# Maternal and Child Health Services Title V Block Grant

## New York

## FY 2026 Application/ FY 2024 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, 2025

Nora Carswell, 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 Ms. Carswell

With this letter, I transmit New York's FFY 2026 Maternal and Child Health Services Block Grant Application and FFY 2024 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

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## 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 *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms",* OMB NO: 0915-0172; Expires: December 31, 2026.

## 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 longest-standing Federal-State partnership to promote the health of mothers, children, youth, including Children and Youth with Special Health Care Needs (CYSHCN), and their families. Administered by the Health Resource and Services Administration's (HRSA) Maternal and Child Health Bureau, the Title V MCH Services Block Grant provides essential funding to states for public health activities focused on MCH.

Within the NYS Department of Health (Department), the Division of Family Health (DFH) leads Title V activities, providing department-wide leadership on MCH and collaborating across programs. In addition to managing many MCH public health programs, a key role is ensuring MCH needs are addressed through policy and cross-sector partnerships. This New York State Title V application demonstrates our ongoing commitment to protecting and promoting the health of women, infants, children, and families amid evolving public health and healthcare landscape, grounded in data-driven, evidence-based practice, and strengthened by meaningful family and community engagement.

This application marks the start of a new five-year federal funding cycle, thus including both the annual report for last year, a comprehensive statewide MCH Needs Assessment, and a new five-year action plan for 2025-30. The Needs Assessment synthesizes an array of data sources including community forums, population health surveys, provider and public surveys, and stakeholder meetings, resulting in 10 cross-cutting themes and seven updated MCH priorities. Our 2025–2030 State Action Plan details objectives, strategies, and measurable targets aligned with these priorities across the five Title V population domains. Reflecting our shared commitment to accountability, these include at least one National Performance Measure (NPM) and one state-developed Evidence-Based Strategy Measure to track our progress and impact for each domain.

**Title V State MCH Priorities and Performance Measures, 2025-30**

| Domain | Priorities | Performance Measures (NPMs) | Evidence-Based Strategy Measures (ESMs) |
|---|---|---|---|
| Women's & Maternal Health (WMH) | Support the health and well-being of women throughout pregnancy and postpartum periods | NPM - Postpartum Visit: A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components | ESM WMH-1: Percent of PICHC clients that attended a postpartum visit within 12 weeks of giving birth<br><br>ESM WMH-2: Percent of regular Big 6 postpartum visit peer learning meetings attended with active participation in presenting and/or responding to peer discussions |
| Perinatal & Infant Health (PIH) | Ensure risk-appropriate care for infants. | NPM - Risk-Appropriate Perinatal Care: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ NICU | ESM PIH-1: Percent of birthing facilities in NYS re-designated with updated perinatal standards |
| Child Health (CH) | Promote comprehensive patient-centered health care for children.<br><br>Promote healthy play and nutrition for all children | NPM – Medical Home: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home<br><br>NPM – Physical Activity: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day | ESM CH-1: Percent of students attending schools that have School Based Health Centers (SBHC) who are enrolled in the SBHC<br><br>ESM CH-2: Percent of SBHC operators that have 3 or more partnerships to promote physical activities for SBHC students ages 6-11. |
| Adolescent Health (AH) | Support physical and mental health and health care for adolescents. | NPM – Mental Health Treatment: Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling. | ESM AH-1: Percentage of Department-funded adolescent-serving programs that receive mental health-related trainings and resources |
| Children and Youth with Special Health Care Needs (CYSHCN) | Promote comprehensive patient-centered care for CYSHCN.<br><br>Support transition for youth with special health care needs to adult roles and care | NPM – Medical Home: Percent of children with special health care needs, ages 0 through 17, who have a medical home<br><br>NPM – Transition: Percent of adolescents with special health care needs, ages 12-17, who received services to prepare for transition to adult health care | ESM CYSHCN-1: Percent of regular Big 6 medical home for CYSHCN peer learning meetings attended with active participation in presenting and/or responding to peer discussions.<br><br>ESM CYSHCN-2: 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. |

Key products resulting from the process described above include the Title V Needs Assessment Summary and the five-year State Action Plan Table and narrative for the 2025-26 project year. Key elements of these documents are highlighted below for each population domain.

**Women's and Maternal Health (WMH):** Postpartum care is a new focus, recognizing this period as critical for maternal well-being. While most women attend postpartum visits, gaps remain in care quality and patient experience. The State Action Plan prioritizes evidence-based home visiting programs, expanded reproductive and family planning services, integration with perinatal regionalization, cross-sector partnerships to improve mental health, and public education. Progress will be monitored through postpartum visit attendance and staff engagement in state collaboration.

> *"It's hard to just give birth not being listened to...you have to advocate for yourself. It's a lot of work. You just want to give birth and know that you're going to be taken care of."*

> *"I started going there and they were so wonderful to me. It's a nurse run program…. They say takes a village and I had found one with these people. They were amazing."*

**Perinatal and Infant Health (PIH):** Risk-appropriate delivery for very low birth weight infants remains below target, with variations across regions. The State Action Plan emphasizes maintaining perinatal regionalization, referral and transport systems, quality improvement, home visiting expansion, improved family health communication, and cross-sector partnerships addressing social determinants. Facility re-designation rates will track progress.

> *"When my baby was in intensive care, the care was really good for him. It's nice, even though you have to see your baby with so many wires on him, an incubator, they tried to make the experience more pleasant."*

> *"Looking into those great eyes was just worth all the pain…the first time my son smiled at me…it's like that sensation that you get in your heart. It's just amazing."*

**Child Health (CH):** Challenges include obesity, behavioral health, dental decay, and low school readiness, compounded by access and environmental barriers. The State Action Plan supports a statewide School Based Health Center (SBHC) network providing comprehensive care to children, promoting insurance enrollment, and partnering with mental health, Medicaid, and community initiatives to improve healthy play and nutrition. Impact is tracked through SBHC enrollment and physical activity partnerships.

> *"I appreciate the health services offered at my kids' school. It's a relief to know that they get health screenings and mental health support there."*

> *"[I] hope there will be changes; our children deserve a better world."*

**Adolescent Health (AH):** Mental health treatment is the selected NPM, reflecting persistent challenges and service gaps. Other issues include obesity, nutrition, physical activity, and social determinants such as housing and safety. The State Action Plan focuses on expanding SBHC services, enhancing provider mental health capacity via the state's Project TEACH (https://projectteachny.org), training local programs, and creating a Youth Advisory Group. Training dissemination and resource provision will be monitored.

> *"Mental health services were helpful in providing positive coping skills to deal with stress."*

> *"If people understood more about how to take care of themselves, like learning about nutrition, exercise, and mental health, I believe we could live healthier lives."*

**Children and Youth with Special Health Care Needs (CYSHCN):** Nearly 20% of NYS children have special needs, yet fewer than 40% have a medical home and few receive comprehensive, coordinated care or transition supports. Families face fragmented services, financial burdens, and provider shortages worsened by COVID-19. The State Action Plan promotes patient-centered care via programs administered by Local Health Departments, connects families to providers, supports SBHC best practices, ensures follow-up for lead poisoning, enhances Medicaid care coordination, engages families, and advances transition services using models like Got Transition®. Progress is tracked through peer collaboration and transition readiness assessments.

*“We are really struggling to figure out how to access things…It has been very, very challenging, both finding things, submitting for them, getting them covered.”*

*“I don't know what's going to happen to my son when he graduates. I'm nervous because no one's really giving me any information.”*

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

Federal Title V funds complement a broad array of state investments in the health of maternal and child health (MCH) populations. New York State offers comprehensive Medicaid benefits for pregnant women, infants, and children; operates a robust state health insurance exchange; and provides universal health insurance access for children through Child Health Plus, our State Child Health Insurance Program (S-CHIP), including subsidized coverage for families up to 400% of the Federal Poverty Level. The state devotes significant state budget appropriations to MCH programs and initiatives. Many of these - including family planning and reproductive health, perinatal home visiting and community-based initiatives and adolescent health - are supported through a combination of federal Title V funding, other federal grants, and state dollars.

A central use of federal Title V funds is to sustain core public health infrastructure, including critical staffing within the Division of Family Health and other key areas of the Department of Health. This staffing ensures robust fiscal and programmatic oversight of both state and federally funded MCH programs as well as policy and guidance development and implementation. It also builds the foundation for successfully pursuing MCH grant applications and implementation of additional federal awards, both directly and through the Department's bona fide agent, Health Research, Inc. (HRI). Notable HRI-administered grants include HRSA and CDC support for the Perinatal Quality Collaborative, Maternal Mortality Review Board, Early Hearing Detection and Intervention system, Pediatric Mental Health Care Access, Rape Prevention Education, and the State Maternal Health Innovation program. These resources complement Title V by supporting special initiatives, such as a pilot for universal virtual home visiting in remote rural areas and expanded capacity for on-site mental health services in School-Based Health Centers. HRI-funded staff work within the NYS Department of Health and in close coordination with state-funded staff across the Division of Family Health and the broader Department of Health.

The Division of Family Health also directly administers several major federal programs that align closely with Title V goals, including the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, the Personal Responsibility Education Program (PREP), Sexual Risk Avoidance Education, Part C of the Individuals with Disabilities Education Act, and Title X Family Planning. Title V supports leadership capacity to align these initiatives and ensure coordination with Title V priorities. Further examples are detailed in the State Action Plan.

Title V also reinforces and extends state-funded efforts. Key examples include support for New York's perinatal regionalization system, School-Based Health Centers, adolescent pregnancy prevention initiatives, and community health workers focused on maternal, perinatal, and infant health. Title V staff work in close partnership with the state's Medicaid program, housed within the Office of Health Insurance Programs at the NYS Department of Health. Title V and Medicaid staff collaborate frequently to align Medicaid policies and initiatives with MCH public health goals - supporting efforts such as Health Homes for children, expanded access to doula care, and school-based health care. Planned collaborations are described in the State Action Plan.

New York's MCH systems are complex and multifaceted. Title V funding and guidance provide a strong backbone for this work, supporting integration, innovation, and sustained capacity to improve the health and wellness of New Yorkers from birth through reproductive age.

**III.A.3. MCH Success Story**

## Centering the Communities' Voices:

The New York State Department of Health values community input, especially for the comprehensive needs assessment. One of our great successes in the past year was the broad engagement of community members – expanding and improving upon our work in the last comprehensive needs assessment completed in 2019-2020.

One of our key efforts focused on community-based organizations. A total of 71 in-person or virtual listening sessions were held across the state, hosted by 26 distinct community-based organizations, engaging a total of 883 community participants. We leveraged trusted relationships with existing community partner organizations that have experience and expertise serving the Maternal and Child Health (MCH) populations to host the sessions, with emphasis on engaging MCH populations across the life course including expectant families, parents/caregivers, children, and adolescents including children and youth with disabilities and/or special health care needs and their families. State Title V staff provided training to each organization along with standardized questions to guide the conversations including people's vision for their own community, what they need to be healthy, the availability of services in their community, and their healthcare and service experiences. Childcare, transportation, refreshments, and gift cards were provided to facilitate participation. Listening sessions were held in 30 counties of the state's 62 counties and engaged residents of 33 counties. Participants came from urban, rural, suburban settings and represented the breadth of the state's population.

We also conducted, through a contractor with expertise in community engagement, a series of eight listening sessions across the state. The focus was more specific to recently giving birth. We heard from a total of 62 people who had given birth within the prior two years to learn more about their experience of care to improve health care services and patient experiences during prenatal, childbirth, and postpartum periods. Using a standardized facilitation guide, participants shared their perspectives on their pregnancy, birthing, and postpartum experiences. Participants in this engagement also came from urban, rural, suburban settings and were all different ages, educational levels, employment statuses, and insurance statuses.

Title V-funded Regional Support Centers (RSCs) conducted surveys and interviews with families of children and youth with special Health care needs (CYSHCN) to explore service access and experiences with local health departments CYSHCN programs. A link to an online survey was sent to families. The survey included multiple-choice and open-ended questions. Following survey completion, RSC staff scheduled semi-structured virtual interviews to gather deeper insights, including recommendations for local programs, desired supports and services, and effective outreach methods. A total of 195 participants completed the survey, with 121 (62%) participating in follow-up interviews. These individuals lived in 47 counties.

The staff within the NYS Department of Health worked diligently on the comprehensive needs assessment and are proud of the final product. More information about the needs assessment and the findings are detailed further within this year's application.

## III.B. Overview of the State

### III.B.1. State Description

According to five-year population estimates from the 2023 American Community Survey, New York State is the fourth most populous state in the country, with just under 20 million people (19,872,319). Within the state, approximately 43% of the population (8,516,202) 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%.

Demographics

New York State is home to a wide-ranging population.

Of New York State's 19,872,319 residents, approximately 53.4% of individuals identify as White alone, 19.6% identify as Hispanic or Latino, 13.6% identify as Black or African American, 8.8% identify as Asian alone, 0.2% identify as American Indian or Alaska Native, and less than 0.0% identify as Native Hawaiian or Other Pacific Islander.

Selected counties in NYC have the highest percentage of Black or African American residents. According to five-year estimates from 2023, more than one quarter 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 54.9% of the total county population identifying as Hispanic or Latino.

Households and Families

According to five-year estimates from the 2023 American Community Survey, there are 7,668,956 households in New York State, with an average of 2.51 people per household. Of these households, 42.9% (3,289,982) are married couple families. Approximately 27.8% (2,130,918) of all households have at least one child under the age of 18.

Income and Poverty

Five-year estimates from the 2023 American Community Survey reveal that the median household income in New York State is $84,578. 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 $140,000.

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 2023 American Community Survey, the average median household income in 2023 inflation-adjusted dollars is $95,712 for White people, $94,665 for Asian people, $61,528 for Black or African American people, $64,615 for Hispanic or Latino people, and $63,315 for American Indian and Alaska Native people.

Differences in earned income has also increased over time in the state. The Gini coefficient has risen from 0.499 in 2010 to 0.52 in 2023. New York State ranks highest among all states in terms of income variation.

According to five-year estimates from the 2023 American Community Survey, 13.7% 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 (26.9%) and Kings County (18.9%), as well as Broome County (18.9%).

Age Distribution

The median age in New York State is 39.6. Approximately 20.7% (4,109,277) of the population is under 18 years of age, and roughly 17.4% (3,461,186) of the population is 65 years or older. The median age has increased over the past decade, rising from 37.7 in 2007.

Women of Childbearing Age

Five-year estimates from the 2023 American Community Survey indicate that 38.5% (3,936,272) of women are of childbearing age (15-44 years). Of these women, 5.6% (221,577) had a birth in the past 12 months.

According to the Pregnancy Risk Assessment Monitoring Survey in 2023, 91.3% of women attend a postpartum checkup within 12 weeks after giving birth. Of those who attend a checkup, only 67.2% received the recommended care components such as mental health guidance and methods for birth control.

Children

Of New York State's 19,872,319 residents, 5.6% of the population is under the age of 5 and 20.7% of the population is under the age of 18. According to five-year estimates from the 2023 American Community Survey, approximately 18.2% of all children in the state are living with families below the federal poverty line. Further, 5.1% of children are living with families where neither parent is in the labor force.

The physical and mental health of children is crucial to their overall health. According to two-year estimates from the 2022-2023 National Survey of Children's Health (NSCH), 24.3% of children aged 6-11 were physically active for at least 60 minutes per day, and only 15.9% of children aged 12-17 met this level of activity every day. In addition, 18.8% of children aged 12-17 had depression or anxiety. Of these children, 13.2% did not receive needed mental health treatment or counseling. Nearly one third (31.4%) of parents or caregivers reported it was "somewhat difficult" for their child to get necessary mental health treatment or counseling, 24.1% reported it was "very difficult," and 2.8% reported that "it was not possible to obtain care".

Children and Youth with Special Health Care Needs

According to 2022-2023 National Survey of Children's Health expanded children with special health care needs criteria, it is estimated that 24.9% (1,002,355) of children ages 0-17 years in New York State had a special health care need. About 90% of New York State children and youth with special health care needs experienced at least one health condition. Caregivers most commonly reported their child as being diagnosed with allergies, followed by anxiety, attention deficit disorder (ADD) or attention-deficit/hyperactivity disorder (ADHD), learning difficulty, behavioral/conduct problem, developmental delay, and speech or language disorder. While the presence of functional difficulty was less common than the presence of health conditions, 63.5% of children and youth with special health care needs experienced at least one functional difficulty.

Nearly one in seven children and youth with special health care needs had their daily activities greatly affected by their health condition(s). More than 5 times as many children and youth with special health care needs ages 6-17 missed 11 or more school days over the past year due to illness, compared to children and youth without a special health care need. Nearly half of children and youth with special health care needs ages 6-17 reported having trouble making or keeping friends, compared to children and youth without a special health care need.

Families of children and youth with special health care needs face more financial strain and spend more time coordinating their child's care than families without children and youth with special health care needs. Nearly four in ten families with children and youth with special health care needs reported spending at least one hour per week coordinating their child's health care. Families of children and youth with special health care needs 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. Nearly all the children and youth with special health care needs have health insurance coverage all year (97.1%); however, families of children and youth with special health care needs were less likely to have adequate health insurance and have insurance benefits that meet their child's needs.

Medical home is a concept that evaluates health care accessibility and quality of care for children with and without special health care needs, as determined by five key components: usual source of sick care, personal doctor or nurse, family-centered care, no problems with referrals, and care coordination. Based on the 2022-2023 National Survey of Children's Health data, only 40.4% of children and youth with special health care needs met all five components of medical home criteria, compared to 46.8% of children and youth without special health care needs in New York State. Care coordination is the deliberate organization of patient care activities between providers, patients, and families across multiple health systems to facilitate the appropriate delivery of health care services. Of the five medical home components, effective care coordination was most frequently reported as being unmet for children and youth with special health care needs. In contrast, family-centered care was the medical home component most frequently reported as being met (82.4%) among children and youth with special health care 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 families are typically the decision makers and sources of support and information for children, a collaborative approach to health care is beneficial. Family-centered care is also comprised of five individual components: doctor spending enough time with child, doctor listening carefully, doctor showing sensitivity to family values and customs, doctor providing information specific to parents' concerns, and doctor helping parents to feel like partners in care. The percent of children and youth with special health care needs who reported always receiving each component ranged from 52.6% to 67.0%, with doctors showing sensitivity ranking the highest and doctors spending enough time with the child ranking the lowest.

In addition to having a medical home, receiving the services necessary to make transitions to adult health care are vital to the long-term health of children with and without special health care needs. Approximately one in five children and youth with special health care needs ages 12-17 received services needed for transition to adult health care. Most adolescents (58.7%) had a chance to speak to their health care provider alone at their last preventive check-up, and most providers (64.4%) actively worked with adolescents with special health care needs to gain the skills to manage their health and health, while only 17.1% of providers discussed the shift to a provider who treats adults.

Education

According to 2023-2024 school year data published by the New York State Department of Education, 2,418,513 children are enrolled in K-12 public schools. Approximately 40% (958,900) of public-school students are White, 30% (731,865) are Hispanic, and 15% (373,563) are Black or African American.

According to a four-year cohort between 2020-2024, 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 80% of Hispanic or Latino students graduate from high school. Additionally, graduation rates differ based on other student characteristics. Students with disabilities (69%) and English language learners (52%) had lower graduation rates compared to the average public-school student. Migrants

(56%) and children in foster care (50%) also had lower graduation rates, although the total number of students for these groups was low.

In terms of educational attainment of adults (ages 25 and over), approximately 87.9% of the population has at least a high school diploma or General Educational Development (GED), while 22.0% of the population has a bachelor's degree, and 17.5% 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 2023 American Community Survey, 69.4% of the population over the age of 5 (13,017,480) speaks only English. Of the 5,751,878 residents that speak a language other than English, 14.7% speak Spanish, 8.9% speak other Indo-European languages, and 5.1% speak Asian and Pacific Island languages. Approximately 13.3% of the population who speaks a language other than English report that they speak English less than "very well."

Health Care

Approximately 6.0% of the non-elderly population (ages 0-64) in New York State has no health insurance. Five-year estimates from the 2023 American Community Survey reveal that uninsured rates vary significantly by ethnicity. While only 3.3% of White people are uninsured, 9.7% of Hispanic people, 13.6% of American Indian or Alaska Native people, 6.0% of Asian people, 12.8% of Native Hawaiian and Pacific Islander people, and 5.6% 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 access across all priority areas including promoting economic wellbeing; promoting mental wellbeing and preventing substance use; promoting safe and healthy communities; promoting health insurance coverage and access to care; and promoting preK-12 student success and educational attainment. The vision for the 2025-2030 Prevention Agenda emphasizes that every individual in New York State has the opportunity, regardless of background or circumstances, to attain their highest level of health across the lifespan. Title V Maternal and Child Health Services Block Grant funded staff ensured that the update in the 2025-2030 Prevention Agenda aligned with NYS's Title V Maternal and Child Health Services Block Grant State Action Plan.

**III.B.2. State Title V Program**

**III.B.2.a. 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 healthy outcomes. Department staff serve as stewards for this funding to ensure that programs support access 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.

To do the work to address support access to high-quality and respectful care, 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.

NYS has been working for the past two years to 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 in 2023-2024 and again in 2025 to discuss sustainability efforts. Title V Block Grant funding was also awarded to 26 organizations as part of the Needs Assessment to receive feedback about the needs of their communities. 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 Title V Block Grant Needs Assessment benefited greatly from this relationship.

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 implementation. 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 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 the Health Resources and Services Administration's (HRSA) Maternal and Child Health 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 across the state. The State Action Plan flows directly from the state's five-year Needs Assessment 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 New Yorkers.

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 area within the NYS Department of Health. As evidenced in the Annual Report and Application section, NYS continues to make substantial progress implementing defined strategies. 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 integrate the voice of our community.

New York State is large. We have a lot of work to do. As we prepare for the upcoming grant cycle and continue to integrate findings from our comprehensive Needs Assessment, we will ensure that the community is at the center driving the work of the Block Grant and that we are held accountable through quantitative and qualitative evaluation.

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 evidence and community voice.

**III.B.2.b. Organizational Structure**

The Title V Maternal and Child Health Services Block Grant is administered by the New York State Department of Health.

The New York State Department of Health (the Department) has been overseeing the health, safety, and well-being of New Yorkers since 1901 – from vaccinations to utilizing new developments in science as critical tools in the prevention and treatment of infectious diseases. The Department maintains a public website at health.ny.gov.

The Department is one of 97 agencies in NYS government. Other key agencies with which the Title V Maternal and Child Health Services Program engage include the Office of Children and Family Services, Office for People with Developmental Disabilities, Office for Mental Health, Office of Addiction and Support Service, Office of Temporary and Disability Assistance, Office for the Prevention of Domestic Violence, Office of Victim Services, Division of Criminal Justice Services, Department of Labor, Department of Education, Department of State, and the Office of Parks, Recreation, and Historic Preservation.

The Title V Program also collaborates with the state's Council on Children and Families (which convenes agencies that serve children and families) and the Council on Developmental Disabilities (which convenes the agencies that serve people across the lifespan with disabilities).

The Department of Health is an Executive Agency, under the direction of the Governor. Dr. James V. McDonald, MD, MPH. There is a leadership team made up of the Executive Deputy Commissioner, Johanne Morne, as well as the Chief of Staff, Maclain Berhaupt. The Department's Executive leadership team also includes the directors of the Department's Offices, many of these staff serve as Deputy or Associate Commissioners. The leadership team oversee the Departments broad portfolio from Medicaid, long-term care and nursing homes, public health, regulatory and safety oversight responsibilities, and the regional offices.

The Department is organized primarily into Offices which represent the major areas of work. Offices are typically nested within the organization into Centers, which have Divisions, which have Bureaus, and Units within the bureaus.

The Title V Program is within the Office of Public Health. This Office, which is one of the largest in the Department, administers the state's public health portfolio. This work includes community intervention and supports such as nutritional assistance programs like WIC and SNAP; chronic disease prevention such as asthma, diabetes, heart disease, and cancer; infectious disease detection and outbreak investigation for communicable diseases such as tick borne and food borne illnesses; vaccination and infectious disease prevention and outbreak mitigation for infectious diseases like measles, pertussis, and other infectious diseases; and family health where the state's Title V Program is situated. The Title V Program collaborates with each of these areas.

At the granular organizational level, the Division of Family Health is responsible for the Title V Program as well as other state federal investments. The largest investment is the state's Early Intervention Program which is authorized federally under Part C of the Individuals with Disabilities Education Act (IDEA) and overseen by the US Department of Education. The Division is responsible for the oversight and administration of this complex program, which is the third largest in the Department after Medicaid and WIC. The program serves 70,000 infants and toddlers with developmental delays every year, providing habilitative services such as physical therapy, occupational therapy, and speech services, at a total cost of almost $700M annually. The program is funded through Medicaid, local revenue and state budget investments.

The Division oversees multiple grants from the US Health and Human Services, either Health Resources and Services Administration or Centers for Disease Control and Prevention. These grants are highlighted throughout the application and include Maternal, Infant, and Early Childhood Home Visiting (MIECHV); ERASE Maternal Mortality; State Maternal Health Innovation; Perinatal Quality Collaborative; Early Hearing Detection and Intervention; Rape Prevention Education; and Pediatric Mental Health Care Access.

The Division administers many state appropriations that support Maternal and Child Health. These investments include funding for two home visiting programs (Perinatal and Infant Community Health Collaborative and Nurse Family Partnership), Regional Perinatal Centers, Perinatal Quality Collaborative support, School-Based Health Centers, teen

pregnancy prevention program, Infertility Reimbursement Program, Comprehensive Family Planning Program, Maternal Mortality Review, Safe Sleep, Sexual Assault Forensics Examiner training and support, and more.

The Office of Public Health oversees the Center for Environmental Health which is responsible for health factors associated with water, air, and land. These activities include safe drinking water, addressing air quality, and lead exposure prevention and mitigation in housing. The Center also oversees children's camps and community pools, including investigating injury and deaths. The Center includes the Congenital Malformations Registry. The Title V Program collaborates regularly with bureaus within the Center for Environmental Health. Title V funding supports the state's lead poison prevention program and regional technical assistance centers.

The Office of Public Health also oversees the state's system for Vital Records data collection. This includes birth and death data for New York State, outside of New York City. The NYC Department of Health and Mental Hygiene administers Vital Records for the five counties/boroughs of NYC. The state's Vital Records office is responsible for integrating the vital records data for NYC and the rest of the state into one data set. These data are used for the state's Vital Statistics, which are compiled, published, and analyzed by a separate office, the Office of Health Service Quality and Analytics which reports through the Department's Executive Deputy Commissioner, Johanne Morne. Title V Program relies upon the data and serves as subject matter experts related to the Department's vital records data collection

There is a new division in the Office of Public Health. It is called the Division of Public Health Infrastructure. This division is tasked with supporting the recruitment, retention, and training of the public health workforce within the Department as well as in the Local Health Departments. They engage with academic training instructions from high school through graduate degree. The Title V Program collaborates with this new division to share our expertise related specifically to Maternal and Child Health and share feedback about the training needs of our workforce.

Within the larger Department, there is the Office of Health Insurance Programs, which is responsible for the state's Medicaid Program. The Title V Program collaborates the most with this Office within the Department. There is an Intra-Agency Agreement (IAA) between the Title V Program and the Medicaid Program. The Title V Program has routine meetings with the Office about women and maternal health and a separate call about child and adolescent health, including children and youth with special health care needs. The topics discuss include pregnancy and postpartum care and reproductive care, as well as neonatal care, child coverage generally and within the context of the state's Early Intervention Program (Part C under the Individuals with Disabilities Act), School-Based Health Centers, and Medicaid's Health Home for Children which provides comprehensive care management for children with more complex medical needs. Staff from each of our offices serve on each other's work groups. We also share recommendations that can be turned into action. Maternal examples include the expansion to 12 months of postpartum care and inclusion of doulas and community health workers as benefits for Medicaid recipients. A child example was the inclusion of sickle cell disease as a singular qualifying condition for Health Home for Children. The Title V Program also actively disseminates Medicaid information and connects our partners at professional organizations and in birthing facilities to support Medicaid's efforts.

The Department has the Office of Primary Care and Health Systems Management which is responsible for the oversight and safety of hospitals and diagnostic and treatment centers. The Title V Program works closely with this Office as it relates to the perinatal regionalization and the efforts to update the state's perinatal regulations that govern birthing facilities. This Office also administers the state's Gestational Surrogacy Program. They will reach out to our Title V staff for review of applications for new birthing facilities, changes to birthing facilities, issues identified at a birthing facility, and for applications establishing Gestational Surrogacy Programs. The Office also includes the state's Office of Rural Health, with which we collaborate about rural issues, especially as maternal deserts are identified in our rural areas of the state.

The Department has a state-of-the-art public health laboratory, called the Wadsworth Center. The Wadsworth Center does critical work to keep NYS safe through detection of pathogens, certifying laboratories, and training public health laboratory scientists. The Title V Program works closes with Wadsworth's Newborn Screening Program. There are many examples highlighted throughout the Annual Report and Application about our shared work.

The Department has recently created the Office of Science. This Office is responsible for leading critical data analysis and overseeing statewide surveillance data systems, including the Pregnancy Risk Assessment Monitoring System (PRAMS). The Title V Program works with this Office on PRAMS, both to receive the data and to provide subject matter expertise on data-related questions and projects. This Office also provides the data support needed for the Division's oral health grant from the Centers for Disease Control and Prevention.

Under the Executive Deputy Commissioner, there are important Offices and Divisions with which we engage. These include the Office of Health Services Quality and Analysis, Division of Legal Affairs, Office for Emergency Preparedness, and Division of Administration.

The Office of Health Services Quality and Analysis as mentioned above is responsible for publishing the state's vital statistics data. The Title V Program relies upon this data and supports this Office by providing subject matter expertise about maternal and child health issues. This Office oversees data that are highlighted in the Other Data Capacity and State Systems Development Initiative (SSDI) sections of this Application and Annual Report.

The Title V Program engages with the Division of Legal Affairs for assistance with state and federal statutory and regulatory questions as well as when we need to make updates to state regulations. This Division reviews Requests for Proposals, Requests for Applications, contracts, and Memoranda of Understanding.

The Office for Emergency Preparedness is critical to the Department's response in time of crisis. The work of the Title V Program to support this Office are highlighted in the MCH Emergency Planning and Preparedness section of the application.

Of note within this area of the Department is the Division of Administration, which ash the Fiscal Management and Human Resources Management Groups. The Department has centralized administrative oversight in this Division. These groups are responsible for oversight of all procurements and contracts, expenditures and invoices, audit functions, and all human resources activities. The Title V Program engages with this Division to execute contracts with community-based partners and to hire staff, all of whom are highlighted throughout the application in every section as the infrastructure that supports Maternal and Child Health in NYS.

The Department's Public Affairs Group and the Office of Governmental and External Affairs reporting to the Chief Staff. The Public Affairs Group supports the Title V Program's media campaigns, press releases, and the public website. The Office of Governmental and External Affairs serves as a liaison with the State Legislature and external partners, including lobbying and special interest groups.

The majority of the Department's workforce are located in Albany, which is the state's capital. Given the size of the state, the Department has established Regional Offices in Western NY (Buffalo and Rochester offices), Central NY (Syracuse office), Capital District (Albany office), and Metropolitan Area (Manhattan and New Rochelle Offices). Regional Office staff are located more closely to their communities. They serve as liaisons to share information and to hear from communities to share back with staff in the Central Office which is the main Department of Health building. Regional Office staff are fully integrated into Title V work. They attend the domain team meetings and participate on the leadership team. They support specific projects and provide subject matter expertise on MCH initiatives.

The Department of Health is a large, complex agency. We prioritize intra-agency collaboration and a sharing of knowledge and expertise. There are formal and informal relationships between the different Department areas and the Title V Program, as there are between the Title V Program and other state agencies.

### III.B.3. Health Care Delivery System

#### III.B.3.a. System of Care for Mothers, Children, and Families

Access to comprehensive health care coverage is a significant factor in ensuring quality health care is accessible and available in a high-quality system of care for a state's population. New York has a comprehensive benefit package for eligible individuals that support primary and preventive health services including access to reproductive health services for infants, children, and adolescents, as well as adult women and men.

Medicaid plays a critical role as a payer of services and to ensure high quality services are delivered. New York's Medicaid program provides comprehensive health coverage to more than 7.5 million New Yorkers (as of December 2023). Medicaid pays for a wide range of services, depending on your age, financial circumstances, family situation, or living arrangements. These services are provided through a large network of health care providers that you can access directly using your Medicaid card or through your managed care plan if you are enrolled in managed care. Some services may have small co-payments, which can be waived based on income.

The state's Medicaid Program is largely managed through Medicaid Care Organizations (MCOs). There are different models of Managed Care Organizations: Health Maintenance Organizations (HMO), Prepaid Health Service Plans (PHSP), Preferred Provider Organization (PPO), HIV Special Need Plans (SNP), and Managed Long-Term Care Plans (MLTC). The State's Medicaid Program is administered by the Department of Health's Office of Health Insurance Programs.

Through the New York State of Health (NYSOH), New Yorkers can enroll into comprehensive health care coverage. New Yorkers shopping for coverage through the Marketplace are offered a wide selection of high-quality comprehensive health plans, with the support of certified enrollment assistors to guide them through the enrollment process, establish eligibility, and determine any potential financial assistance. All plans through the Marketplace provide free preventive care, such as

routine office visits and recommended screenings, and cover doctor's visits, hospital stays, emergency care, maternity and newborn care, mental health and substance abuse disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric dental and vision. The Marketplace has thousands of certified enrollment assistors throughout the state, available with flexible hours, to provide new and returning consumers with free in-person guidance through the enrollment process.

As of the end of May 2022, NY State of Health enrollment stands at nearly 6.6 million individuals, or one in three New Yorkers across the state. Enrollment has continued to grow as seen in the data below. The data below are for individuals who enrolled for insurance through the New York State of Health.

| Program Type | March 2020 Enrollment | May 2022 Enrollment |
|---|---|---|
| Medicaid | 3,387,348 | 4,995,405 |
| Child Health Plus | 456,214 | 384,665 |
| Qualified Health Plan | 265,071 | 225,726 |
| Essential Plan | 792,935 | 986,054 |
| Total | 4,901,568 | 6,591,850 |

(Source: NY State of Health Insurance Coverage Update, July 2022.pdf, https://info.nystateofhealth.ny.gov/sites/default/files/NY%20State%20of%20Health%20Insurance%20Coverage%20Update%2

As described throughout the Application and Annual Report, all Title V Programs prioritize engaging families into health care coverage and, for many programs overseen by the Title V Program, enrollment into health insurance is a required performance measure to promote outreach and engagement to all uninsured women, children and families. Within the Department of Health Title V staff also working closely with the NYS Medicaid Program.

The care that is received by women, men, mothers, fathers, and children are delivered in primary care medical settings, Federally Qualified Health Centers or Community Health Centers, School-Based Health Centers, diagnostic and treatment centers, hospitals, and emergent care. As seen in the State description section, NYS is large. There are tens of thousands of primary care providers, such as pediatricians, family physicians, nurse practitioners, gynecologists, obstetricians, midwives, physician assistants practicing in the state. The Department of Health is responsible for oversight of specific facilities. The NYS Department of Education oversees all licensure including but not limited to health care providers for the state.

For birth, individuals will most typically give birth in a birthing facility or hospital. The state's birthing system has a regional perinatal system of care. Perinatal regionalization is an evidence-based standard of care that ensures all pregnant patients and newborns have timely access to care. New York State's system of regionalized perinatal services includes a hierarchy of four levels of perinatal care provided by the hospitals within a region and led by a Regional Perinatal Center (RPC), a hospital capable of providing all the services and expertise required by the most acutely sick or at-risk pregnant patients and newborns. RPCs provide or coordinate maternal-fetal and newborn transfers of high-risk patients from their affiliate hospitals, and are responsible for support, education, consultation and improvements in the quality of care in the affiliate hospitals within their regions. They must be able to provide pediatric open-heart surgery for newborns within four hours of birth or be able to stabilize and transport newborns to other hospitals for surgery within four hours of birth. RPC quality assurance activities are supported by the Statewide Perinatal Data System that provides affiliate hospital data to them.

The four levels of perinatal care within the regional system are defined by the types of patients that are treated, availability of sub-specialty consultation, qualifications of staff, types of equipment available and volume of high-risk perinatal patients treated. Besides the RPC, there are three other levels of care:

- Level 1 hospitals provide care to normal and low-risk pregnant patients and newborns, and they do not operate NICUs
- Level 2 hospitals provide care to patients at moderate risk and do operate NICUs
- Level 3 hospitals care for patients requiring increasingly complex care and operate NICUs.

The Department funds 16 RPCs to work with their affiliate lower-level birthing hospitals to:

- Improve the quality of perinatal care provided at the RPC and RPC perinatal affiliates through outreach services including: 24-hour specialty and sub-specialty consultation services; patient transport coordination and services; outreach and education
- Improve the quality and uses of Statewide Perinatal Data System (SPDS) Core Module or Electronic Birth Record System and SPDS NICU Module data for the RPC and each affiliated hospital; ongoing technical support for use of the Statewide Perinatal Data System (SPDS); analysis and use of regional SPDS data and other information for identifying opportunities for improvements in the quality of care at the RPC and its affiliates

- Conduct virtual and on-site visits at each affiliate perinatal hospital to review data, quality improvement, and/or provide tailored education and training to affiliate staff
- Conduct Statewide Perinatal Quality Improvement (QI) activities including designing and implementing quality improvement activities, coordinating team efforts, data collection, reconciliation, validation, verification, submission, and analysis associated with each intervention, participation in conference calls and learning collaboratives, developing and providing education for staff/patients/providers and submission of reports in the required format.

The Department is currently working with key internal and external stakeholders to modernize the regionalization regulations. An expert panel of 47 providers and stakeholders convened from Fall 2017 to Summer 2018, leading to a series of Expert Panel recommendations. These recommendations, largely agreed upon by consensus, informed the Department's process to initiate regulatory reforms. Additional resources include standards of care from a variety of national medical organizations, including American College of Obstetricians and Gynecologists, American Academy of Pediatricians, and the American Association of Birth Centers. Proposed regulations were drafted for executive review in September 2020 and were extensively reviewed and discussed. The regulations were published for public comment in May 2023, and over 100 comment submissions were received. Given the extent of the comments and updated guidelines, the Department is further updating the regulations and anticipates posting in late 2025 or early 2026 for a public comment period and ultimately adoption.

Under these proposed regulations, birth centers (physician-led and midwifery-led) will be incorporated into the public health system of perinatal regionalization. These will form the base level for providing care for lowest risk pregnancies.

Health care alone cannot provide the system of care needed for families in NYS. The state invests in community-based supports and services. There is a complex network of home visiting services that are funded and managed by multiple state agencies and community-based organizations. An online navigator was developed to help the public. It can be accessed at https://nysccf.maps.arcgis.com/apps/MapSeries/index.html?appid=bde3bc9d78e84ce193abfbe297dcb0ac.

The Department of Health funds the Nurse Family Partnership, which is an evidence-based program with support from HRSA's Maternal, Infant, and Early Childhood Home Visiting grant and a state appropriation. Nurse Family Partnership programs are in 9 counties and employ nurses to support first-time mothers who are enrolled prior to their 28$^{th}$ week of pregnancy. The Department also supports the Perinatal and Infant Community Health Collaborative, which utilizes community health workers to support people who are pregnant giving birth and postpartum. The Perinatal and Infant Community Health Collaborative has 26 agencies in 31 counties. Trained paraprofessionals who come from a community, know the community, and represent the community provide support education and referrals to services. These systems of care are highlighted in the Women and Maternal Health and Perinatal and Infant Health sections of the Application and Annual Report.

The Department, through the Medicaid Program, has utilized the 1115 waiver process to establish Social Care Networks. The support for these Networks stems from the understanding that addressing social needs such as food insecurity, housing instability, and lack of transportation improves health and lowers health care costs. To ensure that these needs are consistently addressed for New York's Medicaid Members, New York has implemented a coordinated infrastructure and set of processes through which member's unmet social needs can be identified, Members can be connected to services to address those needs, and the organizations that provide those services can be paid.

New York State has established nine regional Social Care Network Lead Entities who are responsible for building a robust Network of Community-Based Organizations (CBOs) and other organizations providing health-related social needs services and coordinating with health care providers (inclusive of behavioral health and primary care providers). Together, each Social Care Network is responsible for ensuring that there is a seamless, consistent, coordinated, end-to-end process in their region for Screening, Navigation, and delivery of health-related social needs services. This requires close collaboration within each Network, as well as shared data and technology provided by the State. Social Care Network Lead Entities also engage a broader ecosystem of partners to achieve their goals, including health insurance plans, local government, and child and family supports. More information can be found at https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/.

Throughout this Application and Annual Report, we highlight the state's system of care and the Title V Program's role to support it. The system of care is foundational to ensuring health outcomes.

#### III.B.3.b. System of Services for CSHCN

Children and youth with special health care needs are first and foremost children and youth. The systems of care and services for our children and youth with special health care needs happens within the system of care described in the prior section.

We know from the National Survey of Children's Health that children with special health care needs and their families require additional supports and services. Data from the National Survey for Children's Health are presented in the State Description and CYSHCN Annual Report sections.

The Department of Health invests in these additional supports and services. One of the key supports is through the state's Medicaid Program. The Health Home Serving Children (HHSC) program was launched in December 2016, with 16 Health Homes designated to serve children.

A ´Health Home´ is not a physical place; it is a group of health care and service providers working together to make sure you get the care and services you need to stay healthy. Once you are enrolled in a Health Home, you will have a care manager that works with a Medicaid member to develop a care plan. A care plan maps out the services an individual needs. Some of the services may include:

- Connecting to health care providers
- Connecting to mental health and substance abuse providers
- Connecting to needed medications
- Help with housing
- Social services (such as food, benefits, and transportation)
- Other community programs that can support and assist you.

(Source: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/index.htm)

Title V Program staff were involved as subject matter experts in the development and launch of the Health Homes for Children and joined Medicaid colleagues on site visits to the Care Management Agencies. The Title V Children and Youth with Special Health Needs Program and the Early Intervention Program continue to work closely with the Medicaid to provide subject matter expertise in the development of policies and practices to ensure appropriate connections with local programs and timely referrals for children who may be eligible and benefit from the program.
The Department also administers the state's Early Intervention Program, which is authorized federally under Part C of the Individuals with Disabilities Education Act (IDEA). To be eligible for services, children must be under 3 years of age and have a confirmed disability or established developmental delay, as defined by the State, in one or more of the following areas of development: physical, cognitive, communication, social-emotional, and/or adaptive.

The Early Intervention Program offers a variety of therapeutic and support services to eligible infants and toddlers with disabilities and their families, including:

- assistive technology devices and services
- audiology
- family education and counseling, home visits, and parent support groups
- nursing services
- nutrition services
- occupational therapy
- physical therapy
- psychological services
- service coordination
- social work services
- special instruction
- speech pathology
- vision services

The Early Intervention Program serves about 70,000 infants and toddlers annually and is overseen within the Division of Family Health where the Title V Program is situated organizationally. Department Early Intervention staff are integrated into the CYSHCN domain work and Title V staff, including the Title V Director and Title V Medical Director provide oversight and guidance to the program.

The Title V program, as required under federal statute, has critical funding supporting the CYSHCN system of services. The Department invests funding to support a CYSHCN outreach and referral program within Local Health Departments as well as a Center of Excellence which employs caregivers with CYSHCN and supports the Local Health Departments as well as families understand their child's diagnosis, identify resources to support them and their family, and collect and review data to support evaluation and strategic planning. The Title V Program also supports the Departments work helping adolescents with sickle cell to transition to adult services. The Title V Program supports the Department's efforts to identify children with elevated lead levels and ensure intervention and mitigation services are provided. The Title V supported system of services is described in more detail in the CYSHCN Annual Report section.

The Division of Family Health oversees the state's Early Hearing Detection and Intervention (EHDI). The goal of the Early Hearing Detection and Intervention (EHDI) Program is to monitor and follow-up with all birthing hospitals and pediatric 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 and 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 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. The EHDI program works to ensure all families and children across NYS have access to hearing screening and intervention services and resources, working alongside our colleagues in the Bureau of Early Intervention.

Outside of the Department of Health, supports and services for CYSHCN are provided by the Office for People with Developmental Disabilities (OPWDD). The New York State Office for People with Developmental Disabilities (OPWDD) is responsible for coordinating services for New Yorkers with developmental disabilities, including intellectual disabilities, cerebral palsy, Down syndrome, autism spectrum disorders, Prader-Willi syndrome and other neurological impairments. OPWDD provides services directly and through a network of approximately 450 nonprofit service providing agencies. Supports and services, which include Medicaid funded long-term care services such as habilitation and clinical services, as well as residential supports and services for over 40,000 people, are primarily provided in community settings across the state.

OPWDD staff are members of the Department's Early Intervention Coordinating Council. The Department has collaborated closely with OPWDD on policy, guidance, and supports for individuals with autism. OPWDD have presented on quarterly webinars with the Title V funded CYSHCN Programs at Local Health Departments to help them understand what services are available and how to access the services.

The NYS Education Department provides services in the context of the school setting through their Special Education Program authorized under Part B of Individuals with Disabilities Education Act. The NYS Education Department provides comprehensive special education services to support students with disabilities, ensuring they receive a free appropriate public education in the least restrictive environment. The Office of Special Education within the Education Department is dedicated to assisting students with disabilities by providing guidance, resources, and support to ensure equal educational opportunities. The Office is responsible for
policy development to comply with federal and state regulations, including the Individuals with Disabilities Education Act (IDEA), technical assistance to school districts and parents regarding special education processes, including evaluations and Individualized Education Programs (IEPs), and training and professional development for educators and staff to improve the quality of special education services.

The Education Department administers the following key programs and resources:

- Special Education Quality Assurance: This program ensures that special education services are effectively implemented across New York State, focusing on improving outcomes for students with disabilities.
- Parent Centers: The Education Department supports several parent centers that provide information, resources, and advocacy for parents of children with disabilities, helping them navigate the special education system.
- Regional Special Education Technical Assistance Support Centers: These centers offer localized support and resources to school districts to enhance their special education programs.
- Early Childhood Direction Centers: These centers assist parents in accessing special education services for preschool children and provide training on the special education process.

Parent support is critical to a system of services for CYSHCN. NYS has Parent to Parent of NYS which is the state's Family Voices. Parent to Parent of New York State, which began in 1994, is a statewide not for profit organization established to support and connect families of individuals with special needs. We have several offices located throughout New York State staffed by Regional Coordinators who are parents or close relatives of individuals with special needs. Parent to Parent of NYS is where families of individuals with special needs and the professionals who serve them can meet and share information.

Parent to Parent offers:

- Support – We offer parents/caregivers the opportunity to connect one-to-one with a parent/caregiver of an individual with the same or similar disability or special health care need – someone who has "been there."
- Information & Referral – We help families and professionals locate the information and services they need
- Training – Workshops are available on various topics to both family and professional audiences

(Source: www.ptopnys.org)

Michele Juda, the Executive Director for Parent to Parent of NYS, is a member of the state Title V Maternal and Child Health Services Block Grant Advisory Group. The Title V Program collaborates and engages Parent to Parent of NYS as an important voice for CYSHCN and their families. Parent to Parent of NYS has distributed surveys and opportunities to their members. The Title V Program distributes information and resources from Parent to Parent of NYS through our network of providers.

New York State, and specifically the Title V Program, invests in a system of services for CYSHCN. We have not met the needs though, based on findings from the National Survey of Children's Health. Families of children and youth with special health care needs face more financial strain and spend more time coordinating their child's care than families without children and youth with special health care needs. Nearly four in ten families with children and youth with special health care needs reported spending at least one hour per week coordinating their child's health care. Families of children and youth with special health care needs 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. Nearly all the children and youth with special health care needs have health insurance coverage all year (97.1%); however, families of children and youth with special health care needs were less likely to have adequate health insurance and have insurance benefits that meet their child's needs.

In the upcoming, new grant cycle for the Title V Program, we will be prioritizing efforts to support better access to medical homes for CYSHCN. We will continue to engage with the state's Medicaid Program as well as our Local Health Departments and community-based partners to better support CYSHCN. We are committed to creating a system of care and services that meet the needs of our children and families.

#### III.B.3.c. Relationship with Medicaid

As required by the Heath Resources and Administration, 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.

Successful activities have included the expansion of Medicaid coverage to one year of postpartum coverage from 60 days, which was a recommendation of the state's Maternal Mortality Review Board. Medicaid has also updated 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. The Title V Program is working with the state's Medicaid program to develop a plan to support pediatric practices to integrate screening for Adverse Childhood Experiences and developing trauma informed practices.

### III.B.4. MCH Emergency Planning and Preparedness

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 8 (Public Health and Medical Services) and collaborates on

Emergency Support Function 6 (Mass Care, Emergency Assistance, Housing, and Human Services) with the Office of Children and Family Services and other human service agencies. In other Emergency Support Functions, the NYS Department of Health assists in identifying methods of serving various populations, including the population birth through reproductive age, when responding to an emergency impacting NYS.

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'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.

The NYS Department of Health's 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.

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.

Title V Program staff helped identify key resources for training as part of the Health Emergency Preparedness and Response Plan Pediatric Surge plan, including Title V Maternal and Child Health Services Block Grant medical director, Dr. Marilyn Kacica. Work will begin on updating the pediatric annex in mid to late 2026.

Title V Maternal and Child Health Services Block Grant staff led the team 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. Most recently, the Division of Family Health worked with the Office of Health Emergency Preparedness (both within the Department of Health) to lead the effort to revise the Pediatric and Obstetric Emergency Preparedness Toolkit. This joint effort brought together experts from across state agencies and local teams to review the toolkit and make updates and revisions. This work is in its final stages with a release date anticipated in early 2026.

Current URL of Hospital Resources that includes the Pediatric and Obstetric Emergency Preparedness Toolkit: https://www.health.ny.gov/environmental/emergency/health_care_providers/hospital_ems_preparedness.htm

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.

## III.C. Needs Assessment

### III.C.1. Five-Year Needs Assessment Summary and Annual Updates

#### III.C.1.a. Process Description

The New York State Department of Health (Department) conducted a comprehensive, multi-method Needs Assessment to identify maternal and child health (MCH) needs, strengths, capacity, and partnerships that will guide the state's Title V priorities and State Action Plan for 2025–2030. The Needs Assessment process was led by the Title V Director and a multidisciplinary leadership team from the Division of Family Health (DFH), with technical assistance from the University at Albany's MCH Program, which is funded through the Health Resources and Services Administration (HRSA). The Needs Assessment integrated quantitative data, qualitative insights, family and community perspectives, and MCH system capacity considerations - and was intentionally aligned with the NYS Prevention Agenda 2025–2030 and State Health Improvement Plan. We gathered and analyzed both quantitative and qualitative data from a wide range of sources including families, community members, and MCH service providers, summarized below.

**Quantitative Methods and Data Sources**

We reviewed over 200 population health indicators across all Title V domains. These included current and potential National Performance Measures (NPMs), National Outcome Measures (NOMs), and additional priority indicators. Data were drawn from more than 20 sources including Vital Statistics, hospital discharge data, population surveys (PRAMS, NSCH, BRFSS, YRBSS, etc.), state registries (lead, newborn screening, etc.), and program-level data systems. We assessed current values, historic trends, and subgroup differences based on demographic and other factors.

**Family and Community Input**

The Department prioritized meaningful engagement with families and community members across the state, employing structured and inclusive approaches to ensure their experiences and perspectives were central to our Needs Assessment.

**Community Listening Forums:** We collaborated with a broad network of partner organizations to convene two sets of listening forums across the state in 2024. The purpose of these forums was to facilitate open discussion and hear firsthand about what matters to families and community members in their own words. Sessions were conducted by community partners with training and standardized facilitation guides from DFH. The information gathered through these sessions was analyzed by the Division of Family Health's Bureau of Data Analytics, Research, and Evaluation (BDARE) using ATLAS.ti to conduct qualitative thematic analyses with deductive and inductive coding. Resulting codebooks were then analyzed for groundedness and co-occurrence to identify emergent themes for each set of forums.

***Community Based Forums*** were done specifically for the Title V Needs Assessment. A total of 71 in-person or virtual sessions were hosted by 26 partner organizations with strong ties to MCH populations, including community and faith-based organizations, local foundations, youth service organizations, and a Nurse Family Partnership program that is funded through HRSA's Maternal Infant, Early Childhood Home Visiting Program. The sessions collectively engaged more than 880 participants across 30 counties, including expectant families, parents/caregivers, children, and adolescents - including Children and Youth with Special Health Care Needs (CYSHCN) and their families. Childcare, language interpretation, transportation, refreshments, and gift cards were provided to facilitate participation.

***Maternal Health Forums*** were completed in collaboration with Cicatelli Associates Inc. as part of the Department's Enhancing Reviews and Surveillance to Eliminate (ERASE) Maternal Mortality initiative, funded through the Centers for Disease Control and Prevention. Eight sessions with 62 people who had recently given birth explored their prenatal, birth, and postpartum care experiences, including two sessions conducted in Spanish. Participants reflected a range of geographies, languages, and demographic backgrounds.

*"Thank you for allowing us to come and share our thoughts and stories, I never knew there were spaces and opportunities like this. It makes me feel like despite all of the crazy things you hear from people and from reading online, that we just might be moving in the right direction as humans and communities."*

**Children and Youth with Special Health Care Needs (CYSHCN) Surveys and Interviews:** Between July 2022 and September 2023, DOH-funded Regional Support Centers conducted surveys and interviews with CYSHCN and their parents/ caregivers to explore access to services, lingering effects of COVID-19, and interactions with local CYSHCN programs. Both surveys and interviews were offered in English, Spanish, or Mandarin. A total of 195 families representing 260 CYSHCN across 47 counties completed the survey, with over 60% (121) proceeding to follow-up interviews. Data were analyzed in Dedoose using mixed methods, including inductive thematic analysis of qualitative data and content analysis to code and count responses to specific survey items.

**Title V Public Survey**: An open web-based survey (January – March 2025) invited broader public input on MCH needs and recommendations for the state Title V program. The 20-question anonymous survey was available in English, Spanish, and Simplified Chinese, and disseminated to program participants and community members by MCH providers and other partner organizations. A total of 251 people responded to the survey, representing all regions of the state. Respondents were primarily women (90%) but otherwise representative of state demographics.

**Provider and Partner Input**

We also gathered input from MCH providers and program staff through multiple channels. A web-based **Provider Survey** was disseminated to more than 30 MCH organizations between January – March 2025, with over 280 responses representing all regions of the state including New York City and a wide range of programs and organization types, including local health departments, health and mental health care, community-based organizations, childcare, faith-based organizations, and others. Questions addressed services and populations served, partnerships, unmet needs, and recommendations for improvement.

