs.

WMH-4.4 Collaborate with NYS Perinatal Quality Collaborative on the NYS Birth Equity Improvement Project. Through a Learning Collaborative model, NYS will continue to assist birthing hospitals and centers: in identifying how individual and systemic racism impacts birth outcomes within their organizations; and in taking action to improve both the experience of care and perinatal outcomes for Black birthing people in the communities they serve.

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The Title V Program, in collaboration with its NYS Perinatal Quality Collaborative, began a comprehensive learning collaborative project, the NYS Birth Equity Improvement Project in 2021 which will continue through May 2024. Seventy-three

New York State birthing hospitals and centers have joined the project, which seeks to assist birthing facilities in identifying how individual and systemic racism impacts birth outcomes at their organizations and taking action to improve both the experience of care and perinatal outcomes for Black birthing people in the communities they serve. Monthly data collection and analysis for the project began in April 2021. Participating facilities have taken part in educational opportunities focused on anti-racism and the impact of bias in perinatal health care, developed new and/or improved existing policies related to birth equity to better meet the needs of their community, and worked to ensure they are centering the experience of Black people who are giving birth through the implementation of a Patient Reported Experience Measure. The Patient Reported Experience Measure, which was implemented in July 2021, is administered to birthing people prior to their discharge from participating hospitals. As of September 30, 2023, more than 44,488 patient-reported surveys have been submitted. The data collected through the Patient Reported Experience Measure survey is stratified by race and ethnicity analyzed by Title V staff and reported back to facilities on a monthly basis. Participating facilities use this experience data to improve equity of care.

WMH-4.5 Monitor Infertility Reimbursement Program contracts and provide guidance and ongoing support to contractors and the public.

NYSDOH awarded six contractors (one upstate and 5 downstate) to participate in the Department's Infertility Reimbursement Program for the award period of 10/1/2022 – 9/30/2024. Title V staff updated eligibility requirements for the new program to align with new state insurance law, effective January 1, 2020, that requires all large cap insurance plans to provide three cycles of in vitro fertilization and fertility preservation services as well as adding requirements that prevent discrimination based on an individual's expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions, or personal characteristics, including age, sex, sexual orientation, marital status, or gender identity. The new law also includes a new state definition of infertility. Patient participation now includes Medicaid recipients, making the program more accessible to individuals with limited income, the unemployed, or those lacking insurance through their employer.

New **WMH-4.6** Improve uptake of the COVID-19 vaccination among people who are pregnant, in the postpartum period and/or lactating, and of those people's families, with an emphasis on equity and those populations disproportionately affected by the COVID-19 pandemic. This included hosting educational webinars for perinatal care providers, assisting NYS birthing facilities with the development and/or updating of their COVID-19 vaccination policies, and developing resources geared towards providers and/or patients.

Title V staff continued work to support the improved uptake of the COVID-19 vaccination among pregnant and parenting individuals and their families, with an emphasis on equity and those populations disproportionately affected by the COVID-19 pandemic. A series of webinars were hosted on these topics, including one titled: COVID-19 Vaccines for Black Birthing Women/People. The webinar enhanced participants' knowledge and competence in relation to improving COVID-19 vaccination rates for people in the perinatal period with an emphasis on Black Birthing people and those disproportionately impacted by COVID-19. The webinar offered free continuing education (CE) credits and the recordings were archived on the NYS Perinatal Quality Collaborative webpage.

The staff at the Division of Family Health in collaboration with other bureaus within the NYSDOH launched the COVID-19 & Pregnancy Media Campaign. Promotional materials (i.e., commercial, Facebook posts, other social media) and creatives were developed for the COVID-19 and Pregnancy Media Campaign to increase vaccination uptake for pregnant and postpartum people, especially among those disproportionately impacted by COVID-19. Phase 1 of the campaign launched in Fall 2022 and focused on promoting COVID-19 vaccination during the perinatal period with the development and dissemination of promotional materials such as Facebook posts, bus flyers, radio spots, and other social media. Phase 2 of the campaign launched mid to late December and focused on sharing testimonials from perinatal providers on their experience with COVID-19 vaccination during pregnancy.

WMH-4.7 Improve the New York State Sexual Assault Victim's Bill of Rights. The Sexual Assault Victim's Bill of Rights was developed in 2019. The Bill of Rights will be updated to improve health literacy and translated into the 10 most common languages in New York State.

The Sexual Violence Prevention Unit has formed an internal working group to begin updating the New York State Sexual Assault Victim's Bill of Rights. This group has made significant progress this year by drafting the first revised document and soliciting feedback from dozens of stakeholders. The group has been able to successfully incorporate all recommendations received from stakeholders so far. A new draft has been developed and gaps in stakeholder feedback have been identified for additional review and feedback.

WMH-4.8 Breastfeeding Support – Title V staff will participate in the Breastfeeding Grand Rounds planning committee in collaboration with Division of Chronic Disease and Division of Nutrition. The 2023 Breastfeeding Grand Rounds was held on November 14, 2023- Role of Legislation in Supporting Pregnant and Breastfeeding Employees in the Workplace.

WMH-4.9 The Rape Prevention and Education (RPE) Program has hired a Health Equity Consultant, Michelle M. Osborne, J.D. & Associates, LLC to conduct a health equity capacity assessment of the NYS RPE Program and develop and deliver a health equity training to staff within the Bureau of Perinatal, Reproductive, and Sexual Health.

Within this grant year, Michelle Osborne and Associates completed a health equity capacity assessment of the New York State Rape Prevention and Education Program. The purpose of the health equity capacity assessment was to determine the Rape Prevention and Education Program's current capacity to enhance and expand health equity work, including an audit of Rape Prevention and Education program staff and materials; a review of current data availability and use of available data; and training and technical assistance on health equity. To conduct the assessment, Michelle Osborne and Associates met with the Rape Prevention and Education Program Director bi-weekly, delivered a survey to all funded and unfunded Rape Prevention and Education Program staff and partners, interviewed all Rape Prevention and Education Program staff within the NYSDOH and four other Rape Prevention and Education Program subrecipients, and completed a deep audit of many core program materials including the website, external and public documents, internal unpublished documents, federal documents, and contract information located on Basecamp (a platform for team collaboration and project management that fosters collaboration and sharing across groups).

Michelle Osborne and Associates views antiracist health equity efforts as a continuous journey up and down the spectrum of *Awareness, Accountability, Advocacy and Action*. Turning insights and findings into specific action is the hallmark of their approach. During the bi-weekly check-ins, Michelle Osborne and Associates has begun to community their findings and recommendations for action. A final report with an action plan was submitted in September. This process has been critical to the RPE Program team and will guide strategic planning for the upcoming Center for Disease Control and Prevention Notice of Funding Opportunity and subsequent procurement for subgrantees.
Additionally, Michelle Osborne and Associates has been preparing to deliver a 12-hour training series on 'Antiracist Health Equity" to internal NYSDOH staff. This is designed as a virtual training that will be delivered in 6 2-hour sessions from October to December 2023.

- Session 1: Health Equity the Destination
- Session 2: Antiracism: The Vehicle
- Session 3: An Intersectional Journey
- Session 4: Locating Racist Power
- Session 5: Locating Antiracist Power
- Session 6: Inside Out

WMH-4.10 Collaborate with the Office of Drug User Health to addressing disparities in family planning/reproductive health in

the substance use population, creating partnerships between Family Planning Program and their Syringe Exchange Programs to strengthen reproductive healthcare and primary care.

The Family Planning Program continued work with the NYSDOH AIDS Institute Office of Drug User Health to address disparities in reproductive and sexual health care in the substance using population. This population is in high need of family planning services, and family planning clinics have the unique position to help de-stigmatize substance use disorders and address sexual and reproductive health needs from a harm reduction perspective. The goal of this work is to strengthen collaboration between Family Planning Programs and Syringe Exchange Programs to increase access to reproductive and primary healthcare A provider survey was sent out in mid-October 2022 and answers were collected/analyzed to gauge awareness of syringe exchange programs in counties that family planning clinics serve, their current partnership status with syringe exchange programs and their interest in strengthening partnerships with the syringe exchange programs. Based off the survey results, two regional meetings were convened. The first was a regional meeting with central/western NY providers, held on May 10, 2023 and the second with capital region/north country providers on September 20,2023. Both these meetings provided time for family planning clinics and syringe exchange programs to network and problem solve challenges they had faced when reaching out to each's respective client population. This work will continue with NYS Family Planning Providers attending Office of Drug User Health monthly workgroup meetings and including this topic in the NYS Family Planning Provider Meeting in May 2024.

In addition to the strategy updates above, the Department has taken great strides to incorporate health equity and racial justice throughout a wide variety of Title V activities, not limited to the activities within this strategy. In July 2022, the Department announced several reorganization efforts, including the creation of the Office of Health Equity and Human Rights. This new office is tasked with addressing health disparities and work to improve diversity, equity, and inclusion within the Department. The Office of Health Equity and Human Rights is a resource for programs across the Department as we work towards common goals of equitable health for all New Yorkers.

Within the Division of Family Health, a new Bureau of Health Equity and Community Engagement was created to address disparities highlighted in the COVID-19 pandemic and build a foundation for future epidemic responses. The bureau focuses on expanding and developing mitigation and prevention resources and services for pandemic response, improving data collection and reporting, and building infrastructure for cross-sector partnerships to align public health, healthcare, and social care interventions. The work of the new Bureau was highlighted in the *Success Story* and in Supporting Document #3. The Bureau has awarded 182 contracts of $49,999 each. These new contractors are non-traditional partners to the Department. There are over 50 contractors that focus specifically on supporting individuals from birth through reproductive age. Contractors include The Breasturant, Out Mommie Village, and Project Stork, as well as many more that support food security, health literacy, mental health, community empowerment, and more. These supports are critical for people to have knowledge, access, and availability to achieve health and well-being.

WMH-4.11 Guidance Document: Resources for Black Birthing People
In 2018, the NYSDOH organized seven community listening sessions with birthing people and other stakeholders. During these sessions, participants expressed that poor communication with healthcare providers was a significant barrier to receiving optimal prenatal care. Participants reported feeling unheard and needing more time with their providers and that few providers reflected on their lived experiences.

An internal ad hoc Department planning committee was formed in 2022 to develop a communication guide for Black birthing people, with a goal of helping pregnant and postpartum individuals to communicate more effectively with their healthcare providers – essentially bridging the communication gap between patients and their healthcare providers. The committee identified that better communication between providers and Black birthing people will be achieved by involving birthing people in their antenatal care and decision-making and that, in turn, will lead to better outcomes for all birthing people.

The planning committee consisted of subject matter experts in maternal and infant health from the Department's Division of Family Health including physicians, health educators, home visiting program staff and an Empire State Fellow. The planning

subcommittee met monthly to develop the guide, and the internal Department planning committee supervised and provided feedback on its development. The committee also consulted with the Department's Bureau of Creative Communications on content, messaging, and dissemination.

The communication guide titled "My Voice Matters" aims to empower birthing people and ensure their voices are heard throughout pregnancy, childbirth, and post-partum care. The content is designed to help birthing people communicate effectively with their healthcare providers, understand respectful care practices, and access resources that can aid them in their prenatal and postnatal care. It provides strategies and tools for patients to confidently address their concerns and needs during antenatal care and decision-making.

The dissemination plan includes distribution to a wide range of partner organizations including birthing facilities, physicians, and home visiting programs. The guide will also be available on the Department's website, with an anticipated distribution date of March 2024. The guide will also be translated into the 12 most spoken non-English languages and designed with patient-centric language to ensure ease of comprehension and be available in print and digital formats, making it accessible to a broader audience statewide.

***NEW* WMH-4.12** Diaper Bank

In 2022, Title V staff in collaboration with other state agency partners, began to engage with MIECHV, PICHC and HFNY partners to promote the availability of diapers through the NYCARES/Baby2Baby Diaper Bank.

Title V staff surveyed PICHC and MIECHV programs in January 2023 to assess the programs need and capacity to store diaper pallets, and shared survey results with our state agency partners. Title V staff continue to work with programs to promote the availability of these items.

The NYS Title V Program established two Evidence-Based Strategy Measures (ESMs) to track the programmatic investments and inputs designed to impact NPM1:

ESM WMH-1: Percent of Maternal and Infant Community Health Collaboratives /PICHC program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker.

Data for this measure is obtained from monthly reports submitted by Maternal/PICHC contractors (note: Maternal and Infant Community Health Collaboratives transitioned to PICHC in 2022). The baseline value for this measure, taken from 6-month program period of 10/1/19-3/31/20, is 52.7%. For the time period of 10/1/2021 to 9/30/2022, there was a slight decline to 51.7%. We believe that the decline is due to the implementation of a new web-based data management system on 4/1/2021. Program uptake of the new data system impacted data completeness and quality. Title V staff are working closely with PICHC programs to ensure participants have a birth plan created.

ESM WMH-2: Percent of Family Planning Program clients with a documented comprehensive medical exam in the past year.

Data for this measure will come from Family Planning Program clinic visit record data. For the time period from 10/1/2022 to 9/30/23, 30.8% of Family Planning Program clients had a documented comprehensive medical exam. This is a decline from the 38.7% of Family Planning Program clients reported in the prior annual report. Providers indicate fewer clients coming for comprehensive annual exams, despite outreach. Changes in the guidance for the timing of pap smear tests from every year to every three years have been cited as a factor in lower annual visit numbers. Family Planning Providers continue to provide outreach and education to community members on the importance of annual medical exams.

Women/Maternal Health - Application Year

For Women's and Maternal Health (WMH), New York's Title V Program selected **National Performance Measure (NPM) 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year.** This NPM was selected because it is foundational to women's health throughout the life course, is supported by population health data demonstrating a need for continued improvement and relates directly to several priorities voiced by birthing people and their families through community listening forums, including awareness of community resources, transportation, social support, and health care access and quality. This NPM also aligns directly with the NYS Prevention Agenda goal to increase use of primary and preventive health care services among women of all ages, especially women of reproductive age.

While NPM 1 directly measures annual preventive medical visits, it should be viewed as part of a continuum of primary and preventive care that also includes preconception, reproductive and sexual health, family planning, prenatal, and postpartum care, and that includes a full spectrum of medical, mental, and behavioral health, oral health, dietary/nutritional, and other supports and services.

NYS will also be addressing the new, required NPM for postpartum visits: a) percent of individuals who attended a postpartum checkup within 12 weeks after giving birth; and b) percent of individuals who attended a postpartum checkup and received recommended care components. The work to review current initiatives, identify gaps, and develop strategies and activities to improve postpartum visits is just beginning in the current grant. We will report on more robust strategies and activities in next year's application.

As described above in the annual report, increasing access to comprehensive, high quality, and equitable health care services has been identified as a key element of efforts to eliminate the striking racial and ethnic disparities in mortality and morbidity outcomes.

The following specific objectives were established to align with this performance measure:

Objective WMH-1: Increase the percent of women, ages 18 through 44, with a preventive medical visit in the past year by 5%, from 79.6% in 2018 to 83.6% in 2022. (Behavioral Risk Factor Surveillance System)

Objective WMH-2: Reduce the maternal mortality rate by 10%, from 17.8 deaths per 100,000 live births in 2014-2018 to 16 deaths per 100,000 live births in 2018-2022. (National Vital Statistics System)

Objective WMH-3: Reduce the rate of severe maternal morbidity per 10,000 delivery hospitalizations by 5%, from 83.5 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2017 to 79.3 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2021. (Healthcare Cost and Utilization project-State Inpatient Database)

Objective WMH-4: Reduce the percent of women who have depressive symptoms after birth by 5%, from 13.0% in 2017 to 12.4% in 2021. (Pregnancy Risk Assessment Monitoring System)

Objective WMH-5: ***NEW*** Increase the percentage of individuals receiving postpartum visits: a) establish baseline percentage and propose a percentage increase for individuals who attended a postpartum checkup within 12 weeks after giving birth; and b) similarly for individuals who attended a postpartum checkup and received recommended care components.

Four strategic public health approaches were identified to accomplish these objectives. These are presented in the State Action Plan Table, and each is described in more detail here, with specific program and policy activities that will be implemented to advance the broader strategic approach in the upcoming year.

Strategy WMH-1: Integrate specific activities across all relevant Title V programs to promote the health and wellness of people of child-bearing age, including enrollment in health insurance, routine well visits, pregnancy planning and prevention, prenatal, and postpartum care.

Improving the health of people of child-bearing age requires a life course approach to be most effective. Preventive medical visits are a key opportunity for delivering health education and reinforcing health-promoting behaviors. Preventive visits help to identify chronic conditions, such as hypertension and diabetes, in child-bearing people that could contribute to maternal morbidity and mortality. Family planning and reproductive health visits ensure that people of child-bearing age have access to contraception for prevention of pregnancy, and counseling on reproductive life planning, appropriate birth spacing, and preconception health. Title V programs also provide enabling services, such as social support and referrals/linkages to a wide range of community services, to holistically address health and wellness, including mental health and social determinants of health, for people of child-bearing age. Incorporating specific activities across programs leverages the public health infrastructure and capacity supported through previous and ongoing Title V investments. Of note, while NYS begins to incorporate the new NPM for postpartum visits, there is ongoing work reflected in the current Application and State Action Plan.

The goal of the Perinatal and Infant Community Health Collaborative (PICHC) program (July 1, 2022 - June 30, 2027) is to improve perinatal health outcomes and eliminate racial, ethnic, and economic disparities in those outcomes. As the core individual-level strategy, PICHC programs will continue to utilize community health workers to conduct basic health and well-being assessments in the prenatal and postpartum periods, using standardized evidence-based and/or validated screening tools, to identify and prioritize needs of the individuals and families served. Assessments are completed at enrollment and updated throughout clients' service periods and individualized care plans are developed based on the PICHC identified. Community Health Workers will continue to receive annual training from the PICHC Training and Technical Assistance provider, which will soon transition from John Snow Inc. (JSI), to Cicatelli Associates, Inc. (CAI), on topics including, but not limited to how to talk with families about difficult topics like mental health and depression using a trauma-informed care approach, how to manage emergency situations; understanding what it means to be anti-racist, and how to support birth equity. Community Health Workers will continue to connect clients and families to needed services and provide enhanced social support. Community Health Workers will continue to help ensure early and consistent participation in preventive and primary health care services, including early prenatal care, particularly for those individuals not engaged in care and other supportive services, and postpartum care. Community Health Workers will also continue to provide health information to increase clients' knowledge and ability to self-advocate and make informed health care decisions, with the goal of helping families achieve optimal health, self-sufficiency, and overall well-being.

The 26 PICHC programs will continue to coordinate outreach and engagement activities with other home visiting programs serving the same communities including programs supported by New York's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative. PICHC and MIECHV programs coordinate outreach, referral, assessment, and intake processes to find and engage pregnant and parenting families and ensure they are engaged with home visiting programs and supportive services responsive to their needs.

The NYS Family Planning Program supports 37 health facilities that are regulated by New York State Department of Health (the Department) under Article 28 of NYS Public Health Law (these include hospitals and clinics) that operate over 160 family planning service sites across the state. Through these service sites, the Family Planning Program delivers comprehensive, confidential reproductive health services for people of reproductive age who are low income and uninsured or underinsured. Services provided include contraceptive services; preconception planning and counseling services; pregnancy testing and related counseling; preventive services such as basic health screening, screening for sexually transmitted diseases, HIV counseling and testing, and breast and cervical cancer screening; and appropriate referrals and health education. Ensuring continued access to these core primary and preventive services is essential.

As reinforced by community forums, increasing awareness of available resources among both consumers and providers is critical. The use of social media messages enhances awareness of the state's Growing Up Healthy Hotline service, which

in turn provides callers with linkages to local community resources, supports, and services including Supplemental Nutrition Program for Women, Infants and Children (WIC), Medicaid, Family Planning, prenatal care, and the NYS Early Intervention Program. Social media and other emerging communication forums online have the potential to reach large and diverse populations. When messages are developed using science-based health messaging, social media can be a communication medium that can educate and influence health decision making.

The NYS Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2024-25 year:

- **Activity WMH-1.1**: Across all Title V programs, enhance promotion of the NYS Growing up Health Hotline to increase awareness of available community resources, supports, and services including Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC); Medicaid; family planning; and prenatal care, Early Intervention Program, and home visiting and parent support programs.
    - Title V staff, including PICHC and MIECHV staff, will continue to promote the Growing up Health Hotline through presentations to Title V programs and partners, broadly share the Growing up Health Hotline flyer available in multiple languages on the Department's website and provide updates to the Growing up Health Hotline as available resources emerge or change.
    - A statewide media campaign to promote the Growing Up Healthy Hotline and the new texting service will be planned and launched in 2025.
- **Activity WMH-1.2:** Through the PICHC and MIECHV programs, integrate use of virtual home visiting services to increase acceptance and support of services for families that have been hard to reach.
    - Recent experience suggests that virtual support visits conducted in the context of the response to COVID-19 have helped to maintain communication and allow for essential Community Health Workers and home visiting services to continue including providing health information, support and referral and follow-up for preventive and prenatal care visits. Since entering the endemic phase of COVID-19, home visiting programs have transitioned to modified in-person visits and continue to use the virtual option as needed to ensure individuals and families continue to receive supportive services.
- **Activity WMH-1.3:** Through the PICHC program, continue to support Community Health Workers to conduct outreach to find and engage high-risk pregnant and postpartum families in consistent and comprehensive preventive and primary care services, including prenatal, interconception, and postpartum care.
    - Community Health Workers will routinely: screen clients for health insurance enrollment and health care engagement and assist them in obtaining care if needed; provide ongoing social support and reinforcement for health care utilization; and provide clients with health information and social support to increase knowledge and ability to self-advocate and make informed health care decisions. Community Health Workers will initiate (or coordinate with Obstetric providers) the development of a birth plan with all prenatal clients, and a postpartum care plan with all postpartum clients, and monitor the number of both plans initiated through the PICHC data management information system.
- **Activity WMH-1.4:** Through the NYS Family Planning Program, continue to support the delivery of comprehensive, confidential reproductive health services for individuals of reproductive age who are low income and uninsured or underinsured at our 160 family planning clinic locations across the state.
    - Barriers to accessing reproductive health care will remain a priority and be addressed through continued use of enhanced telehealth services, discounted fees based on income, emphasizing outreach and education to adolescents, and dispensing a 12-month supply of contraceptives. Family Planning providers will continue to implement sliding fee schedules to ensure cost is never a barrier to care, partner with and refer to other medical and social services to meet the needs of their patients, conduct outreach and education to ensure community members know where they can access comprehensive and affordable services and assist uninsured clients in enrolling in the most appropriate health insurance plans including Medicaid, Family Planning Benefit Program, and Family Planning Extension Program.

- **Activity WMH-1.5:** The Sexual Violence Prevention Unit will continue to support prevention and response services for sexual violence through three programs: Rape Prevention and Education; Rape Crisis; and Sexual Assault Forensic Examiners.
    - NYS's Rape Prevention and Education program aims to promote health equity and prevent sexual violence by addressing social factors like poverty and discrimination that contribute to the prevalence of violence by fostering meaningful engagement and coordination with communities while building sustainable infrastructure. To support survivors of sexual violence, 51 organizations operate about 70Rape Crisis Program sites throughout the state to provide victim support and advocacy services. The Sexual Assault Forensic Examiners Program consists of 51 hospital programs, 6 training programs, and about 550 examiners to respond to survivors of sexual assault and collect forensic evidence.
- **Activity WMH-1.6:** Through public awareness campaigns, promote messages about maternal warning signs to educate pregnant and postpartum women about when to seek help for untoward conditions associated with perinatal complications.
    - The Department's webpage about the Hear Her Campaign promotes messages to consumers about urgent maternal warning signs. Hear Her. You Can Help Save Her Life. (ny.gov). Links on the webpage to print materials that providers may offer birthing people and their partners/families about urgent maternal warning signs will continue to be available.

Strategy WMH-2: Strengthen coordination between birthing hospitals, outpatient health care providers, and other community services to make support for birthing parents and their families more comprehensive and continuous.

Coordination between birthing hospitals, community providers, and community-based organizations that provide essential support to birthing persons and their families is critical to maintaining optimal health and well-being and ensuring continuity of care during a key life course period. PICHC programs routinely coordinate with a wide variety of community-based organizations that provide health and social support services to address needs related to both physical and mental health, and social determinants of health, including safe housing, transportation, poverty, nutrition, and other supports. PICHC programs will also continue to facilitate Community Action Boards/Networks within their communities, focused on issues affecting perinatal health, with memberships consisting of community members and diverse stakeholders, including representatives of birthing hospitals and other health care providers/networks. Birthing hospitals in NYS are required to provide similar referral services through support and social services. As noted above, telehealth services have emerged as a promising approach to delivery of clinical care that can be tailored to the needs of each region and community, both urban and rural. Strengthening the connection between the PICHC providers and individual birthing hospitals will ensure that pregnant New Yorkers, including those with high-risk pregnancies and chronic conditions, are connected to the highest quality of birthing services and support services, including timely postpartum care.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2024-25 year:

- **Activity WMH-2.1**: Collaborate with birthing hospitals and Regional Perinatal Centers to support new regulatory requirements related to providing referral and support for ancillary services, including mental health, alcohol and substance use treatment and other services.
    - Title V staff will continue to coordinate the Department's response to public comments and adopt regulations related to perinatal services in hospitals, as well as the state's regional perinatal network, including midwifery and physician-led birth centers as the first level of care. Following adoption of these regulations, work with Island Peer Review Organization (IPRO), which has a contract with the Department to support this work, to develop and implement a redesignation survey based on the new regulations. Each birthing hospital will complete the survey of their intended level of care (which may mean hospitals requesting to increase or decrease a level of care). These surveys will be reviewed, and a portion of the applicants (20% of birth centers, Level 1 and Level 2 birthing hospitals, and all Level 3 and Regional Perinatal Center applicants) will

have an on-site visit with IPRO staff and contracted neonatologists and/or maternal-fetal medicine specialists, to verify that the applicant meets the regulatory requirements and can provide appropriate care. Title V staff will also coordinate and support Regional Perinatal Centers as they work with their affiliate birthing facilities to meet the new regulatory requirements related to providing referral and support for ancillary services, including mental health, alcohol and substance use treatment, and other services which are not requirements under current regulations.
(See Activity PIH-2.1 for additional details.)

- **Activity WMH-2.2**: Improve coordination and increase bilateral referrals between birthing hospitals and home visiting programs. Title V staff will:
  - Continue to assist in connecting PICHC programs with their local birthing hospitals and support formal meetings where possible. Resources will be shared with programs and evaluation surveys conducted to determine use and effectiveness of resources.
  - PICHC program data will continue to be monitored to track incoming client referrals from birthing hospitals.
  - Share a promising and best practices document with input from established home visiting-birthing hospital partnerships across the state to encourage collaboration.
  - Continue to collaborate with PICHC; Maternal, Infant, and Early Childhood Home Visiting; Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC); and the NYS Office of Children and Family Services on a WIC Referral Project and the State's MIECHV continuous quality improvement project, to improve bi-directional referrals between local WIC sites and local PICHC and MIECHV home visiting programs.

Strategy WMH-3: Apply public health surveillance and data analysis findings to improve services and systems related to maternal and women's health care.

Data-driven, evidence-based practice is essential to achieving public health goals for the Title V program. Across all Title V programs, continuous effort is needed to enhance the collection, analysis, and sharing of data to inform the planning and implementation of Title V-funded programs and policy work. Sharing data with stakeholders, including providers and community members, is critical to raising awareness, empowering community action, and facilitating quality improvement efforts at all levels.

In 2019, the NYS Task Force on Maternal Mortality and Disparate Outcomes released a report that detailed ten recommendations to better address maternal mortality and morbidity. Included in these recommendations was a call to establish in statute a statewide maternal mortality review board. Public Health Law 2509 authorized the establishment of a maternal mortality review board and allowed the Department to enter into an agreement with New York City to conduct reviews of maternal deaths occurring within the NYC. In 2019, the multidisciplinary NYS Maternal Mortality Review Board was established, and NYC continued to operate its Maternal Mortality and Morbidity Review Committee. PHL 2509 also authorized the establishment of an advisory council on maternal mortality and morbidity for the purpose of reviewing the findings of the state and city boards. The council, known as the Maternal Mortality and Morbidity Advisory Council, is authorized to develop recommendations on policies, best practices, and strategies to prevent maternal mortality and morbidity.

Title V staff will continue to implement a comprehensive review process with the multidisciplinary NYS Maternal Mortality Review Board for the purpose of reviewing maternal deaths and maternal morbidity. The Maternal Mortality Review Board will continue to meet virtually, about four to six times per year, to enable timely maternal death reviews. NYS has an established public health surveillance process in place to identify and review cases of maternal death through multiple sources of public health data and chart reviews. The Maternal Mortality Review Board will continue to assess the causes of deaths, factors leading to the deaths, preventability for each maternal death reviewed, and develop recommendations to reduce the risk of maternal mortality and morbidity, including risk resulting from racial, economic, or other disparities. The

Maternal Mortality and Morbidity Advisory Council developed their own recommendations that were released in the spring of 2024. The Maternal Mortality Review Board's recommendations for preventability will be translated into action through collaboration with the Maternal Mortality and Morbidity Advisory Council, the American College of Obstetricians and Gynecologists District II NY, and other key stakeholders, including the development of issue briefs, webinars, and quality improvement projects through the NYS Perinatal Quality Collaborative. *(See Strategy PIH-3 for additional details.)*

In 2023, the Department has been assessing the implementation of 2018 Maternal Mortality Review Board's recommendations and will continue to direct its efforts at implementation of recommendations with partners through policy development and quality improvement work. In 2024-2025, the Department will continue to direct and assess implementation of the 2018-2020 Board's recommendations.

Based on analysis of qualitative data obtained from 2018 listening sessions that engaged over 200 women statewide, the Department has also developed a comprehensive interdisciplinary hospital quality improvement project through the NYS Perinatal Quality Collaborative focused on birth equity and anti-racism. The New York State Birth Equity Improvement Project, which launched in January 2021, has engaged birthing facility staff from clinical, administrative, and executive levels to analyze facility policies and procedures that may contribute to bias and develop strategies to improve outcomes. As with all NYS Perinatal Quality Collaborative projects, Title V staff will continue to collect and analyze project data and share results with partners to influence policy and decision making.

Additional prevention efforts in the areas of congenital syphilis and sexual violence prevention will also be conducted. Efforts to address and eliminate congenital syphilis are currently in development and led by the Department's AIDS Institute's Office of Sexual Health and Epidemiology. Specific activities, and the role(s) of Title V staff, will be determined in collaboration with Office of Sexual Health and Epidemiology.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2024-2025 year:

- **Activity WMH-3.1:** Summarize, share, and discuss findings of the Maternal Mortality Review Board with key partners, including the Maternal Mortality and Morbidity Advisory Council, to inform statewide prevention strategies as described above.
    - Title V staff will continue to meet with the Maternal Mortality and Morbidity Advisory Council at least twice annually to share and discuss findings of the Maternal Mortality Review Board and obtain Maternal Mortality and Morbidity Advisory Council recommendations on statewide prevention strategies. They will also continue to create and publish at least one issue brief annually on a key topic identified by the Maternal Mortality Review Board and Advisory Council that can inform prevention strategies.
- **Activity WMH-3.2:** Issue and disseminate a maternal mortality report and an Executive summary to provide data and information that can be used to improve maternal outcomes.
    - Title V staff will conduct analysis of maternal mortality data for the 2018-2022 cohort. The anticipated publication date is 12/31/2025.
- **Activity WMH-3.3:** Identify cases of severe maternal morbidity through hospital discharge data to conduct an analysis assessing severe maternal morbidity trends, major causes, and disparities during the 2011-2021 period.
    - Title V staff have developed a surveillance report of severe maternal morbidity. The draft report is in the review process with a target publication date of 12/31/2024.
- **Activity WMH-3.4:** Through the NYS Perinatal Quality Collaborative, continue work on the NYS Birth Equity Improvement Project, a comprehensive interdisciplinary quality improvement project focused on implicit bias and birth equity. *(see Strategy WMH-4 below for further detail).*
- **Activity WMH-3.5:** Collaborate with the Department's AIDS Institute and the New York City Department of Health and Mental Hygiene on efforts to address significant increases in the number and rate of infectious primary, secondary, and early latent syphilis among NYS females of childbearing age. *(See Activity PIH-3.5 for additional details and*

activities).

- **Activity WMH-3.6:** SET-NET Provider Engagement Placeholder

Strategy WMH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact women's health and use of health care across the life course.

Women and Maternal Health outcomes are impacted by the social determinants of health, or the conditions in which people are born, live, work, play, learn, and age. The social determinants of health include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of power and resources due to racism and other biases are root causes of inequities in access, availability of services, and quality of care. All ten priorities that emerged from community members' input during the Needs Assessment revolve around the social determinants of health and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities.

The NYS Title V Program strives to contribute to broad-based efforts to address inequity and the social determinants of health. Strategies focus on 1) improving outreach to women, who have been disproportionally impacted by systemic barriers and are located in areas with limited access or have factors limiting their access to care, and their families to ensure they have health insurance and health care, have knowledge of available community resources and supports, receive high quality care and services, and have supports, opportunities, and an environment that promote and facilitate healthy behaviors across the lifespan; 2) involving community members in program implementation and policy; and 3) promoting community engagement and mobilization to proactively address bias and racism and other community and systems-level factors impacting racial and ethnic disparities.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2024-25 year:

- **Activity WMH-4.1:** Through the PICHC programs, continue to work with diverse community stakeholders including community residents to identify and collaboratively address issues and barriers impacting perinatal and infant health outcomes at the community level, including to the following activities:
    - Actively facilitate/participate in community advisory boards, consortiums, or coalitions to address issues impacting perinatal and infant health and identify effective strategies for addressing the social determinants impacting those outcomes.
    - Engage and partner with diverse stakeholders from a wide array of community sectors including community residents, grassroots organizations, community-based service organizations, health care providers, local government, local foundations, and local businesses.
    - Work collaboratively to address relevant community issues such as safe housing, availability and accessibility of resources and services (e.g., health care, mental health, substance abuse services, home visiting, family support resources), social norms (e.g., related to use of preventive care services, breastfeeding, or personal health behaviors), and community mobilization to effectively identify and address community problems.
- **Activity WMH-4.2:** The PICHC programs' Community Health Workers, as well as Maternal, Infant, and Early Childhood Home Visiting's NYSDOH-led Nurse Family Partnership and NYS Office of Children and Family Services-led Healthy Families New York programs, continue to provide supports to individual clients and their families to address behavioral and social determinants of health outcomes, including the following specific program activities:
    - Provide information on available community resources for needs related to housing, food, employment and job training, transportation, and other basic needs. PICHC program policy was developed (per the recommendations of the NYS Expert Panel on Postpartum Care.) to support PICHC contractors to continue functioning as Stress-Free Zones (to the extent it's possible), creating a community in which birthing people have access to essential wraparound and care coordination services.

- Routinely screen for health insurance enrollment, and assist clients with enrollment as needed, including referral to enrollment Navigators and Community Health Advocates.
- Conduct screenings using standardized, evidence-based, or validated tools for domestic violence, substance use, smoking, and depression, and make referrals for follow-up as needed. PICHC, Nurse Family Partnership and Healthy Families New York program data will be collected and monitored via a web-based data management and information system.
- Help families connect and use or enroll in enhanced social support resources and programs including parenting classes, peer support groups, childbirth education and resources, breastfeeding education, and directly support clients to develop birth and postpartum care plans.
- To best support and empower the work of Community Health Workers, the PICHC program established policy to ensure Community Health Workers are fairly compensated with a salary comparable to a living wage. Title V staff will continue to assess the salary and ensure Community Health Workers have a livable wage in light of inflation and other factors.
- Through a new PICHC training and technical assistance contractor, Cicatelli Associates, Inc., tentatively effective summer of 2024, will provide professional development support for Community Health Workers, including annual training on how to talk with families about difficult topics like mental health and depression, using a trauma-informed approach, and how to manage emergency situations. Training and technical assistance will include assessing the training needs of funded grantees and providing appropriate technical assistance, developing/conducting web-based and in-person trainings, ensuring competencies of Community Health Workers and supervisors, standardization of best practice strategies, promoting/conducting Continuous Quality Improvement activities, and conducting an annual learning collaborative. Cicatelli Associates, Inc. will also host a PICHC website/page, providing access to available trainings, resources, and opportunity for PICHC programs to communicate their training needs.

- **Activity WMH-4.3:** Collaborate with partners, including:
  - Prevent Child Abuse New York, the NYS Office of Children and Family Services, and the Schuyler Center for Advocacy and Analysis (SCAA) Home Visiting Workgroup to integrate parent engagement and leadership into state level home visiting efforts. In 2024, MIECHV staff have proposed to initiate and implement a statewide parent advisory committee, which will consist of parents who are current or former home visiting clients. Through parent engagement and leadership, the parent advisory committee will provide input on matters of interest to state agency partners and develop professional skills. Title V and MIECHV staff will share lessons learned with PICHC programs to enhance their community member participation on Community Advisory Boards.
  - NYS Office of Mental Health's Project TEACH, American College of Obstetricians and Gynecologists District II NY, home visiting programs and other community-based organizations, will work together to continue to address mental health in pregnant and postpartum people by increasing screening and follow-up support.
  - The PICHC program will be updating the data management information system to add an additional postpartum depression screening within three months of giving birth (in addition to at initial intake) for all birthing clients. Community Health Workers will continue to assist individuals with the development of a postpartum care plan and provide information, guidance, support, and referrals to needed services. PICHC program staff will be continuously trained and updated on postpartum care and available resources through the dedicated PICHC training website provided by Cicatelli Associates, Inc.
- **Activity WMH-4.4:** Collaborate with NYS Perinatal Quality Collaborative on the NYS Birth Equity Improvement Project.
  - The Title V Program, in collaboration with the NYS Perinatal Quality Collaborative, will continue the work of the NYS Birth Equity Improvement Project to improve outcomes for Black birthing people, as well as their experience of care during the birth hospitalization. The project will have an expanded focus on reducing primary cesarean births for low-risk birthing people (i.e., Nulliparous, Term, Singleton, Vertex, or NTSV, deliveries). Monthly data collection and analysis for the project will continue through the application period.

Participating facilities will continue to participate in educational opportunities focused on anti-racism and the impact of bias in perinatal health care and reducing NTSV cesarean births, develop new and/or improved existing policies, and work to ensure they are centering the experience of Black birthing people through the ongoing administration of the Patient Reported Experience Measure.

- **Activity WMH-4.5** Through the Infertility Reimbursement Program, provide reimbursement for out-of-pocket costs associated with in vitro fertilization (IVF) and fertility preservation services to individuals who meet eligibility criteria.
    - The Infertility Reimbursement Program was developed to align with NYS insurance law effective 1/1/2020, which requires all large cap insurance plans to provide three cycles of in vitro fertilization (IVF), fertility preservation services, and added requirements that prevent discrimination based on an individual's expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, or other health conditions, or based on personal characteristics, including age, sex, sexual orientation, marital status, or gender identity. The new law also includes a state definition of infertility that is more equitable. Infertility Reimbursement Program patient participation is inclusive of Medicaid recipients, making the program more accessible to individuals with limited income, the unemployed, or those lacking health insurance through their employer. Staff will provide guidance, monitor activities, and collect data from six contractors awarded funding for a two-year period from 10/1/22-9/30/24. Additionally, the contracts will be extended for another two-year period from 10/1/24-9/30/26 with approval for contract reporter exemption request received in March 2024. The guidelines for eligibility will be updated based on the current clinical standards and with consideration to the expanded insurance laws. Staff will also monitor the Bureau's mailbox and respond to relevant questions received about how to access infertility services in NYS.
- **Activity WMH-4.6:** Update and improve the NYS Sexual Assault Victim's Bill of Rights.
    - The Sexual Assault Victim's Bill of Rights was developed in 2019. The Bill of Rights will be updated to improve health literacy and translated into the 10 most common languages in NYS. The new Bill of Rights will include improved design features that make it easier for victims/survivors to understand the information and bring the document home safely. Most importantly, the new Bill of Rights will update necessary language on changes to Public Health Law since 2019 that improve access to HIV post-exposure prophylaxis for minors.
- **Activity WMH-4.7:** Breastfeeding Support
    - Title V staff will participate in the Breastfeeding Grand Rounds planning committee in collaboration with Division of Chronic Disease and Division of Nutrition. Breastfeeding Grand Rounds webcasts are created for public health and health care professionals and feature clinical experts paired with public health experts to provide education on current breastfeeding health issues with both clinical and public health significance.
- **Activity WMH-4.8:** Improve reproductive healthcare for the substance use population.
    - The NYS Family Planning Program is collaborating with the AIDS Institute's Office of Drug User Health to address disparities in family planning/reproductive health in the substance use population, creating partnerships and strong referrals between Family Planning Program and their Syringe Exchange Programs to strengthen reproductive healthcare and primary care.
- **Activity WMH-4.9**: Provide resources for birthing people to advocate and communicate effectively with healthcare providers.
    - In 2018, the Department conducted seven community listening sessions with birthing people and other stakeholders. Poor communication with health care providers (e.g., feeling providers were not listening to them, that they were not given enough time with providers, and that few providers reflected their lived experience) was reported as a barrier to receiving optimal prenatal care. As one strategy to address this barrier, a communication guide for birthing people to promote effective communication with their health care provider is being developed and will be disseminated to partner organizations, including home visiting programs. Development plans for the draft guide, titled "My Voice Matters" was presented on 11/16/22 to an internal Department planning committee. The purpose of the guide is to improve birth outcomes by empowering and encouraging all birthing people and their advocates to speak up and participate in their antenatal care and decision-making and improve

communication between providers and all birthing people. A planning subcommittee met monthly to develop the guide and Division of Family Health leadership provided feedback on the guide. The Department provided approval of the content of the guide in March 2024. The guide is being designed by the Bureau of Media and Creative Communications. Once design is complete, dissemination plans to partner organizations will be implemented.

- **Activity WMH-4.10:** Engage with MIECHV (Healthy Families New York and Nurse Family Partnership) and PICHC providers to promote the availability of diapers through the NYCARES/Baby2Baby Diaper Bank.
    - Title V staff will collaborate internally and with state partners at the Office of Temporary Disability and Assistance (OTDA) to coordinate access to free diapers for families served by NYS home visiting programs.

The NYS Title V Program established two Evidence-Based Strategy Measures (ESMs) to track the programmatic investments and inputs designed to impact NPM1:

ESM WMH-1: Percent of PICHC program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker.

Data for this measure will be obtained from monthly reports submitted by local PICHC contractors in the data management information system. The baseline value for this measure, taken from the 12-month program period of 7/1/22-6/30/23, is 60.5%. The PICHC program has set an objective of 66.7% of participants by 2025.

ESM WMH-2: **Percent of Family Planning Program clients with a documented comprehensive medical exam in the past year.**

- Data for this measure will be obtained from Family Planning Program clinic visit record data. For the program period 10/1/21-9/30/22, 37.2% of female Family Planning Program clients had a documented comprehensive medical exam. The Family Planning Program has set an objective of 38.2% in 2024.

Perinatal/Infant Health

National Performance Measures

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
Indicators and Annual Objectives

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	93.7	93	92.4	92.6	92.8
Annual Indicator	91.2	92.2	91.6	91.3	91.6
Numerator	2,782	2,626	2,610	2,437	2,610
Denominator	3,052	2,849	2,850	2,668	2,850
Data Source	NYS VS	NYS VS	NYS VS	NYS VS	NYS VS
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	93.1	93.4

Evidence-Based or –Informed Strategy Measures

ESM RAC.1 - Percent of birthing hospitals with final level of perinatal care designation, in accordance with updated regulations and standards

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			0	0	50
Annual Indicator	0	0	0	0	0
Numerator					
Denominator					
Data Source	NYS Data	NYS Data	NYS Data	NYS Data	NYS Data
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	75.0	100.0

State Performance Measures

SPM 1 - Percent of samples received by the State Newborn Screening lab within 48 hours of collection

Measure Status:	Active				
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			75	77	79
Annual Indicator	70	68	70	70.6	67.2
Numerator					
Denominator					
Data Source	Newborn Blood Spot data	Newborn Blood Spot data	Newborn Blood Spot data	Newborn Blood Spot data	Newborn Blood Spot data
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	81.0	85.0

State Action Plan Table

State Action Plan Table (New York) - Perinatal/Infant Health - Entry 1	
Priority Need	
Address transportation barriers for individuals and families.	
NPM	
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	
Five-Year Objectives	
Objective PIH-1: Increase or maintain the percent of very low birth weight infants born in a hospital with a Level III+ NICU by 2.4%, from the 2017 level of 91.2% to 93.4% by 2021. (NYS Vital Statistics Birth Data)	
Objective PIH-2: Decrease the infant mortality rate by 2.6%, from 4.6 deaths per 1,000 live births in 2017 to 4.49 deaths per 1,000 live births in 2021 (NVSS)	
Strategies	
Strategy PIH-1: Integrate specific activities across all relevant Title V programs to promote access to early prenatal care, access to birthing facilities appropriate to one's needs, postpartum care, and infant care. Please see Supporting Document 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.	
Strategy PIH-2: Implement updated perinatal regionalization standards, designations, and structured clinical quality improvement initiatives in birthing hospitals and centers. Please see Supporting Document 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.	
Strategy PIH-3: Apply public health surveillance and data analysis findings to improve services and systems related to perinatal and infant health care. Please see Supporting Document 2" State Action Plan Table" and domain narrative sections for specific activities related to each strategy.	
Strategy PIH-4: Address social determinants identified by community members that impact infant health and use of perinatal and infant health care and support services. Please see Supporting Document 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.	
ESMs	**Status**
ESM RAC.1 - Percent of birthing hospitals with final level of perinatal care designation, in accordance with updated regulations and standards	Active

NOMs

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

State Action Plan Table (New York) - Perinatal/Infant Health - Entry 2

Priority Need

Increase awareness of resources and services in the community among families and the providers who serve them.

SPM

SPM 1 - Percent of samples received by the State Newborn Screening lab within 48 hours of collection

Five-Year Objectives

Objective PIH-3: Improve the timeliness of Newborn Blood Spot samples received at the NYSDOH Wadsworth Laboratory from 74.34% to greater than 85% of samples received within 48 hours of collection by September 2023. (Newborn Blood Spot data)

Strategies

Strategy PIH-5: Maintain and strengthen a robust statewide population-based Newborn Screening Program. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Perinatal/Infant Health - Annual Report

For Perinatal and Infant Health (PIH), New York's Title V Program selected the National Performance Measure **NPM 3: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU).** This NPM was selected because of its relevance to quality and systems of care for infants who are at high risk for poor outcomes. While NPM 3 specifically measures site of delivery for very low birth weight infants as one critical indicator of care, NYS Title V Program views this indicator more broadly as part of a continuum of supports, services, and systems of care for infants, people who are pregnant, people who recently gave birth, parents/caregivers, families, and service providers. This broader approach aligns with several priorities voiced by families in NYS's needs assessment, including awareness of community resources and services, enhancing supports for families, improving people's health care experiences, ensuring access to transportation, and fostering community engagement and empowerment.

In addition, New York's Title V Program established one State Performance Measure (**SPM) for this domain, state-wide improvement from 74% (2018 baseline) to 85% of newborn bloodspot screening samples received at the lab within 48 hours of collection.** This SPM was developed to reflect the state's continued commitment to ensure that every newborn in the state receives newborn bloodspot screening as a public health service, to identify and support infants with a wide range of medical conditions. As a population-based program, the Newborn Screening program is an integral part of NYS's public health system for supporting the health and lifelong well-being of newborns and their families.

A focus on improving services and outcomes for infants is supported by other measures assessing the perinatal period. The proportions of low birth weight (8.2%) and preterm (9.2%) births in NYS have been stagnant for years, but racial and ethnic disparities continue. Non-Hispanic Black infants experience significantly more low birth weight births (13.3%) and preterm births (13.6%) than non-Hispanic White infants (6.4% and 7.8%, respectively). NYS has improved the proportion of pregnant people entering prenatal care during the first trimester to 80.7%, but again there are disparities with only 71.6% of non-Hispanic Black and 75.0% of Hispanic pregnant women beginning early prenatal care compared to 85.9% of non-Hispanic White pregnant women. (Data Sources: 2020 National Center for Health Statistics from CDC WONDER https://www.cdc.gov/nchs/pressroom/states/newyork/ny.htm; 2019-2021 March of Dimes Low Birthweight by Race/Ethnicity, Preterm Birth Rate by Race/Ethnicity, Early Prenatal Care by Race/Ethnicity https://www.marchofdimes.org).

In our community forums, community members expressed that they do not "feel heard" by their health care providers, that their concerns and treatment preferences are not taken seriously, and that providers do not care about them or understand what they are going through. They indicated people avoid seeking care and services because they feel judged or anticipate being treated poorly. Participants indicated that people would be more likely to visit a provider who shows compassion, has been trained about bias and cultural competence, and who is relatable (i.e., from the community and speaks their language).