**Family Planning Program (FPP) listening sessions**, conducted in partnership with JSI Research & Training Institute in January 2025, reached 98 FPP providers across 33 agencies. Small staff breakout groups addressed population health trends, service gaps, and staff needs. A total of 98 providers from 33 FPP agencies participated, representing 89% of the funded FPP network. Participants included program managers, clinical providers, health educators, counselors, and community outreach staff.

In 2024 our CYSHCN program elicited input from **Local Health Department (LHD) CYSHCN** programs on key program areas including program strengths, challenges/barriers and family/community/client satisfaction through virtual meetings or an 11-question qualitative survey. A total of 47 LHDs participated, with 18 opting for the virtual session and 29 completing the survey. Responses were transcribed and analyzed through ATLAS.ti using the same methodology described above for the community listening forums.

In Fall 2024, the Division of Family Health collaborated with the UAlbany MCH Program to convene a series of three full day listening sessions/ workshops with our own **Title V staff**. The three sessions were organized by topic (Maternal/Infant Health; Sexual and Reproductive Health; and Child Health including CYSHCN), with staff working in rotating groups of 4-6 individuals using a semi-structured process we adapted from Georgetown University's *Strategic Planning Tool: Results-Based Accountability and Root-Cause Analysis)* to assess the current status, trends, and potential root causes of their assigned MCH topics, identify programmatic needs, and consider potential strategies to address those issues and needs. A total of 125 Division of Family Health staff including program, data, and administrative staff from both central and regional offices participated, collectively discussing 30 MCH topics and over 76 health metrics. Within the Division of Family Health, Bureau of Data Analytics, Research, and Evaluation staff analyzed output notes following the same qualitative analysis methodology described for community listening forums above. In addition, staff shared insights and ideas through 'wishing walls' (a place to record open-ended ideas or inspirations), sticker stories' (an exercise to identify staff experiences and expertise that they bring to their work in Title V), and a post-session survey.

We also engaged **statewide partners** through ongoing meetings with the Title V Maternal and Child Health Services Block Grant Advisory Council, NY Early Hearing Detection and Intervention (EHDI) Advisory Group, Early Intervention Coordinating Council (EICC), Maternal Mortality & Morbidity Advisory Council (MMMAC), and others. These groups provided contextual insight, strategic alignment, and feedback throughout the Needs Assessment process.

**Companion Needs Assessments**

To augment our own findings, we reviewed Needs Assessments and strategic plans from other MCH-related initiatives, including:

- **UAlbany MCH Public Health Catalyst Grant Needs Assessment** (2024), focused on MCH workforce needs and strengths, including information from national and state Public Health Workforce Interests & Needs Survey (PH-WINS) data, NYS Association of County Health Officials (NYSACHO) public health workforce assessment, national MCH Leadership Competency self-assessments, and listening sessions with MCH Program alumni and employers.
- **NYS Prevention Agenda for 2025-30** (draft in progress) including NY's State Health Assessment and State Health Improvement Plan to ensure alignment with broader state health priorities and initiatives.
- **NY State Maternal Health Innovation (SMHI) Initiative** (2023), focused specifically on maternal health outcomes and measures.
- **NYS Head Start Collaboration Project State Needs Assessment** (2023), which gathers information from Head Start Program Administrators across the state on health care, services for children with disabilities, child welfare, and many other priority areas consistent with Head Start's holistic approach to child development and early learning.
- **Oral Health Assessment** (2023), focused on population-level oral health outcomes, community water fluoridation, and oral health workforce needs.

**Synthesis of Results**

Quantitative data (population health measures) were made available to internal Department staff through an interactive Title V Dashboard. The dashboard functions as an accessible tool for staff supporting the Title V domains and individual programs to better understand their populations and ensure their work is data-driven. The dashboard merges data from a variety of sources, including federally available data and state datasets, to create a comprehensive inventory on MCH health metrics including current values, trends, and demographic and geographic subgroup comparisons.

Qualitative findings were documented in source-specific reports and synthesized using affinity mapping to identify recurring themes across populations and systems.

#### III.C.1.b. Findings

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

While analysis of MCH measures shows progress in many areas, most five-year objectives have not been met, and several indicators are worsening. Domain-specific detail on **quantitative** indicators is on our Title V Dashboard and below.

We identified 10 cross-cutting themes from the **qualitative** data gathered through community forums and surveys:

1. **Health Information & Literacy** – How people seek, understand, critically evaluate, and use health information.
2. **Social Support & Stress** – The role of support from family, partners, community programs, and doulas, and the impact of stress and isolation.
3. **Health Care Experiences/ Patient-Centered Care** – Interactions with providers related to trust, respect, and communication.
4. **Access to Health Care Services** – Challenges with availability, affordability, and accessibility.

5. **Mental Health & Mental Health Care** – Across the life course including prenatal, postpartum, parents, children, and adolescents including CYSHCN.
6. **Access to Community Programs & Services** – barriers to accessing basic needs and enhanced supports including income, food, housing, childcare, recreation, and services for CYSHCN.
7. **Service Coordination and Navigation** – Patient and family experiences with coordination across providers and systems including consistent vs. conflicting guidance; referrals, and service transitions.
8. **Community & Behavioral Factors** – Non-medical influences on health such as nutrition, physical activity, social connections, stress, education, income, housing, transportation, and safety.
9. **Public Health Partnerships** – System-level coordination and collaboration among programs, agencies, schools, community organizations, and policymakers.
0. **Public Health Program Capacity & Workforce** – System-level capacity to implement effective, evidence-based programs and maintain a strong workforce.

These themes align with input from state Title V staff and local service providers. Additional domain-specific qualitative findings are presented below.

**Domain 1: Maternal & Women's Health**

**Quantitative Findings**

NYS maternal and women's health data generally mirror national trends. Early prenatal care, low birth weight, preterm birth, low-risk Cesarean delivery, severe maternal morbidity (SMM), and maternal mortality are worsening, with NY ranking 46th in SMM and 45th in low-risk Cesareans. Smoking in pregnancy and postpartum visit (PPV) attendance have improved, but postpartum (PP) depression affects over 10% of pregnancies with little improvement. While 91% of NY women report a PPV, only 67% received all recommended services, 78% had mental health screening, and 45% used effective contraception - ranking NYS in the bottom 10 for these measures.

**Qualitative Findings**

In addition to the 10 cross-cutting themes, ERASE MM listening sessions with PP women delved further into their pregnancy, childbirth, and PP experiences. The importance of respectful, trusting relationships with providers was prominent. Many participants described feeling rushed, dismissed, or excluded from decisions during appointments and childbirth. Frequent provider changes, short appointments, communication barriers, and not being taken seriously negatively affected care experiences, while clear communication and shared decision-making improved trust. Participants consistently called for inclusive, respectful, patient-centered care.

> *"It's uncomfortable being in a situation like that…I'm not able to trust my doctor because I feel like my doctor wasn't supportive of me. I felt unsafe with her."*

> "*I know I'm a teen and this is my first time but it's my body. I understand when things are going wrong and none of you believed me.*"

> *"I did feel that she supported me and above all I did not feel that she judged me"*

Effective communication among providers was seen as critical. Poor coordination led to confusion, distress, and near-misses, while good communication eased transitions. Some participants felt supported PP, and described PPV as helpful, while others felt unprepared for recovery, breastfeeding, or mental health challenges or felt dismissed at PPVs. Gaps in follow-up and lack of referrals were common.

> *"Rather than getting on a computer and pulling up my chart, they tried to rush me into labor and delivery... I had to say, 'No, wait, stop. This is going to kill me. I can't deliver. I will die. I'll bleed out. I have to have a C-section.' Then it was, 'Oh, wait. Stop. Pull up her file. Oh my God, let's take her to the ER'."*

> *"I had all of them come in. Social workers giving me information so when I had to leave, if I had…mental*

*issues… reach out to these type of people. Even counseling for mothers that just gave birth. I got a lot of that."*

*"They told me they were going to call me. And to this day I am still waiting for the call, it didn't come."*

Participants reported the need to strongly advocate for themselves due to feeling dismissed or unheard. Pain management was frequently inadequate, birth plans were ignored, or consent was obtained under distress. Many called for better prenatal preparation for emergency procedures and stronger inclusion in decisions.

*"I handled my birthing plan. I asked for the epidural... They did absolutely none."*

*"It's hard to just give birth not being listened to...you have to advocate for yourself. It's a lot of work. You just want to give birth and know that you're going to be taken care of."*

*"Doctors need to listen to the patient, period."*

Participants described numerous barriers to accessing health care, including scheduling, transportation, housing instability, and insurance. Working made attending appointments difficult, and long wait times led to cancellations. Even with insurance co-pays, limited coverage, and provider refusals delayed care. Access to PP services like mental health or breastfeeding support often depended on whether staff offered timely information.

*"You get to an appointment. You're still waiting almost an hour regardless of where you go…That's so hard. I would find myself canceling appointments."*

*"When I came here to New York, they quickly gave me insurance, and at the clinic they treated me very quickly and very well. And they gave me excellent care there."*

*"You're asking the wrong person… the hospital didn't offer me none of those things."*

Support from family, partners, doulas, and programs was vital. Doulas were described as strong advocates. PP resources like mental health care, breastfeeding support, childcare, and nutrition programs were essential. Social workers or doulas helped navigate these services, especially when provider communication was lacking.

*"To have support not just at home but all around, it's what we need."*

*"I need a doula. I need somebody with me, so they wouldn't treat me the way they did the first time."*

*"I started going there and they were so wonderful to me. It's a nurse run program…. They say takes a village and I had found one with these people. They were amazing."*

These themes align with findings from the State Title V and local Family Planning staff forums, which highlighted access to care, provider shortages, transportation, mistrust and misinformation, increased demand for mental health services as key needs.

**Domain 2: Perinatal & Infant Health**

**Quantitative Findings**

Perinatal and infant health outcomes in NYS reflect a mix of progress and persistent challenges. Rates of preterm, early term, and low birth weight births have risen, mirroring national trends. While over 90% of very low birth weight (VLBW) infants are delivered at hospitals with Level III+ NICUs, this has fluctuated and declined overall over the last decade and NYS has not met its target. Perinatal, neonatal, and preterm-related mortality, Neonatal Abstinence Syndrome, and breastfeeding initiation have all improved mirroring national trends, but infant, post-neonatal, and sudden unexpected infant death (SUID) mortality are unchanged and exclusive breastfeeding at six months is

declining. Vaccination rates at 24 months have fluctuated with no significant sustained improvement.

**Qualitative Findings**

Qualitative data specific to infancy were limited in community forums and surveys, but many cross-cutting themes - lack of affordable, safe housing; difficulties accessing food assistance programs; concerns about community safety; and lack of access to healthcare – are relevant. Barriers to accessing health care included insurance coverage, affordability, transportation, and limited local specialty care - including birthing facilities. Health care experiences varied, ranging from supportive to dismissive or discriminatory. MCH providers also highlighted transportation, poverty, social support, and child abuse prevention as major challenges.

ERASE MM forum participants emphasized PP connection to resources like breastfeeding, mental health, and child support programs as critical to family well-being. Those linked to services generally reported smoother transitions and better care, but many lacked awareness of available support. Many described their newborn as the most positive aspect of pregnancy, underscoring early bonding and the child's profound impact on their mental and physical health, including recovery from substance use. Family, partners, and healthcare staff were vital sources of emotional support during this critical period.

> *"They did their research, and they looked for people that I could consult with for mental health, and for breastfeeding, and for early intervention in case my daughter needed it."*

> *"When my baby was in intensive care, the care was really good for him. It's nice, even though you have to see your baby with so many wires on him, an incubator, they tried to make the experience more pleasant. The way they treated him when he arrived…they put stickers on his incubator, they put his name on it, like a sign, it is very nice."*

> *"Looking into those great eyes was just worth all the pain…the first time my son smiled at me, my breasts filled immediately. It's like that sensation that you get in your heart. It's just amazing. So, that's the best part."*

**Domain 3: Child Health**

**Quantitative Findings**

Most child health outcomes in NYS have shown little progress or are worsening, mirroring national trends. Overall child health status remains unchanged, and NY ranks 44th on this measure. Prevalence of tooth decay is unchanged while preventive dental care has declined. Obesity rates were steady for ages 6–17 but worsened for ages 2–4. Adverse childhood experiences (ACEs), household smoking, and access to adequate continuous health insurance show no improvement. NYS Flu vaccination and forgone care measures were stable even as they worsened nationally, but child mortality and behavioral and conduct disorders have worsened. Injury-related hospitalizations have declined but NY still ranks 46th nationally. Less than 70% of kindergarteners were school-ready, and measures of child flourishing have declined for young and older children.

**Qualitative Findings**

Community participants described child health holistically, focusing on basic needs such as affordable housing, healthy food, safety, physical activity, education, social connection, and health care. Participants described living in food deserts with limited nutritious options, exacerbated by financial and transportation barriers. Programs like WIC, SNAP, and school meals were valued but limited by eligibility and application challenges. Many felt their communities lacked sufficient resources, and affordable housing shortages increased family stress, with many priced out of neighborhoods.

> *"As a teacher, I know firsthand that children experiencing homelessness are at risk of falling behind in school and life. Supporting families now helps ensure brighter futures for all of us."*

*“I want to feed my kids nutritious food, but I can’t even get to the store that sells fresh fruits and vegetables without a car.”*

*"WIC allowed me to get milk and fresh veggies when my kids were little. It was very helpful.”*

*“[I] hope there will be changes; our children deserve a better world.”*

Community resources for healthy play were a major concern. Access to safe, affordable spaces to play such as parks, gyms, and recreation centers was limited by cost and location.

*“Local parks help families stay active.”*

*“We need more parks and spaces where people can get outside and be active.”*

*“Safe, free spaces for families to enjoy physical activities are not available.”*

*“We used to have a YMCA…but other than that, there really aren't many things for children…where they can go and spend time after school”*

*“Free youth recreation programs in the summer with free lunches [helps my family stay healthy]”*

Healthcare access was a major concern, with challenges including insurance coverage, finances, transportation, and insufficient local specialty care, especially pediatric, dental, and mental health services. Long wait times and provider shortages, especially in rural areas, limited access. Urgent care, free clinics, and school-based health centers were appreciated when available; telehealth was promising but unevenly accessible. Navigating insurance was frustrating, with Medicaid recipients often struggling to find providers. Mental health services for children were especially inadequate, with long waitlists and limited insurance acceptance. Participants called for increased mental health access, better cultural competence, and improved community awareness.

*"I appreciate the health services offered at my kids' school. It’s a relief to know that they get health screenings and mental health support there."*

*“[Our] community would benefit from more clinics that accept Medicaid.”*

*“Child Health Plus helps me and my family because I cannot afford family coverage on my salary”*

*“Insurance didn't cover counseling for my child, so we had to stop going.”*

Education and safety were also important themes. Participants emphasized the need for affordable childcare citing limited childcare availability and affordability. They said that schools are vital for children’s development but felt current systems fell short with underfunded schools, insufficient physical and mental health education, and few after-school programs. Safety concerns including drug use, violence, and crime led families to restrict children’s outdoor activity and use of community resources. Despite challenges, community and youth programs were valued, with strong interest in expanding accessible childcare and enrichment opportunities.

*“Daycare is only for traditional hours and is expensive.”*

*“Advocating for quality education and healthcare [is] the foundation of a just society, one where every individual has the opportunity to learn, grow and thrive in health and knowledge.”*

*"We could really use more after-school programs for our kids, so they have a safe place to go and keep learning."*

*“I definitely feel isolated in my community sometimes. I’ve been trying to get help for my son, especially with the gun violence and crime around here.”*

Public surveys reinforced these findings, citing chronic conditions, mental health, healthy food, and physical activity as common concerns, and access to mental health services, healthcare, and safe affordable housing as the most pressing community health issues. Oral health, housing assistance, and mental health services were top areas needing improvement. About one-quarter of respondents reported difficulty accessing childcare, mental health services, and specialty healthcare, mainly due to affordability, limited appointments, and inconvenient hours. While about half found it easy for their family to be healthy locally, nearly one-fifth disagreed, highlighting persistent challenges when accessing care and receiving respectful care.

**Domain 4: Adolescent Health**

**Quantitative Findings**

Along with the Federally Available Data from Health Resources and Services Administration (HRSA), we reviewed additional 2021 Youth Risk Behavior Survey (YRBS) data for NYS. Mental health stands out as a critical concern for NYS adolescents: over one-quarter of high school (HS) students reported their mental health was “not good” most or all of the time, and this is even higher among girls. Nearly one-third of students reported persistent sadness or hopelessness, 13% seriously considered suicide and 9% attempted suicide. These troubling trends have worsened over the past decade and highlight a large gap between needs and services, as mental health treatment rates have not increased.

Physical activity and healthy weight are also key challenges. Nearly one-third of HS students are overweight or obese, and 40% are actively trying to lose weight. Measures reflecting inadequate sleep, low vegetable intake, frequent soda consumption, and skipping breakfast may exacerbate both physical and mental health.

Other health indicators show mixed progress. Teen birth rates, injury hospitalizations, HPV vaccination, and tobacco use improved statewide and nationally. E-cigarette use, which previously surged, has declined. However, exposure to violence and feelings of unsafety remain pervasive: 20% of adolescents have witnessed serious violence, 20% have been bullied, and 14% skipped school due to safety fears. Sexual violence, especially among girls, remains alarmingly high.

**Qualitative Findings**

Community forum participants – 10% of whom were age 14-20 – highlighted the foundational importance of basic needs including housing, safety, healthy food, physical activity, and education in shaping adolescent and family health. Participants described how cost and limited availability of groceries, gyms, housing, and transportation constrained their ability to meet these needs. Safety concerns such as neighborhood violence and drug use restricted youth outdoor activities and physical exercise. Survey respondents also identified affordable housing, healthcare, oral health, and mental health services as urgent community needs.

*“When we invest in housing and support services, we reduce crime, improve health outcomes, and create safer, more connected communities."*

*“Motivation is needed, and investment in classes… about financial literacy and education and awareness about schooling, college, trades. It’s hard to find time and resources and services in community to achieve these.”*

*“The community center is an asset. But…[it’s] not consistently open and not well advertised.”*

Mental health was one of the most prominent themes, with frequent concerns about isolation, chronic stress, and barriers to mental health care access including long wait times, cost, insurance coverage gaps, and provider

shortages. Both forums and surveys called for more culturally competent providers, earlier interventions for youth, and expanded school-based mental health supports. Encouragingly, several noted decreasing stigma and growing community awareness of mental health.

> *“Inadequate resources for mental health crises lead to everyone relying on the emergency rooms or law enforcement.”*
>
> *“Mental health services were helpful in providing positive coping skills to deal with stress.”*
>
> *“My psychiatrist was helpful in giving me services… they listened to me and what I needed. I was able to say exactly what was wrong. I felt safe there.”*

Concerns about nutrition, weight, and fitness were also prominent. Many described living in food deserts or lacking affordable access to healthy food. While school meals and sports programs were valued, their quality and availability varied, and participants called for increased investment in affordable, youth-centered recreation opportunities.

> *“We want to eat healthy but cannot afford to.”*
>
> *“[Free school food] definitely helped because my mom could not afford to pay for lunch every day. So it gave me more access to the food I needed every day.”*
>
> *"If people understood more about how to take care of themselves, like learning about nutrition, exercise, and mental health, I believe we could live healthier lives.”*
>
> *“We need more parks and spaces where people can get outside and be active.”*

**Domain 5: Children & Youth with Special Health Care Needs (CYSHCN)**

**Quantitative Findings**

New York’s Title V program conducts an annual analysis of CYSHCN data, enhanced by our 2022 oversampling of the National Survey of Children’s Health (NSCH). Nearly one in five children statewide (about 750,000) has a chronic condition requiring services beyond those of children typically. Most of these children have multiple conditions, with common diagnoses including allergies, asthma, anxiety, ADD/ADHD, developmental delays, and speech or learning difficulties.

Despite progress in some areas, NYS CYSHCN have met fewer than 10% of our Title V objectives - significantly lower than their peers without special health needs. Only 39% of CYSHCN have access to a medical home. Care coordination remains the most frequent gap and the share of those who need care coordination that receive it has decreased over the last five years. Only about 1 in 10 CYSHCN are served by a well-functioning system of care, and this measure is worsening. Fewer than one in five CYSHCN ages 12–17 receive all services to prepare for transition to adult health care: while more than half have had private conversations with a provider and received support to build self-management skills, only one in four discussed transitioning to adult care.

The impact of special health care needs extends beyond medical services. Many CYSHCN experience disruptions to daily life, including high rates of school absenteeism and social challenges such as difficulty forming friendships. Families often face substantial burdens: nearly 40% spend over an hour each week coordinating care, and many must reduce work hours or leave jobs altogether. Out-of-pocket costs are high, and difficulties paying medical bills are common. While nearly all CYSHCN are insured year-round, families frequently report that coverage is inadequate or fails to meet their child’s specific needs.

**Qualitative Findings**

In addition to cross-cutting themes from community forums, surveys and interviews conducted with CYSHCN families

revealed several key themes.

Although the COVID-19 pandemic has officially ended, families described lasting impacts on children and disruptions to services they rely on, with long waitlists, program closures, and ongoing provider shortages, especially in rural areas. The pandemic led to isolation, skill regression, and behavioral challenges that remain unresolved. Telehealth was helpful but inadequate for some services. Caregivers took on expanded roles often at the cost of their own health and employment, with many feeling unsupported, overwhelmed by conflicting information, and overlooked in emergency planning.

> *“In the past, we waited two months for an appointment. Now, they are talking about 4 or 5 months, and we call 50 times to see if they answer”*
>
> *"Three years of school shutdown loss of learning but also peer socializing. My kids were so fearful of going back to school because they felt like they didn't belong anymore”*

CYSHCN families face significant barriers accessing and navigating the broad array of services their children need. They describe a fragmented, confusing system with little guidance, especially after a new diagnosis. Barriers include a lack of clear information, excessive paperwork, language and cultural challenges, and limited help navigating eligibility and care. Even experienced caregivers expressed frustration with shortages and provider turnover. Rural and low-income families reported long travel distances and limited access to community programs. When services are well-coordinated across sectors, families noted meaningful improvement, but such support is rare.

> *“… I was sent home from the hospital with nothing but a poem … from the social worker. I literally navigated everything on my own...”*
>
> *“We are really struggling to figure out how to access things…It has been very, very challenging, both finding things, submitting for them, getting them covered, like classes or camps and things like that.”*
>
> *“There is a lack of activities, programs, and community spaces that will accommodate children with high support needs. All the parents in our advocacy group have the same problems…it's a nightmare being able to know where you can take your child in the community or what resources [exist]”*
>
> *“I am lost, and it is overwhelming”*

Navigating the educational system is a major stress point for CYSHCN families. Parents described confusing processes, extensive paperwork, and inconsistent support. Many felt dismissed or misunderstood, especially when school personnel lacked knowledge of rare or complex conditions. Transitions are a big challenge, particularly post-HS, when they struggled to secure higher education accommodations, vocational supports, or continuity of care alongside reduced parental involvement.

> “*I didn’t know where to navigate. I just started...there wasn’t any assistance. I feel like nobody told me... I was really alone in trying to navigate this”*
>
> *“I do feel lost even though I know they're all nice and they're all trying, but they're kind of not on the same level...it's hard to get through everything”*
>
> *“I don't know what's going to happen to my son when he graduates. I'm nervous because no one's really giving me any information.”*

Raising CYSHCN can profoundly impact the whole family. Caregivers described constant stress balancing care coordination, work, parenting, and finances, often without sufficient support. Emotional exhaustion and isolation were common, especially for single parents and those lacking support networks, and siblings often felt overlooked. Families struggled to find behavioral and mental health providers and are often left to manage complex needs alone. Financial strain was pervasive, with families often falling into a coverage gap of earning too much to qualify for help

but unable to afford care. Mental health and dental services were frequently cited as hard to access. Peer support, especially through parent groups, was a key resource, helping families cope, connect, and advocate for one another. These mirror responses from LHD CYSHCN staff that highlighted shortages of pediatric specialists and mental health providers, lack of peer support groups and childcare, and families being overwhelmed as key challenges.

> *“I'm being pulled in so many directions...some days I feel like I'm going to explode...”*
>
> “*When you have a child that is so dysregulated... no one wants to be around it. Your family can't help because they can't handle him. Your friends don't want to be involved”*
>
> *“We need to make sure that we encompass the sibling piece too... she's like ‘I just need some more [attention].’”*
>
> *“Sometimes [we] just [need] emotional support with other parents or other people that have familiarity with what you're going through”*

Although CYSHCN staff at the Local Health Departments (LHD) highlighted community engagement as a best practice, awareness of the CYSHCN program operated at the LHD remains low: over 80% of surveyed families had never heard of it, and among those who had less than half had used services. Some families said that LHD contact ended after the child transitioned out of Early Intervention at age three, with no connection to the CYSHCN program. Those who did engage had mixed experiences: some received valuable information or financial help, while others found support limited. Families expressed strong interest in learning more and recommended outreach through schools, medical providers, digital platforms, and community spaces.

> *“How come none of the people I've worked with over the past two years has ever mentioned this as a resource?*”
>
> *“They are great at educating me…providing resources for different classes/ webinars/ trainings related to my son’s disability, and local events that we might benefit from”*
> *“We received help paying out of pocket costs for medical supplies, prescriptions, and doctor visits”*
>
> *“To be honest, a program linking people with resources is not helpful if the resources are not there or no one is there to provide the resource…”*

When asked specifically to identify their service priority needs, families identified 21 priorities across multiple areas. Respite was the most frequently cited need, followed by access to mental health care (especially for teens), community habilitation services, speech/occupational therapy/physical therapy, and more generally finding knowledgeable providers and staff. Systems navigation was a key theme for health care, education, and health insurance. Financial assistance to cover unmet medical costs and other basic needs was frequently mentioned, as were a range of family and social support needs including recreational community activities, parent support, and resources to support transition to adulthood.

> *“It would be incredibly helpful if there were a trained pool of workers ready to work with families for respite care”*
>
> *“...It would be a stress relief to have a central office that we could go to, and we knew people had some answers or…knew where to go”*
>
> *“My son…feels isolated and alone. There is no ‘community’ for him.”*
>
> *“...just giving us [recreational] information of what's available. Even like a booklet. It took me two years to find a place where she can go horseback riding”*

"*Definitely parent support. There really isn't a lot of parent support if you have special needs kids, and it can just make it feel, like, very isolating"*

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

##### III.C.1.b.ii.a. Impact of Organizational Structure

NY's Title V Programs, including Children and Youth with Special Health Care Needs (CYSHCN), are based in the New York State Department of Health (Department), Division of Family Health. The Department is an executive branch state agency under the direction of Commissioner James McDonald, MD, MPH, who was appointed by the Governor. Within the Department, the Division of Family Health is within the Office of Public Health, Center for Community Health. Dr. Kirsten Siegenthaler, Director of the Division of Family health, serves as the state Title V Director and Suzanne Swan, Director of the Bureau of Child Health within the same Division, is the state CYSHCN Director.

The Department is responsible for the administration of all programs carried out with allotments under Title V (See Form 5). Several Title-V funded programs are based in other parts of the Department outside of the Division of Family Health, including Migrant Health (Center for Community Health), Lead Poisoning Prevention (Center for Environmental Health), Asthma Prevention and Control (Division of Chronic Disease Prevention) and Newborn Screening (Wadsworth Center).

While Title V funding and structure is critical to our work, the Division, under Dr. Siegenthaler, also oversees numerous key MCH-serving programs that are not directly funded through Title V. These include Early Hearing Detection and Intervention (EHDI), Early Intervention (IDEA Part C), Maternal, Infant, and Early Childhood Home Visiting (MIECHV), Perinatal and Infant Health Collaboratives (PICHC), sexual violence prevention programs, Sickle Cell Disease Program, and others. We also work closely with many other key MCH-serving programs funded outside of Title V that are housed outside of the Division of Family Health, including Immunization, Medicaid, and others. See *III.C.1.b.iii. Title V Program Partnerships, Collaboration, and Coordination* below for more detail.

This organizational structure positions our Title V Program to effectively administer the Title V grant, partner with other MCH-serving programs both within the Division of Family Health and across the Department, and to leverage resources to respond to MCH needs.

##### III.C.1.b.ii.b. Impact of Agency Capacity

Our Title V Program's commitment to protecting and promoting the health and well-being of Maternal and Child Health (MCH) priority population is manifest in a comprehensive array of programs and services. Direct services are carried out at the community level by local partners, while the state Title V program administers and monitors funding and program activities, providing guidance, training, technical assistance, data support, quality improvement, and other policy and program efforts to support the delivery of services through local and regional systems and programs. Our work is guided by key requirements and resources from the federal MCH Bureau at the Health Resources and Services Administration (HRSA) including the *Blueprint for Change: A National Framework for a System of Services for Children and Youth with Special Health Care Needs.*

This work is accomplished through the Division of Family Health's organizational structure, which includes the Division of Family Health's Leadership Team; Office of Medical Directors; Bureau of Administration; Bureau of Data, Analytics, Research and Evaluation; and four programmatic bureaus: Bureau of Perinatal, Reproductive, Adolescent and Sexual Health; Bureau of Child Health; Bureau of Community Engagement; and Bureau of Early Intervention. To support integrated development and implementation of Title V priorities, we convene five cross-division teams, one for each of the five Title V domains, with staff from all bureaus participating.

The Division of Family Health staff coordinate with several other units across the NYS Department of Health that oversee selected Title-V funded programs, as noted under *Organizational Capacity*. Albany-based central office staff coordinate with the Department of Health's Regional Office staff to support and oversee Title V-funded programs. See attached organizational chart and our Annual Reports and State Action Plan for additional information about specific Title V-funded programs and services.

In addition to administering specific programs and initiatives, Title V staff routinely collaborate with a wide array of

partners, both within and outside the NYS Department of Health, to help inform, strengthen, and coordinate statewide systems of services and supports for women, children, and families. See *Section III.C.2.b.iii*. below for more information on partnerships.

The Division of Family Health supports several statewide resource centers/training and technical assistance organizations to augment our capacity for designing, implementing, and evaluating evidence-based programming for multiple key initiatives, including maternal and perinatal health, Perinatal Infant and Community Health Collaborative (PICHC), Family Planning, adolescent health/youth development, and Children and Youth with Special Health Care Needs (CYSHCN). Capacity for quality assurance monitoring and technical support of selected clinical programs is enhanced through a longstanding contract with the Island Peer Review Organization (IPRO).

We meet three times each year with the statewide Maternal and Child Health Services Block Grant Title V Advisory Council, which is established in state law. Members appointed by the governor, including representatives from local health departments, community-based organization, health care, and parent groups. We also convene and meet regularly with several other program or topic-specific key taskforces and advisory groups to inform programming, including Early Intervention, Early Hearing Detection and Intervention, Lead Poisoning Prevention, Maternal Mortality and Morbidity, and the forthcoming new Youth Advisory Group.

NY's Title V Program works extensively with the state's Medicaid program and other partners to support CYSHCN and their families as a priority population, and to ensure statewide and local systems are in place to meet their needs. In NYS, all Social Security Income (SSI) beneficiaries, including blind and disabled children receiving benefits under SSI, are categorically eligible for Medicaid; thus, Title V funds are not used for these direct care services.

#### III.C.1.b.ii.c. Title V Workforce Capacity and Workforce Development

A strong workforce is needed to lead and implement core Maternal and Child Health (MCH) public health functions, effectively administer program resources, and collaborate with families and organizational partners at all levels. The size and complexity of NYS populations and service systems require significant leadership and capacity for program and policy development, program operations and implementation, data analysis and evaluation, and intra- and inter-agency communication and collaboration.

As of June 1, 2025, there are 163 filled Title V-funded positions within the NYS Department of Health's central, regional, and district offices, supplemented with additional non-Title V-funded positions supporting Title V programs and activities. Staff cover the full range of MCH populations and essential public health services.

Key Title V leadership within the NYS Department of Health's Division of Family Health (DFH) includes:

- Kirsten Siegenthaler, PhD, Director, DFH and NYS Title V Program
- Emily DeLorenzo, PhD, MSW, Associate Director, DFH
- Marilyn Kacica, MD, MPH, Medical Director, DFH
- Shaunna Escobar, DO, MPH, Associate Medical Director, DFH
- Dionne Richardson, DDS, MPH, Public Health Dental Director, DFH
- Deborah Rock, Director, DFH Bureau of Administration
- Suzanne Swan, MPH, Director, Bureau of Child Health and NYS Title V Child and Youth Special Health Care Needs (CYSHCN)
- Raymond Pierce, Director, Bureau of Early Intervention
- Solita Jones, DrPh, MS, Director, DFH Bureau of Data, Analytics, Research and Evaluation

The Bureau of Perinatal. Reproductive, and Sexual Health Director position is vacant following Ann-Margret Foley's retirement. Dr. DeLorenzo currently provides oversight to that bureau.

See *Form 7 - Title V Workforce* for additional detail.

NYS has experienced the same workforce trends described in national reports and surveys, including a shrinking public health workforce due to retirements and attrition. The 2021 Public Health Workforce Interests and Needs Survey (PH WINS) shows that national and regional workforce shortages in governmental MCH programs are expected to worsen, with nearly half of state and local health department (LHD) MCH staff planning to retire or leave within five years. Companion data from the Council on State and Territorial Epidemiologists (CSTE) 2024 Capacity Assessment highlights MCH among the top areas of unmet need nationally for epidemiologists.

NYS-specific PH WINS data for the NYS Department of Health's Center for Community Health (Center), which includes the Division of Family Health which oversees the Title V program and other core public health programs, shows that 41% of the Center's staff planned to leave or retire within five years. Like MCH staff nationally, Center staff are older than the general public health workforce, and 40% of staff over age 50 were eligible for retirement within 4 years of the 2021 survey. Statewide 2023 data from the NYS Association of County Health Officials (NYSACHO) show a significant decline in full-time local health department (LHD) staff over the past 15 years, with high vacancy rates for key MCH roles such as public health nurses, health educators, community health workers, epidemiologists, and early intervention service providers; an estimated 88% of NY's LHDs do not have sufficient staff required to provide foundational services.

It is also essential that the workforce have the experience and perspective to meet the needs of individuals, families, and communities. Our staff bring a broad range of personal and professional experiences to their work, enhancing their understanding of the populations we serve. Many have firsthand familiarity with navigating systems such as early intervention, special education, public benefit programs, and clinical or community-based services. Others have personal or family experience with special healthcare needs, NICU care, rural living, multilingual households, and immigration. Team members have experienced challenges such as food insecurity, long commutes, homelessness, and childhood adversity, and some have faced barriers in healthcare settings. These varied perspectives strengthen our ability to design and deliver services that are responsive, respectful, and informed by real-world understanding.

In addition to the size and experience of the workforce, we need to consider the specific knowledge and skills essential for effective MCH practice in a rapidly changing world and evolving public health landscape. Nationally, PH WINS data show that MCH professionals have slightly lower educational attainment and are less likely to hold public health degrees compared to the public health workforce overall, underscoring the need for both undergraduate and graduate level MCH education. A 2024 report in the American Journal of Public Health (Magaña et al) emphasized that public health education must meet changing workforce demands by equipping graduates with interdisciplinary/interprofessional practice skills and building strong collaborations between academic programs, employers, and practitioners.

NY-specific data from PH WINS and New York State Association of County Health Official's workforce assessment show that top staff training needs for both state and local public health staff include leadership & governance, systems and strategic thinking, fiscal management, community engagement, change management, policy engagement, and cross-sectoral partnerships - mirroring national workforce training needs. Input from current students, alumni, and employers gathered by our academic practice partner at UAlbany (see below) identified similar key training needs for the emerging workforce along with professional writing, applied communication, data skills, collaborative project planning, synthesizing information from many sources, policy analysis, and skills for working effectively in hybrid or remote environments.

The information gathered through our own listening forums with state and regional MCH staff provides additional insight to Title V workforce development needs (See *III.C.1.a. Process Description* above). Key priorities identified by our staff included improving communication for the public; enhancing coordination and collaboration with other programs and organizations - including other government programs as well as community-based organizations, schools, and health care providers; and enhancing the use of data to support effective and community-centered MCH work. They also expressed a desire for more work-related training, workshops, professional development, informational resources, and team-building activities with other staff with the Division of Family Health.

The Division of Family Health uses several approaches to recruit, retain, and support a competent and engaged Title V workforce. At the state level, we work closely with Human Resources colleagues to pursue open positions; develop job descriptions tailored to our needs; and identify, interview, and hire candidates in accordance with state civil service or other relevant policies and procedures. We focus on staff development and regularly provide division-wide training to staff on a variety of topics. At the local level, training and technical assistance for both subject matter content (e.g., emerging population health issues) and program management (e.g., data reporting and application, implementation of evidence-based programs) is incorporated in all Title V-funded programs. Our internal capacity for this work is enhanced and supplemented through formal and informal partnerships with external organizations, including the statewide resource, training and technical assistance centers, task forces, and advisory groups referenced in *Section III.C.1.b. ii.b*.

A prime example of a key partnership that enhances the capacity of our Title V workforce to meet its goals is our **academic-practice partnership** with the MCH Program based at University at Albany (UAlbany) College of Integrated Health Sciences (CIHS). Established in 2015 with support from the Health Resources and Services Administration's MCH Public Health Catalyst initiative, the UAlbany MCH program was recently awarded a third cycle of federal grant funding. The College of Integrated Health Sciences MCH program's mission is to recruit and train the next generation of professionals. They offer a graduate-level certificate in public health, Maternal and Child Health courses, and many professional development opportunities. Our mutually beneficial academic-practice partnership is formalized through a multi-year Memorandum of Understanding (MOU), initially established in 2019 and expanded significantly since, which we are currently updating for 2025-30. The current MOU supports technical assistance from UAlbany and up to 18 graduate student internships annually. Title V staff participate in UAlbany guest lectures, an annual networking event, and other professional development activities, benefiting both students and staff - especially those early in their careers. Since 2019 we have mentored and funded more than 70 student internship and practicum projects. Our academic-practice partnership has been highlighted by the National MCH Workforce Development Center and the Association of Maternal and Child Health Programs (AMCHP). Over the next five years we will maintain and enhance this academic-practice partnership with UAlbany MCH Program to expand internships, mentoring, and shared professional development activities for staff and students.

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

One of the main objectives of the State Systems Development Initiative (SSDI) is to build and expand New York State Maternal and Child Health data capacity to support Title V Maternal and Child Health Services Block Grant program activities and contribute to data-supported decision making in Maternal and Child Health programs, including assessment, planning, implementation, and evaluation. Improving data integration and utilization allows for greater ability to assess trends in outcomes. The function of the New York State SSDI program is to improve and enhance access to and the quality of the data that is available to Maternal and Child Health decision makers, program administrators, and staff who are monitoring and evaluating programs and their impact.

**l. 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 Principal Investigator, SSDI coordinator, and other staff guide the collection and analysis of the data that forms the basis for the Title V Maternal and Child Health Services Block Grant (Title V) five-year needs assessment and State Action Plan. Collectively, these describe the Department's priority needs, key strategies and activities, and National Outcome Measures, National Performance Measures, State Performance Measures, and Evidence-Based or Informed Strategy Measures. Staff partner with stakeholders to review and discuss relevant maternal and child health data and recommend structural and process measures used to monitor progress across all maternal and child health population domains.

In 2024, Title V and SSDI data staff led the development, selection, refinement, and tracking of data and performance measures associated with (Title V) priorities to track progress towards achieving reported goals. SSDI led the coordination of data collection of National Outcome Measures, National Performance Measures (NPM), and Evidence-based or -formed Strategy Measures both within and outside the Division of Family Health; contributed to ad hoc data analyses; and wrote summaries of data analyses relevant to the maternal and child health population for the Title V Application/Annual Report. These activities support Title V analysis of the NPMs and related structural/process objectives as part of the Title V Application/Annual Report.

Staff conducted community listening sessions in 2024 that collected data to analyze trends primarily occurring within under-reached populations in the state of New York to support the Title V needs assessment. Information from a variety of Community-Based Organizations were analyzed to assess the needs of communities. Insights derived from these analyses were used to give a deeper understanding of the health status of communities and for determining priorities for the Title V State Action Plan.

In the of Fall 2024 and Spring of 2025, SSDI and Title V staff conducted in-person Title V workshops to promote knowledge sharing and to incorporate staff input for the new grant cycle. Participating staff were given domain-specific one-page summary reports developed by the SSDI team summarizing data from a variety of sources, including the Title V Dashboard. These short reports were used to help staff understand how different measures were performing, both across the state and in specific communities. Data-driven insights generated during these listening sessions were used to select performance measures for the next grant cycle.

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 elements. New York State is currently reporting seven of the Core/National Dataset elements and six of the Core/State Dataset elements as part of Title V.

***Goal 2: Strengthen access to, and linkage of, key maternal and child health datasets to inform Maternal and Child Health Block Grant programming and policy development, and to assure and strengthen information exchange and data interoperability.***

New York State 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 New York State: Newborn Screening Program data; Vital Records (births, deaths); New York City Vital Records; Statewide Perinatal Data System; Children and Youth with Special Health Care Needs Program ; Early Intervention Program; Behavioral Risk Factor Surveillance System; Youth Behavioral Risk Factor Surveillance System; Centers of Disease Control and Prevention (CDC) Pregnancy Risk Assessment Monitoring System and Maternal Mortality Review Information Application (MMRIA); Immunization Information System; New York State Medicaid; New York State Quality Assurance Reporting Requirements; Statewide Planning and Research Cooperative System (i.e., state's hospital discharge data); National Survey of Children's Health; Early Hearing Detection and Intervention 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 Program data; Statewide Health Information Network in New York; Psychiatric Services and Clinical Knowledge Enhancement System; Project TEACH; American Community Survey; and United States Census data.

The SSDI Principal Investigator, the SSDI coordinator, and other Division of Family Health data staff have continued several efforts to increase data capacity and advance the development and utilization of linked information systems between key maternal and child health datasets in New York State to improve access to electronic maternal and child health data.

Through the New York State Maternal Health Innovation Program, the Division of Family Health is implementing a novel data linkage project as one of the key activities outlined in the grant. This linkage project involves the linkage of Pregnancy Risk Assessment Monitoring System data to other sources of maternal health information such as hospital discharge data and vital records. Pregnancy Risk Assessment Monitoring System data were identified for this project as an essential data resource of self-reported maternal health data that would provide fuller context of the complex system under which outcomes occur. This data linkage effort is expected to continue through Fiscal Year 2026 and will be used to support improvements in public health practice for New Yorkers during pregnancy, childbirth, and the postpartum period, and will build upon the existing Pregnancy Risk Assessment Monitoring System infrastructure by linking its survey data with clinical outcomes to allow for a more robust exploration of maternal health outcomes. A complete list of data linkage projects can be found below:

- Birth and Infant Death Data
- Birth, Death and Hospital Discharge Data for Maternal Mortality and Morbidity
- All Payer Database
- New York State Early Intervention Program and Children and Youth with Special Health Care Needs
- Early Hearing Detection and Intervention-Information System
- Pregnancy Risk Assessment Monitoring System Data to New York State Birth and Hospital Discharge Data

***Goal 3: Enhance the development, integration, and tracking of community health factors to inform Title V***

***programming.***

The New York State Perinatal Quality Collaborative Respectful Care and Safe Reduction of nulliparous, term, singleton, vertex (NTSV) Cesarean Birth Project invites all women delivering in a participating birthing facility to complete a Patient Reported Experience Measure Survey during the birth hospitalization. This provides birthing facilities with feedback directly from patients.

The New York State Perinatal Quality Collaborative launched the Neonatal Intensive Care Unit (NICU) Family-Centered Care Project in Fall 2023 and is expected to continue through Fiscal Year 2026. Data collection for the project includes performance measures on screening for language/interpreter needs and for postpartum mood and anxiety disorder stratified by demographic information. Data collection processes also validate NICU standardized processes to screen for broader social support needs and linkage of parents/families to needed community services/resources for to meet those needs. Additionally, the New York State Perinatal Quality Collaborative developed a NICU Parent Reported Experience Measure 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 demographic information. 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 2025, the Title V Dashboard and Title V Data Summaries continued development to assist users in visualizing data, determine subgroups that are not meeting state goals, and inform staff for future decision making specific to Title V programs. Data used in the Title V Dashboard and Data Summaries incorporate a comprehensive list of State Action Plan performance measures for the Title V's five domains. Demographic information, such as age, adverse childhood experiences, health insurance status, sex, location of residence (urban vs. rural), and income combined with zip code are included. Stratified analysis focused on these sub-groups has allowed staff to easily see where improvements can be made in New York State communities experiencing challenges in maternal and child health. Currently, users have access to over 200 maternal and child health metrics built from databases merged from federal and state sources. This includes historical and group-based data when possible. Users can filter data to view a variety of trends, graphs, and maps to see where and how various groups in New York State are performing for any of the included health metrics. SSDI staff also developed a poster summarizing the development and use of the Title V Dashboard and Title V Data Summaries that was presented at the 2025 Association of Maternal and Child Health Programs (AMCHP) Annual Conference. Development and refinement of the Title V Dashboard and Title V Data Summaries will continue through Fiscal Year 2026.

While the dashboard has not been released to the public and is only available to Department staff, there is publicly available data in a Maternal and Child Health dashboard on the Department's website at https://apps.health.ny.gov/public/tabvis/PHIG_Public/mch/. This public dashboard has priority measures available and was created under the Title V Maternal and Child Health Services Block in 2018-2019. The public dashboard data are updated annually.

Results from staff listening sessions held in Fall 2024 and Spring 2025 were leveraged to select priority needs for the upcoming Title V grant cycle. Using a combination of data from health metrics, community anecdotes, and lived experience, staff discussed and identified areas for improvement across domains. In addition to universal measures, each domain selected priority health measures that were integrated into the next grant cycle.

Data linkage 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.***

The New York State SSDI program supports several tools intended to develop maternal and child health data infrastructure within the Department to enhance the capacity for timely maternal and child health data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and

emerging issues/threats. Tools developed include the PRAMS Dashboard, the Maternal and Child Health Dashboard, Title V Dashboard, Prevention Agenda Dashboard, Title V Data Summaries (described further in Section ii). In addition, to ensure the sustainability of the New York State SSDI program, staff are actively engaged in the recruitment, training, and mentoring of student interns and fellows with an interest in maternal and child health data and analysis through a Memorandum of Understanding with the University at Albany's College of Integrated Health Sciences. This unique opportunity allows the SSDI program to attract and train future maternal and child health epidemiologists who will be prepared to address future public health emergencies and emerging threats. Also, the SSDI team participated in collaborative efforts with regional staff in Central New York State to develop a regional maternal and child health data surveillance report to improve access to county-level maternal and child health data at the local level. In addition to this, SSDI staff participated in the Department's Data Modernization Initiative/Data Governance committee focused on improving access to public health data sources to improve data capacity across the Department.

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

**New York State Perinatal Quality Collaborative**
The New York State Perinatal Quality Collaborative works to improve perinatal outcomes. More information about the New York State Perinatal Quality Collaborative can be found in the Women and Maternal Health Annual Report.

The New York State Perinatal Quality Collaborative's Respectful Care & Safe Reduction of NTSV Cesarean Birth Project was launched to all New York State birthing hospitals and centers in January 2021. The project assists facilities to improve both the experience of care and perinatal outcomes for childbearing women in the communities they serve. In Fall 2024, the New York State Perinatal Quality Collaborative expanded the focus of the project to include safely reducing the nulliparous, term, singleton, vertex (NTSV) cesarean birth rate. The New York State Perinatal Quality Collaborative Respectful Care & Safe Reduction of NTSV Cesarean Birth Project aligns with the American College of Obstetricians & Gynecologists Alliance for Innovation on Maternal Health patient safety bundle, Safe Reduction of Primary Cesarean Birth. To date, 76 NYS birthing facilities are participating in the project.

Title V staff has implemented the Patient Reported Experience Measure survey for the Respectful Care & Safe Reduction of NTSV Cesarean Birth Project. Participating facilities are administering the survey, which gives every woman at participating facilities the opportunity to provide feedback on their experience of care. The survey is self-directed and anonymous and is available in 24 languages. Facility-specific QR codes/links have been provided to all participating teams to access the survey, and answers go directly to the Department 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 and feelings around being treated with respect and compassion. All facilities participating in the project receive monthly trend reports.

In addition to collecting patient experience data, participating facilities collect structure measures that focus on the environment of care and its related administrative processes and policies in relation to a facility's ability to provide quality care. Measures are collected for Low-Risk Cesarean Birth, Provider Education on Respectful Care, and Provider Education on Safe Support of Labor and Vaginal Births.

**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. SSDI program staff are currently assisting with the development two fact sheets, highlighting some of the significant findings from the Report on Pregnancy-Associated Deaths in NYS, 2018-2020 (https://www.health.ny.gov/community/adults/women/maternal_mortality/docs/maternal_mortality_review_2018-2020.pdf). Additionally, SSDI program staff aided in the development of the Maternal Mortality and Morbidity Advisory Council Report, 2024 (https://www.health.ny.gov/community/adults/women/maternal_mortality/docs/2023_mmm_council_report.pdf), the Spotlight on Perinatal Substance Use Disorder Issue Brief

(https://www.health.ny.gov/community/adults/women/maternal_mortality/docs/2023-11_spotlight.pdf), a poster for the 2024 CDC Maternal Mortality Review Information Application (MMRIA) User Meeting, by providing key findings and data, and an additional poster for the 2025 AMCHP Annual Conference.

**State Maternal Heath Innovation**

SSDI staff also support efforts related to the New York State Maternal Health Innovation (SMHI) Program. The purpose of the SMHI project is to improve maternal health outcomes, reduce maternal mortality and severe maternal morbidity in New York State's pregnant, birthing and postpartum women. This will be accomplished by 1) collaborating with multidisciplinary maternal health experts; 2) collecting and analyzing maternal health data; and 3) promoting and executing innovations in maternal health service delivery. This project will be accomplished through access to quality health services and high-value programs delivered by a skilled workforce.

Under this program, the Department is convening a multi-disciplinary, collaborative Maternal Health Task Force. The Task Force is 1) assessing maternal care and coverage to identify gaps that impact maternal health outcomes, 2) assisting in the development of a strategic plan aligned with the Title V Needs Assessment, and 3) assessing Severe Maternal Morbidity and associated data, examining low-risk cesarean deliveries and reviewing data linked by the Division's data staff (led by the SSDI Principal Investigator) with the Pregnancy Risk Assessment Monitoring System (PRAMS) and other maternal data sources with the goal to improving state-level maternal health data and surveillance and innovate maternal health service delivery.

The innovative strategies being implemented and assessed by data staff include a universal postpartum virtual home visiting initiative by community health workers in rural areas in partnership with Level 1 birthing facilities and implementing two Perinatal Project ECHO projects. ECHO (Extension for Community Healthcare Outcomes) uses videoconferencing technology to connect a team of interdisciplinary experts with primary care providers, other health services professionals, and community members. The discussions with, and mentoring from, specialists help equip participants to support individuals and their families with health and disabilities related needs in their home communities.

Data components of the State Maternal Health Innovation Program include the development of a maternal health needs assessment summary. SSDI staff support the updating of the needs assessment summary and metrics, and data gathering, and continue to advise on the development of data products to enhance visualization and tracking of all relevant indicators. Data staff are also developing a severe maternal morbidity and NTSV cesarean birth surveillance reports. SSDI staff supported the development of the Department's Severe Maternal Morbidity surveillance report and factsheet which has been published on the Department's public website and shared with New York State Stakeholders. A similar NTSV cesarean birth surveillance report is currently under development and is expected to be finalized in Fiscal Year 2026. SSDI staff will continue to provide support and guidance on future updates. SSDI staff also supported the development of a poster focused on risk factors for NTSV cesarean births in New York State that was presented at the 2025 AMCHP Annual Conference.

Staff are also facilitating novel data linkages for expanded maternal health data disaggregation. SSDI staff have participated in an intra-agency collaboration to facilitate the linkage of Vital Records, hospital discharge, and PRAMS data. Linked files are expected to be accomplished during this next five-year grant cycle.

**New York State Promotion of Strategies to Advance Oral Health**

SSDI staff also support the New York State Promotion of Strategies to Advance Oral Health Initiative led by the Division of Family Health. Through strategic partnerships, oral health data are being collected to inform plans to improve access to care in schools and communities. With improved data collection, New York State will provide more efficient technical assistance in rural communities. In addition, New York State will use data to create awareness about oral health for those with Type 2 diabetes, with the goal of integrating diabetes management and oral health through improved access to oral health evidence-based preventive dental services and medical care through an integrated approach. The project will use data to facilitate expanded access to Evidence-Based Preventive Dental Services for children, especially in populations of focus (e.g., students in schools that qualify for school-based Evidence-Based Preventive Dental Services, have high rates of cavities, are in low-income areas, or

have other factors driving limited dental care and oral disease).

The project will promote access to training resources and guidance to ensure that infection prevention and control is maintained in all modes of dental care settings. This project allows the Department to leverage resources, enhance partnerships, and build new alliances by using effective health communication tools informed by data to enhance support for oral health interventions that have the potential statewide impact.

SSDI staff have supporting this initiative by collaborating with internal partners to use 2022 Behavioral Risk Factor Surveillance System data to examine oral health-related service utilization and tooth loss among New York State adults with and without diabetes and assisted with the development of a data to action report. SSDI staff also collaborated with internal partners to identify appropriate tools, existing secondary data sources including Medicaid data, and indicators to assess the impact of environmental and individual factors that impact the delivery of Evidence-Based Preventive Dental Services. Staff have also supported the use data to prioritize schools for Evidence-Based Preventive Dental Services delivery programs based on relative community need and resources. This activity allowed for data collection from selected schools-based health centers to determine baseline measures for preventive services, including dental sealants. SSDI staff will continue to support this initiative in Fiscal Year 2026.

**Development of Maternal and Child Health Data Products:**

SSDI staff have supported the development of a variety of maternal and child health-focused data products to ensure that maternal and child health priorities are kept at the forefront of the Department's strategic planning efforts. Data products include the Title V Dashboard and Title V Data Summaries (released internally), three posters presented at the 2025 AMCHP Annual Conference, the Severe Maternal Morbidity Report for 2017-2022 surveillance report and Factsheet, the New York State Profile of Children and Youth with Special Health Care Needs, 2022, the 2022 PRAMS Dashboard, the Maternal and Child Health Dashboard, and the Prevention Agenda Dashboard.

**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. Poster for the 2025 MMRIA User Meeting
10. Risk Factors Associated with Nulliparous, Term, Singleton, Vertex Cesarean Births in New York State, 2018-2022 – Poster presented at the 2025 AMCHP Annual Conference
11. Pregnancy-Associated Deaths Related to Mental Health and Substance Use in New York State, 2018-2021 – Poster presented at the 2025 AMCHP Annual Conference
12. Developing a Tableau Dashboard to Improve Maternal and Child Health Data Capacity and Transparency in NYS - Poster presented at the 2025 AMCHP Annual Conference
13. Severe Maternal Morbidity Report for 2017-2022 surveillance report and Factsheet:
    a. https://www.health.ny.gov/community/adults/women/maternal_mortality/docs/2017-2022_severe_maternal_morbidity.pdf
    b. https://www.health.ny.gov/community/adults/women/maternal_mortality/docs/factsheet_severe_maternal
14. New York State Profile of Children and Youth with Special Health Care Needs, 2022: Link: cshcn_profile_2022.pdf
15. New York State PRAMS Dashboard: Pregnancy Risk Assessment Monitoring System
16. New York State Maternal and Child Health Dashboard: New York State Maternal and Child Health (MCH)

Dashboard

7. New York State Prevention Agenda Dashboard: Prevention Agenda Tracking Dashboard
8. Title V Dashboard and Title V Data Summaries (internal release)

**III.C.1.b.ii.e. Other Data Capacity**

NYS' Title V Maternal and Child Health Services Block Grant (Title V) program relies on several robust data and information systems to inform priority setting, monitor health outcomes, and assess programs and policies. These systems include population-level data, representative surveys, and program data systems.

The Division of Family Health (DFH) maintains many systems, and some have made significant updates to further enhance data capacity and functionality.

DFH maintains specific data systems to support individual program needs. These programs include the Family Planning Program; Maternal, Infant, and Early Childhood Home Visiting Program; Perinatal and Infant Community Health Collaborative; School-Based Health Centers and the Pediatric Mental Health Care Access initiative; Adolescent Pregnancy Prevention Programs; Sexual Violence Prevention Programs; the NYS Perinatal Quality Collaborative, the Maternal Mortality Review Initiative, the State Maternal Health Innovation Program, the NYS Promotion of Strategies to Advance Oral Health, and the Children and Youth with Special Health Care Needs Program. Data particular to each program are collected for program monitoring and evaluation. New web-based data systems were developed within the Division of Family Health for the Perinatal and Infant Community Health Collaborative, School-based Health Centers, School-based Dental, the State Maternal Health Innovation Program, and Children and Youth with Special Health Care Needs Programs to increase capacity for data analysis and reporting to support statewide and local program activities.

For population surveillance for newborn hearing screening and follow-up, Division of Family Health developed and maintains the Early Hearing Detection and Intervention System (EHDI-IS 2.0), which is a front-end web application integrated with the NYS Immunization Information System in 2018. DFH currently is in the process to enhance EHDI-IS functionalities to improved documentation and to support refinement of activities to promote timely screening and follow-up. It allows hospitals, audiologists, and primary care practitioners to document all hearing screening, diagnoses, and referrals to early intervention for all New York State infants.

DFH oversees the NYS Early Intervention Program under Part C of Individuals with Disabilities Education Act. The program uses the EI-Hub, which is a new solution. The EI-Hub allows users to seamlessly manage the work they do for children in the Early Intervention Program. With a single sign-on through the Health Commerce System, EI-Hub users can capture and report on child information from referral (intake) to transition, including managing provider data, provider management, claims creation, billing, and payments. The EI-Hub system was launched on October 15, 2024. 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.

Division of Family Health staff access multiple systems via partnership or formal agreements.

The Division access the state's two Vital Records for New York City and NYS outside of NYC.

The NYC vital records system, called 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 Statewide Perinatal Surveillance System, using National Center for Health Statistics standards supplemented by the set of quality improvement variables, but does not currently include the same statistical summary reports and data extraction capabilities as are available in the system for births outside of NYC.

The vital record system for NYS outside of NYC includes data from the Electronic Birth Certificate, collected in the Statewide Perinatal Data System. It is an electronic maternal and newborn data collection system which was established and is currently maintained by the Department with the purpose of improving prenatal, obstetric, and newborn care for mothers and infants in NYS. The Statewide Perinatal Surveillance System was developed to make data available for the Department and hospitals for monitoring and quality improvement. Web-based and modular in design, the Statewide Perinatal Surveillance System includes the Core electronic birth certificate that captures birth

data in hospitals outside of New York City, and the Neonatal Intensive Care Unit (NICU) module. The electronic birth certificate 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. The system meets the requirements of the National Center for Health Statistics standards for collection of electronic birth data. It also includes quality improvement variables.

In addition, the NYS Electronic Death Registration System is a secure web-based system for electronically registering deaths for NYS hospitals, excluding NYC. The Electronic Death Registration System 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 are used to identify pregnancy-related deaths.

The NICU Module is within the Statewide Perinatal Surveillance System and captures detailed clinical information from all hospitals 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.

The Division access the Statewide Planning and Research Cooperative System (SPARCS) which is a comprehensive all-payer data reporting system. 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.

The Department also has developed an All-Payor Database which 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 All-Payor Database includes hospital discharge data, vital records death data, and Medicaid claims and encounter data. Going forward, vital records birth data, commercial claims data, and other public health registries and electronic health records will be integrated.

The following data systems are also accessed:

- Newborn Screening Laboratory Information Management System maintained by the Wadsworth Laboratory is a record of newborn bloodspots, demographics, and results for the 50 different disorders tested and follow-up.
- NYS Immunization Information System collects all immunizations administered to persons less than 19 years of age.
- Statewide Health Information Network for New York 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. 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 provides laboratories that serve NYS with a single electronic system for secure and rapid transmission of reportable disease information to the Department, local health departments, and the NYC 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.
- LeadWeb is a Department-maintained system used by local health departments to carry out the required case management and follow-up activities for children with elevated blood lead levels. All blood lead levels test results for children younger than 18 are reported to LeadWeb by laboratories, and local health departments are notified of new cases identified in their county. LeadWeb also collects information on housing-related hazards and environmental follow-up for each child. Local Health Department staff are required to document when follow-up services are provided for each case, which they input directly into

LeadWeb.

- 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 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 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' sample is representative of the non-institutionalized civilian adult population, aged 18 years and older. There is the ability to add questions to provide insight to statewide health status and trends. The Department has added resources to better understand sexual health, for example.
- 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 Youth Risk Behavior Survey on behalf of the NYS Education Department.
- NYS Office of Mental Health Project TEACH and Psychiatric Services and Clinical Knowledge Enhancement System data.

Staff access publicly available sources such as the National Survey of Children's Health, the American Community Survey, NYS Quality Assurance Reporting Requirements, 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. NYS participated in the over-sampling of National Survey of Children's Health in 2022 providing more robust information on Children and Youth with Special Healthcare Needs and other key demographics.

The Division of Family Health has developed the Title V dashboard and Title V data summary one-pagers to improve the accessibility and analytics of Title V performance measures. The dashboard links data from a variety of sources, including the Federally Available Dataset and state datasets to create a comprehensive inventory on maternal and child health metrics and is updated annually following the release of the Federally Available Dataset.

The Division of Family Health has partnered with the Department's Public Health Information Group to build the Maternal and Child Health Dashboard (https://www.health.ny.gov/MCHdashboard), which is comprised of select national and state performance measures related to the NYS Title V application. It was built to support the assessment of needs, monitor progress towards improving the health of NYS maternal and child health populations. 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 in April 2024 and February 2025. The Division of Family Health also contributed to the NYS PRAMS Dashboard and the NYS Prevention Agenda Dashboard to make data available to researchers and the public.

The Division of Family Health 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. All Title V-funded programs submit quarterly or bi-annual reports with both quantitative and narrative information on program activities, capacity, successes, challenges, training and technical assistant needs. The Division of Family Health uses these data to support ongoing needs assessment, develop annual reports for key populations and programs, monitor performance of local programs, support quality improvement projects, educate partners and the public, and conduct focused evaluation projects.

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

Partnerships and collaborations with other programs, organizations, and community groups are a fundamental way in which NY's Title V Program works to meet the needs of Maternal and Child Health (MCH) populations. We have built and continue to expand extensive partnerships at all levels. Key examples of partners at multiple levels are highlighted below. Collectively, these partnerships serve to expand and enhance the scope, quality, coordination, credibility, and impact of key investments to promote maternal, child, and family health and well-being.

Our Title V Program partners closely with other HRSA Maternal and Child Health Bureau (MCHB)-funded initiatives. Key MCHB investments managed directly *within the Division of Family Health* include the Maternal, Infant, and Early Childhood Home Visiting (MIECHV), State Systems Development Initiative (SSDI), Ryan White Part D HIV programs, and Early Hearing Detection and Intervention (EHDI). Beyond the Division, we partner with the state's *regional* Consortium for Genetics and Newborn Screening Services (managed through the NYS Department of Health's Wadsworth Center); the state's Early Childhood Comprehensive Systems (ECCS) initiative (managed by the NYS Council on Children & Families); the MCH Public Health Catalyst Program (based at University at Albany College of Integrated Health Sciences); Healthy Start grantees; the state's Family2Family Information Center (based at Parent to Parent of NYS); and Leadership Education in Neurodevelopment and Related Disabilities (LEND) grantees in the state.

We also partner with other key federally funded programs that support MCH. Examples of these programs based **within** the Division of Family Health include:

- Individuals with Disabilities Education Act (IDEA) Part C - Early Intervention Program (Federal Office of Special Education Programs)
- Personal Responsibility Education Program (Federal Administration for Children and Families (ACF)
- Oral Health Workforce Development (Federal HRSA)
- Rape Prevention Education (Federal CDC)
- Sexual Risk Avoidance Education Program (Federal ACF).

Key MCH-related federally funded public health programs based **outside** of the Division of Family Health include:

- CDC-funded Asthma Control Program and Behavioral Risk Factor Surveillance System (BRFSS) (based in the NYS Department of Health's Division of Chronic Disease Prevention)
- USDA-funded Child and Adult Care Food Program (CACFP) and Special Supplemental Program for Women, Infants, and Children (WIC) (based in the NYS Department of Health's Division of Nutrition)
- Childhood Lead Poisoning Prevention Program (based in the NYS Department of Health's Center for Environmental Health)
- Pregnancy Risk Assessment Monitoring System (PRAMS) (based in the NYS Department of Health's Office of Public Health Practice).
- Medicaid (based in NYS Department of Health's Office of Health Insurance Programs)
- Vaccines for Children (VFC) and other immunization initiatives (based in NYS Department of Health's Division of Vaccine Excellence)

We partner extensively with other state-funded offices, programs, and initiatives to support MCH. Selected examples include the Infertility Demonstration Program (NYS Department of Health's Division of Family Health); Creating Healthy Schools and Communities (NYS Department of Health's Division of Chronic Disease Prevention); and Enough is Enough sexual violence prevention (NYS Education Department). We routinely engage with other state agencies through workgroups, advisory committees, and joint projects. These include the NYS Offices of Alcoholism and Substance Abuse (OASAS) Children and Family Services (OCFS, which oversees childcare and child welfare systems), Mental Health (OMH), Office for People with Developmental Disabilities (OPWDD), Office of Temporary and Disability Assistance (OTDA), as well as the NYS Education Department.

Partnerships with local health departments are critical to advancing MCH. We work with all the state's 58 Local Health Departments (57 counties and the five counties/boroughs of New York City) through various program grants,

and as a collective through the NYS Association of County Health Officials. The Department also maintain relationships with Native American tribes, tribal organizations, and urban Indian organizations, serving as a liaison with the Nations and consulting with them on relevant topics.

Partnerships with external academic organizations are also key to our work. As described extensively in Workforce Development section, academic-practice partnerships are a key aspect of our work and capacity. We have longstanding partnerships with the MCH Program based in the University at Albany College of Integrated Health Sciences, including their HRSA Maternal and Child Health Bureau (MCHB)-funded MCH Public Health Catalyst grant, and Cornell University's Bronfenbrenner Center for Translational Research.

We regularly coordinate and collaborate with professional medical organizations, including the NY Academy of Medicine; NYS Chapters of the American College of Obstetricians and Gynecologists (ACOG); American Academy of Pediatrics (AAP); NYS Academy of Family Physicians (AFP); NYS Association of Licensed Midwives (NYSALM); Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN); and many others, as well as hospital associations. We also work closely with other non-governmental statewide organizations including the Schuyler Center for Analysis and Advocacy (SCAA), NYS Hands and Voices, and the NY School-Based Health Alliance. As noted in earlier sections addressing capacity, we convene or serve on numerous formal state advisory councils including our state's Maternal and Child Health Services Block Grant Advisory Council.

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

As evidenced by the extensive input from family and community members across our Needs Assessment, our Title V Program places high priority on family and community engagement. We are dedicated to not only getting input from family and community members but partnering with them at all levels to drive and improve our work.

At the state level:

- Michelle Juda, outgoing Executive Director of NYS Parent to Parent and the state's Family2Family Information Center, serves on the Title V Advisory Council.
- We are establishing a new Youth Advisory Council that will embed youth members within our adolescent-serving programs to ensure services and programming meet their needs. Our Assets Coming Together (ACT) for Youth Center for Community Action at Cornell University also has a youth advisory board.
- Community members serve on the Maternal Mortality and Morbidity Advisory Council
- The Children and Youth with Special Health Care Needs (CYSHCN) Statewide Resource Center is required to hire a parent of a CYSHCN as a family liaison and convene family forums to provide direct input on program development.

At the regional level:

- NYS Perinatal Quality Collaborative (NYSPQC) teams include patients, families, and those with lived experience in their educational curricula.
- NYS Department of Health Regional Officed help facilitate connections between community organizations, health care provider facilities, and families to ensure families' needs are met. A prime example of this is extensive collaboration between the Western Regional Office and the Regional Perinatal Center for Western NY at John R. Oishei Children's Hospital. Over a three-year period, staff from these respective organizations worked together to assess and address barriers to re-connecting patients with community providers and resources after delivery at higher level hospitals outside their area, especially patients who were transferred for a higher level of care during or after delivery. Through this collaboration, they were able to establish a process (with patient consent) to alert county health department public health nurses when a patient delivers at an outside birthing facility so that the local departments could connect those patients and families to local resources.

At the community level:

- School Based Health Centers (SBHCs) and Comprehensive Adolescent Pregnancy Prevention (CAPP)

programs routinely engage parents and youth in their programming activities
- Perinatal and Infant Community Health Collaborative (PICHC) programs are engaged in developing work with community advisory boards.
- Local Health Department administer Children and Youth with Special Health Care Needs (CYSHCN) programs which are required to engage families of CYSHCN in their work groups, committees, and task forces to improve the system of care. Families engage in local planning activities, and their input informs training and technical assistance for the local programs.

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

Based on the information described in this Needs Assessment Summary, our Title V Leadership Team considered this driving question:

***How can we be responsive to the themes voiced by families and communities in our Comprehensive Needs Assessment, within the context of existing program infrastructure and resources, and with a focus on making measurable progress in specific areas aligned with the Health Resource and Service s Administration's national performance measures?***

To address this question, we reviewed all the Comprehensive Needs Assessment findings within each domain and the recurring themes that emerged from the listening forums and surveys. Those 10 themes are essential to informing the approaches to improving Maternal and Child Health (MCH) outcomes in our State Action Plan. Our Title V Program collaborated with the UAlbany College of Integrated Health Sciences' Maternal Child Health Program to convene a day-long strategic planning retreat in Spring 2025, with 110 staff representing all the Division of Family Health's Bureaus and Regional Offices participating. Prior to the retreat, all staff viewed a recorded webinar recapping the Title V Needs Assessment process and both qualitative and quantitative findings.

At the spring retreat, staff worked in small groups, each focused on a different topic area, such as postpartum health, adolescent mental health, and medical home for Children and Youth with Special Health Care Needs (CYSHCN). Through three rounds of structured discussions, each group discussed:

- Current, planned, or potential new work related to their topic
- Data measures (including National Performance Measures, or NPMs) that best reflect the impact of that work
- The responsiveness of that work to the qualitative themes from the Needs Assessment.

After reviewing the output of all small groups' discussions through a 'gallery walk,' each participant identified up to five topics and performance measures they viewed as highest priority for our 2025-30 State Action Plan. Finally, the Title V Leadership Team considered all the information within the context of our Title V Program's capacity for action and impact to establish a final set of priorities for the next five years, with at least one priority mapping to each of the five Title V domains. Finally, we identified a relevant National Performance Measure (NPM) for each priority that would meaningfully represent progress in that area over the next five years, including the two required universal measures. We discussed and adopted these proposed measures at the meeting with our Title V Maternal and Child Health Services Block Grant Advisory Council in June 2025.

**DOMAIN: Women's & Maternal Health**

- **Priority:** Support the health and well-being of women throughout pregnancy and postpartum periods
  - **NPM**: Postpartum Visit timeliness (part a) and quality (part b)

**DOMAIN: Perinatal & Infant Health**

- **Priority:** Ensure risk-appropriate care for infants.
  - **NPM:** Risk-appropriate Perinatal Care

**DOMAIN: Child Health**

- **Priority**: Promote comprehensive patient-centered health care for children.
  - **NPM:** Medical Home for children without special health care needs

- **Priority:** Promote healthy play and nutrition for all children.
  - **NPM:** Physical Activity

**DOMAIN: Adolescent Health**

- **Priority:** Support physical and mental health and health care for adolescents.
  - **NPM:** Mental Health Treatment

**DOMAIN: Children and Youth with Special Health Care Needs**

- **Priority:** Promote comprehensive patient-centered care for CYSHCN.
  - **NPM:** Medical Home for CYSHCN

- **Priority**: Support transition for youth with special health care needs to adult roles and care.
  - **NPM:** Transition to Adult Care

### III.D. Financial Narrative

| | 2022 | | 2023 | |
|---|---|---|---|---|
| | Budgeted | Expended | Budgeted | Expended |
| Federal Allocation | $38,909,810 | $37,088,652 | $38,909,810 | $42,013,230 |
| State Funds | $29,285,355 | $29,285,355 | $29,285,355 | $29,285,355 |
| Local Funds | $35,897,127 | $36,881,701 | $36,138,659 | $47,689,009 |
| Other Funds | $0 | $0 | $0 | $0 |
| Program Funds | $21,713,525 | $26,235,808 | $24,571,358 | $17,789,263 |
| SubTotal | $125,805,817 | $129,491,516 | $128,905,182 | $136,776,857 |
| Other Federal Funds | $61,858,217 | $49,502,087 | $62,282,555 | $64,008,683 |
| Total | $187,664,034 | $178,993,603 | $191,187,737 | $200,785,540 |

| | 2024 | | 2025 | |
|---|---|---|---|---|
| | Budgeted | Expended | Budgeted | Expended |
| Federal Allocation | $38,909,810 | $37,194,406 | $38,909,810 | |
| State Funds | $29,285,355 | $29,285,355 | $0 | |
| Local Funds | $47,389,317 | $67,986,422 | $71,957,219 | |
| Other Funds | $0 | $0 | $0 | |
| Program Funds | $18,762,687 | $22,057,913 | $21,296,337 | |
| SubTotal | $134,347,169 | $156,524,096 | $132,163,366 | |
| Other Federal Funds | $66,910,483 | $61,356,351 | $73,115,502 | |
| Total | $201,257,652 | $217,880,447 | $205,278,868 | |

| | 2026 | |
|---|---|---|
| | Budgeted | Expended |
| **Federal Allocation** | $38,909,810 | |
| **State Funds** | $29,285,355 | |
| **Local Funds** | $62,996,303 | |
| **Other Funds** | $0 | |
| **Program Funds** | $24,747,426 | |
| **SubTotal** | $155,938,894 | |
| **Other Federal Funds** | $72,835,998 | |
| **Total** | $228,774,892 | |

**III.D.1. Expenditures**

Federal Fiscal Year (FY) 2024 Expenditures, including Title V Maternal and Child Health Services Block Grant, 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 2024 report and FY 2026 application.

Title V Maternal and Child Health Services Block Grant 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), Cornell's ACT for Youth Center for Community Action, and Family Planning and Reproductive Health Care Program, promote primary and preventive health care, preconception and inter-conception 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 Maternal and Child Health Services Block Grant 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 Maternal and Child Health Services Block Grant 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 Maternal and Child Health Services Block Grant 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. 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 Health Resources and Services Administration's (HRSA) Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program supports evidence-based home visiting and efforts to engage women and families into health insurance, inter-conception 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's Universal Newborn Hearing Screening and the Centers for Disease Control and Prevention's 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 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 local health departments 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 the state's CYSHCN Support Services Program 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 24 appear less 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 24 application reflected a budget of over $18 million in Program Income, but actual expenditures were more than anticipated. This is likely related to the timing of the reporting by local health departments rather than an actual increase 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 Federal Fiscal Year (FY) 2026 budget reflects NYS's commitment to Title V Maternal and Child Health Services Block Grant programs and services. NYS will continue to use FY 2026 Title V funds to support the implementation of NYS's Title V State Action Plan. Title V Maternal and Child Health Services Block Grant 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 Maternal and Child Health Services Block Grant program. NYS's Title V Maternal and Child Health Services Block Grant will continue interagency efforts to address maternal depression.

NYS will continue to move towards a greater understanding of comprehensive health, development, morbidity, and health outcomes, 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 Children and Youth with Special Health Care Needs (CYSHCN) and their families. The Title V Program has previously increased its investment in the CYSHCN program administered by the Local Health Departments to provide more support to local staff who are better able to connect with and support CYSHCN and their families. The Title V Program will also continue to invest in a training and technical assistance center at Cornell University's ACT for Youth. The Department released a Request for Applications (RFA) to competitively select the training and technical assistance center. ACT for Youth provides this support to the Department's youth-serving programs, so it is well positioned to expand to better serve CYSHCN and to integrate lessons learned and trainings across youth-serving programs. The center will 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 Maternal and Child Health Services Block Grant 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, School Based Health Centers 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 access to high-quality, respectful care for everyone 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 FY26 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 outlined 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

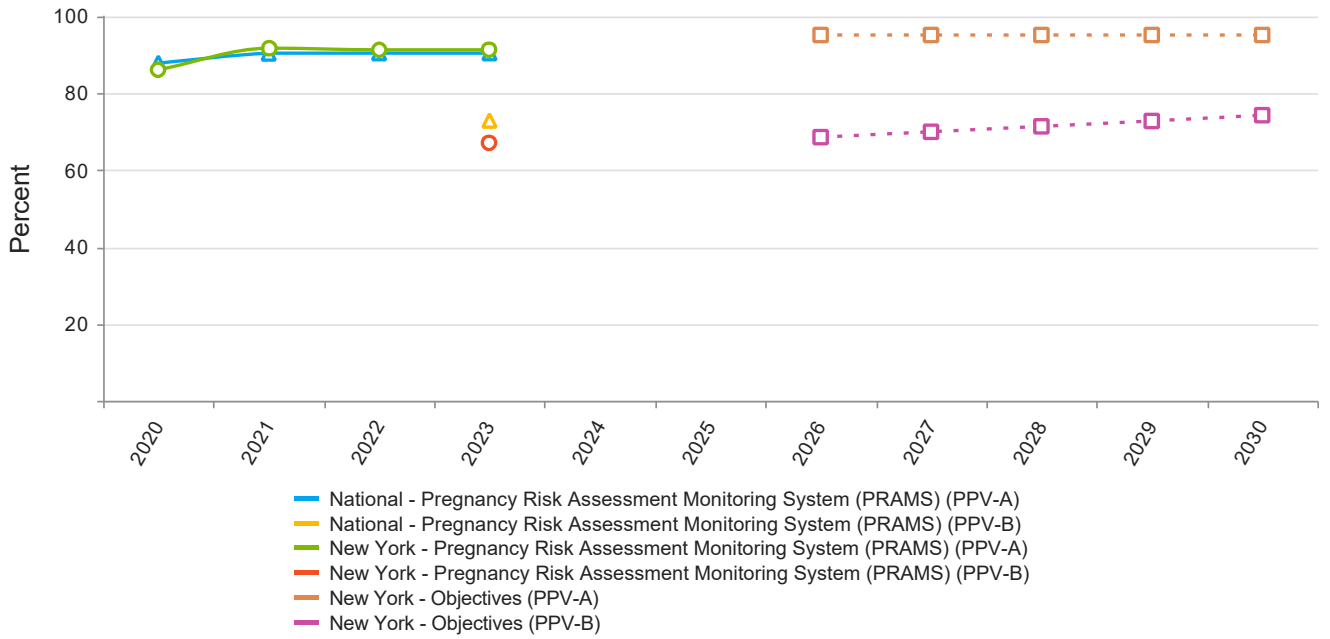
**III.E.3 State Action Plan Narrative by Domain**

*If a Priority Population is selected for an NPM, then this section will display only the data associated with the Priority Population in the charts, data tables, and field notes. Additional NPM data are available in the Form 10 appendix.*

**Women/Maternal Health**

**National Performance Measures**

**NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components - PPV**
**Indicators and Annual Objectives**




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

| Federally Available Data | | |
|---|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | | |
| | **2023** | **2024** |
| Annual Objective | | |
| Annual Indicator | 91.2 | 91.3 |
| Numerator | 166,888 | 162,546 |
| Denominator | 182,980 | 178,064 |
| Data Source | PRAMS | PRAMS |
| Data Source Year | 2022 | 2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2026 | 2027 | 2028 | 2029 | 2030 |
| Annual Objective | 95.0 | 95.0 | 95.0 | 95.0 | 95.0 |

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

| Federally Available Data | | |
|---|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | | |
| | **2023** | **2024** |
| Annual Objective | | |
| Annual Indicator | 76.2 | 67.2 |
| Numerator | 124,429 | 107,840 |
| Denominator | 163,344 | 160,411 |
| Data Source | PRAMS | PRAMS |
| Data Source Year | 2022 | 2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | 68.5 | 69.9 | 71.3 | 72.7 | 74.2 |

**Evidence-Based or –Informed Strategy Measures**

**ESM PPV.1 - Percent of regular Big 6 Postpartum Visit peer learning meetings attended with active participation in presenting and/or responding to peer discussions.**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2026 | 2027 | 2028 | 2029 | 2030 |
| Annual Objective | 90.0 | 90.0 | 90.0 | 90.0 | 90.0 |

**ESM PPV.2 - Percent of Perinatal and Infant Community Health Collaboratives (PICHC) clients who attended a postpartum visit within 12 weeks after giving birth.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2024 |
| Annual Objective | |
| Annual Indicator | 56.2 |
| Numerator | 757 |
| Denominator | 1,348 |
| Data Source | PICHC Program data |
| Data Source Year | 2024 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2026 | 2027 | 2028 | 2029 | 2030 |
| Annual Objective | 59.0 | 60.2 | 61.4 | 62.7 | 63.9 |

**State Action Plan Table**

| State Action Plan Table (New York) - Women/Maternal Health - Entry 1 | |
|---|---|
| **Priority Need** | |
| Support the health and well-being of women throughout pregnancy and postpartum periods | |
| **NPM** | |
| NPM - Postpartum Visit | |
| **Five-Year Objectives** | |
| Objective WMH-1: Increase the percent of women who attended a postpartum checkup within 12 weeks of giving birth by 4%, from 91.3% in 2025 to 95% in 2030. (PRAMS) | |
| Objective WMH-2: Increase the percent of women who attended a postpartum checkup and received recommended care components from by 10%, from 67.2% in 2025 to 74.2% in 2030. (PRAMS) | |
| **Strategies** | |
| Strategy WMH-1: Support perinatal home visiting services for pregnant and postpartum women. | |
| Strategy WMH-2: Support comprehensive, confidential family planning reproductive health services before and after pregnancy. | |
| Strategy WMH-3: Support Sexual Violence programs that prevent and respond to sexual violence as a key factor that affects women's health and well-being. | |
| Strategy WMH-4: Provide pregnant and postpartum women, their families, and community members with accurate information to promote preconception, prenatal, and postpartum health and use of health care services, including mental health and reproductive health care. | |
| Strategy WMH-5: Maintain and enhance a statewide perinatal regionalization system to ensure that pregnant, intrapartum, and postpartum women and newborns receive high quality, risk-appropriate care, including a specific focus on maternal health, morbidity, and mortality. | |
| Strategy WMH-6: Through the Perinatal Quality Collaborative (NYSPQC), engage birthing facilities and other partners in structured quality improvement projects to improve health care services and outcomes for pregnant, intrapartum, and postpartum women. | |
| Strategy WMH-7: Convene, facilitate, and/or participate in partnerships to improve postpartum visits, health, and well-being. | |
| Strategy WMH-8: Apply population health data to support clinical and public health actions that promote maternal health. | |
| **ESMs** | **Status** |
| ESM PPV.1 - Percent of regular Big 6 Postpartum Visit peer learning meetings attended with active participation in presenting and/or responding to peer discussions. | Active |
| ESM PPV.2 - Percent of Perinatal and Infant Community Health Collaboratives (PICHC) clients who attended a postpartum visit within 12 weeks after giving birth. | Active |

NOMs

Maternal Mortality

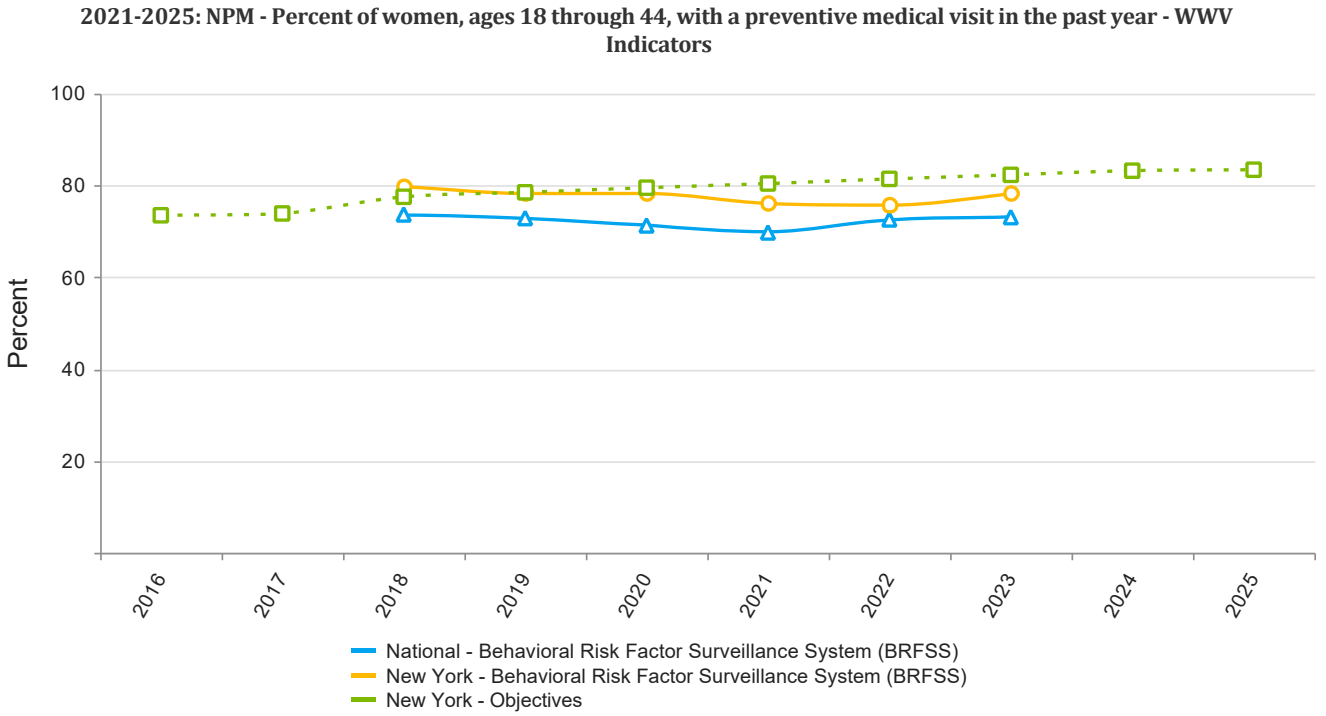
Neonatal Abstinence Syndrome

Women's Health Status

Postpartum Depression

Postpartum Anxiety

**2021-2025: National Performance Measures**




| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: Behavioral Risk Factor Surveillance System (BRFSS)** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 79.4 | 80.3 | 81.3 | 82.2 | 83.1 |
| Annual Indicator | 78.3 | 78.3 | 75.9 | 75.5 | 78.1 |
| Numerator | 2,737,695 | 2,703,220 | 2,698,183 | 2,643,832 | 2,791,769 |
| Denominator | 3,498,639 | 3,451,509 | 3,553,627 | 3,503,858 | 3,573,781 |
| Data Source | BRFSS | BRFSS | BRFSS | BRFSS | BRFSS |
| Data Source Year | 2019 | 2020 | 2021 | 2022 | 2023 |

**2021-2025: Evidence-Based or –Informed Strategy Measures**

**2021-2025: 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** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 55.3 | 58.1 | 61 | 64.1 |
| Annual Indicator | 63.4 | 40.1 | 53.9 | 62.4 | 67.8 |
| Numerator | 2,068 | 573 | 1,299 | 1,668 | 1,970 |
| Denominator | 3,260 | 1,430 | 2,412 | 2,675 | 2,905 |
| Data Source | MICHC Program Data | MICHC Program Data | MICHC Program Data | MICHC Program Data | MICHC Program Data |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | 2024 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

**2021-2025: 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** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 37.5 | 37.7 | 37.9 | 38.2 |
| Annual Indicator | 36.2 | 29.7 | 32.9 | 33.5 | 29.9 |
| Numerator | 92,136 | 58,264 | 66,886 | 64,392 | 58,769 |
| Denominator | 254,718 | 195,847 | 203,468 | 191,962 | 196,690 |
| 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 | 2019 | 2020 | 2021 | 2022 | 2023 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

## Women and Maternal Health Domain Annual Report for October 1, 2023 – September 30, 2024

For Women 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 selected 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 as part of the prior comprehensive needs assessment in 2019-2020, 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 (MMRB) has identified increasing access to comprehensive, high quality health care services as a key element of efforts to improve mortality and morbidity outcomes. NYS is ranked 23rd in the nation for the rate of maternal mortality. While NYS's overall maternal mortality rate has declined from its peak, there are differences in rates of maternal death by demographic information that persist. Severe maternal morbidity (SMM) 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. SMM 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, SMM 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.

**Domain Objectives:** 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. (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 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. (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)

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 or linkages to a wide range of community services to holistically address health and wellness, including mental health and broader social needs that may impact a person's ability to access health care and to healthy options. 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) programs, 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 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. CHWs receive periodic 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. 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 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 complement and collaborate with other home visiting programs serving the same communities including programs supported by New York's funding from HRSA 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 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 timely access to high-quality and respectful care. Funded programs 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 broader social issues that can impact health outcomes. The core individual-level strategy is the use of CHWs to outreach and provide supports to individuals who have increased needs, low income, Medicaid-eligible, and are at risk for or who have a previous history of adverse birth outcomes. Community-level strategies involve collaboration with community partners, including community residents, to mobilize community action to address broader social needs that can impact perinatal health outcomes. In July 2024, a contract was established with Cicatelli Associates, Inc to support PICHC programs with the implementation of best practice community-based strategies to improve perinatal and infant health outcomes through the provision of technical assistance, training, and quality improvement efforts, including development of core trainings for CHW and CHW Supervisors.

PICHC utilizes a data management information system (DMIS) which is maintained by the Research Foundation of the State University of New York to collect and monitor PICHC program data.

The NYS Family Planning Program (FPP) supports 37 health facilities that are regulated by the Department 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. NYSFPP providers use funds to support

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, and breast and cervical cancer screening; appropriate referrals; and health education. To address barriers to receiving reproductive health care, the NYSFPP 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 FPP providers to support telehealth infrastructure, improve access to telehealth services, and support training and technical assistance for the FPP providers. Due to administrative challenges, we were granted a one-year extension through May 31, 2024. Thirty-one telehealth grants were awarded to support the enhancement of telehealth at family planning sites, ensuring continued access to core primary and preventive services.

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 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 New York's population which is large and spread out geographically. 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.

**Strategy Progress:** The NYS Title V Program led the following specific program and policy activities to advance this strategy during the 2023-24 reporting period:

**WMH 1.1** Across all Title V programs, enhance promotion of the NYS Growing up Health Hotline ("the Hotline") to increase awareness of available community resources, supports, and services including WIC, Medicaid, family planning, and prenatal care.

The Hotline contracts with the state preferred vendor, Goodwill of the Finger Lakes, was established through a noncompetitive procurement for July 1, 2023 – June 30, 2026. As part of this contract, the Department is working with the Hotline and a third-party vendor to build text messaging capacity for the Hotline, giving New Yorkers another mechanism to get information about services they are interested in or need. During the program year, Department staff worked with internal stakeholders to support the build-up of the framework for the texting platform and developed decision trees for priority topics including WIC, children and youth with special health care needs, and parent and perinatal support that will be used for consumers texting the GUHH. Development of the texting platform, along with planning for a statewide multimedia awareness campaign continue into the 2024-25 program year.

Staff promoted the Hotline across WIC, perinatal home visiting programs, and family planning programs, as well as the NYS Early Intervention Program. When feasible and relevant, the Department includes the Hotline information as a key resource for programs serving the maternal, infant, and child health populations. This includes social media posts, and inclusion of the website, phone number, and/or QR codes on brochures and presentations. Additionally, information about the Hotline is included in state-supported insurance program materials (Medicaid, Child Health Plus, New York State of Health).

During FFY24, the GUHH handled 16,444 calls, most of which resulted in a referral to WIC local agencies. Other callers were referred to the NYS Marketplace for health insurance coverage or local departments of health for early intervention services. NYS WIC continues to promote the GUHH in brochures and via the online chat service "Wanda".

**WMH 1.2** Through the Regional Perinatal Centers (RPCs) and their networks of affiliated birthing hospitals, support and enhance capacity to provide high quality perinatal telehealth services and perinatal subspecialty providers, particularly to rural communities and communities with limited 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 RPCs that serve a significant rural population identified needs and capacity. RPCs continue to develop and expand telehealth services to increase local access to maternal-fetal medicine specialists. Examples of telehealth services provided this year include lactation consultations, opioid use disorder education, and transfer consultations by the RPCs with affiliates. Tele-ICU services are currently in development with Albany Medical Center and affiliates. 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*

**WMH 1.3** Through the PICHC and MIECHV programs, integrate virtual home visiting services to increase acceptance and support of services for families who have been difficult to reach and stay connected.

Virtual home visits conducted in the context of the response to the COVID-19 pandemic have helped to maintain communication and allow essential 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 COVID-19 pandemic. During the reporting period, PICHC programs conducted 29,661 visits with clients, of which 41% (12,270) were virtual visits. Home visitors continuously disseminated guidance from reputable sources, such as the NYS Department of Health and CDC, on infectious diseases and perinatal health as it became available.

**WMH 1.4** Through the PICHC program, continue to support home visitors 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 home visitors 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, 2023, to September 30, 2024, a total of 5,436 clients were enrolled in the PICHC programs. Home visitors 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, 2023, to September 30, 2024, visitors engaged 2,904 prenatal clients to create a birth plan. Visitors also issued a total of 25,778 referrals, with the top five referral categories overall being clothing/baby care items, transportation, food pantry, housing assistance and dental services.

**WMH 1.5** 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 FPP work. An example was an additional one-time federal grant award to continue supporting telehealth services in service areas beyond the COVID 19 pandemic. Thirty-one family planning providers received telehealth funding to enhance telehealth services in their communities. This allowed providers to develop social media campaigns, purchase advertisements, develop telehealth educational materials, upgrade their infrastructure, equipment and software to enhance telehealth visits and provide mobile health services to high-risk zip codes.

To increase awareness of services offered, the NYSFPP developed a statewide awareness campaign (2/27/24-3/7/25) to promote the availability of high-quality services that are free to low cost for the most vulnerable communities in New York State. Media platforms involved social, digital, radio and out-of-home mediums (transit and place-based advertising). Messaging and images developed for all platforms, aimed to increase knowledge of the availability of Family Planning services including contraceptive education, preconception health services,

counseling and testing for HIV, testing and treatment for sexually transmitted infections, routine screening for chest/breast cancer or other preventive reproductive/sexual health services.

Family Planning Providers continue to support dispensing 12-month supplies of contraceptives when appropriate and continue to assist uninsured clients in enrolling in the most appropriate health insurance plans including Medicaid, Family Planning Benefit Program (FPBP), and Family Planning Extension Program (FPEP).

**WMH 1.6:** 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 assault.

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 infections, 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 cesarean sections (The Sexual Abuse to Maternal Mortality Pipeline). The NYS Rape Prevention and Education program aims to prevent the perpetration and victimization of sexual violence using a public health approach by prioritizing the primary prevention at the broader community and societal levels to shift social norms, policies, practices, and the built environment. To support survivors of sexual violence, 70 Department-approved Rape Crisis Programs sites 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.

**WMH 1.7** Continue to provide training to PICHC and MIECHV programs on the CDC *Learn the Signs Act Early* (LTSAE) campaign and collaborate with the NYS Council on Children and Families (CCF) on the Early Childhood Comprehensive Systems (ECCS) grant, which supports dissemination of LTSAE materials.

In December 2023, PICHC and MIECHV-funded home visiting staff attended a webinar presented by developmental pediatrician and LTSAE ambassador, Dr. Elizabeth Isakson, provided LTSAE training, and a representative from the NYS Council on Children and Families provided an update on developmental monitoring materials which can be obtained without cost and provided to families. Throughout the year, staff met internally and with the Council to learn more about the resources and to identify ways by which the resources could be distributed. LTSAE provides easy-to-understand information about developmental milestones for infants and young children and steps to take if there are concerns.

**WMH 1.8** 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 (HFNY) programs via a new Memorandum of Understanding (MOU) with the NYS Office for Children and Family Services (OCFS), which oversees HFNY programs. New contracts were established with Department-managed Nurse Family Partnership (NFP) programs. In FFY23, NFP and HFNY programs, continued to use 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.

**WMH 1.9:** 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.

As in previous years, the Department continued its support and implementation of the *Hear Her Campaign* statewide. This campaign continues to be recommended through the NYS Maternal Mortality Review Board to increase awareness about 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 campaign ran in September – October 2024. The Department utilized social media platforms (Facebook, Instagram, and Snapchat) to convey information to pregnant people and their partners, friends, and family about pregnancy-related

complications. In addition to previously developed palm cards, the campaign also used a new palm card series tailored to Native American and Alaskan Native birthing people, and one for their family and friends. These palm cards were co-branded, printed, and distributed to NYS home visiting programs for use with clients. The palm cards were translated into the ten languages most commonly spoken in NYS and are available on the Department's website at NYS Hear Her Campaign (ny.gov) for downloading and printing, or they can be ordered from the distribution warehouse free of charge. In addition, the Department co-branded and printed the CDC's *Urgent Maternal Warning Signs* poster (https://www.cdc.gov/hearher/maternal-warning-signs/index.html; in English and Spanish).

All media were prioritized to reach areas with higher incident rates, areas with Native American reservations, and/or locations with higher concentrations of pregnant women, such as birthing facilities.

**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 broader needs 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.

**Strategy Progress:**

**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. *Note: Activity modified due to delayed progress in past reporting periods.*

The Perinatal Services regulation package, covering five sections/parts of Title 10, New York Codes Rules and Regulations, was developed to update and support perinatal services and perinatal regionalization were published for public comment on May 31, 2023, for a 60-day public comment period. This resulted in over 100 submissions from a wide array of stakeholders and interested parties. The Department began review and analysis of the public comments, identifying several hundred individual comments specific to the proposed regulations. Additionally, the Department considered revised *Standards for Levels of Neonatal* Care, published on May 22, 2023.

Comments and revised standards were reviewed and incorporated into an assessment of public comment. Due to the sheer volume of comments received and other technical challenges, the Department was unable to submit revised regulations for further consideration in accordance with the required timeframes. Title V staff continue to review and assess comments, and incorporate changes to the proposed regulations, now anticipated to be published anew in late 2025 or early 2026.

**WMH 2.2** To improve coordination and increase bilateral referrals between birthing hospitals and home visiting programs, Title V staff will assist in connecting PICHCs 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.

Prior to the reporting period, Title V staff and two public health graduate student interns conducted surveys and key informant interviews to understand the current state, promising and best practices to support and strengthen bidirectional relationships between birthing facilities and community-based home visiting programs. Title V staff

continued to work on this project during the reporting period. This activity will be advanced when new program staff begin and are able to work on the remaining elements of the project, which will include developing resources and presentations to share information with both stakeholder groups. Further activity will be reported in future annual reports.

**New Activities:** In addition, Title V staff made progress or completed additional activities related to this strategy:

**WMH 2.3:** Implement a Vaccine Hesitancy Media Campaign to promote COVID-19 vaccination among pregnant and postpartum individuals and their families.

No significant activity was completed during the reporting period.

**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 (MMRB) 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 2021 maternal death cohort review was completed by the end of calendar year 2023. The 2022 maternal death cohort review was completed by the end of calendar year 2024.

Analysis of NYS Perinatal Quality Collaborative (NYSPQC) project data provided by participating birthing facility teams helps to improve services and systems related to maternal health care. The NYSPQC, with support from the American College of Obstetricians and Gynecologists District II of NY (ACOG-NY), Healthcare Association of New York State (HANYS) and Greater New York Hospital Association (GNYHA), has led to a specific improvement project related to access to respectful care during birth, an important area related to maternal mortality and morbidity.

Based on analysis of qualitative data obtained from the 2018 listening sessions that engaged over 200 women statewide, the Department developed and implemented a comprehensive interdisciplinary hospital quality improvement project focused on access to respectful care. The NYS Birth Improvement Project launched in January 2020 and has engaged birthing facility staff from clinical, administrative, and executive levels to analyze policies and procedures that may impede access to high-quality, respectful care and develop strategies to improve outcomes. In Fall 2024, project planning was finalized for an expansion in January 2025 to the NYSPQC Birth Access & Safe Reduction of Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Project, adding an emphasis to reducing the NTSV cesarean birth rate. This included the development of a recruitment package, driver diagram, and project measures. The project has and continues to include a comprehensive training curriculum. As with all NYSPQC projects, Title V staff have been collecting and performing analysis of project data throughout the project period. Details on the expansion will be reported on in the 2024-25 Annual Report.

**Strategy Progress:** The Title V Program led the following specific program and policy activities to advance this strategy during the 2023-24 reporting period:

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

As of September 2024, the Maternal Mortality Review Board (MMRB) was comprised of 29 multidisciplinary experts who served and represented the breadth of the population of New York State. The MMRB reviews

examines information related to pregnancy-associated deaths and issues findings and recommendations to advance the prevention of maternal mortality. MMRB recommendations largely focused on engaging hospitals in quality improvement collaboratives and efforts to improve access to high-quality, respectful care. In March 2024, the Department published the MMRB's report, *New York State Report on Pregnancy-Associated Deaths in 2018-2020*. This statewide report summarizes findings and recommendations from the comprehensive review of New York State pregnancy-associated deaths that occurred in 2018, 2019, and 2020. Statewide, 386 pregnancy-associated deaths of New York State residents occurring in 2018-2020 were identified. Of the 386 pregnancy-associated deaths, 121 were found to be pregnancy-related, 202 were found to be pregnancy-associated but not related, and 63 were found to be pregnancy-associated but unable to determine relatedness. The MMRB developed 685 recommendations for the 2018-2020 maternal death cohort, 18 of which were designated as key recommendations and listed in the statewide report.

The MMRB shared this report with the Maternal Mortality and Morbidity Advisory Council, which is comprised of 19 multidisciplinary experts, including community members, community-based organizations, midwives, physicians, and healthcare executives knowledgeable in the fields of maternal mortality, women's health and public health. MMMAC members reviewed the MMRB's maternal mortality recommendations and developed their own recommendations on policies, best practices, and strategies to prevent maternal mortality and morbidity. In March 2024, the MMMAC published a report, the *New York State Maternal Mortality and Morbidity Advisory Council Report 2023*, that summarizes the activities of the MMMAC, as well as details the MMMAC's key recommendations to prevent maternal mortality and morbidity. The MMMAC made 12 recommendations to reduce maternal mortality and morbidity and address maternal health outcomes. In June 2024, the MMMAC developed a presentation that summarized its report findings for use in the community. The presentation was used by council members to highlight the work and recommendations of the MMMAC and MMRB in their communities.

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

The NYC Department of Health and Mental Hygiene's Maternal Mortality Review Committees (MMRC) published findings and recommendations from its 2016-2020 review of NYC maternal deaths and presented this information during a citywide event on September 25, 2024, *Ending Maternal Mortality in New York City: A Blueprint*.

During the reporting period, the MMRB met virtually five times to review maternal death cases. The MMRB assessed the causes of death, factors leading to the death, and preventability for each maternal death reviewed. Staff developed a written report of the findings and recommendations for the 2018-2020 maternal death cohort to prevent future deaths and reduce risks. In March 2024, the findings of the 2018-2020 maternal death case reviews and related key recommendations were published in the New York State Report on Pregnancy-Associated Deaths, 2018-2020 (https://www.health.ny.gov/community/adults/women/maternal_mortality/docs/maternal_mortality_review_2018-2020.pdf). The NYS Department of Health's report integrates deaths in NYC, and which were reviewed by the city's MMRC.

In November 2023, MMRB members released the issue brief Spotlight on Perinatal Substance Use Disorder (https://www.health.ny.gov/community/adults/women/maternal_mortality/docs/2023-11_spotlight.pdf). Review findings and recommendations for the 2021 cohort will be published in the next reporting period. Title V staff developed dedicated Maternal Mortality pages which were deployed to the NYS Department of Health's website and can be found at https://www.health.ny.gov/community/adults/women/maternal_mortality/.

**WMH 3.3:** Identify cases of Severe Maternal Morbidity (SMM) through hospital discharge data and conduct an analysis using linked birth data and hospital discharge data to define the major causes of maternal morbidity.

The planned Severe Maternal Morbidity (SMM) analysis has been completed and is under Departmental review. Analytic staff identified cases of SMM through hospital discharge data and conducted an analysis using linked birth data and hospital discharge data to define the major causes of maternal morbidity. This project will culminate in the release of a statewide report on SMM, spanning a decade of data. More information will be reported on in the 2024-25 Annual Report.

**WMH 3.4:** Through the New York State Perinatal Quality Collaborative (NYSPQC), continue work with birthing hospital teams and community-based organizations, through the NYS Opioid Use Disorder (OUD) in Pregnancy & Neonatal Abstinence Syndrome (NAS) Project.

While the active phase of the NYSPQC's Opioid Use Disorder (OUD) in Pregnancy & Neonatal Abstinence Syndrome (NAS) Project closed in mid-2023, the NYSPQC has continued to focus on the topic by offering educational webinars, distributing resources, and spreading awareness on learning opportunities related to the topics. The NYSPQC produced two new brochures and a poster on Naloxone, the life-saving medication that can reverse opioid overdose, for people who are pregnant, people who recently gave birth, and their support persons. The posters are available in English and Spanish, and the brochures are available in the top 11 languages spoken in NYS. During the reporting period, the NYSPQC received supplemental grant funding, allowing for continued focus on OUD in pregnancy and NAS work. Specifically, the funding has supported ongoing educational curriculum focused on OUD in pregnancy and NAS for all NYS birthing facilities and perinatal care providers. Additionally, the NYSPQC has developed and shared resources with partners via the listservs, Basecamp, website, and conferences and events.

**WMH 3.5:** Collaborate with the NYS Department of Health'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 or P/S/EL) syphilis among NYS females of childbearing age.

*See PIH 3.5 for details.*

Additionally, in April of 2024, the Family Planning Program, funded by Title X, was invited by the Office of Population Affairs (OPA) to participate in a pilot program to decrease congenital syphilis. Monroe County, which has a high index of congenital syphilis cases, was chosen and a Title X clinic was selected. The clinic was provided with equipment, training, and additional resources to offer point-of-care syphilis testing to each person who has a positive pregnancy test in the clinic at the time of their positive pregnancy test. The pilot program completed in December of 2024.

**New Activities:** In addition to these activities, Title V staff supported additional activities related to this strategy, including:

**WMH 3.6:** Appoint a perinatal psychiatrist to the MMRB to enable recommendations and strategies to reduce maternal mortality related to mental health conditions in pregnant and postpartum women.

A perinatal psychiatrist was appointed to the MMRB to enable recommendations and strategies to reduce maternal mortality related to mental health conditions in pregnant and postpartum individuals.

**WMH 3.7**: Through the New York State Perinatal Quality Collaborative (NYSPQC), engage NYS birthing facilities in a comprehensive interdisciplinary quality improvement project focused on implicit bias.

The NYS Birth Improvement Project (NYSBIP) launched in January 2020. The project seeks to assist birthing facilities in identifying how individual and systemic issues impact birth outcomes and in taking action to improve both the experience of care and perinatal outcomes for all people in the communities they serve. (See Strategy WMH 4 below for further detail). In Fall 2024, a recruitment package, driver diagram, and project measures were developed for the project expansion to the NYSPQC Birth Access and Safe Reduction of NTSV Cesarean Birth Project, adding a focus to reduce the NTSV cesarean birth rate. Details on the expansion will be reported in the 2024-25 Annual Report.

In addition, the NYSPQC began developing the NYSPQC Birth Improvement Toolkit, which contains presentations, tools, resources, and data forms created by the project and participating facility teams. The toolkit will assist birthing facilities that participated in the project with continued efforts and sustainability related to improved access to high-quality and respectful birth care. It will also provide resources to non-participating birthing facilities. The toolkit distribution will occur in the next reporting period.

Over 75 New York State birthing facilities are participating in the expanded project, which seeks to assist birthing facilities in identifying how individual and systemic issues impact birth outcomes at their organizations and taking action to improve both the experience of care and perinatal outcomes for all people in the communities they serve, as well as to reduce the NTSV cesarean birth rate. Monthly data collection and analysis for the project began in April 2021 and is ongoing. Participating facilities have taken part in educational opportunities perinatal health care, as well as reducing the NTSV cesarean birth rate, developed new and/or improved existing policies related to these topics, and worked to ensure they are centering the experience of people who are giving birth through the implementation of a Patient Reported Experience Measure (PREM). The PREM, which was implemented in July 2021, is administered to birthing people prior to their discharge from participating hospitals.