During the forums, many families expressed the need to raise awareness about available community resources and services, especially for postpartum depression, and to increase the availability and scope of services to support families in the postpartum period, including postpartum doulas, home visitors, community health workers, and breastfeeding support. According to the 2020 Pregnancy Risk Assessment Monitoring System Report, 10.0% of NYS women reported experiencing depressive symptoms after giving birth.

NYS historically has been a leader in establishing systems of perinatal regionalization, with consistently high performance in this measure. Building on that success, the Title V Program is currently engaged in a multi-year effort to expand and update perinatal regionalization standards and designations for the state's birthing hospitals and centers. As this work progresses, it is essential to closely monitor NPM-3 and other related measures to ensure that quality of care and key health outcomes are maintained or improved.

Both NPM-3 and SPM-1 align with the NYS Prevention Agenda goal to reduce infant mortality and morbidity.

Three specific objectives were established to align with this performance measure:

Objective PIH-1: Increase or maintain the percent of very low birth weight infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU) by 2.4%, from the 2017 level of 91.2% to 92.6% in 2022. (NYS Vital Statistics Birth Data)

Objective PIH-2: Decrease the infant mortality rate by 2.6%, from 4.58 deaths per 1,000 live births in 2017 to 4.33 deaths per 1,000 live births in 2019 (National Vital Statistics System).

Objective PIH-3: Improve the timeliness of Newborn Blood Spot samples received at the Department's Wadsworth Laboratory from 74% to 77% of samples received within 48 hours of collection by 2022. (Newborn Blood Spot data)

Five strategic public health approaches were identified to accomplish these objectives over the next five years. These are presented in the State Action Plan Table, and each is described in more detail here, with specific program and policy activities that will be implemented to advance the broader strategic approach in the upcoming year.

Strategy PIH-1: Integrate specific activities across all relevant Title V programs to promote access to early prenatal care, access to birthing facilities appropriate to one's needs, postpartum care, and infant care.

Consistent with a life course perspective, improving birth outcomes for infants requires attention to health and health care services for both babies, parents, and people of reproductive age (see the WMH Domain for additional discussion). New York State has made significant strides to reduce infant mortality and morbidities, but more work is still required. Timely and comprehensive prenatal and postpartum medical visits are essential to providing prevention education and anticipatory guidance, screening for risk factors that may negatively affect the health of the neonate, managing chronic conditions and pregnancy complications, and connecting families with a wide array of community services and social supports to holistically address the health and wellness needs of pregnant people, neonates, and new families. Several Maternal and Child Health programs, including the Perinatal and Infant Community Health Collaborative, Newborn Bloodspot Screening, Early Hearing Detection and Intervention ("newborn hearing screening"), New York State Perinatal Quality Collaborative, and Regional Perinatal Centers, play a direct role in promoting comprehensive health and wellness of neonates through population-based systems, public health interventions, and delivering or linking people to health care services.

The Title V Program made progress or completed the following specific program and policy activities to advance this strategy throughout the 2022-23 year:

PIH-1.1: Across all Title V programs, enhance promotion of the NYS Growing Up Healthy Hotline to increase awareness of available community resources, supports, and services including Supplemental Nutrition Assistance Program for Women, Infants, and Children, Medicaid (WIC); family planning; prenatal care; and the NYS Early Intervention Program. During the reporting period, Title V-funded programs and other NYS Department of Health programs promoted the Growing up Health Hotline in a variety of ways, including through social media posts and in print media. The national baby formula shortage that started in May 2022 slowly resolved towards the beginning of this reporting period. The Growing up Health Hotline provided a critical link between consumers and WIC. Infant-serving providers continued to refer to WIC programs for parents in need of support finding appropriate formula. See *WMH-1.1* for additional details.

PIH-1.2: Through the Perinatal and Infant Community Health Collaborative and Maternal, Infant, and Early Childhood Home Visiting programs, integrate use of a birth plan including a discussion of appropriate level of perinatal care (for higher risk pregnancy/childbirth). See *WMH-1.4* for details.

PIH-1.3: In collaboration with the Office of Primary Care and Health Systems Management (OPCHSM), review and approve

applications to establish midwifery-led and freestanding birth centers across New York State. Title V staff continued to work with our partners within the NYS Department of Health's Office of Primary Care and Health Systems Management (OPCHSM) related to midwifery and freestanding birth centers.

The Department received two applications for full establishment of two freestanding birth centers that were temporarily established under emergency authorization due to COVID-19 pandemic. These two facilities were approved during the project period and were either "under construction" or preparing for a pre-opening site visit at the end of this project period. Both were continuing to operate under their emergency authorization license.

The Department also received applications for new establishment of two midwifery-led birth centers. One of these facilities subsequently withdrew its' application due to a lack of funding availability. The other facility was ultimately not approved due to significant concerns related to the character and competence of the owner(s) or principal providers. The Department proposed disapproval of the application to the NYS Public Health and Health Planning Council on January 29, 2023 with subsequent agreement by the Council.

PIH-1.4: Implement a messaging and educational campaign to promote the safety of birthing hospitals, maternity care options (level of care and types of care providers), and infection control, to strengthen community awareness and advocacy for obtaining prenatal and postpartum care at appropriate level of care. Based on the current need and priorities related to COVID-19, the Department has modified this activity. The Department implemented a multimedia educational campaign that promoted COVID-19 vaccination among pregnant and birthing women/people and their families.

The NYS Perinatal Quality Collaborative project team, in collaboration with other programs within the NYS Department of Health including the Bureau of Perinatal, Reproductive, and Sexual Health and the Bureau of Marketing and Creative Communications, launched the COVID-19 Vaccination and Pregnancy Media Campaign in Fall 2022. Phase 1 of the campaign focused on promoting COVID-19 vaccination during the perinatal population with the development of promotional materials such as Facebook posts, bus flyers, and other social media. Phase 2 began in December 2022 and focused on sharing testimonials from perinatal providers on their experience with COVID-19 vaccination. The NYS Perinatal Quality Collaborative identified two perinatal providers who were pregnant and interested in promoting vaccination to the perinatal population for the COVID-19 media campaign. One of the providers is from University of Rochester Medical Center and the other from Northwell Health. The providers reported their testimonials on receiving the COVID-19 vaccination during pregnancy and the benefits of the vaccine. The COVID-19 and Pregnancy Media Campaign ran between January 16, 2023 – March 19, 2023 and delivered 87,516,154 total impressions driving 82,408 clicks to the website.

PIH-1.5: Through the Regional Perinatal Centers and networks of affiliate birthing hospitals, support and enhance capacity to provide high quality perinatal telehealth services and perinatal subspecialty providers, particularly to rural communities and communities with disproportionate access to such services. See *WMH-1.2* for additional details on obstetrical telehealth initiatives.

Through the Department's *Statewide Health Care Facility Transformation Program III,* $2.35M of funding was recommended for approval for perinatal telehealth specific projects. Regional Perinatal Centers were the only eligible applicants. Five applications were received to support a variety of capital expenses for telehealth. These funds can be used over a five-year period.

PIH-1.6: Through the Maternal and Infant Community Health Collaboratives and Maternal, Infant, and Early Childhood Home Visiting programs, integrate use of virtual home visiting services to increase acceptance and support of services for hard-to-reach families*. See WMH-1.3 for details.*

PIH-1.7: Through the Maternal and Infant Community Health Collaboratives and Maternal, Infant, and Early Childhood Home Visiting programs, support community health workers to engage high-risk pregnant and postpartum families in consistent, comprehensive preventive and primary care services, including newborn care, screen and assist families in enrolling in

health insurance, and provide families with social support to enhance health literacy and use of health care. *See WMH-1.4* for details.

PIH-1.8: Through the NYS Perinatal Quality Collaborative, provide educational opportunities and implement structured quality improvement projects with birthing hospitals**.** Progress for this activity is described in *PIH-2.6* below.

Two former activities were unintentionally omitted from the reporting period's proposal:
PIH-1.9: Through the American Indian Health Program, continue to support direct health care and supporting services to ensure access to New York's indigenous populations. Due to staffing shortages with the AIHP, no significant progress or activities was made during the reporting period.

PIH-1.10: Through the Migrant and Seasonal Farmworker Programs, continue to support direct health care and supportive services to ensure access to health care. No notable activities were conducted during the reporting period.

Three new activities were implemented during the program year:

PIH-1.11: Through the Act Early project, train Maternal and Infant Community Health Collaboratives and Maternal, Infant, and Early Childhood Home Visiting programs on CDC's *Learn the Signs Act Early* campaign. Collaborate with the Bureau of Early Intervention to facilitate orders for free *Learn the Signs Act Early* materials from CDC website to programs. See *WMH-1.7* for details.

PIH-1.12: Provide support to birthing families and community-based organizations to address nationwide shortages of infant formula. On Feb 17, 2022, the U.S. Food and Drug Administration warned consumers not to use potentially contaminated products from Abbott Nutrition's Sturgis MI facility, prompting a voluntary recall initiated. Supply shortages started to escalate, receiving local and national media and policymaker attention. Maternal, Infant, and Early Childhood Home Visiting and Title V-funded programs were provided with guidance and resources from the NYS Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC), U.S. Department of Health and Human Services, the U.S. Department of Agriculture, and the Governor's Office for locating formula and appropriate formula substitutions. By the Summer of 2022, the Abbott manufacturing facility was reported to be back online, and complaints of formula shortages greatly declined.

PIH-1.13: In 2023, the Early Hearing Detection and Intervention (EHDI) Program was transferred from the Bureau of Early Intervention to the Bureau of Perinatal, Reproductive, and Sexual Health. The goal of the Early Hearing Detection and Intervention (EHDI) Program is to monitor and follow-up with Article 28 birthing hospitals and audiologists across New York State to assure they are conducting newborn hearing screening before infants reach one month of age, with infants who do not pass receiving prompt re-screening. Infants who do not pass their initial newborn hearing screening & re-screening, should receive a prescription for a diagnostic audiological evaluation before three months of age; those identified with hearing loss should be referred to appropriate early intervention (EI) services no later than six months of age. When hearing loss is left undetected, it can delay a child's speech and language, social, and emotional development. New York State Public Health Law Section 2500-g requires all Article 28 health care providers to report results to the New York Early Hearing Detection and Intervention Information System (NY EHDI-IS) when the provider performs newborn hearing screening and out-patient follow-up hearing screening or diagnostic audiological evaluation on infants less than six months of age. Documentation of results in EHDI-IS is especially important during the first six months of the baby's life to ensure that babies with hearing loss are identified and their families receive the support they need as early as possible. The NY EHDI Program provides technical assistance to birthing facilities and audiologists that serve newborns, related to provision and reporting of newborn hearing screening, in accordance with NYS Public Health Law. The New York Early Hearing Detection and Intervention (EHDI) Program provides frequent group and individualized training and technical assistance to providers who are screening newborns for hearing loss. EHDI has a dedicated staff member who provide training and technical assistance on the use of the EHDI informational system (EHDI-IS), reporting, and other topics that may need to be addressed. Training and technical assistance is provided regularly and on an as needed basis to better support providers across the state conducting newborn hearing screening. In addition to training and technical assistance, the New York Early

Hearing Detection and Intervention (EHDI) Program works to develop guidance documents for providers to enhance knowledge of the program goals and best practices. These documents serve as a valuable resource for providers when understanding the importance of newborn hearing screening and the regulations in place for New York State.

Strategy PIH-2: Implement updated perinatal regionalization standards, designations, and structured clinical quality improvement initiatives in birthing hospitals and centers.

NYS has been a longstanding national leader in implementing statewide systems of regionalized perinatal care. NYS's regulations for perinatal regionalization and designation, as well as perinatal care services, were last updated in 2000 and 2005, respectively. It is imperative for NYS to ensure all perinatal hospitals are functioning in accordance with current standards of care for both maternal and infant outcomes. Since 2017, the Title V Program has worked to develop updates to these regulations to reflect current national standards of obstetrical and neonatal care and perinatal regionalization, changes in health care systems and reimbursements, as well as hospital restructuring and other corporate structural changes. As part of the regulation development process, Title V Program staff conducted an extensive review of current standards, in consultation with a 49-member multi-disciplinary Expert Panel and other topical expert consultants. Additionally, the proposed regulations further integrate recently established midwifery birth centers, along with physician-led birth centers, into the perinatal regional system, and place a greater emphasis on quality care and patient safety, particularly for obstetrical patients. Current efforts to strengthen this public health system includes increased efforts to address maternal morbidity and mortality, integration of physician- and midwifery-led birth centers into the regional systems, and increased access to ancillary services such as alcohol and substance use and mental health services, directly and/or through referral and commensurate with the birthing facility's level of care.

Working within this statewide system of perinatal regionalization, NYS's Title V Program implements the NYS Perinatal Quality Collaborative. The NYS Perinatal Quality Collaborative aims to provide the best, safest, and most equitable care for individuals who are pregnant, giving birth and in the postpartum period and their infants. This is achieved through collaboration with birthing hospitals and centers, perinatal care providers, and other key stakeholders to prevent and minimize harm through the translation of evidence-based guidelines to clinical practice. The NYS Perinatal Quality Collaborative has adapted the Institute for Healthcare Improvement model for Idealized Perinatal Care and Breakthrough Series Methodology as a framework to guide improvement.

Key NYS Perinatal Quality Collaborative activities include:

- Embedding evidence-based guidelines into practice
- Strengthening collaboration and communication within and among neonatal and obstetric providers, administrators, and organizations
- Fostering prepared and proactive care teams
- Assessing, conducting, and sharing surveillance and performance data on maternal and neonatal health indicators
- Continuously evaluating and measuring performance
- Setting priorities and implementing a comprehensive strategy for benchmarking and data driven quality improvement activities
- Providing topic-specific, intensive quality improvement supportive activities, trainings and toolkits that are all-inclusive packages to facilitate improved clinical outcomes, excellent patient care and efficient resource allocation
- Researching best practices
- Continually reassessing outcomes of performance improvement interventions.

Specific priorities set by the NYS Perinatal Quality Collaborative are implemented by all participating NYS birthing hospitals and centers to improve outcomes of perinatal care. Analysis of NYS Perinatal Quality Collaborative project data provided by participating birthing hospitals and centers helps to improve services and systems related to perinatal health care.

The Title V Program led the following specific program and policy activities to advance this strategy through the 2022-23

year:

PIH-2.1: Strengthen the Perinatal Regionalization System through promulgating revised regulations for perinatal services, and subsequent assessment and re-designation of birthing hospitals and birthing centers to match new regulations. The proposed regulations were presented to the Public Health and Health Planning Council on February 9, 2023 for informational purposes and brief discussion. The regulations were subsequently published for public comment in the *New York State Register* on May 31, 2023 for a 60-day public comment period. Approximately 100 stakeholders submitted public comments for over 500 individual comments including duplicated, overlapping, or similar comments. Title V staff continue to respond to the comments in the Assessment of Public Comments.

Although not described in the reporting period's application, additional regulatory activities related to perinatal and infant health was conducted, related to newborn hearing screening. As previously discussed, this program recently transitioned from the Division's Bureau of Early Intervention, into the Bureau of Perinatal, Reproductive, and Sexual Health. In 2022-2023 the NY EHDI Program amended the Newborn Hearing Screening regulations which included establishing a 2-tier inpatient hearing screening protocol at birthing facilities; updating of reporting requirements; clarifying definitions related to the Early Intervention Program and the term prescription; clarifying responsibilities of health care professionals; and a separate standard for infants cared for in NICUs who do not pass the inpatient auditory brainstem response (ABR) screening. Fourteen public comments were received in the requisite public comment period, and minor revisions were made to allow auditory brainstem response (ABR) screening and a separate standard for infants cared for in NICUs. The revised regulations were submitted for approval and publication as a Revised Rulemaking and a second public comment period. The amended regulations were formally adopted on April 17th, 2024.

PIH-2.2: Assess perinatal designation surveys and site visit findings, communicate with birthing hospital staff on identified issues, and issue final designations for perinatal levels of care. As described above, the Department's Perinatal Regulations were published for public comment, and we received significant feedback. During the reporting period, Title V staff worked to assess public comments received from a variety of constituents, including community members, hospital-based clinical providers, midwifery providers, legislators, and others.

PIH-2.3: Improve coordination and increase bilateral referrals between birthing hospitals and home visiting programs. Title V staff will assist in connecting Perinatal and Infant Community Health Collaborative and Maternal, Infant, and Early Childhood Home Visiting-funded programs with their local birthing hospital(s) and support formal meetings.

In Fall of 2022 a second graduate intern developed a survey to assess the referral relationships between birthing hospitals and home visiting programs from the perspective of the birthing hospitals. The survey contained nine questions and was sent to 112 birthing hospitals. Only 24 hospitals responded, which resulted in limited data analysis. In August 2023, a new graduate intern assessed the accessibility of the birthing hospital survey. Changes were made to decrease time required to complete the survey to improve participation. The survey analysis was near completion at the end of the reporting year. Staff intend to develop and share promising practices resources for birthing hospitals and home visiting programs. See *WMH 2.4* for additional details.

PIH-2.4: Collaborate with other NYS Department of Health units to support the programmatic review to establish midwifery-led birthing centers, and support integration of these facilities into the regional perinatal system as a critical foundation for low-risk obstetrical and neonatal patients for childbirth. As described above, progress towards adopting perinatal regulations related to midwifery-led birth centers has been slower than anticipated. As such, any midwifery-led birth centers seeking establishment are only required to meet the current regulations (adopted in 2019). While the Department can review and consider midwifery-led birth centers, full integration of these facilities into the regional perinatal system is on hold until adoption of the revised regulations. As noted in PIH-1.3 above, two applications were received during the reporting period for midwifery birth center establishment; however, one was withdrawn, and the other remained in review for through the reporting period.

PIH-2.5: Collaborate with stakeholders to educate OB-GYN and family practice providers about changes to hospitals' level of perinatal care in their community. As noted above, redesignation of birthing hospitals was not completed during the project period. This remains a long-term goal following adoption of perinatal regulations and subsequent redesignation activities.

PIH-2.6: Lead quality improvement projects through the NYS Perinatal Quality Collaborative, with birthing hospital and center teams, to improve obstetric and neonatal outcomes in specific areas including:

- Identifying and managing the care of pregnant and postpartum women/people with opioid use disorder during pregnancy. Of the 15 birthing hospitals and birth centers that started this project in 2018, the cohort increased the implementation of a universal Opioid Use Disorder screening protocol in place from 20% at Quarter 1of 2019 to 87% at Quarter 3 of 2022. Additionally, participant sites established a protocol or process flow to assess and link pregnant patients with Opioid Use Disorder to supportive services, from 33% in Quarter 1 of 2019 to 87% by Quarter 2 of 2022. Of the additional 24 birthing facilities that joined the project as an expansion phase ("expansion cohort"), the number of facilities with a universal Opioid Use Disorder screening protocol in place increased from 40% in Quarter 4 of 2020 and Quarter 3 of 2022. Expansion sites also implemented protocols or process flows to assess and link pregnant patients with Opioid Use Disorder to support services, increasing from 20% in Quarter 4 of 2020 to 83% in Quarter 3 of 2022.
- Improving the identification, standardization of therapy and coordination of aftercare of infants with neonatal abstinence syndrome. By the end of this reporting period, all pilot hospitals will have put in place standardized pharmacologic and non-pharmacologic guidelines for newborns with opioid exposure. Of the expansion phase hospitals, 83% put in place standardized pharmacologic guidelines and 88% have non-pharmacologic guidelines for newborns with opioid exposure.
- Improving infant outcomes, with a focus on equity in the neonatal intensive care unit (NICU). This project is under development.
- Assisting NYS birthing facilities in identifying how individual and systemic racism impacts birth outcomes at their organizations and taking action to improve both the experience of care and perinatal outcomes for Black birthing people in the communities they serve. 54% of hospitals and birthing centers have policies and procedures in place to address equitable care. 82% of facilities have implemented a Patient Reported Experience Measure survey that is offered to every birthing person prior to discharge. 88% of facilities are collecting race and ethnicity data for birthing people; and 50% are using perinatal data stratified by race and ethnicity to develop targeted actions. A new outcome and balancing measures report was developed for facilities' use. As of Q3 2022, the Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean birth rate was 29.6% for all project participants.

There were no additional activities identified or established during the reporting period.

Strategy PIH-3: Apply public health surveillance and data analysis findings to improve services and systems related to perinatal and infant health care.

Data-driven, evidence-based practice is essential to achieving public health goals for Maternal and Child Health. Across all Title V programs, continuous effort is needed to enhance the collection, analysis, and sharing of data to inform the planning and implementation of Maternal and Child Health programs and policy work. Sharing data with stakeholders, including providers and community members, is critical to raise awareness, empower community action, and facilitate quality improvement efforts at all levels.

The Title V Program led the following specific program and policy activities to advance this strategy over the course of the 2022-23 year:

PIH-3.1: Collaborate with the NYS Office of Children and Family Services to implement a PDSA-style quality improvement

initiative with the goal of increasing referrals from the Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC) to Home Visiting programs including Maternal/Perinatal and Infant Community Health Collaborative and those receiving Maternal, Infant, and Early Childhood Home Visiting funding. Efforts to increase referrals from WIC to Home Visiting programs were completed in previous reporting periods, and this project is in a maintenance phase. During the reporting period, Title V staff updated county-specific program tools for WIC programs to use. The Office of Children and Family Services (who oversee the state's Healthy Families New York programs) indicated interest in re-engaging with the WIC program to strengthen bi-directional referrals with home visiting programs. This request was made late in the reporting period and will be discussed in future reporting periods.

PIH-3.2: Lead quality improvement projects through the NYS Perinatal Quality Collaborative, with birthing facility teams with a focus on reducing maternal morbidity and mortality through the NYS Birth Equity Improvement Project. This initiative seeks to improve outcomes and the experience of care for Black birthing people. The NYSPQC is also focused on reducing infant morbidity and mortality throught he NYSPQC Neonatal Intensive Care Unit (NICU) Project with a goal of improving outcomes for infants receiving care in NYS' NICUs, as well as improving their parents'/caregivers' experience of care while their infant is being treated in the NICU. The NYSPQC also conducted the NYS OUD in Pregnancy & NAS Project which sought to improve the assessment, identification and management of care for pregnant people with OUD, and the identification, standardization of therapy and coordination of aftercare for infants with NAS. This project closed in June 2023. See *PIH-2.6* and *WMH-3.3-8* for more detail on these projects.

PIH-3.3: Summarize, share, and discuss findings of the Maternal Mortality Review Board with key stakeholders, including the Maternal Mortality and Morbidity Advisory Council and American College of Obstetricians and Gynecologists District II NY, to inform statewide prevention strategies to improve maternal outcomes. This includes the development of issue briefs, webinars, and quality improvement projects through the NYS Perinatal Quality Collaborative, and a maternal mortality report. See *WMH-3* for more detail on the Maternal Mortality and Morbidity Advisory Council and Maternal Mortality and Morbidity Advisory Council.

PIH-3.4: Establish a comprehensive perinatal data warehouse of perinatal outcomes to make data available in a timely way to birthing hospitals and support quality improvement activities.
This project continued to be on hold during the reporting period due to competing staff priorities and changes in staffing with collaborative partners. Title V staff continue to engage with partners on this initiative and look forward to progressing in the 2022-23 reporting period.

Additionally, new strategies were developed in response to newly identified needs and opportunities:

PIH-3.5: Collaborate with the NYS Department of Health AIDS Institute and the NYC Department of Health and Mental Hygiene on efforts to address significant increases in the number and rate of infectious (primary, secondary, and early latent) syphilis among NYS females of childbearing age, and the number and rate of congenital syphilis cases. This includes several subtasks:

- **3.5a**: Develop a statewide Congenital Syphilis Elimination Strategic Plan and support the implementation of priority activities. This activity is led by the NYS Department of Health AIDS Institute. Multiple staff from the Division, including Title V staff, participate in the workgroup and subcommittees, predominantly as subject matter experts. Three day-long meetings of the full workgroup, as well as other virtual subcommittee meetings were held during the reporting period. This work continues in the current reporting period.
- **3.5b**: Issue locally tailored and statewide health advisories to alert health care professionals of primary, secondary, and early latent syphilis and Congenital Syphilis surveillance trends, screening requirements and recommendations, and appropriate treatment regimens. This activity is led by the AI.
- **3.5c**: Promote clinical education opportunities to birthing hospital staff, provided through NYS Department of Health-supported Clinical Education Initiative and other CDC-funded provider training initiatives.
- **3.5d**: Provide periodic updates and resources for community-based providers that engage with pregnancy clients, to

promote awareness of STIs that can affect pregnancy, fertility, and the health of a fetus or newborn.

PIH-3.6: Publish an Infant Mortality Report including analysis of the racial and ethnic disparities of infant mortality and risk factors of mortality, and recommendations to reduce infant mortality. In June 2023, the Department published a report to the Commissioner entitled "Infant Mortality in New York State, 2016-2019." The report was developed in response to 2021 state legislation requiring the Department to conduct a study of the effects of racial and ethnic disparities on infant mortality. The report describes trends in infant mortality by demographics, risk factors and other variables. The report was written after an expert workgroup reviewed the state data and provided insights and recommendations to reduce infant mortality and racial and ethnic disparities. While the report was released outside the current reporting project, we want to highlight it in the project and will be doing more to assess the information and determine additional activities in future reporting periods.

In addition to the updates above, the Division of Family Health through the Title V program is advancing public health surveillance and data analysis to improve services and systems related to perinatal and infant health care. A new Bureau of Data Analytics, Research, and Evaluation was created to support research and data needs across the Division of Family Health. The consolidation of data and analytic staff into one Bureau under the direction of a new Bureau Director with a DrPH in Epidemiology will create efficiencies and cross training as well as provide professional development opportunities to further advance the use of data in Maternal and Child Health programs and policy decisions.

Strategy PIH-4: Address social determinants identified by community members that impact infant health and use of perinatal and infant health care and support services.

As noted in other domains, perinatal and infant health outcomes are impacted by the social determinants of health, or the conditions in which people are born, live, work, play, learn, and age. The social determinants of health include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of power and resources due to racism and other biases are root causes of inequities in access, availability of services, and quality of care. All ten priorities that emerged from community members' input during the Needs Assessment revolve around the social determinants of health and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities.

Efforts to improve infant health outcomes must focus directly on addressing longstanding and persistent racial and ethnic disparities in infant health. This persistence of disparities in most of our major health indicators clearly shows that while evidence-based interventions can affect positive change, they alone are not enough to address the larger issues contributing to health inequities. NYS's Title V Program thus seeks to combine the strength of data-driven, evidence-based programs and interventions with authentic community engagement opportunities across all Title V programs that address perinatal and infant health, including discussions and actions related to racial justice, as well as strengthening community-based and clinical/provider relationships, to increase equity in access to health care and social support services. Title V programs seek to engage and empower individuals, families, and communities by increasing awareness of available community resources and supports; working with community stakeholders to improve delivery of care and services; and enhancing social support, health literacy, and self-care and advocacy skills for pregnant and parenting families.

The Title V Program led the following specific program and policy activities to advance this strategy in the 2022-23 year:

PIH-4.1: Distribute a Parent Portal resources flyer, developed by the NYS Council on Children and Families, to birthing hospital and center maternity, obstetrical, neonatal, and social work/patient discharge planning teams. As reported in the 2021-22 progress report, a media campaign was launched from August through October 2022, overlapping into the current reporting period. Over 100,000 clicks were registered at the Parent Portal during the campaign; exact data during the reporting period are not available. The Department continues to provide updates and promote the Parent Portal through a variety of methods, including sharing with funded agencies and other stakeholders. See *PIH-2.3* and *WMH-2.4* for additional information.

PIH-4.2: Through the Perinatal and Infant Community Health Collaborative programs, work with diverse community stakeholders including community residents to identify and collaboratively address issues and barriers impacting maternal and infant health outcomes at the community level. See *WMH-4.1* for further details.

PIH-4.3: Through the Perinatal and Infant Community Health Collaborative and Maternal, Infant, and Early Childhood Home Visiting-funded programs, provide supports to individual clients and their families to address behavioral social determinants of health outcomes. Provide information on community resources, screen and assist families in enrolling in health insurance and health care, worked directly with families to strengthen health literacy, self-care, and advocacy skills, and provided and enrolled families in enhanced social supports and educational opportunities. See *WMH-4.2* for further details.

PIH-4.4: Through the NYS Perinatal Quality Collaborative, continue to lead a quality improvement project with birthing hospital teams and community-based organizations, to improve outcomes for all NYS birthing people and infants by focusing on racial justice and birth equity. See *WMH-4.4* for further details.

PIH-4.5: Title V staff worked to develop a statewide Home Visiting Parent Advisory Committee procurement proposal. As previously reported, the Department had issued a solicitation of interest during the 2021-22 reporting period, which resulted in multiple applicants. As such, and given the limited funding available for this project, Title V and other staff worked to develop a procurement for the Parent Advisory Committee. Due to critical staff departures for the program that oversees this program, further progress on this activity were placed on hold pending recruitment and onboarding of program staff.

In addition of the Home Visiting Parent Advisory Committee, the Early Hearing Detection and Intervention (EHDI) Program has successfully run the New York EHDI Advisory Group quarterly, bringing in perspectives from professionals and parents to better serve Deaf and Hard of Hearing (DHH) children and families in New York State.

PIH-4.6: Provide information and guidance to providers regarding federal Child Abuse Prevention and Treatment Act (CAPTA)/Comprehensive Addiction and Recovery Act (CARA) legislation and implementation of Plans of Safe Care. Due to staffing shortages during the reporting period, no significant activities related to CAPTA/CARA and Plans of Safe Care were implemented during the project period.

In addition to the updates above, the Department has taken great strides to incorporate health equity and racial justice throughout a wide variety of Title V activities, not limited to the activities within this strategy. In July 2022, the Department announced several reorganization efforts, including the creation of the Office of Health Equity and Human Rights. This new office is tasked with addressing health disparities and work to improve diversity, equity, and inclusion within the Department. The Office of Health Equity and Human Rights is a resource for programs across the Department as we work towards common goals of equitable health for all New Yorkers.

As described in the Women and Maternal Health section, a new Bureau of Health Equity and Community Engagement was created within the Division of Family Health to address disparities highlighted in the COVID-19 pandemic and build a foundation for future epidemic responses. Additional information about partnerships and funding to support Perinatal and Infant Health is available in Supporting Document #3.

Strategy PIH-5: Maintain and strengthen a robust statewide population-based Newborn Screening Program.

New York's Newborn Screening Program is a population-based program and public health system that identifies infants who may have one of several rare, but treatable diseases through bloodspot screening shortly after birth. Within NYS Department of Health, the Newborn Screening Program is housed and administered by the Wadsworth Center, NYS's public health laboratory, with direct support from Title V and several other state and federal funding sources. The program currently performs laboratory testing for 50 diseases, following national recommendations for Newborn Screening programs. The program ensures that every newborn in the state receives newborn bloodspot screening as a public health service, with no

fee for testing. The program also performs follow-up case management to ensure newborns with a positive screening result receive appropriate diagnostic testing and treatment. Specialty Care Centers are certified and monitored to ensure newborns have access to specialty care for disease-specific testing and management. In addition, the Newborn Screening program receives separate funding from the Health Resources and Services Administration to support each of the state's 10 Inherited Metabolic Disease Specialty Care Centers to enroll patients with an Inherited Metabolic Disease diagnosis identified by newborn screening for long-term follow-up in the NYS Newborn Screening Patient Registry. These Inherited Metabolic Disease Specialty Care Centers are responsible for entering and tracking for consented patients annually, and for attending an annual meeting to discuss long-term follow-up data. Patients are monitored until age 18, when the individual must consent to continue participation until age 21. In 2021, the program screened 211,203 infants, 99.97% of all NYS resident infants born that year (See Form 4 for further details).

The Newborn Screening program practices continuous quality improvement using LEAN principles, with a focus on improving overall efficiencies, reducing false positives, and improving timeliness in newborn screening for time-critical conditions. The program also strives to promote the growth of the field of Newborn Screening by promoting the development of its staff, participating in national committees, conducting pilot studies, and training other state newborn screening programs. The Newborn Screening program collaborates with other public health programs to support mutual goals. The Newborn Screening has identified a need for continued education for primary care providers and newborn coordinators on newborn screening and genetics.

PIH-5.1: Collaborate with the Newborn Screening Program to provide comprehensive newborn bloodspot screening for every newborn born in NYS.

- Title V staff collaborate with Newborn Screening Program staff on bloodspot screening, including new initiatives to screen for congenital Cytomegalovirus (cCMV) and G6PD screening.
    - Title V staff have collaborated with staff from NYS Department of Health's Wadsworth and the Division of Epidemiology in the Center for Community Health to develop policies and procedures as well as apply for federal funding to support a pilot for Congenital Cytomegalovirus screening. About one out of every 200 babies is born with congenital CMV infection. About one in five babies with Congenital Cytomegalovirus infection will have long-term health problems, such as hearing loss.
    - The Division of Family Health Medical Director, Dr. Marilyn Kacica, supported the NYS Department of Health efforts to implement G6PD screening. A G6PD test is a blood draw to check levels of glucose-6-phosphate dehydrogenase (G6PD). G6PD is a protein that supports red blood cell function. If you have low G6PD, you may develop hemolytic anemia, which occurs when your body destroys red blood cells faster than it makes them.

PIH-5.2 and PIH-5.3: Collaborate with the Newborn Screening Program to perform a quality improvement project to ensure hospitals are meeting benchmarks. Collaborate with the Newborn Screening Program to expand the number of hospital site visits made by NYS Department of Health staff.

- Performed a quality improvement project to ensure hospitals are meeting benchmarks. During the program year, nine (of 121) virtual hospital site visits were conducted, representing approximately 14% of total specimens submitted to the Newborn Screening Program. Site visits are intended to engage birthing hospital staff to improve compliance with five key performance measures:
    - Collection time (within 36 hours of life)
    - Turn-around time (received by lab within 48 hours of collection)
    - Overall specimen quality
    - Specimen quality from samples taken outside of the neonatal intensive care unit (NICU)
    - Completeness of data (including demographic variables).
- Baseline data are presented during the site visit for discussion. Although all five performance measures are addressed on site visits, focus is placed on turn-around time, as most NYS birthing hospitals struggle to improve this metric.

- Newborn Screening program is developing a post-site visit monitoring plan with each hospital, to provide an updated hospital performance summary within 6-8 months post-site visit to evaluate improvement. For example, one hospital engaged with a private courier service to supplement UPS shipping, resulting in a 12.6% improvement in turn-around time and meeting a goal of 80% of specimens received within 48 hours of collection.
- Expand the number of hospital site visits (conducted virtually) made by NYS Department of Health staff. Due to the ongoing COVID-19 pandemic and priorities within the Department and birthing hospitals, focus on expanding the number of hospital site visits was not feasible. Rather, the Newborn Screening program implemented a post-site visit monitoring plan to further enhance the impact of virtual site visits, as described above.

The NYS Title V Program established two Evidence-Based Strategy Measure (ESM) to track the programmatic investments and inputs designed to impact NPM-3 and SPM-1.

ESM PIH-1: Percent of birthing hospitals with final level of perinatal care designation, in accordance with updated regulations and standards.

Data for this measure will come from hospital surveys and site visit reports completed by the NYS Department of Health contractor, Island Peer Review Organization (IPRO) in consultation with Title V staff. Due to delays described above, establishing a baseline for this measure is not yet complete. The baseline value for this measure will be determined after regulations are adopted. The program has set a goal to update designations for 50% of hospitals within the first year, and 100% within 5 years.

ESM PIH-2: Increase the percentage of the birthing hospitals that received site visits from NYS Department of Health staff to evaluate the process of collecting and transmitting Newborn Blood Spot samples to ensure samples are received by the Department's Wadsworth Laboratory within 48 hours of collection.

Data for this measure will come from the Department's Newborn Screening Program. The baseline value for this measure will be determined in 2023. The program has set a goal to visit an additional 40 birthing hospitals by September 2023. This initiative is funded through non-Title V Health Resources and Services Administration funding and a grant from the Association of Public Health Laboratories.

Perinatal/Infant Health - Application Year

For Perinatal and Infant Health (PIH), New York's Title V Program selected **NPM 3: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU).** This National Performance Measure (NPM) was selected because of its relevance to quality and systems of care for high-risk and vulnerable infants. While NPM 3 specifically measures site of delivery for very low birth weight infants as one critical indicator of care, the NYS Title V program views this indicator more broadly as part of a continuum of supports, services, and systems of care for infants, people who are pregnant, people who recently gave birth, parent/caregivers, families, and service providers. This broader approach aligns with several priorities voiced by families in NYS's needs assessment, including awareness of community resources and services, enhancing supports for families, improving people's health care experiences, and fostering community engagement and empowerment.

In addition, New York's Title V Program established one **State Performance Measure (SPM) for this domain, state-wide improvement from 74% to 85% of newborn bloodspot samples received at the lab within 48 hours of collection.** This SPM was developed to reflect the state's continued commitment to ensure that every newborn in the state receives newborn bloodspot screening as a public health service to identify and support infants with a wide range of medical conditions. As a population-based program, the Newborn Bloodspot Screening program is an integral part of the state's public health system for supporting the health and lifelong well-being of newborns and their families.

As described above in the annual report, a focus on improving services and outcomes for infants is supported by other measures assessing the perinatal period. In Title V led community forums, community members expressed that they do not "feel heard" by their health care providers, that their concerns and treatment preferences are not taken seriously, and that providers do not care about them or understand of what they are going through.

NYS historically has been a leader in establishing systems of perinatal regionalization, with consistently high performance in this measure. Building on that success, the NYS Title V Program is currently engaged in a multi-year effort to expand and update perinatal regionalization standards and designations for the state's birthing hospitals and centers. As this work progresses, it is essential to closely monitor NPM-3 and other related measures to ensure that quality of care and key health outcomes are maintained or improved.

The NYS Title V Program works to support the health and wellbeing of pregnant and birthing people, their infants, and family through program implementation, strengthening provider and community collaborations. Across the domain and Title V program, health equity is at the forefront of our actions.

Additionally, the Title V Program staff work to update and develop new policies that further the health and wellbeing of our priority populations. For the Perinatal and Infant Health Domain, this includes regulatory action, such as proposed regulatory changes to strengthen the Early Hearing Detection and Intervention Program or to modernize and expand New York's Perinatal Regionalization system and incorporate birth centers into the system of care. Other policy activities may not be as readily apparent. For example, New York's Medicaid program will begin reimbursement for Community Health Worker services, effective April 1, 2023. To obtain reimbursement, Community Health Worker programs must be enrolled in the Medicaid program and submit billing for services – administrative tasks that smaller community-based organizations may need support to accomplish. Title V staff are working with the Office of Health Insurance Programs to clearly describe the actions necessary for reimbursement and identify supports and provide guidance for enrollment and billing. Finally, Title V staff routinely provide input and comment on relevant legislative bills.

Both NPM-3 and SPM-1 align with the NYS Prevention Agenda goal to reduce infant mortality and morbidity.

Three specific objectives were established to align with this performance measure:

Objective PIH-1: Increase or maintain the percent of very low birth weight infants born in a hospital with a Level III+

neonatal intensive care unit (NICU) by 2.4%, from the 2017 level of 91.2% to 92.6% by 2022. (NYS Vital Statistics Birth Data)

Objective PIH-2: Decrease the infant mortality rate by 2.6%, from 4.58 deaths per 1,000 live births in 2017 to 4.33 deaths per 1,000 live births in 2019 (National Vital Statistics System).

Objective PIH-3: Improve the timeliness of Newborn Blood Spot samples received at the NYSDOH Wadsworth Laboratory from 74% to 77% of samples received within 48 hours of collection by September 2022. (Newborn Bloodspot Screening program data)

Five strategic public health approaches were identified to accomplish these objectives over the next five years. These are presented in the State Action Plan Table, and each is described in more detail here, with specific program and policy activities that will be implemented to advance the broader strategic approach in the upcoming year.

Strategy PIH-1: Integrate specific activities across all relevant Title V funded programs to promote access to early prenatal care, birthing facilities appropriate to one's needs, postpartum care, and infant care.

Consistent with a life course perspective, improving birth outcomes for infants requires attention to health and health care services for infants, parents/caregivers, and people of reproductive age (see MWH section for additional discussion). NYS has made significant strides to reduce infant mortality and morbidity, yet work remains. Timely and comprehensive prenatal and postpartum medical visits are essential to providing prevention education and anticipatory guidance, screening for risk factors that may negatively affect the health of the neonate, managing chronic conditions and pregnancy complications, and connecting families with a wide array of community services and social supports to holistically address the health and wellness needs of pregnant people, neonates, and new families.

Several Title V funded programs, including the Perinatal and Infant Community Health Collaboratives, which was previously named Maternal and Infant Community Health Collaboratives, and the NYS Perinatal Quality Collaborative, play a direct role in promoting comprehensive health and wellness of neonates through population-based systems, public health interventions, and delivering or linking people to health care services. Additionally, Title V-funded staff provide oversight of several programs and initiatives relevant to the strategies of this domain, including the Newborn Screening Program, Early Hearing Detection and Intervention program, and Regional Perinatal Centers. The Regional Perinatal Center grant program was funded by Title V until April 2022, when a state appropriation was passed in the 2022-23 state budget. Title V staff continue to provide leadership and oversight of these programs even if they are funded by state appropriations.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2024-25 year:

- **Activity PIH-1.1:** Across all Title V funded programs, enhance promotion of the NYS Growing Up Healthy Hotline to increase awareness of available community resources, supports, and services including Supplemental Nutritional Programs for Women, Infants and Children (WIC) Program, Medicaid, family planning, home visiting, prenatal care, and the NYS Early Intervention Program.
- **Activity PIH-1.2**: Through the Perinatal and Infant Community Health Collaborative and Maternal, Infant, and Early Childhood Home Visiting programs, integrate use of a birth plan including a discussion of appropriate Level of care (LoC) (high risk = higher LoC) for childbirth.
- **Activity PIH-1.3:** In collaboration with the NYSDOH Office of Health Insurance Programs (i.e., the state's Medicaid program), support funded Community Health Worker programs to become Medicaid-enrolled providers for reimbursement.
- **Activity PIH-1.4:** Support new and ongoing messaging, educational, and social marketing campaigns to promote perinatal and infant health. Campaigns and messaging will be tailored to individuals who are pregnant, neonates/infants, their parents/caregivers, and families; campaign topics will be determined based on emergent

needs and opportunities.

- **Activity PIH-1.5:** Through the Regional Perinatal Centers and networks of affiliate birthing hospitals, support and enhance capacity to provide high quality perinatal telehealth services and perinatal subspecialty providers, particularly to rural communities and communities with disproportionate access to such services. Title V staff will continue to collaborate with OPCHSM on the oversight of $5M in state capital funding earmarked to support perinatal telehealth *(see Activity WMH 1.2 for additional details).*
- **Activity PIH-1.6:** Through the Perinatal and Infant Community Health Collaborative and Maternal, Infant, and Early Childhood Home Visiting programs, integrate use of virtual home visiting services to increase acceptance and support of services for hard-to-reach families *(See Activity WMH 1.3 for details).*
- **Activity PIH-1.7:** Through the Perinatal and Infant Community Health Collaborative and Maternal, Infant, and Early Childhood Home Visiting programs, support community health workers to engage high-risk pregnant and postpartum families in consistent, comprehensive preventive and primary care services, including newborn care, screening, and assisting families in enrolling in health insurance, and providing families with social support to enhance health literacy and use of health care *(See Activity WMH 1.4 for additional details).*
- **Activity PIH-1.8:** Support distribution of free diapers to families in need through the NY Cares/Baby2Baby Diaper Bank program. Perinatal and Infant Community Health Collaborative; Maternal, Infant, and Early Childhood Home Visiting; and other Maternal-Infant-Health-serving programs will be encouraged to obtain diapers from the Diaper Bank and distribute them to enrolled and potential clients as they deem appropriate.
- **Activity PIH-1.9**: Through the American Indian Health Program (AIHP), continue to support direct health care and supporting services to ensure access to health care.
- **Activity PIH-1.10**: Through the Migrant and Seasonal Farmworker (MSFW) Programs, continue to support direct health care and supporting services to ensure access to health care.
- **Activity PIH-1.11**: Through all Title V Programs, offer and provide opportunities for training and technical assistance related to clinical and community topics related to perinatal and infant health. Opportunities related to health equity, health disparities, racial and reproductive justice are presented in Strategy PIH-4 below.

Strategy PIH-2: Implement updated perinatal regionalization standards, designations, and structured clinical quality improvement initiatives in birthing hospitals and centers.

NYS has been a longstanding national leader in implementing statewide systems of regionalized perinatal care. NYS's regulations for perinatal regionalization and designation, as well as perinatal care services, were last updated in 2000 and 2005, respectively. It is imperative for NYS to ensure all perinatal hospitals are functioning in accordance with current standards of care for both obstetrical and neonatal outcomes. Since 2017, the Title V Program has worked to update these regulations to reflect current national standards of obstetrical and neonatal care and perinatal levels of care; changes in health care systems and reimbursements, as well as hospital restructuring and other corporate structural changes. As part of the regulation development process, Title V Program staff conducted an extensive review of current standards, in consultation with a 49-member multi-disciplinary Expert Panel and other topical expert consultants. Additionally, the proposed regulations further integrate recently established midwifery birth centers, along with physician-led birth centers, into the perinatal regional system, and place a greater emphasis on quality care and patient safety, particularly for obstetrical patients.

Current efforts to strengthen this public health system includes increased efforts to address maternal morbidity and mortality, integration of physician- and midwifery-led birth centers into the regional systems, and increased access to ancillary services such as alcohol and substance use and mental health services, directly and/or through referral and commensurate with the birthing facility's level of care.

The NYSDOH submitted the regulatory package for approval in September 2020. Several delays beyond the control of Title V staff have affected the state's ability to adopt regulations and begin the process of redesignating birthing hospitals. In February 2023, the draft regulations were presented to the NYS Public Health and Health Planning Council (PHHPC) for

information. The regulations were resubmitted to the Governor's Executive Office for final approval and were posted in the New York State Register for a 60-day public comment period starting on May 31, 2023. Public comments were accepted through July of 2023 and have been reviewed internally. Responses to comments are in development. Further activities related to this project are described below.

Working within this statewide system of perinatal regionalization, NYS's Title V Program leads the NYS Perinatal Quality Collaborative, which aims to provide the best, safest, and most equitable care for pregnant and birthing people and infants in NYS by collaborating with birthing facilities, perinatal care providers, community-based organizations, patient/family members and other key stakeholders to prevent and minimize harm through the translation of evidence-based guidelines to clinical practice. The NYS Perinatal Quality Collaborative has adapted the Institute for Healthcare Improvement model for Idealized Perinatal Care and Breakthrough Series Methodology as a framework to guide improvement. Key NYS Perinatal Quality Collaborative activities include:

- embedding evidence-based guidelines into practice
- strengthening collaboration and communication within and among neonatal and obstetric providers, administrators, and organizations
- fostering prepared and proactive care teams
- assessing, conducting, and sharing surveillance and performance data on maternal and neonatal health indicators
- evaluating and measuring performance continuously
- setting priorities and implementing a comprehensive strategy for benchmarking and data driven quality improvement activities
- providing topic-specific, intensive quality improvement supportive activities, trainings and toolkits that are all-inclusive packages to facilitate improved clinical outcomes, excellent patient care and efficient resource allocation
- researching best practices
- reassessing outcomes of performance improvement interventions continually.

Specific priorities set by the NYS Perinatal Quality Collaborative are implemented by all participating NYS birthing facilities and partners to improve outcomes for perinatal care. Analysis of NYS Perinatal Quality Collaborative project data provided by participating birthing facilities helps to improve services and systems related to perinatal health care.

In January 2023, the NYS Perinatal Quality Collaborative was realigned to be housed within the Bureau of Perinatal, Reproductive, and Sexual Health, which oversees related work with Regional Perinatal Centers and birthing hospitals. Additionally, the Department's Early Hearing Detection and Intervention program, previously located within the Bureau of Early Intervention, was realigned within the Bureau in this same unit. NYS Perinatal Quality Collaborative, the Early Hearing Detection and Intervention program, and the Regional Perinatal Center grant program all work collaboratively with birthing facilities to accomplish programmatic goals. This realignment will further support program efforts and collaboration between staff formerly located within three different organizational units on three different floors of the NYSDOH's office in the Corning Tower.

The NYS Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2024-25 year:

- **Activity PIH-2.1:** Establish regulations to require birthing hospitals to provide referral and support for ancillary services, including mental health, alcohol and substance use treatment and other services. (*See also Activity WMH-2.1.*)
- **Activity PIH-2.2:** Assess perinatal designation surveys and site visit findings, communicate with birthing hospital staff on identified issues, and issue final designations for perinatal levels of care.
- **Activity PIH-2.3:** To improve coordination and increase bilateral referrals between birthing hospitals and home visiting programs:
    - **2.3a**: Title V staff will continue to assist in connecting Perinatal and Infant Community Health Collaborative and Maternal, Infant, and Early Childhood Home Visiting-funded home visiting programs with their local birthing

hospitals and support formal meetings where possible. Resources will be shared with programs and evaluation surveys conducted to determine use and effectiveness of resources.

- **2.3b**: Title V staff will share promising and best practices from established home visiting-birthing hospital partnerships across the state to encourage collaboration (see Activity WMH-2.3 for additional details).
- **2.3c**: Title V staff will also collaborate with Perinatal and Infant Community Health Collaborative; Maternal, Infant, and Early Childhood Home Visiting; Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC); and the NYS Office of Children and Family Services on the WIC Referral Project and the State's Maternal, Infant, and Early Childhood Home Visiting Continuous Quality Improvement project, to improve bi-directional referrals between local WIC sites and local Maternal and Infant Community Health Collaboratives and Maternal, Infant, and Early Childhood Home Visiting programs.
- **2.3d**: Title V staff will examine the feasibility of a multimedia campaign to support and encourage enrollment in Perinatal and Infant Community Health Collaborative and Maternal, Infant, and Early Childhood Home Visiting programs, including media placements in and around birthing facilities, prenatal care providers, and other tailored locations.
- **2.3e**: Title V staff will engage with the Essex County Department of Health to support implementation of a universal light touch home visiting program reaching all birthing people and families within the county regardless of need. Fueled in part by a disproportionate number of pregnant people who report alcohol or substance use during pregnancy or while breastfeeding (9.8% and 4% respectively), NYSDOH will connect the Essex County Department of Health with birthing hospitals in neighboring counties including the Regional Perinatal Center and will provide other supports from across the Division and Department.

- **Activity PIH-2.4:** Continue collaboration with other NYSDOH units to support the programmatic review to establish midwifery-led birthing centers through national accreditation and streamlined Certificate of Need application, and support integration of these facilities into the regional perinatal system as a critical foundation for obstetrical and neonatal patients who are at low risk.
  - **2.4a:** Collaborate with the NYSDOH Office of Primary Care and Health Systems Management to review Certificate of Need applications from freestanding and midwifery birth centers.
  - **2.4b:** Provide support to Regional Perinatal Centers and freestanding and midwifery-led birth centers to enter into affiliation agreements, participate in outreach and education initiatives, and participate in quality improvement activities.
- **Activity PIH- 2.5:** Collaborate with stakeholders to educate OB-GYN and family practice providers about changes to local birthing hospitals' level of perinatal care designation.

Strategy PIH-3: Apply public health surveillance and data analysis findings to improve services and systems related to perinatal and infant health care.

Data-driven, evidence-based, or informed practice is essential to achieving public health goals for Maternal and Child Health. Across all Title V funded programs, continuous effort is needed to enhance the collection, analysis, and sharing of data to inform the planning and implementation of Maternal and Child Health programs and policy work. Sharing data with stakeholders, including providers and community members, is critical to raise awareness, empower community action, and facilitate quality improvement efforts at all levels.

The NYS Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2024-25 year:

- **Activity PIH-3.1:** Collaborate with the NYS Office of Children and Family Services, Perinatal and Infant Community Health Collaborative; Maternal, Infant, and Early Childhood Home Visiting; and local WIC programs on the WIC Referral Project and the State's Maternal, Infant, and Early Childhood Home Visiting continuous quality improvement project, to improve bi-directional referrals between local WIC sites and local home visiting programs (see *Activity WMH 2.3c* for additional details).

- **Activity PIH-3.2:** Lead quality improvement projects through the NYS Perinatal Quality Collaborative, with birthing facility teams with a focus on:
  - **3.2c:** Improving infant outcomes, with a focus on those in the neonatal intensive care unit (NICU), by improving equity and increasing the practice of family-centered care.
  - **3.2d:** Improving outcomes for all NYS birthing people by focusing on birth equity and reducing low-risk primaray cesaran births (*see Activity WMH 3.5 for additional details).*
- **Activity PIH-3.3:** Summarize, share, and discuss findings and recommendations of the Maternal Mortality Review Board with key stakeholders, including the Maternal Mortality and Morbidity Advisory Council and American College of Obstetricians and Gynecologists District II NY, to inform statewide prevention strategies to improve maternal outcomes. This will include the development of issue briefs, webinars, quality improvement projects through the NYS Perinatal Quality Collaborative, and a maternal mortality report and an Executive summary document. (*See Strategy WMH-3 and Activities WMH-3.1, 3.2 and 3.3 for additional information.)*
- **Activity PIH-3.4:** Establish a comprehensive perinatal data warehouse of perinatal outcomes to make data available in a timely way to birthing hospitals and support quality improvement activities.
- **Activity PIH-3.5:** Collaborate with NYSDOH AIDS Institute and the New York City Department of Health and Mental Hygiene on efforts to address significant increases in the number and rate of infectious (primary, secondary, and early latent) syphilis among New York State females of childbearing age, and number and rate of congenital syphilis cases.
  - **3.5a:** Support the development of a statewide Congenital Syphilis Strategic Plan and support the implementation of priority activities.
  - **3.5b:** Support distribution of NYSDOH-issued locally tailored and statewide health advisories to alert health care professionals of primary, secondary, and early latent syphilis and Congenital Syphilis surveillance trends, screening requirements and recommendations, and appropriate treatment regimens.
  - **3.5c:** Promote clinical education opportunities to birthing hospital staff, provided through the NYSDOH-supported Clinical Education Initiative and other CDC-funded provider training initiatives.
  - **3.5d:** Provide periodic updates and resources for community-based providers that engage with pregnant clients, to promote awareness of sexually transmitted infections (STIs) that can affect pregnancy, fertility, and the health of a fetus or newborn.

Strategy PIH-4: Apply a health equity lens to Title V activities that addresses social determinants and reduces disparities identified by surveillance, research, and community members that impact infant health and use of perinatal and infant health care and support services.

As noted in other domains, perinatal and infant health outcomes are impacted by the social determinants of health, or the conditions in which people are born, live, work, play, learn, and age. The social determinants of health include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of power and resources due to racism and other biases are root causes of inequities in access, availability of services, and quality of care. All ten priorities that emerged from community members' input during the Title V Needs Assessment revolve around the social determinants of health and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities.

Efforts to improve infant health outcomes must focus directly on addressing longstanding and persistent racial and ethnic disparities in infant health. This persistence of disparities in most of our major health indicators clearly shows that while evidence-based interventions can affect positive change, they alone are not enough to address the larger issues contributing to health inequities. NYS's Title V Program thus seeks to combine the strength of data-driven, evidence-based, or evidence-informed programs and interventions with authentic community engagement opportunities across all Title V funded programs that address perinatal and infant health, including discussions and actions related to racial justice, as well as strengthening community-based and clinical/provider relationships, to increase equity in access to health care and social

support services. Title V funded programs seek to engage and empower individuals, families, and communities by increasing awareness of available community resources and supports; working with community stakeholders to improve delivery of care and services; and enhancing social support, health literacy, and self-care and advocacy skills for pregnant and parenting families.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2024-25 year:

- **Activity PIH-4.1:** Title V staff will continue to promote the NYS Council on Children and Families' *NYS Parent Portal* to stakeholders including primary care providers, birthing facilities, and nontraditional partners when feasible and relevant.
- **Activity PIH-4.2:** Through the Perinatal and Infant Community Health Collaborative program, work with diverse community stakeholders including community residents to identify and collaboratively address issues and barriers impacting maternal and infant health outcomes at the community level (*see Activity WMH-4.1 for further detail).*
- **Activity PIH-4.3:** Through the Perinatal and Infant Community Health Collaborative and Maternal, Infant, and Early Childhood Home Visiting programs, provide supports to individual clients and their families to address social determinants of health outcomes. Provide information on community resources, screen and assist families in enrolling in health insurance and health care, work directly with families to strengthen health literacy, self-care, and advocacy skills, and provide and enroll families in enhanced social supports and educational opportunities (*see Activity WMH-4.2 for further detail).*
- **Activity PIH-4.4:** Through the NYS Perinatal Quality Collaborative, continue the work of the NYSPQC NICU Equity Project, a quality improvement project with birthing facility NICU teams , to improve outcomes for all infants admitted to Neonatal Intensive Care Units (NICUs), reduce disparities, and improve the experience of care for their families.
- **Activity PIH-4.5:** Title V staff will collaborate with the Division's Bureau of Health Equity and Community Engagement, to share resources with stakeholders and funded programs serving pregnant and birthing people and their families, as well as to establish or strengthen connections between the Bureau of Health Equity and Community Engagement and Title V-funded programs.
- **Activity PIH-4.6**: Through all Title V programs, provide opportunities for training and technical assistance related to providing services equitably, addressing social determinants of health, health disparities, and promoting racial and reproductive justice.
- **Activity PIH-4.7**: Issue a procurement to establish a statewide Parent Advisory Committee, beginning in 2024, consisting of parents who are current/former home visiting clients and other stakeholders. Through parent engagement and leadership, the PAC will provide input on matters of interest to state agency partners and develop professional skills. Title V and Maternal, Infant, and Early Childhood Home Visiting staff will share lessons learned with home visiting programs to enhance their community member participation on Community Advisory Boards.
- **Activity PIH-4.8**: Support the Department's various breastfeeding/chestfeeding activities, including collaboration with intra-agency workgroups and planning and promoting breastfeeding grand round meetings.

Strategy PIH-5: Maintain and strengthen a robust statewide population-based Newborn Bloodspot Screening Program and Newborn Hearing Screening Program.

The NYS Newborn Screening program is a population-based program and public health system that identifies infants who may have a rare, but treatable disease through bloodspot screening shortly after birth. Within NYSDOH, the Newborn Screening program is housed and administered by the Wadsworth Center, NYS's public health laboratory, with direct support from Title V and several other state and federal funding sources. The Newborn Screening program currently performs laboratory testing for 50 diseases, following national recommendations for Newborn Screening programs. The program ensures that every newborn in the state receives newborn bloodspot screening as a public health service, with no fee for testing. The program also performs follow-up case management to ensure newborns with a positive screening result receive appropriate diagnostic testing and treatment. Specialty Care Centers are certified and monitored to ensure

newborns have access to specialty care for disease-specific testing and management. In addition, the Newborn Screening program contracts with each of the state's 10 Inherited Metabolic Disease Specialty Care Centers to enroll patients with an Inherited Metabolic Disease diagnosis identified by newborn screening in the NYS Newborn Screening Patient Registry. These Inherited Metabolic Disease Specialty Care Centers are responsible for entering and tracking for consented patients annually and for attending an annual meeting to discuss long-term follow-up data. Patients are monitored until age 18, when the individual must consent to continue participation until age 21. In 2021, the program screened 211,203 infants, 99.97% of all NYS resident infants born that year (See Form 4 for further details).

The Newborn Screening program practices continuous quality improvement using LEAN principles, with a focus on improving overall efficiencies, reducing false positives, and improving timeliness in newborn screening for time-critical conditions. The program also strives to promote the growth of the field of Newborn Screening by promoting the development of its staff, participating in national committees, conducting pilot studies, and training other state newborn screening programs. The Newborn Screening program collaborates with other public health programs to support mutual goals. For example, the Newborn Screening program collaborated with the state's Early Hearing Detection and Intervention program on a project to send letters to primary care providers regarding newborns requiring follow-up for failed newborn hearing screening. The Newborn Screening program has identified a need for continued education for primary care providers on newborn screening and genetics.

The NYS Early Hearing Detection and Intervention program is the newborn hearing screening program and supports the US Surgeon General's Healthy People 2020 goal ENT–VSL–1: Increase the proportion of newborns who are screened for hearing loss by no later than age 1 month, have audiologic evaluation by age 3 months, and are enrolled in appropriate intervention services no later than age 6 months.

Universal newborn hearing screening is a component of the NYS Early Hearing Detection and Intervention program. NYS Public Health Law requires all maternity hospitals and birthing centers to administer newborn hearing screening programs. Parents are given information about newborn hearing screening prior to the screening. Then shortly after birth, the baby's hearing is screened, and parents are given the result. If a baby does not pass the initial hearing screening, they may be re-screened prior to discharge. If the baby cannot be re–screened before discharge, or does not pass re-screening, the parents will be given a prescription for their baby to have an outpatient screening and a list of qualified infant hearing screeners. If the infant does not pass a second screening, the baby is referred for a full diagnostic hearing assessment. If hearing loss is detected, the infant is referred to the NYS Early Intervention Program for appropriate intervention services.

The Title V Program will support the Newborn Screening and the NYS Early Hearing Detection and Intervention programs on the following activities to advance this strategy over the upcoming 2024-25 year:

- **Activity PIH- 5.1:** Newborn Screening program staff will continue to conduct virtual site visits and in-person visits when appropriate with birthing facilities and hospitals to provide education to the hospital staff about Part 69-1, newborn screening regulation and compliance. The site visits are part of a birth hospital continuous quality improvement initiative supported by the Association of Public Health Laboratories to improve pre-analytic turnaround times (from collection of newborn dried blood specimens to receipt of specimens by the Program).
- **Activity PIH- 5.2:** Continue implementation and evaluation of a hospital late collection (>120hr) follow-up process with birth hospitals, to ensure timely collection and mitigate any risks of hospital staff oversight.
- **Activity PIH- 5.3:** Continue supporting the ongoing continuous quality improvement initiative at the 10 Inherited Metabolic Disease Centers for Short-term Follow-up compliance. Individual quality reports with the following outcome measures will be provided to each of the 10 Inherited Metabolic Disease Center Directors: total number of referrals for center, percentage/number of referrals closed more than 90 days, percentage/number of referrals lost-to follow-up, and the NYS overall averages in each category. Standard operating procedures for follow-up practices at the Centers will be requested and reviewed. A similar project was completed with the Endocrine Specialty Care Centers in the past (2019-2020).
- **Activity PIH- 5.4:** Through the Early Hearing Detection and Intervention program, provide monthly data reports to

birthing hospitals identifying infants born at their facility that failed an initial hearing screening test and do not have a reported follow-up test within three months of birth, and provide technical support to birthing hospital staff and audiologists as appropriate. The NYS Early Hearing Detection and Intervention program generates aggregated monthly reports for 120 birthing hospitals and 72 audiology practices that serve young children in New York State to support monitoring and surveillance activities. These reports assess the completeness and timeliness of newborn hearing screening and follow-up. Additionally, The NYS Early Hearing Detection and Intervention staff sends monthly child lists and run charts to hospitals and audiology practices that are missing newborn hearing screening and follow-up results or referrals to the NYS Early Intervention Program.

- **Activity PIH-5.5**: The NYS Early Hearing Detection and Intervention program will collaborate with the Newborn Screening program to enhance identification and linkage to care for infants with Congenital Cytomegalovirus (cCMV) Infection who may be at risk for hearing loss.

The NYS Title V Program established two Evidence-Based Strategy Measures (ESM) to track the programmatic investments and inputs designed to impact NPM-3:

ESM PIH-1: Percent of birthing hospitals with final level of perinatal care designation, in accordance with updated regulations and standards.

Data for this measure will be obtained from hospital surveys and site visit reports from the NYSDOH subrecipient (IPRO) and NYSDOH staff. The baseline value for this measure will be determined after regulations are adopted. The program has set a goal to update designations for 50% of hospitals within one year post-adoption and 100% within three years of adoption.

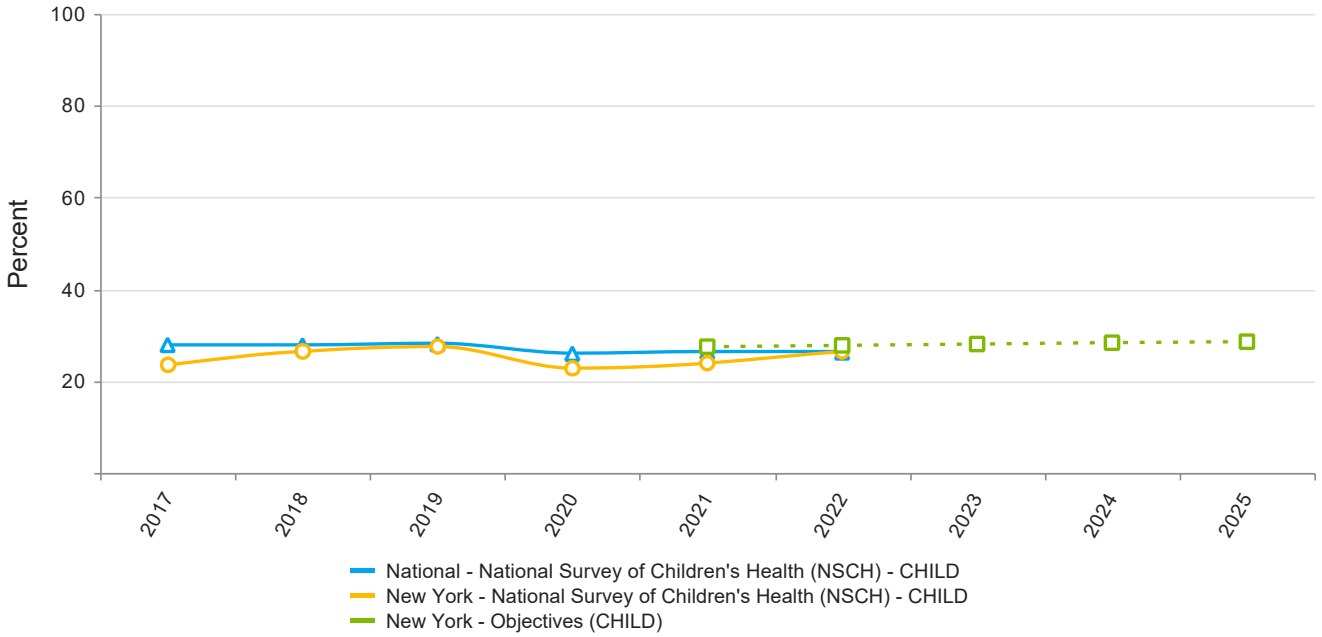
ESM PIH-2: Increase the percentage of the birthing hospitals that received site visits from NYSDOH staff to evaluate the process of collecting and transmitting Newborn Blood Spot samples to ensure samples are received by the NYSDOH Wadsworth Laboratory within 48 hours of collection.

Data for this measure will come from the NYSDOH Newborn Screening Program. The baseline value for this measure will be determined in 2023. The program has set a goal to visit an additional 40 birthing hospitals by September 2023. This initiative is funded through non-Title V Health Resources and Services Administration funding and a grant from the Association of Public Health Laboratories.

Child Health

National Performance Measures

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
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CHILD					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			27.5	27.8	28.1
Annual Indicator	27.0	27.4	22.4	24.1	26.6
Numerator	369,498	316,874	272,297	308,176	345,661
Denominator	1,370,994	1,158,167	1,213,091	1,278,404	1,300,265
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	28.4	28.6

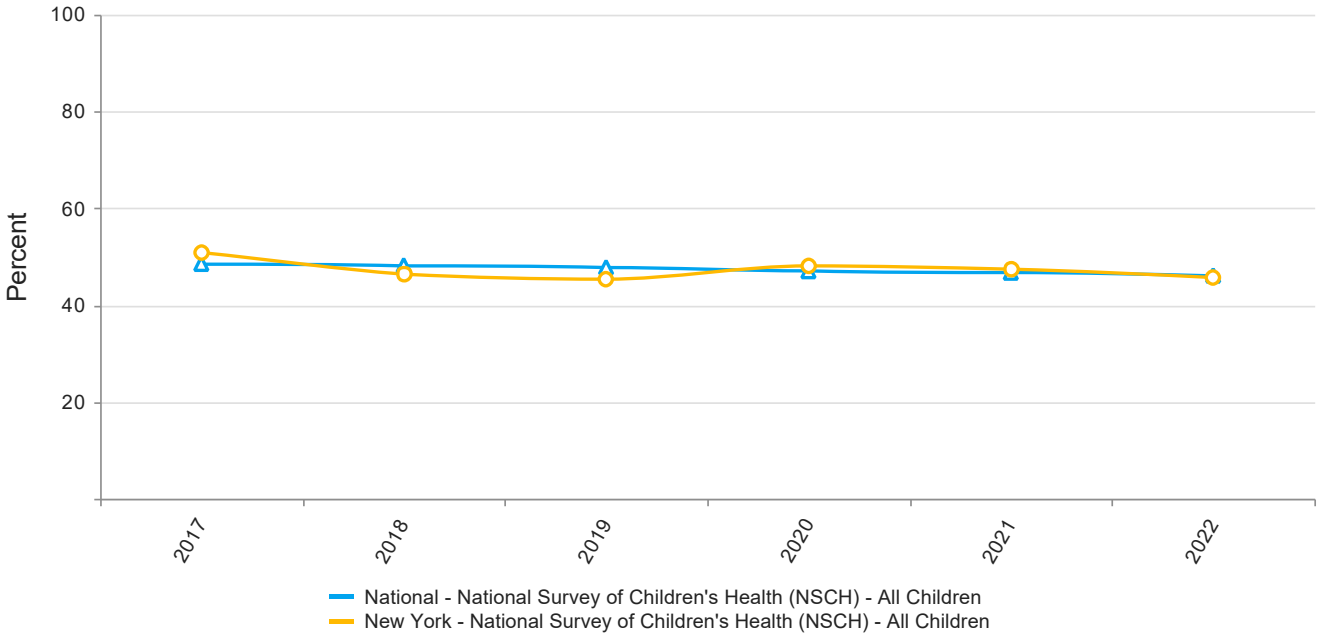
Evidence-Based or –Informed Strategy Measures

ESM PA-Child.1 - Percent of children and youth enrolled in School Based Health Centers (SBHCs) who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a SBHC within the past year.

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			51.6	51.6	52.6
Annual Indicator		51.6	43	35.1	50.6
Numerator		98,941	74,325	54,615	79,697
Denominator		191,920	172,751	155,443	157,601
Data Source		SBHC quarterly report	SBHC quarterly report	SBHC quarterly report	SBHC quarterly report
Data Source Year		2018-2019	2019-2020	2020-2021	2021-2022
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	53.6	54.7

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
Indicators and Annual Objectives



NPM MH - Child Health - All Children

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - All Children	
	2023
Annual Objective	
Annual Indicator	45.6
Numerator	1,834,655
Denominator	4,020,084
Data Source	NSCH-All Children
Data Source Year	2021_2022

Evidence-Based or –Informed Strategy Measures

None

State Action Plan Table

State Action Plan Table (New York) - Child Health - Entry 1	
Priority Need	
Increase access to affordable fresh and healthy foods in communities.	
NPM	
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	
Five-Year Objectives	
Objective CH-1: Increase the percent of NYS children age 6-11 who are physically active at least 60 minutes per day by 3.7%, from 27% in 2017-2018 to 28% in 2021-2022 (NSCH).	
Objective CH-2: Decrease the percent of NYS children age 10-17 who are obese (BMI at or above the 95th percentile) by 2.8%, and from 14.4% of children age 10-17 in 2017-2018 to 14% in 2021-2022 (NSCH).	
Strategies	
Strategy CH-1: Promote evidence-based and family-centered health care for children to promote healthy behaviors and to prevent, identify, and manage chronic health issues so that children can be healthy and active. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.	
Strategy CH-2: Promote home, school, and community environments that support developmentally appropriate active play, recreation, and active transportation for children of all ages and abilities. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.	
Strategy CH-3: Apply public health surveillance and data analysis findings to improve services and systems related to children's health and health care. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.	
Strategy CH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact children’s health and well-being. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.	
ESMs	Status
ESM PA-Child.1 - Percent of children and youth enrolled in School Based Health Centers (SBHCs) who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a SBHC within the past year.	Active

NOMs

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

State Action Plan Table (New York) - Child Health - Entry 2

Priority Need

Address community and environmental safety for children, youth, and families.

NPM

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

Five-Year Objectives

Objective CH-1: Increase the percent of NYS children age 6-11 who are physically active at least 60 minutes per day by 3.7%, from 27% in 2017-2018 to 28% in 2021-2022 (NSCH).

Objective CH-2: Decrease the percent of NYS children age 10-17 who are obese (BMI at or above the 95th percentile) by 2.8%, and from 14.4% of children age 10-17 in 2017-2018 to 14% in 2021-2022 (NSCH).

Strategies

Strategy CH-1: Promote evidence-based and family-centered health care for children to promote healthy behaviors and to prevent, identify, and manage chronic health issues so that children can be healthy and active. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy CH-2: Promote home, school, and community environments that support developmentally appropriate active play, recreation, and active transportation for children of all ages and abilities. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy CH-3: Apply public health surveillance and data analysis findings to improve services and systems related to children's health and health care. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy CH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact children’s health and well-being. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

ESMs	Status
ESM PA-Child.1 - Percent of children and youth enrolled in School Based Health Centers (SBHCs) who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a SBHC within the past year.	Active

NOMs

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

State Action Plan Table (New York) - Child Health - Entry 3

Priority Need

Enhance supports for parents and families, especially those with children with special health care needs, and inclusive of all family members and caregivers

NPM

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

Five-Year Objectives

Establish baseline percentage and propose a percentage increase of children with and without special health care needs, ages 0 through 17, who have a medical home.

Strategies

The NYS Title V Program is working to ensure postpartum visits through a number of our current strategies and activities. The Child Health Domain Team will review data from the five (5) National Survey of Children's Health components that inform the Medical Home NPM: usual source of sick care, personal doctor or nurse, family-centered care, no problems getting referrals, and effective care coordination when needed. Upon review, annual objectives and strategies will be identified for the FY 2026 Application. Where possible, these activities will align with the Blueprint for Change.

ESMs | Status

No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.

NOMs

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.

Child Health - Annual Report

For Child Health (CH), New York's Title V Program selected **National Performance Measure (NPM) 8.1: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day.** This NPM was selected because it is responsive to concerns voiced directly by families in New York State (NYS) and reinforced by state-specific population health data. According to the National Survey of Children's Health, during the 2022 reporting period, 16.3% of NYS children ages 10-17 were obese (0.7% decrease compared to 2020-2021 data), and only 25.2% of NYS children ages 6-11 years were physically active for at least 60 minutes daily (1.1% increase compared to 2020-2021 data). NYS families identified the availability and accessibility of amenities that support children's safe, active play and access to healthy foods as top priority needs, alongside priorities for community and environmental safety for children and community transportation. Supporting healthy, active play and recreation for children and youth of all ages and abilities is critical to promoting healthy weight as well as general physical and mental health during childhood and throughout the life course. In addition, this measure provides opportunities to be responsive to the Title V priorities for health care access and quality, social support, and social cohesion. This NPM aligns directly with NYS Prevention Agenda goals for physical activity and chronic disease prevention.

NYS's Title V Program has the capacity to address these priorities through its School-Based Health Center program and through collaboration with the New York State Department of Health (Department) Creating Healthy Schools and Communities program to enhance environmental infrastructure and supports, both in schools and in the community, to support physical activity. School-Based Health Centers serve NYS's communities that have been most impacted by systemic barriers and face the greatest challenges and provide critical access to quality primary care for school-aged children.

In the summer of 2022, Title V staff discussed the Pediatric Mental Health Care Access (PMHCA) grant on a Title V Advisory Council meeting to strengthen the support for mental health access in School-Based Health Centers. A key strategy of the PMHCA grant is a partnership with the Office of Mental Health and that office's Project TEACH (Training and Education for the Advancement of Children's Health) which is aimed at enhancing primary care provider capacity to provide mental health services. Since the presentation, Project TEACH has been actively reaching out to all School-Based Health Centers and creating relationships to engage School-Based Health Centers in Project TEACH trainings, referrals, and one on one consultation services. In addition, Project TEACH is developing a training series for several mental health topics (ADHD, depression, anxiety, and aggression) that will be offered exclusively to School-Based Health Centers. The New York School-Based Health Alliance (NYSBHA) is partnering with the Division of Family Health to further align telehealth activities on the PMHCA grant. In the past year, they have conducted several surveys and focus groups with the sole intention of understanding mental health telehealth services in School-Based Health Centers. Eventually, this information will be used to establish mental health telehealth services in School-Based Health Centers. In addition to this, NYSBHA has contacted School-Based Health Centers and determined what equipment is needed to support mental health telehealth. In the future, grant funds will be used to purchase equipment that School-Based Health Centers have requested.

Two specific objectives were established to align with this performance measure:

Objective CH-1: Increase the percent of NYS children ages 6-11 who are physically active at least 60 minutes per day by 5%, from 27% in 2017-2018 to 28.4% in 2021-2022 (National Survey of Children's Health).

Objective CH-2: Decrease the percent of NYS children ages 10-17 who are obese (BMI at or above the 95th percentile) by 2.8%, and from 14.4% of children ages 10-17 in 2017-2018 to 14% in 2021-2022 (National Survey of Children's Health).

Four strategic public health approaches were identified to accomplish these objectives over the five-year grant.

Strategy CH-1: Promote evidence-based and family-centered health care for children to promote healthy behaviors and to prevent, identify, and manage chronic health issues so that children can be healthy and active.

To be physically active, children's basic health needs for growth, development, and good nutrition must be met. Health care providers play an important role in promoting physical activity and other healthy behaviors, and in managing children's health needs including mental health, obesity, asthma, and other special health care needs and challenges that may impinge on children's ability to participate in active play and recreation. Health care providers follow current evidence-based guidelines for anticipatory guidance, screening, counseling, and disease management, including guidelines specific to physical activity and healthy weight, and help guide children and their families in finding and using available community resources for active play and recreation.

School-Based Health Centers are an important source of primary and preventive care services for thousands of NYS children and have the opportunity and capacity to holistically address children's needs. During this reporting period, Title V staff worked with School-Based Health Centers statewide to ensure anticipatory guidance to promote proper nutrition and daily physical activity, weight status assessment, and attention to overall health promotion and chronic disease management, as part of routine primary and preventive care for children. In addition, the Title V Program continued to support an array of core public health programs that address children's health and wellness and access to primary and preventive health care services. The Title V staff led the following specific program and policy activities to advance this strategy in the 2022-23 year.

CH-1.1: Provide guidance and add quarterly reporting requirements for all funded School-Based Health Centers to increase provision of 1) age-appropriate anticipatory guidance regarding physical activity and nutrition and 2) routine assessment for indicators of overall health, one of which will be weight status, but it will not be the sole factor. Data from quarterly reports will be reviewed and reports will be generated for feedback to School-Based Health Centers to assess progress and drive improvements in these practices.

The Title V Program continued to provide guidance on the quarterly reporting requirements for all 44 School-Based Health Center operators to increase provision of 1) age-appropriate anticipatory guidance regarding physical activity and nutrition and 2) routine assessment for weight status based on Body Mass Index (BMI)-for-age percentile for students receiving care in School-Based Health Centers. Data from quarterly reports using the current data system was reviewed and feedback was provided to each School-Based Health Center. This is part of routine contract management where operators ensure strategies are developed and implemented to improve provider performance on quality indicators.

As mentioned in the last reporting period, the prior School-Based Health Center data system was outdated and needed to be replaced. Reports were generated manually, there was no trend reporting capability, and there was no way to easily compare operator performance. A grant was received in 2019 from Health Research, Inc. (HRI) to replace the current data system. During this reporting period, the Title V Program worked on developing the new School-Based Health Center data system to be integrated into the Health Commerce System that receives and integrates data for all School-Based Health Centers, meets the needs of the state and includes performance metrics that will generate reliable reports, empowering the New York State Department of Health to assess operators' performance and support quality improvement efforts. This new system will provide the Department with the ability to identify areas in need of improvement, ensure quality services are rendered to NYS children, and assess the performance in terms of age-anticipatory guidance as related to physical activity and nutrition. Title V staff participated in the design and testing of this new data system. One of the elements of the new data system is the inclusion of updated instructions on providing age-appropriate anticipatory guidance to children and adolescents which includes physical activity and nutrition. The new data system will be used for Quarterly Report submissions, though improvements, bug-fixes, and testing are still underway.

While the new data system was launched for School-Based Health Center Dental providers during this reporting period, the system for School-Based Health Center Medical providers was still under review but is anticipated to be implemented in the next reporting period. In anticipation of this, a Health Commerce System data presentation was held on August 31, 2023, for all Medical Operators. A new data submission guide has also been developed.

CH-1.2: Promote the use of the American Academy of Pediatrics Bright Futures™ model for anticipatory guidance in

School-Based Health Centers and seek opportunities to engage the Academy of Pediatrics for assistance to promote this resource.

To promote the use of the American Academy of Pediatrics Bright Futures™ model for anticipatory guidance in School-Based Health Centers and to seek opportunities to engage the American Academy of Pediatrics for assistance to promote this resource, the Department's Division of Family Health staff met to develop a plan. It was determined that the first step is to build internal capacity regarding Bright Futures™. This will include what it is, who developed it, how it is used in the field, and what it says about anticipatory guidance. An internal training was conducted by a physician from the School of Public Health in November 2022. The training introduced and oriented staff to Bright Futures™ and began the conversation on how School-Based Health Centers may use Bright Futures™. The plan is to explore Bright Futures™ in more depth related to our objectives and plan preliminary conversations with our School-Based Health Centers to determine their current knowledge, current practice and their support needs to advance strategies with the Child Health objectives.

CH-1.3: Incorporate guidance, reporting, and tracking to support School-Based Health Centers to engage their dental patients in conversations about physical activity and nutrition through the delivery of anticipatory guidance on nutrition including water and sugar-sweetened beverage consumption, and work with School-Based Health Centers to ensure that enrolled students have an established dental home to promote optimal oral and overall health.

The Title V Program continued to work on incorporating guidance, reporting, and tracking to support School-Based Health Centers to engage their dental patients in conversations about physical activity and nutrition through the delivery of anticipatory guidance on nutrition, including water and sugar-sweetened beverage consumption. To ensure that students enrolled in School-Based Health Centers have an established dental home to promote optimal oral and overall health, the Title V Program released a 2023-2028 School-Based Dental Home Program Request for Application in August 2022. Subsequently, 19 School-Based Health Center dental clinics were awarded the five-year School-Based Dental Home Program funding opportunity, effective July 1, 2023-June 30, 2028. These funded School-Based Health Center dental clinics support the program's overarching goals to provide anticipatory guidance that includes physical activity and nutrition, establish a consistent source of dental care for children, improve oral health outcomes, engage families to support their health goals, and reduce racial and ethnic disparities in children's oral health outcomes. School-Based Dental Home funded programs deliver high-quality, accessible dental services in the school setting to children, with a focus on serving low-income, uninsured, and underinsured individuals. Services provided by funded programs include biannual examinations/screenings, preventive services, anticipatory guidance, referrals for needed oral health services, follow-up on any untreated dental disease, and ensuring quality and continuity of care.

The New York State Department of Health is committed to investing public health resources in communities most impacted by historical, structural, and institutional inequities that manifest in disproportionately poor health outcomes, especially for racial and ethnic minorities. To achieve that goal, the Department seeks to fund programs that provide services to historically marginalized populations and groups and demonstrate the greatest impact on advancing health equity by improving overall population health outcomes.

CH-1.4: Explore opportunities to collaborate with New York School-Based Health Alliance to support School-Based Health Centers' increased effort towards promoting physical activity such as hosting webinars with subject matter experts.
Staff explored opportunities to collaborate with the New York School-Based Health Alliance to support School-Based Health Centers' increased efforts to promote physical activity. Title V staff met to discuss a plan for joint quarterly calls with the School-Based Health Center Medical and Dental programs. Title V staff invited the New York School-Based Health Alliance and School-Based Health Center Medical and Dental programs to participate in this planning call. This stakeholder engagement helped formulate a new style for the quarterly calls to ensure topics relate to attendees. Title V staff will continue to collaborate with the New York School-Based Health Alliance to develop ideas for topics most closely related to our objectives.

CH-1.5: Within the Title V program, strengthen collaboration between child- and adolescent-serving programs to enhance

promotion of physical activity through established programs that focus on adult-led activities and social-emotional wellness.

To strengthen collaboration between child- and adolescent-serving programs to enhance promotion of physical activity through established programs that focus on adult-led activities and social-emotional wellness, staff working in the Child Health Domain continued to collaborate with the staff focused on Adolescent Health Domain work. Staff from the two domains meet internally to explore opportunities for School-Based Health Centers on topics of interest related to adolescents. For example, Adolescent Health staff were invited to participate in the Bright Futures™ training that was conducted in November 2022 so they could learn more about the model as well.

CH-1.6: Collaborate with the Department's Division of Nutrition to incorporate public health nutrition messaging with physical activity guidance across child health programs, including School-Based Health Center and Children and Youth with Special Health Care Needs programs. While contacts within the Division of Nutrition were initiated, no specific program within that Division has been selected and no project has been established to achieve this goal. This is a top priority for the upcoming period.

CH-1.7: Continue to directly support a portfolio of Title V-funded programs and services that promote children's wellness and enhance access to comprehensive primary and preventive care services for children, including:

- School-Based Dental Home and Drinking Water Fluoridation programs to promote children's oral health and reduce dental caries as key contributors to children's overall health and well-being.
- Comprehensive Services and Health Systems Approaches to Improve Asthma Control in New York State to improve the quality and availability of guidelines-based asthma care.

The Division of Family Health continues to directly support a portfolio of Title V-funded programs and services that promote children's wellness and enhance access to comprehensive primary and preventive care services for children. The School-Based Sealant Program (and later in the year, the School-Based Dental Home Program) and Drinking Water Fluoridation program promote children's oral health and reduce dental caries as key contributors to children's overall health and well-being.

The NYS-funded School-Based Sealant Program aims to reduce the prevalence of dental caries among New York State's children by providing dental sealants to first molars of second and third grade children through School-Based Health Centers. School-based dental sealant delivery programs are recommended by the U.S. Department of Health and Human Services' Community Preventive Services Task Force based on strong evidence of effectiveness in preventing tooth decay. The 21 contractors that are health facilities regulated by the New York State Department of Health under Article 28 of NYS Public Health Law were funded to provide dental sealants to second and third graders in schools across the state. These programs prioritized supporting schools with a higher percentage of children eligible for the federal free or reduced-price school lunch program. In addition to applying sealants, School-Based Sealant Programs were expected to provide the full array of services including outreach and education, dental screening, education and anticipatory guidance, sealant retention assessment, and referrals and follow-up care. The contract period for the School-Based Sealant Program ended as of June 30, 2023.

Subsequently,19 contractors that are health facilities regulated by the New York State Department of Health under Article 28 of NYS Public Health Law were awarded a new five-year funding opportunity through the School-Based Dental Home Program, effective July 1, 2023-June 30, 2028. The intention of the School-Based Dental Home Program is to ensure that students enrolled in School-Based Health Centers have an established dental home to promote optimal oral and overall health. These funded contractors support the program's overarching goals to provide anticipatory guidance that includes physical activity and nutrition, establish a consistent source of dental care for children, improve oral health outcomes, engage families to support their health goals, and reduce racial and ethnic disparities in children's oral health outcomes. The operators deliver high-quality, accessible dental services in the school setting to children, with a focus on serving low-income, uninsured, and underinsured individuals. Services provided include biannual examinations/screenings, preventive services, anticipatory guidance, referrals for needed oral health services, follow-up on any untreated dental disease, and

ensuring quality and continuity of care.

In partnership with the Title V program, Title V staff assisted with the contract development and monitoring of the Department's Drinking Water Fluoridation grant. The purpose of this grant is to provide NYS residents access to optimally fluoridated water to prevent tooth decay and promote good oral health, which is important to maintaining overall health. The grant focuses on providing technical and financial support to communities to initiate and maintain Community Water Fluoridation. Title V funded a contract with the New York Rural Water Association (August 2018-July 2023) to provide technical assistance to public water systems via onsite visits and operator trainings, to help ensure fluoridated public water systems are maintained and operated in compliance with all laws, rules, and regulations. As the five-year contract ended on July 31, 2023, the Bureau of Water Supply Protection developed a new Technical Assistance to Small Public Water Systems and Fluoridating Public Water Systems Request for Proposals (RFP), in which the Division of Family Health provided comments to update the fluoridation piece of the new procurement. The RFP was released in March 2023, and New York Rural Water Association was awarded the new grant in September 2023, with the expected start date of October 1, 2023. Title V staff attend quarterly meetings held with Bureau of Water Supply Protection and New York Rural Water Association, review fluoridation site visit reports (25 per year), fluoridation training reports (4 per year), and the annual work plan. Title V staff also remain in continuous communication with Bureau of Water Supply Protection on any fluoridation related questions, site visits, and fluoridation issues.

The Drinking Water Fluoridation Program also provides technical assistance to local and regional health departments, elected officials, and local, state, and national Community Water Fluoridation stakeholders and champions, including the benefits, risks, effectiveness, and cost-effectiveness of Community Water Fluoridation, along with the legal requirements to meet NYS Public Health Law §1100-a. During this reporting period, Title V staff monitored 12 state-funded grants awarded to public water systems through the Drinking Water Fluoridation Grant Program. Also, 19 public water systems received technical support from New York Rural Water Association to maintain or initiate community water fluoridation. New York Rural Water Association also provided four trainings to public water systems operators during this period, with a total of 43 operators receiving the training. A total of 71.2% of NYS residents served by community water systems have optimally fluoridated water, based on 2021 data captured by the Safe Drinking Water Information System as of August 2021, which is an Environmental Protection Agency database managed by the Department's Center for Environmental Health.

The Comprehensive Services and Health Systems Approaches to Improve Asthma Control in New York State aims to improve the quality and availability of guidelines-based asthma care. During this reporting period, Division of Family Health staff continued to collaborate with the Asthma Guidance Team, led by the Department's Division of Chronic Disease Prevention, to improve asthma control in NYS and management of asthma in schools by meeting with Division of Chronic Disease Prevention to discuss Asthma Self-Management Education in School-Based Health Centers. Because exercise-induced asthma is common in adolescents, the asthma action plan includes the importance of exercise being managed in schools so that students can fully participate. Treatment with prescribed medications before vigorous activity or exercise can prevent symptoms. This reporting period also included collaborating with the Division of Chronic Disease Prevention to discuss continued partnering with School-Based Health Centers for asthma self-management training services to School-Based Health Center patients. A promotional opportunity webinar was developed and presented to introduce this project to the School-Based Health Centers in February 2022 by the American Lung Association with Asthma Control Program and discuss what the expectations of the projects are. Through the School-Based Health Centers' education with the students, the students will be better able to manage their asthma symptoms, decrease asthma complications and exercise-induced asthma so they can participate more fully in physical activity in/outside of schools. There were 5 School-Based Health Center operators and 9 sites participating in this reporting period; 92 students were served, and 43 School-Based Health Center staff trained including nurse practitioners, medical and nursing directors, and medical assistants. Students had a pre-assessment mean score of 44.4% and a post-assessment mean score of 67.4%. The post-assessment mean score improvement is attributed to the flip chart, which is used as an asthma education tool and includes asthma control and severity assessment, the use of controller/rescue medications and techniques, asthma action plans and environmental triggers. The asthma facilitator uses this flipchart to educate their students and they keep a roster of students who receive education with the use of the flipchart. Another webinar is soon to be offered to start a new cohort for this project.

Strategy CH-2: Promote home, school, and community environments that support developmentally appropriate active play, recreation, and active transportation for children of all ages and abilities.

CH-2.1: Collaborate with the Department's Division of Chronic Disease Prevention to implement multi-pronged strategies to enhance the work of Creating Healthy Schools and Communities grantees, and other initiatives.

To achieve state goals related to increasing physical activity among children, children and their families need safe, appealing, and accessible places to play and be active – at home, in school, and in their neighborhoods and communities. Across the community listening forums conducted in 2019 for the latest Title V Needs Assessment, families and children voiced a desire for amenities in their neighborhoods that provide opportunities for active play and daily physical activity, such as playgrounds, athletic facilities, greenspace, and community centers. They want streets, sidewalks, and trails that are accessible and safe for walking and biking, both for transportation and recreation. They want these areas to be clean, appealing, and safe for children and families. They want to know what is available, have a way to get there, and feel welcome and included. These concepts are central to the mission of the Creating Healthy Schools and Communities program. Title V staff worked to develop strong relationships with this program and integrate School-Based Health Center staff into the program's local efforts to enhance outcomes for the communities served. The Title V Program led many program and policy activities to advance this strategy over the 2022-23 reporting period.

CH-2.2: Facilitate partnerships between local Creating Healthy Schools and Communities grantees (as available) and School-Based Health Centers to engage and educate community partners, families, and community residents on the benefits of physical activity through Complete Streets implementation, including Safe Routes to School programs. Collaboration with the Department's Division of Chronic Disease Prevention helps to implement multi-pronged strategies to enhance the work of Creating Healthy Schools and Communities grantees and other initiatives aimed at increasing children's physical activity. In June 2021, Creating Healthy Schools and Communities funding was approved for 26 contracts through May 2026. Title V staff met with Division of Chronic Disease Prevention staff to finalize a plan to encourage collaboration among School-Based Health Centers and Creating Healthy Schools and Communities grantees. This collaboration is aimed at facilitating partnerships between local Creating Healthy Schools and Communities grantees and School-Based Health Centers to engage and educate community partners, families, and community residents on the benefits of physical activity including through Complete Streets implementation and Safe Routes to School programs. Title V staff worked to develop a list of schools and school districts that have a School-Based Health Center and are a Creating Healthy Schools and Communities grantee. This list was used to share a collaboration webinar opportunity to introduce and familiarize Creating Healthy Schools and Communities grantees and School-Based Health Centers with each other as well as identify overlap and discuss potential collaboration ideas. The collaboration webinar was held in the previous reporting period and subsequent information was sent to the list with contact information for the School-Based Health Center and Creating Healthy Schools and Communities grantees and collaboration webinar slide deck. Title V staff and Division of Chronic Disease Prevention staff planned to check in on School-Based Health Center and Creating Healthy Schools and Communities grantees to confirm collaboration and connections were made and determine how else State level staff can help assist them in these efforts. Plans were developed during this reporting period to resume the conversation with the Division of Chronic Disease Prevention to facilitate partnerships between Creating Healthy Schools and Communities grantees and School-Based Health Centers. A webinar and additional activities are planned for the next reporting period to re-establish the connections and help facilitate collaboration between the two programs.

CH-2.3: Actively participate in Division of Chronic Disease Prevention's Pediatric Obesity Prevention Work Group, contribute to the direction of the group, and establish mutually beneficial priorities.

The Pediatric Obesity Prevention Work Group was interrupted by the COVID-19 pandemic and has not resumed.

Strategy CH-3: Apply public health surveillance and data analysis findings to improve services and systems related to children's health and health care.

Data-driven, evidence-based practice is essential to achieving public health goals for Maternal and Child Health. Across all Title V programs, continuous effort is needed to enhance the collection, analysis, and sharing of data to inform the planning and implementation of Maternal and Child Health programs and policy work. Sharing data with stakeholders, including providers and community members, is critical to raise awareness, empower community action, and facilitate quality improvement efforts at all levels. The Title V Program led several specific program and policy activities to advance this strategy over this reporting period.

CH-3.1: Collaborate with the U.S. Census Bureau to conduct an over-sample of NYS 2022 National Survey of Children's Health for NYS to allow for enhanced sampling of Black/African-American, Hispanic, and Children and Youth with Special Health Care Needs populations.

During the last reporting period, Title V staff collaborated with the U.S. Census Bureau to develop a plan to conduct an over-sample of National Survey of Children's Health in NYS to increase the number of samples for Black/African-American, Hispanic, and Children and Youth with Special Health Care Needs populations. During this reporting period, the sampling plan was being implemented and the survey was completed. Title V staff completed the New York amendment for the Sub-State Analysis of National Survey of Children's Health Oversamples for State and Local Public Health Planning & Assessment project to access oversample data. The project amendment was approved by the U.S. Census Bureau on March 23, 2023. After the approval, four Title V staff were identified for Special Sworn Status application. The project will be continued to the following reporting year when data becomes available.

CH-3.2: Design and implement a School-Based Health Center data collection system that allows School-Based Health Centers to identify, track, and address disparities within the School-Based Health Centers.

As mentioned in Strategy CH-1, Title V staff continued working to design and implement a new School-Based Health Center data collection system that will be integrated into the Health Commerce System and allow School-Based Health Centers to identify, track, and address disparities within the School-Based Health Centers. During this reporting period, Title V staff participated in the design and testing of this new data system and companion data submission guides. While the new data system was launched for the School-Based Health Center Dental providers during this reporting period, the system for the School-Based Health Center Medical providers was still under review but is anticipated to be implemented in the next reporting period. In anticipation of this, a Health Commerce System data presentation was held on August 31, 2023, for all Medical Operators.

CH-3.3: Engage and survey stakeholders to identify, track, and address disparities within the School-Based Health Centers. This work will begin in the upcoming program year once the data system has been implemented.

CH-3.4: Explore collaborative opportunities with Division of Chronic Disease Prevention Bureau of Chronic Disease Evaluation and Research to review and share information on student weight status assessments to inform School-Based Health Center work in this area. This work will begin in the upcoming program year.

In addition to the updates above, the Division of Family Health through the Title V program is advancing public health surveillance and data analysis to improve services and systems related to perinatal and infant health care. The new Bureau of Data Analytics, Research, and Evaluation that was created to support research and data needs across Division of Family Health continues to create efficiencies and cross training as well as provide professional development opportunities to further advance the use of data in Maternal and Child Health programs and policy decisions. Bureau of Data Analytics, Research, and Evaluation staff further support the Title V program to complete the planned activities.