As of September 30, 2024, more than 70,000 PREMs have been submitted. The data collected through the PREM is analyzed by Title V staff and reported back to facilities. 82% of facilities have implemented a Patient Reported Experience Measure (PREM) survey that is offered to every birthing person prior to discharge. 88% of facilities are collecting demographic data for birthing people; 50% are using perinatal data stratified by demographic information to develop specific actions to support their patients. In response to the project scope expansion, a new outcome and balancing measures report was developed for facilities' use, related to NTSV cesarean births.

**WMH 3.8:** The Rape Prevention and Education Program created Regional Profiles to serve as living documents of publicly available data across the 17 counties covered by the six Regional Centers for Sexual Violence Prevention. These profiles are used to assist the Regional Centers in making informed decisions when working with their communities utilizing various data sources such as the State Liquor Authority, New York State Education Department and the US Census.

The Rape Prevention and Education Program created "Regional Profiles" to serve as living document of publicly available data across the 17 counties covered by the six Regional Centers for Sexual Violence Prevention in New York State. This work was completed in the 2022-23 reporting period, and no further work was done in this reporting period.

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 (BDARE) was created to support research and data needs across DFH. 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 MCH programs and policy decisions.

**Strategy WMH 4: Address broader social issues that impact women's health and their ability to access and use health care across the life course.**

Women and Maternal Health outcomes are impacted by the broader social issues that are influenced by the conditions in which people are born, live, work, play, learn, and age. These social issues include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of resources are barriers to people's ability to access services and the quality of clinical care. All ten priorities that emerged from community members' input during the needs assessment touch upon these broader social issues and needs. These factors impact the health outcomes of both individuals and entire communities.

The NYS Title V Program strives to contribute to broad-based efforts to address these broader social needs. 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 community and systems-level factors impacting these social issues.

The PICHC program incorporates a multi-faceted approach to ensure that addressing these broader social needs

are embedded in the program's framework. The overall intended outcomes of PICHC are to help families achieve an optimal level of health, self-sufficiency, and overall well-being.

As part of the PICHC contractual agreement, Title V staff worked to ensure that home visitors are compensated with a living wage and afforded promotional opportunities to the greatest extent possible. Title V staff continue to provide information to PICHC programs about living wages when PICHC programs are hiring new program staff. Title V staff also continue to support the use of the CHW to CHW Supervisor pathway developed by Title V staff which supports experienced CHWs to advance to a supervisory role using a specific development plan that includes submission of the CHWs 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.

CHWs 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 breastfeeding, parenting/childbirth classes, doula support, financial and health literacy resources, and referral to 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 (CAB) if none exist in the catchment area (with 25% of the board consisting of community members) or participate in an existing CAB whose focus is improving perinatal and infant health. Participation in these boards is intended to facilitate partnership and collaboration, including identifying gaps and barriers in the community, and developing strategies to address these gaps and broader social issues that impact perinatal health outcomes. CABs are also required to develop and utilize mechanisms to obtain community input and provide pertinent information back to the community at large.
2. Promote civic engagement by training community members to participate on CABs and other advocacy groups, and train 10-20 community members annually to develop leadership and advocacy skills.

**Strategy Progress:** The Title V Program led the following specific program and policy activities to advance this strategy during the 2023-24 reporting period:

**WMH 4.1** Through the PICHC programs, contracted staff, including CHWs, routinely worked with 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 broader social issues impacting those outcomes.
- Engaged and partnered with 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 7,809 community partners at more than 941 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. CHWs issued more than 25,778 health care and social support referrals to PICHC clients. The top five social support referrals are clothing/ baby care items, transportation, food pantry, housing assistance, and WIC.

**WMH 4.2** Through the PICHC and MIECHV-funded programs, provide supports to individual clients and their families to address behavioral social determinants of health outcomes.

Title V staff continue to provide support to PICHC and MIECHV-funded programs by sharing information on available community resources for needs related to housing, food, employment and job training, transportation, and other basic needs; requiring that programs screen for health insurance enrollment, assist with enrollment or referral to enrollment Navigators or 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; connect families to enhanced social support resources and programs including parenting classes, peer support groups, childbirth education and resources to develop birth and postpartum care plans, and breastfeeding education, and directly support clients to develop birth plans.

**WMH 4.3** Collaborate with partners, including but not limited to, the Office of Mental Health's Project TEACH, ACOG-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.

Title V staff continued to collaborate with partners, including the NYS Office of Mental Health's Project TEACH, ACOG-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 planned for March 2025 focusing on the Project TEACH and resources available to Mental health Professionals across New York State.

**WMH 4.4** Collaborate with NYSPQC on the NYS Birth Improvement Project.

Through a Learning Collaborative model, NYS continued to assist birthing hospitals and centers in identifying how individual and systemic issues impacts birth outcomes within their organizations and in taking action to improve both the experience of care and perinatal outcomes for individuals who give birth.

*See WMH 3.7 above.*

**WMH 4.5** Through the Infertility Reimbursement Program (IRP), provide reimbursement for out-of-pocket costs associated with in vitro fertilization (IVF) and fertility preservation services to individuals who meet eligibility criteria.

The NYS Department of Health awarded six contractors (one upstate and five downstate) to participate in the Department's Infertility Reimbursement Program (IRP), formerly known as the Infertility Demonstration Program, for the award period of 10/1/2022 – 9/30/2024. On 3/13/24, a request to extend the six contracts for two years (10/1/24 – 9/30/26) was approved. Eligibility requirements were updated 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 (IVF) and fertility preservation services (FPS) as well as adding requirements that prevent decisions based on an individual's information to prevent the services from being covered. The new law also includes a new state definition of infertility. Based on these changes to the law, the Department developed new criteria for patient and provider participation in the IRP, in consultation with expert stakeholders, including ACOG and the Association of Reproductive Medicine, using the CDC's Assisted Reproductive Technology (ART) Success Rate Report to obtain objective performance data on provider eligibility. 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.

**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.

This work was completed in the 2022-2023 reporting period. No further work was done during this reporting period.

**WMH 4.7** Improve the NYS *Sexual Assault Victim's Bill of Rights* (SAVBOR), including updates to improve health literacy, and translation into the 10 most common languages in New York State.

The SAVBOR was initially developed in 2019. During the reporting period, the SAVBOR was significantly updated to improve plain language and align with new legal requirements. This involved significant consultation and

collaboration with a variety of community-based stakeholders and state and local government agencies. The SAVBOR was also redesigned into a poster, a flyer, and a pocket card for printing and distribution to hospitals. Not yet completed during the reporting period is the translation of materials into the 10 most common languages in New York State, updating the Department's website to include critical information for survivors of sexual violence, and further distribution and awareness of the revised SAVBOR to hospital emergency departments, urgent care centers, and other key stakeholders statewide.

**WMH 4.8** Collaborate with intra- and inter-agency partners to support breastfeeding activities, such as provider and consumer education, staff training, and other opportunities.

Title V staff participated in the Breastfeeding Grand Rounds planning committee in collaboration with the Division of Chronic Disease and the Division of Nutrition. The *Impact of Social Media on Breastfeeding* was the topic of the 2024 Breastfeeding Grand Rounds, which was held on December 18, 2024 to an audience of public health and health care professionals. Additional information will be provided in the 2024-25 annual report.

**WMH 4.9** Develop and deliver a health training to staff within the Division of Family Health staff about sexual violence prevention initiatives.

The Sexual Violence Prevention Unit's Rape Prevention and Education Program hired a consultant to develop and deliver a training series for 50 internal staff. This training consisted of six live, two-hour virtual trainings from October to December 2023. The consultant also submitted a final report of evaluations from each individual training and an aggregate assessment of the combined trainings with recommendations for potential future training about ways the Division can better support access to high-quality and respectful care.

**WMH 4.10** Collaborate with the Office of Drug User Health to support family planning and reproductive health among people who use illicit substances, creating partnerships to strengthen reproductive healthcare and primary care.

Within the NYS Department of Health, the Family Planning Program partners with the AIDS Institute Office of Drug User Health (ODUH) to support access to reproductive and sexual health care in the substance using population. This population is in high need of family planning services, and family planning clinics are uniquely positioned 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 to increase access to reproductive and primary healthcare. Building off the 2022 survey responses and the two networking sessions held in 2023, the NYSFPP and their training and technical assistance partner, JSI, incorporated this work into the May 2024 Family Planning Provider Day. During the meeting, a session titled *Increasing Linkages Between Sexual/Reproductive Health and Substance Use Service Settings: A Toolkit for Practitioners* was provided with the goal of better meeting the sexual and reproductive health needs of people who use substances.

**WMH 4.11** Provide resources for birthing people to advocate and communicate effectively with healthcare providers.

During the reporting period, the Division of Family Health provided support and oversight to an Empire Fellow, who worked to develop a consumer guide to talking with healthcare providers during the prenatal through postpartum period. The Empire Fellow drew from her experience as an Early Head Start provider in New York City and worked with staff to fine-tune messaging and recommendations. The materials were submitted for approval, graphic design, and translation into the top 12 non-English spoken languages during the reporting period.

**New Activities:** In addition, Title V staff engaged in additional activities relevant to this strategy:

**WMH 4.12** Continue to review gestational surrogacy program application sections relevant to DFH areas of expertise, including a gestational surrogacy program policy and procedure for screening of potential gestational surrogates (per Department guidelines), screening of intended parents (per American Society for Reproductive Medicine), appropriate use and monitoring of Surrogates' Bill of Rights, and appropriateness of Informed Consent.

Gestational surrogacy has been legal and regulated in New York State since 2020. Title V staff and other Department colleagues continue to review and approve new applicants. Additionally, staff review any updated guidance documents as agencies apply for their annual licensure renewal. During the program year, the Department newly licensed four new gestational surrogacy programs and reapproved 34 programs, bringing the total to 38 programs currently licensed as of 9/30/2024. Surrogacy programs have reported a total of 47 live births between 1/1/22 and 12/31/23. Data are collected on an annual basis, and data for 2024 are not yet available.

Additionally, during the reporting period, Division staff collaborated with the Office of Primary Care and Health Systems Management (primary oversight of the Gestational Surrogacy Program) and Division of Legal Affairs to review and provide feedback on a significant proposed bill that would modify the requirements of the Gestational Surrogacy Program, including minor updates to the Surrogates' Bill of Rights. Legislation was not put into effect during the reporting period.

**Evidence-based Strategy Measures (ESMs)**

The NYS Title V Program established two 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 CHW.**

Data for this measure is obtained from monthly reports submitted by PICHC contractors10/1For the time period of 10/1/2023 to 9/30/2024,67.6% of PICHC program participants engaged prenatally created a birth plan during a visit with a CHW.

**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 FPP clinic visit record (CVR) data. For the time period from 10/1/2022 to 9/30/23, 35.7% of FPP clients had a documented comprehensive medical exam. This is a slight decline from the 38.7% figure in the previous period.

## Women and Maternal Health Application Year (FY26)

For the upcoming Title V grant cycle from 2025-30, our Title V Program will focus on the key priority to support the health and well-being of women throughout pregnancy and postpartum periods. This aligns with the new National Performance Measure **NPM - Postpartum Visit,** which includes both the percent of women who attended a postpartum checkup within 12 weeks after giving birth and the percent of women who attended a postpartum checkup and received recommended care components. This is a new NPM for the next five-year Title V grant cycle.

Consistent with the focus on a life course approach that has become a foundation for MCH practice over the past two decades, there is increasing recognition of the critical importance of the postpartum period, sometimes referenced as the 'fourth trimester.' As noted in the Title V guidance, more than half of pregnancy-related deaths nationally and over three-quarters of pregnancy-related deaths in NYS, occur in the postpartum period. Comprehensive postpartum visits provide a key opportunity to support maternal health and identify persistent or new risk factors, and professional medical standards for postpartum care and support have been expanded accordingly. However, as demonstrated in our Needs Assessment, there is a need to improve performance in this area to ensure that all women receive comprehensive postpartum visits that include the full range of services they may need, including attention to both physical and mental health needs and support planning of potential future pregnancies and adequate birth spacing. Mirroring the national performance measure, this has emerged as a core focus within our maternal health public health programs, reflected in our ESM for this domain: **ESM WMH-1: Percentage of clients served by the Perinatal and Infant Community Health Collaborative (PICHC) who attended a postpartum visit within 12 weeks of giving birth**.

While the new NPM and companion ESM focus specifically on the importance of postpartum care, we know that this specific indicator of care must be addressed within the context of a broader continuum of supports, services, and systems of care to support maternal health and well-being and reduce maternal mortality and morbidity - spanning from preconception through the prenatal and postpartum periods, and including a full spectrum of medical, mental health, oral health, nutrition, and other key aspects of health and health care. Accordingly, our State Action Plan includes targeted strategies for improving postpartum visits as well as broader efforts to enhance supports for women throughout their reproductive life course.

The strategies and accompanying activities for the upcoming grant year for this domain are summarized in our State Action Plan Table and described further below. Of note, there is significant and necessary overlap between strategies focused on maternal health and perinatal and infant health (see Perinatal and Infant Health Domain section below).

**Strategy WMH-1: Support perinatal home visiting services for pregnant and postpartum women.**

Decades of evidence support the use of voluntary home visiting programs for families from pregnancy through early childhood. Our Title V Program oversees two statewide public health programs with MCH home visiting services: **Perinatal and Infant Community Health Collaborative (PICHC**) and **Maternal, Infant, and Early Childhood Home Visiting (MIECHV),** which in turn encompasses two evidence-based home visiting program models: Nurse Family Partnership (NFP) and Healthy Families New York (HFNY). These two models were chosen specifically by NYS in part because they have a strong evidence base for improving both maternal and infant health outcomes. Additionally, the Title V Program provides leadership and guidance to a third state-developed home visiting model, the **Universal Virtual Home Visiting (UVHV)** program, which is being piloted using funding through HRSA's State Maternal Health Innovation grant.

**PICHC** is a NYS-developed and funded program that supports collaborative community-based strategies to improve perinatal health outcomes for both mothers and babies, with priority for high-need, low-income individuals and their families. There are 26 funded local PICHC programs covering all regions of the state including both urban and rural communities. PICHC programs implement both individual/family-level and community-level strategies. The core individual-level strategy employs Community Health Workers (CHWs) who work one-on-one with families in their homes. Community Health Workers provide a spectrum of support to families, including:

- Education on pregnancy, prenatal care and postpartum care, and health behaviors
- Screening pregnant and postpartum women for relevant risks and needs using standardized, evidence-based or validated screening tools (e.g., postpartum depression, domestic violence, substance use), with referrals for follow-up as indicated (e.g., maternal mental health care, addiction services, WIC, family planning)
- Enrollment in health insurance and linkage to prenatal and postpartum care services, including support for scheduling, keeping, and engaging effectively in health care visits
- Information and linkage to other community resources for basic needs (e.g., housing, food, job training, transportation) and social support (e.g., childbirth classes, group prenatal care)

- Assisting clients to develop and use birthing and postpartum plans and advocate for themselves throughout the care process.

Key focus areas in the prenatal and postpartum periods include normal pregnancy and pregnancy risk factors, early and consistent use of prenatal care, nutrition, social support, childbirth education and resources, communication with health care providers, and more. These individual home visiting services complement community-level strategies to improve and coordinate services and address non-medical factors that influence health through partnerships with community members and a wide array of other community organizations. Local programs are supported by a statewide PICHC Center for Community Action and a Data Management and Information System (DMIS).

The companion **MIECHV** program is funded through HRSA along with a state appropriation. As the designated lead MIECHV agency for NYS, the Division of Family Health directly oversees funds for local Nurse Family Partnership (NFP) programs and collaborates with the NYS Office of Children and Family Services (OCFS) which oversees both MIECHV and state funds for local Healthy Families New York (HFNY) programs. Both models have a rigorous evidence base based on the Home Visiting Evidence of Effectiveness (https://homvee.acf.gov/). Employing trained public health nurses and paraprofessionals, respectively, both NFP and HFNY provide one-on-one home visiting services to families in their homes, following program-specific curricula developed by their respective national service organizations.

The **Universal Virtual Home Visiting (UVHV)** program is a new model of virtual home visiting developed by New York State that is being piloted with funding from HRSA's Statewide Maternal Health Innovation (SMHI) grant. Similar to the PICHC model, it trains community home workers to provide screening, referral, and patient support services. It is distinguished by its "light touch" approach, providing three to four virtual visits within the first two to three months postpartum, and its universal nature as it is offered to all postpartum patients within a service area, regardless of insurance, income, or other factors. The program currently funds two projects, each pairing a Level 1 birthing hospital that is located near a maternity care desert with a community-based organization that has home visiting experience within the same region. Current pilot sites are located in the Southern Tier and North Country. This brief, virtual model provides an accessible entry point to postpartum services. Clients are screened for social needs (e.g., transportation, food, housing, infant supplies), health concerns (e.g., substance use, tobacco, postpartum mood and anxiety disorders), and are offered education, referrals, and support tailored to their needs and local or virtual resources.

As a core MCH public health strategy, home visiting touches on all 10 themes that emerged from our Needs Assessment: health information and literacy; social support and stress; access to health care and improving care experiences; mental health; access to other community programs and services; service navigation and coordination; addressing non-medical influences on health; organizational partnership; and public health workforce.

**Activities for 2025-26:**

- **WMH-1.1:** Continue grant contracts to 26 local PICHC programs (7/1/22-6/30/27), 8 MIECHV programs (10/1/24-9/30/29), and two local UVHV projects (9/30/23-9/29/28) Begin development of competitive procurement for next anticipated 5-year PICHC grant cycle.
- **WMH-1.2:** Monitor local home visiting contracts through quarterly reports, quarterly grantee meetings, and ongoing communication with individual grantees.
- **WMH-1.3:** Continue to fund and coordinate with the PICHC Center for Community Action (operated by CAI Global, Inc. 7/1/24-9/30/27) to provide training and technical assistance to local PICHC programs, including annual core training for new Community Health Workers (CHWs) and additional topics based on an annual assessment of PICHC provider needs. Expand selected trainings that complement NFP national service office (Changent) curricula to MIECHV programs. Assess local program training needs on topics such as postpartum mood disorder screening, postpartum visits, and breastfeeding/lactation support, and support delivery of trainings to meet identified needs.
- **WMH -1.4:** Continue to fund and coordinate with the University at Albany Center for Human Services Research to manage the PICHC Data Management and Information System (DMIS) to support both local and state level PICHC programming (9/1/22 - 8/31/27). Establish or amend a contract to support DMIS services for the UVHV program, anticipated 10/1/25 – 9/30/28.
- **WMH 1.5:** Through local home visiting programs, provide direct support to pregnant and postpartum women and their families through home visits that include education, screening, referral, and social support, including emphasis on pregnancy health, prenatal and postpartum health care, and linkage to other more intensive services and/or community resources as needed.
- **WMH -1.6:** Continue to facilitate local efforts to serve hard-to-reach families through the integration of virtual home visiting services and service delivery in non-traditional settings such as temporary housing or shelters.

**Strategy WMH-2: Support comprehensive, confidential family planning reproductive health services before and**

**after pregnancy.**

Family planning and reproductive health visits provide individuals of reproductive age with access to contraception for pregnancy prevention, as well as counseling on reproductive life planning, optimal birth spacing, and preconception health. Evidence demonstrates that both preconception and inter-conception health services play a vital role in reducing adverse pregnancy outcomes, including maternal morbidity and mortality, low birth weight, preterm birth, and infant mortality. This strategy aligns with our Needs Assessment themes related to health care access and patient care experiences, access to community programs and services, service coordination, public health partnerships, public health systems, and workforce capacity.

**Activities for 2025-26:**

- **WMH-2.1:** Continue grant contracts to a statewide network of 160 family planning clinic locations (1/1/22-12/31/26) to support the delivery of comprehensive, confidential reproductive health services for individuals of reproductive age who are low income and uninsured or underinsured. Release a competitive procurement to establish contracts for the next five-year funding period.
- **WMH-2.2:** Monitor Family Planning grantee activities through a contract with the Island Peer Review Organization (IPRO) (10/1/23-9/30/28) in conjunction with the Department's Regional Offices.
- **WMH-2.3:** Provide training and technical assistance through a contract with the NYS Family Planning Training Center (1/1/23-12/31/27) to strengthen the capacity of providers to deliver comprehensive evidence-based reproductive health care services including enhanced postpartum services.
- **WMH-2.4:** Develop a prenatal and postpartum resource directory for family planning patients who receive a positive pregnancy test who want to continue the pregnancy to enhance services and support for postpartum patients.

**Strategy WMH-3: Support Sexual Violence programs that prevent and respond to sexual violence as a key factor that affects women's health and well-being.**

Sexual violence is a public health issue that can have a profound impact on lifelong health, opportunity, and well-being of individuals and communities. Data shows over half of U.S. women have experienced some form of sexual violence involving physical contact during their lifetimes. Sexual violence victimization can lead to serious short- and long-term health consequences for individuals including physical and psychological injury, depression, anxiety, suicidal thoughts, and chronic health problems such as post-traumatic stress disorder, sexual health problems, and health risk behaviors (e.g., smoking, abusing alcohol/drugs, risky sexual activity). This strategy aligns with our Needs Assessment themes related to patient care experiences, access to community programs and services, social support, community and behavioral influences on health, public health partnerships, public health systems, and workforce capacity.

**Activities for 2025-26:**

- **WMH-3.1:** Continue to update the New York State Sexual Assault Victim's Bill of Rights (BORs) and disseminate and promote it to hospital emergency departments and other key partners.
- **WMH-3.2:** Continue grant contracts and/or standards-based approvals to support prevention and response services for sexual violence through three Division programs: Rape Prevention and Education; Rape Crisis; and Sexual Assault Forensic Examiners.
- **WMH-3.3**: Support New York State hospitals with Emergency Departments so they are trained to provide care to victims of sexual assault.
- **WMH-3.4**: Explore opportunities to collaborate with subject matter experts and local or state partner organizations to train and provide information to providers who serve women on sexual violence impact and resources.

**Strategy WMH-4: Provide pregnant and postpartum women, their families, and community members with accurate information to promote preconception, prenatal, and postpartum health and use of health care services, including mental health and reproductive health care.**

Health communication is an essential public health and MCH service that must extend beyond individual- and family-level services to population-based education. There is evidence to support both general and topic-specific (e.g., folic acid consumption, contraceptive use) health communication campaigns, especially when multiple communication channels are used and communication is paired with other intervention components, such as the distribution of related free or low-cost tangible goods (e.g., transportation vouchers). This strategy aligns with our Needs Assessment themes related to health information and literacy as well as access to community services and resources.

**Activities for 2025-26:**

- **WMH-4.1:** Promote the availability of Department-developed outreach and education materials designed for

preconception, pregnant, and postpartum women and families through e-mail and Dear Provider letters.

- **WMH-4.2:** Promote awareness of maternal warning signs, educating pregnant and postpartum women and their families about when to seek help for signs, symptoms, or adverse conditions associated with maternal health complications, morbidity, and mortality through social media and sharing communication resources with health care providers, birthing facilities, and community-based social service organizations.
- **WMH-4.3:** Promote utilization of the NYS Growing Up Healthy Hotline to increase awareness of available community resources, supports, and services including WIC, Medicaid, family planning, and prenatal care through social media and sharing communication resources with partner organizations as noted in WMH-4.2.

**Strategy WMH-5: Maintain and enhance a statewide perinatal regionalization system to ensure that pregnant, intrapartum, and postpartum women and newborns receive high quality, risk-appropriate care, including a specific focus on maternal health, morbidity, and mortality.**

Statewide perinatal regionalization is a well-established evidence-based strategy for improving birth outcomes for high-risk infants, but has been less consistent in focusing on maternal health, despite evolving professional medical guidelines for levels of maternal care (https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2019/08/levels-of-maternal-care).

As detailed further in the 2025-26 State Action Plan narrative for the Perinatal and Infant Health Domain below, our Title V Program oversees the state's perinatal regionalization system and is in the midst of a multi-year process to update regulations and standards for birthing facilities. The proposed revised regulations address several key components, including specifically revising the levels of care (I, II, III, and IV) based on risk-appropriate care for both women and infants. In addition, the revised regulations will address requirements for establishment of a freestanding physician led and midwifery birth center and requirements for birthing hospitals and birth centers to provide referral and support for ancillary services, including mental health, alcohol and substance use treatment and other services that are critical to maternal health in both prenatal and postpartum periods. This strategy aligns with our Needs Assessment themes related to health care access and patient care experiences, service coordination, public health systems, and workforce capacity.

**Activities for 2025-26:**

- **WMH-5.1:** Revise state regulations for perinatal regionalization, including enhanced attention to the maternal health-related elements outlined above.
- **WMH-5.2:** Once revised regulations are adopted, conduct perinatal re-designation surveys and site visits, assess findings, communicate with hospital staff on any issues, and issue final designations based on revised perinatal levels of care.
- **WMH-5.3:** Engage with Regional Perinatal Centers through quarterly meetings and at the New York State Perinatal Association's Annual Meeting to foster peer learning and sharing of promising and best practices for supporting the regional system of perinatal care facilities, including strengthening affiliate hospital relationships and clinical education.
- **WMH-5.4**: Continue an ongoing multi-year initiative to improve coordination and increase bilateral referrals between birthing hospitals and home visiting programs as a key approach for bridging the transition from pregnancy and delivery to the postpartum period. Facilitate sharing of challenges and best practices from established home visiting-birthing hospital partnerships across the state with other providers.

**Strategy WMH-6: Through the Perinatal Quality Collaborative (NYSPQC), engage birthing facilities and other partners in structured quality improvement projects to improve health care services and outcomes for pregnant, intrapartum, and postpartum women.**

The New York State Perinatal Quality Collaborative (NYSPQC) is a nationally recognized initiative which engages a statewide network of birthing facilities and community-based organizations to improve the quality of care for mothers and newborns. Initiated in 2010, NYSPQC is led by the Division of Family Health with Title V Program staff working closely with state and national professional organizations and associations, health care facilities and staff, and community partners including families. NYSPQC employs structured, evidence-based rapid-cycle quality improvement (QI) processes and tools to engage multi-disciplinary health care teams in exploring, testing, and institutionalizing practices that lead to better health outcomes.

Since its inception NYSPQC has led more than a dozen structured QI projects spanning obstetric and neonatal care, including maternal health-focused projects related to non-medically indicated scheduled deliveries, maternal hemorrhage and hypertension, and opioid use disorder in pregnancy. The current obstetrical quality project, which began in 2021,

focuses on improving respectful patient-centered care experiences and safe reduction of nulliparous, term, singleton, vertex (NSTV) Cesarean birth rates. This strategy aligns with our Needs Assessment themes related to patient-centered health care services, public health partnerships, public health systems, and workforce.

**Activities for 2025-26:**

- **WMH-6.1:** Continue recruitment of NYS birthing facilities to participate in the current multi-year NYSPQC QI project focused on improving respectful patient-centered care experiences and safe reduction of NSTV Cesarean birth rates.
- **WMH-6.2:** Host monthly coaching call webinars for participating birthing facility NYSPQC teams to support teams in meeting their QI goals and objectives through facilitating sharing of challenges best practices, progress, and evidence-based or informed practices.
- **WMH-6.3:** Continue to collect, analyze, and report project data for participating teams to support QI activities, including reports of project-specific measures and a Patient Reported Experience measure.
- **WMH-6.4:** Through NYSPQC and partnerships with other state agencies and professional organizations, continue to disseminate resources from previous NYSPQC projects related to the identification and management of substance use disorder (SID) and opioid use disorder (OUD) in the perinatal period.

**Strategy WMH-7: Convene, facilitate, and/or participate in partnerships to improve postpartum visits, health, and well-being.**

As emphasized in our Needs Assessment, collaborative partnerships are a core aspect of our approach to MCH. Mobilizing both current and new partnerships will be key to effectively addressing the expanding focus and performance measure on postpartum care. This strategy encompasses several strategic partnerships related to systems improvements in postpartum health and health care. In particular, we are participating in the 'Big 6' Initiative to engage in peer learning on the new universal postpartum NPM among the six largest states (California, Texas, Florida, Pennsylvania, Illinois, and New York), which together account for over 50% of live births in the nation. Convening regularly with other large state Title V Leaders helps strengthen a collective understanding of successful strategies and approaches, with the goal of learning across states and better serving mothers and families in NYS. This strategy aligns with our Needs Assessment themes related to public health partnerships, systems, and workforce capacity. It also directly aligns with **ESM WMH-1** adopted in conjunction with our participation in the Big 6 initiative for postpartum visits.

**Activities for 2025-26:**

- **WMH-7.1:** Actively participate in the Title V Big Six States group focused on the Postpartum Visit NPM. Participate in expert review and feedback sessions from peer states and subject matter expert panels to increase knowledge and gain insight from others to improve its selected strategies and increase performance on the related measures. Share challenges and successes from NY's current and emerging work on this topic, provide feedback on peer states' approaches, and explore opportunities to apply promising strategies from the group to our work in NYS.
- **WMH-7.2:** Collaborate with the NYS Office of Mental Health's Project TEACH (*see Child Health and Adolescent Health domains*), the American College of Obstetricians and Gynecologists (ACOG) District II, NYS Association of Licensed Midwives, home visiting programs, and other community-based organizations, to explore and advance opportunities for addressing mental health in pregnant and postpartum people by increasing screening and follow-up support.
- **WMH-7.3:** Release a competitive procurement to develop a new Parent Advisory Council. The selected contractor will establish, recruit, train, and oversee a Parent Advisory Council composed of parents from across NYS to provide guidance and insight to the Department to ensure high-quality and responsive home visiting systems and provide parent input on statewide initiatives including outreach materials, media campaigns, and procurements.
- **WMH-7.4:** Collaborate with state medical associations (e.g., ACOG, NYS Association of Licensed Midwives, and others), other state agencies, and other key stakeholders to develop guidelines and associated information and training resources related to standards for responsive perinatal and birthing care, including maternal mental health screening, diagnosis, and treatment, consistent with state legislation enacted in 2025.
- **WMH-7.5**: Continue to participate in the NYS Office of Health Insurance Programs (NYS Medicaid Program) review and update to *NYS Medicaid Perinatal Care Standards*.
- **WMH-7.3:** Continue an ongoing multi-year initiative to improve coordination and increase bilateral referrals between birthing hospitals and home visiting programs as a key approach for bridging the transition from pregnancy and delivery to the postpartum period. Facilitate sharing of challenges and best practices from established home visiting-birthing hospital partnerships across the state with other providers. *See WMH-5.4 above*

**Strategy WMH-8: Apply population health data to support clinical and public health actions that promote maternal health.**

Surveillance and assessment are essential public health services that should inform all other actions. The use of data to maintain an ongoing and dynamic understanding of health within our state and communities is fundamental to identifying persistent and emerging issues, understanding causes and contributing factors, and evaluating the impact of our work. It is also a powerful tool for engaging, communicating with, and empowering partners – including families and community members. Core data systems that support WMH-related work in NYS including the Statewide Perinatal Data System (SPDS) and the Maternal Mortality Review (MMR) initiative. We also rely on the national Pregnancy Risk Assessment and Monitoring System (PRAMS) – managed by the Department's Office of Science – as a unique source of population data on health behaviors, practices, and experiences in the preconception, prenatal, and postpartum periods.

The Statewide Perinatal Data System (SPDS) is a modular electronic maternal and newborn data collection system that was established by the NYSDOH for the purpose of monitoring and improving prenatal, obstetric, and newborn care for mothers and infants in NYS. The SPDS is comprised of two modules. The Core Electronic Birth Certificate module (SPDS Core EBC) captures data for use in vital records birth registration, rapid enrollment of eligible newborns in Medicaid, populating other related data systems, such as the Early Hearing Detection and Intervention (EHDI) and NYS Immunization Information (NYSIIS) systems, and MCH public health surveillance of hospitals and communities. The Department maintains the web application for capturing birth certificate data for hospitals outside of NYC, while the New York City Department of Health and Mental Hygiene captures the same information for NYC in a separate web-based system. The Neonatal Intensive Care Unit (NICU) module captures demographic and clinical data on newborns requiring high risk care at statewide hospitals certified to provide such special care. Both modules provide the infrastructure for NYS's Regionalized Perinatal Care initiatives, providing statistical summary reports and data extraction capability to Regional Perinatal Centers (RPCs) and affiliate birthing hospitals to support their quality assurance and improvement efforts. The Department's Vital Records and Vital Statistics staff oversee the use of the Core EBC data for statewide surveillance and federal reporting purposes, while data analysts in the Division of Family Health and other parts of the Department utilize the data for other special purposes/mandates related to maternal and child health.

In 2010, the NYS Department of Health created the MMR initiative to review and analyze all maternal deaths in NYS. This was formalized and expanded under state public health law in 2019 to require and authorize a multi-disciplinary state maternal mortality review board to examine information related to pregnancy-associated deaths and issue findings and recommendations, including a biennial report. A companion Maternal Mortality and Morbidity Advisory Council (MMMAC) reviews the findings and recommendations from the MMRB to focus on broader factors contributing to adverse maternal outcomes, including non-medical determinants, and develops recommendations on policies, best practices, and other strategies to prevent maternal mortality and morbidity. Division of Family Health leads the work of both the MMRB and MMMAC with Title V Program staff convening and coordinating the Review Board and Council. The data and recommendations stemming from these initiatives directly inform NYSPQC (see strategy WMH-6 above) and other maternal health programs and policies, such as Medicaid's coverage of members who are pregnant, giving birth, or postpartum.

This fundamental public health strategy aligns with our Needs Assessment themes related to public health program capacity and is foundational to other strategies and activities described throughout the state action plan for this domain.

**Activities for 2025-26:**

- **WMH-8.1:** Continue to support the Statewide Perinatal Data System (SPDS), including maintenance of systems and reports related to perinatal regionalization designations. Routinely confirm that SPDS is correctly feeding other data systems. Use SPDS data to support ongoing MCH assessment, program development, and QI-related activities.
- **WMH-8.2:** Continue to review and analyze data and relevant hospital, autopsy, and other pertinent records related to maternal deaths occurring during pregnancy or within one year following the end of a pregnancy. Develop and publish annual statewide surveillance report to summarize the MMRB findings and recommendations and apply key findings to inform public health interventions to reduce maternal mortality and severe maternal morbidity in NYS.
- **WMH-8.3**: Review national and NYS PRAMS data annually and engage with the Department's Office of Science to explore additional data analyses as needed to support Title V activities.

**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) - RAC**

**Indicators and Annual Objectives**

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

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | | 92.4 | 92.6 | 92.8 | 93.1 |
| Annual Indicator | 92.2 | 91.6 | 91.3 | 91.6 | 92.4 |
| Numerator | 2,626 | 2,610 | 2,437 | 2,610 | 2,363 |
| Denominator | 2,849 | 2,850 | 2,668 | 2,850 | 2,556 |
| Data Source | NYS VS | NYS VS | NYS VS | NYS VS | NYS VS |
| Data Source Year | 2018 | 2019 | 2020 | 2021 | 2022 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2026 | 2027 | 2028 | 2029 | 2030 |
| Annual Objective | 93.4 | 93.4 | 93.4 | 93.4 | 93.4 |

**Evidence-Based or –Informed Strategy Measures**

**ESM RAC.1 - Percent of birthing hospitals re-designated with updated standards**

| Measure Status: | | | | Active | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 0 | 0 | 50 | 75 |
| Annual Indicator | 0 | 0 | 0 | 0 | 0 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | NYS Data | NYS Data | NYS Data | NYS Data | NYS Data |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | 2024 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

**State Action Plan Table**

| State Action Plan Table (New York) - Perinatal/Infant Health - Entry 1 | |
|---|---|
| **Priority Need** | |
| Ensure risk-appropriate care for infants | |
| **NPM** | |
| NPM - Risk-Appropriate Perinatal Care | |
| **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 1%, from 92.3% in 2025 to 93.4% by 2030. | |
| **Strategies** | |
| Strategy PIH-1: Support perinatal home visiting services for families with infants and young children. | |
| Strategy PIH-2: Provide families with accurate information to promote infant health, development, and use of health care services. | |
| Strategy PIH-3: Maintain and enhance the statewide perinatal regionalization system to ensure that pregnant women and newborns receive high quality, risk-appropriate care, including a specific focus on infant morbidity and mortality. | |
| Strategy PIH-4: Maintain robust statewide population-based Newborn Bloodspot Screening and Newborn Hearing Screening Programs. | |
| Strategy PIH-5: Through the Perinatal Quality Collaborative (NYSPQC), engage birthing facilities and other partners in structured quality improvement projects to improve health care services and outcomes for infants. | |
| Strategy PIH-6: Convene, facilitate, and/or participate in cross-sector and interdisciplinary partnerships to enhance coordination of services and improve health outcomes for infants and their families. | |
| Strategy PIH-7: Apply population health data to support clinical and public health actions that promote infant health. | |
| **ESMs** | **Status** |
| ESM RAC.1 - Percent of birthing hospitals re-designated with updated standards | Active |
| **NOMs** | |
| Stillbirth | |
| Perinatal Mortality | |
| Infant Mortality | |
| Neonatal Mortality | |
| Postneonatal Mortality | |
| Preterm-Related Mortality | |

**2021-2025: State Performance Measures**

**2021-2025: SPM 1 - Percent of samples received by the State Newborn Screening lab within 48 hours of collection**

| **Measure Status:** | | | | **Active** | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 75 | 77 | 79 | 81 |
| Annual Indicator | 68 | 70 | 70.6 | 67.2 | 66 |
| 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 | 2020 | 2021 | 2022 | 2023 | 2024 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

## Perinatal and Infant Health Domain Annual Report for October 1, 2023 – September 31, 2024

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+ 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 the site of delivery for VLBW 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 (NBS) 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 a timely newborn bloodspot screening as a public health service to identify and support infants with a wide range of medical conditions. Many of the conditions are "time-critical" and getting samples as soon as possible is essential. As a population-based program, the NBS 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 (LBW) (8.5%) and preterm (9.6%) births in NYS increased slightly.

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.

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 (PRAMS) Report, 10.0% of NYS women reported experiencing depressive symptoms after giving birth. Unfortunately, this rate increased to 11.9% in 2022.

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+ NICU by 2.4%, from the 2017 level of 91.2% to 92.4% 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 4.28 deaths per 1,000 live births in 2022. (NVSS)

**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. 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 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 MCH programs, including Maternal and Infant Community Heath Collaboratives (MICHC) which was renamed to the Perinatal and Infant Community Health Collaborative (PICHC) in 2022, Newborn Bloodspot Screening (NBS), New York State Perinatal Quality Collaborative (NYSPQC), and Regional Perinatal Centers (RPCs), 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.

**Strategy Progress:** The Title V Program made progress or completed the following specific program and policy activities to advance this strategy throughout the 2023-24 year:

**PIH 1.1**: Across all Title V programs, enhance promotion of the NYS Growing Up Healthy Hotline (GUHH) to increase awareness of available community resources, supports, and services including WIC, Medicaid, family planning, prenatal care, and the NYS Early Intervention Program.

*See WMH 1.1 for details.*

**PIH 1.2**: Through the PICHC and MIECHV 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 NYS Department of Health's 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 OPCHSM related to midwifery and freestanding birth centers.

During the reporting period, the Department received three applications to establish birthing centers – two midwifery-led birth centers (BSD Birthing Center Rockland and Birth Center of Fort Greene), and one free-standing birth center (Holistic Birth Center of New York). BSD Birthing Center Rockland received approval in August 2024 to begin construction, while Holistic Birth Center of New York received approval for construction in June 2024. Birth Center of Fort Greene withdrew its application. Additionally, Brooklyn Birth Center (a previously approved freestanding birth center that was established under emergency executive orders) withdrew its application to become a fully established birth center shortly after this reporting period (November 2024).

Once the two approved birth centers finish construction, this will bring New York's total to five freestanding birth centers and one midwifery-led birth center.

**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.

*See WMH 1.9 for details on messaging and educational campaigns.*

**PIH 1.5**: Through the Regional Perinatal Centers (RPCs) 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.

Regional Perinatal Centers continued to provide telehealth supports and services, both for health care providers (consultation, review of imaging, etc.) and direct patient care (remote patient monitoring, remote appointments with affiliate providers and patients). Other telehealth services provided in the 2023-24 year include lactation consultations, opioid use disorder education, and transfer consultations by the RPCs with affiliates. Tele-ICU services are currently in development with an upstate RPC and affiliates, and New York City-based RPCs are implementing some telehealth services to improve timely access to care.

One of the largest barriers to ongoing telehealth services is the cost to ensure physicians are available for consultation 24/7, particularly when the audience is primarily rural birthing hospitals with generally low birth volumes. This is further exacerbated by shortages of physicians. The RPCs involved in the project spent considerable time discussing potential solutions, and several ended up modifying their projects to best accommodate the needs of staff and their rural affiliates. Another barrier identified is that teleconsultation that did not ultimately lead to a patient transfer or the RPC directly engaging with the patient is not a billable service.

*See WMH 1.2 for additional details on obstetrical telehealth initiatives.*

**PIH 1.6**: Through the Perinatal and Infant Community Health Collaboratives (PICHC) and Maternal, Infant, and Early Childhood Home Visiting (MIECHV) 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 PICHC and MIECHV programs, support community health workers (CHWs) and other home visitors 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**: Support distribution of free diapers to families in need through the NY Cares/Baby2Baby Diaper Bank program. PICHC, MIECHV, 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.

This activity was led out of the NYS Office of Temporary and Disability Assistance. Our partner agency, with Title V staff support, engaged with key stakeholders and made planning progress towards this activity. However, the program was not launched during the reporting period.

In response to identified needs from PICHC programs related to ongoing inflation pressures faced by lower income households, Title V funds were identified, and Title V staff purchased emergency supplies including portable cribs, safe sleep sacks and onesies, diapers, and other items. In accordance with state procurement laws, this initiative required significant coordination and collaboration with multiple state agencies, several vendors, and frequent communication with PICHC programs to identify needs, available products, and prepare for distribution. Distribution began in October 2024 and will be reported in the 2024-25 annual report. MIECHV programs received separate funding through the American Rescue Plan, which allowed local implementing agencies to directly

purchase comparable supplies for emergency use.

**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.

The American Indian Health Program is managed in a separate office within the NYS Department of Health. During this reporting period, Department staff actively supported the processing and payment of claims for services provided to eligible individuals.

**PIH 1.10**: Through the Migrant and Seasonal Farmworker Program, continue to support direct health care and supportive services to ensure access to health care.

The Migrant and Seasonal Farmworker Program is managed in a separate office within the NYS Department of Health. During this reporting period, services were provided by local organizations through executed contracts to deliver services to eligible populations.

**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 training are presented in Strategy PIH 4 below.

**New Activities:** Three new activities implemented during the program year:

**PIH 1.12**: Through the Act Early project, train PICHC and MIECHV programs on CDC's Learn the Signs Act Early (LTSAE) campaign. Collaborate with the Bureau of Early Intervention to facilitate orders for free LTSAE materials from CDC website to programs.

*See WMH 1.7 for details.*

**PIH 1.13**: Provide support to birthing families and community-based organizations to address nationwide shortages of infant formula.

While this activity was anticipated for the 2023-24 program year, issues related to the 2022 formula shortage had resolved prior to the reporting period. No significant activities were performed during the reporting period.

**PIH 1.14:** Support community-based programs and health care facilities to promote and provide infant safe sleep-related information and supplies to new parents.

Resulting from updated guidelines from the American Academy of Pediatricians, the Department collaborated with partner agencies to update infant safe sleep materials to include "smoke-free" information. These updates coincide with development of two infant safe sleep-related initiatives supported by Title V staff. First, the 2024-25 Executive Budget included $2M in funding to the Office of Children and Family Services to purchase and distribute portable cribs and other safe sleep items to be distributed to birthing hospitals and birth centers. These cribs were purchased during the reporting period, and distribution began in October 2024. Further information will be provided in the 2024-25 annual report.

Safe sleep supplies, including portable cribs with safe sleep educational materials were included in the emergency supply activity described in *PIH 1.8* above.

**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 NYSPQC. The NYSPQC aims to provide the best, safest, and respectful 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 NYSPQC has adapted the Institute for Healthcare Improvement (IHI) model for Idealized Perinatal Care and Breakthrough Series Methodology as a framework to guide improvement. Specific priorities set by the NYSPQC are implemented by all participating NYS birthing hospitals and centers to improve outcomes of perinatal care. Analysis of NYSPQC project data provided by participating birthing hospitals and centers helps to improve services and systems related to perinatal health care.

**Strategy Progress:** The Title V Program led the following specific program and policy activities to advance this strategy through the 2023-24 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.

*See WMH 2.1 for details.*

**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 noted in *WMH 2.1*, the regulations for perinatal regionalization have not yet been adopted. As such, work towards this activity is paused.

**PIH 2.3**: Improve coordination and increase bilateral referrals between birthing hospitals and home visiting programs.

*See WMH 2.2 for 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.

*See PIH 1.3 above for details on this activity.*

**PIH 2.5**: Collaborate with stakeholders to educate obstetricians/gynecologists, family practice providers, and midwives 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 NYSPQC, with birthing hospital and center teams, to improve obstetric and neonatal outcomes in specific areas including:

- **2.6a:** Identifying and managing the care of pregnant and postpartum women/people with opioid use disorder (OUD) during pregnancy.
    - Of the 15 birthing hospitals and birth centers that started this project in 2018, the cohort increased the implementation of a universal OUD screening protocol in place from 20% at Q1 2019 to 87% at Q3 2022. Additionally, participant sites established a protocol or process flow to assess and link pregnant patients with OUD to supportive services, from 33% in Q1 2019 to 87% by Q2 2022. Of the additional 24 birthing facilities that joined the project as an expansion phase ("expansion cohort"), the number of facilities with a universal OUD screening protocol in place increased from 40% in Q4 2020 and Q3 2022. Expansion sites also implemented protocols or process flows to assess and link pregnant patients with OUD to support services, increasing from 20% in Q4 2020 to 83% in Q3 2022.
- **2.6b:** Improving the identification, standardization of therapy and coordination of aftercare of infants with neonatal abstinence syndrome (NAS), with 100% of pilot hospitals implementing 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.
- **2.6c:** Improving neonatal outcomes and improve family experiences of care as evidenced by (a) an increase of 10% in reported care experience in each survey domain of the NICU Parent Experience of Care Measure Survey (NPREM); (b) an overall 20% improvement from baseline for breastfeeding/human milk feeding at discharge from the birthing facility.

**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 MCH. 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 MCH 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.

**Strategy Progress:** The Title V Program led the following specific program and policy activities to advance this strategy over the course of the 2023-24 year:

**PIH 3.1**: Collaborate with the Office of Children and Family Services (OCFS) to implement a PDSA-style quality improvement initiative with the goal of increasing referrals from WIC to Home Visiting programs including PICHC and those receiving MIECHV 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, providing tools for WIC staff to connect clients with appropriate resources within their communities. These program tools are periodically reviewed and updated as changes are identified, or Title V staff are informed of changes to programs outside of Title V and the Department's purview.

**PIH 3.2**: Lead quality improvement projects through the NYSPQC, with birthing hospital and center teams and community-based organizations, with a focus on identifying and managing the care of pregnant and postpartum people with OUD during pregnancy; improving the identification, standardization of therapy and coordination of aftercare of infants with NAS; improving neonatal outcomes and improve family experiences of care; identifying how individual and systemic issues impact birth outcomes at their organizations and taking action to improve both the experience of care and perinatal outcomes in the communities they serve; and enabling participating birthing facility teams to safely reduce the NTSV cesarean birth rate.

*See PIH 2.6 and WMH 3.4, 3.7, and 4.4 for more detail on these projects.*

**PIH 3.3**: Summarize, share, and discuss findings of the Maternal Mortality Review Board (MMRB) with key stakeholders, including the Maternal Mortality and Morbidity Advisory Council (MMMAC) and ACOG-NY, to inform statewide prevention strategies to improve maternal outcomes. This includes the development of issue briefs, webinars, and quality improvement projects through the NYSPQC, and a maternal mortality report.

*See WMH 3.1 and 3.2 for more detail on the MMRB and MMMAC.*

**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.

While this project has not advanced during the reporting period due to technical challenges. Title V staff continue to engage with partners on this and similar perinatal data resource projects and support access to data.

**New Activities:** 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 or P/S/EL) syphilis among NYS females of childbearing age, and the number and rate of congenital syphilis (CS) cases.

This includes several subtasks:

- **3.5a**: Develop a statewide Congenital Syphilis Elimination Strategic Plan and support the implementation of priority activities.
    - The Department's AIDS Institute led a multidisciplinary workgroup to establish a congenital syphilis elimination plan. During the reporting period, Division of Family Health (Medical Director, Associate Medical Director) and Bureau of Perinatal, Reproductive, and Sexual Health (Associate Director, Health Program Administrator I), and Bureau of Data Analytics, Research, and Evaluation (Research Scientist 3) participated in several full day meetings and committee meetings. These meetings focused on reviewing public health data, developing tools for community engagement and feedback, reviewing recommendations and action steps, and contributing to the final Work Group Report. The report was submitted for Departmental approval, which was obtained after this reporting period.
- **3.5b**: Issue locally tailored and statewide health advisories to alert health care professionals of P/S/EL syphilis and CS surveillance trends, screening requirements and recommendations, and appropriate treatment regimens.
    - During the reporting period, no regional health advisories regarding increases in P/S/EL or CS were issued by the Department. In May 2024, the Department issued a Dear Provider letter (https://www.health.ny.gov/diseases/communicable/congenital_syphilis/providers/docs/third_trimester_s alerting health care providers to recent changes to NYS Public Health Law §2308, now requiring syphilis screening of pregnant persons early in the third trimester. Patient educational materials (https://www.health.ny.gov/publications/21454.pdf ) reflecting the new requirements and increased focus on congenital syphilis were developed and published in May 2024. Interim guidance was subsequently issued in June 2024, and a comprehensive frequently asked questions document (https://www.health.ny.gov/publications/21452.pdf ) was developed during the reporting period, but was distributed outside this reporting period. Throughout these activities, Title V staff shared information with all birthing hospitals and birth centers through various mechanisms including e-mail, discussion on program calls, and listserv distribution.
- **3.5c**: Promote clinical education opportunities to birthing hospital staff, provided through Department-supported Clinical Education Initiative and other CDC-funded provider training initiatives.
    - During the reporting period, Title V staff encouraged Regional Perinatal Centers and other birthing hospitals to participate in clinical education offerings related to sexually transmitted infections through

the Clinical Education Initiative. Hospital staff were encouraged to sign up directly for updates from the initiative, as there are many offerings throughout each year, and Title V staff are not always informed of opportunities with sufficient lead time to share with partners.
    - The Division was invited to participate in the Congenital Syphilis Case Reviews that the AIDS Istitute leads. This has allowed Division staff to review cases and understand how Title V clinical and community-based programs and services (RPCs, Family Planning, PICHC and MIECHV for example) can better address the congenital syphilis epidemic.
- **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.
    - As previously mentioned above, a new patient education booklet was developed to raise awareness of syphilis during pregnancy.

**PIH 3.6**: In addition to the updates above, the Division 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 Bureau of Data Analytics, Research and Evaluation (BDARE) was created to support research and data needs across the Division. consolidated data and analytic staff into one Bureau under the direction of a new Bureau Director with a DrPH in Epidemiology. BDARE has been growing in size and scope to create efficiencies and cross training as well as provide professional development opportunities to further advance the use of data in MCH programs and policy decisions. An update of the Infant Mortality report released in 2023 will be developed pending anticipated hiring of additional analytic staff.

**Strategy PIH 4: Address broader social issues 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 broader social issues that are influenced by the conditions in which people are born, live, work, play, learn, and age. These social issues include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of resources are barriers to people's ability to access services and the quality of clinical care. All ten priorities that emerged from community members' input during the needs assessment touch upon these broader social issues and needs. These factors impact the health outcomes of both individuals and entire communities.

Efforts to improve infant health outcomes must focus directly on addressing broader social issues impacting infant health. 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, as well as strengthening community-based and clinical/provider relationships, to increase 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.

**Strategy Progress:** The Title V Program led the following specific program and policy activities to advance this strategy in the 2023-24 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. Evaluation will include development of follow-up measures to assess usage of the resource by institutions, as well as monitoring referrals from birthing hospitals to PICHC as reported via the home visiting program data management information systems.

Information on the Portal continues to be hosted on the Department's home visiting webpages, periodically shared through Departmental social media platforms, and promoted as a resource during programmatic trainings as appropriate.

**PIH 4.2**: Through the PICHC programs, work with 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 details.*

**PIH 4.3**: Through the PICHC and MIECHV-funded programs, provide supports to individual clients and their families to address broader social issues and their impact on health outcomes.

See *WMH 4.2* for details.

**PIH 4.4**: Through the NYSPQC, 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 access to high-quality, respectful care.

See *WMH 4.4* for further details. The NYSPQC developed the NICU Improvement Project focused on improving neonatal outcomes and family experiences of care.

**PIH 4.5:** Title V staff will collaborate with the Division's Bureau of 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 Community Engagement and Title V-funded programs.

The Bureau of Community Engagement was established within the Division of Family Health in 2022 through a grant from the CDC. The bureau's mission is to engage, build trust, and create partnerships with community-based organizations that are credible messengers and who are responsive to the needs of their community. The Bureau has created a strong foundation for contracting with small, nontraditional community-based partners throughout NYS, excluding NYC, and developed highly successful strategies for making the funding of community partners accessible.

**PIH 4.6**: Through all Title V programs, provide opportunities for training and technical assistance.

*See PIH 2.6 for details.*

**PIH 4.7**: Issue a procurement to establish a statewide Parent Advisory Committee (PAC), 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.

The Department issued a Solicitation of Interest to establish a Parent Advisory Committee coordinating agency. Due to the outcome of the Solicitation, a single contractor could not be selected. Th Department is working on developing a Request For Proposals.

**PIH 4.8**: Support the Department's various breastfeeding activities, including collaboration with intra-agency workgroups and planning and promoting breastfeeding grand round meetings.

*See WMH 4.8 for details.*

**New Activities:** In addition, the following activities have been added to the domain:

**PIH 4.9**: 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.

A series of webinars was presented and posted on the Department website to provide information on CAPTA/CARA legislation background and history, data collection and reporting requirements for birthing facilities, implicit bias, and supporting providers, especially those working in obstetrics and/or family practice in the development of Plans of Safe Care. These webinars and other resources provided on the website were shared and reviewed with home visiting programs. The programs were given an opportunity to provide feedback and ask questions related to these topics. In addition, the Department maintains a public mailbox and addresses questions and concerns that come into the mailbox and continues to collaborate with the NYS Office of Children and Family Services to ensure timely and complete data submissions.

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

New York's Newborn Screening (NBS) 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. The NBS Program is housed and administered by the Department's 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 more than 50 diseases, following national recommendations for NBS 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. The program screened 204,758 infants born in 2023 (See Form 4 for further details).