Strategy CH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact children's health and well-being.

As noted in other domains, Maternal and Child Health outcomes are impacted by social determinants of health, or the conditions in which people are born, live, work, play, learn, and age. The social determinants of health, also known as health-related social needs, include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of power and resources due to racism and other biases are root causes of inequities in access, availability of services, and quality of care. All ten priorities that emerged from community members' input in the 2019 Title V Needs Assessment revolve around the social determinants of health and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities.

CH-4.1: Design the new School-Based Health Center data collection system with a racial justice and health equity lens, building a reporting tool that allows School-Based Health Centers to identify, track, and address disparities within the School-Based Health Centers (site or provider level).

School-Based Health Centers are located in the areas of NYS that have been most impacted by systemic barriers and, therefore least likely to gain access to high-quality services and most at risk for poor health outcomes. The communities are disadvantaged economically and disproportionately impacted by key social determinants of health such as housing, transportation, employment, access to health care, and sources of healthy food. Families facing day-to-day challenges of poverty and racism may be less able to prioritize or take advantage of opportunities for recreational physical activity.

Development of community resources, public health programs, and other opportunities to promote physical activity need to be viewed through an equity lens. School-Based Health Center staff can have a direct effect on their school communities by assessing the physical activity needs and weight status of the students, helping to identify barriers to exercise and healthy food, and partnering with key stakeholders to take action to create a more equitable distribution of resources. These steps can contribute to environmental improvements that lead to increased physical activity and reduce health disparities attributed to lack of exercise and an unhealthy lifestyle.

CH-4.2: Partner with key stakeholders such as the Community Health Care Association of New York State and the New York School-Based Health Alliance to identify and share best practices for School-Based Health Centers to address racial justice and health equity.
The Title V Program began to discuss some program and policy activities to advance this strategy over this reporting period, including the new School-Based Health Center data collection system and partnering with key stakeholders to address racial justice and health equity. In discussions of building the new School-Based Health Center data collection system, as mentioned above, Title V staff continued to discuss ways to utilize a racial justice and health equity lens. These discussions will continue into the next reporting period as the data collection system is fully developed and tested. Additionally, Title V staff continued internal discussions on how to collaborate and partner with key stakeholders such as the Community Health Care Association of New York State and New York School-Based Health Alliance to identify and share best practices for School-Based Health Centers to address racial justice and health equity.

In addition to the strategy updates above, the Department has taken great strides to incorporate health equity and racial justice throughout a wide variety of Title V activities, not limited to the activities within this strategy. In July 2022, the Department announced several reorganization efforts, including the creation of the Office of Health Equity and Human Rights. This new office is tasked with addressing health disparities and work to improve diversity, equity, and inclusion within the Department. The Office of Health Equity and Human Rights is a resource for programs across the Department as we work towards common goals of equitable health for all New Yorkers.

As described in the Women and Maternal Health section, a new Bureau of Health Equity and Community Engagement was created within the Division of Family Health to address disparities highlighted in the COVID-19 pandemic and build a foundation for future epidemic responses. The Bureau of Health Equity and Community Engagement is funded through CDC’s COVID-19 Health Disparities grant, with a goal to fund community-based programs and services to reduce COVID-

19 health disparities, increase COVID-19 health literacy and engage and build trust with non-traditional community partners, as well as build their capacity to respond to future public health emergencies and state funding opportunities. Within the last reporting period, the Bureau of Health Equity and Community Engagement awarded 182 community-based organizations with Small Wellness Mini Bids of $49,999 each. Awarded community-based organizations, such as Confident Girl Mentoring Program, Inc., Hood's House of Hoops, and Peace of the City, support children health's.

The NYS Title V Program established one Evidence-based Strategy Measure (ESM) to track the programmatic investments and inputs designed to impact NPM 8.1.

ESM CH-1: **Percent of children and youth enrolled in School-Based Health Centers who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a School-Based Health Center within the past year.**

Since the last reporting period, Title V staff updated the data collection to include anticipatory guidance. Data for this measure comes from the School-Based Health Center quarterly reports. The baseline of 51.6% was established based on 2018-2019 School-Based Health Center quarterly reports. 2018-2019 was chosen as the baseline because it was the last full year of school before COVID-19. 2019-2020 is not an accurate representation of School-Based Health Center performance due to the pandemic. Improvement targets have been established to achieve a 2% increase each year, except for 2022 as the first year is primarily a planning year and an increase in anticipatory guidance delivery is not expected. The next reporting period will offer a complete review of the 2023 target and progress will be reported at that time.

Targets are as follows:

Baseline/2021	51.6%
2022 Target	51.6%
2023 Target	52.6%
2024 Target	53.6%
2025 Target	54.7%

Child Health - Application Year

For the Child Health (CH) domain, New York State's (NYS) Title V Program selected **National Performance Measure (NPM) 8.1: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day.** This NPM was selected because it is responsive to concerns voiced directly by families in NYS and reinforced by state-specific population health data.

NYS will also be addressing the new, required NPM for Medical Home. The work to review current initiatives, identify gaps, and develop strategies and activities to improve Medical Homes for children is just beginning in the current grant. We will report on more robust strategies and activities in next year's application.

According to the National Survey of Children's Health, during the 2022 reporting period, 16.3% of New York State (NYS) adolescents ages 10-17 are obese, and only 25.2% of NYS children ages 6-11 years are physically active for at least 60 minutes daily. NYS families identified the availability and accessibility of amenities that support children's safe, active play and access to healthy foods as top priority needs, alongside priorities for community and environmental safety for children and community transportation. Supporting healthy, active play and recreation for children and youth of all ages is critical to promoting healthy weight as well as general physical and mental health during childhood and throughout the life course. In addition, this measure provides opportunities to be responsive to the Title V priorities for health care access and quality, social support, and social cohesion. This NPM aligns directly with NYS Prevention Agenda goals for physical activity and chronic disease prevention.

The NYS Title V Program has the organizational capacity to address these priorities through its School-Based Health Center program and through collaboration with the New York State Department of Health (NYSDOH) Creating Healthy Schools and Communities program to enhance environmental infrastructure and supports, both in schools and in the community, to support physical activity. School-Based Health Centers serve NYS's highest need communities and provide critical access to quality primary care for school-aged children up to age 21.

Two specific objectives were established to align with this performance measure:

Objective CH-1: Increase the percent of NYS children ages 6-11 who are physically active at least 60 minutes per day by 5%, from 27% in 2017-2018 to 28.1% in 2021-2022 (National Survey of Children's Health).

Objective CH-2: Decrease the percent of NYS children ages 10-17 who are obese (BMI at or above the 95th percentile) by 2.8%, and from 14.4% of children ages 10-17 in 2017-2018 to 14% in 2021-2022 (National Survey of Children's Health).

Four strategic public health approaches were identified to accomplish these objectives over this five-year period. These are presented in the State Action Plan Table, and each is described in more detail here, with specific program and policy activities that will be implemented to advance the broader strategic approach in the upcoming year.

Strategy CH-1: Promote evidence-based and family-centered health care for children to promote healthy behaviors and to prevent, identify, and manage chronic health issues so that children can be healthy and active.

To be physically active, children's basic health needs for growth, development, and good nutrition must be met. Health care providers play an important role in promoting physical activity and other healthy behaviors. They manage children's health needs including mental health, obesity, asthma, and other conditions and challenges that may impinge on children's ability to participate in active play and recreation. Health care providers should follow current evidence-based guidelines for anticipatory guidance, screening, counseling, and disease management, including guidelines specific to physical activity and healthy weight, and help guide children and their families in finding and using available community resources for active play and recreation.

School-Based Health Centers are an important source of primary and preventive health care services for thousands of NYS children, including Children and Youth with Special Health Care Needs, and have the opportunity and capacity to holistically address children's needs. Title V staff will work with School-Based Health Centers statewide to ensure anticipatory guidance to promote proper nutrition and daily physical activity, weight status assessment, and attention to overall health promotion and chronic disease management, as part of routine primary and preventive care for children. In addition, the Title V Program will continue to support an array of core public health programs that address children's health and wellness and access to primary and preventive health care services.

School-Based Health Centers will also play an important part of the work we do to advance Medical Homes for Children. We have begun some work but will further review and identify strategies and activities in the current grant year.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2024-25 year:

- **Activity CH-1.1**: Provide guidance and add quarterly reporting requirements for all funded School-Based Health Centers to increase provision of 1) age-appropriate anticipatory guidance regarding physical activity and nutrition and 2) routine assessment for indicators of overall health, one of which will be weight status, but it will not be the sole factor. Data from quarterly reports will be reviewed and reports will be generated for feedback to School-Based Health Centers to assess progress and drive improvements in these practices.
- **Activity CH-1.2**: Promote the use of the American Academy of Pediatrics' Bright Futures™ model for anticipatory guidance in School-Based Health Centers and seek opportunities to engage the Academy of Pediatrics for assistance to promote this resource.
- **Activity CH-1.3**: Incorporate guidance, reporting, and tracking to support School-Based Health Centers in engaging their dental patients in conversations about physical activity and nutrition through the delivery of anticipatory guidance on nutrition including water and sugar-sweetened beverage consumption, and work with School-Based Health Centers to ensure that enrolled students have an established dental home to promote optimal oral and overall health.
- **Activity CH-1.4**: Explore opportunities to collaborate with New York School-Based Health Alliance to support School-Based Health Centers' increased effort towards promoting physical activity, such as hosting webinars with subject matter experts.
- **Activity CH-1.5**: Within the Title V program, strengthen collaboration between child-and adolescent-serving programs to enhance promotion of physical activity through established programs that focus on adult-led activities and social-emotional wellness.
- **Activity CH-1.6**: Collaborate with the NYSDOH Division of Nutrition to incorporate public health nutrition messaging with physical activity guidance across child health programs, including School-Based Health Center and Children and Youth with Special Health Care Needs programs.
- **Activity CH-1.7**: Continue to directly support a portfolio of Title V-funded programs and services that promote children's wellness and enhance access to comprehensive primary and preventive care services for children, including:
    - School-Based Dental Home and Community Water Fluoridation programs to promote children's oral health and reduce dental caries as key contributors to children's overall health and well-being.
    - Comprehensive Services and Health Systems Approaches to Improve Asthma Control in New York State to improve the quality and availability of guidelines-based asthma care.
    - Collaborate with the Division of Chronic Disease Prevention's Asthma Control Program to promote asthma self-management education with School-Based Health Centers to improve asthma management outcomes and increase students' participation in physical activity.
- **Activity CH-1.8**: Serve on the NYS Council on Developmental Disabilities and its Individuals and Families Committee to promote inclusion of a child-specific focus to the Council's agenda and policy portfolio.
    - **Activity CH-1.8.a**: Participate in the NYS Developmental Disabilities Planning Council Policy Workgroup to

inform policy focus areas; review and help distribute policy papers; review and respond to legislation at state and federal levels; and provide advocacy and information to interested parties.

Strategy CH-2: Promote home, school, and community environments that support developmentally appropriate active play, recreation, and active transportation for children of all ages and abilities.

To achieve state goals related to increasing children's physical activity, children and their families need safe, appealing, and accessible places to play and be active – at home, in school, and in their neighborhoods and communities. Across the community listening forums, families and children voiced a desire for amenities in their neighborhoods that provide opportunities for active play and daily physical activity, such as playgrounds, athletic facilities, greenspace, and community centers. They want streets, sidewalks, and trails that are accessible and safe for walking and biking, both for transportation and recreation. They want these areas to be clean, appealing, and safe for children and families. They want to know what is available, have a way to get there, and feel welcome and included. These concepts are central to the mission of the NYSDOH Creating Healthy Schools and Communities program. Title V staff will develop strong relationships with this program and integrate School-Based Health Center staff into the program's local efforts to enhance outcomes for the communities served.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2024-25 year:

- **Activity CH-2.1**: Collaborate with the NYSDOH Division of Chronic Disease Prevention to implement multi-pronged strategies to enhance the work of Creating Healthy Schools and Communities grantees, and other initiatives aimed at increasing children's physical activity.
- **Activity CH-2.2**: Continue to collaborate with Division of Chronic Disease Prevention to assess what partnerships were formed between Creating Healthy Schools and Communities grantees and School-Based Health Centers as a result of year 2 activities and determine if any successes were identified.
- **Activity CH-2.3**: Actively participate in Division of Chronic Disease Prevention's Pediatric Obesity Prevention Work Group, contribute to the direction of the group, and establish mutually beneficial priorities.

Strategy CH-3: Apply public health surveillance and data analysis findings to improve services and systems related to children's health and health care.

Data-driven, evidence-based practice is essential to achieving public health goals for the Title V program. Across all Title V programs, continuous effort is needed to enhance the collection, analysis, and sharing of data to inform the planning and implementation of Title V-funded programs and policy work. Sharing data with stakeholders, including providers and community members, is critical to raise awareness, empower community action, and facilitate quality improvement efforts at all levels.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2024-25 year:

- **Activity CH-3.1**: Continue to collaborate with the U.S. Census Bureau to conduct data analysis for the over-sample of NYS 2022 National Survey of Children's Health project for NYS to understand health disparities among Black/African American, Hispanic, and Children and Youth with Special Health Care Needs populations.
- **Activity CH-3.2**: Design improvements to and continue to implement a School-Based Health Center data collection system that allows School-Based Health Centers to identify, track, and address disparities within the School-Based Health Centers.
- **Activity CH-3.3**: Engage and survey stakeholders to identify, track, and address disparities within the School-Based Health Centers.
- **Activity CH-3.4**: Explore collaborative opportunities with Division of Chronic Disease Prevention's Bureau of Chronic

Disease Evaluation and Research to review and share information on student weight status assessments to inform School-Based Health Center work in this area.

Strategy CH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact children's health and well-being.

Child health outcomes are impacted by social determinants of health, or the conditions in which people are born, live, work, play, learn, and age. The social determinants of health include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of power and resources due to racism and other biases are root causes of inequities in access, availability of services, and quality of care. All ten priorities that emerged from community members' input during the Title V Needs Assessment revolve around the social determinants of health and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities.

School-Based Health Centers are located in areas of NYS with the highest needs. The school communities served are disadvantaged economically and disproportionately impacted by key social determinants of health such as housing, transportation, employment, access to health care, and sources of healthy food. Families facing day-to-day challenges of poverty and racism may be less able to prioritize or take advantage of opportunities for recreational physical activity.

Development of community resources, public health programs, and other opportunities to promote physical activity need to be viewed through an equity lens. School-Based Health Center staff can have a direct effect on their school communities by assessing the physical activity needs and weight status of the students, helping to identify barriers to exercise and healthy food, and partnering with key stakeholders to take action to create a more equitable distribution of resources. These steps can contribute to environmental improvements that lead to increased physical activity and reduce health disparities attributed to lack of exercise and unhealthy lifestyle.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2024-25 year:

- **Activity CH-4.1**: Utilize the new School-Based Health Center data collection system, and with a racial justice and health equity lens, to build a reporting tool that allows School-Based Health Centers to identify, track, and address disparities within the School-Based Health Centers (site or provider level). Continue to review feedback from users to make improvements to the data collection system.
- **Activity CH-4.2**: Partner with key stakeholders such as the Community Health Care Association of New York State and the New York School-Based Health Alliance to identify and share best practices for School-Based Health Centers to address racial justice and health equity.

The NYS Title V Program established one Evidence-based Strategy Measure (ESM) to track the programmatic investments and inputs designed to impact NPM 8.1:

ESM CH-1: **Percent of children and youth enrolled in School-Based Health Centers who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a School-Based Health Center within the past year.**

Data for this measure come from the School-Based Health Center quarterly reporting system. The baseline for 2021 (51.6%) was established using program year 2018-2019 data. Targets have been established to achieve a 2% increase each year, except for 2022 as the first year is primarily a planning year and an increase in anticipatory guidance delivery is not expected. Targets are as follows:

Baseline/2021	51.6%
2022 Target	51.6%
2023 Target	52.6%
2024 Target	53.6%
2025 Target	54.7%
2026 Target	55.8%

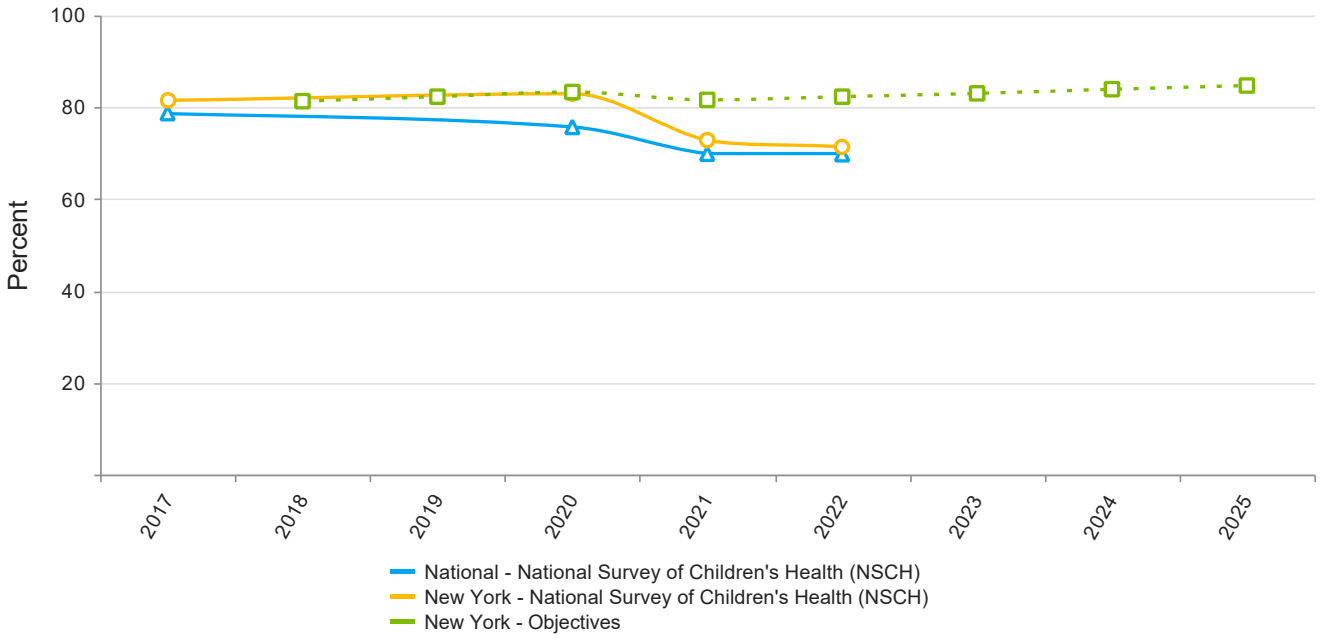
Future NPM: Medical Home. Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

The Child Health Domain Team will review data from the five (5) National Survey of Children's Health components that inform the Medical Home NPM: *usual source of sick care, personal doctor or nurse, family-centered care, no problems getting referrals, and effective care coordination when needed*. Upon review, annual objectives and strategies will be identified for the FY 2026 Application. Where possible, these activities will align with the Blueprint for Change.

Adolescent Health

National Performance Measures

NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	82.2	83.2	81.5	82.2	82.9
Annual Indicator	81.3	86.3	82.9	72.8	71.3
Numerator	1,081,532	1,367,654	1,218,475	976,520	972,723
Denominator	1,331,106	1,583,876	1,469,455	1,341,167	1,363,869
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	83.8	84.6

Evidence-Based or –Informed Strategy Measures

ESM AWV.1 - Percent of youth-serving programs that provide training on adult preparation subjects, such as accessing health insurance, maintaining their routine preventive medical visits, healthy relationships, effective communication, financial literacy, etc.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			96.3	96.3	98.2
Annual Indicator		96.3	100	100	96.1
Numerator		52	52	52	49
Denominator		54	52	52	51
Data Source		Survey of CAPP and PREP Programs	Survey of CAPP and PREP Programs	Survey of CAPP and PREP Programs	Survey of CAPP and PREP Programs
Data Source Year		2020	2021	2022	2023
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	100.0	100.0

ESM AWV.2 - Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			68.7	70.1	71.6
Annual Indicator		68.7	78.1	79.4	73.3
Numerator		46	50	50	44
Denominator		67	64	63	60
Data Source		Survey of CAPP, PREP, and SRAE Programs	Survey of CAPP, PREP, and SRAE Programs	Survey of CAPP, PREP, and SRAE Programs	Survey of CAPP, PREP, and SRAE Programs
Data Source Year		2020	2021	2022	2023
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	73.1	74.0

State Action Plan Table

State Action Plan Table (New York) - Adolescent Health - Entry 1

Priority Need

Cultivate and enhance social support and social cohesion opportunities for individuals and families who experience isolation as a result of systemic barriers including racism, across the life course

NPM

NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV

Five-Year Objectives

Objective AH-1: Increase the percent of adolescents, ages 12-17, with a preventive medical visit in the past year by 5%, from 81.3% in 2016-2017 to 85.4% in 2021-2022. (NSCH)

Objective AH-2: Increase the percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling by 5%, from 53.5% in 2017-2018 to 56.2% in 2021-2022. (NSCH)

Objective AH-3: Increase the percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine by 8%, from 67.3% in 2018 to 72.7% in 2022. (NIS)

Objective AH-4: Increase the percent of NYS adolescents without special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 16.4% in 2017-2018 to 17.2% in 2021-2022. (NSCH)

Strategies

Strategy AH-1: Incorporate specific activities to promote the wellness of adolescents across all Title V programs, including promoting and facilitating routine well visits, reproductive health care, oral health, and behavioral health. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy AH-2: Promote supports for adolescents to gain the knowledge, self- efficacy, and resources they need to prepare for and transition to adulthood. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy AH-3: Apply public health surveillance and data analysis findings to improve services and systems related to children's health and health care. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy AH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact adolescents’ health and well-being. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

ESMs	Status
ESM AWV.1 - Percent of youth-serving programs that provide training on adult preparation subjects, such as accessing health insurance, maintaining their routine preventive medical visits, healthy relationships, effective communication, financial literacy, etc.	Active
ESM AWV.2 - Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation	Active

NOMs
NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM
NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle
NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide
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 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS
NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu
NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV
NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP
NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN
NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB

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For Adolescent Health, New York's Title V Program selected NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year. This NPM was selected because it aligns with both population health data indicators and concerns voiced directly by adolescents in New York State (NYS). Most teens (ages 12-17) had a preventive medical (86.3%) and preventive dental (89.1%) visit in 2019, but NYS continues to work towards increasing the total number of adolescents who have obtained annual preventive medical and dental visits as well as reducing current disparities. 86.0% of Hispanic adolescents had a preventive medical visit compared to 89.3% of non-Hispanic White adolescents and only 78.2% of adolescents on Medicaid had an annual visit compared to 91.5% adolescents with private insurance.

In a series of adolescent focus groups conducted in 2019 by the New York State Department of Health (the Department) through the Assets Coming Together (ACT) for Youth Center for Community Action, adolescents across the state discussed that their medical providers lack compassion and respect for their young patients, and that youth would prefer visiting providers who are more affirming and reflective of the youth themselves. The importance of social support and the need for more people to talk to positive mentors were frequently mentioned by adolescents. They discussed feeling socially isolated and wanting opportunities for community engagement or building a sense of belonging. Beyond assuming responsibility for their own health care, adolescents voiced a desire for education about financial literacy, healthy cooking, navigating relationships, and other aspects of adulthood.

Preventive medical visits are one component of overall wellness, but data and community input point to other areas such as social emotional development and adult preparation that could assist with adolescents' proper growth and development. As indicated in the 2021 Youth Risk Behavior Surveillance System, over 33% of New York high school students reported feeling sad or hopeless for more than two weeks in the past year and almost 10% reported that they attempted suicide. From 2011 to 2021, the percentage of NYS youth seriously considering attempting suicide increased from 16% to 22%. The Youth Risk Behavior Surveillance System also showed that Hispanic students are more likely to report depression symptoms and suicide attempts, and there are dramatic disparities based on sexual identity as well, with 58% of students identifying as gay, lesbian, or bisexual reporting feeling sad or hopeless and 25% reporting a suicide attempt.

Adolescence is often a very challenging stage in a person's life. During this time, adolescents experience growth through physical development, cognitive development, social-emotional development, identity, and sexual development. Supporting adolescents' health and development and helping them prepare for their futures can have a lasting impact throughout the life course. The multifaceted nature of adolescent development and wellness means the selected NPM, and its associated strategies are responsive to most of the priority areas, particularly health care, social support and cohesion, community services and amenities, and awareness of resources. This NPM also aligns directly with established priorities encompassed in the NYS Prevention Agenda goals to support and enhance children and adolescents' social-emotional development and relationships, strengthen opportunities to build well-being and resilience across the lifespan, facilitate supportive environments that promote respect and dignity for people of all ages, and other Prevention Agenda goals related to mental health and substance use, including prevent underage drinking and excessive alcohol consumption by adults, prevent opioid and other substance misuse and deaths, prevent and address adverse childhood experiences (ACEs), reduce the prevalence of major depressive disorders, prevent suicides, and reduce the mortality gap between those living with serious mental illness and the general population. (New York State Prevention Agenda 2019-2024 https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/ship/overview.pdf)

Four specific objectives were established to align with this performance measure:

Objective AH-1: Increase the percentage of adolescents, ages 12-17, with a preventive medical visit in the past year by 5%, from 81.3% in 2016-2017 to 85.4% in 2021-2022. (National Survey for Children's Health (National Survey of Children's Health)

Objective AH-2: Increase the percentage of children, ages 3 through 17, with a mental/behavioral condition who receive

treatment or counseling by 5%, from 53.5% in 2017-2018 to 56.2% in 2021-2022 (National Survey of Children's Health)

Objective AH-3: Increase the percentage of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine by 8%, from 67.3% in 2018 to 72.7% in 2022 (National Immunization Survey-Teen [NIS-Teen])

Objective AH-4: Increase the percentage of NYS adolescents without special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 16.4% in 2017-2018 to 17.2% in 2021-2022 (National Survey of Children's Health)

Four strategic public health approaches were identified to accomplish these objectives over the next five years. These are presented in the State Action Plan Table, and each is described in more detail here, with specific program and policy activities that will be implemented to advance the broader strategic approach in the upcoming year.

Strategy AH-1: Incorporate specific activities to promote the wellness of adolescents across all Title V programs, including promoting and facilitating routine well visits, reproductive health care, oral health, and behavioral health.

Adolescence is a critical stage of development when children grow physically, cognitively, emotionally, and socially to become adults. The lifestyle choices, behaviors, and relationships established during this time can affect an adolescent's current and future health. Routine well visits during adolescence are recommended by the American Academy of Pediatrics and Bright Futures™ as one way to foster health in the present and build a foundation for wellness into the future. They are an opportunity to promote healthy behaviors, discuss risky behaviors, provide important vaccinations, and address conditions that can interfere with healthy development. Likewise, comprehensive, and inclusive reproductive health care and education are opportunities to help adolescents avoid or mitigate risky sexual behaviors. Title V Programs also provide enabling services to adolescents, such as referrals to and linkages with community services and social supports to holistically address health and wellness, including mental health and social determinants of health.

The key programs that work to support adolescent wellness and help connect adolescents to needed services include Comprehensive Adolescent Pregnancy Prevention program, Personal Responsibility Education Program, Sexual Risk Avoidance Education, Children & Youth with Special Health Care Needs, School-Based Health Centers, Family Planning Program, and Sexual Violence Prevention programs. ACT for Youth Center for Community Action at Cornell University works with the Department of Health to provide technical assistance, training, and evaluation services for the Comprehensive Adolescent Pregnancy Prevention program, Personal Responsibility Education Program, and Sexual Risk Avoidance Education programs.

The Title V Program established the following specific program and policy activities to advance this strategy over the 2022-2023 year:

AH-1.1: Through the Personal Responsibility Education Program and Comprehensive Adolescent Pregnancy Prevention program, provide information to adolescents and parents on the offering and arranging of adolescent sexual health reproductive services.

The Comprehensive Adolescent Pregnancy Prevention program and the Personal Responsibility Education Program support the delivery of evidence-based programs to youth. These evidence-based programs are curriculums that have been rigorously tested in controlled settings, proven effective, and translated into practical models that are widely available to community-based organizations. Evidence-based programming on reproductive and sexual health was completed for 22,389 youth during this reporting period through the Comprehensive Adolescent Pregnancy Prevention program and the Personal Responsibility Education Program.

The Comprehensive Adolescent Pregnancy Prevention program funds youth-serving organizations to work with

adolescents, ages 10-21 that lack social and economic opportunities to develop their full potential. This includes (but is not limited to): racial/ethnic minorities, youth from socioeconomic disadvantaged communities, youth living in foster care, youth who identify as lesbian, gay, bisexual transgender and questioning, youth who are homeless, and youth involved in the juvenile justice system. The Comprehensive Adolescent Pregnancy Prevention program provides evidence-based programs to youth to reduce the adolescent pregnancy rate and the rate of unintended pregnancy by practicing health promotion and risk-reduction behaviors and ensuring access to confidential reproductive health care and family planning services for adolescents.

The Personal Responsibility Education Program is similar to the Comprehensive Adolescent Pregnancy Prevention program but is fully federally funded. It supports implementation of evidence-based program models and educates youth on at least three of the following six adult preparation subjects: Healthy Relationships, Adolescent Development, Financial Literacy, Parent-Child Communication, Educational and Career Success, and/or Healthy Life Skills. The Personal Responsibility Education Program also promotes activities to ensure youth access to comprehensive reproductive health care and family planning services.

Programs provide and arrange referrals for services identified as appropriate and outreach and education to youth and parents is reported biannually by programs. Department of Health staff review biannual reports, provide feedback and follow-up as needed. Programs use social media to promote programming, access to services, and education and programs collaborate with community partners to promote education and access to services. Many Comprehensive Adolescent Pregnancy Prevention program and Personal Responsibility Education Program providers promote their resources on social media platforms popular with youth, such as Instagram, Snapchat, TikTok, WeChat, and occasionally Twitter and Facebook. For example, Community Healthcare Network's Comprehensive Adolescent Pregnancy Prevention program and Personal Responsibility Education Program used an innovative youth-as-partners model to involve peer educators in the creation of five social media campaigns and public service announcements during the reporting period on TikTok and on their Instagram and Facebook pages. They can provide educational content featuring authentic youth voice and connect youth to Community Healthcare Network's programming and sexual health services via these platforms. The State University of New York (SUNY) Downstate Personal Responsibility Education Program hosts a YouTube talk show "The Chat" that is created, developed, and implemented by program staff and youth Peer Leaders. The Mothers and Babies Perinatal Network Personal Responsibility Education Program maintains a Facebook page primarily geared towards parents, caregivers, and adults who work with youth. They use their Facebook page and Instagram to provide guidance on how to set boundaries, conflict management, suicide prevention, mental health awareness, birth control options & local clinic information, time management, and self-esteem building.

A new Request for Applications was issued for the Comprehensive Adolescent Pregnancy Prevention program in the fall of 2022, with an enhanced focus on health equity. The Request for Application required applicants to "apply a health equity lens to activities to address social determinants of health and reduce disparities that impact adolescents' health and well-being." The programs work to increase the percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, (including racial and social injustice) in program planning and implementation. The Comprehensive Adolescent Pregnancy Prevention Program Request for Application asked applicants how they had engaged youth in the design of this aspect of the program and how they would continue to increase youth voice. Forty-one new Comprehensive Adolescent Pregnancy Prevention programs were awarded during this reporting period, with five-year contracts that started on 7/1/2023.

A new Request for Applications was issued for the Personal Responsibility Education Program in the fall of 2023. Seven new Personal Responsibility Education Programs were awarded during this reporting period, with five-year contracts that will start on 10/1/2023.

AH-1.2: Through the Sexual Risk Avoidance Education program, provide medically accurate and complete sexuality health education services to youth.

The Sexual Risk Avoidance Education program focuses efforts on youth ages 10-13 living in resource poor communities, and, like the Personal Responsibility Education Program, is also federally funded. The Sexual Risk Avoidance Education program has three components. The first provides sexual risk avoidance education with an evidence-based approach based on adolescent learning and developmental theories for the age group receiving the education. The education includes medically accurate and complete information and normalizes the optimal health behavior of avoiding sexual activity. The second component focuses on adult-supervised activities with the youth. These activities stimulate cognitive, social, physical and/or emotional growth and provide a context for building positive relationships.

Programs report on attendance, reach and dosage of the curriculum implemented biannually. The third component is evaluation. Programs also conduct entry and exit surveys with each cycle implemented. Department of Health staff review biannual program reports, provide feedback to programs, and follow up with programs as needed.

Evidence-based programming was completed for 855 youth during this reporting period for the Sexual Risk Avoidance Education programs, which represents an increase of 119% over the last reporting period.

A new Request for Applications for the Sexual Risk Avoidance Education program was released toward the end of this reporting period, with applications due in November 2023. It is anticipated that approximately 12 grants will be awarded during the next reporting period for five-year contracts beginning 7/1/2024.

AH-1.3: Through the Comprehensive Adolescent Pregnancy Prevention program, Personal Responsibility Education Program, and Sexual Risk Avoidance Education program, increase access to health care services for adolescents through a referral process that includes confirmation as permitted while ensuring confidentiality.

The programs increase access to health care by directly referring youth internally within their organization or through a Memorandum of Understanding with clinical providers and other providers. All programs report biannually the number of adolescents referred for comprehensive health care. A total of 342 comprehensive health care referrals were made in 2022, of which 92 referrals were for reproductive health care. A total of 4,054 referrals were made during January-June 2023 for primary health care, nutrition, housing, employment, and to other youth serving organizations. Of the 4,054 total referrals, 3,038 were for reproductive health care. Programs ensure confidentiality through continuous staff trainings and by providing education to the public, communities, and community-based organizations (CBOs). Outreach and education efforts, including community events, presentations, and social media posts are reported biannually. Department of Health staff review biannual reports, provide feedback to programs and follow-up as needed.

AH-1.4: Division of Family Health staff and community youth-serving organizations provide trauma-informed education and training on social emotional wellness and positive youth development for children and adolescents.

All adolescent health programs provide programming using positive youth development and a trauma-informed approach. On-going trainings to providers on trauma-informed approach and social-emotional wellness are provided to program providers through ACT for Youth Center for Community Action. ACT for Youth Center for Community Action also provided in person training in New York City and Ithaca on Positive Youth Development. ACT for Youth Center for Community Action provided updated guidance on positive youth development and trauma informed care, as part of a website redesign and update that involved content contribution and review from adolescent health and development specialists and experts in positive youth development at Cornell University and the University of Rochester Medical Center.

The Adolescent Health Unit shared informational and training resources with Comprehensive Adolescent Pregnancy Prevention, Personal Responsibility Education Program, and Sexual Risk Avoidance Education program providers, such as: Teaching Students with Intellectual or Developmental Disabilities about Sexuality and Health Relationships; Healthy Sexuality for Youth in Foster Care: An Online Training for Parents and Caregivers of Youth in Foster Care; Spanish-Language Mental Health Resources; Innovative Practices for Providing Sexual Health Education and Services in Schools; and a New York

State Public Health Association webinar series. Department of Health staff review biannual reports, provide feedback, and follow-up as needed.

The 2022 Comprehensive Adolescent Pregnancy Prevention Program Request for Application included an enhanced focus on social-emotional wellness. The goal of the program is to increase percentage of adolescents who live in supportive and cohesive communities, implement multi-dimensional educational, vocational, economic, and recreational opportunities for youth on multiple health and developmental related topics that introduce them to new situations, ideas and people, and challenge them to build or learn skills. During the reporting period, ACT for Youth Center for Community Action provided a series of trainings and hosted learning community meetings for Comprehensive Adolescent Pregnancy Prevention Program providers on Component 2, the programmatic component of that covers this focus on social-emotional wellness and positive youth development.

AH-1.5: Within the Title V program, enhance collaboration between adolescent serving programs, including the Comprehensive Adolescent Pregnancy Prevention program, the Sexual Risk Avoidance Education program, School Based Health Centers, and Children and Youth with Special Health Care Needs programs, to promote holistic adolescent health through provision of comprehensive physical exams and anticipatory guidance, including BMI, behavioral health, oral health, and reproductive health, for adolescents with and without special health care needs.

Title V staff working with Children and Youth with Special Health Care Needs, Child Health, and Adolescent Health exchanged resources about their programs as well as training and webinar opportunities for adolescent health topics. Staff in the Adolescent Health domain forwarded resource information and webinar opportunities to other Title V staff when appropriate, including presentations by our federal grantors, such as online resources from the Health and Human Services, Administration for Children & Families to “Support the Sexual Health Needs of Youth with Intellectual Disabilities” and webinar opportunities such as “Teaching Students with Intellectual or Developmental Disabilities about Sexuality and Healthy Relationships,” "Announcing the Strong Resilient Youth: Supporting Children and Youth Experiencing Trauma Training," and "Training for Parents, Caregivers, and Families on the Mental Health of Children."

Staff in the Adolescent Health Unit and the School Health Unit are developing a comprehensive list of where School Based Health Centers and Adolescent Health Unit pregnancy prevention providers overlap.

AH-1.6: Collaborate with internal and external stakeholders, including AIDS Institute, Bureau of Immunization, and the NYS Human Papilloma Virus (HPV) Coalition to promote HPV vaccination with clinical providers.

Title V staff participates in meetings and communications with the New York State HPV Coalition, along with the AIDS Institute and the Bureau of Immunization. Staff supporting the Adolescent Health domain attend quarterly HPV Coalition meetings and receive informational updates. HPV vaccination information was also disseminated to adolescent health program providers and ACT for Youth Center for Community Action. Participation in NYS HPV Coalition and contact with other organizations is ongoing.

AH-1.7: Refer adolescent parents to family planning providers for contraception and birth planning, including School Based Health Centers, where available.

All the Comprehensive Adolescent Pregnancy Prevention and Personal Responsibility Education Program programs are required to provide access to family planning. Programs that are not located in health facilities that are regulated by the Department under Article 28 of NYS Public Health Law are required to have an on-going Memorandum of Understanding with an Article-28 regulated facility to provide these services to youth. As needed, staff discuss with each provider their interaction and relationship with their designated family planning providers and School Based Health Centers if applicable.

Two Comprehensive Adolescent Pregnancy Prevention providers offer the evidence-based program for adolescent mothers, “Be Proud, Be Responsible, Be Protective.”.

AH-1.8: Promote access to confidential reproductive health care services and preventive medical visits for adolescents, including through School Based Health Centers, where available. Family planning providers provide counseling and services related to contraception, promotion of healthy relationships, preventive medical care, and preconception/interconception health.

The Comprehensive Adolescent Pregnancy Prevention program and Personal Responsibility Education Program that are not at Article-28 regulated facilities are required to have a Memorandum of Understanding in place with a family planning program to provide these services. A list of the Comprehensive Adolescent Pregnancy Prevention program and Personal Responsibility Education Program located in schools with School Based Health Centers was developed and shared with Title V staff.

AH-1.9: Promote healthy relationships and sexual violence prevention using policy change, protective environment strengthening, healthy social norms reinforcement, and skill-building to address individual, relationship, community, and societal risk and protective factors. Focus on groups experiencing disproportionate burden of sexual violence, including communities of color, adolescents and young adults, domestic violence victims, those experiencing low income, people affected by alcohol and drug abuse, and LGBTQ+ persons.

Through use of the Adolescent Sexual Health Needs Index (ASHNI), adolescent-serving programs identify priority populations – youth lacking social and economic opportunities that can enable them to develop to their full potential.

All programs incorporate healthy relationship education and skills building. The Comprehensive Adolescent Pregnancy Prevention program programs must include youth-led, multi-dimensional (educational, social, vocational, economic, and recreational) opportunities for adolescents to provide alternatives to sexual activity and to develop skills that can support a successful transition into healthy young adults. The Personal Responsibility Education Program requires each provider to teach at least three Adulthood Preparation Subjects such as healthy relationships, including positive self-esteem and relationship dynamics, friendships, dating, romantic involvement, marriage, and family interactions; adolescent development, such as the development of healthy attitudes and values; educational and career success, such as developing skills for employment preparation; and healthy life skills, such as goal-setting, decision making, negotiation, communication, interpersonal skills, and stress management. The Sexual Risk Avoidance Education program must teach youth the benefits associated with personal responsibility, self-regulation, goal setting, healthy decision-making, healthy relationships, avoiding poverty, resisting sexual coercion and dating violence, and other youth risk behaviors, such as drug and alcohol usage.

Adolescent Health program providers make referrals as needed for physical, social, emotional, educational, and developmental support or services, including mental health, social-emotional wellness, substance abuse counseling, interpersonal violence prevention, nutrition (e.g., food pantry), and employment services. Referrals are noted in biannual reports submitted to the Department by all program providers.

Some providers prioritize engaging LGBTQ+ populations in their catchment area, offering educational opportunities and support resources. All Personal Responsibility Education Programs and Comprehensive Adolescent Pregnancy Prevention programs must consider the needs of LGBTQ+ youth and identify how their programs will be inclusive of and non-stigmatizing toward such participants as part of the application process. In addition to this standard, some programs identify LGBTQ+ youth as a priority population. For example, the AIDS Community Resources Comprehensive Adolescent Pregnancy Prevention program regularly provides workshops to youth and partners on LGBTQ+ health topics. During their LGBTQ Health Promotion presentation, AIDS Community Resources educators taught parents barriers to sexual and reproductive health care for LGBTQ+ youth, allowed parents to share how they help their children, and provided parents with tools and resources about how to become advocates for better health care and policies. At a local Beyond the Binary Conference, AIDS Community Resources conducted two presentations: “Behaviors, Boundaries and Binaries,” focusing on communication, boundaries and consent through an LGBTQ lens, and “Navigating Puberty for Parents”, which focused on

how to support trans and gender diverse youth going through puberty.

Adolescent health program providers partner with community youth-serving organizations to share resources and collaborate on community outreach efforts. For example, the State University of New York (SUNY) Downstate Personal Responsibility Education Program is part of the Brooklyn Association of Teen Educators (BATES) Network, a collaboration of 18 community partners, which has conducted an annual conference for 30 years. This annual conference held in June 2023 was held in-person for the first time since the beginning of the COVID-19 pandemic. This all-day event saw an attendance of over 320 youth, community providers, public health advocates and performers. Conference participants attended workshops on Pregnancy Prevention, Mental Health, Youth Justice, and STI/HIV Awareness. The State University of New York (SUNY) Downstate Personal Education Program also partnered with the with LGBTQ+ programs run by a Comprehensive Adolescent Pregnancy Prevention provider, Church Avenue Block Merchant Association (CAMBA), to implement a National Black HIV/AIDS Awareness Day Program. In addition, in the Comprehensive Adolescent Pregnancy Prevention Program Request for Applications and the Personal Responsibility Education Program Request for Applications, the respondents were asked to identify community resources and which stakeholders were involved.

AH-1.10: Promote adolescents' social-emotional wellness and positive developmental assets through established Title V programs.

All adolescent health programs incorporate a positive youth development framework, a holistic approach to adolescent health – social-emotional wellness, youth development, engaging parents and community providers, and providing resources to youth for their health care needs within their communities.

Title V staff continue to stress the importance of social-emotional wellness and positive youth development during regular contact with adolescent-serving providers.

As discussed in AH 1.4, ACT for Youth Center for Community Action offered educational and training opportunities to adolescent health program providers on positive youth development throughout the reporting period.

Strategy AH-2: Promote supports for adolescents to gain the knowledge, self-efficacy, and resources they need to prepare for and transition to adulthood.

For young adults, with or without special health care needs, the transition to adulthood is a crucial time in their development. Young adults may move away from their parents, transition to adult health care, become increasingly sexually active, continue their education, and/or start a career. Navigating these transitions can be difficult for youth as their independence continues to grow. Often, an increased sense of independence can lead to an increase of unhealthy risky behaviors. Title V programs will provide youth with support to help prepare for and navigate this transition.

The Title V Program established the following specific program and policy activities to advance this strategy over the 2022-23 reporting period:

AH-2.1: Ensure adolescent providers have a mechanism in place to provide adolescent-related health care service referrals to other providers of health care services, including substance abuse (e.g., alcohol, tobacco cessation), mental health issues, and intimate partner violence.

Adolescent health providers are required to have a mechanism in place to refer youth for services when needs are identified. Adolescent health programs have Memoranda of Understanding in place for youth referrals to partner agencies. Referrals for services are reported biannually. A total of 342 comprehensive health care referrals were made in 2022, of which 92 referrals were for reproductive health care. A total of 4,054 referrals were made during January-June 2023 for primary health care, nutrition, housing, employment, and to other youth serving organizations. Of the 4,054 total referrals, 3,038 were for reproductive health care. Biannual reports submitted by Adolescent Health Unit program providers are

reviewed by Department of Health staff, who provide feedback and follow up as needed.

AH-2.2: Refer adolescent parents to family planning providers or School Based Health Centers for contraception and birth planning.

All Comprehensive Adolescent Pregnancy Prevention programs and Personal Responsibility Education Programs are required to provide access to family planning. Programs that are not located in an Article-28 regulated facility are required to have an on-going Memorandum of Understanding with an Article 28 regulated facility to provide these services to youth. At a minimum, Department staff will discuss with each provider biannually their interaction and relationship with their designated Family Planning Program providers and School Based Health Centers if applicable. In addition, several Comprehensive Adolescent Pregnancy Prevention programs implement an adult role model parent/parent peer education program designed to provide parents with the information and skills they need to become the primary sexuality educators of their children. This education includes information regarding family planning services. Support pregnant and birthing adolescent parents in attending prenatal, postpartum, and well-baby appointments.

AH-2.3: Support pregnant and birthing adolescent parents in attending prenatal, postpartum, and well-baby appointments.

Where available, adolescent health programs will refer pregnant and birthing adolescents to Perinatal and Infant Community Health Collaborative programs, Home Visiting programs including Nurse Family Partnership, Healthy Families NY, and Community Health Worker Programs. Adolescent health programs are aware of the supporting programs available within their catchment area.

AH-2.4: Promote access to confidential reproductive health care services and preventive medical visits for adolescents. Family planning providers provide counseling and services related to contraception, promotion of healthy relationships, preventive medical care, and preconception/interconception health.

All Comprehensive Adolescent Pregnancy Prevention programs and Personal Responsibility Education Programs are required to provide access to family planning. Programs that are not located in an Article-28 regulated facility are required to have an on-going Memorandum of Understanding with an Article-28 regulated facility to provide these services to youth. At a minimum, Department staff will discuss with each provider biannually their interaction and relationship with their designated Family Planning Program providers and School Based Health Center if applicable.

AH-2.5: Ensure adolescent-serving programs provide training on adulthood preparation subjects, such as healthy relationships, effective communication, career and education opportunities, health care transition, and financial literacy for adolescents with and without special health care needs to prepare them for a transition into adulthood.

Personal Responsibility Education Programs and Comprehensive Adolescent Pregnancy Prevention programs include adult preparation topics, which are meant to help build youth capacity to understand their own development, form healthy relationships, and navigate adolescence successfully. The 2022 procurement for the Comprehensive Adolescent Pregnancy Prevention program made this programmatic component mandatory and no longer optional to increase opportunities for youth. As of July 2023, all Comprehensive Adolescent Pregnancy Prevention providers offer adult preparation topics. ACT for Youth Center for Community Action provides training, webinars, and workgroups to programs in support of delivering adult preparation subjects. In addition to delivery of evidence-based program course curriculum, adolescent health program providers offer workshops and other events that address adult preparation topics. During this reporting period, programs have moved to more in-person delivery of programming, but some continue to offer education virtually through websites and online meeting platforms (e.g., Zoom).

Some Personal Responsibility Education Program providers delivered individually designed summer programs, separate from evidence-based practice courses. Specifically, programs included job training, a conference on bias and working with people from diverse backgrounds, and education on civic participation and community advocacy.

Strategy AH-3: Apply public health surveillance and data analysis findings to improve services and systems related to children's health and health care.

Data-driven, evidence-based practice is essential to achieving public health goals for Maternal and Child Health. Across all Title V programs, continuous effort is needed to enhance the collection, analysis, and sharing of data to inform the planning and implementation of Maternal and Child Health programs and policy work. Sharing data with stakeholders, including providers and community members, is critical to raise awareness, empower community action, and facilitate quality improvement efforts at all levels.

The combination of public survey data gleaned from sources such as the National Survey of Children's Health and the Youth Risk Behavior Surveillance System with data from the Adolescent Health Sexual Needs Index, vital Statistics and other data systems provide information to identify areas throughout the state with the most pressing health needs for youth.

The Title V Program established the following specific program and policy activities to advance this strategy over the 2022-23 year:

AH-3.1: Collaborate with the U.S. Census Bureau and the Health Resources and Services Administration to conduct an over-sample of NYS 2021 National Survey of Children's Health for NYS to allow for enhanced sampling of Black/African-American, Hispanic, and Children and Youth with Special Health Care Needs populations.

Department staff collaborated with Children and Youth with Special Health Care Needs program staff to discuss this oversampling initiative. Implementation of this project began in the Spring of 2022. The survey has been completed but data are not anticipated to be ready and available for review until the second half of 2024.