In addition, during the program year, the NBS program receives separate funding from HRSA to support each of the state's 10 Inherited Metabolic Disease (IMD) Specialty Care Centers to enroll patients with an IMD diagnosis identified by newborn screening for long-term follow-up (LTFU) in the NYS Newborn Screening Patient Registry. These IMD 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. To strengthen the sustainability of the NBS LTFU patient registry, the NBS program has been developing an in-house LTFU portal in the NYS Department of Health's Health Commerce System for clinical outcome data collection. NBS program staff continues to provide user training and technical assistance to the 10 IMD Specialty Care Centers on logistics and data collection processes. In addition, a new LTFU Families Resources Brochure for families navigating an IMD diagnosis was created. The digital versions of the brochures in 13 languages are shared on the NBS program webpage to promote access to the resources and to raise awareness of the importance of LTFU.

The NBS 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 NBS by promoting the development of its staff, participating in national committees, conducting pilot studies, and training other state newborn screening programs. The NBS program collaborates with other public health programs to support mutual goals. The NBS Program has identified a need for continued education for primary care providers and newborn coordinators on newborn screening and genetics.

**Strategy Progress:**

**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.

The cCMV pilot was funded for a one-year period, from 10/02/2023 to 10/01/2024. Testing has been completed, and the Program is currently performing final data analysis. Families of infants who screened positive for CMV have

also been invited to participate in a long-term follow-up study by enrolling in a new patient registry. The goal is to assess clinical outcomes of infants with cCMV.

Diagnostic G6PD deficiency testing is performed for infants determined to be at risk by healthcare providers, per NYS Public Health Law sections 2500-a and 2500-f.

Title V staff have collaborated with staff from Wadsworth Center and the Division of Epidemiology to develop policies and procedures as well as apply for federal funding to support a pilot for cCMV screening. About one out of every 200 babies is born with cCMV infection. About one in five babies with cCMV infection will have long-term health problems.

The Division of Family Health Medical Director, Dr. Marilyn Kacica, supported the Department's 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**: Collaborate with the Newborn Screening Program to perform a quality improvement project to ensure hospitals are meeting benchmarks.

**PIH 5.3:** Collaborate with the Newborn Screening Program to expand the number of hospital site visits made by Department staff.

A virtual hospital site visit is a meeting between NBS program staff and the hospital's key newborn screening team members to outline hospital's strengths and weaknesses regarding newborn screening, and to discuss quality improvement efforts that may work well for the hospital. The site visit format was selected to engage a larger number of hospital stakeholders and strengthen relationships through discussion.

Hospitals that use Health Level 7 (HL7) electronic data entry are presented with a unique set of barriers related to NBS data exchange. With approximately 28% of hospitals in NYS using HL7, the NBS program staff prioritized these hospitals for HL7 specific site visits. This intervention focused on educating all hospital HL7 users about proper data entry procedures. These site visits also allowed an opportunity to discuss hospital performance specifically related to missing data.
During the reporting period, NBS program conducted virtual site visits with 12 birth hospitals (10% of all birth hospitals across NYS). The overarching goal is to improve communication and information exchange on the newborn screening quality metrics and compliance issues with 120 birthing hospitals across NYS. The NBS program staff has worked together with the technical Information Technology Services team to develop and implement the Hospital Communication Portal which is integrated with several internal and external data systems. The Hospital Communication Portal is an integral piece of the quality improvement project as a centralized hub for collaborative communication, site visit documentation, non-compliance and corrective action tracking, and NBS quality metrics data visualization. Currently there are more than 500 registered users from the birth hospitals in the Hospital Communication Portal.

**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 Department's 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 five years.

**ESM PIH 2: Increase the percentage of the birthing hospitals that received site visits from Department's 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 come from the Department's Newborn Screening Program. The NBS program initiated the site visit program in November 2020. On average, the NBS Program staff can conduct 10 site visits per year and our goal is to continue to sustain the number of hospitals we do site visits with. Site visits are intended to engage birthing hospital staff to improve compliance with key NBS metrics.
**Education on key newborn screening processes -** Materials cover an overview of the newborn screening processes according to the most recent regulations. NBS program staff add material to address topics of interest indicated by the participating hospital.

**Hospital Performance Summary -** The hospital performance summary is a visual aid meant to provide an informative overview of a hospital's most recent 18 months of data. This is presented during the site visit meeting and sent to staff after the site visit for review in more detail. Information provided includes average specimen count and a snapshot of the hospital's compliance and performance compared to the NYS compliance goals. Each visit also includes tailored recommendations for improvement and a review of the hospital's strengths.

**Monthly Report Cards -** Hospital designees are sent monthly report cards with data about their performance in five key newborn screening metrics. Report cards are uploaded to the Hospital Communication Portal for review and download. Upon request, designees can be provided with breakdown data for each metric. The breakdown data are sent in an Excel file with newborns and their associated demographic information. Designees are then able to review individual records and facilitate corrective actions or changes to their hospital procedures for frequent mistakes.

**Perinatal and Infant Health Application Year (FY26)**

For the upcoming Title V grant cycle from 2025-30, our Title V Program will focus on the key priority of ensuring risk-appropriate care for infants, aligned with the National Performance Measure **NPM for Risk Appropriate Care: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ NICU**. This is a continued NPM from our previous Title V grant cycle.

A core strategy for this domain, as detailed further below for Strategy PIH-3, is the oversight of a **statewide perinatal regionalization system**. As noted in the Title V guidance document, infants born with very low birth weight (VLBW; <1,500 grams) are among the most medically vulnerable newborns, facing a risk of death approximately 100 times higher than babies born at a normal birthweight. VLBW infants have a much better chance of survival and healthy development when delivered at hospitals with Level III Neonatal Intensive Care Units (NICUs), which are equipped to provide specialized care for high-risk newborns.

Based on strong evidence linking facility level to outcomes, the American Academy of Pediatrics (AAP) recommends that very preterm (earlier than 32 weeks' gestation) and VLBW infants be delivered only in Level III or IV centers. An organized statewide system of perinatal regionalization – in which every birthing facility is designated Level I-IV based on its level of care for both mothers and infants, with coordination of transfers and quality assurance/improvement activities led by a Regional Perinatal Center (RPC) for each region – is critical to meeting this standard. An ongoing multi-year process to update and implement state regulations for perinatal regionalization is currently in progress in NYS. Our ESM for this domain aligns directly with this work: **ESM PIH-1: Percentage of birthing facilities in NYS re-designated with updated perinatal standards.**

While the Risk-Appropriate Infant Care NPM specifically measures site of delivery for VLBW infants, we believe that this specific indicator of care must be addressed within the context of a broader continuum of supports, services, and systems of care to reduce infant morbidity and mortality and promote optimal health and development - spanning from pregnancy through the infant's first year of life. Accordingly, our State Action Plan includes targeted strategies for perinatal regionalization as well as broader efforts to strengthen support for infants and their families. In this context, the universal NPM for Medical Home – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home – also aligns with our Perinatal and Infant Health action plan (focus on ages 0-1), even though it is not an available NPM option for the Perinatal and Infant Health domain.

The strategies and accompanying activities for the upcoming grant year for this domain are summarized in our State Action Plan Table and described further below. Of note, there is significant necessary overlap between strategies focused on perinatal and infant health and maternal health (see WMH Domain section above).

**Strategy PIH-1**: **Support perinatal home visiting services for families with infants and young children.**

Decades of evidence support the use of voluntary home visiting programs for families from pregnancy through early childhood. As detailed in the WMH domain application year narrative our Title V Program oversees two statewide MCH home visiting programs - Perinatal and Infant Community Health Collaborative (PICHC) and Maternal, Infant, and Early Childhood Home Visiting (MIECHV) – and one new pilot project Universal Virtual Home Visiting (UVHV).

Please refer to *Strategy WMH-*1 for detail on these program models, noting that they include specific focus on infant health, including:

- Education on infant health and development and positive parenting practices
- Screening infants and parents for relevant risks using standardized, evidence-based or validated screening tools (e.g., postpartum depression, infant development), with referrals for follow-up as indicated (e.g., maternal mental health care, Early Intervention services)
- Enrollment in health insurance and linkage to ongoing primary and preventive health care (i.e., medical home)
- Information and linkage to other community resources for basic needs (e.g., housing, food, job training, transportation) and social support (e.g., parenting classes, peer support groups, lactation support).

Through federal MIECHV funding and state funding, the Department administers the Nurse Family Partnership program and, through a Memorandum of Understanding with the NYS Office for Children and Family Services, the Healthy Families New York program. Both programs have extensive scientific evidence supporting a variety of positive infant health outcomes, including:

- increased breastfeeding and infant vaccination
- improved parenting practices

- early literacy and cognitive/language development
- preventing child abuse and neglect.

Moreover, home visiting programs' strong focus on improving maternal health and health care in the prenatal and postpartum periods are essential to infant health and development through their impact on key outcomes including preterm birth, low birthweight, and maternal depression and mental health.

As noted in WMH-1, there are extensive implementation supports for our home visiting programs including curricular materials, training, technical assistance, and data management and information systems. These supports are provided through Centers for Community Action, with each program having an assigned organization to provide this support. For the Perinatal and Infant Community Health Collaborative (PICHC), which employs trained paraprofessional community health workers, there is a Center for Community Action supported through a contract with CAI Global, Inc. There is also support for data collection and management through a contract with the UAlbany Center for Human Services Research for both PICHC and the new pilot for Universal Virtual Home Visiting (UVHV), which is supported through a HRSA grant for State Maternal Health Innovation and described in more detail in the Women and Maternal Health Annual Report section. MIECHV supports the Nurse Family Partnership (NFP) and Healthy Families New York (HFNY). For the Nurse Family Partnership Program there is an organization call Changent, which was formerly the NFP National Service Office. Healthy Families New York, which administered by the NYS Office for Children and Family Services, has a national technical support center at Healthy Families America and within NYS there is Prevent Child Abuse New York.

As a core MCH public health strategy, home visiting touches on all 10 themes that emerged from our Needs Assessment: health information and literacy; social support and stress; access to health care and improving care experiences; mental health; access to other community programs and services; service navigation and coordination; addressing non-medical influences on health; organizational partnership; and public health workforce.

**Activities for 2025-26:**

- **PIH-1.1:** Continue grant contracts to 26 local Perinatal and Infant Community Health program (7/1/22-6/30/27), the MIECHV programs (10/1/24-9/30/29), and two rural Universal Virtual Home Visiting projects (9/30/23 - 9/29/28). Begin development of competitive procurement for next anticipated five-year PICHC grant cycle. *Cross-over with WMH-1.1*
- **PIH-1.2:** Monitor local PICHC contracts through quarterly reports, quarterly grantee meetings, and ongoing communication with individual grantees. *Cross-over with WMH-1.2*
- **PIH-1.3:** Continue to fund and coordinate with the PICHC Center for Community Action (operated by CAI Global, Inc. 7/1/24-9/30/27) to provide training and technical assistance to local PICHC programs, including annual core training for new CHWs and additional topics based on an annual assessment of PICHC provider needs. Expand selected trainings that complement NFP national service office (Changent) curricula to MIECHV programs. Assess local program training needs on topics such as postpartum mood disorder screening, breastfeeding/lactation support, infant immunizations, early literacy development, parenting skills, and support delivery of trainings to meet identified needs. *Cross-over with WMH-1.3*
- **PIH-1.4:** Continue to fund and coordinate with the University at Albany Center for Human Services Research to manage the PICHC Data Management and Information System (DMIS) to support both local and state level PICHC programming (9/1/22 - 8/31/27). Establish or amend a contract to support DMIS services for the UVHV program, anticipated 10/1/25 – 9/30/28. *Cross-over with WMH-1.4*
- **PIH-1.5:** Through local home visiting programs, provide direct support to high-risk infants and their families through home visits that include education, screening, referral, and social support, including emphasis on infant health and development, engaging in routine well-baby care, and linkage to other more intensive services and/or community resources as needed.
- **PIH-1.6:** Continue to facilitate local efforts to serve hard-to-reach families through the integration of virtual home visiting services and service delivery in non-traditional settings such as temporary housing or shelters. *Cross-over with WMH-1.5*

**Strategy PIH-2**: **Provide families with accurate information to promote infant health, development, and use of health care services.**

Health communication is an essential public health and MCH service that must extend beyond individual- and family-level services to population-based education. There is evidence to support both general and topic-specific (e.g., Safe Sleep) health communication campaigns, especially when multiple communication channels are used and communication is paired with other intervention components, such as the distribution of free or low-cost tangible goods (e.g., cribs). This aligns with our Needs Assessment themes related to health information and literacy as well as access to community

services and resources.

**Activities for 2025-26:**

- **PIH-2.1:** Through legislatively mandated communication materials, provide all new parents with information on key topics following the birth of a child, including infant safe sleep, breastfeeding and lactation, pediatric abusive head trauma prevention, newborn bloodspot and hearing screening, congenital cytomegalovirus, and other topics.
- **PIH-2.2:** Through the Early Hearing Detection and Intervention (EHDI) program, continue to provide families of Deaf and Hard of Hearing infants with information through the NYSDOH website, family engagement events, and other materials.
- **PIH-2.3:** Continue to collaborate with the NYS Council on Children and Families to share information about health-related services and resources through its Parent Portal (https://ccf.ny.gov/nysparenting/) and Help Hub for Families (https://helphubforfamilies.ny.gov/). Explore additional opportunities for collaboration to enhance health-related information and resources shared through the portal.
- **PIH-2.4:** Enhance collaboration with the Department's Divisions of Chronic Disease Prevention and Nutrition, respectively, to provide families with current information and resources to support breastfeeding.
- **PIH-2.5**: Continue and enhance coordination with the Department's Public Affairs Group, which supports media campaigns and press releases, to incorporate timely and accurate information on infant health and development within the Department's website and social media accounts.
- **PIH-2.6:** Promote utilization of the NYS Growing Up Healthy Hotline to increase awareness of available community resources, supports, and services including WIC, Medicaid, vaccinations, and well-baby care.

**Strategy PIH-3: Maintain and enhance the statewide perinatal regionalization system to ensure that pregnant women and newborns receive high quality, risk-appropriate care, including a specific focus on infant morbidity and mortality.**

As noted above, statewide perinatal regionalization systems are an essential core public health evidence-based strategy for improving birth outcomes for high-risk infants, especially those born very preterm and/or with VLBW. Our Title V Program oversees the state's perinatal regionalization system in consultation with the Department's Office of Primary Care and Health Systems Management (the department's health care facilities regulatory Office).We are in the midst of a multi-year process to update standards for birthing facilities, which requires revision to state regulations using a formal rule-making process), followed by a process to review and re-designate every birthing facility.

The proposed revised regulations address:

- requirements for hospitals and birthing centers providing prenatal through postpartum care and birthing hospitals providing varying degrees of neonatal intensive care (Level II, III, or Level IV/Regional Perinatal Center designation)
- establishment of regional system of perinatal birthing hospitals and birth centers, including affiliation agreements between the Regional Perinatal Center and other regional facilities and designation of level of care
- staffing, transfer, capacity of care, and ancillary services requirements for operation of hospital-based perinatal care services, and freestanding physician-led and midwifery birth centers
- requirements for establishment and operation of freestanding physician-led and midwifery birth centers
- requirements for birthing hospitals and birthing centers to provide referral and support for ancillary services, including mental health, alcohol and substance use treatment and other services.

This core strategy aligns with our Needs Assessment themes related to access to health care and other community resources, improving health care experiences, service navigation and coordination, and public health systems capacity, and directly ties to **ESM PIH-1: Percentage of birthing facilities in NYS re-designated with updated perinatal standards.**

**Activities for 2025-26:**

- **PIH-3.1:** Revise state regulations for perinatal regionalization. Planned activities for this project year include publishing a second round of proposed rule changes and receiving and incorporating public comments on those changes as necessary steps prior to adopting the revised rule and proceeding with re-designation of all birthing facilities under the updated standards.
- **PIH-3.2:** Once revised regulations are adopted, conduct perinatal re-designation surveys and site visits, assess findings, communicate with hospital staff on any issues, and issue final designations based on revised perinatal levels of care.

**Strategy PIH-4: Maintain robust statewide population-based Newborn Bloodspot Screening and Newborn Hearing Screening Programs.**

Early recognition and treatment of certain disorders recognizable at birth – including numerous genetic conditions and hearing loss – through newborn screening is associated with better health and developmental outcomes for infants and is the standard of care nationally. NYS Public Health Law requires all birthing hospitals and birthing centers to administer newborn bloodspot screening and newborn hearing screening programs. Within NYS Department of Health, the Newborn Screening Program (bloodspot screening) operates within the Wadsworth Center, which is the state's public health laboratory, and the Early Hearing Detection and Intervention (EHDI) program is within the Division of Family Health. Newborn bloodspot samples are collected in the birthing facility and submitted to Wadsworth Center for analysis and reporting, with follow-up services for confirmatory diagnoses and treatment. Newborns are screened for more than 50 disorders including all 38 on the Recommended Uniform Screening Panel (RUSP), with congenital hypothyroidism and Sickle Cell Disease as the most common disorders identified. Newborn hearing tests are typically performed in the birthing facility with results reported through the NY's EHDI Information System (EHDI-IS).

These fundamental public health activities align with our Needs Assessment themes related to health care services, health care experiences, service coordination and navigation, and public health program capacity.

**Activities for 2025-26:**

- **PIH-4.1:** Continue to implement a population-based universal newborn bloodspot screening program including screening and follow-up diagnostic confirmatory testing; short- and longer-term follow-up for infants with abnormal results; and education, quality assurance, and/or quality improvement activities to ensure timely collection, submission, analysis, and reporting of newborn bloodspot specimens (Wadsworth Center).
- **PIH-4.2:** Continue to support the NY's EHDI-IS to collect information related to hearing screenings, diagnostic testing, and amplification for infants in NYS and serve as a repository of this information for health care and other service providers. Lead education, quality assurance and quality improvement activities to ensure timely testing, reporting, follow-up, and resources for families (EHDI). [*see Strategy PIH-7 below for additional information]*
- **PIH-**4.3: Continue to facilitate partnerships to enhance early linkages for children with specific conditions or risk factors requiring follow-up (e.g., EHDI and Early Intervention Services; EHDI and Newborn Bloodspot Screening for congenital CMV infection).

**Strategy PIH-5: Through the Perinatal Quality Collaborative (NYSPQC), engage birthing facilities and other partners in structured quality improvement projects to improve health care services and outcomes for infants.**

The New York State Perinatal Quality Collaborative (NYSPQC) is a nationally recognized initiative which engages a statewide network of birthing facilities and community-based organizations that seek to provide the best, safest, and respectful care for NYS' birthing people and infants. Initiated in 2010, NYSPQC is led by the Division of Family Health with Title V Program staff working closely with state and national professional organizations and associations, health care facilities and staff, and community partners including families. NYSPQC employs structured, evidence-based rapid-cycle quality improvement (QI) tools and processes to engage multi-disciplinary health care teams in exploring, testing, and institutionalizing practices that lead to better health outcomes. Since its inception NYSPQC has led more than a dozen structured QI projects spanning obstetric and neonatal care, including infant-focused projects related to breastfeeding, safe sleep, enteral nutrition, NICU infections, and Neonatal Abstinence Syndrome. The current neonatal quality project, which began in 2023, focuses on improving family-centered care experiences and improving neonatal health outcomes for infants admitted to NICUs.

This strategy aligns with our Needs Assessment themes related to patient-centered health care services, public health partnerships, public health systems, and workforce.

**Activities for 2025-26:**

- **PIH-5.1:** Continue to lead a multi-year quality improvement project with birthing facility NICU teams to improve outcomes for all infants admitted to Neonatal Intensive Care Units (NICUs) to improve family-centered care and improve the experience of care for their families.
- **PIH-5.2:** Through NYSPQC and partnerships with other state agencies and professional organizations, continue to disseminate resources from previous NYSPQC projects related to the identification and management of substance use disorder (SID) and opioid use disorder (OUD) in the perinatal period. *Crossover with WMH-6.4.*

**Strategy PIH-6: Convene, facilitate, and/or participate in cross-sector and interdisciplinary partnerships to enhance coordination of services and improve health outcomes for infants and their families.**

MCH is by its nature an interdisciplinary field that relies on contributions and perspectives from multiple sectors both within

and outside of government. The national MCH leadership competencies emphasize the importance of MCH professionals engaging in collaborative partnerships that draw on the perspectives, skills, expertise, and experience of professionals and community members to address challenges at all levels. While this approach is embedded in our ongoing approach to all aspects of our work (see Needs Assessment *III.C.1.b.iv. Family and Community Partnerships),* it specifically encompasses selected specific projects that focus explicitly on building or enhancing partnerships for the purpose of improving family and community experiences and outcomes. This strategy aligns with our Needs Assessment themes related to public health partnerships, service coordination and system navigation, and access to community resources.

**Activities for 2025-26:**

- **PIH-6.1:** Continue an ongoing multi-year project to improve bilateral referrals between local home visiting programs and birthing hospitals.
- **PIH-6.2:** Continue an ongoing multi-year project to improve bilateral referrals between local home visiting and WIC programs
- **PIH-6.3:** Building on the successful model for past listening sessions (see *Needs Assessment Process* section), collaborate with local and regional infant health service providers to host regional listening sessions in areas with disproportionately high infant mortality rates to learn more about key factors and experiences related to infant health, morbidity, and mortality.
- **PIH-6.4:** Collaborate with the NYS Offices of Children and Family Services (OCFS) and the Temporary and Disability Assistance (OTDA) to streamline efforts for supporting infant health, including infant safe sleep and distribution of infant supplies including cribs and other basic needs.
- **PIH-6.5:** Release a competitive procurement to develop a new Parent Advisory Council. The selected contractor will establish, recruit, train, and oversee a Parent Advisory Council composed of parents from across NYS to provide guidance and insight to the Department to ensure high-quality and responsive home visiting systems and provide parent input on statewide initiatives including outreach materials, media campaigns, and procurements. *Crossover with WMH-7.3.*
- **PIH-6.6**: Explore collaborations with the American Academy of Pediatrics New York Chapters, NYS Speech-Language Hearing Association, NYS Early Intervention providers, and other key stakeholders to identify opportunities for trainings related to newborn hearing screening requirements, language access, and other identified topics.

**Strategy PIH-7: Apply population health data to support clinical and public health actions that promote infant health.**

Assessment is a core public health function that should inform all other public health services, as defined by the Institute of Medicine, CDC, and reflected in the national MCH Leadership Competencies. The use of data to maintain an ongoing and dynamic understanding of health within our state and communities is fundamental to identifying persistent and emerging issues, understanding causes and contributing factors, and evaluating the impact of our work. It is also a powerful tool for engaging, communicating with, and empowering partners including families and community members. Core data systems that support PIH-related work in NYS including the Statewide Perinatal Data System (SPDS) (*see WMH-8 for detail),* Early Hearing Detection and Intervention Information System (EHDI-IS). We also rely on the national Pregnancy Risk Assessment and Monitoring System (PRAMS) and National Survey of Children's Health (NSCH) as unique sources of population data on health practices and experiences in the infant period.

The EHDI-IS was established in 2012 to support the change to New York State Public Health Law Section 2500-g and Chapter 585 of the Laws of 1999 and corresponding regulations which require providers to report newborn hearing screening information. The EHDI-IS gathers information from vital records and carries in information on the initial newborn hearing screening completed after birth, which is indicated in the birth certificate. The providers report follow-up hearing screening results, diagnostic evaluation results, and referral to Early Intervention (EI). Monthly EHDI follow-up lists are generated for providers to ensure that all infants born in New York have timely and appropriate hearing screening, diagnostic evaluation, and intervention. The Division of Family Health continues to provide technical support and training to providers and enhance EHDI-IS as needed.

This fundamental public health strategy aligns with our Needs Assessment themes related to public health program capacity and is foundational to other strategies and activities described throughout the state action plan for this domain.

**Activities for 2025-26:**

- **PIH-7.1:** Maintain SPDS. *See Strategy WMH-8.1.*
- **PIH-7.2:** Maintain and enhance the EHDI-IS system to support more accurate reporting of newborn hearing screening results from birthing facilities and audiologists and improve the transmission and matching of infant records within the

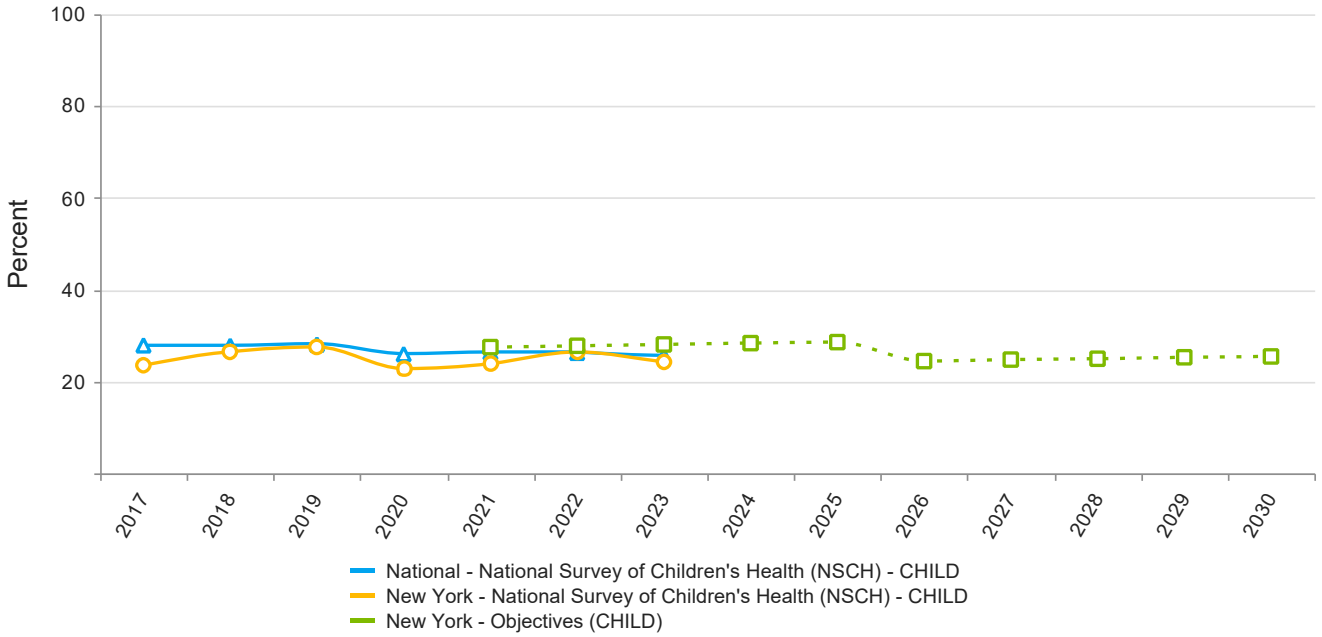
system. Utilize monthly reports to assess system data for completeness, accuracy, and timeliness of reporting, and apply results to improve steps as indicated. [*see Strategy PIH-4 above for additional information]*

- **PIH-7.3:** Review relevant population data related to infant health and well-being from available sources – including SPDS/Vital Statistics, PRAMS, and NSCH to identify trends and emerging issues and inform ongoing public health activities. Explore opportunities to collaborate with KIDS Count data initiative based at NYS Council on Children and Families to enhance the annual assessment of infant health.

**Child Health**

**National Performance Measures**

**NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child Indicators and Annual Objectives**




| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CHILD** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 27.5 | 27.8 | 28.1 | 28.4 |
| Annual Indicator | 27.4 | 22.4 | 24.1 | 26.6 | 24.3 |
| Numerator | 316,874 | 272,297 | 308,176 | 345,661 | 316,349 |
| Denominator | 1,158,167 | 1,213,091 | 1,278,404 | 1,300,265 | 1,302,487 |
| Data Source | NSCH-CHILD | NSCH-CHILD | NSCH-CHILD | NSCH-CHILD | NSCH-CHILD |
| Data Source Year | 2018_2019 | 2019_2020 | 2020_2021 | 2021_2022 | 2022_2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | 24.5 | 24.8 | 25.0 | 25.3 | 25.5 |

**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: | Inactive - Replaced | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 51.6 | 51.6 | 52.6 | 53.6 |
| Annual Indicator | 51.6 | 43 | 35.1 | 50.6 | 52.8 |
| Numerator | 98,941 | 74,325 | 54,615 | 79,697 | 80,331 |
| Denominator | 191,920 | 172,751 | 155,443 | 157,601 | 152,178 |
| Data Source | SBHC quarterly report | SBHC quarterly report | SBHC quarterly report | SBHC quarterly report | SBHC quarterly report |
| Data Source Year | 2018-2019 | 2019-2020 | 2020-2021 | 2021-2022 | 2022-2023 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

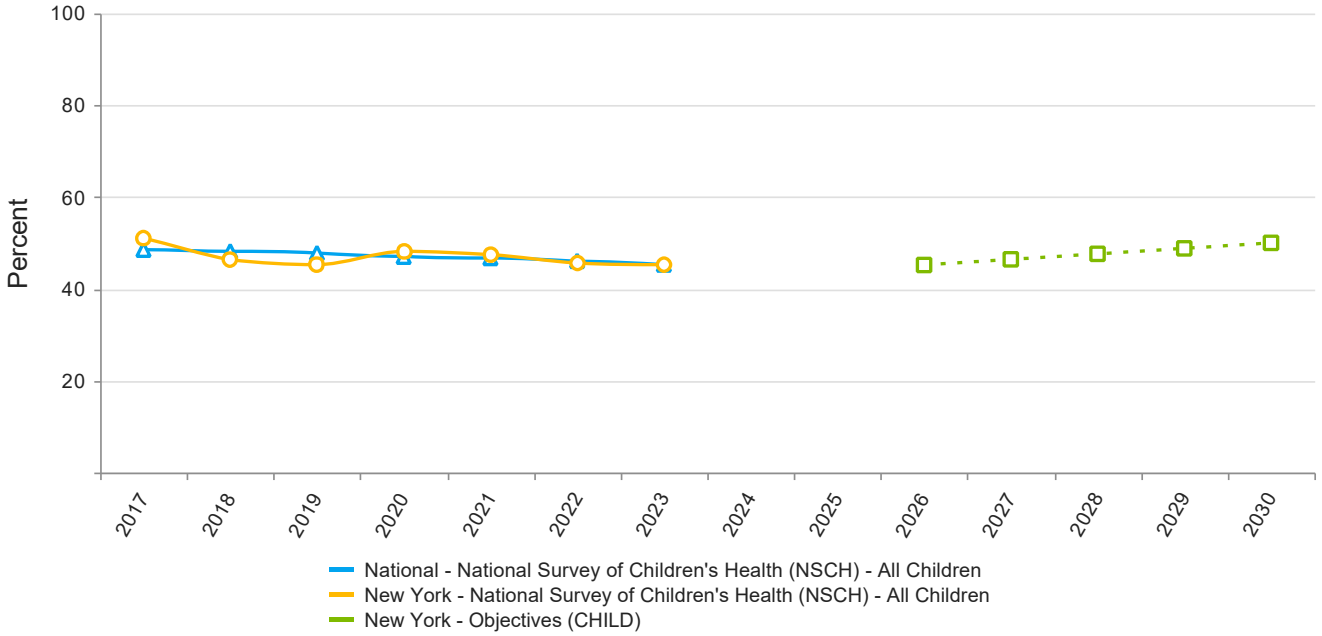
**ESM PA-Child.2 - Percent of School Based Health Centers (SBHCs) operators that have 3 or more partnerships to promote physical activity.**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | 20.0 | 40.0 | 60.0 | 80.0 | 100.0 |

**NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH Indicators and Annual Objectives**




**NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Child Health - All Children**

| Federally Available Data | | |
|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - All Children** | | |
| | **2023** | **2024** |
| Annual Objective | | |
| Annual Indicator | 45.6 | 45.2 |
| Numerator | 1,834,655 | 1,814,014 |
| Denominator | 4,020,084 | 4,012,745 |
| Data Source | NSCH-All Children | NSCH-All Children |
| Data Source Year | 2021_2022 | 2022_2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | 45.2 | 46.4 | 47.6 | 48.8 | 50.0 |

**Evidence-Based or –Informed Strategy Measures**

**ESM MH.1 - Percent of students attending schools that have School Based Health Centers (SBHCs) who are enrolled in the SBHC program**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2024 |
| Annual Objective | |
| Annual Indicator | 63.4 |
| Numerator | 158,604 |
| Denominator | 250,000 |
| Data Source | SBHC quarterly report |
| Data Source Year | 2022-2023 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2026 | 2027 | 2028 | 2029 | 2030 |
| Annual Objective | 65.8 | 68.1 | 70.4 | 72.7 | 75.0 |

**ESM MH.2 - Percent of regular Big 6 medical home for CYSHCN peer learning meetings attended with active participation in presenting and/or responding to peer discussions.**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2026 | 2027 | 2028 | 2029 | 2030 |
| Annual Objective | 90.0 | 90.0 | 90.0 | 90.0 | 90.0 |

**State Action Plan Table**

| State Action Plan Table (New York) - Child Health - Entry 1 | |
|---|---|
| **Priority Need** | |
| Promote healthy play and nutrition for all children | |
| **NPM** | |
| NPM - Physical Activity - 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 5%, from 24.3% in 2025 to 25.5% in 2030. (NSCH) | |
| **Strategies** | |
| Strategy CH-5: Through the SBHC program, implement both clinical practices and community partnerships that promote healthy active play and physical activity. | |
| **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. | Inactive |
| ESM PA-Child.2 - Percent of School Based Health Centers (SBHCs) operators that have 3 or more partnerships to promote physical activity. | Active |
| **NOMs** | |
| Children's Health Status | |
| Child Obesity | |

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

### Priority Need

Promote comprehensive patient-centered health care for children

### NPM

NPM - Medical Home

### Five-Year Objectives

Objective CH-2: Increase the percent of children ages 0 through 17 who have a medical home by 11%, from 45.2% in 2025 to 50.0% in 2030. (NSCH)

### Strategies

Strategy CH-1: Support a statewide School-Based Health Center (SBHC) program to provide comprehensive, evidence-based, patient-centered primary and preventive health care services - including medical, mental, and dental care - to children in low-income communities.

Strategy CH-2: Promote health insurance enrollment and primary health care utilization for children through all child-serving Title V Programs.

Strategy CH-3: Provide families with accurate information to promote children's health, development, and use of health care services.

Strategy CH-4: Apply population and program-specific health data to support clinical and public health actions that promote child health.

| ESMs | Status |
|---|---|
| ESM MH.1 - Percent of students attending schools that have School Based Health Centers (SBHCs) who are enrolled in the SBHC program | Active |
| ESM MH.2 - Percent of regular Big 6 medical home for CYSHCN peer learning meetings attended with active participation in presenting and/or responding to peer discussions. | Active |

### NOMs

Children's Health Status

CSHCN Systems of Care

Flourishing - Young Child

Flourishing - Child Adolescent - CSHCN

Flourishing - Child Adolescent - All

## Child Health Domain Annual Report for October 1, 2023 – September 30, 2024

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 2022-2023 reporting period, 17% of NYS children ages 6-17 were obese, and only 24.3% of NYS children ages 6-11 years were physically active for at least 60 minutes daily (0.9% decrease compared to 2022 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 as well as 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.

One of the initiatives addressing access to care for school-aged children, specifically mental health access in School-Based Health Centers, is the Pediatric Mental Health Care Access (PMHCA) grant, funded through the Health Resources and Services Administration (HRSA). A key strategy of the PMHCA grant is a partnership with the Office of Mental Health's Project TEACH, which is the Families Thrive with Good Mental Health program and is aimed at enhancing primary care provider capacity to provide mental health services. 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 tele-consultation services. In addition, Project TEACH developed a training series for several mental health topics (attention deficit hyperactivity disorder, depression, anxiety, and aggression) that was offered exclusively to School-Based Health Centers; 109 School-Based Health Center staff attended these trainings. An additional round of the training series was developed and offered in the spring of 2025.

The New York School-Based Health Alliance 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 aligning mental health telehealth services to the School-Based Health Centers. This information will be used to develop guidance and practical tools to implement mental health telehealth services in School-Based Health Centers. One of the first steps based on survey results was the need to make sure they had the appropriate equipment to offer telehealth services. PMHCA grant funds were used to purchase the equipment identified by the surveys, and the equipment was distributed to the School-Based Health Centers. Additional equipment orders are planned for the future to ensure that the School-Based Health Centers have all the necessary equipment to effectively offer mental health telehealth services.

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 95$^{th}$ 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 care needs including mental health, obesity, asthma, and other special health care needs and challenges that may impair a child'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 hundreds of 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 2023-24 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 45 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 replaced by a new data system which is integrated into the Health Commerce System. This new system provides 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. The new data system is being used for Quarterly Report submissions, though improvements are still underway. The School Health Unit helps School-Based Health Centers submit corrected quarterly reports. Staff are finalizing data for 2023-2024 academic year.

**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.

The Title V Program seeks to encourage and increase the use of the American Academy of Pediatrics Bright Futures™ model for anticipatory guidance in School-Based Health Centers and to coordinate with the American Academy of Pediatrics for assistance to promote this resource. An internal training for Department staff was conducted by the University at Albany School of Public Health in November 2022, though staff turn-over will necessitate a new training before proceeding. The training will introduce and orient staff to Bright Futures™ and begin 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 has allocated funding to establish the School-Based Dental Home Program. The School-Based Health Center operators with dental clinics were awarded the five-year funding opportunity to 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 the impact of socio-economic variances in children's oral health outcomes. School-Based Dental Home Program 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. Currently, 18 School-Based Health Center Dental clinics receive funding to operate their School-Based Dental Home Programs.

**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.
Title V 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. However, it was determined that behavioral health issues were the more pressing need in the 2023-24 time period.

In the interim, 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 were important to attendees from the School-Based Health Center. 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, the needs of the school-based health centers and the populations they serve.

**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.

Staff working in the Child Health domain routinely engage with the staff focused on Adolescent Health domain and the Children and Youth with Special Health Care Needs (CYSHCN) domain to strengthen collaboration between child- and adolescent-serving programs with the ultimate goal of enhancing promotion of physical activity through established programs that focus on adult-led activities and social-emotional wellness. Staff from the various domains meet internally to explore opportunities for School-Based Health Centers on topics of interest related to adolescents. For example, Adolescent Health and CYSHCN staff participate in recurring Child Health Domain meetings to exchange ongoing progress on activities between the domains. While physical activity has not yet been the focus, the Adolescent Health Unit presented trainings, information-sharing webinars and written guidance documents, which were shared with School-Based Health Centers. These trainings included Nuanced Dimensions of Consent: Working with youth about the topic of consent; Recognizing human trafficking in healthcare settings;

Intersectionality of Disabilities and Adolescent Development; and Disability Advocacy. Including staff from the CYSHCN domain is critical, because they center the inclusion of all abilities in the promotion and accessibility of physical activity programs.

**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 again during this reporting period, Title V staff have not been successful yet in establishing a sustained relationship. This strategy will be revisited again to determine if collaboration efforts can be achieved.

**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 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 Dental Home Program

The focus 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 18 funded contractors are health facilities regulated by the New York State Department of Health under Article 28 of NYS Public Health Law. They 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 socio-economic variances 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.

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 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 developed by the American Lung Association with Asthma Control Program was relaunched and presented to the School-Based Health Centers in February 2024 to encourage more School-Based Health Centers to participate in the project. 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. Five School-Based Health Center operators and three sites participated in the project during this reporting period; 40 students were served, and 22 School-Based Health Center staff were trained which included nurse practitioners, medical and nursing directors, and medical assistants. Students had a pre-assessment mean score of 60% and a post-assessment mean score of 88%. 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 keeps a roster of students who receive education with the use of the flipchart.

**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 aimed at increasing children's physical activity.

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. At the community listening forums conducted in 2019 for the prior Title V Comprehensive 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. In addition, a staff member from the Division of Chronic Disease Prevention will be added to the Child Health Domain Team for better collaboration and information sharing.

**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 in May 2022 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.

Title V staff continued 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 in the second year of collaboration, what activities were implemented, and determine if any successes were identified. In January 2024, a webinar was held that included Title V staff, Division of Chronic Disease Prevention staff, Creating Healthy Schools and Communities grantees, and School-Based Health Centers. The webinar provided an overview of Title V, the Creating Healthy Schools and Communities program, the School-Based Health Center program, and included breakout sessions to allow the programs to facilitate ideas on how the programs can collaborate in the schools they operate in. Some ideas that came out of the breakout sessions included hosting collaborative breakfast hours for the parents, with representatives from both programs and featuring healthy food and snacks. Another idea that was discussed was creating short tutorial videos highlighting how to make quick, but healthy meals/snacks or teaching the latest TikTok dance and then post to each program's social media accounts. Conducting a joint presentation at school health fairs and creating a monthly wellness newsletter were other ideas that were discussed.

Title V staff followed up with the School-Based Health Centers during the year to gauge the outcomes of the collaborative relationships. In one relationship, the Syracuse Creating Healthy Schools and Communities and School-Based Health Center programs worked on food insecurity. They initiated a partnership with Central New York Food Pantry and began a project to give boxes of food to School-Based Health Center enrolled students and their families every third Thursday of the month. The boxes included a link to the Center for Disease Control and Prevention's guide for healthy eating for school students. As an example, 200 boxes were given in February 2024, and 300 boxes were given in March 2024. Creating Healthy Schools and Communities also shared coloring books with School-Based Health Center dental program.

**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 has not formally met since 2020, however staff from this Work Group remain on the Child Health Domain Team and discuss topics related to pediatric obesity and priorities. In addition, pediatric obesity is discussed and addressed in various ways throughout Title V programs including School-Based Health Centers providing anticipatory guidance and nutrition guidance around sugar-sweetened beverages.

**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.

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 surveys to allow for more statistically reliable stratified analyses. The sampling plan was being implemented, and the survey was completed in 2022. 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 and 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. Two additional Title V staff are in the process for Special Sworn Status application. The project will be continued to the following reporting year when data become 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 improve health outcomes 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 is integrated into the Department's Health Commerce System, a secure online system. School-Based Health Centers can identify, track, and improve health outcomes within the School-Based Health Centers. During this reporting period, Title V staff participated in the design and testing of the new data system and companion data submission guides. Data collection tools were developed including the medical quarterly report, dental quarterly and annual report, and School-Based Dental Home Program quarterly and annual report. All School-Based Health Centers successfully enrolled in the Health Commerce System through a formal organization affiliation and role assignment process. Data submission guides, data upload templates and blank entry forms were sent to all School-Based Health Centers. Multiple trainings on the data system were provided to School-Based Health Center dental operators on October 2 and November 1, 2023, and to School-Based Health Center medical operators on January 9 and January 25, 2024. School-Based Health Centers were

required to submit their reports using the new data system starting October 30, 2023. State program managers can access report and data in a timely manner. Program Managers review the data quarterly to assure program quality and opportunities for program improvement. Orientation for new staff and on-going training and technical assistance is provided to staff when needed.

**CH-3.3**: Engage and survey stakeholders to identify, track, and address health outcomes 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.

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 Division of Family Health created the Bureau of Data Analytics, Research, and Evaluation to support research and data needs across the division. The bureau continues to create efficiencies and ensures 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 support the Title V program to complete the planned activities. The success of this bureau is further highlighted in the State Systems Development Initiative (SSDI) annual progress report.

**Strategy CH-4: Apply a health outcome lens to Title V activities to address the broader social issues that impact children's health and well-being.**

As noted in other domains, child health outcomes are impacted by the broader social issues that are influenced by the conditions in which people are born, live, work, play, learn, and age. These social issues include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of resources are barriers to people's ability to access services and the quality of clinical care. All ten priorities that emerged from community members' input during the needs assessment touch upon these broader social issues and needs. These factors impact the health outcomes of both individuals and entire communities.

**CH-4.1**: With the new School-Based Health Center data collection system, build a reporting tool that allows School-Based Health Centers to identify, track, and address outcomes within the School-Based Health Centers (site or provider level).

Development of community resources, public health programs, and other opportunities to promote physical activity is vital for positive health outcomes. 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 plan for distribution of resources. These steps can contribute to environmental improvements that lead to increased physical activity and reduce health issues attributed to lack of exercise and an unhealthy lifestyle. The new data collection system gives them better access to information to support their work.

**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 poor health outcomes.
The Community Health Care Association of New York State (CHCANYS) is New York's Primary Care Association, a membership organization representing New York's 80 Community Health Centers, which are typically Federally Qualified Health Centers (FQHCs). These centers provide care for 1-in-8 New Yorkers at almost 900 locations across the state. Many of the School-Based Health Center operators are FQHCs, so CHCANYS is their professional organizations. CHCANYS provides training and technical assistance to New York's CHCs in areas including clinical quality improvement, emergency management, data and technology, workforce development, and compliance and operations.

The New York School-Based Health Alliance was formed in 1992 as an advocacy organization representing the interests of school-based health centers in New York State. The Alliance's mission is to create access to comprehensive, high-quality primary care, including medical, mental, oral, and community health services, for all children and youth statewide through SBHCs. The Alliance is a state affiliate of the national School-Based Health Alliance. The Alliance is the professional member organization for the state's School-Based Health Centers.

Title V staff have partnered formally and informally with 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. Staff have also identified the School-Based Health Foundation which is a promising partner. Conversations are continuing to develop a relationship and to leverage shared goals, especially related to data collection and dissemination to improve health outcomes for children in the school setting.

**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 2020-2021 School-Based Health Center quarterly reports. Data for the 2019-2020 academic year was impacted by 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 (FY26)

For the upcoming Title V grant cycle from 2025-30, our Title V Program will focus on two key priorities to promote comprehensive patient-centered health care for children and promote healthy play and nutrition for all children. These align with two National Performance Measures (NPMs): **NPM – Medical Home:** percent of children with and without special health care needs, ages 0 through 17, who have a medical home and **NPM – Physical Activity:** Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day. Medical Home is a new universal NPM for 2025-30, and Physical Activity is a continued NPM from the 2021-2025 cycle.

Receiving ongoing primary and preventive health care through a medical home is foundational to supporting children's health. Based on the American Academy of Pediatrics (AAP) definition of medical home, such care includes seven essential characteristics – it must be accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. Medical home is the standard of pediatric care, elaborated in the AAP *Bright Futures* resource and incorporated in NY's Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines, also referred to as the Child-Teen Health Plan. As summarized by the MCH Evidence Center (https://www.mchevidence.org/), research shows that children who have a stable and continuous source of health care are more likely to receive age-appropriate preventive care, less likely to be hospitalized for preventable conditions, and more likely to be diagnosed and treated early for chronic or disabling conditions.

Beyond clinical health care, children thrive when they are raised in healthy, safe, and supportive environments that nurture health-promoting behaviors, experiences, and relationships that support their holistic physical, social, emotional, and cognitive development. This includes opportunities for regular physical activity and access to healthy foods. For children, physical activity is most often through play. This includes both structured activities such as sports or physical education classes as well as less structured recreational activities in their homes, schools, and neighborhoods. As summarized by the MCH Evidence Center, physical activity not only supports healthy weight and physical fitness, but improves bone health, cardiovascular function, brain development, and mental health – which in turn support optimal health in childhood and reduce the risk for chronic diseases throughout life. This is consistent with our commitment to a life course approach to supporting child and adult health for Maternal and Child Health (MCH) populations.

The strategies and accompanying activities for the upcoming grant year for this domain are summarized in our State Action Plan Table and described further below. Of note, the objectives and strategies in this domain include all children, including those with special health care needs.

**Strategy CH-1: Support a statewide School-Based Health Center (SBHC) program to provide comprehensive, evidence-based, patient-centered primary and preventive health care services - including medical, mental, and dental care - to children in low-income and communities with dental care deserts.**

School-Based Health Centers (SBHCs) are a longstanding evidence-based approach for improving comprehensive health care for children, especially those in communities with limited access to high quality health care. SBHCs are clinics located in school buildings that deliver primary and preventive health care services to children, typically through clinical teams that include physicians, nurse practitioners, and nurses. They are distinct from and work in coordination with school nurses or other school district health services. SBHCs provide preventive care including vaccinations, screening, and check-ups, as well as management of acute and chronic health conditions. They may serve as a child's primary care provider or work in coordination with an outside primary care provider (PCP).

NYS has the largest network of SBHCs in the nation, providing regulatory oversight, guidance, and grant funding - including a recent $2 million increased annual state investment - to nearly 250 school-based medical clinics sponsored by 44 Article 28 facilities (hospitals, diagnostic and treatment centers, or county health departments under their Article 28 certificates) providing care to over 158,000 enrolled children annually. Many SBHCs also provide mental health care, preventive dental/oral health care, and reproductive health care services on site, and all are required to make referrals for these services if not offered directly. As a companion to the SBHC program, we support a School-Based Dental Home Program.

SBHC services are provided at no out-of-pocket cost to children, and services for Medicaid-eligible children are covered by Medicaid, as well as some other health insurers. Title V staff collaborate with the NYS Department of Health's Office of Primary Care and Health Systems Management (the department's regulatory office for health care facilities and the Certificate of Need process) and the NY School-Based Health Alliance (NYSBHA) which represents the state's SBHC providers. Maintaining and supporting this SBHC network is a core strategy for ensuring health care through a medical home for children in NYS.

This strategy aligns with Needs Assessment themes focused on health information and literacy, social support, health care

access, patient-centered care, mental health and health care, service coordination, and public health systems and workforce. It also directly impacts **ESM CH-1:** percent of students attending schools with SBHCs who are enrolled in the SBHC program.

**Activities for 2025-26:**

- **CH-1.1:** Continue to provide grant funding to 246 SBHC programs (operated by 44 sponsoring organizations) across NYS to provide comprehensive, patient-centered primary and preventive health care services to children throughout the state.
- **CH-1.2:** Monitor local SBHC contracts and services through quarterly reports, quarterly grantee calls, and ongoing communication with individual grantees.
- **CH-1.3:** Provide training and technical assistance to SBHCs to support delivery of services and compliance with program requirements. In the upcoming year, this will include developing at least one new training and/or resource related to Medical Home and *Bright Futures* guidelines for pediatric care.
- **CH-1.4:** Facilitate sharing of challenges and best practices related to outreach, enrollment, and service provision between SBHCs through the SBHC program listserv, quarterly provider calls, and participating in the annual meeting convened by the NYS School-Based Health Alliance.
- **CH-1.5:** Through the Pediatric Mental Health Care Access grant, continue to enhance the partnership with the NYS Office of Mental Health to promote SBHC provider participation in Project TEACH to enhance SBHC provider capacity for providing mental health services.

**Strategy CH-2: Promote health insurance enrollment and primary health care utilization for children through all child-serving Title V Programs.**

Having affordable and adequate health insurance is foundational to children's ability to receive health care services. As summarized by the MCH Evidence Center, research shows that children with health insurance are more likely to have access to a usual source of care, receive well-child visits including immunizations and recommended screenings, receive needed prescription medicines, and have earlier identification and better management of chronic health conditions. Children with health insurance have fewer preventable hospitalizations, better health outcomes, and miss less school. NYS has been a national leader in making low- or no-cost health insurance available to children through the state's Medicaid, Child Health Plus (NY's State Child Health Insurance Program), and health insurance marketplace. It is essential that we continue to promote and facilitate enrollment in health insurance and primary health care services through partnerships with insurers, including Medicaid, and by integrating basic information and resources related to health insurance and health care across all Title V programs serving children and their families. This strategy aligns with Needs Assessment themes focused on health information and literacy, health care access, mental health and health care, and public health program capacity.

**Activities for 2025-26:**

- **CH-2.1:** Through the SBHC program, continue to track and report the percent of SBHC enrollees with health insurance by insurance type, and provide technical assistance to SBHC operators to increase insurance enrollment, especially for those with higher –than-average reported rates of uninsured or unspecified insurance status.
- **CH-2.2:** Through the SBHC program, continue to coordinate and collaborate with the Department's Office of Health Insurance Programs (Medicaid Program) to ensure reimbursement for SBHC services provided to Medicaid-eligible children.
- **CH-2.3:** Through the Department's adolescent-serving programs, continue to incorporate information and resources for youth to enroll in health insurance and obtain ongoing health care visits through a regular source of care.
- **CH-2.4**: Within the Department, explore opportunities for Title V staff training related to children's health insurance and health care quality initiatives, including NYS Patient-Centered Medical Home (https://www.health.ny.gov/technology/nys_pcmh/), to ensure that our staff have the knowledge and capacity to incorporate relevant information and resources across our child-serving Title V programs.

**Strategy CH-3: Provide families with accurate information to promote children's health, development, and use of health care services.**

As noted under previous domains, health communication is an essential public health and MCH service. There is evidence to support both general and topic-specific health communication campaigns, especially when multiple communication channels are used and communication is paired with other intervention components, such as the distribution of related free or low-cost tangible goods. This strategy aligns with our Needs Assessment themes related to health information and

literacy as well as access to community services and resources. Both developmentally appropriate health education for children and parent education about child health and development are important for promoting children's health and use of health care services.

**Activities for 2025-26:**

- **CH-3.1:** Promote utilization of the NYS Growing Up Healthy Hotline to increase awareness of available community resources, supports, and services including WIC, Medicaid, and well-childcare for families with young children.
- **CH-3.2:** Continue to collaborate with the NYS Council on Children and Families to share information about health-related services and resources through its Parent Portal (https://ccf.ny.gov/nysparenting/) and Help Hub for Families (https://helphubforfamilies.ny.gov/). Explore additional opportunities for collaboration to enhance health-related information and resources shared through the portal.
- **CH-3.3:** Explore opportunities to collaborate with the Department's Divisions of Chronic Disease Prevention, Nutrition, and Vaccine Excellence to enhance cross-program health communication messages and resources for children and families.
- **CH-3.4:** Continue and enhance coordination with the Department's Public Affairs Group to incorporate timely and accurate information on child health, development, and health care within the department's website and social media accounts. The Adolescent Mental Health campaign was created in partnership with the Department's Public Affairs Group, which supports media campaigns and press releases, to implement the campaign to destigmatize Mental Health as well as increase access to Mental Health services. The campaign will run statewide through September 2026.
- **CH-3.5:** Through the School-Based Dental Health program, promote oral health through education on preventive practices, including age-appropriate oral hygiene practices, examinations, oral prophylaxis, application of sealants, and other preventive and restorative services.

**Strategy CH-4: Apply population and program-specific health data to support clinical and public health actions that promote child health.**

As noted for other domains above, surveillance and data analysis are core public health functions that should inform all other public health services. The use of data to maintain an ongoing and dynamic understanding of children's health within our state and communities is fundamental to identifying persistent and emerging issues, understanding causes and contributing factors, and evaluating the impact of our work. It is also a powerful tool for engaging, communicating with, and empowering partners – including families and community members. Because services for children span dozens of public health programs, state agencies, and data systems, it is especially challenging to maintain a complete picture of child health and well-being, making ongoing knowledge of and relationships with other child-serving programs essential for Title V programs. This fundamental public health strategy aligns with our Needs Assessment themes related to public health program capacity and is foundational to other strategies and activities described throughout the state action plan for this domain.

**Activities for 2025-26:**

- **CH-4.1:** Review relevant population data related to child health and well-being from available sources – including Vital Statistics, National Survey of Children's Health, and others – to identify trends and emerging issues and inform ongoing public health activities annually.
- **CH-4.2:** Explore opportunities for Title V staff training and partnerships with other state programs and agencies that manage child health data – including KIDS Count which is a comprehensive data compilation administered by the NYS Council on Children and Families (https://ccf.ny.gov/kids-count/) – to build staff knowledge and capacity for locating and applying data to Title V work.

**Strategy CH-5: Through the SBHC program, implement both clinical practices and community partnerships that promote healthy active play and physical activity.**

As described under Strategy CH-1 above, SBHCs are a critical part of the public health infrastructure for providing primary and preventive health care to children in NYS. There is good evidence to support individual patient-centered counseling by health care providers to positively influence health behaviors as one aspect of overall approaches to promoting physical activity among youth. Moreover, SBHCs' location and relationship with schools provides a unique opportunity to explore partnerships that go beyond individual care to encompass other evidence-based and emerging family, school, and community interventions. This strategy aligns with Needs Assessment themes related to health information and literacy, social support, patient-centered care, mental health, access to community programs, and public health partnerships. To enhance this strategy, the Department recently received a new state investment of $1m annually to expand access to

Community Health Workers in School-Based Health Centers. The goal is to support the system of care for children within the SBHC by linking students and their families with community resources and referrals

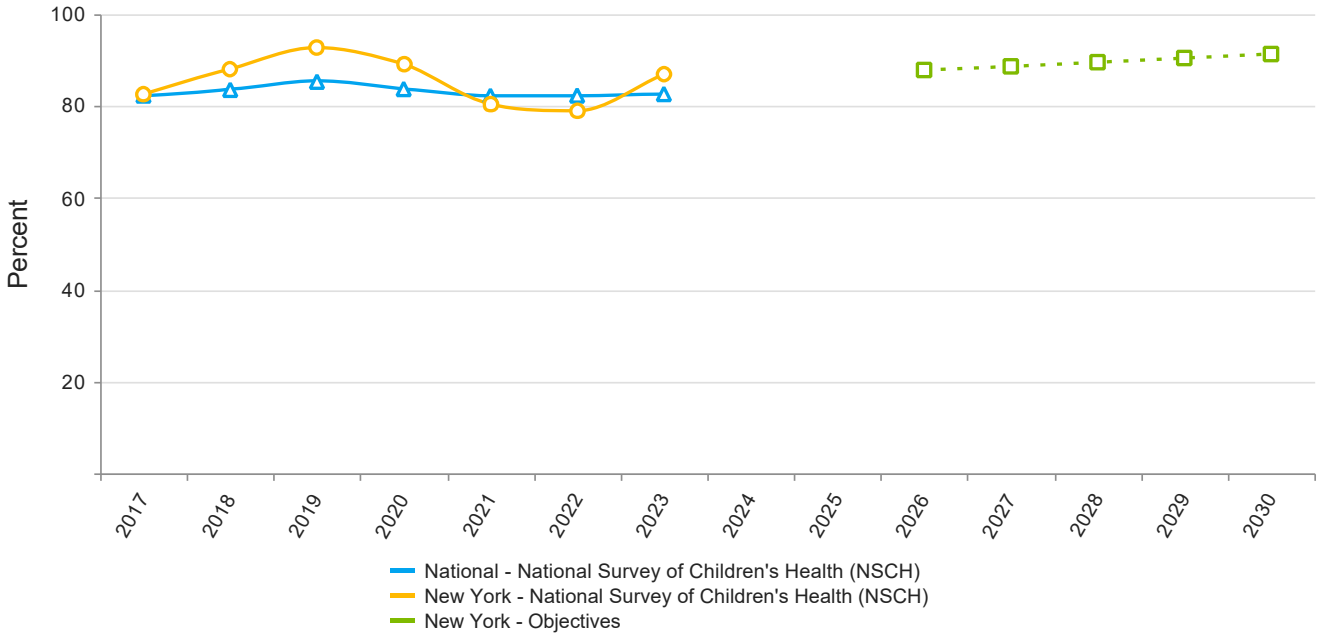
**Activities for 2025-26:**

- **CH-5.1:** Work with SBHCs to continue providing anticipatory guidance, screening, and counseling on physical activity, screen time, and healthy eating as part of routine preventive health care visits, consistent with *Bright Futures* guidelines for pediatric care and within the context of holistic child physical and social-emotional well-being including connection to mental health.
- **CH-5.2:** Continue and enhance collaboration with the Department's Division of Chronic Disease Prevention's Creating Healthy Schools and Communities Program, including facilitating local linkages between SBHCs and Creating Healthy Schools and Communities Program grantees.
- **CH-5.3:** Explore opportunities for Title V staff and local SBHC programs to engage in and support Governor Hochul's *Unplug and Play* initiative launched in 2025.

**Adolescent Health**

**National Performance Measures**

**NPM - Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling - MHT**
**Indicators and Annual Objectives**




| Federally Available Data | |
|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | |
| | **2024** |
| Annual Objective | |
| Annual Indicator | 86.8 |
| Numerator | 267,589 |
| Denominator | 308,156 |
| Data Source | NSCH |
| Data Source Year | 2022_2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | 87.7 | 88.5 | 89.4 | 90.3 | 91.2 |

**Evidence-Based or –Informed Strategy Measures**

**ESM MHT.1 - Percent of DFH-funded adolescent-serving programs that receive mental health-related trainings and resources.**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2026 | 2027 | 2028 | 2029 | 2030 |
| Annual Objective | 85.0 | 90.0 | 95.0 | 100.0 | 100.0 |

**State Action Plan Table**

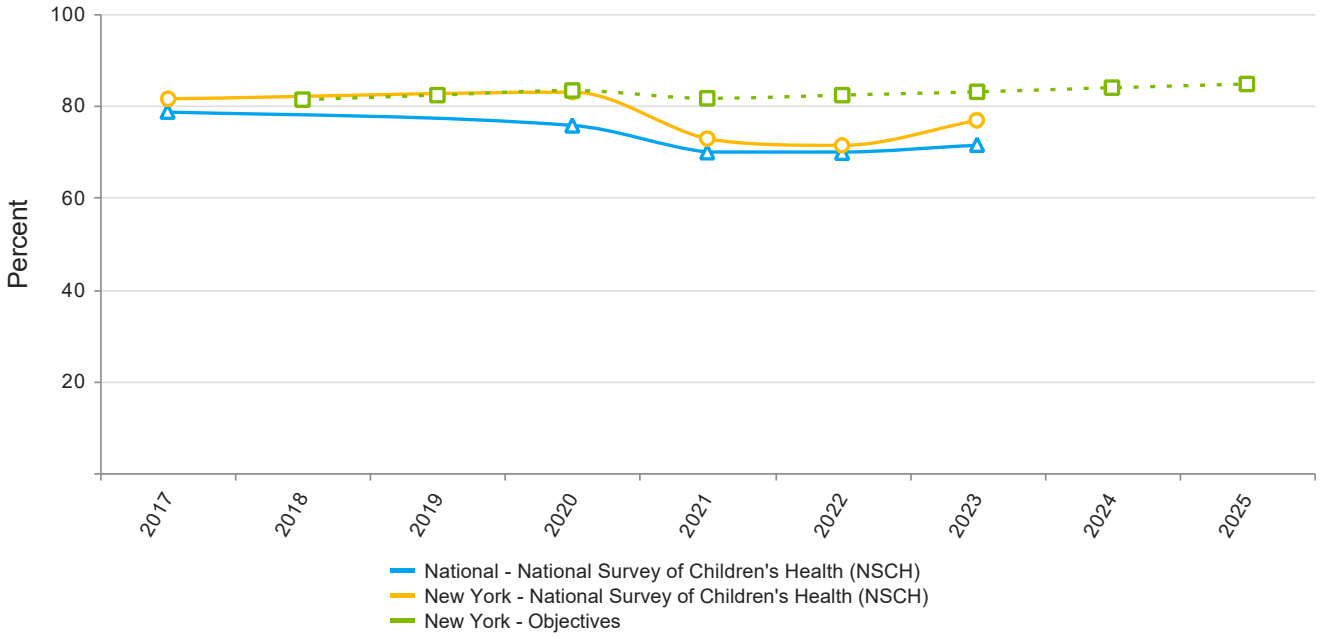
| State Action Plan Table (New York) - Adolescent Health - Entry 1 | |
|---|---|
| **Priority Need** | |
| Support physical and mental health and health care for adolescents | |
| **NPM** | |
| NPM - Mental Health Treatment | |
| **Five-Year Objectives** | |
| Objective AH-1: Increase the percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling by 5%, from 86.8% in 2025 to 91.2% in 2030. (NSCH) | |
| **Strategies** | |
| Strategy AH-1: Support a statewide School-Based Health Center (SBHC) program to provide comprehensive, evidence-based, patient-centered primary and preventive health care services - including medical, mental, health, and dental care - to adolescents in low-income communities. | |
| Strategy AH-2: Partner with the NYS Office of Mental Health Project TEACH program to enhance primary care provider capacity for providing mental health services in SBHCs and other youth-serving programs statewide. | |
| Strategy AH-3: Incorporate information and resources to promote the physical, mental, and behavioral health and wellness of adolescents across all youth-serving Title V programs. | |
| Strategy AH-4: Establish a Youth Advisory Group to directly inform and participate in Title V youth programs, policies, and initiatives. | |
| Strategy AH-5: Analyze and apply quantitative and qualitative data on adolescent health behaviors, service utilization, and outcomes to drive Title V youth-serving initiatives and programs. | |
| **ESMs** | **Status** |
| ESM MHT.1 - Percent of DFH-funded adolescent-serving programs that receive mental health-related trainings and resources. | Active |

## NOMs

| |
|---|
| Adolescent Mortality |
| Adolescent Suicide |
| Adolescent Firearm Death |
| Adolescent Injury Hospitalization |
| Children's Health Status |
| Adolescent Depression/Anxiety |
| CSHCN Systems of Care |
| Flourishing - Child Adolescent - CSHCN |
| Flourishing - Child Adolescent - All |

**2021-2025: National Performance Measures**

**2021-2025: NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV Indicators**



| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 83.2 | 81.5 | 82.2 | 82.9 | 83.8 |
| Annual Indicator | 86.3 | 82.9 | 72.8 | 71.3 | 76.8 |
| Numerator | 1,367,654 | 1,218,475 | 976,520 | 972,723 | 1,065,930 |
| Denominator | 1,583,876 | 1,469,455 | 1,341,167 | 1,363,869 | 1,388,262 |
| Data Source | NSCH | NSCH | NSCH | NSCH | NSCH |
| Data Source Year | 2019 | 2019_2020 | 2020_2021 | 2021_2022 | 2022_2023 |

**2021-2025: Evidence-Based or –Informed Strategy Measures**

**2021-2025: 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** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 96.3 | 96.3 | 98.2 | 100 |
| Annual Indicator | 96.3 | 100 | 100 | 96.1 | 100 |
| Numerator | 52 | 52 | 52 | 49 | 54 |
| Denominator | 54 | 52 | 52 | 51 | 54 |
| 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 | Survey of CAPP and PREP Programs |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | 2024 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

**2021-2025: ESM AWV.2 - Percent of youth-serving programs that engage youth in program planning and implementation**

| Measure Status: | | | | Active | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 68.7 | 70.1 | 71.6 | 73.1 |
| Annual Indicator | 68.7 | 78.1 | 79.4 | 73.3 | 84.4 |
| Numerator | 46 | 50 | 50 | 44 | 54 |
| Denominator | 67 | 64 | 63 | 60 | 64 |
| 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 | Survey of CAPP, PREP, and SRAE Programs |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | 2024 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

## Adolescent Health Domain Annual Report for October 1, 2023 – September 30, 2024

For Adolescent Health, New York's Title V Program selected 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 New York State (NYS). According to the 2022-2023 National Survey for Children's Health (NSCH), 76.8% of adolescents had a preventive visit in the last year. NYS continues to work towards increasing the total number of adolescents who have obtained annual preventive medical and dental visits. Only 44.5% of uninsured adolescents had a well visit in the past year, compared with 61.1% of adolescents with a mix of public and private insurance, 74.6% with public health insurance, and 84% with private health insurance. (NSCH 2022-2023)

In a series of adolescent focus groups conducted in 2019 by the New York State Department of Health (Department) through the Assets Coming Together (ACT) for Youth Center for Community Action at Cornell University, adolescents across the state shared that their medical providers lack compassion and respect for their young patients, and the youth would prefer visiting providers who are more reflective of the youth themselves. The youth frequently mentioned the importance of social support, and the need for more positive mentors to talk to. 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 2023 Youth Risk Behavior Surveillance System, about 36% of New York high school students reported feeling sad or hopeless for more than two weeks in the past year. The percentage of high school students who have attempted suicide has increased in 2023, with 13.6% of New York City (NYC) students and 9.4% of rest of state students reporting that they attempted suicide in the past year.

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. This is accomplished by strengthening opportunities to build well-being and resilience across the lifespan; facilitating supportive environments that promote respect and dignity for people of all ages; and addressing mental health and substance use, including prevention underage drinking, education about excessive alcohol consumption by adults, prevention of opioid and other substance misuse and deaths; preventing and addressing adverse childhood experiences (ACEs); reducing the prevalence of major depressive disorders through more effective access to treatment; preventing suicides; and reducing mortality for individuals living with serious mental illness. (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 2022-2023. (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 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 HPV vaccine by 8%, from 67.3% in 2018 to 72.7% in 2023 (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 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 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 prevention opportunities, and address conditions that can interfere with healthy development. Likewise, comprehensive 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 the broader social issues that may impact their ability access care and healthy options.

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 2023-2024 year:

**AH-1.1**: Through the Personal Responsibility Education Program (PREP) and Comprehensive Adolescent Pregnancy Prevention (CAPP) 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 curricula 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 28,119 youth during this reporting period through the Comprehensive Adolescent Pregnancy Prevention program and the Personal Responsibility Education Program. ACT for Youth reviews the latest research and best practices regarding pre-adolescent health and will assist the Department in collecting and analyzing program data and evaluating the outcomes of the services provided by the funded CAPP, PREP, and Sexual Risk Avoidance Education (SRAE) sub-awardees. ACT for Youth has established methods for collecting and analyzing data for evaluating the effectiveness of funded programs and program models that have been reviewed and approved by the Department.

The Comprehensive Adolescent Pregnancy Prevention (CAPP) program funds youth-serving organizations to work with adolescents, ages 10-21 that lack social and economic opportunities to develop their full potential. 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.

Children's Aid Society, one of the CAPP programs, utilize their youth leaders to spearhead youth engagement on their social media platforms. On YouTube, they introduce youth to their peer educator program, highlight CAPP events, and share sexual health related facts. On their TikTok channel, they created eleven videos about healthy relationships, Sexually Transmitted Infections (STIs), family planning and contraception, and menstruation, which resulted in over 1,600 views. On their Instagram channel, they also share CAPP events, provide clinic information, and answer sexual health related questions. Their youth leaders created eighteen posts to spread awareness about breast cancer, suicide prevention, polycystic ovary syndrome, and immunizations.

One of our other CAPP programs, Sun River Health, facilitated a youth health promoter session titled, "Becoming a Teen Influencer," where participants learned how to educate their peers and amplify health messages through social media, with a focus on mental health. These efforts allowed them to raise awareness among their peers in a way that felt relatable and impactful. Participants were also trained in content creation tools like Canva and color theory to design creative Instagram posts and other social media materials.

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 used an innovative youth-as-partners model to involve peer educators in the creation of social media campaigns and public service announcements during the reporting period on TikTok and on their Instagram and Facebook pages, with an approximate reach of 15,000. They provided educational content featuring authentic youth voice and connected 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 and local clinic information, time management, and self-esteem building.

A new Request for Applications was issued for the Comprehensive Adolescent Pregnancy Prevention (CAPP) program in the fall of 2022. 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 contracts were awarded. These five-year contracts, which started on July 1, 2023, include a total of forty-eight separate CAPP programs.

A new Request for Applications was issued for the Personal Responsibility Education Program in the fall of 2022. Seven new Personal Responsibility Education Programs (PREP) were awarded, with five-year contracts that started

on October 1, 2023. All seven PREP providers served youth throughout this reporting period.

**AH-1.2:** Through the Sexual Risk Avoidance Education program, provide medically accurate and complete sexual health education services to youth.

The Sexual Risk Avoidance Education (SRAE) 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.

Sub-awardees are funded through a competitive procurement process to support a program model that incorporates evidence-based education for youth ages 10 to 13 and with programs that have existing youth development programming and linkages with other youth-serving organizations. A five-year grant cycle concluded on 06/30/2024 and a new five-year grant cycle commenced on 07/01/2024 where eleven sub-awardees were allotted grant funds. Current SRAE sub-awardees meet the grant objectives through innovative strategies to promote abstinence from sexual activity and a healthy transition to adolescence.

The following four SRAE sub-awardees demonstrate how they creatively engage youth and their communities in meeting this objective.

Sunset Park Health Council encourages SRAE program participants to also join their Youth Health Council program, which enables middle schoolers to gain essential knowledge about topics like puberty, social responsibility, hygiene, cliques, stigma, and more. This initiative strengthens the evidence-based programming that they are receiving.

BronxWorks partnered with Casita Maria, a youth serving arts, culture, and education organization, to offer evidenced-based programming and adult-supervised activities to their youth. This partnership has fostered continued programming at this site as well as interest for parent and guardian workshops.

Brownsville Community Development hosted their 2nd annual Art in the Park Event which combines adult-supervised activities and outreach to engage youth and families in evidence-based programming. They utilized a carnival-style art intense platform and collaborated with community partners to offer resources and facilitate art and wellness activities. This event resulted in 100 referrals to participants, their families and other community members.

New Alternatives for Children implemented the evidence-based program Teen Outreach Program which runs for nine months. All the caregivers of youth involved attended their commencement event. They expressed a great deal of gratitude to the health educator for her passion and commitment along with appreciation of the delivered programming. They acknowledged witnessing growth and impact on their children as a result of this program. The youth and their caregivers expressed interest in continued participation in SRAE programming the following academic school year.

**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.

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.

For the Comprehensive Adolescent Pregnancy Prevention (CAPP) program, a total of 7,209 comprehensive health care referrals were made during the period of 7/1/2023 – 12/31/2024, of which 5,362 referrals were for reproductive health care. During this period a total of 2,730 referrals were made for other services such as nutrition, housing, employment, educational support, and to other youth serving organizations. A total of 9,939 referrals were made during this period by CAPP program providers.

For the Sexual Risk Avoidance Education (SRAE) program, a total of 1,098 comprehensive health care referrals were made during the period of 7/1/2023 – 12/31/2024, of which 277 referrals were for reproductive health care. During this period a total of 1,211 referrals were made for other services such as nutrition, housing, employment, educational support, and to other youth serving organizations. A total of 2,309 referrals were made during this period by SRAE program providers.

For the Personal Responsibility Education Program (PREP), a total of 8,307 comprehensive health care referrals were made during the period of 10/1/2023 – 9/30/2024, of which 5,639 referrals were for reproductive health care. During this period a total of 3,941 referrals were made for other services such as nutrition, housing, employment, educational support, and to other youth serving organizations. A total of 12,248 referrals were made during this period by PREP program providers.

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 also provided in person training in New York City and Ithaca on Positive Youth Development. ACT for Youth 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 (CAPP), Personal Responsibility Education Program (PREP), and Sexual Risk Avoidance Education (SRAE) program providers, such as Nuanced Dimensions of Consent, A Call to Action for Adolescent Health and Well-Being & Toolkit, Getting Social Savvy-Helping Youth Navigate Social Media, Co-Regulation and Youth: What It Is and How You Matter, Strengthening the Roots: Positive Childhood Experiences, Supporting Youth Mental Health: An Action Guide for Schools, New Tools for Educating Youth about Sexual Coercion and Consent, Bridging the Gap: Connecting Shared Principles of Substance Use Prevention and Sexual and Reproductive Health Education, and Supporting Mental Health in SRAE Programs. Department of Health staff review biannual reports, provide feedback, and follow up as needed.

In addition to sexual and reproductive health education, the Comprehensive Adolescent Pregnancy Prevention program includes a programmatic component that focuses on social-emotional wellness and positive youth development. 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.

**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.

The Adolescent Health Unit participates in cross-domain staff meetings with Child Health and Children and Youth with Special Health Care Needs domains. The Adolescent Health Unit is collaborating with the Bureau of Child Health to increase opportunities for contact between School-Based Health Centers and adolescent-serving programs described in this domain section. The Adolescent Health Unit and the Bureau of Child Health are developing a plan to conduct an informational webinar with School-Based Health Centers, ACT for Youth Center for Community Action, and adolescent-serving 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. These were distributed to Adolescent Health Unit providers, Family Planning Program Providers, School-Based Health Centers, and Local Health Departments during the reporting period. One Comprehensive Adolescent Pregnancy Prevention program, Community Healthcare Network's Teens PACT, reported back that they distributed the fact sheets to youth during their menstrual health youth summit, "Period Power."

Title V staff working with Children and Youth with Special Health Care Needs, Child Health, Sexual Violence Prevention, 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: Nuanced Dimensions of Consent, Intersectionality of Disabilities and Adolescent Development, Recognizing Human Trafficking in Health Care Settings, Back to Basics: What will it take to prevent sexual and intimate partner violence, Measuring Love in the Journey to End Sexual & Intimate Partner Violence, and a youth-serving newsletter.

Staff in the Adolescent Health Unit and the Bureau of Child Health have begun collaborative efforts to develop comprehensive list of where School-Based Health Centers and Adolescent Health Unit pregnancy prevention providers are located. Once complete, this list will be issued to all School-Based Health Centers and Adolescent Health Unit pregnancy prevention providers. It is anticipated that this will be completed in the next reporting period.

Staff from the Adolescent Health Unit (AHU) and the Bureau of Child Health met with the NYS Department of Health's Bureau of Tobacco Control, which presented on their Drop the Vape Campaign. The Bureau of Tobacco Control led social media campaigns on vaping. The Department subsequently issued an announcement of an effort to Reduce Vaping Among Youth, which was disseminated to all adolescent-serving program providers.

To respond to the current youth mental health crisis, the Department is working to create a public health media campaign on adolescent mental health. The campaign aims to reduce stigma and educate youth on how to access to mental health services at School-Based Health Centers. The media campaign is expected to launch during the next reporting period.

**AH-1.6:** Collaborate with internal and external stakeholders, including the Department's AIDS Institute and its Bureau of Immunization, as well as 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.

The Adolescent Sexual Health Needs Index (ASHNI) is an indicator, calculated at the ZIP code level, to provide a single, multidimensional measure related to adolescent pregnancy and sexually transmitted diseases (STDs). The ASHNI takes into consideration a variety of key factors related to these outcomes, including the size of adolescent population, actual burden (number) of adolescent pregnancies and STD cases, and a number of specific demographic and community factors (education, economic, and other indicators) that are significantly associated with adverse sexual health outcomes. Adolescent-servicing programs utilize the ASHNI to 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 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.

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 (PREP) 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 2024 was held in-person. This all-day event saw an attendance of over 200 youth, community providers, public health advocates and performers. Conference participants attended workshops on Pregnancy Prevention, Mental Health, and Sexually Transmitted Infection (STI)/HIV Awareness. Over 30 service providers engaged youth in a health fair, providing information on services available in their communities. Throughout the event, youth were provided opportunities to be tested for HIV and other STIs.

In Syracuse, three CAPP providers, ACR Health, Planned Parenthood Central Western New York, and REACH Central New York, meet quarterly to coordinate their outreach efforts and align their coverage across the community. 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. In our efforts to encourage adolescent health programs to do so, the Adolescent Health Unit has developed a quarterly newsletter aimed at amplifying resources specific to social-emotional learning, health outcomes, and adolescent health for our sub-awardees. The newsletter contains health related facts and topics that impact adolescents as well as provide social media posts to reshare that are centered on positive youth development. We successfully published the first issue in January of 2025 and sent it to all adolescent health unit providers.

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 2023-2024 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.

For the Comprehensive Adolescent Pregnancy Prevention (CAPP) program, a total of 7,209 comprehensive health care referrals were made during the period of 7/1/2023 – 12/31/2024, of which 5,362 referrals were for reproductive health care. During this period a total of 2,730 referrals were made for other services such as nutrition, housing, employment, educational support, and to other youth serving organizations. A total of 9,939 referrals were made during this period by CAPP program providers.

For the Sexual Risk Avoidance Education (SRAE) program, a total of 1,098 comprehensive health care referrals were made during the period of 7/1/2023 – 12/31/2024, of which 277 referrals were for reproductive health care. During this period a total of 1,211 referrals were made for other services such as nutrition, housing, employment, educational support, and to other youth serving organizations. A total of 2,309 referrals were made during this period by SRAE program providers.

For the Personal Responsibility Education Program (PREP), a total of 8,307 comprehensive health care referrals were made during the period of 10/1/2023 – 9/30/2024, of which 5,639 referrals were for reproductive health care. During this period a total of 3,941 referrals were made for other services such as nutrition, housing, employment, educational support, and to other youth serving organizations. A total of 12,248 referrals were made during this period by PREP program providers.

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 support and educate their children. This education includes information regarding family planning services. Support is provided to adolescents who are pregnant or have given birth in attending prenatal, postpartum, and well-baby appointments.

**AH-2.3**: Support adolescents who are pregnant or have given birth 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 required to maintain a listing of current programs within their catchment area to support their referral services.

**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.

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.

During the reporting period, several Family Planning Providers conducted marketing and outreach to adolescents through the Family Planning Telehealth Infrastructure Enhancement and Expansion Grant, which is described in the Women and Maternal Health domain annual report.

The Children's Aid Society health educator created visuals that can be shared with patients via social media and Google Ads to alert and remind patients of this service that they offer. The Door Adolescent Health Center marketed to adolescents via social media to bring in new clients and engage with existing clients. They promoted ease of access for young people in school or currently working. Livingston County Reproductive Health implemented a comprehensive outreach and marketing plan highlighting their telehealth services in English and Spanish on Snapchat, Facebook and Instagram, and targeted teens and young adults utilizing Spotify. They also developed rack cards, wallet cards, and magnets in English and Spanish highlighting telehealth availability. Erie County Department of Health upgraded to utilize telehealth in partnership with the youth detention facility, allowing access for teens. During this reporting period they worked with Buffalo Public Schools to place materials in the school nursing offices.

The Family Planning Program also launched a statewide campaign to promote and educate the public on the availability of free or low-cost quality reproductive healthcare services through the family planning program. The campaign work group engaged with Cornell Act for Youth Center for Community Action to provide stakeholder feedback on tailoring messaging to adolescents, developing scripts, and creating an FAQ document for individuals under age 18. During the summer of 2024, the campaign used credible messengers to reach adolescents on social media with an influencer campaign that generated 13,600 social engagements and 6.5 million impressions across Meta and TikTok.

**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 (described above) 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).

**Strategy AH-3: Apply public health surveillance and data analysis findings to improve services and systems related to adolescent'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 2023-2024 year:

**AH-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.

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 dissemination until 2025. This work is described in the Child Health domain annual report, CH-3.1.

**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 Department procurements for adolescent health programs.

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, and other demographic information) 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. 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, Eating Disorder Basics for Health Educators, provider collaboration forums, and healthy relationships. ACT for Youth Center for Community Action hosted orientations for new and returning Sexual Risk Avoidance Education program providers, 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.

The ACT for Youth Center for Community Action website includes resources such as Adolescent Development Toolkit; Youth Mental Health: Understanding Positive Youth Development; and Adolescent Health and Development. ACT for Youth 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 the Department's 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.

The Adolescent Health Domain has representation on the Alcohol Surveillance and Epidemiology Workgroup, which is hosted by the Bureau of Chronic Disease Evaluation and Research and meets quarterly to discuss the latest findings and prevention efforts across the state.

Adolescent Health plans to work with the Bureau of Chronic Disease Evaluation to discuss the results of the 2023

Youth Risk Behavior Surveillance System.

**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.**

Source data for this measure is 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 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 in program planning and implementation.**

Source data for this measure is 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 73.3% (1/1/23 – 12/31/23, note: seven of 67 programs have missing data).

## Adolescent Health Application Year (FY26)

For the upcoming Title V grant cycle from 2025-30, our Title V Program will focus on the key priority to support physical and mental health and health care for adolescents. This aligns with the National Performance Measure **NPM – Mental Health Treatment: Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling.** This is a new NPM for the 2025-30 cycle.

As evidenced by the findings detailed in our Needs Assessment Summary, mental health is a prominent concern for adolescent health and well-being that continues to grow. While national survey data suggest that most (86.5%) of adolescents ages 12-17 who needed mental health counseling and treatment received it, there are significant persistent variations in this measure, and it has not improved over time. Moreover, a broader array of related health outcome indicators and qualitative input from youth and families suggest that the picture is more complex, with a large and growing proportion of adolescents reporting persistent feelings of depression and anxiety and concerning statistics for suicidal ideation and attempts.
As discussed in other domains, we view our selected NPM both as an indicator of specific service needs related to mental health treatment *and* within the context of a broader continuum of adolescent health, wellness, and service needs. Data and community input detailed in our Needs Assessment point to other areas that are essential for helping adolescents thrive, including injury prevention, sexual health, substance use, physical activity and diet, healthy relationships, social-emotional well-being, and preparing for transition to adult roles and responsibilities. The importance of social supports and the need for more access to positive mentors to talk with were frequently mentioned by adolescents.

From a life course perspective, adolescence is a key transition period and can be a challenging stage in a person's life, marked by both risk and opportunity. For decades, NYS has been a national leader in embracing and integrating an asset-based Positive Youth Development approach throughout its adolescent health initiatives. Our selected NPM and associated strategies also aligns directly with specific priorities from the NYS 2025-2030 Prevention Agenda related to mental wellbeing and substance abuse as well as its broader focus on economic stability, safe and healthy communities, health care access and quality, and education.

The strategies and accompanying activities for the upcoming grant year for this domain are summarized in our State Action Plan Table and described further below. Of note, the objectives and strategies in this domain include all adolescents, including those with special health care needs.

**Strategy AH-1: Support a statewide School-Based Health Center (SBHC) program to provide comprehensive, evidence-based, patient-centered primary and preventive health care services - including medical, mental, health, and dental care - to adolescents in low-income communities.**

As described in more detail within the action plan for the Child Health Domain, School-Based Health Centers (SBHCs) are a longstanding evidence-based approach for improving comprehensive health care for adolescents, especially those in communities with limited access to high quality health care. Thousands of young people in New York State have limited access to comprehensive health services because of financial, geographical and other barriers to care. NYS has the largest network of SBHCs in the nation, providing regulatory oversight, guidance, and grant funding to nearly 250 school-based clinics sponsored by 44 hospitals or diagnostic and treatment centers (D&TCs). SBHCs improve access to primary care for youth by bringing comprehensive primary and preventive health care services to school buildings and provide services to address health problems and concerns that make it difficult for students to learn. SBHCs are especially valuable for adolescents as they develop health literacy and health care systems navigation skills and increasingly may seek confidential health care services.
As noted, most NYS SBHCs serving teens provide mental health and/or reproductive health services on-site, and all are required to help arrange for such services by referral if not provided directly. SBHC mental health services are typically provided by psychologists or licensed clinical social workers, in consultation with medical providers. SBHC mental health services (authorized under Article 28 of the NYS Public Health law) complement and coordinate with more intensive licensed behavioral health clinics (authorized under Article 31of NYS Mental Hygiene Law) that are operated in some schools under the oversight of the NYS Office of Mental Health.

This strategy aligns with Needs Assessment themes focused on health information and literacy, social support, health care access, patient-centered care, mental health & health care, service coordination, and public health systems and workforce. It also contributes to the ESM established and described in the previous Child Health domain *(ESM CH-1: percent of students attending schools with SBHCs who are enrolled in the SBHC program).*

**Activities for 2025-26:**

- **AH-1.1:** Continue to provide grant funding to SBHC programs across NYS to provide comprehensive, patient-centered

primary and preventive health care services to adolescents throughout the state. Begin development of competitive procurement for next anticipated five-year SBHC grant cycle. *Crossover with CH-1.1*

- **AH-1.2:** In conjunction with NYS Department of Health Regional Offices, Island Peer Review Organization (IPRO) contract, and Department-run electronic data reporting and management systems, monitor local SBHC contracts and services through quarterly reports, quarterly grantee calls, and ongoing communication with individual grantees. *Crossover with CH-1.2*
- **AH-1.3:** Provide training and technical assistance to SBHCs to support delivery of services and compliance with program requirements. In the upcoming year, this will include developing at least one new training and/or resource related to adolescent mental health. *Crossover with CH-1.3.*
- **AH-1.4:** Facilitate sharing of challenges and best practices related to SBHC services including specifically mental health services through the SBHC program listserv, quarterly provider calls, and participating in the annual meeting convened by the New York School Based Health Alliance.

**Strategy AH-2: Partner with the NYS Office of Mental Health Project TEACH program to enhance primary care provider capacity for providing mental health services in SBHCs and other youth-serving programs statewide.**

The Project TEACH mission is to strengthen and support the ability of New York's Maternal Health and Pediatric Primary Care Providers (PCPs) to deliver care to children and families who experience mild-to-moderate mental health concerns. Project TEACH is a child, adolescent, and perinatal psychiatry access program. Project TEACH provides education and consultation support to providers, allowing providers in New York State to speak directly with child and adolescent psychiatrists to ask questions, discuss cases, review treatment options, or obtain referral assistance. Through telehealth consultations Project TEACH supports the mental health needs of patients in SBHCs and other youth-serving programs statewide. Participation in Project TEACH trainings and consultation resources is open to all New York State clinicians who treat children, adolescents, and perinatal patients at no cost to participating providers. This program is currently funded through the New York State Office of Mental Health (OMH), with expansion to SBHCs supported through our federal Pediatric Mental Health Care Access Grant (9/30/22-9/29/26).

Project TEACH has seven hubs so that every region of New York state has a team that is known to the practitioners in that area. Each team consists of child and adolescent psychiatrists, reproductive psychiatrists, and a liaison coordinator. They are all based out of medical school Departments of Psychiatry and are faculties in good standing at their respective universities. The child and adolescent psychiatrists and reproductive psychiatrists are all experts in their field, and many are known as national leaders. The teams work together closely to provide all services in the program.
https://projectteachny.org/about/hub-sites/

This strategy aligns with Needs Assessment themes focused on mental health and health care, public health systems, and workforce capacity. It also directly impacts **ESM AH-1: Percent of DFH-funded adolescent-serving programs that receive mental health-related trainings and resources**.

**Activities for 2025-26:**

- **AH-2.1:** Support a dedicated Title V staff liaison with mental health practice experience to serve as a liaison with NYS OMH for this project.
- **AH-2.2:** Meet regularly with the OMH Project TEACH team to develop and implement collaborative activities.
- **AH-2.3**: Through this collaboration, promote local SBHC program participation in Project TEACH, including trainings and 1:1 telehealth consultation service.
- **AH-2.4:** Incorporate relevant information about mental and behavioral health and Project TEACH resources across other Title V clinic-based programs that serve adolescents.

**Strategy AH-3: Incorporate information and resources to promote the physical, mental, and behavioral health and wellness of adolescents across all youth-serving Title V programs.**

Adolescence is a formative period when health-related attitudes, behaviors, and relationships take root, shaping both current and future health outcomes. The American Academy of Pediatrics' *Bright Futures*™ recommends routine well visits as a key opportunity to support adolescent health - offering a platform to reinforce healthy behaviors, address risky behaviors, deliver recommended immunizations, and identify emerging health concerns. Title V-funded programs advance adolescent well-being not only by promoting routine use of preventive health care services, but also by connecting youth to enabling supports - such as referrals to community resources, educational and social services, and recreational opportunities - that address mental health needs within the broader context of non-medical behavioral and community social factors that influence health.

Mental and behavioral health are essential components of adolescent well-being and are closely linked to other aspects of health. For example, access to inclusive reproductive health care and sexual health education helps young people navigate relationships with confidence, reducing stress and risk and developing lifelong communication, negotiation, and problem-solving skills. Physical activity, healthy eating, and reduced screen time not only help youth maintain healthier weight but also can help youth build confidence and pro-social relationships and support mental health. Social-emotional development, including the ability to form healthy relationships and positive self-image, plays a protective role in mental health. Addressing these domains in silos misses the reality that adolescent health is multidimensional and deeply interconnected.

New York's robust portfolio of adolescent health programs offers a significant infrastructure for supporting multiple dimensions of adolescent health, including mental and behavioral health and social-emotional development. While each program has distinct priorities and approaches, they share a common foundation in Positive Youth Development. Positive Youth Development emphasizes strength-building, youth voice, and supportive relationships as key to fostering resilience and promoting long-term health. Implementation supports for Positive Youth Development, including the training, technical assistance, and other resources provided through the ACT for Youth Center for Community Action, ensure this unifying approach is embedded across programs. By incorporating these and other resources across youth-serving programs, we can enhance their collective impact. This strategy promotes integrated, holistic approaches to adolescent health across key initiatives, including School-Based Health Centers (SBHCs), Comprehensive Adolescent Pregnancy Prevention (CAPP), Personal Responsibility Education Program (PREP), Sexual Risk Avoidance Education (SRAE), Children and Youth with Special Health Care Needs (CYSHCN), Family Planning, and Sexual Violence Prevention programs. This approach complements additional statewide initiatives such as a media campaign we developed - informed by the Surgeon General's report on adolescent mental health, NY Governor's listening tour, and published research literature – to destigmatize use of mental health care services among teens. This campaign launched in Summer 2025, will roll out in phases through Fall 2025, and is planned to run through June of 2026.

As a systems-level approach, this strategy aligns with all 10 Needs Assessment themes focused on health information & literacy, social support, health care access, patient-centered care, mental health and health care, access to community programs and services, service coordination, community and behavioral factors, public health partnerships, public health program capacity and workforce. It also directly impacts our ESM for this domain, **ESM AH-1: Percent of local Title V youth-serving programs that receive information on mental health trainings and resources from the Department.**

**Activities for 2025-26:**

- **AH-3.1:** Continue to support a statewide ACT for Youth Center for Community Action based at the Cornell University Bronfenbrenner Center for Translational Research
- **AH-3.2**: Through the statewide ACT for Youth, support effective translation of evidence-based and informed public health practices grounded in an asset-based Positive Youth Development framework by providing training, technical assistance, centralized web-based data reporting, quality improvement activities, and other implementation support resources to local providers and programs. In the upcoming year, collaborate with the ACT for Youth to host at least one mental health-related training for adolescent providers.
- **AH-3.3**: Through the Comprehensive Adolescent Pregnancy Prevention (CAPP) and Personal Responsibility and Education Program (PREP) provide adolescents and parents with information, resources, and assistance in obtaining sexual and reproductive health care services as appropriate for their needs.
- **AH-3.4**: Through the Sexual Risk Avoidance Education (SRAE) program, provide medically accurate and complete sexual health education services to youth.
- **AH-3.5:** Building on the special mental health edition done in Summer 2015, incorporate a standing element of mental and behavioral health within the newsletter disseminated to all Adolescent Health providers.
- **AH-3.6**: Through the ACT for Youth, provide state Title V and local program staff in youth-serving programs and organizations with trauma-informed education and training on social emotional wellness and positive youth development for children and adolescents, as a foundation for youth programming.
- **AH-3.7:** Through the ACT for Youth, ensure adolescent-serving programs provide training on the federally defined Adulthood Preparation Subjects including adolescent development, healthy relationships, parent-child communication, educational and career success, healthy life skills, and financial literacy to help prepare and support youth in transition to adult roles and responsibilities.
- **AH-3.8:** Continue planned roll-out of adolescent mental health media campaign and assess its impact through campaign metrics and feedback from Youth Advisory Group members (*see Strategy AH-4 below*).

**Strategy AH-4: Establish a Youth Advisory Group to directly inform and participate in Title V youth programs, policies, and initiatives.**

The mission of the Youth Advisory Group is to serve as a permanent, sustainable source of **direct youth feedback** for New York State Department of Health's Division of Family Health policies and programs. The Youth Advisory Group is youth-led and youth-run to ensure the perspectives and priorities of young people drive the work. This group is rooted in lived experience to ground all initiatives and decisions in real-world youth experiences.

This project year, our Title V program will launch an innovative pilot program to integrate youth voices and lived experiences into the program and policy development work. The Youth Advisory Group will allow youth from across New York State to give meaningful input on youth-related programs, policies, and initiatives. The Youth Advisory Group will play a pivotal role in shaping programs and policies related to youth, including School-Based Health Centers, Comprehensive Adolescent Pregnancy Program, Personal Responsibility Education Program, Sexual Risk Avoidance Education, Children and Youth with Special Health Care Needs, and Sexual Violence prevention programs. This will ensure that the voices of New York's youth are not only heard but are also incorporated into program design and implementation.

This strategy aligns with Needs Assessment themes focused on health information and literacy, social support, patient-centered care experiences, mental health and health care, access to community programs and services, service coordination, community and behavioral factors, public health partnerships, public health program capacity, and workforce.

**Activities for 2025-26:**

- **AH-4.1**: Establish a new contract with a selected vendor to convene and manage the Youth Advisory Group
- **AH-4.2**: Work with the selected vendor to launch a one-year pilot program to recruit and support approximately 24 youth from across New York State to participate in the Youth Advisory Group.
- **AH-4.3:** Provide Youth Advisory Group members with information on current and planned Title V programs and initiatives.
- **AH-4.4**: Facilitate structures and processes that meaningfully engage Youth Advisory Group members in providing meaningful input and feedback on Title V programs and initiatives.

**Strategy AH-5**: **Analyze and apply quantitative and qualitative data on adolescent health behaviors, service utilization, and outcomes to drive Title V youth-serving initiatives and programs.**

As noted for other domains above, surveillance and data analysis are core public health functions that should inform all other public health services. The use of data to maintain an ongoing and dynamic understanding of adolescent health within our state and communities is fundamental to identifying persistent and emerging issues, understanding causes and contributing factors, and evaluating the impact of our work. It is also a powerful tool for engaging, communicating with, and empowering partners – including youth, their families, and community members. This fundamental public health strategy aligns with our Needs Assessment themes related to public health program capacity and is foundational to other strategies and activities described throughout the state action plan for this domain.

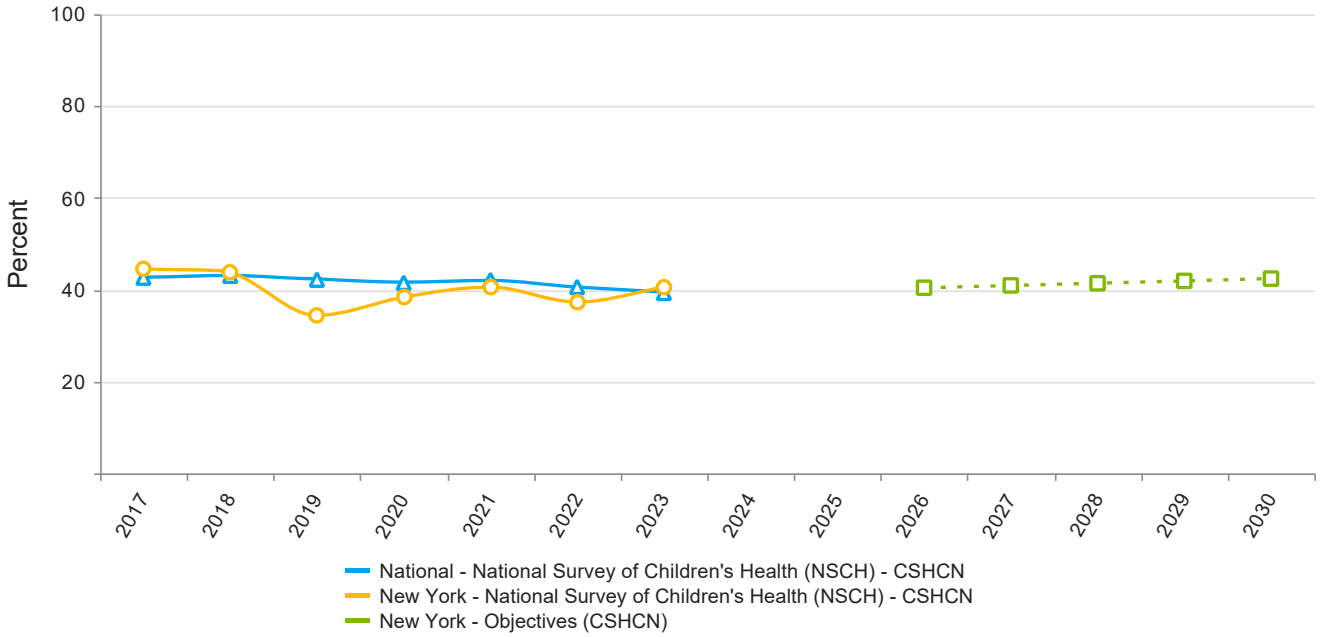
**Activities for 2025-26:**

- **AH-5.1:** Continue to review publicly available population related to adolescent health and well-being from available sources – including Vital Statistics, National Survey of Children's Health, Youth Risk Behavioral Surveillance System, and others – to identify trends and emerging issues and inform ongoing public health activities annually.
- **AH-5.2:** Continue to review state and local program data from youth-serving programs to identify areas of success and challenges and to improve program performance in key areas.
- **AH-5.3:** Explore opportunities for Title V staff training and partnerships with other state programs and agencies that manage child health data – including KIDS Count which is a comprehensive data compilation administered by the NYS Council on Children and Families (https://ccf.ny.gov/kids-count/) – to build staff knowledge and capacity for locating and applying data to Title V work. *Crossover with CH-4.2*

**Children with Special Health Care Needs**

**National Performance Measures**

**NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH Indicators and Annual Objectives**




**NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Children with Special Health Care Needs**

| Federally Available Data | | |
|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CSHCN** | | |
| | **2023** | **2024** |
| Annual Objective | | |
| Annual Indicator | 37.4 | 40.4 |
| Numerator | 274,332 | 404,726 |
| Denominator | 734,189 | 1,001,467 |
| Data Source | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | 2021_2022 | 2022_2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | 40.4 | 40.9 | 41.4 | 41.9 | 42.4 |

**Evidence-Based or –Informed Strategy Measures**

**ESM MH.1 - Percent of students attending schools that have School Based Health Centers (SBHCs) who are enrolled in the SBHC program**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2024 |
| Annual Objective | |
| Annual Indicator | 63.4 |
| Numerator | 158,604 |
| Denominator | 250,000 |
| Data Source | SBHC quarterly report |
| Data Source Year | 2022-2023 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2026 | 2027 | 2028 | 2029 | 2030 |
| Annual Objective | 65.8 | 68.1 | 70.4 | 72.7 | 75.0 |

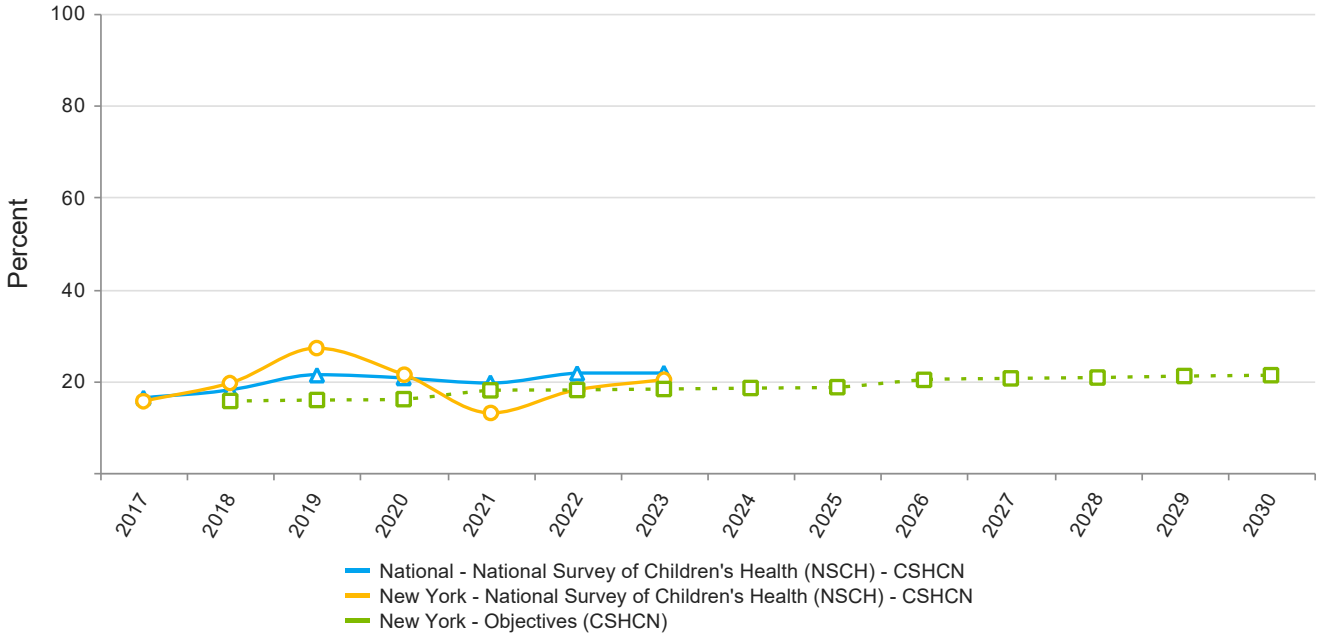
**ESM MH.2 - Percent of regular Big 6 medical home for CYSHCN peer learning meetings attended with active participation in presenting and/or responding to peer discussions.**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2026 | 2027 | 2028 | 2029 | 2030 |
| Annual Objective | 90.0 | 90.0 | 90.0 | 90.0 | 90.0 |

**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 - TAHC**
**Indicators and Annual Objectives**




**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 - TAHC - Children with Special Health Care Needs**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CSHCN** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 16.1 | 18 | 18.1 | 18.3 | 18.5 |
| Annual Indicator | 23.6 | 19.1 | 11.8 | 17.9 | 20.3 |
| Numerator | 87,040 | 73,058 | 40,243 | 59,380 | 97,868 |
| Denominator | 369,539 | 381,623 | 340,705 | 331,183 | 482,867 |
| Data Source | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | 2018_2019 | 2019_2020 | 2020_2021 | 2021_2022 | 2022_2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | 20.3 | 20.6 | 20.8 | 21.1 | 21.3 |

**Evidence-Based or –Informed Strategy Measures**

**ESM TAHC.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: | Inactive - Replaced | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 40.3 | 41.1 | 41.5 | 41.9 |
| Annual Indicator | 62.4 | 66.1 | 74.8 | 67.5 | 22.1 |
| Numerator | 295 | 323 | 450 | 291 | 193 |
| Denominator | 473 | 489 | 602 | 431 | 875 |
| Data Source | Contractor Reports | Contractor Reports | Contractor Reports | Contractor Reports | Contractor Reports |
| Data Source Year | 2019-2020 | 2020-2021 | 2021-2022 | 2022-2023 | 2023-2024 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

**ESM TAHC.2 - Percent of individuals ages 14-21 with sickle cell disease who had subsequent 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 | |
|---|---|
| | 2024 |
| Annual Objective | |
| Annual Indicator | 22.1 |
| Numerator | 193 |
| Denominator | 875 |
| Data Source | Contractor Reports |
| Data Source Year | 2023-2024 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2026 | 2027 | 2028 | 2029 | 2030 |
| Annual Objective | 22.0 | 23.1 | 24.3 | 25.5 | 26.7 |

**State Action Plan Table**

| State Action Plan Table (New York) - Children with Special Health Care Needs - Entry 1 | |
|---|---|
| **Priority Need** | |
| Promote comprehensive patient-centered care for CYSHCN | |
| **NPM** | |
| NPM - Medical Home | |
| **Five-Year Objectives** | |
| Objective CYSCHN-1: Increase the percent of children with special health care needs, ages 0-17, who have a medical home by 5%, from 40.4% in 2025 to 42.44% in 2030 | |
| **Strategies** | |
| Strategy CYSHCN-1: Support Local Health Department (LHD)-based CYSHCN programs to provide comprehensive assistance to CYSHCN and their families | |
| Strategy CYSHCN-2: Work with SBHCs to provide best practice care for children with chronic medical and developmental needs and coordinate with specialty providers as needed. | |
| Strategy CYSHCN-3: Through LHD-based Lead Poisoning Prevention Programs and Regional Lead Resource Centers, ensure that children with lead poisoning receive timely and appropriate medical and environmental follow-up services. | |
| Strategy CYSHCN-4: Convene, facilitate, and/or participate in collaborative partnerships to advance implementation of the medical home model for children and youth with special health care needs (CYSHCN). | |
| CYSHCN-5: Directly engage CYSHCN and their families in state and local efforts to improve practices, services, and systems to support them. | |
| Strategy CYSHCN-6: Apply public health surveillance and data analysis findings to improve services and systems related to health and health care for CYSHCN. | |
| **ESMs** | **Status** |
| ESM MH.1 - Percent of students attending schools that have School Based Health Centers (SBHCs) who are enrolled in the SBHC program | Active |
| ESM MH.2 - Percent of regular Big 6 medical home for CYSHCN peer learning meetings attended with active participation in presenting and/or responding to peer discussions. | Active |

## NOMs

| |
|---|
| Children's Health Status |
| CSHCN Systems of Care |
| Flourishing - Young Child |
| Flourishing - Child Adolescent - CSHCN |
| Flourishing - Child Adolescent - All |

| State Action Plan Table (New York) - Children with Special Health Care Needs - Entry 2 |
|---|
| Priority Need |
| Support transition for youth with special health care needs to adult roles and care |
| NPM |
| NPM - Transition To Adult Health Care |
| Five-Year Objectives |
| Objective CYSCHN-2: 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 20.3% in 2025 to 21.3% in 2030. (NSCH) |
| Strategies |
| Strategy CYSHCN-7: Support local and regional programs to support transition of youth with special health care needs, based on the evidence-based Got Transition® model. |
| Strategy CYSHCN-8: Facilitate partnerships between the CYSHCN Program and other youth-serving programs and agencies to identify and implement practices for holistically addressing broader health needs of CYSHCN as emerging adults. |

| ESMs | Status |
|---|---|
| ESM TAHC.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. | Inactive |
| ESM TAHC.2 - Percent of individuals ages 14-21 with sickle cell disease who had subsequent 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 |
|---|
| CSHCN Systems of Care |

**2021-2025: State Performance Measures**

**2021-2025: 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** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 3.6 | 12.1 | 12 | 11.9 |
| Annual Indicator | 3.6 | 12.1 | 10.4 | 10.4 | 9.5 |
| Numerator | 1,772 | 6,063 | 4,443 | 4,412 | 4,131 |
| Denominator | 498,946 | 502,219 | 428,592 | 423,739 | 435,672 |
| 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 | NYS Child Health Lead Poisoning Prevention Program |
| Data Source Year | 2018 | 2019 | 2020 | 2021 | 20.22 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

## Child and Youth with Special Health Care Needs Domain Annual Report for October 1, 2023 – September 30, 2024

For Children and Youth with Special Health Care Needs (CYSHCN), New York'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 CYSHCN 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 in 2017-2018. This is consistent with findings from the NYS Department of Health'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 CYSHCN.