AH-3.2: Division staff will continue to use publicly available and internal surveillance data to identify adolescent needs and/or health behavior trends to support optimum adolescent health and development and determine funding areas for NYSDOH adolescent health procurements.

The Adolescent Sexual Health Needs Index (ASHNI) was updated in September 2021. The index is an indicator, calculated at the ZIP code level, to provide a single, multidimensional measure related to adolescent pregnancy and Sexually Transmitted Infections (STIs). It takes into consideration of key factors related to these outcomes, including size of the adolescent population, actual number of adolescent pregnancies and number of adolescents diagnosed with an STI, and specific of demographic and community factors (education, economic, race/ethnicity) associated with sexual health outcomes. The Adolescent Sexual Health Needs Index supports the State's ability to prioritize public health resources to areas with the poorest health outcomes and with the least access to services with the goal of reducing disparities. This tool was used for development of the new Comprehensive Adolescent Pregnancy Prevention program and Personal Responsibility Education Program procurements in 2022, and the Sexual Risk Avoidance Education procurement in 2023.

AH-3.3: Through ACT for Youth Center for Community Action trainings, webinars, and web posts, provide information and education to youth-serving organizations.

ACT for Youth Center for Community Action provided training and informational opportunities to adolescent health program providers throughout this period. In addition to training on evidence-based programs (EBPs), webinars addressed positive youth development, trauma and trauma-Informed approaches, STI education and prevention, youth mental health, diversity and cultural differences, provider collaboration forums, civic engagement, social media, healthy relationships, and a variety of trainings on working virtually. ACT for Youth Center for Community Action hosted orientations for new and returning Comprehensive Adolescent Pregnancy Prevention and Personal Responsibility Education Programs, in addition to regular trainings on evidence-based programs, Training of Educators, Facilitation Fundamentals, Making Evaluation Fun and Pleasurable, New Educator Learning Community meetings, Supervisor Learning Community meetings, and Component

Two Learning Community Meetings.

ACT for Youth Center for Community Action offers monthly webinars focusing on a myriad of adolescent health-related topics. The ACT for Youth Center for Community Action website includes resources such as: Adolescent Development Toolkit: Youth Mental Health: Understanding Positive Youth Development; Adolescent Health and Development. ACT for Youth Center for Community Action redesigned and updated their website. The update involved content contribution and review from adolescent health and development specialists and experts in positive youth development at Cornell University and the University of Rochester Medical Center.

AH-3.4: Explore collaborative opportunities with Division of Chronic Disease Prevention's Bureau of Chronic Disease Evaluation and Research to review and share information gathered through the Youth Risk Behavior Surveillance System.

Adolescent Health plans to work with the Bureau of Chronic Disease Evaluation to discuss the results of the 2021 Youth Risk Behavior Surveillance System.

Strategy AH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact adolescents' health and well-being.

Maternal and Child Health outcomes are impacted by the social determinants of health, or the conditions in which people are born, live, work, play, learn, and age. The social determinants of health include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of power and resources due to racism and other biases are root causes of inequities in access, availability of services, and quality of care. All ten priorities that emerged from community members' input during the Needs Assessment revolve around the social determinants of health and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities. Adolescents who participated in the listening sessions and focus groups were aware of how things such as quality housing, safe communities, employment, and community services affect their health and well-being and that of their families and were aware of the inequities in the access and quality for their communities. They discussed seeing their parents struggle and wanting change for their parents and for themselves as they near adulthood. Strategies focus on involving stakeholders who represent the populations impacted by health inequities, particularly engaging and collaborating with youth, to inform program planning and implementation and policy development.

The Title V Program established the following specific program and policy activities to advance this strategy over the 2022-2023 year:

AH-4.1: Collaborate with other state agencies and youth-serving organizations on adolescent-centered priorities through the Youth Development Team. The Youth Development Teams includes representation from the Department, NYS Office of Children and Family Services, the NYS Council on Children and Families, and the NYS Developmental Disabilities Planning Council in coordination with youth-led organizations.

The Youth Development Team has not been officially active in recent years,, however the majority of the prior membership, including the Department's Adolescent Health Unit have been part of cross-agency collaboratives involving youth development, such as NYS's Division of Criminal Justice - Runaway and Homeless Youth Intervention Workgroup, NYS's Children's Aid Society – Foster Youth Success Alliance Working Group, the NYS Office of Addiction Services and Supports Alcohol Surveillance and Epidemiology Workgroup; and representation on the Governor's Youth Council Statewide Advisory Group.

AH-4.2: Ensure that New York State Department of Health's health equity teams review materials before being widely disseminated to youth and youth-serving organizations.

Currently the Division of Family Health's cross-division Racial Justice and Health Equity Team reviews Request for Applications through a Health Equity lens. As a result, the Comprehensive Adolescent Pregnancy Prevention program, the Personal Responsibility Education Program, and the Sexual Risk Avoidance Education Request for Applications included language that indicated the Department's dedication to improving health outcomes and advancing health equity, directly asking applicants to focus on the health and racial disparities among youth in their communities, placing an emphasis on the inequities of historically marginalized populations, such as Black, Indigenous, and People of Color and LGBTQ+ populations) and how they plan to address through our programming. In addition, applicants were asked to account for the disproportionate numbers of youth affected by issues of systemic racism within their communities (i.e., lack of transportation, inadequate healthcare, and food deserts) and ways to collaborate with partner agencies to meet the needs of the impacted youth. The Request for Application for Comprehensive Adolescent Pregnancy Prevention program was issued on September 30, 2022. The Personal Responsibility Education Program Request for Application was released in early 2023. Forty-one new Comprehensive Adolescent Pregnancy Prevention programs were awarded, with five-year contracts beginning 7/1/2023. Seven new Personal Responsibility Education Programs were awarded, with five-year contracts beginning 10/1/2023. The Sexual Risk Avoidance Education Request for Applications was released in late September 2023. It is anticipated that approximately 12 grants will be awarded during the next reporting period for five-year contracts beginning 7/1/2024.

Health equity has been a focus in the Division of Family Health and has been prioritized. Adolescent Health staff have attended several webinars and workshops on Health Equity, including: 2022 Ending the Epidemic Summit and World AIDS Day: Partnerships in Health Equity, Personal Responsibility Education Program Share & Learn: Health Equity, Integrating Health Equity Into Sexual and Domestic Violence Prevention: Key Concepts and Components of Strategies and Approaches, Health Equity in Practice: How to build cross-movement partnerships to advance health equity. Adolescent Health staff also attended the panel, Promoting Health Equity within Adolescent Pregnancy Prevention Programming, during the 2023 Adolescent Pregnancy Prevention Conference hosted by the federal Family & Youth Services Bureau. Adolescent Health Staff presented about what they learned at the panel, Promoting Health Equity within Adolescent Pregnancy Prevention Programming, to the Bureau of Perinatal, Reproductive, and Sexual Health. Domain staff are also registered to attend a six-part Antiracism & Health Equity Workshop early in the next reporting period.

AH-4.3: Collaborate with youth through focus groups and community forums for direct input with state initiatives and special projects.

To respond to the current youth mental health crisis, the Department is working to create a public health campaign to promote positive mental health development of youth. To ensure that this campaign is effective, we are seeking to use credible messengers to create and deliver the campaign content. Credible messengers have the greatest influence among the communities they represent because they are people from the community and trusted more than voices from outside the community. In this case, the most credible messengers are youth themselves. Additionally, this community-based organization will identify youth for participation in a pilot Youth Advisory Board (YAB). The Youth Advisory Board will work with Division of Family Health staff to provide input into planning for public health programs for youth.

AH-4.4: Involve stakeholders, who represent the populations most impacted by racism and health inequities, in programmatic decisions.

The procurement for the Comprehensive Adolescent Pregnancy Prevention program incorporated youth stakeholder input to identify program opportunities for social-emotional wellness. The Comprehensive Adolescent Pregnancy Prevention program providers increase the percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, (including racial and social injustice) in program planning and implementation Increase the percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, (including racial and social injustice) in program planning and implementation. The Comprehensive Adolescent Pregnancy Prevention, Personal Responsibility Education Program, and the Sexual Risk Avoidance Education

procurements required applicants to describe how stakeholder input informed the design of their program.

As mentioned in AH-4.3, the Division of Family Health is developing a Youth Advisory Board. The board will provide youth who have been most impacted by racism and health inequities an opportunity to shape and provide feedback on programmatic decisions across the Division.

Adolescent Health staff regularly attend stakeholder meetings and events. During the reporting period, staff attended a summit hosted by New York City Mayor Eric Adams and New York City Department of Health and Mental Hygiene (DOHMH) Commissioner Dr. Ashwin Vasan on social media, assembling national experts and affected stakeholders to discuss potential pathways for action to protect the mental health of children and youth. Adolescent Domain staff also attended a statewide Child Welfare Summit hosted by the Foster Youth Success Alliance. The summit convened elected officials, impacted individuals, and advocates together to learn about and discuss child welfare-related policy priorities.

In addition to the updates above, the Department has taken great strides to incorporate health equity and racial justice throughout a wide variety of Title V activities, not limited to the activities within this strategy. In July 2022, the Department announced several reorganization efforts, including the creation of the Office of Health Equity and Human Rights. This new office is tasked with addressing health disparities and work to improve diversity, equity, and inclusion within the Department. The Office of Health Equity and Human Rights is a resource for programs across the Department as we work towards common goals of equitable health for all New Yorkers.

As described in the Women and Maternal Health section, a new Bureau of Health Equity and Community Engagement was created within the Division of Family Health to address disparities highlighted in the COVID-19 pandemic and build a foundation for future epidemic responses. Funded contracts supporting adolescent health include Youth Empowered for Change, Celebrities Barbershop, and Youth Making Change. Additional information about partnerships and funding to support Adolescent Health is available in Supporting Document #3.

AH-4.5: Through the New York State Department of Health adolescent providers, issue information on locally available resources and provide referrals specific to addressing the social determinants of health with adolescents from populations impacted by disparities.

In collaboration with our Perinatal Regionalization Unit, the Adolescent Health Unit participated in the development of adolescent health pamphlets on pelvic exam and heavy menstrual bleeding. These health promotion initiatives will educate female adolescents on the importance of self-monitoring as it relates to vaginal health and checkups with a health care provider. Completion and distribution of these materials are anticipated early in the next reporting period.

The Jewish Organization of Women's Medical Association (JOWMA), in consultation with the Department , created and designed a pamphlet on puberty for adolescent females of all races to inform this young and growing population on things to look for, who to talk to, and what to do during this stage of life. The Department supports this organization's initiative by providing printing and translation services for pamphlet distribution. Completion and distribution of these materials are anticipated early in the next reporting period.

All providers are required to maintain a robust network of resources to provide referrals to comprehensive services for youth. These referrals include resources that address the social determinants of health such as nutrition assistance, housing assistance, mental health, substance abuse, social-emotional wellness, interpersonal violence prevention, immigrant support services, educational support and assessments, Americans with Disabilities Act resources, employment and other social services. As part of the recent procurements for all three programs, providers were required to describe these partnerships and resources, how they provide referrals, and the process through which they are identified, executed, and tracked. During the reporting period, current Comprehensive Adolescent Pregnancy Prevention, Personal Responsibility Education Program, and the Sexual Risk Avoidance Education providers provided 1,016 referrals for services other than reproductive health care.

It is important to note, the NYS Title V Program established two Evidence-Based Strategy Measures (ESMs) to track the programmatic investments and inputs designed to impact NPM 10.

ESM AH-1: Percent of youth-serving programs that provide training on adult preparation subjects, such as healthy relationships, effective communication, financial literacy, and adult health care for adolescents with and without special health care needs to prepare them for a transition into adulthood.

Data for this measure will come from annual surveys of adolescent health providers. The baseline value for this measure, taken from a six-month program period of 7/1/2021 – 12/31/22, is 100%. The program has set an improvement target of 100% by 2025. For the most recent reporting period, the value is 100% (1/1/22 – 12/31/22, note: one of 53 programs had missing data).

ESM AH-2: Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation.

Data for this measure will come from annual surveys of adolescent health providers. The baseline value for this measure, taken from a six-month program period of 7/1/2020 – 12/31/20, is 68.7%. The program has set an improvement target of 75% by 2025. For the current most recent reporting period, the value is 79.4% (1/1/22 – 12/31/22, note: three of 65 programs have missing data).

Adolescent Health - Application Year

For Adolescent Health, New York's Title V Program selected **the National Performance Measure (NPM) 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.** This NPM was selected because it aligns with both population health data indicators and concerns voiced directly by adolescents in NYS. Most adolescents ages 12-17 had a preventive medical (71.3%) and preventive dental (80.8%) visits in 2021-2022, but there is room for improvement and disparities persist – only 66.3% of Hispanic adolescents had a preventive medical visit compared to 80.6% of non-Hispanic White adolescents and only 63.7% of adolescents on Medicaid had their annual visit compared to 81.8% with private insurance. Adolescents across the state discussed that their medical providers lack compassion and respect for their young patients and that youth would prefer visiting providers who are more affirming and reflective of the youth themselves. As the NPM's are self-reported the actual data measures may be lower than indicated.

As detailed above in the annual report, preventive medical visits are one part of overall wellness, but data and community input point to other areas that could help adolescents thrive, such as building healthy relationships, social-emotional wellbeing, and preparation for taking on the responsibilities of adulthood. There are dramatic disparities based on sexual identity as well. The importance of social support and the need for more people to talk to positive mentors were frequently mentioned by adolescents. Adolescents voiced a desire for education about financial literacy, healthy cooking, navigating relationships, and other aspects of adulthood. https://www.cdc.gov/healthyyouth/data/yrbs/index.htm

As mentioned in the annual report, adolescence is often a very challenging stage in a person's life. The multifaceted nature of adolescent development and wellness means the selected NPM and its associated strategies are responsive to most of the priority areas, particularly health care, social support and cohesion, community services and amenities, and awareness of resources. This NPM also aligns directly with established priorities encompassed in the NYS Prevention Agenda goals.

Four specific objectives were established to align with this performance measure:

Objective AH-1: Increase the percentage of adolescents, ages 12-17, with a preventive medical visit in the past year by 5%, from 81.3% in 2016-2017 to 85.4% in 2022-2023 (National Survey of Children's Health).

Objective AH-2: Increase the percentage of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling by 5%, from 53.5% in 2017-2018 to 56.2% in 2022-2023 (National Survey of Children's Health).

Objective AH-3: Increase the percentage of adolescents, ages 13 through 17, who have received at least one dose of the Human Papilloma Virus (HPV) vaccine by 8%, from 67.3% in 2018 to 72.7% in 2023 (NIS).

Objective AH-4: Increase the percentage of NYS adolescents without special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 16.4% in 2017-2018 to 17.2% in 2022-2023 (National Survey of Children's Health).

Four strategic public health approaches were identified to accomplish these objectives over the next five years. These are presented in the State Action Plan table, and each objective is described in more detail, with specific program and policy activities that will be implemented to advance the broader strategic approach in the upcoming year.

Strategy AH-1: Incorporate specific activities to promote the wellness of adolescents across all Title V programs, including promoting and facilitating routine well visits, reproductive health care, oral health, and behavioral health.

The lifestyle choices, behaviors, and relationships established during adolescence can affect their current and future health. Routine well visits during adolescence are recommended by the American Academy of Pediatrics' Bright Futures™ as one way to foster health in the present and build a foundation for wellness into the future. Well visits are an opportunity to

promote healthy behaviors, discuss risky behaviors, provide important vaccinations, and address conditions that can interfere with healthy development. Comprehensive and inclusive reproductive health care and education are opportunities to help adolescents avoid or mitigate risky sexual behaviors. Title V funded programs also provide enabling services to adolescents, such as referrals to and linkages with community services and social supports to holistically address health and wellness, including mental health and social determinants of health.

The key programs that work to support adolescent wellness and help connect adolescents to needed services include Comprehensive Adolescent Pregnancy Prevention program, Sexual Risk Avoidance Education program, Personal Responsibility Education Program, Children and Youth with Special Health Care Needs programs, School Based Health Centers, Family Planning Program, and Sexual Violence Prevention program.

A new Comprehensive Adolescent Pregnancy Prevention (CAPP) program procurement was issued September 2022. Forty-one awards were made for a new five-year period, which began 7/1/2023. A new Personal Responsibility Education Program (PREP) procurement was issued January 2023, and seven new PREP awards were made 7/24/2023 that began on 10/1/2023. These awards included three new PREP program providers. A new Sexual Risk Avoidance Education program procurement was issued 9/21/2023 for new five-year contracts beginning 7/1/2024. Eleven awards were announced 3/13/2024 for the new SRAE contracts, which include four new SRAE program providers.

The NYS Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2024-2025 year:

- **Activity AH-1.1**: Through the Comprehensive Adolescent Pregnancy Prevention program, provide information to adolescents and parents on the offering and arranging of adolescent sexual health reproductive services. The federally funded Personal Responsibility and Education Program also provides this information, in partnership with the Title V program.
- **Activity AH-1.2**: Through the Sexual Risk Avoidance Education program, provide medically accurate and complete sexuality health education services to youth.
- **Activity AH-1.3**: Through the Comprehensive Adolescent Pregnancy Prevention program, Personal Responsibility Education Program, and Sexual Risk Avoidance Education program, increase access to health care services for adolescents through a referral process that includes confirmation as permitted while ensuring confidentiality.
- **Activity AH-1.4**: NYSDOH staff, including Title V funded staff, and community youth-serving organizations provide trauma-informed education and training on social emotional wellness and positive youth development for children and adolescents.
- **Activity AH-1.5**: Within the Title V program, enhance collaboration between adolescent serving programs, including the Comprehensive Adolescent Pregnancy Prevention program, Sexual Risk Avoidance Education program, School Based Health Center, Sexual Violence Prevention program, and Children and Youth with Special Health Care Needs programs, to promote holistic adolescent health through provision of comprehensive physical exams and anticipatory guidance, including body mass index (BMI), behavioral health, oral health, and reproductive health, for adolescents with and without special health care needs. The Adolescent Health Unit (AHU) is collaborating with the Bureau of Child Health to increase opportunities for contact between School Based Health Centers (SBHCs) and AHU program providers. The Adolescent Health Unit and the Bureau of Child Health are developing a plan to conduct an informational webinar with SBHCs, ACT CCA, and AHU programs. The Adolescent Health Unit, in collaboration across the Division of Family Health, developed a set of menstrual health fact sheets using age-appropriate language for middle- and high-school age youth. Adolescent Domain staff will be collaborating with School Based Health Centers, AHU program providers to disseminate this information.
- **Activity AH-1.6**: Collaborate with internal partners, including NYSDOH AIDS Institute and Bureau of Immunization, and external partners, such as the NYS Humans Papilloma Virus (HPV) Coalition, to promote HPV vaccination with clinical providers.
- **Activity AH 1.7**: Refer adolescents and their parents to family planning providers for contraception and birth planning, including School Based Health Centers, where available.

- **Activity AH-1.8**: Promote access to confidential reproductive health care services and preventive medical visits for adolescents, including through School Based Health Centers, where available. Family planning providers deliver counseling and services related to contraception, promotion of healthy relationships, preventive medical care, and preconception/inter-conception health.
- **Activity AH-1.9**: Promote healthy relationships and sexual violence prevention using policy change, protective environment strengthening, healthy social norms reinforcement, and skill-building to address individual, relationship, community, and societal risk and protective factors. Focus on groups experiencing disproportionate burden of sexual violence, including communities of color, adolescents and young adults, domestic violence victims, those experiencing low income, people affected by alcohol and drug abuse, and LGBTQ+ persons. Staff supporting the Adolescent Health domain will work with staff in the Sexual Violence Prevention unit to ensure that providers are implementing effective and informative programming regarding healthy and safe relationships.
- **Activity AH-1.10**: Promote adolescents' social-emotional wellness and positive developmental assets through established Title V programs.

Strategy AH-2: Promote supports for adolescents to gain the knowledge, self-efficacy, and resources they need to prepare for and transition to adulthood.

For young adults, with or without special health care needs, the transition to adulthood is a crucial time in their development. Young adults may move away from their parents, transition to adult health care, become increasingly sexually active, continue their education, and/or start a career. Navigating these transitions can be difficult for youth as their independence continues to grow. Often, an increased sense of independence can lead to an increase of unhealthy risky behaviors. Title V programs will provide youth with support to help prepare for and navigate this transition.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2024-2025 year:

- **Activity AH-2.1**: Ensure adolescent providers have a mechanism in place to provide adolescent-related health care service referrals to other providers of health care services, including substance abuse (e.g., alcohol, tobacco cessation), mental health issues, sexual violence, and intimate partner violence.
- **Activity AH-2.2**: Refer adolescent parents to family planning providers or School Based Health Centers for contraception and birth planning.
- **Activity AH-2.3**: Support pregnant and birthing adolescent parents in attending prenatal, postpartum, and well-baby appointments.
- **Activity AH-2.4**: Promote access to confidential reproductive health care services and preventive medical visits for adolescents. Family planning providers provide counseling and services related to contraception, promotion of healthy relationships, preventive medical care, and preconception/inter-conception health.
- **Activity AH-2.5**: Ensure adolescent-serving programs provide training on Adulthood Preparation Subjects, such as healthy relationships, effective communication, career and education opportunities, health care transition, and financial literacy for adolescents with and without special health care needs to prepare them for a transition into adulthood. All Personal Responsibility Education Program programming includes Adult Preparation Subjects. All 41 current Comprehensive Adolescent Pregnancy Prevention program contractors include Adulthood Preparation Subject training in their programming.
- **Activity AH-2.6**: Work collaboratively with units inside and outside of the Department of Health to gain insight into ways to practice the most effective methods to support all aspects of adolescent health – emotional, mental, and physical – as they transition into adulthood. Adolescent Domain staff will participate in the cross-division Adolescent Mental Health Work Group. The Workgroup has presented on adolescent mental health to several bureaus in the Division of Family Health and plans to continue working collaboratively with Title V staff and with other agencies.

Strategy AH-3: Apply public health surveillance and data analysis findings to improve services and systems

related to children's health and health care.

Data-driven, evidence-based practice is essential to achieving public health goals for NYSDOH and the NYS Title V program. Across all Title V funded programs, continuous effort is needed to enhance the collection, analysis, and sharing of data to inform the planning and implementation of programs and policies. Sharing data with stakeholders, including providers and community members, is critical to raise awareness, empower community action, and facilitate quality improvement efforts at all levels.

The combination of public survey data gleaned from sources like National Survey of Children's Health and the Youth Risk Behavior Surveillance System with data from NYS's Adolescent Sexual Health Needs Index (ASHNI), Vital Statistics and other data systems provide information to identify areas throughout the state with the most pressing health needs for youth.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2024-2025 year:

- **Activity AH-3.1**: Collaborate with the US Census Bureau and the Health Resources and Services Administration to conduct an over-sample of NYS National Survey of Children's Health, for NYS to allow for enhanced sampling of Black/African American, Hispanic, and Children and Youth with Special Health Care Needs populations during the 2022 data collection period. This survey has been completed and work is underway to make data available in in the second half of 2024.]
- **Activity AH-3.2**: Title V staff will continue to use publicly available and internal surveillance data to identify adolescent needs and/or health behavior trends to support optimum adolescent health and development and determine funding areas for NYSDOH adolescent health procurements.
- **Activity AH-3.3**: Through ACT for Youth Center for Community Action trainings, webinars, and web posts, provide information and education to youth-serving organizations.
- **Activity AH-3.4**: Explore collaborative opportunities with the NYSDOH Division of Chronic Disease Prevention's Bureau of Chronic Disease Evaluation and Research, which works with the NYS Education Department, to review and share information gathered through the Youth Risk Behavior Surveillance System.

Strategy AH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact adolescents' health and well-being.

Adolescent health outcomes are impacted by the social determinants of health, defined as the conditions in which people are born, live, work, play, learn, and age. The social determinants of health include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of power and resources due to racism and other biases are root causes of inequities in access, availability of services, and quality of care. All ten priorities that emerged from community members' input during the Title V Needs Assessment revolve around the social determinants of health and inequities.

These factors and inequities impact the health outcomes of both individuals and entire communities. Adolescents who participated in the listening sessions and focus groups were aware of how things like quality housing, safe communities, employment, and community services affect their health and well-being and that of their families and were aware of the inequities in the access and quality for their communities. They discussed seeing their parents struggle and wanting change for their parents and for themselves as they near adulthood. Strategies focus on involving stakeholders who represent populations impacted by health inequities, particularly engaging and collaborating with youth, to inform program planning and implementation and policy development.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2024-2025 year:

- **Activity AH-4.1**: Collaborate with other state agencies, within the Department of Health, and with youth-serving

organizations on adolescent-centered priorities through the Youth Development Team. The Youth Development team includes representation from NYSDOH, NYS Office of Children and Family Services, the NYS Council on Children and Families, and the NYS Developmental Disabilities Planning Council in coordination with youth-led organizations. The Youth Development Team has not been officially active in recent years, however the majority of the prior membership, including the Department's Adolescent Health Unit will continue to participate in cross-agency collaboratives involving youth development, such as NYS's Division of Criminal Justice - Runaway and Homeless Youth Intervention Workgroup, NYS's Children's Aid Society – Foster Youth Success Alliance Working Group, the NYS Office of Addiction Services and Supports Alcohol Surveillance and Epidemiology Workgroup; and representation on the Governor's Youth Council Statewide Advisory Group. Adolescent Domain staff are also involved in launching a pilot Youth Advisory Group for the Division of Family Health.

- **Activity AH-4.2**: Ensure that NYSDOH health equity teams review materials before being widely disseminated to youth and youth-serving organizations.
- **Activity AH-4.3**: Collaborate with youth through focus groups and community forums for direct input with state initiatives and special projects.
- **Activity AH-4.4**: Involve stakeholders that are representative of the populations most impacted by racism and health inequities in programmatic decisions.
- **Activity AH-4.5**: Through NYSDOH adolescent providers, issue information on locally available resources and provide referrals specific to addressing the social determinants of health with adolescents from populations impacted by disparities.

The NYS Title V Program established two Evidence-Based Strategy Measures (ESMs) to track the programmatic investments and inputs designed to impact NPM 10:

ESM AH-1: Percent of youth-serving programs that provide training on adult preparation subjects, such as accessing health insurance, maintaining their routine preventive medical visits, healthy relationships, effective communication, financial literacy, and adult health care for adolescents with and without special health care needs to prepare them for a transition into adulthood.

Data for this measure comes from surveys of adolescent health providers. The baseline value for this measure, taken from a six-month program period of 7/1/2021 – 12/31/22, is 100%. The program has set an improvement target of 100% by 2025. For the most recent data, the value is 96.1% (1/1/23 – 12/31/23, note: four of 55 programs had missing data).

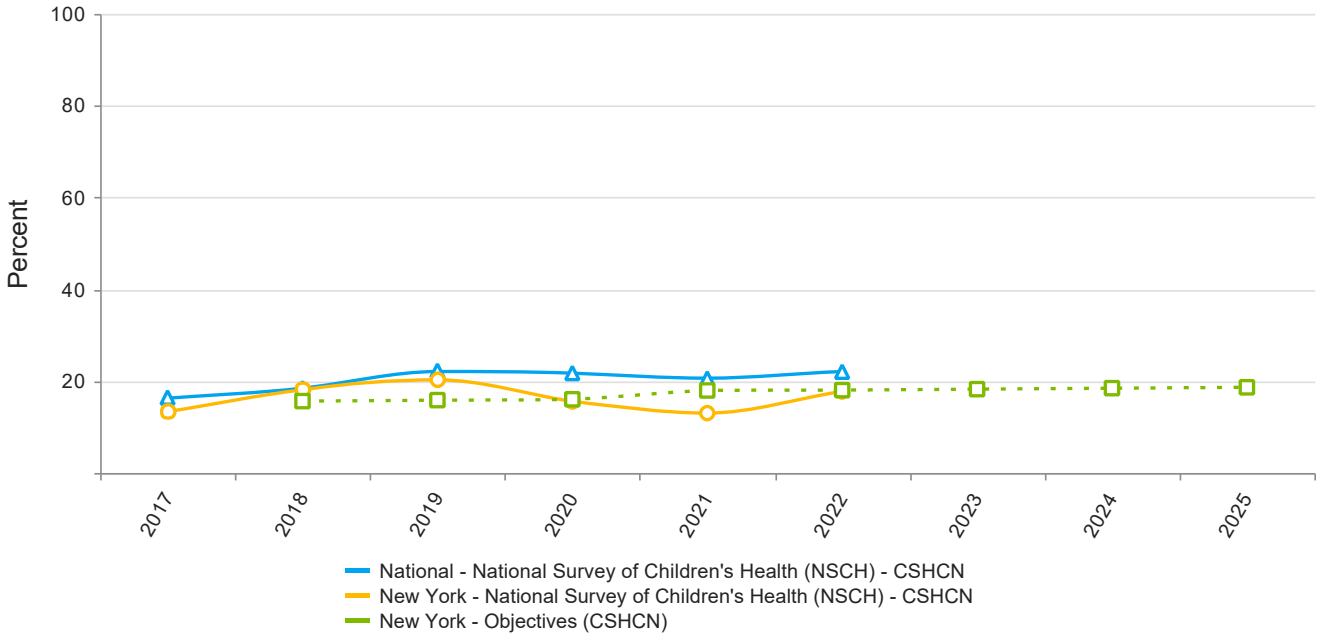
ESM AH-2: Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation.

Data for this measure comes from surveys of adolescent health providers. The baseline value for this measure, taken from a six-month program period of 7/1/2020 – 12/31/20, is 68.7%. The program has set an improvement target of 75% by 2025. For the most recent data, the value is 77.3% (1/1/23 – 12/31/23, note: seven of 67 programs had missing data).

Children with Special Health Care Needs

National Performance Measures

NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR
Indicators and Annual Objectives



NPM TR - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	15.9	16.1	18	18.1	18.3
Annual Indicator	17.8	23.6	19.1	11.8	17.9
Numerator	48,580	87,040	73,058	40,243	59,380
Denominator	273,067	369,539	381,623	340,705	331,183
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	18.5	18.7

Evidence-Based or –Informed Strategy Measures

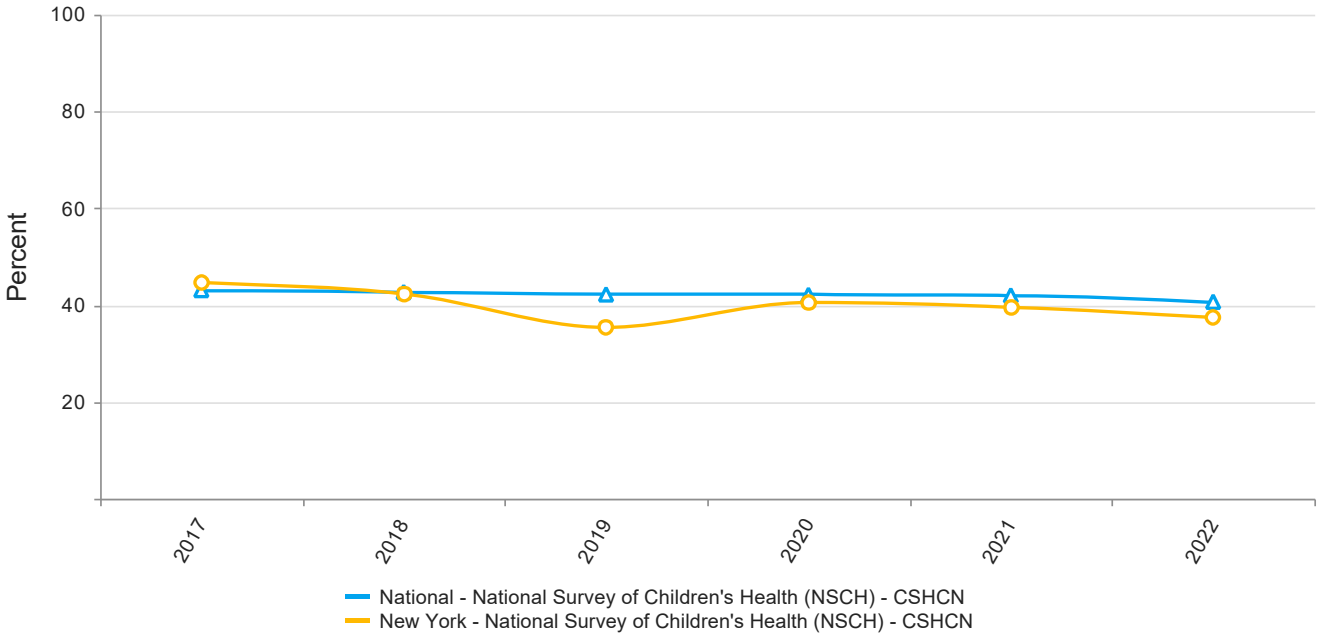
ESM TR.1 - Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			40.3	41.1	41.5
Annual Indicator	40.3	62.4	66.1	74.8	67.5
Numerator		295	323	450	291
Denominator		473	489	602	431
Data Source	Contractor Reports	Contractor Reports	Contractor Reports	Contractor Reports	Contractor Reports
Data Source Year	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	41.9	42.3

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
Indicators and Annual Objectives



NPM MH - Children with Special Health Care Needs

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2023
Annual Objective	
Annual Indicator	37.4
Numerator	274,332
Denominator	734,189
Data Source	NSCH-CSHCN
Data Source Year	2021_2022

Evidence-Based or –Informed Strategy Measures

None

State Performance Measures

SPM 2 - Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			3.6	12.1	12
Annual Indicator		3.6	12.1	10.4	10.4
Numerator		1,772	6,063	4,443	4,412
Denominator		498,946	502,219	428,592	423,739
Data Source		NYS Child Health Lead Poisoning Prevention Program	NYS Child Health Lead Poisoning Prevention Program	NYS Child Health Lead Poisoning Prevention Program	NYS Child Health Lead Poisoning Prevention Program
Data Source Year		2018	2019	2020	2021
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	11.9	11.8

State Action Plan Table

State Action Plan Table (New York) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Enhance supports for parents and families, especially those with children with special health care needs, and inclusive of all family members and caregivers	
NPM	
NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR	
Five-Year Objectives	
Objective CYSCHN-1: Increase the percent of NYS adolescents with special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 17.8% in 2017-2018 to 18.7% in 2021-2022 (NSCH)	
Objective CYSCHN-2: Increase the percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system by 5%, from 15.2% in 2017-2018 to 16% in 2021-2022 (NSCH)	
Strategies	
Strategy CYSHCN-1: Engage youth with special health care needs (YSHCN) and their families in state and local efforts to improve systems and practices for supporting YSHCN. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.	
Strategy CYSHCN-2: Enhance care coordination, including transition support services, for children and youth with special health care needs. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.	
Strategy CYSHCN-3: Apply public health surveillance and data analysis findings to improve services and systems related to health and health care for children and youth with special health care needs. Please see Supporting Document 2“ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.	
Strategy CYSHCN-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact the health and well- being of children and youth with special health care needs. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.	
ESMs	**Status**
ESM TR.1 - Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.	Active

NOMs

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

State Action Plan Table (New York) - Children with Special Health Care Needs - Entry 2

Priority Need

Promote awareness and enhance availability, accessibility and coordination of services for families and youth, including CYSHCN, with a focus on areas impacted by systemic barriers, including racism

NPM

NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR

Five-Year Objectives

Objective CYSCHN-1: Increase the percent of NYS adolescents with special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 17.8% in 2017-2018 to 18.7% in 2021-2022 (NSCH)

Objective CYSCHN-2: Increase the percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system by 5%, from 15.2% in 2017-2018 to 16% in 2021-2022 (NSCH)

Strategies

Strategy CYSHCN-1: Engage youth with special health care needs (YSHCN) and their families in state and local efforts to improve systems and practices for supporting YSHCN. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy CYSHCN-2: Enhance care coordination, including transition support services, for children and youth with special health care needs. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy CYSHCN-3: Apply public health surveillance and data analysis findings to improve services and systems related to health and health care for children and youth with special health care needs. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy CYSHCN-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact the health and well- being of children and youth with special health care needs. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

ESMs	Status
ESM TR.1 - Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.	Active

NOMs

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

State Action Plan Table (New York) - Children with Special Health Care Needs - Entry 3

Priority Need

Enhance supports for parents and families, especially those with children with special health care needs, and inclusive of all family members and caregivers

NPM

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

Five-Year Objectives

Establish baseline percentage and propose a percentage increase of children with special health care needs, ages 0 through 17, who have a medical home.

Strategies

The NYS Title V Program is working to ensure Medical Homes for children visits through a number of our current strategies and activities. The Child and Youth with Special Health Care Needs Domain Team will review data from the five (5) National Survey of Children's Health components that inform the Medical Home NPM: usual source of sick care, personal doctor or nurse, family-centered care, no problems getting referrals, and effective care coordination when needed. Upon review, annual objectives and strategies will be identified for the FY 2026 Application. Where possible, these activities will align with the Blueprint for Change.

ESMs	Status

No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.

NOMs

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.

State Action Plan Table (New York) - Children with Special Health Care Needs - Entry 4

Priority Need

Increase the availability and quality of affordable housing.

SPM

SPM 2 - Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months

Five-Year Objectives

Objective CYSHCN-3: Reduce the incidence of confirmed high blood lead levels at 5 micrograms per deciliter or greater per 1,000 tested children aged less than 72 months, with baseline incidence and benchmarks established in 2020-21 program year. The current incidence of confirmed blood lead levels at 10 micrograms per deciliter or greater is 3.7 per 1,000 children tested in 2016. (NYS Child Health Lead Poisoning Prevention Program Data)

Strategies

Strategy CSHCN-5: Support comprehensive public health efforts to prevent, identify, and manage childhood lead poisoning. Please see Supporting Document 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Children with Special Health Care Needs - Annual Report

For Children and Youth with Special Health Care Needs (CYSCHN), New York (NY)'s Title V Program selected **National Performance Measure 12: Percent of adolescents with special health care needs, ages 12-17, who received services necessary to make transitions to adult health care.** This performance measure was selected because it was voiced as a key priority by youth with special health care needs and their families, reinforced by state-specific population health data. Families reported that only 15% of CYSCHN receive care in a well-functioning system, and less than 18% of youth ages 12-17 with special health care needs received services necessary to make transitions to adult health care. This is consistent with findings from NY's Care Mapping process conducted in 2017-2018, and with findings from the community listening forums conducted for this application. This performance measure also aligns directly with NYS Prevention Agenda goals and interventions related to support for CYSCHN.

In addition, NY's Title V Program established one **State Performance Measure for this domain 2: Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months**. This performance measure was developed to reflect the state's longstanding commitment to eliminating childhood lead poisoning as a key public health problem in NYS. It is responsive to cross-cutting priorities voiced by families related to safe and healthy environments to support children's development, and access to comprehensive, high quality health care services. It is also responsive to specific concerns shared by families regarding challenges in accessing and coordinating medical care and related services for children with special health care needs. It builds on critical public health investments and capacity to prevent, identify, and address lead poisoning in NYS, including recent amendments to state public health law, as discussed further below.

Three specific objectives were established to align with this performance measure:

Objective 1: Increase the percent of NYS adolescents with special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 17.8% in 2017-2018 to 18.7% in 2021-2022 (National Survey of Children's Health).

Objective 2: Increase the percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system by 5%, from 15.2% in 2017-2018 to 16% in 2021-2022 (National Survey of Children's Health).

Objective 3: Reduce the incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months by at least 5%, from 3.55 per 1,000 children tested in 2018 to below 2.89 in 1,000 children tested in 2022 (NYS Child Health Lead Poisoning Prevention Program Data).

Strategy CYSHCN-1: Engage youth with special health care needs (YSHCN) and their families in state and local efforts to improve systems and practices for supporting CYSCHN.

Families and youth need to be directly involved in program and policy planning and implementation in meaningful roles at all levels. This is consistent with the Title V program's longstanding commitments to family-centered care/family-professional partnerships and positive youth development. This is a theme woven into all CYSCHN-serving Title V programs.

For example, the Title V Program contracts with three federally designated University Centers for Excellence in Developmental Disabilities (UCEDDs), or Regional Support Centers, to provide training and technical assistance to Local Health Department programs and to conduct family engagement. The Regional Support Centers are required to employ a family/parent liaison that is a parent of a child with special health care needs, a critical component of the Regional Support Centers' work with families and Local Health Departments. Family liaisons bring firsthand experience, perspective, and knowledge of barriers and gaps in care to all aspects of Regional Support Centers' activities, including meeting with families and resource gathering. Family liaisons are responsible for conducting family engagement sessions with a prescribed set of

questions to gauge the needs of families with CYSCHN and they use this feedback to inform educational materials and trainings for Local Health Departments.

In addition, the 2020-2025 Local Health Department CYSCHN program contract period includes deliverables to address family and community engagement at many levels. The local staff involved families of CYSCHN in work groups, committees, task forces, and/or advisory committees to improve the system of care as well as in local planning activities, such as the Community Health Assessment, and use feedback from families of CYSCHN to develop training for staff and providers.

Finally, the state's sickle cell disease contractors at three Hemoglobinopathy Specialty Care Centers (Centers) work directly and exclusively with youth with sickle cell disease and their families to provide supportive services. This includes peer support groups, system navigation supports, and self-care services. The Centers conduct peer support groups to gauge barriers to care and transition for youth and young adults with sickle cell disease. Peer support groups also provide opportunity for advocacy and linkages with other individuals and families living with sickle cell disease. Transition Navigators at Hemoglobinopathy Specialty Care Centers engage youth with sickle cell disease to promote and support the transition from pediatric to adult care providers, ensure compliance with appointments and medication, self-management, and preventive health care including non-medical mechanisms for pain management and understand what barriers youth experience in caring for themselves.

The Title V Program led the following specific program and policy activities to advance this strategy over the 2022-23 reporting period:

CYSHCN-1.1: Maintain at least one dedicated family representative on the state's Title V Maternal and Child Health Services Block Grant Advisory Council and engaged all Council members in updates and discussions related to CYSCHN program activities.

There is one parent representative from Parent to Parent on the Title V Maternal and Child Health Services Block Grant Advisory Council. The CYSCHN (CYSHCN) Program engages council members in updates and discussions related to program activities. On 10/13/22 the NYS Department of Health CYSHCN staff attended the MCHSBG Advisory Council meeting where the Bureau of Child Health Director/Title V CYSHCN Director presented updates and the current status of the program.

CYSHCN-1.2: Collaborate with advocacy groups like Parent to Parent to understand the needs of CYSCHN and their families, facilitate information sharing, and promote Local Health Department CYSCHN programs.

The NYSDOH CYSCHN (CYSHCN) Program staff shared information by e-mail on 12/20/2022 with local health department staff state-wide about the NYS Parent to Parent Special Education Information Center, Family Empowers Advocacy Series Training.

Title V Program staff participate in cross-systems workgroups to facilitate information and resource sharing to improve the systems of care for CYSCHN and their families. An example of a cross-systems work groups includes the Title V Program leadership - Kirsten Siegenthaler, Title V Director, and Suzanne Swan, Title V CYSCHN Director - participation bi-weekly in the Council on Children and Families Commissioners' Cross-Systems Work Group. The Cross-Systems Work Group reviews care coordination for and placement of youth with developmental disabilities. The group focuses on managing extreme cases of long hospital stays, youth placement in care settings outside the home, and increasing efficiencies in the process where possible. In addition, Bureau leadership participated in the Office of Mental Health cross-system workgroup as well as the Pediatric cross-agency workgroup which meets quarterly and is led by the Office of Health Insurance Programs and the Department of Health. CYSCHN DOH staff participated on the Association of Maternal and Child Health Program's (AMCHP) Family Engagement Community of Practice (CoP) work group. The goal of the work group was to increase the Title V capacity to engage families. The CoP provided a platform for professional development and opportunity to share ideas, innovations, lessons learned, successes, and best practices from subject matter experts. Bureau staff also participated in the May 9, 2023, What's Great in Our State conference to learn valuable strategies and tools to improve mental health and wellness in the community. Strategic partnerships were developed in follow up to participation.

NYSDOH staff continued a collaboration with other strategic partners. For example, staff met with the NYS Office of

Children and Family Services HEARS (Help, Empower, Advocate, Reassure and Support) Family Line staff on 10/18/2022 who then presented for the local health department CYSHCN staff state-wide on November 30, 2022. The HEARS Family Line supports parents and families by providing resources and referrals to a variety of services. Caring representatives guide families to services including food, clothing, housing, medical and behavioral health care services, parenting education, and childcare. Representatives are available Monday through Friday from 8:30 am to 4:30 pm. Another example of a collaboration is with the NY Connects Program (https://www.nyconnects.ny.gov/). NYSDOH staff had the opportunity to review and comment on the NY Connects training for local NY Connects Specialists. This included contributing slides about the CYSCHN program. On 9/12/2023, the NY Connects staff presented on a quarterly CYSHCN contractor call for DOH staff and local health department CYSHCN staff about their program activities and resources. DOH staff also met with the Center for Autism and Related Disabilities staff on 07/24/2023 (https://www.albany.edu/autism) and disseminated information about their training opportunities for professionals and families on the 9/12/2023 quarterly contractor meeting. On 9/20/2023 DOH staff met with the Brain Injury Association of NYS staff and planned a presentation for local health department staff.

Title V staff along with Newborn Screening Center at Wadsworth Center staff met with the community-based organization Sickle Cell/Thalassemia Patients Network (SCTPN) on 10/17/2022 to learn about the work SCTPN is doing in New York State (NYS) including a Health Resource and Service Administration (HRSA) grant that supports community education/awareness events.

An example of information sharing includes when NYSDOH staff routinely shared consumer report recalls with the program staff to share with and inform families in their counties. Examples of information shared include,

- Consumer Product Safety Commission (CPSC) Warns Consumers to Immediately Stop Using Crib Bumpers Due to Suffocation Hazard; Violation of the Federal Ban on Crib Bumpers; Sold Exclusively on Amazon.com.
- CPSC Warns Consumers to Immediately Stop Using “Baby Loungers” Due to Suffocation Risk and Fall Hazard; Failure to Meet Federal Safety Regulation for Infant Sleep Products.
- Cinnamon Applesauce Pouches recalled, Elevated Lead & Chromium Levels (November 2023).
- Mary Meyer Recalls Bubba Bull Plush Toys Due to Choking Hazard.

CYSHCN-1.3: Support Regional Support Centers to employ parents of CYSCHN as family/parent liaisons/specialists. Regional Support Centers and parent liaisons conducted surveys, family engagement sessions and family forums to assess and share family needs and apply results to inform family resources and technical assistance for Local Health Department programs.

The family specialists for the Regional Support Centers continued to work on every aspect of this project to ensure that the family perspective is a priority. They provided support to families by developing educational materials and family engagement plans with the Local Health Department Program staff.

The family specialists collaborated to develop resources for CYSCHN and their families such as: the System Navigation Guide, Social Media Resource, CYSCHN Informational sheets focused on topics such as: Accessing Supports and Services, Navigating the Educational System, Accessing the Community, Impact on the Family Unit, and Parent Feedback. Family Specialists also supported the Regional Support Centers in the development of a CYSCHN Resource Directory that will be made available online to provide families, Local Health Departments, and health care providers with current information about state-wide services and supports. The Resource Directory is routinely updated to ensure a reliable source of information.

CYSHCH-1.4: Support Regional Support Centers to develop a CYSCHN Resource Directory that will provide families and health care providers with current information about services and supports.

Title V staff support the Regional Support Center staff in expanding the Resource Directory by making recommendations for updates. DOH staff continues to research avenues to post the Resource Directory so that it is accessible to the public. In

addition to the Resource Directory, the Regional Support Centers have developed resources and information about services and supports for CYSCHN and their families. For example, they developed Transition Timelines that are organized by age group specific needs, a Health Conditions Guide that is organized by health conditions, and monthly CYSHCN Clips that provides news, announcements, and resources. The Regional Support Center staff presented at the AMCHP conference "Families Influencing Change! Promoting Health Equity for CYSCHN through Family Engagement".

Title V staff continue to develop and strengthen strategic partnerships at NYS DOH, other state partners, and community-based organizations in order to provide current information about services and supports throughout NYS and NYC. For example, at the May 3, 2023, NYS Association of County Health Officials (NYSACHO) conference for Early Intervention and CYSCHN staff, the NYS Conference of Local Mental Hygiene Directors presented and shared information about their programs and resources. Another example is a webinar presentation by NY Connects for local health department staff about their long-term services and supports in New York State for people of all ages or with any type of disability. Title V staff also shared information about the Center for Autism and Related Disabilities resources and evidence-based training opportunities for professionals and families.

NYS CYSCHN Program staff routinely review the required Local Health Departments' quarterly reports which includes CYSCHN and their families' involvement in work groups, committees, task forces or advisory committees and other Local Health Department assessment and planning activities.

Title V staff provided technical assistance to Local Health Departments throughout the reporting period by reviewing required quarterly narratives and data reports and providing follow-up technical assistance by e-mail, phone, and webinar. In addition, staff are regularly available and provide training and technical assistance on an as-needed basis. NYSDOH staff presented a Back-to-Basics webinar training for the local health departments, Regional Support Centers, and the NYS DOH Regional Office staff in June of 2023.