In addition, the NYS 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 12.1 per 1,000 children tested in 2019 to below 11.8 in 1,000 children tested in 2022 (NYS Child Health Lead Poisoning Prevention Program Data).

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

**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 CYSHCN.**

Families and youth should be directly involved in meaningful roles, at all levels of program and policy planning and implementation. 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 CYSHCN-serving Title V programs.

For example, the NYS DOH Title V Program contracted with three federally designated University Centers for Excellence in Developmental Disabilities (UCEDDs), or Regional Support Centers, during this period to provide training and technical assistance to Local Health Department programs and to conduct family engagement. The Regional Support Centers were required to employ a family/parent liaison who 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 CYSHCN and they use this feedback to inform educational materials and trainings for Local Health Departments. The Children and Youth with Special Health Care Needs Regional Support Centers Family Engagement report was submitted to the Department in September of 2024. The report represents an analysis of responses to surveys and interviews that were conducted between July 2022 and September 2023. During the surveys and interviews, CYSHCN and their families reported their experiences accessing services and supports, the continued impact of COVID-19, and their interactions with their local health departments and CYSHCN programs. In total, 195 participants completed the survey, with 121 (62.1%) completing a follow-up interview. The report and recommendations were beneficial and informed CYSHCN program policy development and plans for relationship building at the state and local level.

The Regional Support Center contracts were set to expire in 2024. The department issued a competitive Request For Applications for a CYSHCN Center of Excellence on November 7, 2023. Cornell University was awarded the contract with a term of five years to start October 1, 2024. The project includes a requirement that the team of staff include at least three parent(s) or caregiver(s) of a child with a special health care need, or young adults/peers with special health care needs. Further, the CYSHCN Center of Excellence must gather feedback from CYSHCN and their families in all regions and represent the breadth of the state through listening sessions and telephone interviews as well as convening an advisory council.

In addition, the 2020-2025 Local Health Department CYSHCN program contract period includes deliverables to address family and community engagement at many levels. The local health department (LHD) CYSHCN staff involved families of CYSHCN 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, CYSHCN program activities, and to develop training for staff and providers. During this period, one local health department CYSHCN staff met with their CYSHCN Family Advisory Committee on 7/25/24 about the upcoming 2025 Community Health Assessment (CHA). Another local CYSHCN program parent participant attended a family focus group, with twelve families, focused on strengthening the system of care framework in the community. In another county, a parent served by the CYSHCN program attended the Regional Early Childhood Coalition meetings and the OPWDD Committee meetings to provide input about experiences suggestions, strengths, and barriers within their support systems of services.

Local CYSHCN programs also hosted group activities for CYSHCN and their families during the reporting period. For example, one county collaborated with community partners to host parent/child support groups and music and movement classes. The groups provided an opportunity to share information and resources as well as feedback about needs and opportunities to improve the system of care in the community.

Finally, the state's sickle cell disease contractors at five 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 the 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 2023-24 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 Council members in updates and discussions related to CYSHCN 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 CYSHCN Program engages Council members in updates and discussions related to program activities. On 6/10/24 the NYS Department of Health CYSHCN staff attended the Maternal and Child Health Services Block Grant Advisory Council meeting at which the Bureau of Child Health staff presented CYSHCN program stories from the field. The stories included a county-led family resource fair, a transition for youth workshop, and education coordinated by the local CYSHCN program and presented by the Brain Injury Association of New York State, local physician, and University athletic trainer.

**CYSHCN-1.2**: Collaborate with advocacy groups like Parent to Parent to understand the needs of CYSHCN and their families, facilitate information sharing, and promote Local Health Department CYSHCN programs.

The Title V-funded CYSHCN Program staff routinely shared information by e-mail with local health department staff state-wide about the NYS Parent to Parent Special Education Information Center workshops and resources. In January, the CYSHCN Program shared the request from Parent to Parent for a Volunteer Support Parent of a child aged 10 or younger with special needs to volunteer and provide support to parents within the community. Volunteer Support Parents share experiences, insights, and coping strategies with parents who are navigating the journey of raising a child with special needs and offer a listening ear, understanding, and empathy to parents who may be going through challenging times.

Title V Program staff participate in cross-systems workgroups to facilitate information and resource sharing to improve the systems of care for CYSHCN and their families. Kirsten Siegenthaler (Director, Division of Health), Title V Director, and Suzanne Swan (Director, Bureau of Child Health), Title V CYSHCN Director participate in a bi-weekly Deputy Commissioners' Cross-Systems Work Group coordinated by the NYS Council on Children and Families. The Deputy Commissioners' 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, Division of Family Health staff participated in the Pediatric Cross-agency Workgroup which meets quarterly and is led by the Department's Office of Health Insurance Programs (i.e., State Medicaid Program). This group convenes to discuss priorities and concerns for the CYSHCN population and to develop solutions and next steps to address them.

Division 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.

Title V Staff also participated in the "What's Great in Our State conference" on May 7, 2024, about children's mental health to learn valuable strategies and tools to wellness in the community. Strategic partnerships were developed in follow-up to participation.

Staff continued collaborations with other strategic partners to promote the CYSHCN program and share resources between programs. Title V staff met with the NYS Office of Children and Family Services HEARS (Help, Empower, Advocate, Reassure and Support) Family Line staff in February 2024. The HEARS Family Line assists 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 child care.

Additional examples of collaboration include the Healthy Families Program in November 2023, NY Connects Program in March and September 2024, the NYS Education Department about ACCESS-VR in April 2024, and the NYS Department of Labor in June and September 2024.

**CYSHCN-1.3**: Support Regional Support Centers to employ parents of CYSHCN 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 CYSHCN Program staff.

The family specialists collaborated to develop resources for CYSHCN and their families such as the System Navigation Guide; Social Media Resource; and CYSHCN 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 CYSHCN Resource Directory for 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 CYSHCN 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. Department staff continues to research opportunities to include in the Resource Directory. In addition to the Resource Directory, the Regional Support Centers have developed resources and information about services and supports for CYSHCN and their families. The Regional Support Centers continued to provide technical assistance and support to the Local Health Department staff including helping the Local Health Departments to develop county-specific Family Engagement Plans. Each plan was created uniquely with the individual county in mind. The overall objective was to increase the capacity and success rate with family engagement and services provided to the community.

Title V staff continue to develop and strengthen strategic partnerships within the Department and with other state partners and community-based organizations to provide current information about services and supports throughout NYS and NYC and to add resources to the Resource Directory.

Department staff routinely review the Local Health Departments' quarterly reports which includes updates about CYSHCN 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. Staff are regularly available and provide training and technical assistance. In March 2024, a program orientation was provided by the Department staff for new Local Health Department CYSHCN program staff. Department staff also hold routine quarterly calls to share information and resources.

**CYSHCN-1.5**: Support Local Health Department CYSHCN programs to involve CYSHCN 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 CYSHCN to develop training for CYSHCN staff and providers.

Title V staff support Local Health Department CYSHCN programs to involve CYSHCN and their families in work groups, committees, task forces or advisory committees, local health assessment and planning activities, and other systems development work. The Department of Health's Regional Office staff also provide support, resources, and technical assistance through email, phone and in-person visits.

In addition, the Title V Program contracted 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 CYSHCN 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 CYSHCN program contract includes deliverables to address family and community engagement at many levels. The Local Health Department staff involved families of CYSHCN in work groups, committees, task forces, and/or advisory committees for their perspective about how to improve the system of care for CYSHCN. To inform the next five-year cycle of grants to Local Health Departments, the Title V CYSHCN staff requested that the Local Health Department staff respond to a series of eleven questions by either written response or a one-hour Webex meeting. Responses were received September 20, 2024, and the interviews were completed in early October. Questions related to community needs assessments and how local programs engage youth and families to improve the system of care for CYSHCN were included. Examples included identifying ways families are involved in work groups, committees, task forces or advisory committees. The staff within the Division's program bureau and data bureau worked together to compile, review, and report results.

Title V staff routinely participate in professional development to support the Local Health Department program activities. Staff attend the Regional Support Centers trainings as well as Title V trainings and condition specific trainings. In March 2024, the Title V CYSHCN Program distributed a survey from NYS Office of Children and Family Services to the local CYSHCN staff to gather feedback from parents, providers, and New Yorkers at large about their experiences with childcare services, what they look for when choosing childcare, and what reflects a quality childcare program. The survey was titled "Impact Project Quality Survey Distribution".

**CYSHCN-1.6**: Engage the New York State Association of County Health Officials (NYSACHO) to promote and bolster Local Health Department CYSHCN programs to raise awareness of CYSHCN services and reach and serve more families.

The CYSHCN program contracts with the New York State Association of County Health Officials (NYSACHO) 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. On May 21 and 22, 2024, NYSACHO hosted the second annual meeting for the Early Intervention and CYSHCN Programs. Title V CYSHCN staff presented program and data updates. Many resources were shared, including presentations from Parent to Parent, the state's Medicaid Health Homes for Children, and the state's Early Hearing Detection and Intervention Program, also known as newborn hearing screening. CYSHCN Local Health Department staff presented best practices and creative ideas in a panel format. State and community-based organizations with additional resources tabled during the conference.

NYSACHO facilitated four regional webinars with local CYSHCN staff from November 14 to November 28, 2023. The purpose was to hear about the successes and challenges Local Health Department CYSHCN staff have identified while working on the program. As a result of the webinars, we identified themes, successes and best practices, challenges and recommendations to inform next steps.

**CYSHCN-1.7**: Support Sickle Cell Disease programs at five 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 five 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 five Hemoglobinopathy Specialty Care Centers regularly share information through their quarterly reports about program activities and performance measures. The five 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.

An orientation and three quarterly calls were held with the five contractors during the reporting period. The program held an orientation session for the five contractors who were awarded the Sickle Cell Disease Adolescent Transition Services contract for the 10/1/2023-9/30/2028 period. Subsequently, staff presented on Assembly Bill A2609A and Candice's Sickle Cell Fund shared information about the work their organization offers in the greater metropolitan area of New York. The Wadsworth Center Newborn Screening Program was invited to present on their efforts to detect sickle cell disease in newborns and connect them with the appropriate care and follow-up. The contractors were also provided with contact information for the Children and Youth with Special Health Care Needs program and New York State Medicaid Health Homes to help strengthen community connections to care. Finally, contractors were invited to share their Sickle Cell Awareness Month activities which included back to school activities, sickle cell walks, blood drives, family events, and advocacy groups.

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.

In December 2023, the Governor signed into law, Assembly Bill A2609A, which directs the Department's Health Council to advise the Commissioner of Health regarding sickle cell disease on issues related to the promotion of screening and detection, public education and the benefits of early detection, as well as counseling and referral services. In the spring of 2024, an intern from UAlbany School of Public Health joined the Department to compile a list of sickle cell disease stakeholders who could provide robust feedback to inform the Health Council. Two stakeholder meetings were hosted, one with health care clinicians and one with community-based organizations serving those living with sickle cell disease. The Title V CYSHCN Director/Bureau of Child Health Director, Suzanne Swan, presented twice to the Health Council about the New York State Department of Health's efforts in response to the legislation.

Title V staff collaborate with other programs within the Department. They participated in the NYS Medicaid Sickle Cell Disease Health Home Managed Care Organization Subcommittee. The subcommittee to discuss topics such as network adequacy, education and training resources for Health Homes, transition age youth, and Health Home policy.

On July 30, 2024, staff toured the Newborn Screening Center at Wadsworth Center. Staff were able to learn about the newborn screening process and how the Wadsworth Center supports newborns across the state. This opportunity allows for staff to better understand the program and assist external partners about the state's Newborn Screening Program and creates opportunities for leveraging shared priorities.

Examples of contractor activities include, on March 22, 2024, Sickle Cell Disease contractors, Brookdale and Interfaith Medical Centers, in collaboration with Sickle Cell Advisory Consortium of New York, hosted a Sickle Cell Disease Symposium for physicians, nurses, social workers, other health care professionals, community-based organizations, and patients and families. Updates about curative treatments for sickle cell disease including bone marrow transplant and gene therapy were discussed as well as presentations on the global impact of sickle cell disease, pain management, leg ulcers, and transition issues. The symposium also included a patient panel. On September 21, 2024, Sickle Cell Disease Contractors participated in a walkathon organized by the Sickle Cell Thalassemia Patients Network to raise awareness and education about sickle cell disease.

**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 CYSHCN.

Staff who support the CYSHCN initiatives actively collaborate with other Title V and Division of Family Health adolescent serving programs. The Adolescent Health unit staff within the Division Family have actively participated on the Title V CYSHCN Domain Team. The CYSHCN Domain was expanded to include staff from the Asthma Prevention Program, Early Intervention, Regional Office staff, and Wadsworth Newborn Screen. Staff shared and disseminated program resources through each other's email listservs routinely. Examples include shared information about the New York State Department of Health's School Based Health Center's Asthma Project. On 2/27/24, the Child Health Director, Sue Swan, attended the Asthma Guidance Team meeting and learned about their new program activities, including the School-Based Health Center Asthma Project in collaboration with the American Lung Association.

The Title V CYSHCN Director serves on the NYS Council on Developmental Disabilities, the Individuals and Families Committee and a Transitions Subcommittee to promote inclusion of CYSHCN-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 CYSHCN 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 sickle cell disease contractors in this work.

In this reporting period, Title V staff shared information about the Children and Youth with Special Health Care Needs and the Sickle Cell Disease Adolescent Transition Services programs with Medicaid Health Homes. Title V staff continue to be participants on 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 CYSHCN-specific focus to the Council's agenda and policy portfolio.

The Title V CYSHCN Director represents the CYSHCN program ongoing at the quarterly NYS Council on Developmental Disabilities, the Individuals and Families Committee, and a Transitions Subcommittee to promote the inclusion of CYSHCN specific focus for the Council's agenda and policy portfolio.

**Strategy CYSHCN-2: Enhance care coordination, including transition support services, for CYSHCN.**

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 2022 National Survey of Children's Health data for NYS show that about 69.9% of all children, and 56.6% of CYSHCN 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 CYSHCN and their families. Only 22.0% 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 57.4% 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 65.4% 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 22.9% 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. CYSHCN 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 CYSHCN and their families to manage their health and family needs during key periods of change and over time.

The Title V Program led program and policy activities to advance this strategy during the reporting period as described throughout the report through strategic partnerships and information sharing within the Department and with other state agencies such as the NYS Department of Labor, the Department of Health's Medicaid Health Homes for Children, and NYS Education Department, the local CYSHCN programs, Sickle Cell Disease Adolescent Transition Services contractors, and the CYSHCN Domain. The Title V Program also routinely share information and resources with the local CYSHCN programs through our listserv. In April we disseminated information about The National Alliance to Advance Adolescent Health GOT Transition on "Aging out of Public Program Services" webinar. The webinar discussed eligibility and enrollment challenges and impacts in Medicaid, Child Health Insurance Program (CHIP), Supplemental Security Income (SSI), and Title V, as well as new and innovative policy and program recommendations. It featured findings from a five-state case study that focuses special attention on youth with disabilities, including intellectual and/or developmental disabilities. Participants also heard firsthand from a self-advocate about his experiences with aging out.

**CYSHCN-2.1**: Provide funding and program guidance to Local Health Department CYSHCN 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 CYSHCN from pediatric to adult health care.

The Children and Youth with Special Health Care Needs (CYSHCN) program contracts with 51 of the state's 58 Local Health Departments to implement the CYSHCN program during the period 10/01/2020-09/30/2025. Throughout the contract year Title V staff from programmatic and data areas provided technical assistance and support to the Local Health Department staff. Program monitoring included quarterly narrative and data reports and conversations around engagement of medical providers, schools, and childcare providers and information and referrals being made by the Local Health Departments. In March of 2024, a program orientation was provided for new Local Health Department CYSHCN program staff. The title V CYSHCN team host quarterly calls to share information and resources. The Regional Support Center's continued to provide technical assistance and support to the Local Health Department staff including the development of Family Engagement Plans. The Department's Regional Office staff also provide local support and technical assistance. As noted above, the Cornell University Children with Special Health Care Needs Center of Excellence contract began on October 1, 2024.

During the Summer of 2024, a a summer intern from the University at Albany School of Public conducted a national review and thematic analysis of other state CYSHCN program models. They gathered, analyzed, and summarized information about other state's programs. The goal of this project was to compare state models and to assist in developing key informant interview questions for the 51 contracted Local Health Departments in NYS. This research informed the evolution of the work plan for the new five-year CYSHCN Program grant cycle, 10/01/2025-09/30/2030. On July 16, 2024, the intern presented her findings to the Department. The benefit of the Academic-Public Partnership between UAlbany and the Department is highlighted in the Title V Work Force Capacity and Work Force Development section.

On May 21 and 22, 2024, the second annual contractor meeting for the Early Intervention and CYSHCN Programs was held and facilitated by the New York State Association of County Health Officials. Title V CYSHCN staff presented program and data updates. Many resources were shared, including presentations from Parent to Parent, Health Homes, and Early Hearing Detection and Intervention. Additionally, CYSHCN Local Health Department staff panel presentations and tabling were held.

Title V CYSHCN staff strengthened several collaborations during this period. For example, staff met with the Department of Labor in May 2024 and the NYS Office of the Aging (Caregiver and Respite Programs and

Resources) in June 2024. The state agencies shared information and resources that were later presented on a quarterly call with the Local Health Department staff June 2024. The Respite Program presentation included state and federal partners (ARCH National Respite Network).

Other collaborations included meeting with NYS Education Department Access VR (Vocational Rehabilitation) staff on April 20, 2024, to share program resources and on June 14, 2024, to learn about the library accessibility project. On July 30, 2024, the Bureau of Child Health staff attended an in-person meeting and tour at Wadsworth Center with the Newborn Screening staff. To increase collaborative efforts, several additional programs were invited to participate on the CYSHCN Domain workgroup. Bureau of Child Health staff also participate routinely on the Child Health and Adolescent Health Domains to share resources and information across programs.

**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 CYSHCN 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 CYSHCN and their families. As described in the previous strategy, families and youth are deeply involved in guiding this work.

The CYSHCN program contracted with three Regional Support Centers throughout the period. As a part of the Centers ongoing work, staff worked with all 51 contracted Local Health Departments to develop Family Engagement Plans and provide technical assistance as needed. Additionally, the Centers distribute information and resources to Local Health Departments, which includes the CYSHCN Clips email newsletter, webinar and training information.

In October 2023, the CYSHCN resource guide was posted for staff use on the CYSHCN Portal housed by Westchester Institute for Human Development. The guide included over 770 resources to start, with contributions from both State and Local Health Departments. The Title V CYSHC staff continued efforts to explore opportunities for the resource list to be public facing.

In May 2024, the Regional Support Centers' staff tabled at the annual NYS Association of County Health Officials (NYSACHO) Early Intervention/CYSHCN conference. Staff were available to answer questions and provide resources and support to the Local Health Department staff in attendance. Some Regional Support Center highlights during the reporting period include developing a social media template and handbook for LHD staff, School Toolkit for navigating educational transitions, and five Informational Sheets (Accessing Services and Supports, Navigating the Educational System, Accessing the Community, Impact on the Family Unit, COVID-19, and the Impact of Families). Additionally, a Systems Navigation guide was developed for use as a starting point for families faced with a diagnosis and provided brief program descriptions and systems of support with contact information for families to learn more about how to access services. The Regional Support Centers also hosted several webinars that were available to Local Health Department staff. Examples include, on December 4, 2023, a webinar around the Bronx Developmental Disabilities Council. On March 25, 2024, a webinar titled "CYSHCN and FACE Centers: Opportunities in Collaboration" was held. On March 19, 2024, an educational webinar titled "Mental Health and CYSHCN".

On July 10, 2024, the Regional Support Centers were informed that the program would be ending at the end of the five-year cycle effective, September 30, 2024, On the September 2024 Local Health Department quarterly call, counties were notified that Cornell University CYSHCN Center of Excellence has been selected for an award in response to the recent request for application. On September 11, 2024, the Regional Support Centers hosted a final collaborative meeting with the Local Health Departments to showcase the collaborative efforts and resources that they developed.

**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 Local Health Department CYSHCN staff work with local school systems and medical community to support the transition of youth and young adults with special health care needs ages 14 to 21 years from pediatric to adult health care by providing information to youth and their families. One local CYSHCN program led a family resource fair that included a transition for youth workshop. The Regional Support Centers hosted webinars for staff and families of CYSHCN. One webinar was called the Guardianship and Alternatives to Guardianship: Considering the Individual Rights of People with Developmental Disabilities hosted in January of 2024. In addition, the Regional Support center staff provided on-going training and technical assistance related to family engagement plans that has been described above.

The Regional Support Center staff also developed resources for Local Health Department staff and families, which included a school toolkit to support families with CYSHCN through various stages of transition and their children's educational journey. The guide covers various topics, including early education, primary school, middle school, and high school, and a section that includes other resources and support. They also developed a Systems Navigation Guide to Help Families and Caregivers Navigate Systems of Care for Children and Youth (Birth to 21 Years of Age).

The Transition Navigators at the five contracted 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 barriers youth experience in caring for themselves.

**CYSHCN-2.4**: Administer CYSHCN 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 (98.0%) of NYS's CYSHCN are insured according to the 2022 National Survey of Children's Health data, families continue to experience financial challenges meeting the needs of their CYSHCN. The Title V Program provides funding for direct services through the CYSHCN Support Services. In 2024, 44 children received treatment services funded through CYSHCN Support Services. Services included medications (38%), medical/surgical supplies (21%), physician office visits (16%), medical tests (10%), occupational therapy or physical therapy (5%).

**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.

State funding is allocated to five 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. See CYSHCN Activity-1.7 above for details about Program activities.

**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.

As described above, there is routine contact in the form of orientation session and quarterly calls with the Centers and the care coordinators.

**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 CYSHCN including social emotional health, oral health, healthy relationships, and sexual reproductive

health.

As described in the Adolescent Health domain, staff who serve the CYSHCN programs are collaborating on shared resources, lists of programs, and webinars.

In the 2023-2024 period, the CYSHCN Domain expanded to include additional Title V and youth serving programs. The domain team members meet every six weeks to share resources and highlight work being done in their programs to support CYSHCN and their families.

The Title V CYSHCN staff partner with the Westchester Institute of Human Development to facilitate the Leadership Education in Neurodevelopmental and related Disabilities (LEND) Virtual Poster Symposium on May 2, 2024. The purpose of the Symposium is to provide an opportunity for the LEND trainees to showcase their research projects and meet with Department staff to learn about Maternal and Child Health Programs. Through their research projects, LEND trainees develop knowledge and skills to become leaders working with and on behalf of children with special health care needs, and their families, to improve health outcomes.

**CYSHCN-2.8**: Provide subject matter and technical support to NYS Medicaid Program to implement enhanced care coordination and transition support services for CYSHCN through Medicaid's Health Homes Serving Children, including integration of eligible children also receiving services through the Early Intervention Program, referral of CYSHCN to Health Homes, and transition from Health Homes Serving Children to Health Homes Serving Adults.

Enrollment data is for the time of 10/1/2023-9/30/2024: the number of children enrolled in Health Home Serving Children for this time period is reported to be 47,684 unique members, a decrease from the 50,487 children enrolled in Health Homes Serving Children for the previous year.

The fifty-one CYSHCN Local Health Department contractors and the five Sickle Cell Disease Adolescent Transition Services contractors were provided information about each other and their local Health Homes and encouraged to develop partnerships and make referrals as appropriate.
Title V staff participated on the NYS Medicaid Sickle Cell Disease Health Home Managed Care Organization Subcommittee to provide insight and feedback from contractors who serve children and young adults with sickle cell disease. The subcommittee met on December 7, 2023, April 17, 2024, and June 26, 2024, to discuss topics such as network adequacy, education and training resources for Health Homes, transition age youth, and Health Home policy. The contractors were also provided with contact information for the Children and Youth with Special Health Care Needs program and New York State Medicaid Health Homes to help strengthen community connections to care.

**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 2023-24 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 506 physicians during the 2023-2024 program year, technical assistance to providers and Local Health Department programs, individual case consultation and treatment of lead poisoning was conducted 1336 times, and chelation treatment was performed 82 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 2023-2024 program year, the three Regional Lead Resource Centers participated in 194 regional and community-based lead poisoning prevention coalition meetings. A NYS Lead Advisory Council meeting was held on November 8th, 2023. This meeting was focused on the NYS Rental Registry Program.

**Strategy CYSHCN-4: Apply public health surveillance and data analysis findings to improve services and systems related to health and health care for CYSHCN.**

The Department of Health continues to assess all available data sources to inform public health improvement strategies related to CYSHCN. A summary document titled “New York State Profile of Children and Youth with Special Health Care Needs, 2022", 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 CYSHCN 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 CYSHCN receive care in a well-functioning system. This report uses National Survey of Children’s Health data. As additional data become available, Department staff continue to update this report, make it available through the New York State Department of Health public website, and share it with CYSHCN 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 2023-24 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 CYSHCN in New York State.

Department of staff completed a careful analysis of the updated National Survey of Children’s Health to assess available measures, trends, and other updates related to CYSHCN in NYS. Based on the 2022 NYS Profile of Children with Special Health Care Needs report, key findings included that 41.0% of CYSHCN live in households with income below 200% of the federal poverty level. About 18.1% of CYSHCN have their daily activities greatly affected by their health condition(s); 17.3% of CYSHCN ages 6-17 missed 11 or more school days in a year, compared to 4.8% of NYS children without Special Health Care Needs; and nearly half (49.0%) of CYSHCN ages 6-17 had trouble making or keeping friends. Families of CYSHCN 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 2022, the five key components indicating a child meets medical home criteria showed only 39.2%

of care met the criteria, compared to 46.0% 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.

The Department's progress toward this activity is described in the Child Health domain, CH-3.1.

**CYSHCN-4.3:** Analyze and report on available CYSHCN 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 CYSHCN 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. The 2022 NYS Profile of Children with Special Health Care Needs report is posted here: https://www.health.ny.gov/community/special_needs/docs/cshcn_profile_2022.pdf

**CYSHCN-4.4:** Develop and implement plans for updating the current data reporting methods (quarterly and annual reports) of Local Health Department CYSHCN 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 CYSHCN.

Department staff developed and implemented plans for updating the current data reporting methods (quarterly and annual reports) of Local Health Department CYSHCN. Staff analyzed and shared relevant data collected from programs to improve services and inform larger program and policy work related to CYSHCN.

The Department continues to collect data from Local Health Departments including quarterly narrative submission through the Department's Health Commerce System Health Electronic Response Data System (HERDS) and quarterly CYSHCN information submission through the Person Electronic Response Data System (PERDS). Data submission guides, quick reference guide, frequently asked questions, blank forms, and training materials were sent to the Local Health Departments, and those documents were updated as needed.

Department program staff and data team staff conducted one-on-one trainings with Local Health Departments to answer questions and review the data collection tools. Staff used the data gathered from the CYSHCN programs to identify specific areas for further improvement and to inform improvement activities.

An analysis of the Local Health Department CYSHCN data for 2022-2023 program data demonstrated, a total of the 1,953 children were served, which is an 60% increase from the 1,224 children were served in 2021-2022. Based on the 2022-2023 Local Health Department CYSHCN data, 53.83% children had Medicaid, 23.85% had commercial insurance, 5.99% had Child Health Plus insurance, 9.55% had other insurance, and 2.28% had no health insurance reported. Additionally, 5.73% of children had Supplemental Security Income (SSI). The percent of children reported to have a primary care provider was 85.71%, which is an increase from the 78.4% in 2021-2022 data. 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=74, 3.79%), 34.81% needed assistance for a service not covered by insurance, 20.25% needed help with co-pays, 18.35% for a service exceeding the limit of the benefit package, 15.82% for deductible costs, and 10.76% for premium costs. In addition, information about referrals from the New York State's Early Intervention Program was included. Approximately 20.94% of CYSHCN were referred by Early Intervention Program which is drop from last year (23.70%). There was one child referred to Health Homes in 2022-2023.

**Strategy CYSHCN-5: Apply a health outcome lens to Title V activities to address the broader social issues that impact the health and well-being of children with special health care needs.**

As noted in other domains, child health outcomes are impacted by the broader social issues that are influenced by the conditions in which people are born, live, work, play, learn, and age. These social issues include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of resources are barriers to people's ability to access services

and the quality of clinical care. All ten priorities that emerged from community members' input during the needs assessment touch upon these broader social issues and needs. These factors impact the health outcomes of both individuals and entire communities.

Many NYS families of CYSHCN 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 CYSHCN and their families to engage, and ensure that there is opportunity for families to access the care they need.

The Title V Program led the following specific program and policy activities to advance this strategy over the 2023-24 year:

**CYSHCN-5.1**: Support local CYSHCN programs based in Local Health Departments.

Local CYSHCN programs based in Local Health Departments received a total of $5.2 million dollars annually. The funding supports 51 Local Health Departments state-wide, including NYC, for staff time as well as non-personal service expenses to implement the CYSHCN program during the 10/01/2023 to 09/30/2024 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 CYSHCN and their families. To strengthen the workforce, the Program provides professional development, training and technical assistance for the Local Health Department CYSHCN staff. Professional development for contractors included quarterly webinars; a state-wide contractor meeting for Early Intervention/CYSHCN staff on May 21-22, 2024; Program orientation for new staff and refresher for current staff in March of 2024 and on-going technical assistance. The Department's Regional Office staff also provide on-going support and are located closer to the programs and are familiar with local resources and communities.

Regional meetings were hosted by the NYS Association of County Health Officials (NYSACHO) and the Department of Health's staff from November 14, 2023, to November 28, 2023, to learn about the successes and challenges the Local Health Department CYSHCN staff have identified while working on the Program. The feedback informed training and resource needs, strategic partnerships, and program recommendations. 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. Quarterly webinars for LHD CYSHCN staff were facilitated by Department staff and presented by the Brain Injury Association of NYS (December 2023), NYS Office of the Aging and ARCH National Respite Network (June 2024), Department of Labor, and the Office of Mental Health *Family Resource Toolkit* (September 2024).

The Regional Support centers worked with the Local Health Departments to develop family engagement plans. They also provided a Family Engagement Plan Report that reviews the
successes and challenges faced by Local Health Departments to serve New York families.

To inform the next five-year cycle of grants to Local Health Departments, Department staff surveyed Local Health Department staff. Results from the listening sessions helped inform the Bureau of Child Health Unit staff when writing the CYSHCN workplan for the 2025-2030 contract cycle.

**CYSHCN-5.2:** Work with the Regional Support Centers and Local Health Department CYSHCN programs to integrate health outcomes into written materials, communication, outreach, and referrals for CYSHCN and families, Health literacy will be supported by providing information at appropriate reading levels and abilities.

The Program staff worked with the Regional Support Center staff and Local Health Department CYSHCN (CYSHCN) programs state-wide, including NYC, to ensure that health outcomes are integrated into written materials, communication, outreach, referrals, and engagement strategies and reflects the community. Health literacy was

supported by encouraging counties to provide accessible information at appropriate reading levels and abilities.

The Department's Health Information Document is a pre-folded pocket card resource for CYSHCN 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.

On April 30, 2024, the School of Public Health Intern that was employed in the Summer of 2023, presented at a poster session at SUNY Albany about her intern project that looked at the Children and Youth with Special Health Care Needs Program. She provided a thematic analysis of quarterly narrative reports with a focus on local CYSHCN program activities that focused on access to respectful care and health outcomes during the 2021-2022 fiscal year.

**CYSHCN-5.3**: Develop and implement data collection systems that allows Local Health Department CYSHCN programs and Sickle Cell Disease care transition grantees to identify, track, and address barriers to care.

Program information is collected from Bureau of Child Health contractors quarterly in narrative and data report templates. The data systems on the Health Commerce System are a secure online system supporting the exchange of health information by Local Health Department CYSHCN program staff. Department staff and Local Health Department CYSHCN program staff can access data in a timely manner to identify, track, and address successes and barriers to care among CYSHCN. Department staff 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 support access to high-quality, respectful care.

Department staff partnered with key stakeholders such as Parent to Parent, Local Health Departments, and Regional Support Centers to identify and share best practices.

On May 22, 2024, Parent to Parent presented at the second annual CYSHCN and Early Intervention conference facilitated by the New York State Association of County Health Officials (NYSACHO). The Department staff routinely share information and resources from partners with the Local Health Department staff. A newsletter was shared from Lucile Packard Foundation. The newsletter included information from the American Academy of Pediatrics about their policy statement to optimize Medicaid and CHIP and a factsheet that provided an overview on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), along with a snapshot and data related to EPSDT. The newsletter also included information to register for webinars on "Personal/Attendant Care - What Does it Mean and Who Qualifies?", "Leveraging Medicaid to Support Children and Youth Living with Complex Behavioral Needs", and "Visualizing Loss" Films. Another example is a webinar/speaker series hosted by the Center for Transition to Adult Health Care for Youth with Disabilities on "Healthcare Transition: Options for Providing Decision- Making Support for Youth with Intellectual and/or Developmental Disabilities".

Regional Support Centers produce a newsletter for the Local Health Department CYSHCN Program staff and partners called CYSHCN Clips. The newsletter features news, events, and resources supporting CYSHCN in NY state.

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 Adolescent Transition Services 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.

Five hemoglobinopathy centers were awarded a contract as a result of the request for application, Sickle Cell Disease Adolescent Transition Services, for the 10/1/2023 to the 09/30/2028 period. Two of the five contractors had been funded for the previous Coordinating Care and Supporting Transition for Children, Adolescents and Young Adults with Sickle Cell Disease program. The start-up for the contracts included a program orientation and contractor efforts to establish their staff and program models. The number of individuals ages 14-21 who kept a routine medical appointment and completed transition readiness assessments for this period was 297 individuals or 37%. We anticipate an improved data report next year since the contractors have established their programs during the first year.

## Children and Youth with Special Health Care Needs (CYSHCN) Application Year (FY26)

For the upcoming Title V grant cycle from 2025-30, our Title V Program will focus on two key priorities to promote comprehensive patient-centered health care for CYSHCN and support transition for youth with special health care needs to adult roles and care. These align with two NPMs: **NPM – Medical Home:** percent of children with special health care needs, ages 0 through 17, who have a medical home and **NPM – Transition**: Percent of adolescents with special health care needs, ages 12-17, who received services to prepare for transition to adult health care. Medical Home for CYSHCN is a new universal NPM for 2025-30, and Transition is a continued NPM from the 2021-2025 cycle.

As discussed in the Child Health domain plan, ongoing primary and preventive health care delivered through a medical home is foundational to supporting children's health and is especially critical for children and youth with special health care needs. CYSHCN are defined as those who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and require health and related services beyond those generally needed by other children. The central importance of the medical home model - defined by the American Academy of Pediatrics (AAP) as an approach to care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective - is strongly supported by our Needs Assessment findings for CYSHCN and their families. Within this broader medical home framework, the elements of continuity and care coordination specifically highlight the critical need to support youth with special health care needs as they transition from child to adult roles, responsibilities, and health care systems.

The strategies and accompanying activities for the upcoming grant year for this domain are summarized in our State Action Plan Table and described further below. While this domain focuses specifically on CYSHCN, it is important to recognize that the objectives and strategies in the companion Child Health and Adolescent Health domains also apply to CYSHCN, and there is significant intersection between these three domains.

**Strategy CYSHCN-1: Support Local Health Department (LHD)-based CYSHCN programs to provide comprehensive assistance to CYSHCN and their families**

The Local Health Department-based CYSHCN Program is the core Title V initiative for supporting CYSHCN from birth through 21 years of age. These local CYSHCN programs provide families with education about available services, assist in obtaining health insurance, facilitate referrals to primary and specialty medical providers as well as other community support resources, and help families navigate local health, education, and social services systems. For the new five-year funding cycle set to begin October 2025, the LHD CYSHCN grant workplan was updated to expand its focus on population-based approaches and partnerships, alongside continued individual/family-based information, gap-filling resources and referral services.

In addition to the core LHD CYSHCN program, nine counties currently participate in an additional optional county-administered CYSHCN-Supportive Services (CYSHCN-SS) program component. The CYSHCN-SS program provides direct gap-filling financial assistance to families for out-of-pocket medical expenses not covered by their health insurance, consistent with county-established eligibility criteria and approval processes. Although the scope of the CYSHCN-SS is limited by funding and county participation, the program addresses a meaningful access barrier for families facing financial barriers to their children's care.

Title V staff support for local CYSHCN programs is augmented through a statewide CYSHCN Center of Excellence (COE), funded through Title V and based at Cornell University's Bronfenbrenner Center for Translational Research. The COE supports local programs by providing training and technical assistance, maintaining the CYSHCN Resource Directory, and facilitating family engagement at both state and local levels.

This strategy is consistent with evidence from the MCH Evidence Center and the *Blueprint for Change*, which demonstrate that proactive linkage to coordinated health and community services improves health outcomes for CYSHCN populations and is a cornerstone of building high-performing, family-centered systems of care. It aligns with our Needs Assessment themes related to health information and literacy, social support, access to health care, mental health, and other community services, service coordination and navigation, community factors influencing health, public health partnerships, and program capacity and workforce.

**Activities for 2025-26:**

- **CYSHCN-1.1:** Support grant contracts with 53 Local Health Department (LHD)-based CYSHCN programs for a new five-year funding cycle beginning October 1, 2025. Monitor local CYSHCN LHD contracts and services through quarterly reports, quarterly grantee calls, and ongoing communication with individual grantees. Facilitate sharing of challenges and best practices among LHD CYSHCN programs through

listservs, quarterly provider calls, webinars, and an annual meeting.

- **CYSHCN-1.2:** For participating counties, allocate funding, review claims from LHDs, and reimburse approved claims consistent with CYSHCN-SS program guidance and public health law. Monitor the program through annual reports.
- **CYSHCN-1.3:** Continue grant funding to support the CYSHCN Center of Excellence (10/1/24- 9/30/29). Through the COE, provide training and technical assistance to support LHDs in effectively implementing the program, with a focus on the medical home model and performance measures. Maintain and update the CYSHCN Resource Directory to ensure families have resources and incorporate at least one new training and/or resource related to the Medical Home model for CYSHCN.
- **CYSHCN-1.4:** In collaboration with Department's Office of Science, continue and enhance engagement with the New York State Association of County Health Officials (NYSACHO), which is the statewide membership association for LHDs, to promote and support LHD-based CYHSHCN programs through participation in LHD calls and meetings and dissemination of information and resources.

**Strategy CYSHCN-2: Work with SBHCs to provide best practice care for children with chronic medical and developmental needs and coordinate with specialty providers as needed.**

As detailed in the Child Health domain action plan, School-Based Health Centers (SBHCs) are a critical access point for primary and preventive health care services for many children in New York State, including those with chronic medical and developmental needs. By operating directly within schools, SBHCs reduce common barriers to care, such as transportation, scheduling challenges, and time away from school or work, which is especially significant for families of CYSHCN. SBHCs are frequently involved in supporting students with 504 plans, which provide individualized accommodations under federal civil rights law to ensure students with disabilities can access and succeed in school settings. They may serve as a child's primary care provider (PCP) or in coordination with outside PCP and they communicate and coordinate with additional specialty medical or other service providers.

Research shows that SBHCs are effective in reducing emergency department use and improving health outcomes, particularly for children with chronic conditions or special needs. Studies have found that students served by SBHCs are more likely to receive disease-specific education, follow-up care, and care coordination than those in schools without SBHCs. These outcomes align closely with Title V goals for CYSHCN and reinforce the importance of integrating CYSHCN priorities into SBHC programming.

Within the Division of Family Health's Bureau of Child Health, CYSHCN and SBHC program staff collaborate to promote the integration of best practices for managing chronic conditions and other special health care needs within SBHCs, and to strengthen communication among SBHCs, local health department CYSHCN programs, schools, and community service providers. Cross-program collaboration, including resource sharing and joint planning, helps ensure SBHC providers have the tools, knowledge, and referral connections needed to deliver patient-centered care tailored to the needs of CYSHCN.

This strategy aligns with our Needs Assessment themes related to access to health and mental health care services, patient-centered care, service coordination, public health partnerships, and public health program capacity and workforce.

**Activities for 2025-26:**

- **CYSHCN-2.1:** Within the Division of Family Health, continue and enhance collaboration between CYSHCN and SBHC program staff to share information, resources, and best practices, and coordinate efforts supporting children with chronic and developmental needs through cross-participation in respective Title V domain teams and ongoing communication.
- **CYSHCN-2.2:** Through the CYSHCN Title V Domain Team and with support from the CYSHCN COE, facilitate at least one shared training for state staff on the Medical Home model and related evidence-based practices and resources relevant to the SBHC setting.
- **CYSHCN-2.3:** Provide local SBHC operators and providers with updated contact information, resource materials, and training opportunities relevant to Local Health Department CYSHCN programs, and facilitate communication pathways between SBHCs, LHD CYSHCN programs, schools, and community service providers to improve care coordination for CYSHCN.
- **CYSHCN-2.4:** Within the Department, explore opportunities for Title V staff training related to children's health insurance and health care quality initiatives, including the NYS Patient-Centered Medical Home, to ensure staff have the knowledge and capacity to incorporate current information and resources across all child-serving Title V programs. (*Overlaps with CH-2.5)*

**Strategy CYSHCN-3: Through LHD-based Lead Poisoning Prevention Programs and Regional Lead Resource Centers, ensure that children with lead poisoning receive timely and appropriate medical and environmental follow-up services.**

Lead poisoning remains a significant public health concern for children in NYS, with well-documented adverse effects on cognitive development, behavior, and overall health. LHD-based Lead Poisoning Prevention Programs work closely with families, health care providers, and community partners to provide community-wide education, identify children with elevated blood lead levels, coordinate medical evaluation and treatment, and facilitate environmental investigations and remediation to reduce ongoing exposure. Regional Lead Resource Centers (RLRCs) provide specialized medical expertise and support to LHDs, enhancing their capacity to respond effectively to lead poisoning cases and promote prevention efforts. These Title V-supported programs are administered and managed through the Department's Center for Environmental Health. They are part of a comprehensive public health approach that integrates education, medical care, environmental intervention, and family support, and complements other state-funded primary prevention strategies to reduce sources of lead in children's environments before they are exposed.

This approach aligns with CDC evidence indicating that timely identification and coordinated follow-up care significantly reduce lead exposure-related harms and improve long-term developmental outcomes. Furthermore, multi-component lead prevention programs combining environmental interventions with family education and healthcare coordination are recognized as best practices for reducing blood lead levels. This strategy aligns with our Needs Assessment themes focused on health information and literacy, health care access and experience, service coordination and navigation, community and behavioral factors contributing to health, and public health program capacity and workforce. Activities for Strategy CYHSHCN-3 are led by our partners in the Department's Center for Environmental Health.

**Activities for 2025-26:**

- **CYSHCN-3.1:** Continue grant funding and support for Local Health Department-based Lead Poisoning Prevention Programs to conduct outreach, screening, case management, and follow-up services for children with elevated blood lead levels.
- **CYSHCN-3.2:** Continue grant funding to support Regional Lead Resource Centers to provide specialized medical consultation, training, and technical assistance to Local Health Departments and healthcare providers to improve management and prevention of lead poisoning.
- **CYSHCN-3.3:** Monitor and evaluate lead poisoning prevention program performance through quarterly data reporting to identify gaps and inform continuous quality improvement.
- **CYSHCN-3.4:** continue to partner with state and local environmental and housing agencies to support primary prevention initiatives that reduce lead exposure sources in communities at risk, as part of a comprehensive continuum of public health prevention for childhood lead poisoning.

**Strategy CYSHCN-4: Convene, facilitate, and/or participate in collaborative partnerships to advance implementation of the medical home model for children and youth with special health care needs (CYSHCN).**

As emphasized in our Needs Assessment, collaborative partnerships are central to our approach to improving systems of care for CYSHCN. This strategy supports the dissemination and implementation of the medical home model by leveraging national, state, and local partnerships. As part of this work, Title V staff actively participate in the "Big 6" Peer Learning Collaborative, which brings together the six largest states (California, Texas, Florida, Pennsylvania, Illinois, and New York) to strengthen care systems through shared learning and exchange. Within this group, there is a subgroup which focuses on Medical Home for CYSHCN. The medical home model is a well-supported, evidence-based approach that improves care coordination, family engagement, and health outcomes for CYSHCN.

Within the Division of Family Health, the NYS CYSHCN Domain Workgroup brings together representatives from across Title V programs serving CYSHCN. Through quarterly meetings, periodic reporting, and ongoing interim communication, this group facilitates sharing information and promoting alignment of efforts to implement the Title V State Action Plan. In the upcoming project year, this group will engage our academic practice partner at UAlbany MCH Program to further enhance its work.

This strategy aligns with our Needs Assessment themes related to systems coordination, workforce capacity, and patient- and family-centered care, and directly impacts the new universal national performance measure on medical home for CSYCHN and our associated **ESM CYHSHCN-1**: Percent of regular Big 6 medical home for CYSHCN peer learning meetings attended with active participation in presenting and/or responding to peer discussions.

**Activities for 2025-26:**

- **CYSHCN-4.1:** Participate in the Title V CYSHCN "Big 6" peer learning collaborative, which includes regular meetings focused on advancing implementation of the medical home model. NYS Title V staff will actively engage in these sessions by presenting, co-leading, and responding to peer discussions.
- **CYSHCN-4.2:** Utilize available resources and trainings related to medical home implementation offered by national, state, and local partners. For this project year this specifically will include exploring resources and opportunities through the National Center for Medical Home Implementation.
- **CYSHCN-4.3:** Share relevant medical home resources and implementation strategies with other Department youth-serving programs and with the newly established Youth Advisory Group through regular meetings and electronic communications.
- **CYSHCN-4.4:** Participate in Adolescent Health and Child Health Domain activities to identify shared priorities and opportunities for promoting comprehensive, patient-centered care for CYSHCN.
- **CYSHCN-4.5:** Serve on the NYS Council on Developmental Disabilities and its Individuals and Families Committee to ensure inclusion of CYSHCN-specific priorities in the Council's agenda and policy development. The Council includes parents of CYSHCN who play a direct role in decision-making.
- **CYSHCN-4.6:** Collaborate with key state partners, including Medicaid, the Office for People with Developmental Disabilities, the Office of Children and Family Services, and the Office of Mental Health, to identify shared priorities and opportunities to strengthen systems of care for CYSHCN.

**Strategy CYSHCN-5: Directly engage CYSHCN and their families in state and local efforts to improve practices, services, and systems to support them.**

New York's Title V program recognizes youth and family engagement as essential to systems improvement for CYSHCN. As emphasized in our Needs Assessment, we have taken intentional steps to center youth and family voices in shaping priorities, identifying barriers, and developing and implementing solutions across all levels of our work. This strategy reflects our commitment to ensuring that CYSHCN and their families are actively involved in informing policies, improving services, and building more responsive, inclusive systems of care. By creating structured opportunities for engagement at both the state and local levels, we aim to ensure that our policies and programs are respectful, responsive, and grounded in authentic collaboration that recognizes the unique strengths and expertise of families and youth. This approach is supported by a strong evidence base, including research synthesized through the MCH Evidence Center and key frameworks such as the *Blueprint for Change*, which identify family partnership as a cornerstone of high-performing systems for CYSHCN. This strategy aligns with Needs Assessment themes related to social support, family-centered care, behavioral and community determinants of health, public health partnerships, and overall program capacity.

**Activities for 2025-26:**

- **CYSHCN-5.1:** In conjunction with the CYSHCN Statewide Center of Excellence (COE), provide grant funding and program guidance to LHD CYSHCN programs to support youth and family engagement, including gathering direct input from youth and families through listening sessions, participation on advisory groups or workgroups, and other approaches as outlined in the new LHD CSYHCN grant workplan.
- **CYSHCN-5.2:** Fund and oversee the CYSHCN COE team, which includes a project director and at least three individuals with lived experience such as parents, caregivers, or young adults with special health care needs who help lead and deliver program supports and services for statewide programming.
- **CYSHCN-5.3:** Provide grant funding to the CYSHCN COE to develop and facilitate a standing Advisory Council composed of youth with special health care needs and their families/caregivers to increase awareness, improve access, and inform system navigation strategies.
- **CYSHCN-5.4:** Maintain a dedicated family representative on the Title V Advisory Council and engage all Council members in updates and discussions related to CYSHCN activities.
- **CYSHCN-5.5:** Collaborate with professional and advocacy organizations, such as Parent to Parent of NYS (the state's federally funded Family2Family Information Center) to understand family and youth needs, promote local CYSHCN program visibility, and support family-to-family and peer information exchange.

**Strategy CYSHCN-6: Apply public health surveillance and data analysis findings to improve services and systems related to health and health care for CYSHCN.**

As noted in other domains above, surveillance and data analysis are core public health functions that should inform all other public health services. The use of data to maintain an ongoing and dynamic understanding of the health and well-being of CYSHCN and their families within our state and communities is fundamental to identifying persistent and emerging issues,

understanding causes and contributing factors, and evaluating the impact of our work. It is also a powerful tool for engaging, communicating with, and empowering partners, including families and community members.

New York's Title V program is committed to using data not only to inform internal planning and quality improvement efforts, but also to identify persistent and emerging needs, assess access and outcomes, and support local and state-level system change. This approach is grounded in a strong evidence base, including research synthesized by the MCH Evidence Center and key frameworks such as the *Blueprint for Change*, which underscore the critical role of actionable data in creating coordinated, effective systems of care. This fundamental public health strategy aligns with our Needs Assessment themes related to public health program capacity and is foundational to other strategies and activities described throughout the state action plan for this domain.

**Activities for 2025-26:**

- **CYSHCN-6.1:** Maintain and enhance the centralized, web-based data reporting system for local CYSHCN programs through the state's Health Commerce System (HCS).
- **CYSHCN-6.2:** Collaborate across the Bureau of Data Analysis, Research and Evaluation (BDARE) and the Bureau of Child Health (BCH) to analyze quarterly narrative and data reports submitted by local CYSHCN programs via HCS. Use findings to identify improvement opportunities, particularly related to medical home, and to guide quality improvement efforts.
- **CYSHCN-6.3:** Share and review annual state and local CYSHCN program data with Local Health Departments to support continuous monitoring, program evaluation, and improvement. Promote use of the real-time data dashboard available to LHDs through HCS.
- **CYSHCN-6.4:** Analyze relevant state-level data related to CYSHCN and their families - including findings from the National Survey of Children's Health and other available sources - to identify trends and emerging issues. Use findings to inform Title V program activities.
- **CYSHCN-6.5:** Disseminate synthesized findings in public-facing reports and through direct outreach to Local Health Departments and stakeholders via the Department's website and communication channels.
- **CYSHCN-6.6:** Explore opportunities for staff training and partnerships with other state programs and agencies that manage child health data – including KIDS Count which is a comprehensive data compilation administered by the NYS Council on Children and Families (https://ccf.ny.gov/kids-count/) – to strengthen capacity for locating, interpreting, and applying data to Title V activities focused on CYSHCN.

**Strategy CYSHCN-7: Support local and regional programs to support transition of youth with special health care needs, based on the evidence-based Got Transition® model.**

The transition from pediatric to adult health care is a pivotal period for youth with special health care needs (CYSHCN). Coordinated planning and support during this time can significantly improve long-term health outcomes, foster independence, and enhance quality of life. Evidence from the MCH Evidence Center and the *Blueprint for Change* underscores that structured, comprehensive transition programs reduce gaps in care, lower emergency department use, and increase patient and family satisfaction. Effective transition services are developmentally appropriate, family-centered, and include care coordination, peer support, and strong connections to health and community resources.

Within our Title V Program, New York State funds Hemoglobinopathy Specialty Care (HSC) Centers to provide specialized, regional support for adolescents and young adults with sickle cell disease (SCD)—one of the largest and most medically vulnerable CYSHCN populations. These centers focus on care coordination, navigation, and transition to adulthood, addressing the unique challenges faced by youth with SCD, including limited access to adult specialty care and complex barriers to navigating the health system. HSCs implement a comprehensive transition care model aligned with the nationally recognized Got Transition® Six Core Elements, which includes transition readiness assessments, peer support, family engagement, appointment support, and linkages to social and medical services.

In addition, we are working with the CYSHCN Center of Excellence (COE) to apply lessons from the SCD program to strengthen transition supports across all LHD-based CYSHCN programs statewide. These efforts complement broader work with the NYS Medicaid Program to implement Health Homes Serving Children, which fund care coordination services —including transition planning—for eligible youth with special health care needs.

This strategy addresses key Needs Assessment themes, including health information and literacy, social support, access to care, patient-centered experiences, navigation and coordination of services, public health partnerships, and program capacity. It also supports our selected National Performance Measure on transition and directly impacts **ESM CYSHCN-2:** Percent of individuals ages 14–21 with sickle cell disease who had transition readiness assessments completed, among those served through the Sickle Cell Disease Care Transition program and who kept a routine medical appointment.