CYSHCN-1.5: Support Local Health Department CYSCHN (CYSHCN) programs to involve CYSCHN and their families in work groups, committees, task forces or advisory committees, local health assessment and planning activities, and other systems development work. Use feedback from families of CYSCHN to develop training for CYSCHN staff and providers.

Title V staff support Local Health Department CYSCHN programs to involve CYSCHN and their families in work groups, committees, task forces or advisory committees, local health assessment and planning activities, and other systems development work. The NYSDOH Regional Office staff also provide support, resources, and technical assistance through email, phone and in-person visits.

In addition, the Title V Program contracts with the state's three University Centers for Excellence in Developmental Disabilities (UCEDDs), which are referred to as the Regional Support Centers (Centers). The Centers provide training and technical assistance to Local Health Department CYSCHN programs. They assist counties to develop a Family Engagement Plan to meet their identified community engagement goals. The Centers also conduct family engagement activities state-wide, including NYC. The feedback from families informs the development of training for the CYSHCN Program.
The Regional Support Centers employ a family/parent liaison that is a parent of a child with special health care needs.

The Local Health Department CYSCHN program contract includes deliverables to address family and community engagement at many levels. The Local Health Department staff involved families of CYSCHN in work groups, committees, task forces, and/or advisory committees for their perspective about how to improve the system of care for CYSCHN.

The NYSDOH staff developed and disseminated a Dear Provider letter template for local health department staff to promote the program in their community. Staff also routinely share information with Local Health Department CYSCHN programs. For example, in December 2022, Parent to Parent of NYS - Family Empowerment Advocacy Series training; February 2023, Family and Youth Service Bureau - New resources to support the Sexual Health Needs of Youth with Intellectual Disabilities; March 2023, New HHS Child and Adolescent Health Emergency Planning Toolkit.

Title V staff routinely participate in professional development to support the local health department staff Program activities. For example, staff attend RSC trainings, and Bureau of Administration fiscal training on 9/15/2023 to support optimal fiscal management.

CYSHCN-1.6: Engage the New York State Association of County Health Officials (NYSACHO) to promote and bolster Local Health Department CYSCHN programs to raise awareness of CYSCHN services and reach and serve more families.

The CYSCHN (CYSHCN) program contracts with the New York State Association of County Health Officials to convene an annual in-person state-wide meeting, facilitate virtual webinars, promote training opportunities, conduct surveys of the local health department staff, and promote the program with other programs. For example, the New York State Association of County Health Officials sent an invitation local health department staff about the Office of Children and Family Services HEARS (Help, Empower, Advocate, Reassure and Support) presentation which was hosted on November 30, 2022; surveyed staff about their satisfaction with and use of Regional Support Centers resources on 2/17/23; and hosted an in-person (with virtual option), two day, conference on May 2 and 3, 2023, for Early Intervention and CYSCHN local health department staff. In addition, they hosted four regional meetings with local health department and NYS DOH staff to hear about the successes and challenges local health department CYSHCN staff have identified while working on the Program.

On 2/08/23, the Community-Based Health Unit Manager attended the New York State Association of County Health Officials state and local health department Regional Roundtable event at the Crowne Plaza Desmond Hotel in Albany to meet staff and learn about their program successes and challenges.

CYSHCN-1.7: Support Sickle Cell Disease programs at three Hemoglobinopathy Specialty Care Centers to provide supports by and for youth with sickle cell disease, including peer support groups, system navigation supports, and self-care services.

As described above, the state's three Sickle Cell Disease contractors support youth with Sickle Cell Disease and their families. They provide peer support groups, system navigation supports, and self-care services. Hemoglobinopathy Specialty Care Centers conduct peer support groups to gauge barriers to care and transition for youth and young adults with Sickle Cell Disease. Peer support groups also provide opportunity for advocacy and linkages with other individuals and families living with sickle cell disease. Transition Navigators at Hemoglobinopathy Specialty Care Centers engage youth with sickle cell disease to promote and support the transition from pediatric to adult care providers, ensure compliance with appointments and medication, self-management, and preventive health care including non-medical mechanisms for pain management and understand what barriers youth experience in caring for themselves.

The Sickle Cell Disease contractors utilize Got Transition® which is a federally funded national resource center on health care transition.

The three Hemoglobinopathy Specialty Care Centers regularly share information through their quarterly reports about program activities and performance measures. The three Sickle Cell Disease contractors report an increase in the number of clients who were compliant in keeping appointments, medication adherence, self-management, and preventive health care including non-medical mechanisms for pain management. Appointment reminders, flexibility in scheduling, availability of transition navigators, home visits and tele-health visits have positively impacted compliance. In addition, virtual support groups and webinars resulted in greater attendance and an increase in interactions among participants.

During this reporting period, additional funding was awarded through legislative appropriations to Sickle Cell Disease organizations and Hemoglobinopathy Specialty Care Centers with existing state funding. Title V staff engaged with the Office of Health Insurance Programs (i.e., the state's Medicaid program), on a Medicaid Redesign Team for sickle cell disease outcomes, which includes community partners, clinicians, and experts in sickle cell disease. The team generated a list of recommendations for Medicaid to reduce costs and hospitalizations for patients with sickle cell disease. Based on the recommendations of the committee, the Centers for Medicare and Medicaid Services (CMS) State Plan Amendment (SPA) #21-0026, was approved and includes sickle cell disease as a single qualifying condition for Health Homes Serving Adults

and Health Homes Serving Children, effective March 24, 2022. NYS Medicaid has established the Sickle Cell Disease Health Home Managed Care Organization Subcommittee with intention of following the Medicaid State Plan Amendment progress as well as to plan and troubleshoot implementation. The subcommittee's activities also include the development of informational materials, promotion of Health Homes, and identification of capacity issues. Title V staff serve on the subcommittee.

On October 17, 2022, the Bureau of Child Health, Community-Based Health Unit staff as well as Newborn Screening Center at Wadsworth Center staff, met with Mark Goodwin, Project Director of the Sickle Cell/Thalassemia Patients Network (SCTPN) to learn about the work they are doing in New York State which includes a Health Resources and Service Administration (HRSA) grant that supports community education/awareness events. The Bureau of Child Health staff and Central and Western Regional Office staff met with the Sickle Cell/Thalassemia Patients Network on 11/7/2022 to discuss additional opportunities for community collaboration.

The Title V CYSHCN Director/Bureau of Child Health Director, Suzanne Swan, presented to the New York State Health Equity Council about New York State Department of Health sickle cell disease programs along with Wadsworth Center staff on 3/24/2023.

On September 19, 2023, Sickle Cell Disease contractors hosted a Sickle Cell Disease Grand Rounds for physicians, nurses, social workers, other health care professionals, and community-based organizations. Updates about curative treatments for sickle cell disease including bone marrow transplant, gene therapy, as well as updates on transfusion issues in sickle cell disease were discussed. Sickle Cell Disease Contractors participated in a walkathon organized by the Sickle Cell/Thalassemia Patients Network on September 16, 2023, to raise awareness and education about sickle cell disease.

Information about the new advancements in sickle cell disease research and updated 2023 transition coding and corresponding Medicare fees and relative value units (RVUs) were shared with contractors in September 2023.

A Request for Application for Sickle Cell Disease Adolescent Transition Services was released on 10/06/2022, with an anticipated start date of 10/01/2023. Five applicants were awarded for a five-year contract term from 10/01/2023 to 09/30/2028. An orientation was developed and planned for October 2023.

CYSHCN-1.8: Collaborate with other Title V and Division of Family Health adolescent-serving programs, including School-Based Health Centers, Comprehensive Adolescent Pregnancy Prevention, and ACT for Youth Center for Community Action to identify additional opportunities to meaningfully engage adolescents in program and policy development that impacts CYSCHN (CYSHCN).

The NYSDOH staff actively collaborate with other Title V and Division of Family Health adolescent serving programs. We also expanded our Title V CYSHCN Domain Team to include staff from the NYSDOH Asthma Prevention Program and Regional Office staff. Staff disseminated program resources through each other's list serves routinely. Examples include, the Title V staff shared information about the New York State Department of Health Disability and Health Program's free physical activity and nutrition program toolkit for clients with intellectual and developmental disabilities, and NYSDOH provider trainings about Accessible Care and Effective Communication. On 9/18/23 CYSHCN staff attended the Asthma Guidance Team meeting and learned about their new program activities and dashboard.

The Title V staff attended "What's Great in Our State" and collaborated with internal and external partners. On May 4, 2023, the Office of the Medical Director presented at the annual *Leadership Education in Neurodevelopmental and related Disabilities* meeting, Westchester Institute for Human Development learning poster session which was hosted virtually. The purpose of the poster session was to have the *Leadership Education in Neurodevelopmental and related Disabilities* trainees meet with Title V program directors, staff, and other state agencies to share about their team research projects related to CYSCHN and their families. Staff participate monthly in the Sickle Cell Disease Health Home Managed Care Organization subcommittee meetings led by the Office of Health Insurance Programs to provide insight and feedback on

children and young adults with sickle cell disease. The Title V CYSCHN Director serves on the NYS Council on Developmental Disabilities, the Individuals and Families Committee, and a Transitions Subcommittee to promote inclusion of CYSCHN-specific focus to the Council's agenda and policy portfolio. The NYS Council on Developmental Disabilities membership includes state agency representation, non-profit leadership, and parents of CYSCHN from around NYS who are directly involved in decision-making regarding funding opportunities and policy development.

CYSHCN-1.9: Engage a youth representative in work with the Office of Health Insurance Programs/Medicaid Program on the Medicaid Redesign Team II work group regarding best practices for transition care.

This work as reported in the prior reporting period culminated in the inclusion of sickle cell disease as a single qualifying condition for eligibility for the NYS Medicaid Health Homes Serving Children and Health Homes Serving Adults, which provide comprehensive care management services. The Title V program includes leadership and youth from the state's three Sickle Cell Disease contractors in this work.

In this reporting period, Title V staff presented to NYS Sickle Cell Advisory Committee on the Sickle Cell Disease program, the Office of Health Insurance Program's Medicaid Redesign Team II Work Group and the work being done related to the addition of sickle cell disease as a single qualifying condition for Medicaid Health Homes.

CYSHCN-1.10: Serve on the NYS Council on Developmental Disabilities and Committees to promote inclusion of CYSCHN-specific focus to the Council's agenda and policy portfolio.

The Title V CYSCHN Director represents the CYSCHN program ongoing at the quarterly NYS Council on Developmental Disabilities, the Individuals and Families Committee, and a Transitions Subcommittee to promote the inclusion of CYSCHN specific focus for the Council's agenda and policy portfolio.

Strategy CYSHCN-2: Enhance care coordination, including transition support services, for CYSCHN.

The Institute of Medicine identified care coordination as a key strategy to improve the effectiveness, safety, and efficiency of the U.S. health care system, improving outcomes for patients, providers, and payers. The 2020-2021 National Survey of Children's Health data for NYS show that about 72.2% of all children, and 62.5% of CYSCHN age birth to 17 years who needed care coordination services received effective services. Preparing for and supporting the transition from youth to adulthood is especially important for CYSCHN and their families. Only 11.8% of youth ages 12-17 with special health care needs received services necessary to make transitions to adult health care, highlighting the need for more specific attention to program and systems improvements in this area. Within this overall measure, there is variation in individual components of transition services. About 53.2% of Adolescents with Special Health Care Needs had a chance to speak to their health care provider alone at their last preventive check-up. While 75.0% of adolescents with Special Health Care Needs reported that their health care provider actively worked with them to gain skills to manage their health, health care, and understand changes in health care happening around age 18, only 20.7% reported that their doctors discussed the shift to a provider who treats adults, if needed.

Title V staff identified supports to help youth and families coordinate care, including a specific focus on transition services, to improve efficiency, quality, health outcomes and patient satisfaction. CYSCHN often require specialty medical services across multiple providers and service settings and may experience multiple transitions as they develop and "age out" of specific programs or services, move across service and community settings, and become more independent growing from children to youth to adults. Care coordination services and more informal transition supports can be critical for CYSCHN and their families to manage their health and family needs during key periods of change and over time.

The Title V Program led the following specific program and policy activities to advance this strategy during this reporting period:

CYSHCN-2.1: Provide funding and program guidance to Local Health Department CYSCHN programs to work with medical providers, childcare providers, and local school systems to improve communications between service providers to assist families with the referral process and support the transition of CYSCHN from pediatric to adult health care.

The following support and guidance were provided:

- For the CYSCHN database that was created in the Health Commerce System, there remains biweekly meetings to discuss the details of the tool the Local Health Department staff utilize to collect information about their encounters with CYSCHN and their families.
- Staff from the Office of Children and Family Services (OCFS) joined the Division of Family Health to provide an overview of the Help, Empower, Advocate, Reassure and Support (HEARS) Family Line. The Division learned more about this resource and discussed future collaborations. The Help, Empower, Advocate, Reassure and Support Family Line provides resources and referrals on a variety of services. Trained representatives assist families and parents in finding services related to childcare, parenting education, health care, behavioral health, food, clothing, and housing. https://ocfs.ny.gov/programs/cwcs/hears.php
- On April 20, 2023, the CYSCHN staff met with the Early Intervention staff to discuss children transitioning out of Early Intervention to Committee on Preschool Special Education and Committee on Special Education.
- On October 6, 2022, the CYSCHN (CYSHCN) program hosted a local health department contractor webinar: Enhanced CYSCHN funding, Program Overview, and Best Practices. Staff spoke with the counties and learned about their best practices and innovative ideas to reach CYSCHN and their families.
- In follow up to the 10/6/22 webinar, on 11/27/2022, a follow up email was sent to the Local Health Departments on CYSCHN enhanced funding.
- On October 18, 2022, program sent out basic program orientation to the Local Health Departments.
- On October 20, 2022, the Health Information Document was approved to be printed in French and Urdu.
- On November 14, 2022, the CYSCHN staff attended a training on Bright Futures. The purpose of this meeting was to provide an overview of Bright Futures (BF). Promoting the use of the Bright Futures model for anticipatory guidance in School Based Health Centers and seeking opportunities to engage the American Academy of Pediatrics (AAP) for assistance to promote this resource is one of the tasks on the Child Health Domain workplan. Dr. Rachel de Long, a professor from the local School of Public Health, provided an overview to further our understanding of Bright Futures.
- Staff from the Help, Empower, Advocate, Reassure and Support Family Line presented to the Local Health Departments on 11/30/22.
- On December 9, 2022, New York State had a Developmental Screening Virtual Convening. This convening was hosted by the Council on Children and Families on the virtual platform Airmeet. CYSCHN staff and Local Health Departments attended and were sent the information.
- Training was provided by the CYSCHN data team on 12/20/22 on the CYSCHN entry form for the Health Commerce System Person Electronic Response Data (Person Electronic Response Data System).
- On 2/28/23 and 3/6/23, conversations were had with Office of Temporary and Disability Assistance Title XVI staff and CYSCHN staff regarding referral requirements.
- Quarterly CYSCHN program conference call/webinar with Local Health Departments, Regional Support Centers, Regional Office, and Central Office staff were held on 3/2/2023, 6/1/2023 and 9/12/2023. Agenda topics include updates, upcoming events and meetings, available resources, quarterly reports, reporting requirements and tips, and open discussions.
- On May 2nd and 3rd, 2023, the first annual statewide contractor meeting was held for the Early Intervention and CYSCHN Programs and was facilitated by the New York State Association of County Health Officials. DOH staff presented on the Back to Basics, and had group discussions on outreach and engagement, partnerships, transitions, and resources. Many resources were provided, including a presentation from the Conference of Local Mental Hygiene Directors.
- On May 24, 2023, the CYSCHN Program met with the Regional Office staff to continue our conversations and support to the Local Health Departments. NYSDOH Regional Office staff provide additional technical assistance, support, and reinforce the Regional Support Center work. They also share additional linkages and collaborations available to CYSCHN (i.e., Regional Interagency Technical Assistance Team under Office of Mental Health Council for Children and Families). These meetings continue to be held on a quarterly basis.
- On May 25, 2023, CYSHCN staff attended the Pyramid Model Leadership Team Meeting.
- On June 22 and June 28, 2023, DOH staff held a virtual orientation for new Local Health Department CYSCHN staff.
- On August 15, 2023, a DOH student intern presented to the CYSCHN program on her finding on CYSCHN health equity.
- On the 9/12/23 quarterly call, New York Connects presented to the Local Health Departments on the resources that they have.
- Our Community-Based Unit staff met with the Brain Injury Association of New York State on 9/20/23 to learn about

the resources that they have.
- DOH staff continue to provide quarterly technical assistance to the Local Health Departments and check in about engagement of medical providers, schools, and childcare providers. Program will also keep track of referrals being made by the Local Health Departments.

The Local Health Department CYSCHN programs were notified September 14, 2022, that effective October 1, 2022, additional funding in the amount of $3.2 million dollars for a total of $5.2 million dollars will be provided to Local Health Department CYSCHN programs. The enhanced funding will support additional staff time dedicated to the program and related administrative responsibilities, as well as related non-personal services such as travel, space, and operating expenses. Currently, 51 out of 58 Local Health Departments implement the CYSCHN program in their counties.

CYSHCN-2.2: Continue to support three University Centers for Excellence in Developmental Disabilities, or Regional Support Centers, to support youth, families, and Local Health Department CYSCHN programs. Regional Support Centers will identify resources and develop a comprehensive resource guide for Local Health Departments and families; provide technical assistance to Local Health Departments; conduct family engagement opportunities; identify webinars or professional development for Local Health Departments; develop training and education materials; facilitate communication among Local Health Departments; and identify barriers, unmet needs, and opportunities for CYSCHN and their families. As described in the previous strategy, families and youth are deeply involved in guiding this work.

- Email distribution list was created by the Regional Support Centers so information could be distributed to the Local Health Departments.
- *CYSCHN Clips* email newsletter was restarted by the Regional Support Centers on 10/14/2022.
- The Regional Support Centers work with each Local Health Department on a quarterly basis to develop a family engagement plan.
- It is noteworthy that Dr. Kuo, co-author of the Blueprint for Change, is now part of the University of Rochester Regional Support Center team and had offered to provide guidance and input on projects moving forward.
- The Department hosted a virtual meeting with the three Regional Support Center staff on December 12, 2022, to discuss program activities for the new grant year.
- Transition Timelines (reference document for CYSHCN transitioning from toddler through adult) was developed by the Regional Support Centers and approved 12-19-22.
- The Westchester Institute for Human Development staff presented– “Families Influencing Change! Promoting Health Equity for CYSCHN through Family Engagement" at Association of Maternal and Child Health Programs conference May 2023.
- The Regional Support Centers created the Conditions Guide (reference document with 27 conditions and resources, intended for use by Local Health Departments) and was approved 10/11/22.
- The Regional Support Centers created three social media templates which were approved 10/28/22.
- The Regional Support Centers developed a CYSCHN Project Portal to be used by the Regional Support Centers and Local Health Departments as a place to find resources, interact with other Local Health Departments and Regional Support Centers staff, and keep up to date with announcements and meetings.
- On 2/28/2023 “The Effects of the new American Academy of Pediatrics Obesity Guidelines on the Pediatric Population with Special Health Care Needs” webinar was offered to the Local Health Departments.

- May 3, 2023, Regional Support Centers staff presented about program resources in-person at the New York State Association of County Health Officials hosted Early Intervention/CYSCHN conference.

CYSHCN-2.3: In collaboration with the Regional Support Centers, facilitate professional development and information sharing between Local Health Department programs related to transition, including a webinar on Got Transition®'s Six Core Elements(TM).

The Regional Support Centers presented a webinar Planning for Transition to Adulthood which included two parents sharing

their experience with the transition process and their children with additional needs on 12/16/22.

The Transition Timeline guide was approved 12/19/22 and shared with the CYSCHN staff.

CYSHCN-2.4: Administer CYSCHN Support Services, a gap-filling supplemental program that provides reimbursement for specialty health care services for severe chronic illness or physically handicapping conditions in children who meet county financial and medical eligibility criteria.

While (95.4%) of NYS's children are insured according to the 2022 National Survey of Children's Health data, families continue to experience financial challenges meeting the needs of their CYSCHN. The Title V Program provides funding for direct services through the CYSCHN Support Services. In 2023, 0 children received an evaluation and 58 received treatment services funded through CYSCHN Support Services. Services included were durable medical equipment (21%), medical/surgical (20%), orthodontia services (18%), medications (17%) and enteral formula and specialty foods (9%). enteral formula and specialty foods (16%), medications (16%), medical surgical (12%) and physician office (8%). The racial distribution for these CYSCHN are 59 White and for ethnicity there were 1 Hispanic, 5 Other and 12 Unknown.

CYSHCN-2.5: Provide grant funding, evidence-based strategies (Got Transition®) and technical assistance to Hemoglobinopathy Specialty Care Centers to support successful transition to adult services for young adults with sickle cell disease, including but not limited to transition policy, tracking and monitoring, transition readiness and planning, transfer of care, and transition feedback and completion.

See *CYSHCN Activity-1.7* above for details about activities. State funding is allocated to three Sickle Cell Disease contractors at Hemoglobinopathy Specialty Care Centers. The Sickle Cell Disease contractors utilize Got Transition® which is a federally funded national resource center on health care transition.

CYSHCN-2.6: Support care coordinators at Hemoglobinopathy Specialty Care Centers to help patients with sickle cell disease with appointments, scheduling, education, peer support and other health care transition services.

These providers serve as "transition navigators," to assist the adolescent make a successful transition to an adult hematologist or other adult medical care provider. They also focus on providing these adolescents with the skills they need to successfully transition to adult care as evidenced by evaluation of readiness and follow-up post transition for satisfaction with care.

NYSDOH staff updated the quarterly reports and held a call with the three grantees to review the reporting tool and year data summary. The Coordinating Care and Supporting Transition for Children/Adolescents and Young Adults with Sickle Cell Disease contractors were provided a no cost extension for the period 07/01/23 to 09/30/2023 to cover the gap in services and ensure continuum of care until the new contract period began 10/01/2023.

An orientation session for the five new Sickle Cell Disease Adolescent Transition Services Program grantees is planned for October 2023.

CYSHCN-2.7: Facilitate collaboration between Title V programs serving youth, including School- Based Health Center and Comprehensive Adolescent Pregnancy Prevention programs, to inclusively address broader health needs of CYSCHN including social emotional health, oral health, healthy relationships, and sexual reproductive health.

DOH staff are developing a list of Adolescent Health Unit programs located at sites with School-Based Health Centers. Adolescent health programs, which include Comprehensive Adolescent Pregnancy Prevention program, Personal Responsibility Education Program, and the Sexual Risk Avoidance Education program, were surveyed to identify sites that overlap with School-Based Health Center programs. The survey results were combined with the list of School-Based Health Centers to develop a comprehensive list.

The Comprehensive Adolescent Pregnancy Prevention contracts were awarded in July of 2023 and included a component which provide youth-led, multi-dimensional (educational, social, vocational, economic, and recreational) opportunities for adolescents to provide alternatives to sexual activity and to develop skills that can support a successful transition into healthy young adulthood and are fully inclusive of CYSHCN.

CYSHCN-2.8: Provide subject matter and technical support to New York State Medicaid Program to implement enhanced care coordination and transition support services for CYSCHN through Medicaid's Health Homes Serving Children, including integration of eligible children also receiving services through the Early Intervention Program, referral of CYSCHN to Health Homes, and transition from Health Homes Serving Children to Health Homes Serving Adults.

NYSDOH staff participate in Health Homes site visits. A review of agencies' policies and procedures is conducted the week prior to the virtual site visit. CYSCHN staff provide technical support in reviewing the policy and procedures of each of the Health Homes. Staff has provided subject matter and technical support on enhanced care coordination and transition (i.e., transition, language) support during the review of the records during the site visit. The following site visit took place in September 2023: Collaborative for Children and Families.

Enrollment data is for the time of 10/1/2022-9/30/2023: the number of children enrolled in Health Home Serving Children for this time period is reported to be 50,487 unique members, an increase from the 49,945 children enrolled in Health Homes Serving Children for the previous year.

Strategy CYSHCN-3: Support comprehensive public health efforts to prevent, identify, and manage childhood lead poisoning.

Studies show that no amount of lead exposure is safe for children. Even low levels of lead in blood have been shown to affect a variety of adverse health effects including reduced growth indicators; delayed puberty; lowered Intelligence Quotient; and hyperactivity, attention, behavior, and learning problems. Children under six years old are more likely to be exposed to lead than any other age group, as their normal behaviors result in them breathing in or swallowing dust from old lead paint that gets on floors, windowsills, and hands, and can be found in soil, toys, and other consumer products. NY has more pre-1950 housing containing lead paint than any other state in the nation, with approximately 43% of all of NY's dwellings containing lead-based paint.

Effective October 2019, NYS Public Health Law (§1370) and regulations (Part 67 of Title 10 of the NY Codes, Rules, and Regulations) were amended to lower the definition of an elevated blood lead level in a child to 5 micrograms per deciliter (µg/dL), from the previous level of 10 µg/dL. Health care providers in NYS are required to assess or test all young children in accordance with public health regulations, to confirm and report test results, and to ensure appropriate follow-up evaluation and management as needed. Local Health Departments are required to ensure follow up including environmental management based on the child's blood lead level. The Title V Program supports supplemental grants for lead poisoning prevention programs in Local Health Departments, as well as Regional Lead Resource Centers based in academic medical centers to provide outreach and education to health care provider and families, technical assistance, individual case consultation and treatment of childhood lead poisoning. These programs are administered by the Center for Environmental Health. These Title V-funded program elements complement other components of the state's comprehensive public health approach that also includes laboratory testing and reporting, surveillance, outreach and education, and neighborhood-based primary prevention and healthy housing initiatives.

The Title V Program led the following specific program and policy activities to advance this strategy over the 2022-23 year:

CYSHCN-3.1: Provide continued grant funding to Local Health Department Lead Poisoning Prevention Programs and a statewide network of Regional Lead Resource Centers to support enhanced regional and local efforts to reduce the

prevalence of elevated blood lead levels in children birth to 18 years.

All 58 NYS counties are offered grant funding, and 56 accepted funding. The three approved Regional Lead Resource Centers are as follows: Kaleida Health/Oishei Children's Hospital sub-contracted with University of Rochester Medical Center (Western Region), the State University of New York (SUNY) Upstate Medical University sub-contracted with Albany Medical Center (Central/Eastern Region), and the Children's Hospital at Montefiore (Metro/Hudson Valley Region).

CYSHCN-3.2: Work with Lead Poisoning Prevention Programs, Regional Lead Resource Centers, and other partners to ensure that all blood lead test results, including testing done in permitted/registered laboratories and point of service testing conducted in health care provider offices, are reported within the timeframes required.

Staff worked with Lead Poisoning Prevention Programs, Regional Lead Resource Centers, and other partners to ensure that all blood lead test results, including testing done in permitted/registered laboratories and point of service testing conducted in health care provider offices, are reported within the timeframes required.

All Regional Lead Resource Centers perform on-site and virtual education sessions with practice manager staff to ensure laboratories and health care provider offices are reporting all blood lead results analyzed by point of care devices. Email correspondence is used regularly for follow-up to ensure completion of enrollment process for reporting blood lead level results to the Lead Poisoning Prevention Programs.

CYSHCN-3.3: Through the Regional Lead Resource Centers, support the provision of outreach and education to health care provider and families, technical assistance to providers and Local Health Department programs, individual case consultation, and treatment of lead poisoning among children, pregnant women, and newborns, including chelation treatment where indicated.

During educational sessions, guidelines and regulations are discussed to confirm understanding of reporting expectations and what the data reported is used for by Local Health Departments.

Regional Lead Resource Centers connected labs to Lead Poisoning Prevention Programs to enroll for reporting. Local Health Departments reach out with lab issues to Lead Poisoning Prevention Programs. The Regional Lead Resource Centers supported the provision of outreach and education to health care provider and families, technical assistance to providers and Local Health Department programs, individual case consultation, and treatment of lead poisoning among children, pregnant women, and newborns, including chelation treatment where indicated. The three Regional Lead Resource Centers provided outreach and education to over 525 physicians during the 2022-2023 program year, technical assistance to providers and Local Health Department programs, individual case consultation and treatment of lead poisoning was conducted over 974 times, and chelation treatment was performed 71 times.

CYSHCN-3.4: Through the Local Health Department Lead Poisoning Prevention Programs and Regional Lead Resource Centers, promote clinical prevention and screening practices in accordance with state requirements.

The Local Health Department Lead Poisoning Prevention Programs and Regional Lead Resource Centers promoted clinical prevention and screening practices in accordance with state requirements, including:

- Routine blood lead testing for all children at age one year and again at age two years.
- Assessment of all children ages six months to six years at every well visit for risk of lead exposure, with blood lead testing as indicated by risk assessment.
- Provision of anticipatory guidance for all families about lead poisoning prevention as part of routine care.

CYSHCN-3.5: Through the Local Health Department Lead Poisoning Prevention Programs and Regional Lead Resource Centers, ensure that all children with elevated blood lead levels received appropriate evaluation and management.

The Local Health Department Lead Poisoning Prevention Programs and Regional Lead Resource Centers ensured that all children with elevated blood lead levels received appropriate evaluation and management, including:

- Confirmatory venous blood lead testing for capillary screening results > 5 µg/dL.
- A complete diagnostic evaluation that includes a detailed lead exposure assessment, nutritional assessment, and developmental screening.
- Medical treatment, as needed.
- Referral to the appropriate Local Health Department for environmental management.

CYSHCN-3.6: Through the Regional Lead Resource Centers, increase capacity and sustainability in local health care and public health systems by engaging health care providers and professional medical groups in leadership roles within regional or community coalitions focused on the prevention and elimination of lead poisoning.

During the 2022-2023 program year, the three Regional Lead Resource Centers participated in over 200 regional and community-based lead poisoning prevention coalition meetings. A NYS Lead Advisory Council meeting was held on May 2, 2023. Various topics were discussed including Childhood Lead Poisoning Prevention Program update, Housing Hygiene Program overview, new guidelines release, draft Bylaw overview, Rental Registry proposal and plan goal.

Strategy CYSHCN-4: Apply public health surveillance and data analysis findings to improve services and systems related to health and health care for CYSCHN.

NYSDOH continue to assess all available data sources to inform public health improvement strategies related to CYSCHN. A recently drafted summary document titled “New York State Profile of CYSCHN, 2020-2021", updated annually, may serve as one starting point for additional work in this area. This report explores the demographic, health, and functional difficulty profile of the New York State CYSCHN population, determines the impact that having special health care needs has on children and families, and identifies areas in most need of improvement to ensure New York State CYSCHN receive care in a well-functioning system. This report uses National Survey of Children’s Health data. As additional data become available, DOH staff will update this report, make it available through the New York State Department of Health Department of Health public website, and share it with CYSCHN contractors, partner organizations like Parent to Parent and the New York State Association of County Health Officials.

The Title V Program led the following specific program and policy activities to advance this strategy during the 2022-23 year:

CYSHCN-4.1: Complete a careful analysis of the revised National Survey of Children’s Health when available to assess available measures, trends, and other updates related to CYSCHN in New York State.

NYSDOH staff completed a careful analysis of the updated National Survey of Children’s Health to assess available measures, trends, and other updates related to CYSCHN in NYS. Based on the 2020-2021 NYS Profile of Children with Special Health Care Needs report, key findings included that 42.7% of CYSCHN live in households with income below 200% of the federal poverty level. About 11.5% of CYSCHN have their daily activities greatly affected by their health condition(s); 10.1% of CYSCHN ages 6-17 missed 11 or more school days in a year, compared to 1.8% of NYS children without Special Health Care Needs; and nearly half (45.3%) of CYSCHN ages 6-17 had trouble making or keeping friends. Families of CYSCHN report higher out-of-pocket medical expenses, have trouble paying medical bills, spend more time coordinating their child’s health care, and report reducing or stopping work due to their child’s health. In 2020–2021, the five key components indicating a child meets medical home criteria showed only 39.6% of care met the criteria, compared to 48.5% of children without Special Health Care Needs.

CYSHCN-4.2: Collaborate with the U.S. Census Bureau to conduct an over-sample of NYS 2022 National Survey of Children’s Health for NYS to allow for enhanced sampling of Black/African American, Hispanic, including CYSCHN.

Title V staff collaborated with the U.S. Census Bureau to conduct an over-sample of NYS 2022 National Survey of Children's Health for NYS to allow for enhanced sampling of Black/African American, Hispanic, and CYSCHN populations. The sampling plan was being implemented and survey was completed. Title V staff completed the NY's amendment for the Sub-State Analysis of National Survey of Children's Health Oversamples for State and Local Public Health Planning & Assessment project to access oversample data. The project amendment was approved by the U.S. Census Bureau on March 23, 2023. After the approval, four Title V staff were identified for Special Sworn Status application. The project will be continued to the following reporting year.

CYSHCN-4.3: Analyze and report on available CYSCHN data for NYS, including data from the National Survey of Children's Health, share reports with Local Health Departments and other stakeholders, and post on the Department's public website.

Title V staff analyzed and reported on available CYSCHN data for NYS, including data from the National Survey of Children's Health, share reports with Local Health Departments and other stakeholders, and post on the Department's public website. 2020-2021 NYS Profile of Children with Special Health Care Needs report is posted here: https://www.health.ny.gov/community/special_needs/docs/cshcn_profile_2020-21.pdf.

CYSHCN-4.4: Develop and implement plans for updating the current data reporting methods (quarterly and annual reports) of Local Health Department CYSCHN programs and Sickle Cell Disease care transition programs. Analyze and share relevant data collected from programs to improve services and inform larger program and policy work related to CYSCHN.

NYSDOH staff developed and implemented plans for updating the current data reporting methods (quarterly and annual reports) of Local Health Department CYSCHN. Staff analyzed and shared relevant data collected from programs to improve services and inform larger program and policy work related to CYSCHN.

New York State Department of Health CYSCHN program continues to collect data from Local Health Departments. A new data collection system went live on the Department's Health Commerce System on October 1, 2021. All NYSDOH CYSCHN staff received training on the Health Commerce System. A data submission guide and training materials for the Local Health Departments were written and updated as needed. The NYSDOH staff did a data submission training on 11/8/22 which was offered to the Local Health Departments on quarterly narrative report submission through the Health Commerce System. The Person Electronic Response Data System (PERDS) data submission guide, webinar, and blank entry form were sent to Local Health Department staff. A training on the data system was provided to Local Health Department staff on 11/22/22. Also, a modified CYSCHN survey for the Local Health Departments on Person Electronic Response Data System rolled out in December 2022. NYSDOH CYSCHN program hosted a webinar 12/202/2022 with the Local Health Department to demonstrate the new Health Electronic Response Data System.

CYSCHN Quick Reference Guide was developed by the NYSDOH data team and was sent to the Local Health Department on 3/9/23. CYSCHN Health Commerce System Frequently Asked Questions on Health Electronic Response Data System and Person Electronic Response Data System was updated and sent to the Local Health Department on 6/6/23.

CYSCHN program staff and data team staff conducted one-on-one trainings with Local Health Departments to answer questions and review the data collection survey. Staff used the data gathered from the CYSCHN programs to identify specific areas for further improvement and to inform improvement activities.

An analysis of the Local Health Department CYSCHN data for 2021-2022 program data demonstrated that of the 1,224 children served, 45.29% had Medicaid, 25.19% had commercial insurance, 6.76% had Child Health Plus insurance, 22.45% had other insurance, and 5.24% had no insurance reported. Additionally, 5.97% of children had Supplemental Security Income (SSI). Fifty-four percent of CYSCHN served were White, 9.33% African American, 3.19% Asian or Pacific Islander, 0.49% American Indian or Alaska Native, 5.4% more than one race, 0.98% other race, and 26.92% unknown race; 14.48% of children were Hispanic. The percent of children reported to have a primary care provider was only 78.40%, which is a drop from the 99.29 % in 2020-2021 data. The drop is likely caused by the transition of the data reporting system since

20.79% children reported no responses or unknown to the question about having a primary care provider or not. Follow up with counties was conducted to learn more. A required data field for type of financial assistance needed by families for aspects of care was added. Among those who responded need assistance (n=82, 6.71 %), 48.85% needed assistance for a service not covered by insurance, 24.14% for a service exceeding the limit of the benefit package, 13.79% needed help with co-pays, 8.62% for deductible costs, and 4.6% for premium costs. In addition, information about referrals from the state's Early Intervention Program was included. Approximately 27.37% of CYSCHN were referred by Early Intervention Program which is drop from last year (36.33 %). There were four children referred to Health Homes in 2021-2022, compared to 12 children the year before.

The annual CYSCHN data that is collected from all the Local Health Departments was compiled and corrected for errors. A webinar was held September 21, 2022, to report to local health departments on the statewide CYSCHN findings. An individual county data report was sent to each county and the webinar included guidance on how to read the individual report. The report serves as a program quality improvement tool as well. The CYSCHN data profile report included allocated funds, funds spent, the estimated number of CYSCHN percent and actual number of children served. In this webinar, staff also reminded Local Health Departments that sickle cell disease is approved as a single qualifying condition for Health Home eligibility. Lastly, the Regional Support Centers gave an update on their work and family sessions.

Strategy CYSHCN-5: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact the health and well-being of CYSCHN.

As noted in other domains, maternal and child health outcomes are impacted by the social determinants of health, or the conditions in which people are born, live, work, play, learn, and age. The social determinants of health, also referred to as health-related social needs, include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of power and resources due to racism and other biases are root causes of inequities in access, availability of services, and quality of care. All ten priorities that emerged from community members' input during the Needs Assessment revolve around the social determinants of health and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities.

Many NYS families of CYSCHN are struggling with poverty, transportation, access to care (including availability of specialists), and sometimes employment, as many caregivers reported having to decrease hours worked or leaving jobs altogether to care for their children and/or coordinate care. Families facing day-to-day challenges like these may be less able to seek and use programs, or to take advantage of opportunities to provide feedback to Local Health Departments or Regional Support Centers. Regional Support Centers and Local Health Departments need to meet people where they are, provide multiple methods and means for CYSCHN and their families to engage, and ensure that a diverse population is being assisted and retained by Local Health Departments.

The Title V Program led the following specific program and policy activities to advance this strategy over the 2022-23 year:

CYSHCN-5.1: Support local CYSCHN programs based in Local Health Departments, with 52 counties beginning October 1, 2022.

Support local CYSCHN programs based in Local Health Departments, in the amount of $5.2 million dollars annually. The funding will support 52 Local Health Departments state-wide, including NYC, for staff time as well as non-personal service expenses to implement the CYSCHN program during the 10/01/2022 to 09/30/2023 contract year.

The Program has been focused on professional development and strengthening strategic partnerships at the state level and in local communities to ensure a safety net of resources to support CYSCHN and their families. To strengthen the workforce, the Program provides professional development, training and technical assistance for the local health department CYSCHN staff. Professional development for contractors included quarterly webinars; a state-wide contractor

meeting for Early Intervention/CYSCHN staff on May 2-3, 2023; Program orientation for new staff and refresher for current staff June 28, 2023; and on-going technical assistance that is provided by Program Managers, fiscal Contract Managers, the Data team, and the Regional Support Centers by phone and webinar. The Title V CYSHCN team strengthened collaborative efforts with strategic partners at the state level and disseminated resources to local health department staff through webinars and e-mail. For example, webinars were provided by NY Connects (September 2023), the Office of Children and Family Services HEARS Family Line staff, and information was shared about the NYS Regional Centers for Autism Spectrum Disorders (September 2023). We also hosted four regional meetings to solicit feedback from the local health department staff about their identified successes and challenges related to Program activities.

CYSHCN-5.2: Work with the Regional Support Centers and Local Health Department CYSCHN programs to integrate health equity into written materials, communication, outreach, and referrals for CYSCHN and families, all of which will reflect the ethnicity and diversity of the community, including engagement strategies. Health literacy will be supported by providing information in multiple languages, at appropriate reading levels and abilities, as available.

The Program staff worked with the Regional Support Center staff and Local Health Department CYSCHN (CYSHCN) programs state-wide, including NYC, to ensure that health equity is integrated into written materials, communication, outreach, referrals, and engagement strategies and reflects the diversity of the community. Health literacy was supported by encouraging counties to provide information in multiple languages, at appropriate reading levels and abilities.

The Health Information Document, that was developed by NYSDOH CYSHCN staff, is a pre-folded pocket card resource for CYSCHN to help communicate vital life-saving information during an emergency, medical appointment, school setting, etc. and provides an emergency contact. It is posted on our public facing website in twelve languages. Notable for this reporting period is that it was translated into Urdu and French.

On June 29, 2022, Bureau of Child Health Director and Assistant Director joined the inter-departmental Adverse Childhood Experiences (ACEs) workgroup and have continued as active participants on the workgroup. This group discussion includes the high incidence of Adverse Childhood Experiences among CYSCHN.

The Community-Based Health Unit employed a summer intern (6 credit hours) from the University at Albany School of Public to complete a health equity improvement project with the CYSCHN Program. The Community-Based Health Unit Manager mentored the intern throughout the project. The project included a thematic analysis of quarterly narrative reports with a focus on health equity for the CYSCHN program for fiscal year 2021-2022. The project also included key informant interviews with local health department staff. The goal of the project was to identify best practices to share with contractors as well as program recommendations for program assurance and program improvement. The intern presented her findings to the Community-Based Health Unit.

The Bureau of Child Health leadership staff along with Wadsworth Center Newborn Screen staff presented to the Health Equity Council on March 24, 2023, about Department's activities related to sickle cell disease. Activities include promoting health equity, the newborn screening program for hemoglobinopathies, the initiative to improve the rate of transition from pediatric care to adult/self-care in children with sickle cell disease, partnerships with community-based organizations, and sickle cell disease as a single qualifying condition for Medicaid Health Homes. In addition, the Bureau leadership has further developed strategic partnerships with community-based organizations who serve people with sickle cell disease.

The Regional Support Centers provide on-going training and technical assistance for local health department staff to develop family engagement plans which includes written materials, communication, outreach and referrals for CYSHCN and their families.

CYSHCN-5.3: Develop and implement data collection systems that allows Local Health Department CYSCHN programs and Sickle Cell Disease care transition grantees to identify, track, and address disparities.

Program information is collected from Bureau of Child Health contractors quarterly in narrative and data report templates. The CYSCHN program narrative report was modified, and local health department staff were required to submit their report in the Health Electronic Response Data System (HERDS) application in the Health Commerce System (HCS). The

CYSCHN data collection tool in the Person-based Electronic Response Data System (PERDS) application in the Health Commerce System was initially rolled out October 1, 2021. Based on feedback from local health department staff, the data collection tool was modified to improve the reporting response rate and rolled out December 2022. The HERDS and PERDS data systems on the Health Commerce System are a secure online system supporting the exchange of health information by Local Health Department CYSCHN program staff. State program managers and Local Health Department CYSCHN program staff can access data in a timely manner to identify, track, and address disparities among CYSCHN. Orientation for new staff and on-going training and technical assistance is provided to Local Health Department staff when needed. Program Managers review the data quarterly to assure program quality and opportunities for program improvement.

A quarterly reporting tool is utilized by the Sickle Cell Disease grantees for contract reporting. The quarterly narrative and data report is reviewed by the Program Managers to assure program quality as well as to identify opportunities for program improvement.

CYSHCN-5.4 Partner with key stakeholders such as Parent to Parent, Local Health Departments, and Regional Support Centers to identify and share best practices to address racial justice and health equity.

NYSDOH staff partnered with key stakeholders such as Parent to Parent, Local Health Departments, and Regional Support Centers to identify and share best practices to address racial justice and health equity.

The Department funded Regional Support Centers produce a newsletter for the Local Health Department CYSCHN Program staff and partners called CYSHCN Clips. The newsletter features professional development opportunities, upcoming events, and recent research. Examples of the features of the newsletter include:

- In-person and virtual workshops and conferences. For example, information about the Annual International Conference about attention deficit hyperactivity disorder (ADHD) November 2022.
- Information related to recreational opportunities, resources, and community events. For example, baseball opportunities, Legoland (a certified autism center and developed sensory guides), Dutchess County Fair, Genesee County-Disability Celebration Pride 2023, and a Special Olympics athlete.
- Information about vocational and career opportunities included the Autism Tech, Innovation and Career Expo held in NYC and a research opportunity for persons with intellectual and development disabilities from the New York State Dental Association.
  Funding opportunities, such as the entrepreneur grant by the National Down Syndrome Society and a pre-apprenticeship program for neurodivergent and autistic learners to learn skills in advanced manufacturing at the University of Rochester Medical Center were also shared.

In addition to the strategy updates above, the Department has taken great strides to incorporate health equity and racial justice throughout a wide variety of Title V activities, not limited to the activities within this strategy. In July 2022, the Department announced several reorganization efforts, including the creation of the Office of Health Equity and Human Rights. This new office addresses health disparities and work to improve diversity, equity, and inclusion within the Department. The Office of Health Equity and Human Rights is a resource for programs across the Department as we work towards common goals of equitable health for all New Yorkers.

As described in the Women and Maternal Health section, a new Bureau of Health Equity and Community Engagement was created within the Division of Family Health to address disparities highlighted in the COVID-19 pandemic and build a foundation for future epidemic responses. Funded contracts supporting CYSCHN include Bring on the Spectrum, which delivers movement, fitness, and Recreation opportunities for students from K-12 in rural areas. Additional information about partnerships and funding to support Adolescent Health is available in Supporting Document #3.

The NYS Title V Program established one Evidence-Based Strategy Measures (ESM) to track the programmatic investments and inputs designed to impact NPM 12:

ESM CYSHCN-1: Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease care transition program and kept a routine medical appointment.

Data for this measure comes from the Sickle Cell Disease care transition contractor reports. The baseline value for this measure from the 2018-19 program grant cycle was 40.3%. The program exceeded the improvement target of 5% for 2022, to reach 42.3%. The data for 2022-23 was up 3% from 2021-22 to 68% completed transition readiness assessments among those who were served through the Sickle Cell Disease care transition program and kept a routine medical appointment.

Children with Special Health Care Needs - Application Year

For Children and Youth with Special Health Care Needs (CYSCHN), the NYS Title V Program selected **National Performance Measure (NPM) 12: Percent of adolescents with special health care needs, ages 12-17, who received services necessary to make transitions to adult health care.** This NPM was selected because it was voiced as a key priority by youth with special health care needs and their families and reinforced by state-specific population health data. Families reported that only 15% of CYSCHN receive care in a well-functioning system, and less than 18% of youth ages 12-17 with special health care needs received services necessary to make transitions to adult health care. This is consistent with findings from New York's care mapping process conducted in 2017-2018, and with findings from the community listening forums conducted for this application, as detailed in the Needs Assessment summary, and discussed further below. Similar feedback was heard through family sessions conducted by Regional Support Centers in 2020 and 2021. This NPM also aligns directly with NYS Prevention Agenda goals and interventions related to support for CYSCHN.

NYS will also be addressing the new, required NPM for Medical Home. The work to review current initiatives, identify gaps, and develop strategies and activities to improve Medical Homes for children with special health care needs is just beginning in the current grant. We will report on more robust strategies and activities in next year's application.

In addition, New York's Title V Program established one State Performance Measure (SPM) for this domain, **SPM 2: Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months**. This SPM was developed to reflect the state's longstanding commitment to eliminating childhood lead poisoning as a key public health problem in NYS. It is responsive to cross-cutting priorities voiced by families related to safe and healthy environments to support children's development, and access to comprehensive, high quality health care services. It is also responsive to specific concerns shared by families regarding challenges in accessing and coordinating medical care and related services for CYSCHN. It builds on critical public health investments and capacity to prevent, identify, and address lead poisoning in NYS, including recent amendments to state public health law, as discussed further below.

Three specific objectives were established to align with these performance measures:

Objective CYSHCN-1: Increase the percentage of NYS adolescents with special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 17.8% in 2017-2018 to 18.7% in 2021-2022 (National Survey of Children's Health).

Objective CYSHCN-2: Increase the percentage of CYSCHN, ages 0 through 17, who receive care in a well-functioning system by 5%, from 15.2% in 2017-2018 to 16% in 2021-2022 (National Survey of Children's Health).

Objective CYSHCN-3: Reduce the incidence of confirmed high blood lead levels at 5 micrograms per deciliter or greater per 1,000 tested children aged less than 72 months. The current incidence of confirmed blood lead levels at 5 micrograms per deciliter or greater was 10.4 per 1,000 children tested in 2021. (NYS Child Health Lead Poisoning Prevention Program Data)

Five strategic public health approaches were identified to accomplish these objectives over the five-year grant period. These are presented in the State Action Plan table, and each is described in more detail here, with specific program and policy activities that will be implemented to advance the broader strategic approach in the upcoming year.

Strategy CYSHCN-1: Engage youth with special health care needs (YSHCN) and their families in state and local efforts to improve systems and practices for supporting YSHCN.

As described above in the annual report, families and youth need to be directly involved in program and policy planning and implementation in meaningful roles at all levels. This is consistent with the Title V program's longstanding commitments to

family-centered care/family-professional partnerships and positive youth development. Families of CYSCHN face unique challenges and bring knowledge, experience, and strengths that are a tremendous asset; they are the experts about their needs and care.

As described above, the Title V Program contracts with three Health Resources and Services Administration-designated University Centers for Excellence in Developmental Disabilities (UCEDDs), knowns as Regional Support Centers, to provide training and technical assistance to Local Health Department CYSCHN programs and to conduct family engagement. The Regional Support Centers each have a family liaison who is a parent/caregiver of a Child with Special Health Care Needs. The family liaison role is seen as a critical component of the Regional Support Centers work with families, CYSCHN, and Local Health Departments. Family liaisons bring firsthand experience, perspective, and knowledge of barriers and gaps in care to all aspects of Regional Support Center activities, including meeting with families and resource gathering. Family liaisons are involved in all cross functional teams including educational, data, technical assistance to Local Health Departments, and Resource Directory and are responsible for conducting family engagement sessions with a prescribed set of questions to gauge the needs of families with CYSCHN.

In addition, the NYSDOH has established contracts with Local Health Departments to administer the CYSCHN program locally, with the current contract timeframe from October 2020 to September 2025 and deliverables which include addressing family and community engagement at many levels. Local Health Departments will involve families of CYSCHN in work groups, committees, task forces or advisory committees to improve the system of care for CYSCHN, involve families and CYSCHN in local planning activities, such as the Community Health Assessment, and use feedback from families of CYSCHN to develop training for CYSCHN staff and providers.

Sickle Cell Disease Adolescent Transition Services contractors at five Hemoglobinopathy Specialty Care Centers work directly and exclusively with youth in transition support services. Hemoglobinopathy Specialty Care Centers conduct peer support groups to gauge barriers to care and transition for youth and young adults with Sickle Cell Disease. Transition navigators at Hemoglobinopathy Specialty Care Centers engage youth with Sickle Cell Disease to ensure compliance with care regimens and to understand what barriers youth experience in caring for themselves.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2024-25 year:

- **Activity CYSHCN-1.1**: Maintain at least one dedicated family representative on the state's Title V Advisory Council and engage all Council members in updates and discussion related to CYSCHN program activities.
- **Activity CYSHCN-1.2**: Collaborate with advocacy groups like Parent to Parent of NYS to understand the needs of CYSCHN and their families, facilitate information sharing, and promote Local Health Department CYSCHN programs.
- **Activity CYSHCN-1.3**: Support Regional Support Centers to employ parents of CYSCHN as parent liaisons. Work with the Regional Support Centers and their parent liaisons to conduct surveys, family engagement sessions and family forums to assess and share family needs and apply results to inform family resources and technical assistance for Local Health Department programs. Support the Sickle Cell Disease Adolescent Transition Services Program to involve individuals and families in all phases of program development, evaluation, and the provision of supports to children and AYA with SCD and their families to ensure quality services.
- **Activity CYSHCN-1.4**: Support Regional Support Centers to develop a CYSCHN Resource Directory that will be made available online to provide families, Local Health Departments, and health care providers with current information about services and supports.
- **Activity CYSHCN-1.5**: Support Local Health Department CYSCHN programs and the Sickle Cell Disease Adolescent Transition Services Program to involve CYSCHN and their families in work groups, committees, task forces or advisory committees, local health assessment and planning activities, and other systems development work. Use feedback from families of CYSCHN to develop program resources as well as professional and community

training.

- **Activity CYSHCN-1.6**: Engage the New York State Association of County Health Officials to promote and bolster Local Health Department CYSCHN programs to raise awareness of Local Health Department CYSCHN services and reach and serve more families. The New York State Association of County Health Officials will provide opportunities for Title V staff to speak directly to their members, participate in calls with Local Health Departments, and help disseminate information and opportunities for CYSCHN and families.
- **Activity CYSHCN-1.7**: Support Sickle Cell Disease programs in five Hemoglobinopathy Specialty Care Centers to provide transition supports by and for youth with sickle cell disease, including peer support groups, system navigation supports, and self-care services.
- **Activity CYSHCN-1.8:** Collaborate with other Title V and Division of Family Health adolescent-serving programs, including School-Based Health Centers, Comprehensive Adolescent Pregnancy Prevention, and ACT for Youth Center for Community Action to identify additional opportunities to meaningfully engage adolescents in program and policy development that impacts CYSCHN.
- **Activity CYSHCN-1.9**: Serve on the NYS Council on Developmental Disabilities and its Individuals and Families Committee to promote inclusion of CYSCHN-specific focus to the Council's agenda and policy portfolio. The NYS Council on Developmental Disabilities membership includes parents of CYSCHN from around New York State who are directly involved in decision making regarding funding opportunities and policy development.
    - **Activity CYSHCN-1.9.a**: Participate in the NYS Council on Developmental Disabilities Policy Workgroup to inform policy focus areas for the Council; review and help distribute policy papers; review and respond to legislation at state and federal levels; and provide advocacy and information to interested parties.
- **Activity CYSHCN-1.10**: Collaborate with state partners, such as Early Intervention, the Division of Chronic Disease Prevention, Office of Children and Family Services, and Office of the Aging-NY Connects to identify and utilize additional resources.

Strategy CYSHCN-2: Enhance care coordination, including transition support services, for CYSCHN.

The Institute of Medicine identified care coordination as a key strategy to improve the effectiveness, safety, and efficiency of the U.S. health care system, improving outcomes for patients, providers, and payers. The most recent 2020-2021 National Survey of Children's Health data for NYS show that about 72.2% of all children, and 62.5% of CYSCHN, ages birth to 17 years who needed care coordination services received effective services. Preparing for and supporting the transition from youth to adulthood is especially important for CYSCHN and their families. Only 11.8% of youth ages 12-17 with special health care needs received services necessary to make transitions to adult health care, highlighting the need for more specific attention to program and systems improvements in this area. Within this overall measure, there is variation in individual components of transition services. About 60.3% of adolescents with special health care needs had a chance to speak to their health care provider alone at their last preventive check-up. While 75% of adolescents with Special Health Care Needs reported that their health care provider actively worked with them to gain skills to manage their health, health care, and understand changes in health care happening around age 18, only 20.7% reported that their doctors discussed the shift to a provider who treats adults, if needed.

Title V staff will identify supports to help youth and families coordinate care, including a specific focus on transition services, to improve efficiency, quality, health outcomes and patient satisfaction. CYSCHN often require specialty medical services across multiple providers and service settings and may experience multiple transitions as they develop and "age out" of specific programs or services, move across service and community settings, and become more independent growing from children to youth to adults. Care coordination services and more informal transition supports can be critical for CYSCHN and their families to manage their health and family needs during key periods of change and over time.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2024-25 year:

- **Activity CYSHCN-2.1**: Provide funding and program guidance to Local Health Department CYSCHN programs to work with medical providers, childcare providers, and local school systems to improve communications between service providers to assist families with the referral process and support the transition of CYSCHN from pediatric to adult health care. Local Health Departments will provide timely and appropriate information and referrals to insurance, health services, transportation, and community resources to support transition and other services for CYSCHN. The Sickle Cell Disease Adolescent Transition Services Program includes a transition and care management model using health care professionals or community health workers/paraprofessionals under the supervision of qualified professionals.
    - **Activity CYSHCN-2.1.a**: Require additional Local Health Department staff using the enhanced funding award from October 10, 2022. For example, county staff went from a required 0.2 full time equivalent (FTE) to a 0.5 FTE and 0.4 FTE to 1.0 FTE.
- **Activity CYSHCN-2.2**: Continue to support three Health Resources and Services Administration-designated UCEDDs, which are known as the Regional Support Centers, to support youth, families, and Local Health Department CYSCHN programs. Regional Support Centers will identify resources and develop a comprehensive Resource Directory for Local Health Departments and families; provide technical assistance to Local Health Departments; conduct family engagement opportunities; identify webinars or professional development for Local Health Departments; develop training and education materials; facilitate communication among Local Health Departments; and identify barriers, unmet needs and opportunities for CYSCHN and their families. As described in the previous strategy, families and youth are deeply involved in guiding this work.
- **Activity CYSHCN-2.3**: In collaboration with the Regional Support Centers, facilitate professional development and information sharing between Local Health Department programs related to transition, including information on Got Transition®'s Six Core Elements of Health Care Transition™.
- **Activity CYSHCN-2.4**: Administer the CYSCHN Support Services, a gap-filling supplemental program that provides reimbursement for specialty health care services for severe chronic illness or physically handicapping conditions in children who meet county financial and medical eligibility criteria.
- **Activity CYSHCN-2.5**: Provide grant funding, evidence-based strategies (NYS uses Got Transition®) and technical assistance to Hemoglobinopathy Specialty Care Centers to support successful transition to adult services for young adults with sickle cell disease, including but not limited to transition policy, tracking and monitoring, transition readiness and planning, transfer of care, and transition feedback and completion.
- **Activity CYSHCN-2.6**: Support care coordinators at five Hemoglobinopathy Specialty Care Centers to help patients with sickle cell disease with appointments, scheduling, education, peer support and other health care transition services. These providers serve as “transition navigators,” to assist the adolescent make a successful transition to an adult hematologist or other adult medical care provider. They also focus on providing these adolescents with the skills they need to successfully transition to adult care as evidenced by evaluation of readiness and follow-up post transition for satisfaction with care.
    - **Activity CYSHCN-2.6a**: Require funded Hemoglobinopathy Specialty Care Centers transition coordinators to proactively coordinate with local health department CYSCHN Programs to enhance the efficiency of both programs.
- **Activity CYSHCN-2.7**: Facilitate collaboration between Title V programs serving youth, including School Based Health Center and Comprehensive Adolescent Pregnancy Prevention programs, to inclusively address broader health needs of CYSCHN including social emotional health, oral health, healthy relationships, and sexual reproductive health.
- **Activity CYSHCN-2.8**: Provide subject matter and technical support to NYS Medicaid Program to implement enhanced care coordination and transition support services for CYSCHN through Medicaid Children’s Health Home, including integration of eligible children also receiving services through the Early Intervention Program, referral of CYSCHN to Health Homes, and transition from Children’s to Adult Health Homes. This includes site visits to Children’s Health Homes around NYS where chart reviews are conducted, policies and procedures are reviewed, and feedback is provided to the agencies.

- **Activity CYSHCN-2.9**: Provide representation, subject matter expertise, and policy implementation support for the Health Home Managed Care Organization subcommittee focused on sickle cell disease, which formed following the state's effort to identify sickle cell disease as a single qualifying condition for Health Home enhanced care coordination services. This change makes it easier for individuals with sickle cell disease to gain access to the enhanced care coordination of Medicaid's Health Home.
- **Activity CYSHCN-2.10:** The CYSHCN Domain Workgroup will review the Blueprint for Change and develop a plan to further CYSHCN Domain Activities to support CYSHCN and their families throughout NYS. Staff reviewed and created a crosswalk of the focus areas, required CYSHCN Blueprint for Change activities, and current CYSHCN Domain activities. The crosswalk identified current strengths and best practices as well as opportunities and areas for expansion. A crosswalk of the current strategies and activities compared to the Blueprint for Change has been completed in the current grant year as a preliminary step. The Crosswalk is included as Supporting Document #4.

Strategy CYSHCN-3: **Support comprehensive public health efforts to prevent, identify, and manage activities for children who have confirmed elevated blood lead levels.**

Studies show that no amount of lead exposure is safe for children. Even low levels of lead in blood have been shown to affect a variety of adverse health effects including reduced growth indicators, delayed puberty, and lowered Intelligence Quotient, as well as hyperactivity, attention, behavior, and learning problems. Children under six years old are more likely to be exposed to lead than any other age group, as their normal behaviors result in them breathing in or swallowing dust from old lead paint that gets on floors, windowsills, and hands, and can be found in soil, toys, and other consumer products. New York has more pre-1950 housing containing lead paint than any other state in the nation, with approximately 43 percent of all of New York's dwellings containing lead-based paint.

Effective October 2019, NYS Public Health Law (§1370) and regulations (Part 67 of Title 10 of the New York Codes, Rules, and Regulations) were amended to lower the definition of an elevated blood lead level in a child to 5 micrograms per deciliter (µg/dL), from the previous level of 10 µg/dL. Health care providers in NYS are required to assess or test all young children in accordance with public health regulations, to confirm and report test results, and to ensure appropriate follow-up evaluation and management as needed. Local Health Departments are required to ensure follow up including environmental management based on the child's blood lead level. The Title V Program supports supplemental grants for lead poisoning prevention programs in local health departments, as well as Regional Lead Resource Centers based in academic medical centers to provide outreach and education to health care providers and families, technical assistance, individual case consultation and treatment of childhood lead poisoning. These programs are administered by the NYSDOH Center for Environmental Health. These Title V-funded program elements complement other components of the state's comprehensive public health approach that also includes laboratory testing and reporting, surveillance, outreach and education, and neighborhood-based primary prevention and healthy housing initiatives.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2024-25 year:

- **Activity CYSHCN-3.1**: Provide continued grant funding to local health department Lead Poisoning Prevention Programs and a statewide network of Regional Lead Resource Centers to support enhanced regional and local efforts to reduce the prevalence of elevated blood lead levels in children birth to 18 years.
- **Activity CYSHCN-3.2**: Work with Lead Poisoning Prevention Programs, Regional Lead Resource Centers, and other partners to ensure that all blood lead test results, including testing done in permitted/registered laboratories and point of service testing conducted in health care provider offices, are reported to the NYSDOH within the timeframes required.
- **Activity CYSHCN-3.3**: Through the Regional Lead Resource Centers, support the provision of outreach and education to health care provider and families, technical assistance to providers and Local Health Department programs, individual case consultation, and treatment of lead poisoning among children, pregnant women, and

newborns, including chelation treatment where indicated.

- **Activity CYSHCN-3.4**: Through the Local Health Department Lead Poisoning Prevention Programs and Regional Lead Resource Centers, promote clinical prevention and screening practices in accordance with state requirements, including:
    - Routine blood lead testing for all children at age one year and again at age two years
    - Assessment of all children ages six months to six years at every well visit for risk of lead exposure, with blood lead testing as indicated by risk assessment.
    - Provision of anticipatory guidance for all families about lead poisoning prevention as part of routine care.
- **Activity CYSHCN-3.5**: Through the Local Health Department Lead Poisoning Prevention Programs, ensure that all children with elevated blood lead levels receive appropriate evaluation and management, including:
    - Confirmatory venous blood lead testing for capillary screening results ≥ 5 µg/dL
    - A complete diagnostic evaluation that includes a detailed lead exposure assessment, nutritional assessment, and developmental screening
    - Medical treatment, as needed.
    - Referral to the appropriate local health department for environmental management.
- **Activity CYSHCN-3.6**: Through the Regional Lead Resource Centers, increase capacity and sustainability in local health care and public health systems by engaging health care providers and professional medical groups in leadership roles within regional or community coalitions focused on the prevention and elimination of lead poisoning.

Strategy CYSHCN-4: Apply public health surveillance and data analysis findings to improve services and systems related to health and health care for CYSCHN.

As noted in other domains, data-driven, evidence-based practice is essential to achieving public health goals for CYSCHN. Continuous efforts are needed to enhance the collection, analysis, and sharing of data to inform the planning and implementation of CYSCHN programs and policy work. Sharing data with stakeholders, including providers, families, youth, and other community members, is critical to raise awareness, empower community action, and facilitate quality improvement efforts at all levels. Title V staff will continue to assess all available data sources to inform public health improvement strategies related to CYSCHN. A recently published summary document titled “New York State Profile of CYSCHN, 2020-2021”, which updates the program’s 2019-2020 summary, and may serve as one starting point for additional work in this area. This report explores the demographic, health, and functional difficulty profile of the NYS CYSCHN population, determines the impact that having special health care needs has on children and families, and identifies areas in most need of improvement to ensure NYS CYSCHN receive care in a well-functioning system. As additional data become available (about annually), Title V staff will update this report, make it available through the NYSDOH public website, and share it with CYSCHN grantees, partner organizations like Parent to Parent and the New York State Association of County Health Officials.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2024-25year:

- **Activity CYSHCN-4.1**: Complete a careful analysis of the revised National Survey of Children’s Health when available to assess available measures, trends, and other updates related to CYSCHN in NYS.
- **Activity CYSHCN-4.2**: Collaborate with the U.S. Census Bureau to conduct an over-sample of NYS 2022 National Survey of Children’s Health data for NYS to allow for enhanced sampling of Black/African-American, Hispanic, including CYSCHN populations.
- **Activity CYSHCN-4.3**: Analyze and report on available CYSCHN data for NYS, including data from the National Survey of Children’s Health, share reports with Local Health Departments and other stakeholders, and post on the Department’s public website.
- **Activity CYSHCN-4.4**: Develop and implement plans for updating the current data reporting methods (quarterly and

annual reports) of Local Health Department CYSCHN programs and Sickle Cell Disease Adolescent Transition Services programs to NYSDOH Title V program. Analyze and share relevant data collected from programs to improve services and inform larger program and policy work related to CYSCHN.

- **Activity CYSHCN-4.5**: Use the data gathered from the CYSCHN programs to identify specific areas for further improvement and to inform improvement activities.
- **Activity CYSHCN-4.6**: Use the data combined from the Local Health Department quarterly narrative and data reports to accurately reflect the population served.

Strategy CYSHCN-5: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact the health and well-being of CYSCHN.

As noted in other domains, Maternal and Child Health outcomes are impacted by the social determinants of health, or the conditions in which people are born, live, work, play, learn, and age. The social determinants of health include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of power and resources due to racism and other biases are root causes of inequities in access, availability of services, and quality of care. All ten priorities that emerged from community members' input during the Title V Needs Assessment revolve around the social determinants of health and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities.

Many NYS families of CYSCHN are struggling disproportionally with poverty, transportation, access to care which includes availability of specialists in their areas and employment opportunities, caregivers reported having to decrease hours worked or leaving jobs altogether to care for their children and to coordinate their children's care. Families facing day-to-day challenges may be less able to seek and use programs or to even have the time to engage with the State's CYSCHN programs at the Local Health Department or the State's three Regional Support Centers located at the federally designated Centers of Excellence for Developmental Disabilities (UCEDDs). Recognizing this challenge, NYSDOH, Regional Support Centers, and Local Health Departments need to meet people where they are, provide multiple methods and means for CYSCHN and their families to engage, and ensure that a diverse population is being recruited and retained by Local Health Departments.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2024-25 year:

- **Activity CYSHCN-5.1**: Support 51 local CYSCHN programs based in Local Health Departments, including encouraging inclusion and health equity measures in outreach and referrals.
- **Activity CYSHCN-5.2**: Work with the Regional Support Centers and Local Health Department CYSCHN programs and Sickle Cell Disease Adolescent Transition Services Program contractors to integrate health equity into written materials, communication, outreach, and referrals for CYSCHN and families, all of which will reflect the ethnicity and diversity of the community, including engagement strategies. Health literacy will be supported by providing information in multiple languages, at appropriate reading levels and abilities, as available.
- **Activity CYSHCN-5.3**: Develop and implement data collection systems that allows Local Health Department CYSCHN programs and Sickle Cell Disease Adolescent Transition Services contractors to identify, track, and address disparities.
- **Activity CYSHCN-5.4**: Partner with key stakeholders such as Parent to Parent, Local Health Departments, and Regional Support Centers to identify and share best practices to address racial justice and health equity.

The NYS Title V Program established one Evidence-Based Strategy Measure (ESM) to track the programmatic investments and inputs designed to impact NPM 12:

ESM CYSHCN-1: Percent of individuals ages 14-21 with sickle cell disease who had transition readiness

assessments completed, among those who were served through the Sickle Cell Disease Adolescent Transition Services program and kept a routine medical appointment.

Data for this measure is from Sickle Cell Disease Care Transition contractor quarterly reports. The initial baseline value for this measure from the 2018-2019 program grant cycle was 40.3%; the recent 2022-2023 data reflects an on-going upward trend of 68%. The program improvement target of 5% for 2023 has been met. We will aim to retain the current rate of 68% and set an improvement target of 5%.

Future NPM: Medical Home. Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

The Child Health Domain Team will review data from the five (5) National Survey of Children's Health components that inform the Medical Home NPM: *usual source of sick care, personal doctor or nurse, family-centered care, no problems getting referrals, and effective care coordination when needed*. Upon review, annual objectives and strategies will be identified for the FY 2026 Application. Where possible, these activities will align with the Blueprint for Change.

Cross-Cutting/Systems Building

Cross-Cutting/Systems Building - Annual Report

No content was entered for the Cross-Cutting/Systems Building - Annual Report in the State Action Plan Narrative by Domain section.

Cross-Cutting/Systems Building - Application Year

No content was entered for the Cross-Cutting/Systems Building - Application in the State Action Plan Narrative by Domain section.

III.F. Public Input

The mission of the NYS Title V Program is to improve the health and wellness of women, children, and families. Engaging the community to gain a more comprehensive understanding of those factors impacting the health of the community and practical strategies to impact those factors is critical. When the community is engaged, new insights emerge, and ideas staff thought to be true were challenged or refined based on input from those who are directly impacted by the work. Developing approaches to improve health outcomes for all NYS's families requires commitment and partnerships with families, health and human service providers and professionals, organizations, and advocacy groups as well as other key stakeholders.

The NYS Title V Program has always sought public input to ensure the state's Title V strategies and efforts reflected the needs, thoughts, and priorities of all Maternal and Child Health stakeholders. During the reporting period, in addition to the stakeholder group conversations that staff conduct on an on-going basis, a more formal and systematic approach was used to intentionally prioritize specific groups to delve deeply into communities from whom greater understanding of life experience might shed light on disparate health outcomes.

In collaboration with the NYS Maternal, Infant, and Early Child Home Visiting program and a broad network of community-based organizations, forums were hosted across the state with families and community members to facilitate open discussion about individual, family, and community health and services. A total of 37 forums were held in 18 NYS counties and in the Akwesasne Territory of the St. Regis Mohawk Tribe, with over 700 community members. Each forum focused on specific populations including expectant parents and parents of young children, done in partnership with the Maternal, Infant, and Early Childhood Home Visiting program; other adult men and women; adolescents; and families of Children and Youth with Special Health Care Needs. Notes of the discussions were recorded by community partners. Participants were racially diverse and reported primary languages of English, Spanish, Chinese, and Haitian/Creole.

Ten common themes emerged reflecting the voices of forum participants across all population groups and geographic areas. Specific quotes from community members are invaluable in understanding the issues they face. Some powerful examples are included below for each theme.

1. Lack of awareness of resources and services in the community
    - *If it was not for finding myself in a shelter due to a domestic violence situation, I would have not known about resources in my community and I do not feel like that is a good thing. (Expectant or new parent)*
    - *You hear about services too late; you're already struggling. (Expectant or new parent)*
2. Transportation barriers
    - *...here are big gaps in the day when you either have to spend your whole day… go early and spend your whole day waiting for your appointment. So you waste a lot of your day, that you [could] have worked or done something else. (Adolescent)*
    - *I have to let one bill go if I have to go to Buffalo [for medical care]. (Family of a Child with Special Health Care Needs)*
3. Availability and accessibility of services and amenities in the community
    - *There needs to be more after school programs for children and things for them to do so they can use their time. Rather than becoming invested in drugs because they have all this time. (Adolescent)*
    - *Not all providers are a good fit for your child. Due to the limited providers, you have to deal with it not being a good fit if you want your child to receive services because there are no other options. (Family of a Child with Special Health Care Needs)*
4. Poverty and issues of the working poor
    - *If you are in poverty, you are more likely to spend more money because there is this like whole thing of like you pay for something to get it immediately rather than saving up to get something that lasts, so you end up buying something that will break really quick. So you end up spending more money. So really, being poor is expensive. (Adolescent)*

- *Teach children about finances and budgets so they can better manage their futures. (Adult)*
- *If you are making a 'livable wage' you can't qualify for certain services. The system is made for us to fail. If you do improve, you lose services, you fall back. (Expectant or new parent)*

5. Supports for parents and families
   - *I had a c-section and was alone at home. I did not have help. (Expectant or new parent)*
   - *I felt welcome at prenatal visits when they introduced themselves and included me [dad] in the conversation. The doctor let me know as a father how much I can help. Included both of us. (Father)*
   - *I have no family support in this country. (Expectant or new parent)*
6. Social support and social cohesion
   - *Everybody needs to talk even for one second or ten minutes. Even boys. (Adolescent)*
   - *I feel isolated because not everyone is experiencing what I am experiencing. (Family of a Child with Special Health Care Needs)*
   - *Having a village, not doing it alone. (Expectant or new parent)*
7. Health care access, quality, and bias
   - *I've skipped appointments for myself because I can't afford the co-pay. (Adult)*
   - *…you go into the clinic and you see someone different every time. So there's not that relationship with doctors. (Adult)*
   - *If you have a lifestyle, they [providers] don't agree with, they won't respect you. (Adolescent)*
8. Community and environmental safety
   - *I want a community where they can grow up and know that they're safe and can go anywhere they want to go and trust the adults in their community. Right now I am scared for my kids… (Adult)*
   - *I see syringes in the stairs, in the elevators, this is a big need in my building. (Family of a Child with Special Health Care Needs)*
9. Housing
   - *I don't feel there's a system in place to make sure landlords treat you like human beings. (Expectant or new parent)*
   - *My mom waited 3 years for them to put on a door. (Adolescent)*
10. Healthy food
    - *There is never enough to go around. We go to soup kitchen, pantries but there needs to be more. (Adolescent)*
    - *We need more healthy food in the hood all hoods have crappy food. (Expectant or new parent)*

The most common suggestions raised by community members (each mentioned in a quarter of the forums) to help foster healthy, thriving communities included:

- More education for both adolescents and adults about financial literacy and life skills, such as budgeting, taxes, credit, parenting, etc.
- More access to healthy foods through community gardens or farmers markets
- Removing sources of and advertising for unhealthy foods, fast food, bars, and alcohol in communities
- Clean up programs to tidy parks and public spaces.

In addition to the forums, web-based surveys designed for the public and service providers were posted on the NYSDOH website and social media and distributed widely through a broad network of over 20 organizational partner groups. Through a mix of closed- and open-ended questions, providers were asked about what's working and what can be strengthened in their communities; social determinants, root causes, disparities, and health outcomes; community partnerships; population engagement strategies; and to rate a range of potential Maternal and Child Health priorities. Consumer respondents were asked about factors that affect health in their communities, available and needed services, and barriers to and satisfaction with existing services. Over 770 providers and over 320 individual consumers responded, representing all regions of the state.

The Children and Youth with Special Health Care Needs Program sought family feedback through the Regional Support

Centers and their family liaisons by holding meetings with families and resource gathering. Family liaisons are responsible for conducting family engagement sessions with a prescribed set of questions to gauge the needs of Children and Youth with Special Health Care Needs families and they use this feedback to inform educational materials and trainings for Local Health Departments. During this reporting year, these meetings were all virtual, and not in-person as intended, due to the COVID-19 public health emergency. Qualitative data from family sessions was compiled and presented to families and a Family Engagement Report was made available to all Local Health Departments. Information from that Report was also used to present to Local Health Department Children and Youth with Special Health Care Needs programs on a quarterly call in 2022.

Division of Family Health engaged the Title V Maternal and Child Health Advisory Council, which includes the Executive Director of Parent to Parent of NYS and a member from the Schuyler Center for Analysis and Advocacy. The Title V Director and staff reviewed the Needs Assessment and the Maternal and Child Health priorities with the Maternal and Child Health Advisory Council on June 17, 2020. Each year in June, the State's Title V annual report and application are reviewed with the Advisory Council, and their feedback is elicited.

The Division of Family Health is engaging state agencies that serve the Maternal and Child Health population, including the NYS Office for Children and Family Services, the NYS Education Department (NYSED), Office for Temporary and Disability Assistance (OTDA), Council on Children and Families, Office for People with Developmental Disabilities (OPWDD), Office of Mental Health (OMH), Office for Addiction Services and Supports (OASAS), Office of Victim Services (OVS), NYS Parks Department, Department of Agriculture and Markets, Department of Transportation (DOT), NYS Division of Criminal Justice Services (DCJS), Department of State, and the Department of Labor.

The Division of Family Health will continue to seek public input on the Maternal and Child Health Priorities and State Action Plan in the coming year and will further reflect this input in subsequent applications/annual reports.

III.G. Technical Assistance

NYS's Title V Program welcomes opportunities to have periodic teleconferences facilitated by Health Resources and Services Administration staff with other large states focused on specific topics, programs, and initiatives to support Title V outcomes. Several states are focusing on the same of similar priority areas. We appreciate HRSA's renewed support for collaborations between the "Big 5" States. These have been very informative, and we anticipate will continue to be informative in the development of a more comprehensive approach to supports and services for Children and Youth with Special Health Care Needs and their families as well in planning for the comprehensive Needs Assessment for next year's full five-year application.

NYS would benefit from focused discussions on efforts related to perinatal regionalization including the development of metrics and processes for ongoing quality improvement, strategies to best engage birthing hospitals to participate in quality improvement work with limited funding, telehealth models to improve access to health care supports and services, state efforts to identify and address maternal mortality and morbidity, specifically related to efforts to address the impact of racism on perinatal health outcomes. Other topics of importance are supporting pregnant and parenting individuals experiencing substance use disorders in the development and implementation of Plans of Safe Care while mitigating the impact of racism and bias in child welfare reporting. Discussions with colleagues in other large states on establishing policy to promote systems change, identifying evidence-based or evidence-informed practices on an ongoing basis, modifying evidence-based programs to better fit the needs of certain populations, and addressing public health issues in more rural areas where the burden is not as great, and resources are limited are just a few additional examples of areas that may be of benefit to discuss in a forum with large states.

As described in the Maternal and Child Health Workforce Development section, New York's Title V Program has a strong established collaborative relationship with the University at Albany School of Public Health's Health Resources and Services Administration-funded Maternal and Child Health Catalyst program. Our programs have worked closely together for over five years to support mutual goals related to Maternal and Child Health workforce development, including efforts to engage and train students and to support the professional development of current Title V staff. The University at Albany's Maternal and Child Health Catalyst Program has provided technical assistance to the Title V Program for several major projects, including extensive support to plan, implement, and document the comprehensive five-year Needs Assessment and state action plan for this application. The Catalyst Program Co-Directors' strong working knowledge of New York's Title V Program and larger state systems, as well as the geographic proximity of the programs (especially in light of current and anticipated travel restrictions), make this a uniquely strong approach to technical assistance for our program. In the upcoming year and beyond, NYS's Title V Program is interested in working with the Health Resources and Services Administration Maternal and Child Health Bureau to explore how the Bureau may support this relationship to facilitate future technical assistance support from the University at Albany's Maternal and Child Health Catalyst Program.

Finally, as we approach a new Needs Assessment and five-year grant cycle, technical assistance and support about the Needs Assessment and best practices on integrating strategies and activities to support the new required areas (postpartum care and medical homes) are appreciated.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Intra Agency Agreement between Title V and Medicaid.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - 1. Public and Private Partnerships.pdf

Supporting Document #02 - 2.State Action Plan Table.pdf

Supporting Document #03 - 3.Poster and Compendium.pdf

Supporting Document #04 - 4.CYSHCN Blueprint for Change Crosswalk.pdf

Supporting Document #05 - 5.Title V Funded Internships 2019-Summer 2024.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - VI.DOH-OPH-CCH-DFH Org Charts.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: New York

	FY 25 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 38,909,810	
A. Preventive and Primary Care for Children	$ 14,406,897	(37%)
B. Children with Special Health Care Needs	$ 21,220,207	(54.5%)
C. Title V Administrative Costs	$ 2,646,765	(6.9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 38,273,869	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 0	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 71,957,219	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 21,296,337	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 93,253,556	
A. Your State's FY 1989 Maintenance of Effort Amount $ 58,268,752		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 132,163,366	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 73,115,502	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 205,278,868	

OTHER FEDERAL FUNDS	FY 25 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 2,633,414
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 12,400,151
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 11,808,930
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 29,456,955
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 3,553,611
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Medicaid Match	$ 13,262,441

	FY 23 Annual Report Budgeted		FY 23 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 38,909,810 (FY 23 Federal Award: $ 39,915,601)		$ 42,013,230	
A. Preventive and Primary Care for Children	$ 13,172,738	(33.9%)	$ 18,628,775	(44.3%)
B. Children with Special Health Care Needs	$ 22,527,401	(57.9%)	$ 18,385,773	(43.7%)
C. Title V Administrative Costs	$ 2,609,055	(6.7%)	$ 3,820,885	(9.1%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 38,309,194		$ 40,835,433	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 29,285,355		$ 29,285,355	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 36,138,659		$ 47,689,009	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 24,571,358		$ 17,789,263	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 89,995,372		$ 94,763,627	
A. Your State's FY 1989 Maintenance of Effort Amount $ 58,268,752				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 128,905,182		$ 136,776,857	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 62,282,555		$ 64,008,683	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 191,187,737		$ 200,785,540	

OTHER FEDERAL FUNDS	FY 23 Annual Report Budgeted	FY 23 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 2,636,629	$ 1,042,333
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 8,613,186	$ 7,627,187
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 3,446,426	$ 2,891,967
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 11,808,930	$ 11,764,755
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 26,526,888	$ 26,526,888
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Medicaid Match	$ 8,550,496	$ 5,200,342
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning Telehealth	$ 700,000	$ 147,472
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > American Rescue Plan Act Funding for Home Visiting		$ 960,865
US Department of Education > Office of Special Education Programs > Individuals with Disabilities Act-Special Education/American Rescue Plan Act of 2021		$ 7,846,874

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Actual expenses are more than the Annual Report Budgeted due to the timing of funds being disbursed and the NYS Department of Health's ability to leverage other State resources to support MCH activities.	
2.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Actual expenses are less than the Annual Report Budgeted due to the timing of funds being disbursed and the NYS Department of Health's ability to leverage other State resources to support MCH activities.	
3.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Actual expenses are more than the Annual Report Budgeted due to the timing of funds being disbursed and the NYS Department of Health's ability to leverage other State resources to support MCH activities.	
4.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: NY’s FY 23 application reflected a budget of over $71 million in Local MCH Funds, but actual expenditures were less than anticipated. This is likely related to the timing of the reporting by LHDs rather than an actual decrease in expenses.	
5.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: NY’s FY 23 application reflected a budget of over $21 million in Program Income, but actual expenditures were less than anticipated. This is likely related to the timing of the reporting by LHDs rather than an actual decrease in income.	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: New York

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Pregnant Women	$ 2,173	$ 367,989
2. Infants < 1 year	$ 552,966	$ 1,273,949
3. Children 1 through 21 Years	$ 13,853,931	$ 17,354,826
4. CSHCN	$ 21,220,207	$ 18,385,773
5. All Others	$ 633,768	$ 809,808
Federal Total of Individuals Served	$ 36,263,045	$ 38,192,345

IB. Non-Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Pregnant Women	$ 25,369,375	$ 17,628,696
2. Infants < 1 year	$ 10,764,694	$ 8,086,888
3. Children 1 through 21 Years	$ 27,848,071	$ 22,639,356
4. CSHCN	$ 28,950,031	$ 18,674,893
5. All Others	$ 29,606,739	$ 27,718,792
Non-Federal Total of Individuals Served	$ 122,538,910	$ 94,748,625
Federal State MCH Block Grant Partnership Total	$ 158,801,955	$ 132,940,970

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: Form 2, Line 1A, Preventive and Primary Care for Children includes Infants < 1 year and Children 1 though 21 years.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Form 2, Line 1A, Preventive and Primary Care for Children includes Infants < 1 year and Children 1 though 21 years.	

Data Alerts:

- Children 1 through 21 Years, Application Budgeted does not equal Form 2, Line 1A, Preventive and Primary Care for Children Application Budgeted. A field-level note indicating the reason for the discrepancy was provided.
- Children 1 through 21 Years, Annual Report Expended does not equal Form 2, Line 1A, Preventive and Primary Care for Children, Annual Report Expended. A field - level note indicating the reason for the discrepancy was provided.

Form 3b
Budget and Expenditure Details by Types of Services

State: New York

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Direct Services	$ 16,499,812	$ 14,383,453
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 16,499,812	$ 14,383,453
2. Enabling Services	$ 15,518,400	$ 19,087,964
3. Public Health Services and Systems	$ 6,891,598	$ 8,541,813
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 14,383,453
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 14,383,453
Federal Total	$ 38,909,810	$ 42,013,230

IIB. Non-Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Direct Services	$ 38,476,291	$ 22,628,376
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 21,729,579	$ 12,033,970
B. Preventive and Primary Care Services for Children	$ 16,746,712	$ 10,594,406
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 33,579,411	$ 35,301,931
3. Public Health Services and Systems	$ 15,269,516	$ 15,100,720
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
Other		$ 22,628,376
Direct Services Line 4 Expended Total		$ 22,628,376
Non-Federal Total	$ 87,325,218	$ 73,031,027

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIB. - Other - Other**
	Fiscal Year:	**2025**
	Column Name:	**Annual Report Expended**

Field Note:
This level of detail is not available

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: New York

Total Births by Occurrence: 204,701 **Data Source Year: 2023**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	204,594 (99.9%)	1,370	316	316 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Guanidinoacetate Methyltransferase (GAMT) Deficiency	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type I (MPS I)	Mucopolysaccharidosis Type II (MPS II)	Primary Congenital Hypothyroidism
Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences
Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency
X-Linked Adrenoleukodystrophy				

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
HIV	204,594 (99.9%)	297	0	0 (0%)
Tyrosinemia, type 2, 3	204,594 (99.9%)	8	0	0 (0%)
Krabbe disease	204,593 (99.9%)	13	3	3 (100.0%)
Short-chain acyl-CoA dehydrogenase deficiency/IBCD	204,594 (99.9%)	19	8	8 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Infants in NY are followed until we receive a confirmatory diagnosis. We have begun a long-term follow-up program for some of the inherited metabolic diseases with limited funding from NYS to pay the Centers to enter data. Uptake has been slow. We have worked with Centers on progress reports and getting Institutional Review Board approvals at all 10 sites. The plan is to enroll children until age 18 and re-consent enrollees at that age until age 21. We have worked with the Newborn Screening Translational Research Network and their Longitudinal Pediatric Data Resource to create a series of common data elements to be collected. We are in the process of applying for additional funding to move this work forward as there are limited staff within the newborn screening program at present to conduct this work and the necessary follow-up with providers. We are expecting a new module to be added to our Laboratory Information Management System that will allow Centers for easier data entry.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**HIV - Total Number Confirmed Cases**
	Fiscal Year:	**2023**
	Column Name:	**Other Newborn**
	Field Note: Not available. This information cannot be reported. Follow-up conducted by AIDS Institute.	
2.	**Field Name:**	**HIV - Total Number Referred For Treatment**
	Fiscal Year:	**2023**
	Column Name:	**Other Newborn**
	Field Note: Not available. This information cannot be reported. Follow-up conducted by AIDS Institute.	

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: New York

Annual Report Year 2023

Form 5a – Count of Individuals Served by Title V (Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	144,771	48.0	0.0	51.0	1.0	0.0
2. Infants < 1 Year of Age	208,816	48.0	0.0	51.0	1.0	0.0
3. Children 1 through 21 Years of Age	358,884	43.0	0.0	54.0	3.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	141,043	47.0	0.0	50.0	3.0	0.0
4. Others	201,895	24.0	0.0	70.0	5.0	1.0
Total	914,366					

Form 5b – Total Percentage of Populations Served by Title V (Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	207,774	No	205,421	100.0	205,421	144,771
2. Infants < 1 Year of Age	208,777	No	208,816	100.0	208,816	208,816
3. Children 1 through 21 Years of Age	4,801,395	Yes	4,801,395	71.3	3,423,395	358,884
3a. Children with Special Health Care Needs 0 through 21 years of age^	912,938	Yes	912,938	46.6	425,429	141,043
4. Others	14,661,010	Yes	14,661,010	1.7	249,237	201,895

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2023**

Field Note:
Data for Form 5a were aggregated from reports provided by specific Maternal and Child Health programs that are either funded by Title V or funded by state and other funds but with Title V funded staff support for subject matter expertise.

The following MCH serving programs were included in Form 5a for Pregnant Women:
+ Comprehensive Adolescent Pregnancy Prevention and ACT for Youth Center of Excellence
+ Family Planning Program
+ Regional Perinatal Centers
+ Community Water Fluoridation
+ Perinatal & Infant Community Health Collaborative
+ Maternal, Infant, and Early Child Home Visiting (MIECHV) Programs - Nurse Family Partnership and Healthy Families
+ Immunization

Estimates for the Primary Source of Coverage were provided by HRSA.

2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2023**

Field Note:
All NYS infant receive Title V funded or supported services as a result of investments in the state's Newborn Metabolic Screening Program for the screening, as well as Newborn Hearing Screening, services through the perinatal system, and home visiting.

Estimates for the Primary Source of Coverage were provided by HRSA.

3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2023**

Field Note:
Data for Form 5a were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by Title V or funded by state and other funds but with Title V funded staff support for subject matter expertise.

The following MCH serving programs were included in Form 5a for Children 1-21 years old:
+ Asthma Program
+ Child Lead Poisoning Prevention Program
+ Local Health Department Children with Special Healthcare Needs Programs
+ Comprehensive Adolescent Pregnancy Prevention Program and ACT for Youth Center of Excellence
+ School Based Health Center Program
+ Family Planning Program
+ Maternal, Infant, and Early Child Home Visiting (MIECHV) Programs - Nurse Family Partnership and Healthy Families
+ Sickle Cell Disease Transition Grants to Hemoglobinopathy Centers
+ Children and Youth with Special Health Care Needs Support Services (CYSHCNSS)
+ Immunization

Estimates for the Primary Source of Coverage were provided by HRSA

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2023**

Field Note:
Data for Form 5a were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by Title V or funded by state and other funds but with Title V funded staff support for subject matter expertise. Children and Youth with Special Healthcare Needs (CYSHCN) counts are a subset of the counts for Infants under 1 and Children ages 1-21 years old.

The following MCH serving programs were included in Form 5a for CYSHCN:
+ Asthma Program
+ Child Lead Poisoning Prevention Program
+ Local Health Department Children with Special Healthcare Needs Programs
+ School Based Health Center Program
+ Maternal, Infant, and Early Child Home Visiting (MIECHV) Programs - Nurse Family Partnership and Healthy Families
+ Migrant Health
+ Family Planning Program
+ Sickle Cell Disease Transition Grants to Hemoglobinopathy Centers
+ Children and Youth with Special Health Care Needs Support Services (CYSHCNSS)
+ Immunization

Estimates for the Primary Source of Coverage were provided by HRSA.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2023**

Field Note:
Data for Form 5a were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by Title V or funded by state and other funds but with Title V funded staff support for subject matter expertise.

The following MCH serving programs were included in Form 5a for Other Populations:
+ Asthma Program
+ Family Planning Program
+ Migrant Health Program
+ Perinatal & Infant Community Health Collaborative
+ Maternal, Infant, and Early Child Home Visiting (MIECHV) Programs - Nurse Family Partnership and Healthy Families
+ Immunization

Estimates for the Primary Source of Coverage were provided by HRSA.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2023**

Field Note:
All pregnant women in NYS benefit from Title V funding as a result of investments in training and quality improvement initiatives with the Regional Perinatal Centers and birthing hospitals as well as work with other medical and healthcare providers.

Data for Form 5b for pregnant women served are reported based on NYS Vital Statistics data report in Form 6 of the Title V application.

2.	**Field Name:**	**Pregnant Women Denominator**
	Fiscal Year:	**2023**

Field Note:
Data for Form 5b for pregnant women served are reported based on NYS Vital Statistics data report in Form 6 of the Title V application.

3.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2023**

Field Note:
All NYS infants receive Title V funding as a result of investments in the state's Newborn Metabolic Screening Program for the screening, as well as Newborn Hearing Screening, services through the perinatal system, and home visiting.

Data for Form 5b for infants < 1 year of age served are reported based on NYS Vital Statistics data report in Form 6 of the Title V application.

4.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2023**

	Field Note: Data for Form 5b for infants < 1 year of age served are reported based on NYS Vital Statistics data report in Form 6 of the Title V application.	
5.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2023**
	Field Note: Data for Form 5b were aggregated from reports provided by MCH programs directly funded by Title V or funded by state/other funds but with Title V funded staff support for subject matter expertise. The following MCH serving programs were included in Form 5b for Children 1-21 years old: + Asthma Program + Child Lead Poisoning Prevention Program* + Local Health Department Children with Special Healthcare Needs Programs + Comprehensive Adolescent Pregnancy Prevention Program and ACT for Youth Center of Excellence + School Based Health Center Program + Family Planning Program + Maternal, Infant, and Early Child Home Visiting (MIECHV) Programs - Nurse Family Partnership and Healthy Families + Community Water Fluoridation + Immunization + Medicaid MMC Kids** * Footnore: Children 0-17 years old. Children 1-21 values suppressed to avoid duplication, same population counted for Medicaid,Community Water Fluoridation,and Immunization program. ** Footnote: Since approximately 50% of NYS children have Medicaid coverage and would be counted in the Medicaid MMC Kids program, the other MCH serving programs were reduced by 50% to reduce the potential for overcounting or double counting of children served by Title V.	
6.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2023**

Field Note:
Data for Form 5b were aggregated from reports provided by MCH programs directly funded by Title V or funded by state/other funds but with Title V funded staff support for subject matter expertise.

The following MCH serving programs were included in Form 5b for CYSHCN:
+ Asthma Program
+ Child Lead Poisoning Prevention Program
+ Local Health Department Children with Special Healthcare Needs Programs
+ Comprehensive Adolescent Pregnancy Prevention Program and ACT for Youth Center of Excellence
+ School Based Health Center Program
+ Maternal, Infant, and Early Child Home Visiting (MIECHV) Programs - Nurse Family Partnership and Healthy Families
+ Migrant Health
+ Family Planning Program
+ Sickle Cell Disease Transition Grants to Hemoglobinopathy Centers
+ Children and Youth with Special Health Care Needs (CYSHCN)
+ Children and Youth with Special Health Care Needs Support Services (CYSHCNSS)
+ Immunization
+ Medicaid MMC Kids**

* Footnore: Children 0-17 years old. Children 1-21 values suppressed to avoid duplication, same population counted for Medicaid,Community Water Fluoridation,and Immunization program.

** Footnote: Since approximately 50% of NYS children have Medicaid coverage and would be counted in the Medicaid MMC Kids program, the other MCH serving programs were reduced by 50% to reduce the potential for overcounting or double counting of children served by Title V.

7.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2023**

Field Note:
Data for Form 5b were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by Title V or funded by state and other funds but with Title V funded staff support for subject matter expertise.

The following MCH serving programs were included in Form 5b for Other Populations:
+ Asthma Program
+ Family Planning Program
+ Perinatal & Infant Community Health Collaborative
+ Maternal, Infant, and Early Child Home Visiting (MIECHV) Programs - Nurse Family Partnership and Healthy Families
+ Community Water Fluoridation
+ Immunization

Data Alerts:

1.	Infants Less Than One Year, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: New York

Annual Report Year 2023

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	205,421	99,491	26,582	50,204	319	20,703	90	3,432	4,600
Title V Served	205,421	99,491	26,582	50,204	319	20,703	90	3,432	4,600
Eligible for Title XIX	103,398	34,640	17,433	36,553	212	9,755	47	1,669	3,089
2. Total Infants in State	208,816	101,227	27,151	50,853	321	20,994	91	3,491	4,688
Title V Served	208,816	101,227	27,151	50,853	321	20,994	91	3,491	4,688
Eligible for Title XIX	104,952	35,144	17,817	37,000	214	9,887	48	1,694	3,148

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
Title V Program Workforce

State: New York

Reporting on Form 7 in the 2025 Application/2023 Annual Report is optional. The state has opted-out of providing Form 7 data. Reporting on Form 7 is mandatory for 2026 Application/2024 Annual Report.

Form Notes for Form 7:

None

Field Level Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: New York

1. Title V Maternal and Child Health (MCH) Director	
Name	Kirsten Siegenthaler, PhD
Title	Director, Division of Family Health
Address 1	New York State Department of Health
Address 2	Corning Tower Rm 890
City/State/Zip	Albany / NY / 12237
Telephone	(518) 474-6968
Extension	
Email	Kirsten.Siegenthaler@health.ny.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Suzanne Swan, MPH
Title	Director, Bureau of Child Health
Address 1	New York State Department of Health
Address 2	Corning Tower Rm 878
City/State/Zip	Albany / NY / 12237
Telephone	(518) 474-1961
Extension	
Email	Suzanne.Swan@health.ny.gov

3. State Family Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

4. State Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

5. SSDI Project Director	
Name	Solita Jones, DrPH
Title	Director, Bureau of Data Analytics, Research and Evaluation
Address 1	New York State Department of Health
Address 2	Corning Tower Rm 984
City/State/Zip	Albany / NY / 12237
Telephone	(518) 956-0223
Extension	
Email	Solita.Jones@health.ny.gov

6. State MCH Toll-Free Telephone Line	
State MCH Toll-Free “Hotline” Telephone Number	(800) 522-5066

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: New York

Application Year 2025

No.	Priority Need
1.	Address equity, bias, quality of care, and barriers to access in health care services for women and families, especially for communities of color and low-income communities
2.	Promote awareness and enhance availability, accessibility and coordination of services for families and youth, including CYSHCN, with a focus on areas impacted by systemic barriers, including racism
3.	Enhance supports for parents and families, especially those with children with special health care needs, and inclusive of all family members and caregivers
4.	Cultivate and enhance social support and social cohesion opportunities for individuals and families who experience isolation as a result of systemic barriers including racism, across the life course
5.	Increase access to affordable fresh and healthy foods in communities.
6.	Address community and environmental safety for children, youth, and families.
7.	Acknowledge and address the fundamental challenges faced by families in poverty and near-poverty, including the “working poor” as a result of systemic barriers, including racism.
8.	Increase awareness of resources and services in the community among families and the providers who serve them.
9.	Increase the availability and quality of affordable housing.
10.	Address transportation barriers for individuals and families.

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Address equity, bias, quality of care, and barriers to access in health care services for women and families, especially for communities of color and low-income communities	New
2.	Promote awareness and enhance availability, accessibility and coordination of services for families and youth, including CYSHCN, with a focus on areas impacted by systemic barriers, including racism	New
3.	Enhance supports for parents and families, especially those with children with special health care needs, and inclusive of all family members and caregivers	New
4.	Cultivate and enhance social support and social cohesion opportunities for individuals and families who experience isolation as a result of systemic barriers including racism, across the life course	New
5.	Increase access to affordable fresh and healthy foods in communities.	New
6.	Address community and environmental safety for children, youth, and families.	New
7.	Acknowledge and address the fundamental challenges faces by families in poverty and near-poverty, including the “working poor” as a result of systemic barriers, including racism.	New
8.	Increase awareness of resources and services in the community among families and the providers who serve them.	New
9.	Increase the availability and quality of affordable housing.	New
10.	Address transportation barriers for individuals and families.	New

Form 10
National Outcome Measures (NOMs)

State: New York

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM - Percent of pregnant women who receive prenatal care beginning in the first trimester (Early Prenatal Care, Formerly NOM 1) - PNC

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	79.5 %	0.1 %	160,888	202,341
2021	80.7 %	0.1 %	165,046	204,508
2020	80.6 %	0.1 %	164,090	203,541
2019	81.3 %	0.1 %	175,882	216,241
2018	80.9 %	0.1 %	177,826	219,882
2017	80.6 %	0.1 %	180,884	224,372
2016	80.7 %	0.1 %	185,073	229,239
2015	80.3 %	0.1 %	184,418	229,561
2014	79.1 %	0.1 %	182,737	231,024
2013	75.4 %	0.1 %	173,442	230,047
2012	74.5 %	0.1 %	173,825	233,372
2011	73.7 %	0.1 %	172,588	234,324
2010	73.9 %	0.1 %	174,690	236,300
2009	74.1 %	0.1 %	174,327	235,200

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM PNC - Notes:

None

Data Alerts: None

NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	118.7	2.5	2,321	195,546
2020	112.1	2.4	2,240	199,887
2019	92.2	2.1	1,946	211,097
2018	88.5	2.0	1,923	217,176
2017	83.5	2.0	1,849	221,444
2016	80.0	1.9	1,788	223,595
2015	93.2	2.4	1,581	169,707
2014	94.9	2.1	2,153	226,888
2013	88.3	2.0	1,982	224,369
2012	86.3	2.0	1,983	229,658
2011	86.2	2.0	1,930	223,901
2010	87.5	2.0	1,962	224,289
2009	75.5	1.8	1,718	227,545
2008	70.4	1.8	1,622	230,494

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM SMM - Notes:

None

Data Alerts: None

NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2018_2022	22.4	1.4	241	1,075,631
2017_2021	19.8	1.3	217	1,097,594
2016_2020	17.7	1.3	198	1,121,135
2015_2019	18.4	1.3	211	1,149,071
2014_2018	17.8	1.2	208	1,166,305

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2023
Annual Indicator	15.7
Numerator	
Denominator	
Data Source	
Data Source Year	

NOM MM - Notes:

NYS Maternal Mortality Review data, 2021 result, provisional.

Data Alerts: None

NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	8.6 %	0.1 %	17,735	207,341
2021	8.4 %	0.1 %	17,678	210,339
2020	8.2 %	0.1 %	17,079	208,958
2019	8.1 %	0.1 %	17,821	221,153
2018	8.1 %	0.1 %	18,208	225,864
2017	8.1 %	0.1 %	18,543	229,334
2016	7.9 %	0.1 %	18,573	233,979
2015	7.8 %	0.1 %	18,507	236,941
2014	7.9 %	0.1 %	18,722	238,423
2013	8.0 %	0.1 %	18,847	236,671
2012	7.9 %	0.1 %	19,074	240,654
2011	8.1 %	0.1 %	19,557	241,031
2010	8.2 %	0.1 %	20,049	244,116
2009	8.2 %	0.1 %	20,341	247,850

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM LBW - Notes:

None

Data Alerts: None

NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	9.5 %	0.1 %	19,609	207,371
2021	9.7 %	0.1 %	20,390	210,396
2020	9.2 %	0.1 %	19,279	208,997
2019	9.2 %	0.1 %	20,312	221,211
2018	9.0 %	0.1 %	20,281	225,904
2017	9.0 %	0.1 %	20,607	229,382
2016	9.0 %	0.1 %	20,956	233,991
2015	8.7 %	0.1 %	20,531	236,998
2014	8.9 %	0.1 %	21,114	238,475
2013	8.9 %	0.1 %	21,052	236,558
2012	9.1 %	0.1 %	21,884	240,504
2011	9.2 %	0.1 %	22,117	240,932
2010	9.4 %	0.1 %	22,904	244,016
2009	9.5 %	0.1 %	23,527	247,770

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM PTB - Notes:

None

Data Alerts: None

NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	27.4 %	0.1 %	56,769	207,371
2021	26.5 %	0.1 %	55,657	210,396
2020	25.5 %	0.1 %	53,193	208,997
2019	24.7 %	0.1 %	54,745	221,211
2018	23.7 %	0.1 %	53,647	225,904
2017	23.5 %	0.1 %	53,936	229,382
2016	23.4 %	0.1 %	54,862	233,991
2015	22.8 %	0.1 %	54,082	236,998
2014	22.7 %	0.1 %	54,104	238,475
2013	22.9 %	0.1 %	54,190	236,558
2012	23.4 %	0.1 %	56,356	240,504
2011	23.5 %	0.1 %	56,643	240,932
2010	24.2 %	0.1 %	59,001	244,016
2009	24.9 %	0.1 %	61,620	247,770

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM ETB - Notes:

None

Data Alerts: None

NOM - Percent of non-medically indicated early elective deliveries (Early Elective Delivery, Formerly NOM 7) - EED

Data Source: CMS Hospital Compare

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2022/Q1-2022/Q4	2.0 %			
2021/Q4-2022/Q3	2.0 %			
2021/Q3-2022/Q2	2.0 %			
2021/Q2-2022/Q1	2.0 %			
2021/Q1-2021/Q4	2.0 %			
2020/Q4-2021/Q3	2.0 %			
2020/Q3-2021/Q1	2.0 %			
2019/Q4-2020/Q3	1.0 %			
2019/Q1-2019/Q4	1.0 %			
2018/Q4-2019/Q3	1.0 %			
2018/Q3-2019/Q2	1.0 %			
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	1.0 %			
2017/Q3-2018/Q2	1.0 %			
2017/Q2-2018/Q1	1.0 %			
2017/Q1-2017/Q4	1.0 %			
2016/Q4-2017/Q3	1.0 %			
2016/Q3-2017/Q2	1.0 %			
2016/Q2-2017/Q1	1.0 %			
2016/Q1-2016/Q4	1.0 %			
2015/Q4-2016/Q3	1.0 %			
2015/Q3-2016/Q2	2.0 %			

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	4.0 %			
2013/Q3-2014/Q2	4.0 %			
2013/Q2-2014/Q1	5.0 %			

Legends:

NOM EED - Notes:

None

Data Alerts: None

NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	4.8	0.2	1,009	211,325
2020	5.0	0.2	1,041	209,912
2019	4.9	0.2	1,084	222,125
2018	5.4	0.2	1,230	226,927
2017	5.3	0.2	1,218	230,389
2016	5.4	0.2	1,267	234,975
2015	5.2	0.2	1,234	237,919
2014	5.5	0.2	1,315	239,457
2013	5.8	0.2	1,386	237,712
2012	5.8	0.2	1,398	241,663
2011	6.1	0.2	1,483	242,097
2010	6.2	0.2	1,521	245,195
2009	6.3	0.2	1,561	248,922

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM PNM - Notes:

None

Data Alerts: None

NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	4.2	0.1	876	210,742
2020	4.1	0.1	855	209,338
2019	4.3	0.1	959	221,539
2018	4.3	0.1	979	226,238
2017	4.6	0.1	1,053	229,737
2016	4.5	0.1	1,056	234,283
2015	4.6	0.1	1,098	237,274
2014	4.6	0.1	1,102	238,773
2013	4.9	0.1	1,169	236,980
2012	5.0	0.1	1,207	240,916
2011	5.1	0.2	1,236	241,312
2010	5.1	0.1	1,242	244,375
2009	5.4	0.2	1,331	248,110

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM - Notes:

None

Data Alerts: None

NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	2.6	0.1	545	210,742
2020	2.6	0.1	552	209,338
2019	2.9	0.1	633	221,539
2018	2.9	0.1	656	226,238
2017	3.1	0.1	710	229,737
2016	3.0	0.1	713	234,283
2015	3.1	0.1	747	237,274
2014	3.2	0.1	767	238,773
2013	3.5	0.1	829	236,980
2012	3.4	0.1	808	240,916
2011	3.5	0.1	855	241,312
2010	3.5	0.1	863	244,375
2009	3.7	0.1	918	248,110

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Neonatal - Notes:

None

Data Alerts: None

NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	1.6	0.1	331	210,742
2020	1.4	0.1	303	209,338
2019	1.5	0.1	326	221,539
2018	1.4	0.1	323	226,238
2017	1.5	0.1	343	229,737
2016	1.5	0.1	343	234,283
2015	1.5	0.1	351	237,274
2014	1.4	0.1	335	238,773
2013	1.4	0.1	340	236,980
2012	1.7	0.1	399	240,916
2011	1.6	0.1	381	241,312
2010	1.6	0.1	379	244,375
2009	1.7	0.1	413	248,110

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Postneonatal - Notes:

None

Data Alerts: None

NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	128.6	7.8	271	210,742
2020	137.6	8.1	288	209,338
2019	139.0	7.9	308	221,539
2018	141.0	7.9	319	226,238
2017	172.8	8.7	397	229,737
2016	152.0	8.1	356	234,283
2015	168.2	8.4	399	237,274
2014	175.9	8.6	420	238,773
2013	184.0	8.8	436	236,980
2012	188.4	8.9	454	240,916
2011	182.3	8.7	440	241,312
2010	191.9	8.9	469	244,375
2009	197.9	8.9	491	248,110

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Preterm Related - Notes:

None

Data Alerts: None

NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	67.9	5.7	143	210,742
2020	71.2	5.8	149	209,338
2019	67.3	5.5	149	221,539
2018	58.3	5.1	132	226,238
2017	58.3	5.0	134	229,737
2016	47.4	4.5	111	234,283
2015	56.5	4.9	134	237,274
2014	48.6	4.5	116	238,773
2013	55.7	4.9	132	236,980
2012	54.8	4.8	132	240,916
2011	51.4	4.6	124	241,312
2010	50.3	4.5	123	244,375
2009	60.9	5.0	151	248,110

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-SUID - Notes:

None

Data Alerts: None

NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	5.2 %	1.0 %	5,200	99,446
2021	6.0 %	1.0 %	6,174	102,639
2019	7.8 %	1.4 %	8,029	102,532
2018	8.4 %	1.3 %	8,636	102,696
2017	7.3 %	1.3 %	7,606	103,903
2016	6.0 %	0.9 %	6,230	104,133
2015	8.3 %	0.7 %	17,596	213,268
2014	9.5 %	0.7 %	20,794	218,296
2013	9.5 %	0.8 %	20,516	216,615
2012	9.9 %	1.0 %	10,943	110,416
2011	8.4 %	0.7 %	18,417	218,407
2010	8.1 %	0.7 %	18,042	222,166
2008	7.3 %	1.0 %	8,464	115,245
2007	8.4 %	0.7 %	19,845	235,020

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM DP - Notes:

None

Data Alerts: None

NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	4.0	0.1	781	195,735
2020	4.9	0.2	973	199,487
2019	4.6	0.2	940	204,919
2018	4.7	0.2	953	203,573
2017	5.0	0.2	1,091	218,652
2016	4.7	0.2	1,058	224,123
2015	4.2	0.2	709	170,164
2014	3.7	0.1	858	229,739
2013	3.7	0.1	839	228,951
2012	2.8	0.1	646	231,715
2011	2.6	0.1	619	234,599
2010	1.9	0.1	443	237,744
2009	1.8	0.1	436	240,486
2008	1.5	0.1	353	240,674

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM NAS - Notes:

None

Data Alerts: None

NOM - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL) (Newborn Screening Timely Follow-Up, Formerly NOM 12) - NBS

Federally available Data (FAD) for this measure is not available/reportable.

NOM NBS - Notes:

None

Data Alerts: None

NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR

Federally available Data (FAD) for this measure is not available/reportable.

NOM SR - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	11.6 %	0.9 %	445,545	3,828,081
2020_2021	11.9 %	1.2 %	449,364	3,786,140
2019_2020	12.0 %	1.3 %	450,486	3,757,972
2018_2019	11.4 %	1.6 %	432,729	3,794,007
2017_2018	11.2 %	1.7 %	434,334	3,872,991
2016_2017	10.5 %	1.5 %	405,084	3,841,768

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM TDC - Notes:

None

Data Alerts: None

NOM - Child Mortality rate, ages 1 through 9, per 100,000 (Child Mortality, Formerly NOM 15) - CM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	15.1	0.9	295	1,950,055
2021	13.5	0.8	273	2,027,416
2020	11.6	0.8	232	2,001,766
2019	14.1	0.8	284	2,020,962
2018	13.7	0.8	278	2,031,885
2017	13.1	0.8	270	2,064,799
2016	13.1	0.8	272	2,071,007
2015	13.3	0.8	278	2,084,298
2014	14.7	0.8	306	2,084,950
2013	15.1	0.9	314	2,083,766
2012	14.5	0.8	303	2,084,583
2011	15.0	0.9	311	2,076,119
2010	13.9	0.8	291	2,087,905
2009	15.8	0.9	330	2,082,079

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM CM - Notes:

None

Data Alerts: None

NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	24.6	1.0	572	2,323,066
2021	22.8	1.0	541	2,372,231
2020	24.3	1.0	546	2,243,929
2019	20.4	1.0	465	2,276,104
2018	21.9	1.0	506	2,306,162
2017	22.1	1.0	523	2,363,270
2016	22.8	1.0	544	2,389,012
2015	21.5	0.9	517	2,409,802
2014	21.1	0.9	513	2,436,467
2013	22.7	1.0	557	2,458,767
2012	23.2	1.0	578	2,494,939
2011	25.8	1.0	651	2,520,885
2010	25.9	1.0	668	2,577,734
2009	27.0	1.0	702	2,603,195

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM - Notes:

None

Data Alerts: None

NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2022	5.7	0.4	202	3,556,656
2019_2021	5.0	0.4	176	3,537,487
2018_2020	4.5	0.4	160	3,517,371
2017_2019	4.4	0.4	159	3,585,673
2016_2018	4.6	0.4	169	3,647,654
2015_2017	5.0	0.4	186	3,709,210
2014_2016	5.0	0.4	187	3,750,090
2013_2015	5.7	0.4	215	3,792,482
2012_2014	6.1	0.4	233	3,850,581
2011_2013	6.6	0.4	257	3,911,971
2010_2012	6.7	0.4	269	3,998,477
2009_2011	7.5	0.4	305	4,071,307
2008_2010	7.2	0.4	296	4,137,652
2007_2009	8.2	0.4	339	4,159,162

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Motor Vehicle - Notes:

None

Data Alerts: None

NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2022	3.1	0.2	215	6,939,226
2019_2021	3.4	0.2	231	6,892,264
2018_2020	3.6	0.2	243	6,826,195
2017_2019	3.9	0.2	274	6,945,536
2016_2018	3.9	0.2	276	7,058,444
2015_2017	3.5	0.2	251	7,162,084
2014_2016	3.2	0.2	233	7,235,281
2013_2015	3.0	0.2	216	7,305,036
2012_2014	3.3	0.2	243	7,390,173
2011_2013	3.5	0.2	260	7,474,591
2010_2012	3.4	0.2	257	7,593,558
2009_2011	3.1	0.2	236	7,701,814

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Suicide - Notes:

None

Data Alerts: None

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17 (CSHCN, Formerly NOM 17.1) - CSHCN

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	18.2 %	0.9 %	734,189	4,031,523
2020_2021	18.2 %	1.2 %	727,397	3,987,943
2019_2020	19.7 %	1.4 %	793,471	4,020,535
2018_2019	20.8 %	1.7 %	850,709	4,085,077
2017_2018	18.5 %	1.8 %	766,342	4,141,058
2016_2017	16.5 %	1.4 %	689,766	4,170,622

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM CSHCN - Notes:

None

Data Alerts: None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	11.0 %	1.3 %	80,403	734,189
2020_2021	12.1 %	2.4 %	87,975	727,397
2019_2020	14.2 %	2.7 %	112,492	793,471
2018_2019	12.6 %	2.5 %	106,847	850,709
2017_2018	15.0 %	3.3 %	114,765	766,342
2016_2017	13.9 %	3.0 %	95,681	689,766

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM SOC - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder (Autism, Formerly NOM 17.3) - ASD

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	3.5 %	0.5 %	116,467	3,353,403
2020_2021	3.0 %	0.6 %	100,665	3,339,863
2019_2020	2.2 %	0.4 %	72,709	3,370,589
2018_2019	3.2 %	0.9 %	106,183	3,340,872
2017_2018	4.0 %	1.0 %	134,974	3,416,292
2016_2017	2.7 %	0.6 %	94,017	3,453,975

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM ASD - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) (ADD or ADHD, Formerly NOM 17.4) - ADHD

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	8.2 %	0.7 %	272,554	3,338,512
2020_2021	7.5 %	0.9 %	250,572	3,325,077
2019_2020	7.3 %	0.9 %	246,111	3,365,123
2018_2019	6.9 %	1.1 %	229,577	3,337,236
2017_2018	5.9 %	1.1 %	203,372	3,418,949
2016_2017	6.2 %	0.9 %	211,889	3,433,074

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM ADHD - Notes:

None

Data Alerts: None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	52.3 %	3.5 %	241,018	460,493
2020_2021	50.8 %	4.7 %	215,749	424,816
2019_2020	60.9 %	5.0 %	261,250	428,872
2018_2019	60.5 %	6.2 %	258,157	426,431
2017_2018	54.0 %	7.4 %	167,192	309,390
2016_2017	46.4 %	5.8 %	133,314	287,167

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM MHTX - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	90.4 %	0.8 %	3,627,665	4,012,655
2020_2021	91.6 %	1.0 %	3,628,211	3,960,825
2019_2020	91.9 %	1.1 %	3,675,140	3,999,806
2018_2019	91.4 %	1.3 %	3,721,695	4,074,011
2017_2018	90.7 %	1.4 %	3,747,708	4,133,342
2016_2017	89.8 %	1.4 %	3,725,138	4,146,770

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM CHS - Notes:

None

Data Alerts: None

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

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	13.6 %	0.1 %	14,137	103,959
2018	14.0 %	0.1 %	23,080	164,822
2016	13.7 %	0.1 %	25,048	182,401
2014	14.3 %	0.1 %	27,888	195,413
2012	15.1 %	0.1 %	28,760	189,928
2010	16.1 %	0.1 %	30,128	186,760
2008	16.4 %	0.1 %	27,601	168,629

Legends:

Indicator has a denominator <20 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	16.1 %	1.6 %	106,407	661,227
2019	13.4 %	0.9 %	93,266	696,658
2017	12.4 %	0.9 %	86,909	699,950
2015	13.1 %	0.8 %	93,740	713,323
2013	10.6 %	0.5 %	75,265	711,539
2011	11.0 %	0.6 %	85,634	777,042
2009	10.8 %	0.9 %	69,040	639,137
2007	10.8 %	0.6 %	80,363	745,792
2005	10.3 %	0.7 %	78,925	765,158

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	18.3 %	1.3 %	468,552	2,554,048
2020_2021	17.4 %	1.7 %	435,503	2,505,994
2019_2020	15.2 %	1.8 %	379,910	2,503,198
2018_2019	15.0 %	2.0 %	375,016	2,502,148
2017_2018	16.2 %	2.1 %	404,958	2,504,952
2016_2017	16.3 %	1.9 %	404,924	2,491,296

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM OBS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, without health insurance (Uninsured, Formerly NOM 21) - UI

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	2.6 %	0.1 %	102,641	3,979,141
2021	2.7 %	0.2 %	109,214	4,099,187
2019	2.3 %	0.1 %	92,621	4,017,665
2018	2.2 %	0.1 %	91,033	4,060,665
2017	2.7 %	0.2 %	112,728	4,146,346
2016	2.5 %	0.2 %	103,337	4,173,030
2015	2.5 %	0.1 %	105,108	4,203,284
2014	3.4 %	0.2 %	142,448	4,218,611
2013	4.1 %	0.2 %	172,518	4,229,729
2012	4.0 %	0.2 %	170,847	4,255,688
2011	4.4 %	0.2 %	188,067	4,276,363
2010	4.8 %	0.2 %	205,478	4,310,594
2009	4.8 %	0.2 %	211,576	4,422,300

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM UI - Notes:

None

Data Alerts: None

NOM - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months (Childhood Vaccination, Formerly NOM 22.1) - VAX-Child

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	70.7 %	2.4 %	156,000	221,000
2017	70.2 %	2.7 %	159,000	226,000
2016	63.8 %	3.1 %	154,000	241,000
2015	66.9 %	2.8 %	157,000	234,000
2014	68.3 %	2.5 %	161,000	236,000
2013	69.7 %	2.5 %	165,000	236,000
2012	66.3 %	2.7 %	158,000	238,000
2011	66.2 %	2.9 %	159,000	241,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM VAX-Child - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	61.5 %	1.2 %	2,376,707	3,864,564
2021_2022	63.4 %	1.1 %	2,352,560	3,712,038
2020_2021	64.7 %	1.4 %	2,431,000	3,757,342
2019_2020	69.6 %	1.1 %	2,645,284	3,800,695
2018_2019	69.6 %	1.3 %	2,682,388	3,852,898
2017_2018	64.9 %	1.4 %	2,540,516	3,914,345
2016_2017	65.9 %	1.2 %	2,577,837	3,909,960
2015_2016	65.6 %	1.3 %	2,586,217	3,943,606
2014_2015	67.0 %	1.4 %	2,665,415	3,975,858
2013_2014	64.5 %	1.3 %	2,569,841	3,983,768
2012_2013	60.9 %	1.4 %	2,443,270	4,014,396
2011_2012	54.8 %	1.8 %	2,235,474	4,081,388
2010_2011	54.3 %	1.8 %	2,196,305	4,044,760
2009_2010	47.8 %	2.4 %	1,749,743	3,660,551

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM VAX-Flu - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	81.8 %	2.0 %	953,153	1,165,590
2021	75.9 %	2.4 %	836,764	1,101,902
2020	79.1 %	2.0 %	883,063	1,116,158
2019	70.8 %	2.8 %	796,876	1,125,173
2018	67.3 %	2.7 %	774,548	1,151,627
2017	68.5 %	2.2 %	802,423	1,170,574
2016	71.5 %	2.1 %	843,600	1,179,474
2015	61.3 %	2.3 %	730,501	1,192,326

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM VAX-HPV - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	90.4 %	1.6 %	1,053,577	1,165,590
2021	87.3 %	1.8 %	962,030	1,101,902
2020	93.0 %	1.3 %	1,038,391	1,116,158
2019	93.4 %	1.2 %	1,050,427	1,125,173
2018	91.7 %	1.3 %	1,056,227	1,151,627
2017	92.9 %	1.1 %	1,087,093	1,170,574
2016	91.2 %	1.3 %	1,075,050	1,179,474
2015	89.0 %	1.5 %	1,061,525	1,192,326
2014	91.5 %	1.5 %	1,101,490	1,204,315
2013	89.5 %	1.5 %	1,079,545	1,206,859
2012	90.3 %	1.5 %	1,098,346	1,216,701
2011	88.5 %	1.3 %	1,096,560	1,238,598
2010	82.9 %	1.8 %	1,041,143	1,255,446
2009	69.2 %	2.4 %	901,124	1,302,154

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM VAX-TDAP - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	96.5 %	0.9 %	1,125,030	1,165,590
2021	93.8 %	1.3 %	1,033,948	1,101,902
2020	93.7 %	1.2 %	1,045,669	1,116,158
2019	95.0 %	1.1 %	1,068,518	1,125,173
2018	94.9 %	1.2 %	1,092,813	1,151,627
2017	89.3 %	1.5 %	1,045,009	1,170,574
2016	89.2 %	1.5 %	1,052,380	1,179,474
2015	86.2 %	1.6 %	1,028,154	1,192,326
2014	79.6 %	2.1 %	958,880	1,204,315
2013	83.4 %	1.7 %	1,005,909	1,206,859
2012	78.5 %	2.1 %	954,645	1,216,701
2011	74.9 %	1.9 %	927,636	1,238,598
2010	71.2 %	2.3 %	893,640	1,255,446
2009	62.9 %	2.6 %	818,840	1,302,154

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM VAX-MEN - Notes:

None

Data Alerts: None

NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	8.6	0.1	5,031	585,508
2021	9.1	0.1	5,373	592,626
2020	10.0	0.1	5,681	566,924
2019	11.4	0.1	6,606	577,660
2018	11.7	0.1	6,847	584,413
2017	12.5	0.1	7,480	600,098
2016	13.2	0.2	8,003	607,309
2015	14.6	0.2	8,961	612,905
2014	16.1	0.2	9,954	619,857
2013	17.6	0.2	11,128	630,896
2012	19.6	0.2	12,592	642,269
2011	21.0	0.2	13,718	652,723
2010	22.8	0.2	15,126	663,928
2009	24.2	0.2	16,306	673,401

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM TB - Notes:

None

Data Alerts: None

NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression, Formerly NOM 24) - PPD

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	12.0 %	0.9 %	21,822	182,333
2021	11.7 %	0.9 %	21,602	184,546
2020	10.0 %	1.0 %	8,396	84,005
2019	12.9 %	1.1 %	25,052	194,416
2018	13.2 %	1.0 %	25,880	196,096
2017	13.0 %	0.9 %	26,713	204,888
2016	13.6 %	0.9 %	28,516	209,969
2015	12.2 %	0.9 %	25,899	212,047
2014	11.4 %	0.8 %	24,427	214,506
2013	11.0 %	0.8 %	23,561	213,692
2012	12.0 %	1.1 %	13,109	109,303

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM PPD - Notes:

None

Data Alerts: None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	3.0 %	0.4 %	121,676	3,996,524
2020_2021	3.5 %	0.7 %	139,450	3,944,330
2019_2020	2.8 %	0.6 %	113,100	3,985,954
2018_2019	1.9 %	0.6 %	77,821	4,006,173
2017_2018	2.3 %	0.9 %	92,322	4,022,048
2016_2017	2.2 %	0.8 %	89,530	4,105,754

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM FHC - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: New York

NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective		79.4	80.3	81.3	82.2
Annual Indicator	79.6	78.3	78.3	75.9	75.5
Numerator	2,826,660	2,737,695	2,703,220	2,698,183	2,643,832
Denominator	3,550,054	3,498,639	3,451,509	3,553,627	3,503,858
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2018	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	83.1	83.3

Field Level Notes for Form 10 NPMs:

None

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

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	93.7	93	92.4	92.6	92.8
Annual Indicator	91.2	92.2	91.6	91.3	91.6
Numerator	2,782	2,626	2,610	2,437	2,610
Denominator	3,052	2,849	2,850	2,668	2,850
Data Source	NYS VS	NYS VS	NYS VS	NYS VS	NYS VS
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	93.1	93.4

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CHILD					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			27.5	27.8	28.1
Annual Indicator	27.0	27.4	22.4	24.1	26.6
Numerator	369,498	316,874	272,297	308,176	345,661
Denominator	1,370,994	1,158,167	1,213,091	1,278,404	1,300,265
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	28.4	28.6

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	82.2	83.2	81.5	82.2	82.9
Annual Indicator	81.3	86.3	82.9	72.8	71.3
Numerator	1,081,532	1,367,654	1,218,475	976,520	972,723
Denominator	1,331,106	1,583,876	1,469,455	1,341,167	1,363,869
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	83.8	84.6

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	15.9	16.1	18	18.1	18.3
Annual Indicator	17.8	23.6	19.1	11.8	17.9
Numerator	48,580	87,040	73,058	40,243	59,380
Denominator	273,067	369,539	381,623	340,705	331,183
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	18.5	18.7

Field Level Notes for Form 10 NPMs:

None

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	91.2
Numerator	166,888
Denominator	182,980
Data Source	PRAMS
Data Source Year	2022

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	76.2
Numerator	124,429
Denominator	163,344
Data Source	PRAMS
Data Source Year	2022

Field Level Notes for Form 10 NPMs:

None

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 - Child Health - All Children

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - All Children	
	2023
Annual Objective	
Annual Indicator	45.6
Numerator	1,834,655
Denominator	4,020,084
Data Source	NSCH-All Children
Data Source Year	2021_2022

Field Level Notes for Form 10 NPMs:

None

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 - Children with Special Health Care Needs

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2023
Annual Objective	
Annual Indicator	37.4
Numerator	274,332
Denominator	734,189
Data Source	NSCH-CSHCN
Data Source Year	2021_2022

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: New York

SPM 1 - Percent of samples received by the State Newborn Screening lab within 48 hours of collection

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			75	77	79
Annual Indicator	70	68	70	70.6	67.2
Numerator					
Denominator					
Data Source	Newborn Blood Spot data	Newborn Blood Spot data	Newborn Blood Spot data	Newborn Blood Spot data	Newborn Blood Spot data
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	81.0	85.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: QI project did not begin until December 2019, snow storm after Thanksgiving caused shipping delays that impact timeliness of the lab receiving samples.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2020 data was significantly impacted by the 2019 snow storm and subsequent holiday shipping delays early in the year and then by the COVID-19 pandemic for the remainder of the year. 2020 data was reported as preliminary in 2022 application and now finalized for 2023 application.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: With the change of the OGS contract, we were forced to move all 120+ birth hospitals to FedEx and were not able to extend UPS during the conversion, which led to some delays in receipt / shipping and receipt. Onboarding took the greater part of 8 months.	

SPM 2 - Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			3.6	12.1	12
Annual Indicator		3.6	12.1	10.4	10.4
Numerator		1,772	6,063	4,443	4,412
Denominator		498,946	502,219	428,592	423,739
Data Source		NYS Child Health Lead Poisoning Prevention Program	NYS Child Health Lead Poisoning Prevention Program	NYS Child Health Lead Poisoning Prevention Program	NYS Child Health Lead Poisoning Prevention Program
Data Source Year		2018	2019	2020	2021
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	11.9	11.8

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2021 is the baseline year. Incidence of confirmed (>=10 ug/dL) high blood lead levels per 1,000 tested children aged less than 72 months' is 3.55 for test year 2018.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Update baseline to test year 2019 for incidence of confirmed (>=5 ug/dL) high blood lead levels per 1,000 tested children aged less than 72 months. 2016-2019 NYS Child Health Lead Poisoning Prevention Program Data as of September 2021 from Community Health Indicator Reports (CHIRS).	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Per data reported in CHIRS dashboard for birth year 2018 cohort.	

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: New York

ESM WWV.1 - Percent of Maternal and Infant Community Health Collaboratives (MICHC) program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker (CHW)

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			55.3	58.1	61
Annual Indicator	52.7	63.4	40.1	53.9	62.4
Numerator		2,068	573	1,299	1,668
Denominator		3,260	1,430	2,412	2,675
Data Source	MICHC Program Data	MICHC Program Data	MICHC Program Data	MICHC Program Data	MICHC Program Data
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	64.1	67.3

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Baseline data period for 10/1/19-3/31/20	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data collection period was 10/1/19-9/30/20, note the first half of this period is inclusive of the baseline data period.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numbers reported for program period of 4/1/21- 9/30/21 as new data system was implemented as of 4/1/21. Current measure is updated and more accurate with the use of data system than previous data collection allowed.	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Per data reported in DMIS for 10/1/22 to 9/30/23.	

ESM WWV.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			37.5	37.7	37.9
Annual Indicator	37.3	36.2	29.7	32.9	33.5
Numerator		92,136	58,264	66,886	64,392
Denominator		254,718	195,847	203,468	191,962
Data Source	Family Planning Program Client Visit Record data	Family Planning Program Client Visit Record data	Family Planning Program Client Visit Record data	Family Planning Program Client Visit Record data	Family Planning Program Client Visit Record data
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	38.2	38.2

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Decline in 2020 rates assumed due to COVID

ESM RAC.1 - Percent of birthing hospitals with final level of perinatal care designation, in accordance with updated regulations and standards

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			0	0	50
Annual Indicator	0	0	0	0	0
Numerator					
Denominator					
Data Source	NYS Data	NYS Data	NYS Data	NYS Data	NYS Data
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	75.0	100.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Re-designation process still underway, no data to report. Anticipate completion in December 2021.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Re-designation still in process; no data to report	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Re-designation still in process; no data to report	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Re-designation still in process; no data to report.	

ESM PA-Child.1 - Percent of children and youth enrolled in School Based Health Centers (SBHCs) who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a SBHC within the past year.

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			51.6	51.6	52.6
Annual Indicator		51.6	43	35.1	50.6
Numerator		98,941	74,325	54,615	79,697
Denominator		191,920	172,751	155,443	157,601
Data Source		SBHC quarterly report	SBHC quarterly report	SBHC quarterly report	SBHC quarterly report
Data Source Year		2018-2019	2019-2020	2020-2021	2021-2022
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	53.6	54.7

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data is based on July 1, 2018-June 30, 2019. 10 SBHC sites were excluded because their percentage exceeded 100%. Measure wording changes: ESM 8.1.1 - Percent of children and youth enrolled in School Based Health Centers (SBHCs) who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a SBHC within the past year"	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data is based on July 1, 2019-June 30, 2020. Data notes: 8 SBHC sites were excluded because their percentage exceeded 100%. Many SBHCs closed in March of 2020 due to the COVID-19 public health emergency.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Grant cycle: July 1, 2020-June 30, 2021. Six SBHC sites were excluded because their percentage exceeded 100%.	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Data is based on July 1, 2021-June 30, 2022. Data notes: 10 SBHC sites were excluded because their percentage exceeded 100%.	

ESM AWV.1 - Percent of youth-serving programs that provide training on adult preparation subjects, such as accessing health insurance, maintaining their routine preventive medical visits, healthy relationships, effective communication, financial literacy, etc.

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			96.3	96.3	98.2
Annual Indicator		96.3	100	100	96.1
Numerator		52	52	52	49
Denominator		54	52	52	51
Data Source		Survey of CAPP and PREP Programs	Survey of CAPP and PREP Programs	Survey of CAPP and PREP Programs	Survey of CAPP and PREP Programs
Data Source Year		2020	2021	2022	2023
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	100.0	100.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Baseline data period 7/1/20-12/31/20. Surveyed CAPP &/or PREP providers, those who checked that they did training or education with youth/adolescent participants in the following topics included in numerator: Accessing health insurance, Healthy relationships, Educational and career success, Financial literacy, Healthy life skills, Maintaining routine preventive medical visits, Transitioning to adult health care, and relevant "Other" topics. 100% response rate	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data from 1/1/2021 - 12/31/2021. Surveyed CAPP &/or PREP providers, those who checked that they did training or education with youth/adolescent participants in the following topics included in numerator: Accessing health insurance, Healthy relationships, Educational and career success, Financial literacy, Healthy life skills, Maintaining routine preventive medical visits, Transitioning to adult health care, and relevant "Other" topics. Response rate: 96.3% (52/54)	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Total of 53 programs, one did not respond (missing data)	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Data from 1/1/2023 - 12/31/2023. Total of 55 programs, four did not respond (missing data)	

ESM AWV.2 - Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			68.7	70.1	71.6
Annual Indicator		68.7	78.1	79.4	73.3
Numerator		46	50	50	44
Denominator		67	64	63	60
Data Source		Survey of CAPP, PREP, and SRAE Programs	Survey of CAPP, PREP, and SRAE Programs	Survey of CAPP, PREP, and SRAE Programs	Survey of CAPP, PREP, and SRAE Programs
Data Source Year		2020	2021	2022	2023
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	73.1	74.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data from 7/1/2020 - 12/31/20. Baseline data period is 7/1/20-12/31/20. Surveyed CAPP, PREP, & SRAE providers, those who responded yes to engaging youth in program planning and implementation included in numerator, 100% response rate	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data from 1/1/2021 - 12/31/21. Surveyed CAPP, PREP, & SRAE providers, those who responded yes to engaging youth in program planning and implementation included in numerator. Response rate: 97.0% (64/66).	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Total of 65 programs, two did not respond (missing data)	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Data from 1/1/2023 - 12/31/23. Total of 67 programs, seven did not respond (missing data)	

ESM TR.1 - Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			40.3	41.1	41.5
Annual Indicator	40.3	62.4	66.1	74.8	67.5
Numerator		295	323	450	291
Denominator		473	489	602	431
Data Source	Contractor Reports	Contractor Reports	Contractor Reports	Contractor Reports	Contractor Reports
Data Source Year	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	41.9	42.3

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Baseline based on 2018-2019 data	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Based on 2019-2020 data.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data from 7/1/2020 - 6/30/2021	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data from July 1, 2021-June 30, 2022	
5.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Data from 7/01/2022-6/30/2023. Data represents numerator and denominator for individuals who had transition readiness assessments completed. Previous years data from 7/01/2021-6/30/2022 mistakenly represents the numerator and denominator for individuals who kept an appointment.	

Form 10
State Performance Measure (SPM) Detail Sheets

State: New York

SPM 1 - Percent of samples received by the State Newborn Screening lab within 48 hours of collection
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	The goal is to achieve state-wide improvement from 74.34% to greater than 85% of samples received at the lab within 48 hours of collection by September 2023
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of samples received within 48 hours of collection **Denominator:** Number of births
Data Sources and Data Issues:	NYS Newborn Blood Spot Data
Significance:	This SPM was developed to reflect the state's continued commitment to ensure that every newborn in the state receives newborn bloodspot screening as a public health service, to identify and support infants with a wide range of medical conditions. As a population-based program, the NBS program is an integral part of NY's public health system for supporting the health and lifelong well-being of newborns and their families. In 2018, the program screened 222,049 infants, 99.98% of all NYS resident infants born that year, and timely receipt of the sample is critical to ensure appropriate care can be provided. The Title V Program will collaborate with the Newborn Blood Spot Program to support the quality improvement initiative to improve timely receipt of newborn blood spot samples.

SPM 2 - Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months
Population Domain(s) – Children with Special Health Care Needs

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Reduce the incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months by at least 5% each year.</td></tr>
<tr><td>Definition:</td><td><table>
<tr><td>Unit Type:</td><td>Rate</td></tr>
<tr><td>Unit Number:</td><td>1,000</td></tr>
<tr><td>Numerator:</td><td>Number of children ages less than 72 months old with blood lead levels 5.0 micrograms per deciliter or greater</td></tr>
<tr><td>Denominator:</td><td>Number of children ages less than 72 months old with blood lead tests</td></tr>
</table></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Baseline data is based on the confirmed high blood lead levels (>=10 ug/dL) from 2015-2018 NYS Child Health Lead Poisoning Prevention Program Data as of November, 2020.</td></tr>
<tr><td>Significance:</td><td>This SPM was developed to reflect the state’s longstanding commitment to eliminating childhood lead poisoning as a key public health problem in NYS. It is responsive to cross-cutting priorities voiced by families related to safe and healthy environments to support children’s development, and access to comprehensive, high quality health care services. It is also responsive to specific concerns shared by families regarding challenges in accessing and coordinating medical care and related services for children with special health care needs. It builds on critical public health investments and capacity to prevent, identify, and address lead poisoning in NYS, including recent amendments to state public health law</td></tr>
</table>

Form 10
State Outcome Measure (SOM) Detail Sheets

State: New York

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: New York

ESM WWV.1 - Percent of Maternal and Infant Community Health Collaboratives (MICHC) program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker (CHW)
NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV

Measure Status:	Active
Goal:	The baseline value for this measure, taken from 6-month program period of 10/1/19-3/31/20, is 52.7%. The program has set an improvement target of 5% annually, to 67.3% of participants by 2024.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of MICHC participants engaged prenatally who have created a birth plan during a visit with a CHW **Denominator:** Number of MICHC participants engaged prenatally with a CHW
Data Sources and Data Issues:	Data for this measure will come from quarterly and annual reports submitted by local MICHC contractors.
Significance:	Through the Maternal & Infant Community Heath Collaboratives (MICHC) program, community health workers (CHWs) conduct basic health and well-being assessments in the prenatal and postpartum periods, using standardized evidence-based and/or validated screening tools, to identify and prioritize needs of the individuals and families served. Assessments are completed at enrollment and updated throughout clients' service periods and individualized care plans are developed based on the needs identified. CHWs receive annual training on how to talk with families about difficult topics like mental health and depression, using a trauma informed care approach, and including how to manage emergency situations. CHWs also connect clients and families to needed services and provide enhanced social support. CHWs help ensure early and consistent participation in preventive and primary health care services, including early prenatal care, particularly for those individuals not engaged in care and other supportive services. CHWs provide health information to increase clients' knowledge and ability to self-advocate and make informed health care decisions, with the goal of helping families achieve optimal health, self-sufficiency, and overall well-being.

ESM WWV.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year
NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV

Measure Status:	Active
Goal:	Current FPP data for program year 2018 shows 37.3% of female FPP clients had a documented comprehensive medical exam. The FPP program has set a five-year improvement target of 2.5%, to 38.2% of clients in 2023.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Family Planning Program clients with a documented comprehensive medical exam in the past year **Denominator:** Number of FPP clients
Data Sources and Data Issues:	Data for this measure will come from FPP clinic visit record (CVR) data.
Significance:	The NYS Family Planning Program (FPP) supports 43 Article 28 health facilities (i.e., hospitals and clinics) that operate 156 family planning service sites across the state. Through these service sites, the FPP delivers comprehensive, confidential reproductive health services for low-income, uninsured and underinsured women and men of reproductive age. Services provided include: contraceptive services; preconception planning and counseling services; pregnancy testing and related counseling; preventive services such as basic health screening, screening for sexually transmitted diseases, HIV counseling and testing, breast and cervical cancer screening; and appropriate referrals and health education.

ESM RAC.1 - Percent of birthing hospitals with final level of perinatal care designation, in accordance with updated regulations and standards
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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>The baseline value for this measure will be determined after regulations are adopted (anticipated in December 2021). The program has set a target to update designations for 50% of hospitals within one year post-adoption and 100% within three years.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of birthing hospitals with final level of perinatal care designation</td></tr>
<tr><td>Denominator:</td><td>Number of birthing hospitals</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data for this measure will come from hospital surveys and site visit reports from IPRO/NYSDOH staff</td></tr>
<tr><td>Significance:</td><td>NYS historically has been a leader in establishing systems of perinatal regionalization, with consistently high performance in this measure. Building on that success, the Title V program is currently engaged in a multi-year effort to expand and update perinatal regionalization standards and designations for the state’s birthing hospitals and centers. As this work progresses, it is essential to closely monitor the success of designating birthing hospitals in accordance with updated regulations as well as performance and outcome measures to ensure that quality of care and key health outcomes are maintained or improved.</td></tr>
</table>

ESM PA-Child.1 - Percent of children and youth enrolled in School Based Health Centers (SBHCs) who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a SBHC within the past year.
NPM – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day (Physical Activity - Child, Formerly NPM 8.1) - PA-Child

Measure Status:	Active
Goal:	The baseline for 2021 (51.6%) has been established using program year 2018-2019 data. Targets have been established to achieve a 2% increase each year.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Children and youth enrolled in SBHCs who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a SBHC within the past year **Denominator:** Children with a visit to a SBHC within the past year
Data Sources and Data Issues:	Data for this measure comes from the SBHC quarterly reports. Targets have been established to achieve a 2% increase each year, except for 2022 as the first year is primarily a planning year and an increase in anticipatory guidance delivery is not expected.
Significance:	NY's Title V program has important capacity to address these priorities through its School Based Health Center (SBHC) program. SBHCs serve NYS's highest need communities and provide critical access to quality primary care for school-aged children. SBHCs are an important source of primary and preventive care services for thousands of NYS children, and have the opportunity and capacity to holistically address children's needs. Title V staff will work with SBHCs statewide to ensure anticipatory guidance to promote proper nutrition and daily physical activity, weight status assessment, and attention to overall health promotion and chronic disease management, as part of routine primary and preventive care for children.

ESM AWV.1 - Percent of youth-serving programs that provide training on adult preparation subjects, such as accessing health insurance, maintaining their routine preventive medical visits, healthy relationships, effective communication, financial literacy, etc.
NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>The baseline value for this measure, taken from a 6-month program period of 7/1/2020 – 12/31/20, is 96.3%. The program has set an improvement target of 100% by 2025.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of youth-serving programs that provide training on adult preparation subjects for adolescents with and without special health care needs to prepare them for a transition into adulthood</td></tr>
<tr><td>Denominator:</td><td>Number of youth-serving programs that provide training on adult preparation subjects for adolescents with and without special health</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data for this measure will come from biannual reports and annual data requests submitted by local adolescent health providers.</td></tr>
<tr><td>Significance:</td><td>Adolescence is a critical stage of development when children grow physically, cognitively, emotionally, and socially to become adults. The lifestyle choices, behaviors, and relationships established during this time can affect an adolescent’s current and future health. Comprehensive and inclusive reproductive health care and education are opportunities to help adolescents avoid or mitigate risky sexual behaviors. Title V Programs also provide enabling services to adolescents, such as referrals to and linkages with community services and social supports to holistically address health and wellness, including mental health and social determinants of health.</td></tr>
</table>

ESM AWV.2 - Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation
NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV

Measure Status:	Active
Goal:	The baseline value for this measure, taken from a 6-month program period of 7/1/2020 – 12/31/20, is 68.7%. The program has set an improvement target of 75% by 2025.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation **Denominator:** Number of youth-serving programs
Data Sources and Data Issues:	Data for this measure will come from biannual reports and annual data requests submitted by adolescent health providers.
Significance:	Significance needed

ESM TR.1 - Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.
NPM – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transitions to adult health care (Transition, Formerly NPM 12) - TR

Measure Status:	Active
Goal:	The baseline value for this measure, from the 2018-19 program grant cycle, is 40.3%. The program has set an improvement target of 5% for 2022, to 42.3%.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed **Denominator:** Individuals ages 14-21 with sickle cell disease who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment
Data Sources and Data Issues:	Sickle Cell Disease Care Transition contractor reports
Significance:	Sickle cell disease (SCD) grantees at three (3) Hemoglobinopathy Centers (HC) work directly and exclusively with youth in support services. HCs conduct peer support groups to gauge barriers to care and transition for youth and young adults with SCD. Transition navigators at HCs engage youth with SCD to ensure compliance with care regimens and to understand that barriers youth experience in caring for themselves. In studies by Treadwell et al. (2011) and Telfair (2004) participants with SCD voiced a fear of leaving their pediatric health care providers, expressing concern that adult care providers might not understand their needs and might not believe their complaints of pain. The youth also expressed concerns about having limited information about transition and about adult health care programs. There is increased risk for individuals with SCD during this transition period.

Form 11
Other State Data

State: New York

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
Part 1 – MCH Data Access and Linkages

State: New York

Annual Report Year 2023

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Quarterly	3		• Hospital Discharge
2) Vital Records Death	Yes	Yes	Quarterly	3	Yes	• Hospital Discharge • Infant Birth and Death • Mother death linked to infant birth
3) Medicaid	Yes	No	Quarterly	3	Yes	
4) WIC	No	No	Never	NA	No	
5) Newborn Bloodspot Screening	Yes	No	Annually	12	No	
6) Newborn Hearing Screening	Yes	Yes	Annually	12	Yes	• New York State Immunization Information System
7) Hospital Discharge	Yes	Yes	Quarterly	3	Yes	• Birth and Death
8) PRAMS or PRAMS-like	Yes	No	Monthly	12	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None

Form 12
Part 2 – Products and Publications (Optional)

State: New York

Annual Report Year 2023

Form 12 Products And Publications