**Activities for 2025-26:**

- **CYSHCN-7.1:** Provide grant funding to five Hemoglobinopathy Specialty Care Centers (certified through NYS Wadsworth Center) to support smooth transition for adolescents and young adults (ages 12 to 21) with sickle cell disease into adult health care through comprehensive care coordination and navigation services. (10/1/23 – 9/30/28).
- **CYSHCN-7.2:** Through the CYSHCN Center of Excellence contract, deliver training and technical assistance to LHD CYSHCN programs focused on supporting transition services for adolescents and young adults, and facilitate shared learning between Hemoglobinopathy Specialty Care Centers grantees and LHD CYSHCN programs around challenges and best practices.
- **CYSHCN-7.3:** Administer legislatively allocated funding to specific community-based organizations serving young people with sickle cell disease to support parallel or complementary goals with the Hemoglobinopathy Specialty Care Centers.
- **CYSHCN-7.4:** Monitor Sickle Cell Disease Transition, CYSHCN, and Center of Excellence program implementation and expenditures through quarterly reports, routine meetings, and ongoing contract management communication.
- **CYSHCN-7.5:** Maintain ongoing consultation with the Medicaid Health Homes program to ensure MCH public health perspectives and expertise are incorporated in this key program for providing and funding care coordination services for CYSHCN.

**CYSHCN-8: Facilitate partnerships between the CYSHCN Program and other youth-serving programs and agencies to identify and implement practices for holistically addressing broader health needs of CYSHCN as emerging adults.**

New York's Title V program recognizes that supporting youth with special health care needs into emerging adulthood requires a holistic, cross-sector approach that goes beyond medical care to address social emotional health, healthy relationships, sexual health, and other key aspects of well-being and adult readiness. Within the Division of Family Health, this strategy fosters collaboration with other Title V youth-serving programs, such as School-Based Health Centers, Comprehensive Adolescent Pregnancy Prevention Programs, and Sexual Violence Prevention, through cross-program participation in domain teams, with CYSHCN staff contributing to the Adolescent and Child Health teams, and reciprocally, those program staff engaging in the CYSHCN domain team. It also encompasses expanding collaboration with other relevant Department programs, such as chronic disease prevention, cancer screening, disability health, and Medicaid, and other relevant state agencies and organizations.

Collaborative efforts are grounded in evidence that integrated, youth-centered approaches improve health outcomes, self-efficacy, and readiness for adult roles. The MCH Evidence Center and frameworks like the *Blueprint for Change* emphasize the importance of multi-sector partnerships and youth engagement in designing responsive, accessible programs that address both clinical and social determinants of health. Additionally, the *Positive Youth Development* framework described in the Adolescent Health domain supports this strategy's emphasis on building strengths, fostering supportive environments, and preparing youth for independence and adult systems.

This strategy aligns with Needs Assessment themes including health information and literacy, health care access and experiences, social support and stress, mental health, public health partnerships, and public health systems.

**Activities for 2025–2026:**

- **CYSHCN-8.1:** Support collaboration between Hemoglobinopathy Specialty Care Center Sickle Cell Disease Transition programs, LHD-based CYSHCN programs, and Medicaid Health Homes for children to promote sustained health care engagement for emerging adults with special health care needs.
- **CYSHCN-8.2:** Facilitate information-sharing and joint planning with other Department youth-serving programs through regular meetings and ongoing communications.
- **CYSHCN-8.3:** Engage the CYSHCN Center of Excellence Advisory Council and new Youth Advisory Group (see Adolescent Health domain) to gather stakeholder input and inform program planning on adolescent and young adult health.
- **CYSHCN-8.4:** Explore potential interagency collaboration with state partners such as the Department of Labor, Office for People with Developmental Disabilities, and State Education Department to align supports for CYSHCN transitioning to adulthood.

**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

Our Title V Program is deeply committed to ongoing, meaningful partnerships with families, community members, and frontline providers. As outlined throughout this application, we engaged a wide range of partners and stakeholders in developing our 2025–30 Title V Maternal and Child Health Services Block Grant Needs Assessment and State Action Plan. Using a comprehensive, multi-method approach, we actively sought feedback from families, youth, community members, Maternal and Child Health (MCH) service providers, and other key stakeholders, ensuring the voices of those most affected by MCH issues directly shaped our work. This robust engagement process was central to identifying priorities and shaping the strategies for our State Action Plan, as further described in the Needs Assessment Summary.

Our Title V Program conducted extensive outreach across New York State, partnering with 26 community-based organizations to host 71 listening sessions in 30 counties, engaging over 880 participants in total. These in-person and virtual sessions allowed families and community members to share their experiences and perspectives on MCH needs in an open, supportive environment. Sessions included forums with recent mothers focused on pregnancy, birthing experiences, and maternal health. We also conducted surveys and interviews with 250 families, as well as 195 families with children and youth with special health care needs (CYSHCN), ensuring broad representation across the state. In addition to these targeted efforts, we hosted a web-based public survey available in multiple languages. We also gathered valuable input from over 280 frontline MCH providers through a combination of surveys and listening sessions. The feedback from all sources was rigorously analyzed to identify core themes and authentic insights directly from community members.

Recognizing the importance of internal expertise, we also engaged our Title V staff, who bring a wealth of both professional and personal perspectives to the process. In Fall 2024 and Spring 2025, we convened staff listening forums and a full-day strategic planning retreat, with over 100 Division of Family Health (DFH) staff members contributing their insights.
We also consulted with the NYS Title V Maternal and Child Health Services Block Grant Advisory Council, chaired by a retired MCH public health nurse with decades of service as a local health department director. The Council includes representation from community-based organizations, health care providers, advocacy groups, and a parent leader from the state's Family to Family Information Center, who brings personal experience as a parent of a child with special health care needs. In June 2025, we met with the Advisory Council to review the Needs Assessment findings, share resulting priorities, and discuss the translation of these findings into actionable strategies for the State Action Plan. The Council offered valuable feedback and reaffirmed its ongoing support for our work in the next five-year cycle.

The insights gathered through this inclusive, multi-faceted process directly informed the identification of seven priorities and ten cross-cutting themes that will guide our approach to addressing these priorities and associated performance measures in the 2025–30 State Action Plan.

This application process has reaffirmed NYSDOH’s commitment to meaningful public engagement. The full Title V application will be posted on our public website, and as we implement our action plan and track progress, we will continue to solicit input from families, community members, providers, and other stakeholders—including our Title V Advisory Council. We will also facilitate ongoing input for continuous updates to our Needs Assessment through additional listening sessions, surveys, and other opportunities for engagement.

## III.G. Technical Assistance

NYS's Title V Program welcomes opportunities for technical assistance facilitated by Health Resources and Services Administration's Maternal and Child Health Bureau.

One specific area of technical assistance that is much appreciated is the continued support to convene 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 ongoing support for collaborations between what are now the "Big 6" States – California, Texas, Florida, Pennsylvania, Illinois, and New York. Pennsylvania recently joined the group when Census data demonstrated that they had an increase in population above Illinois. These sessions 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 to support the improvement of postpartum visits as part of the Women and Maternal Health domain.

NYS benefits from webinars and technical assistance more broadly across the nation. Topics of interest include 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, and state efforts to identify and address maternal mortality and morbidity. Another topic of importance is supporting individuals experiencing substance use disorders in the development and implementation of Plans of Safe Care. Finally, discussions with colleagues in other states on establishing policy to promote systems change, identifying evidence-based or evidence-informed practices on an ongoing basis, modifying evidence-based programs in more rural areas where resources are limited would be important.

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 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, 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.

## IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - VIII. Medicaid IAA.pdf

## V. Supporting Documents

No Supporting documents were provided by the state.

## VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - VI. DOH-OPH-CCH-DFH Org Charts July 2025.pdf

## VII. Appendix

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## Form 2
## MCH Budget/Expenditure Details

**State: New York**

| | FY 26 Application Budgeted | |
|---|---|---|
| 1. FEDERAL ALLOCATION<br>(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 | $ 13,446,532 | (34.5%) |
| B. Children with Special Health Care Needs | $ 22,201,034 | (57%) |
| C. Title V Administrative Costs | $ 2,618,926 | (6.8%) |
| 2. Subtotal of Lines 1A-C<br>(This subtotal does not include Pregnant Women and All Others) | $ 38,266,492 | |
| 3. STATE MCH FUNDS<br>(Item 18c of SF-424) | $ 29,285,355 | |
| 4. LOCAL MCH FUNDS<br>(Item 18d of SF-424) | $ 62,996,303 | |
| 5. OTHER FUNDS<br>(Item 18e of SF-424) | $ 0 | |
| 6. PROGRAM INCOME<br>(Item 18f of SF-424) | $ 24,747,426 | |
| 7. TOTAL STATE MATCH<br>(Lines 3 through 6) | $ 117,029,084 | |
| A. Your State's FY 1989 Maintenance of Effort Amount<br>$ 58,268,752 | | |
| 8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL<br>(Total lines 1 and 7) | $ 155,938,894 | |
| 9. OTHER FEDERAL FUNDS<br>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) | $ 72,835,998 | |
| 11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL<br>(Partnership Subtotal + Other Federal MCH Funds Subtotal) | $ 228,774,892 | |

| OTHER FEDERAL FUNDS | FY 26 Application Budgeted |
|---|---|
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP) | $ 3,656,266 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants | $ 28,644,959 |
| 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) | $ 12,654,399 |
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE) | $ 2,809,003 |
| Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Medicaid Match | $ 13,262,441 |

| | FY 24 Annual Report Budgeted | | FY 24 Annual Report Expended | |
|---|---|---|---|---|
| 1. FEDERAL ALLOCATION<br>(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year) | $ 38,909,810<br>(FY 24 Federal Award: $ 39,813,564) | | $ 37,194,406 | |
| A. Preventive and Primary Care for Children | $ 13,769,335 | (35.4%) | $ 15,022,272 | (40.3%) |
| B. Children with Special Health Care Needs | $ 21,713,203 | (55.8%) | $ 18,665,715 | (50.1%) |
| C. Title V Administrative Costs | $ 2,814,956 | (7.2%) | $ 3,169,650 | (8.6%) |
| 2. Subtotal of Lines 1A-C<br>(This subtotal does not include Pregnant Women and All Others) | $ 38,297,494 | | $ 36,857,637 | |
| 3. STATE MCH FUNDS<br>(Item 18c of SF-424) | $ 29,285,355 | | $ 29,285,355 | |
| 4. LOCAL MCH FUNDS<br>(Item 18d of SF-424) | $ 47,389,317 | | $ 67,986,422 | |
| 5. OTHER FUNDS<br>(Item 18e of SF-424) | $ 0 | | $ 0 | |
| 6. PROGRAM INCOME<br>(Item 18f of SF-424) | $ 18,762,687 | | $ 22,057,913 | |
| 7. TOTAL STATE MATCH<br>(Lines 3 through 6) | $ 95,437,359 | | $ 119,329,690 | |
| A. Your State's FY 1989 Maintenance of Effort Amount<br>$ 58,268,752 | | | | |
| 8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL<br>(Total lines 1 and 7) | $ 134,347,169 | | $ 156,524,096 | |
| 9. OTHER FEDERAL FUNDS<br>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) | $ 66,910,483 | | $ 61,356,351 | |
| 11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL<br>(Partnership Subtotal + Other Federal MCH Funds Subtotal) | $ 201,257,652 | | $ 217,880,447 | |

| OTHER FEDERAL FUNDS | FY 24 Annual Report Budgeted | FY 24 Annual Report Expended |
|---|---|---|
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP) | $ 2,636,629 | $ 2,636,629 |
| 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 | $ 8,613,186 |
| Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning | $ 11,808,930 | $ 11,376,841 |
| US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA) | $ 27,142,871 | $ 27,142,871 |
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE) | $ 3,446,426 | $ 3,020,045 |
| Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Medicaid Match | $ 13,262,441 | $ 8,566,779 |

**Form Notes for Form 2:**

None

**Field Level Notes for Form 2:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **Federal Allocation, B. Children with Special Health Care Needs:** |
| | **Fiscal Year:** | **2024** |
| | **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. | |
| 2. | **Field Name:** | **Federal Allocation, C. Title V Administrative Costs:** |
| | **Fiscal Year:** | **2024** |
| | **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. | |
| 3. | **Field Name:** | **4. LOCAL MCH FUNDS** |
| | **Fiscal Year:** | **2024** |
| | **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:** | **6. PROGRAM INCOME** |
| | **Fiscal Year:** | **2024** |
| | **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. | |

**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 26 Application Budgeted | FY 24 Annual Report Expended |
|---|---|---|
| 1. Pregnant Women | $ 2,399 | $ 28,271 |
| 2. Infants < 1 year | $ 569,000 | $ 549,042 |
| 3. Children 1 through 21 Years | $ 12,877,532 | $ 14,473,230 |
| 4. CSHCN | $ 22,201,034 | $ 18,665,715 |
| 5. All Others | $ 640,919 | $ 308,498 |
| Federal Total of Individuals Served | $ 36,290,884 | $ 34,024,756 |

| IB. Non-Federal MCH Block Grant | FY 26 Application Budgeted | FY 24 Annual Report Expended |
|---|---|---|
| 1. Pregnant Women | $ 21,904,738 | $ 24,812,873 |
| 2. Infants < 1 year | $ 9,438,740 | $ 11,264,723 |
| 3. Children 1 through 21 Years | $ 27,165,555 | $ 28,929,558 |
| 4. CSHCN | $ 27,520,803 | $ 21,306,261 |
| 5. All Others | $ 30,999,246 | $ 32,852,731 |
| Non-Federal Total of Individuals Served | $ 117,029,082 | $ 119,166,146 |
| Federal State MCH Block Grant Partnership Total | $ 153,319,966 | $ 153,190,902 |

**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:** | **2026** |
| | **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:** | **2024** |
| | **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 26 Application Budgeted | FY 24 Annual Report Expended |
|---|---|---|
| 1. Direct Services | $ 3,446,250 | $ 3,027,629 |
| 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 | $ 3,446,250 | $ 3,027,629 |
| 2. Enabling Services | $ 26,246,865 | $ 23,947,172 |
| 3. Public Health Services and Systems | $ 9,216,695 | $ 10,219,605 |
| 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 | | $ 3,027,629 |
| 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 | | $ 3,027,629 |
| **Federal Total** | $ 38,909,810 | $ 37,194,406 |

| IIB. Non-Federal MCH Block Grant | FY 26 Application Budgeted | FY 24 Annual Report Expended |
|---|---|---|
| 1. Direct Services | $ 34,210,093 | $ 33,396,613 |
| A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One | $ 18,326,457 | $ 18,534,414 |
| B. Preventive and Primary Care Services for Children | $ 15,883,636 | $ 14,862,199 |
| C. Services for CSHCN | $ 0 | $ 0 |
| 2. Enabling Services | $ 33,501,835 | $ 40,162,581 |
| 3. Public Health Services and Systems | $ 15,100,620 | $ 17,699,426 |
| 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 | | $ 33,396,613 |
| Direct Services Line 4 Expended Total | | $ 33,396,613 |
| **Non-Federal Total** | $ 82,812,548 | $ 91,258,620 |

**Form Notes for Form 3b:**

None

**Field Level Notes for Form 3b:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **IIB. - Other - Other** |
| | **Fiscal Year:** | **2026** |
| | **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: 206,728** **Data Source Year: 2024**

**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 | 206,562 (99.9%) | 1,622 | 381 | 381 (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 | 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 | 206,562 (99.9%) | 274 | 0 | 0 (0%) |

**3. Screening Programs for Older Children & Women**

None

**4. Long-Term Follow-Up**

Our long-term follow-up program allows individuals with a confirmed inherited metabolic disorder (IMD) to consent to participate in our newborn screening patient registry until age 18 and re-consent at that age until age 21. We provide training and technical assistance to the 10 IMD Specialty Care centers to consent patients and conduct data collection. We initially worked with Newborn Screening Translational Research Network (NBSTRN) and their Longitudinal Pediatric Data Resource to be the host of our REDCap data repository. Unexpectedly, NBSTRN closed out their resources in February 2024. The NBS program was able to secure additional funding from HRSA and has begun building an in-house data repository for our long-term follow-up program in the Health Commerce System. We anticipate completing the initial build phase of the data repository in spring 2025.

**Form Notes for Form 4:**

None

**Field Level Notes for Form 4:**

None

**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 2024**

### 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 | 168,815 | 49.0 | 0.0 | 50.0 | 1.0 | 0.0 |
| 2. Infants < 1 Year of Age | 204,817 | 49.0 | 0.0 | 50.0 | 1.0 | 0.0 |
| 3. Children 1 through 21 Years of Age | 517,264 | 42.0 | 0.0 | 55.0 | 3.0 | 0.0 |
| 3a. Children with Special Health Care Needs 0 through 21 years of age^ | 190,553 | 43.0 | 0.0 | 54.0 | 3.0 | 0.0 |
| 4. Others | 120,179 | 25.0 | 0.0 | 70.0 | 5.0 | 0.0 |
| Total | 1,011,075 | | | | | |

### 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 | 203,612 | No | 201,601 | 100.0 | 201,601 | 168,815 |
| 2. Infants < 1 Year of Age | 204,765 | No | 204,817 | 100.0 | 204,817 | 204,817 |
| 3. Children 1 through 21 Years of Age | 4,744,839 | Yes | 4,744,839 | 73.3 | 3,477,967 | 517,264 |
| 3a. Children with Special Health Care Needs 0 through 21 years of age^ | 1,233,673 | Yes | 1,233,673 | 47.9 | 590,929 | 190,553 |
| 4. Others | 14,616,704 | Yes | 14,616,704 | 1.0 | 146,167 | 120,179 |

^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:** | **2024** |
| | **Field Note:**<br>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.<br><br>The following MCH serving programs were included in Form 5a for Pregnant Women:<br>+ Comprehensive Adolescent Pregnancy Prevention and ACT for Youth Center of Excellence<br>+ Family Planning Program<br>+ Regional Perinatal Centers<br>+ Community Water Fluoridation<br>+ Perinatal & Infant Community Health Collaborative<br>+ Maternal, Infant, and Early Child Home Visiting (MIECHV) Programs - Nurse Family Partnership and Healthy Families<br>+ Immunization<br><br>Estimates for the Primary Source of Coverage were provided by HRSA. | |
| 2. | **Field Name:** | **Infants Less Than One YearTotal Served** |
| | **Fiscal Year:** | **2024** |
| | **Field Note:**<br>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.<br><br>Estimates for the Primary Source of Coverage were provided by HRSA. | |
| 3. | **Field Name:** | **Children 1 through 21 Years of Age** |
| | **Fiscal Year:** | **2024** |

**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:** | **2024** |

**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:** | **2024** |

**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:** | **2024** |

**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:** | **2024** |

**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.

| | | |
|---|---|---|
| 3. | **Field Name:** | **Infants Less Than One Year Total % Served** |
| | **Fiscal Year:** | **2024** |

**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:** | **2024** |

**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.

| | | |
|---|---|---|
| 5. | **Field Name:** | **Children 1 through 21 Years of Age Total % Served** |
| | **Fiscal Year:** | **2024** |

**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:** | **2024** |

**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. Additionally, Medicaid coverage increased for children with special health care needs due to the expanded criteria for special health care needs status from the National Survey of Children's Health. Due to the expanded criteria, the children with special health care needs population increased in New York State from 18.8% in 2022 to 25.6% in 2023. This change in criteria for special health care needs status artificially increased their representation in Medicaid and other programs.

| | | |
|---|---|---|
| 7. | **Field Name:** | **Others Total % Served** |
| | **Fiscal Year:** | **2024** |

**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 2024**

**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 | 201,601 | 96,609 | 24,957 | 50,952 | 318 | 20,123 | 89 | 3,573 | 4,980 |
| Title V Served | 201,601 | 96,609 | 24,957 | 50,952 | 318 | 20,123 | 89 | 3,573 | 4,980 |
| Eligible for Title XIX | 103,283 | 34,507 | 16,672 | 37,259 | 217 | 9,541 | 44 | 1,649 | 3,394 |
| 2. Total Infants in State | 204,817 | 98,206 | 25,480 | 51,615 | 321 | 20,377 | 90 | 3,650 | 5,078 |
| Title V Served | 204,817 | 98,206 | 25,480 | 51,615 | 321 | 20,377 | 90 | 3,650 | 5,078 |
| Eligible for Title XIX | 104,837 | 35,028 | 17,024 | 37,722 | 218 | 9,659 | 45 | 1,681 | 3,460 |

**Form Notes for Form 6:**

None

**Field Level Notes for Form 6:**

None

# Form 7
# Title V Program Workforce

**State: New York**

Form 7 Entry Page

| A. Title V Program Workforce FTEs | |
|---|---|
| **Title V Funded Positions** | |
| 1. Total Number of FTEs | 163 |
| 1a. Total Number of FTEs (State Level) | 163 |
| 1b. Total Number of FTEs (Local Level) | 0 |
| 2. Total Number of MCH Epidemiology FTEs (subset of A. 1) | 12 |
| 3. Total Number of FTEs eliminated in the past 12 months | 0 |
| 4. Total Number of Current Vacant FTEs | 44 |
| 4a. Total Number of Vacant MCH Epidemiology FTEs | 1 |
| 5. Total Number of FTEs onboarded in the past 12 months | 22 |
| **B. Training Needs (Optional)** | |
| No training needs were reported by the state. | |

**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) 522-5006 |

**Form Notes for Form 8:**

None

## Form 9
## List of Priority Needs – Needs Assessment Year

**State: New York**

**Application Year 2026**

| No. | Priority Need | Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period) |
|---|---|---|
| 1. | Support the health and well-being of women throughout pregnancy and postpartum periods | New |
| 2. | Ensure risk-appropriate care for infants | New |
| 3. | Promote comprehensive patient-centered health care for children | New |
| 4. | Promote healthy play and nutrition for all children | New |
| 5. | Support physical and mental health and health care for adolescents | New |
| 6. | Promote comprehensive patient-centered care for CYSHCN | New |
| 7. | Support transition for youth with special health care needs to adult roles and care | New |

**Form Notes for Form 9:**

None

**Field Level Notes for Form 9:**

None

## Form 10
## National Outcome Measures (NOMs)

**State: New York**

**Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.**

None

**NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations - SMM**

**Data Source: HCUP - State Inpatient Databases (SID)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 123.9 | 2.5 | 2,398 | 193,605 |
| 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 - MM**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2019_2023 | 21.8 | 1.4 | 230 | 1,053,005 |
| 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 | |
|---|---|
| | **2024** |
| **Annual Indicator** | 17.4 |
| **Numerator** | |
| **Denominator** | |
| **Data Source** | |
| **Data Source Year** | |

**NOM MM - Notes:**

NYS Maternal Mortality Review data, 2022 result, provisional.

**Data Alerts: None**

**NOM - Teen birth rate, ages 15 through 19, per 1,000 females - TB**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2023 | 8.5 | 0.1 | 5,000 | 587,856 |
| 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 low birth weight deliveries (<2,500 grams) - LBW**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2023 | 8.6 % | 0.1 % | 17,381 | 203,178 |
| 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 gestation) - PTB**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2023 | 9.6 % | 0.1 % | 19,544 | 203,179 |
| 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 - Stillbirth rate per 1,000 live births plus fetal deaths - SB**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 5.8 | 0.2 | 1,211 | 208,985 |
| 2021 | 6.1 | 0.2 | 1,285 | 212,027 |
| 2020 | 6.4 | 0.2 | 1,338 | 210,676 |
| 2019 | 6.0 | 0.2 | 1,331 | 222,870 |
| 2018 | 6.4 | 0.2 | 1,463 | 227,701 |
| 2017 | 6.3 | 0.2 | 1,453 | 231,190 |
| 2016 | 6.5 | 0.2 | 1,526 | 235,809 |
| 2015 | 6.5 | 0.2 | 1,554 | 238,828 |
| 2014 | 6.8 | 0.2 | 1,634 | 240,407 |
| 2013 | 7.3 | 0.2 | 1,740 | 238,720 |
| 2012 | 7.7 | 0.2 | 1,874 | 242,790 |
| 2011 | 8.4 | 0.2 | 2,032 | 243,344 |
| 2010 | 8.3 | 0.2 | 2,036 | 246,411 |
| 2009 | 8.2 | 0.2 | 2,053 | 250,163 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM SB - Notes:**

None

**Data Alerts: None**

**NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths - PNM**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 4.6 | 0.2 | 965 | 208,315 |
| 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 - IM**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 4.3 | 0.1 | 885 | 207,774 |
| 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 - IM-Neonatal**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 2.7 | 0.1 | 551 | 207,774 |
| 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 - IM-Postneonatal**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 1.6 | 0.1 | 333 | 207,774 |
| 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 - IM-Preterm Related**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 110.7 | 7.3 | 230 | 207,774 |
| 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 - IM-SUID**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 68.3 | 5.7 | 142 | 207,774 |
| 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 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations - NAS**

**Data Source: HCUP - State Inpatient Databases (SID)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 3.5 | 0.1 | 689 | 195,623 |
| 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 children meeting the criteria developed for school readiness - SR**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022_2023 | 68.7 % | 2.6 % | 468,121 | 681,821 |

**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 SR - Notes:**

None

**Data Alerts: None**

**NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year - TDC**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022_2023 | 9.8 % | 0.7 % | 373,589 | 3,823,996 |
| 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 - CM**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2023 | 15.7 | 0.9 | 303 | 1,929,143 |
| 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 - AM**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2023 | 24.2 | 1.0 | 560 | 2,318,795 |
| 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 - AM-Motor Vehicle**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2021-2023 | 5.6 | 0.4 | 200 | 3,601,277 |
| 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 10 through 19 per 100,000 - AM-Suicide**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2021_2023 | 3.2 | 0.2 | 226 | 7,014,092 |
| 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 - Adolescent firearm mortality rate, ages 10 through 19 per 100,000 - AM-Firearm**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2021_2023 | 3.7 | 0.2 | 260 | 7,014,092 |
| 2020_2022 | 3.8 | 0.2 | 265 | 6,939,226 |
| 2019_2021 | 3.2 | 0.2 | 219 | 6,892,264 |
| 2018_2020 | 2.8 | 0.2 | 192 | 6,826,195 |
| 2017_2019 | 2.5 | 0.2 | 172 | 6,945,536 |
| 2016_2018 | 2.6 | 0.2 | 186 | 7,058,444 |
| 2015_2017 | 2.7 | 0.2 | 192 | 7,162,084 |
| 2014_2016 | 2.5 | 0.2 | 182 | 7,235,281 |
| 2013_2015 | 2.3 | 0.2 | 170 | 7,305,036 |
| 2012_2014 | 2.5 | 0.2 | 183 | 7,390,173 |
| 2011_2013 | 3.1 | 0.2 | 233 | 7,474,591 |
| 2010_2012 | 3.8 | 0.2 | 292 | 7,593,558 |
| 2009_2011 | 4.0 | 0.2 | 306 | 7,701,814 |
| 2008_2010 | 3.9 | 0.2 | 301 | 7,812,278 |
| 2007_2009 | 3.8 | 0.2 | 298 | 7,888,176 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM AM-Firearm - Notes:**

None

**Data Alerts: None**

**NOM - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9 - IH-Child**

**Data Source: HCUP - State Inpatient Databases (SID)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 143.6 | 2.6 | 3,109 | 2,164,801 |
| 2021 | 146.7 | 2.6 | 3,283 | 2,238,647 |
| 2020 | 137.9 | 2.5 | 3,065 | 2,222,738 |
| 2019 | 145.8 | 2.6 | 3,273 | 2,244,892 |
| 2018 | 145.1 | 2.5 | 3,278 | 2,259,768 |
| 2017 | 171.0 | 2.7 | 3,932 | 2,299,457 |
| 2016 | 161.3 | 2.7 | 3,718 | 2,304,699 |
| 2015 | 192.6 | 3.3 | 3,355 | 1,741,960 |
| 2014 | 184.3 | 2.8 | 4,285 | 2,324,754 |
| 2013 | 192.8 | 2.9 | 4,478 | 2,323,064 |
| 2012 | 213.3 | 3.0 | 4,953 | 2,321,651 |
| 2011 | 225.9 | 3.1 | 5,238 | 2,318,399 |
| 2010 | 244.3 | 3.3 | 5,668 | 2,319,777 |
| 2009 | 246.5 | 3.3 | 5,716 | 2,319,058 |
| 2008 | 246.6 | 3.3 | 5,707 | 2,314,204 |

**Legends:**

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM IH-Child - Notes:**

None

**Data Alerts: None**

**NOM - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 - IH-Adolescent**

**Data Source: HCUP - State Inpatient Databases (SID)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 204.1 | 3.0 | 4,741 | 2,323,066 |
| 2021 | 205.6 | 2.9 | 4,877 | 2,372,231 |
| 2020 | 200.5 | 3.0 | 4,499 | 2,243,929 |
| 2019 | 199.1 | 3.0 | 4,532 | 2,276,104 |
| 2018 | 203.5 | 3.0 | 4,692 | 2,306,162 |
| 2017 | 221.0 | 3.1 | 5,222 | 2,363,270 |
| 2016 | 223.9 | 3.1 | 5,348 | 2,389,012 |
| 2015 | 250.9 | 3.7 | 4,534 | 1,807,352 |
| 2014 | 239.2 | 3.1 | 5,829 | 2,436,467 |
| 2013 | 254.3 | 3.2 | 6,253 | 2,458,767 |
| 2012 | 289.1 | 3.4 | 7,212 | 2,494,939 |
| 2011 | 302.7 | 3.5 | 7,631 | 2,520,885 |
| 2010 | 327.3 | 3.6 | 8,438 | 2,577,734 |
| 2009 | 340.5 | 3.6 | 8,863 | 2,603,195 |
| 2008 | 340.0 | 3.6 | 8,947 | 2,631,349 |

**Legends:**

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM IH-Adolescent - Notes:**

None

**Data Alerts: None**

**NOM - Percent of women, ages 18 through 44, in excellent or very good health - WHS**

**Data Source: Behavioral Risk Factor Surveillance System (BRFSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2023 | 50.5 % | 1.3 % | 1,834,038 | 3,630,508 |
| 2022 | 54.9 % | 1.2 % | 1,946,568 | 3,544,341 |
| 2021 | 59.4 % | 1.0 % | 2,152,066 | 3,622,127 |
| 2020 | 64.6 % | 1.3 % | 2,258,881 | 3,495,554 |
| 2019 | 57.1 % | 1.5 % | 2,023,093 | 3,544,892 |
| 2018 | 56.4 % | 1.1 % | 2,022,730 | 3,585,820 |
| 2017 | 54.5 % | 1.4 % | 1,970,443 | 3,614,061 |
| 2017 | 54.5 % | 1.4 % | 1,970,443 | 3,614,061 |
| 2016 | 57.2 % | 1.3 % | 2,079,474 | 3,636,070 |
| 2015 | 58.3 % | 1.4 % | 2,117,306 | 3,632,063 |
| 2014 | 57.0 % | 1.8 % | 2,059,042 | 3,610,076 |
| 2013 | 57.9 % | 1.6 % | 2,086,269 | 3,601,248 |
| 2012 | 58.3 % | 2.0 % | 2,075,579 | 3,560,151 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

**NOM WHS - Notes:**

None

**Data Alerts: None**

**NOM - Percent of children, ages 0 through 17, in excellent or very good health - CHS**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022_2023 | 88.5 % | 1.0 % | 3,550,184 | 4,011,482 |
| 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 6 through 17, who are obese (BMI at or above the 95th percentile) - 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: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022_2023 | 17.0 % | 1.3 % | 441,249 | 2,589,199 |
| 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 women who experience postpartum depressive symptoms - PPD**

**Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2023 | 11.0 % | 1.0 % | 19,534 | 177,409 |
| 2022 | 12.0 % | 0.9 % | 21,822 | 182,333 |
| 2021 | 11.7 % | 0.9 % | 21,602 | 184,546 |
| 2020 | 10.2 % | 1.0 % | 18,587 | 182,590 |
| 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 women who experience postpartum anxiety symptoms - PPA**

**Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2023 | 17.8 % | 1.2 % | 31,619 | 177,746 |

**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 PPA - Notes:**

None

**Data Alerts: None**

**NOM - Percent of children, ages 6 through 11, who have a behavioral or conduct disRecordOrder - BCD**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022_2023 | 9.5 % | 1.5 % | 126,785 | 1,332,275 |
| 2021_2022 | 6.6 % | 1.4 % | 87,160 | 1,316,958 |
| 2020_2021 | 7.2 % | 1.7 % | 93,403 | 1,288,759 |
| 2019_2020 | 9.6 % | 2.1 % | 125,209 | 1,308,371 |
| 2018_2019 | 9.2 % | 2.1 % | 123,116 | 1,340,763 |
| 2017_2018 | 5.3 % | 1.3 % | 71,292 | 1,345,577 |
| 2016_2017 | 5.5 % | 1.2 % | 74,990 | 1,357,612 |

**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 BCD - Notes:**

None

**Data Alerts: None**

**NOM - Percent of adolescents, ages 12 through 17, who have depression or anxiety - ADA**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022_2023 | 18.8 % | 1.8 % | 265,106 | 1,407,412 |
| 2021_2022 | 17.2 % | 1.4 % | 239,664 | 1,394,915 |
| 2020_2021 | 16.0 % | 1.8 % | 218,010 | 1,366,752 |
| 2019_2020 | 13.9 % | 1.7 % | 190,109 | 1,365,958 |
| 2018_2019 | 13.4 % | 2.3 % | 185,536 | 1,379,776 |
| 2017_2018 | 10.7 % | 2.3 % | 149,651 | 1,396,009 |
| 2016_2017 | 10.1 % | 1.8 % | 141,348 | 1,399,289 |

**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 ADA - 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 - SOC**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022_2023 | 14.5 % | 1.7 % | 145,174 | 1,001,467 |
| 2021_2022 | 10.5 % | 1.1 % | 97,804 | 928,899 |
| 2020_2021 | 12.5 % | 2.4 % | 112,828 | 903,945 |
| 2019_2020 | 15.0 % | 2.6 % | 152,185 | 1,016,978 |
| 2018_2019 | 13.5 % | 2.4 % | 142,036 | 1,051,123 |
| 2017_2018 | 17.0 % | 3.1 % | 155,023 | 913,062 |
| 2016_2017 | 13.8 % | 2.7 % | 125,352 | 906,567 |

**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 6 months through 5, who are flourishing - FL-YC**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022_2023 | 72.9 % | 2.3 % | 830,620 | 1,139,050 |
| 2021_2022 | 76.3 % | 1.9 % | 919,980 | 1,206,142 |
| 2020_2021 | 78.7 % | 2.6 % | 979,885 | 1,245,658 |
| 2019_2020 | 80.5 % | 3.0 % | 978,611 | 1,215,526 |
| 2018_2019 | 80.9 % | 3.2 % | 987,224 | 1,220,579 |

**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 FL-YC - Notes:**

None

**Data Alerts: None**

**NOM - Percent of children with and without special health care needs, ages 6 through 17, who are flourishing - FL-CA**

**Data Source: National Survey of Children's Health (NSCH)-CSHCN**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022_2023 | 35.3 % | 2.6 % | 288,552 | 817,124 |
| 2021_2022 | 40.1 % | 2.8 % | 295,322 | 735,840 |
| 2020_2021 | 43.9 % | 3.7 % | 315,987 | 719,382 |
| 2019_2020 | 49.1 % | 3.8 % | 394,793 | 803,773 |
| 2018_2019 | 55.1 % | 4.4 % | 463,847 | 841,269 |

**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 FL-CA - Notes:**

None

**Data Alerts: None**

**NOM - Percent of children with and without special health care needs, ages 6 through 17, who are flourishing - FL-Child Adolescent**

**Data Source: National Survey of Children's Health (NSCH)-All Children**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022_2023 | 61.3 % | 1.6 % | 1,649,611 | 2,690,115 |
| 2021_2022 | 62.3 % | 1.6 % | 1,651,526 | 2,650,832 |
| 2020_2021 | 63.3 % | 2.0 % | 1,639,429 | 2,590,867 |
| 2019_2020 | 66.6 % | 2.1 % | 1,760,197 | 2,644,484 |
| 2018_2019 | 71.5 % | 2.3 % | 1,944,422 | 2,718,596 |

**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 FL-Child Adolescent - Notes:**

None

**Data Alerts: None**

**NOM - Percent of children, ages 0 through 17, who have experienced 2 or more Adverse Childhood Experiences - ACE**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022_2023 | 14.1 % | 0.9 % | 555,996 | 3,931,002 |
| 2021_2022 | 13.4 % | 0.9 % | 527,919 | 3,926,321 |
| 2020_2021 | 14.2 % | 1.3 % | 547,992 | 3,856,348 |
| 2019_2020 | 15.2 % | 1.4 % | 590,615 | 3,896,100 |
| 2018_2019 | 14.1 % | 1.6 % | 555,388 | 3,949,074 |
| 2017_2018 | 15.1 % | 1.8 % | 608,581 | 4,022,349 |
| 2016_2017 | 15.7 % | 1.6 % | 643,772 | 4,103,365 |

**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 ACE - Notes:**

None

**Data Alerts: None**

## Form 10
## National Performance Measures (NPMs)

**State: New York**

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

| Federally Available Data | | |
|---|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | | |
| | **2023** | **2024** |
| Annual Objective | | |
| Annual Indicator | 91.2 | 91.3 |
| Numerator | 166,888 | 162,546 |
| Denominator | 182,980 | 178,064 |
| Data Source | PRAMS | PRAMS |
| Data Source Year | 2022 | 2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | 95.0 | 95.0 | 95.0 | 95.0 | 95.0 |

**Field Level Notes for Form 10 NPMs:**

None

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

| Federally Available Data | | |
|---|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | | |
| | **2023** | **2024** |
| Annual Objective | | |
| Annual Indicator | 76.2 | 67.2 |
| Numerator | 124,429 | 107,840 |
| Denominator | 163,344 | 160,411 |
| Data Source | PRAMS | PRAMS |
| Data Source Year | 2022 | 2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | 68.5 | 69.9 | 71.3 | 72.7 | 74.2 |

**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) - RAC**

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

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | | 92.4 | 92.6 | 92.8 | 93.1 |
| Annual Indicator | 92.2 | 91.6 | 91.3 | 91.6 | 92.4 |
| Numerator | 2,626 | 2,610 | 2,437 | 2,610 | 2,363 |
| Denominator | 2,849 | 2,850 | 2,668 | 2,850 | 2,556 |
| Data Source | NYS VS | NYS VS | NYS VS | NYS VS | NYS VS |
| Data Source Year | 2018 | 2019 | 2020 | 2021 | 2022 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2026 | 2027 | 2028 | 2029 | 2030 |
| Annual Objective | 93.4 | 93.4 | 93.4 | 93.4 | 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 - PA-Child**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CHILD** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 27.5 | 27.8 | 28.1 | 28.4 |
| Annual Indicator | 27.4 | 22.4 | 24.1 | 26.6 | 24.3 |
| Numerator | 316,874 | 272,297 | 308,176 | 345,661 | 316,349 |
| Denominator | 1,158,167 | 1,213,091 | 1,278,404 | 1,300,265 | 1,302,487 |
| Data Source | NSCH-CHILD | NSCH-CHILD | NSCH-CHILD | NSCH-CHILD | NSCH-CHILD |
| Data Source Year | 2018_2019 | 2019_2020 | 2020_2021 | 2021_2022 | 2022_2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | 24.5 | 24.8 | 25.0 | 25.3 | 25.5 |

**Field Level Notes for Form 10 NPMs:**

None

**NPM - Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling - MHT**

| Federally Available Data | |
|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | |
| | **2024** |
| Annual Objective | |
| Annual Indicator | 86.8 |
| Numerator | 267,589 |
| Denominator | 308,156 |
| Data Source | NSCH |
| Data Source Year | 2022_2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | 87.7 | 88.5 | 89.4 | 90.3 | 91.2 |

**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 - MH - Children with Special Health Care Needs**

| Federally Available Data | | |
|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CSHCN** | | |
| | **2023** | **2024** |
| Annual Objective | | |
| Annual Indicator | 37.4 | 40.4 |
| Numerator | 274,332 | 404,726 |
| Denominator | 734,189 | 1,001,467 |
| Data Source | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | 2021_2022 | 2022_2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | 40.4 | 40.9 | 41.4 | 41.9 | 42.4 |

**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 - MH - Child Health - All Children**

| Federally Available Data | | |
|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - All Children** | | |
| | **2023** | **2024** |
| Annual Objective | | |
| Annual Indicator | 45.6 | 45.2 |
| Numerator | 1,834,655 | 1,814,014 |
| Denominator | 4,020,084 | 4,012,745 |
| Data Source | NSCH-All Children | NSCH-All Children |
| Data Source Year | 2021_2022 | 2022_2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | 45.2 | 46.4 | 47.6 | 48.8 | 50.0 |

**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 - TAHC - Children with Special Health Care Needs**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CSHCN** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 16.1 | 18 | 18.1 | 18.3 | 18.5 |
| Annual Indicator | 23.6 | 19.1 | 11.8 | 17.9 | 20.3 |
| Numerator | 87,040 | 73,058 | 40,243 | 59,380 | 97,868 |
| Denominator | 369,539 | 381,623 | 340,705 | 331,183 | 482,867 |
| Data Source | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | 2018_2019 | 2019_2020 | 2020_2021 | 2021_2022 | 2022_2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | 20.3 | 20.6 | 20.8 | 21.1 | 21.3 |

**Field Level Notes for Form 10 NPMs:**

None

## Form 10
## National Performance Measures (NPMs) (2021-2025 Needs Assessment Cycle)

**State: New York**

**2021-2025: NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 83.2 | 81.5 | 82.2 | 82.9 | 83.8 |
| Annual Indicator | 86.3 | 82.9 | 72.8 | 71.3 | 76.8 |
| Numerator | 1,367,654 | 1,218,475 | 976,520 | 972,723 | 1,065,930 |
| Denominator | 1,583,876 | 1,469,455 | 1,341,167 | 1,363,869 | 1,388,262 |
| Data Source | NSCH | NSCH | NSCH | NSCH | NSCH |
| Data Source Year | 2019 | 2019_2020 | 2020_2021 | 2021_2022 | 2022_2023 |

**Field Level Notes for Form 10 NPMs:**

None

**2021-2025: NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: Behavioral Risk Factor Surveillance System (BRFSS)** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 79.4 | 80.3 | 81.3 | 82.2 | 83.1 |
| Annual Indicator | 78.3 | 78.3 | 75.9 | 75.5 | 78.1 |
| Numerator | 2,737,695 | 2,703,220 | 2,698,183 | 2,643,832 | 2,791,769 |
| Denominator | 3,498,639 | 3,451,509 | 3,553,627 | 3,503,858 | 3,573,781 |
| Data Source | BRFSS | BRFSS | BRFSS | BRFSS | BRFSS |
| Data Source Year | 2019 | 2020 | 2021 | 2022 | 2023 |

**Field Level Notes for Form 10 NPMs:**

None

## Form 10
## State Performance Measures (SPMs)

**State: New York**

## Form 10
## State Performance Measures (SPMs) (2021-2025 Needs Assessment Cycle)

**2021-2025: SPM 1 - Percent of samples received by the State Newborn Screening lab within 48 hours of collection**

| **Measure Status:** | | | | **Active** | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 75 | 77 | 79 | 81 |
| Annual Indicator | 68 | 70 | 70.6 | 67.2 | 66 |
| 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 | 2020 | 2021 | 2022 | 2023 | 2024 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

**Field Level Notes for Form 10 SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>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:**<br>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:**<br>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. | |
| 4. | **Field Name:** | **2024** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>NBS program staff continued to work with FedEx and 120+ hospitals to improve the process for pickup and delivery. Even though this metric is largely out of our control since it relies on the business operation of FedEx, we always remind hospitals to track their FedEx packages and notify our staff to document any missed or delayed pickups during our hospital site visits. | |

**2021-2025: 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** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 3.6 | 12.1 | 12 | 11.9 |
| Annual Indicator | 3.6 | 12.1 | 10.4 | 10.4 | 9.5 |
| Numerator | 1,772 | 6,063 | 4,443 | 4,412 | 4,131 |
| Denominator | 498,946 | 502,219 | 428,592 | 423,739 | 435,672 |
| 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 | NYS Child Health Lead Poisoning Prevention Program |
| Data Source Year | 2018 | 2019 | 2020 | 2021 | 20.22 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

**Field Level Notes for Form 10 SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2020** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>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:**<br>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.<br>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:**<br>Per data reported in CHIRS dashboard for birth year 2018 cohort. | |
| 4. | **Field Name:** | **2024** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Per data reported in CHIRS dashboard for birth year 2019 cohort. | |

## Form 10
## Evidence-Based or –Informed Strategy Measures (ESMs)

**State: New York**

**ESM PPV.1 - Percent of regular Big 6 Postpartum Visit peer learning meetings attended with active participation in presenting and/or responding to peer discussions.**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2026 | 2027 | 2028 | 2029 | 2030 |
| Annual Objective | 90.0 | 90.0 | 90.0 | 90.0 | 90.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM PPV.2 - Percent of Perinatal and Infant Community Health Collaboratives (PICHC) clients who attended a postpartum visit within 12 weeks after giving birth.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2024 |
| Annual Objective | |
| Annual Indicator | 56.2 |
| Numerator | 757 |
| Denominator | 1,348 |
| Data Source | PICHC Program data |
| Data Source Year | 2024 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2026 | 2027 | 2028 | 2029 | 2030 |
| Annual Objective | 59.0 | 60.2 | 61.4 | 62.7 | 63.9 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM RAC.1 - Percent of birthing hospitals re-designated with updated standards**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | | 0 | 0 | 50 | 75 |
| Annual Indicator | 0 | 0 | 0 | 0 | 0 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | NYS Data | NYS Data | NYS Data | NYS Data | NYS Data |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | 2024 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2026 | 2027 | 2028 | 2029 | 2030 |
| Annual Objective | 100.0 | 100.0 | 100.0 | 100.0 | 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. | |
| 5. | **Field Name:** | **2024** |
| | **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: | Inactive - Replaced | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 51.6 | 51.6 | 52.6 | 53.6 |
| Annual Indicator | 51.6 | 43 | 35.1 | 50.6 | 52.8 |
| Numerator | 98,941 | 74,325 | 54,615 | 79,697 | 80,331 |
| Denominator | 191,920 | 172,751 | 155,443 | 157,601 | 152,178 |
| Data Source | SBHC quarterly report | SBHC quarterly report | SBHC quarterly report | SBHC quarterly report | SBHC quarterly report |
| Data Source Year | 2018-2019 | 2019-2020 | 2020-2021 | 2021-2022 | 2022-2023 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2020** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data is based on July 1, 2018-June 30, 2019.<br>10 SBHC sites were excluded because their percentage exceeded 100%.<br>Measure wording changes:<br>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:**<br>Data is based on July 1, 2019-June 30, 2020.<br>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:**<br>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:**<br>Data is based on July 1, 2021-June 30, 2022.<br>Data notes: 10 SBHC sites were excluded because their percentage exceeded 100%. | |
| 5. | **Field Name:** | **2024** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data is based on July 1, 2022-June 30, 2023.<br>Eleven SBHC sites were excluded because their percentage exceeded 100%. | |

**ESM PA-Child.2 - Percent of School Based Health Centers (SBHCs) operators that have 3 or more partnerships to promote physical activity.**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2026 | 2027 | 2028 | 2029 | 2030 |
| Annual Objective | 20.0 | 40.0 | 60.0 | 80.0 | 100.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM MHT.1 - Percent of DFH-funded adolescent-serving programs that receive mental health-related trainings and resources.**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2026 | 2027 | 2028 | 2029 | 2030 |
| Annual Objective | 85.0 | 90.0 | 95.0 | 100.0 | 100.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM MH.1 - Percent of students attending schools that have School Based Health Centers (SBHCs) who are enrolled in the SBHC program**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2024 |
| Annual Objective | |
| Annual Indicator | 63.4 |
| Numerator | 158,604 |
| Denominator | 250,000 |
| Data Source | SBHC quarterly report |
| Data Source Year | 2022-2023 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2026 | 2027 | 2028 | 2029 | 2030 |
| Annual Objective | 65.8 | 68.1 | 70.4 | 72.7 | 75.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM MH.2 - Percent of regular Big 6 medical home for CYSHCN peer learning meetings attended with active participation in presenting and/or responding to peer discussions.**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2026 | 2027 | 2028 | 2029 | 2030 |
| Annual Objective | 90.0 | 90.0 | 90.0 | 90.0 | 90.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM TAHC.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: | Inactive - Replaced | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 40.3 | 41.1 | 41.5 | 41.9 |
| Annual Indicator | 62.4 | 66.1 | 74.8 | 67.5 | 22.1 |
| Numerator | 295 | 323 | 450 | 291 | 193 |
| Denominator | 473 | 489 | 602 | 431 | 875 |
| Data Source | Contractor Reports | Contractor Reports | Contractor Reports | Contractor Reports | Contractor Reports |
| Data Source Year | 2019-2020 | 2020-2021 | 2021-2022 | 2022-2023 | 2023-2024 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Baseline based on 2018-2019 data | |
| 2. | **Field Name:** | **2020** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Based on 2019-2020 data. | |
| 3. | **Field Name:** | **2021** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data from 7/1/2020 - 6/30/2021 | |
| 4. | **Field Name:** | **2022** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data from July 1, 2021-June 30, 2022 | |
| 5. | **Field Name:** | **2023** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data from 7/01/2022-6/30/2023.<br>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. | |
| 6. | **Field Name:** | **2024** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Another 5-year contract cycle began 10/01/2023. 2 of the 5 contractors were funded for the previous Sickle Cell Disease program. The start-up included a program orientation and contractor efforts to establish their staff and program models. The 10/1/2023-9/30/2024 data represents numerator is the number of individuals who had a subsequent transition assessment completed and the denominator is among who had kept an appointment. | |

**ESM TAHC.2 - Percent of individuals ages 14-21 with sickle cell disease who had subsequent 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 | |
|---|---|
| | 2024 |
| Annual Objective | |
| Annual Indicator | 22.1 |
| Numerator | 193 |
| Denominator | 875 |
| Data Source | Contractor Reports |
| Data Source Year | 2023-2024 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2026 | 2027 | 2028 | 2029 | 2030 |
| Annual Objective | 22.0 | 23.1 | 24.3 | 25.5 | 26.7 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2024** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
Data: 10/1/2023-9/30/2024. The 5-year contract cycle began 10/01/2023. Two of the 5 contractors were funded for the previous Sickle Cell Disease program.

## Form 10
## Evidence-Based or -Informed Strategy Measures (ESMs) (2021-2025 Needs Assessment Cycle)

**2021-2025: 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** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 96.3 | 96.3 | 98.2 | 100 |
| Annual Indicator | 96.3 | 100 | 100 | 96.1 | 100 |
| Numerator | 52 | 52 | 52 | 49 | 54 |
| Denominator | 54 | 52 | 52 | 51 | 54 |
| 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 | Survey of CAPP and PREP Programs |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | 2024 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2020** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>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:**<br>Data from 1/1/2021 - 12/31/2021.<br><br>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:**<br>Total of 53 programs, one did not respond (missing data) | |
| 4. | **Field Name:** | **2023** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data from 1/1/2023 - 12/31/2023.<br>Total of 55 programs, four did not respond (missing data) | |
| 5. | **Field Name:** | **2024** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>54 programs were surveyed for this measure, response rate was 100%. | |

**2021-2025: ESM AWV.2 - Percent of youth-serving programs that engage youth in program planning and implementation**

| Measure Status: | | | | Active | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 68.7 | 70.1 | 71.6 | 73.1 |
| Annual Indicator | 68.7 | 78.1 | 79.4 | 73.3 | 84.4 |
| Numerator | 46 | 50 | 50 | 44 | 54 |
| Denominator | 67 | 64 | 63 | 60 | 64 |
| 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 | Survey of CAPP, PREP, and SRAE Programs |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | 2024 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2020** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data from 7/1/2020 - 12/31/20.<br><br>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:**<br>Data from 1/1/2021 - 12/31/21.<br><br>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:**<br>Total of 65 programs, two did not respond (missing data) | |
| 4. | **Field Name:** | **2023** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data from 1/1/2023 - 12/31/23.<br>Total of 67 programs, seven did not respond (missing data) | |
| 5. | **Field Name:** | **2024** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Out of 65 programs surveyed for this measure there was 1 non-responder. Response rate is 98.46%. | |

**2021-2025: 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** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 55.3 | 58.1 | 61 | 64.1 |
| Annual Indicator | 63.4 | 40.1 | 53.9 | 62.4 | 67.8 |
| Numerator | 2,068 | 573 | 1,299 | 1,668 | 1,970 |
| Denominator | 3,260 | 1,430 | 2,412 | 2,675 | 2,905 |
| Data Source | MICHC Program Data | MICHC Program Data | MICHC Program Data | MICHC Program Data | MICHC Program Data |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | 2024 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Baseline data period for 10/1/19-3/31/20 | |
| 2. | **Field Name:** | **2020** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>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:**<br>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:**<br>Per data reported in DMIS for 10/1/22 to 9/30/23. | |
| 5. | **Field Name:** | **2024** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Per data reported in DMIS for 10/1/23 to 9/30/24. | |

**2021-2025: 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** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 37.5 | 37.7 | 37.9 | 38.2 |
| Annual Indicator | 36.2 | 29.7 | 32.9 | 33.5 | 29.9 |
| Numerator | 92,136 | 58,264 | 66,886 | 64,392 | 58,769 |
| Denominator | 254,718 | 195,847 | 203,468 | 191,962 | 196,690 |
| 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 | 2019 | 2020 | 2021 | 2022 | 2023 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

**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 | |
| 2. | **Field Name:** | **2024** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** Data reported in FPDMIS 10/1/23-9/30/24. | |

## Form 10
## State Performance Measure (SPM) Detail Sheets

**State: New York**

No State Performance Measures were created by the State.

## 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 PPV.1 - Percent of regular Big 6 Postpartum Visit peer learning meetings attended with active participation in presenting and/or responding to peer discussions.**
**NPM – A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components - PPV**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Attend regular Big 6 postpartum visit subgroup and the whole group meetings, sharing New York SAP components related to postpartum visit with peers, and providing feedback and suggestions to other states' SAPs as appropriate. |
| **Definition:** | **Unit Type:** Percentage<br>**Unit Number:** 100<br>**Numerator:** The number of regular peer learning meetings attended.<br>**Denominator:** The number of regular peer learning meetings will be the number of postpartum visit subgroup meetings plus the number of whole group meetings. |
| **Data Sources and Data Issues:** | Meeting Minutes |
| **Evidence-based/informed strategy:** | ESM: Percent of regular Big 6 Postpartum Visit peer learning meetings attended with active participation in presenting and/or responding to peer discussions.<br>1) This ESM aligns directly with Strategy WMH-7: Convene, facilitate, and/or participate in partnerships to improve postpartum visits, health, and well-being.<br>2) As described in our SAP narrative for Strategy WMH-4, collaborative partnerships are central to our approach to increasing postpartum visits. As part of this work, Title V staff will actively participate in the "Big 6" Postpartum Visit Peer Learning Collaborative, which brings together the six largest states to strengthen public health approaches through peer learning and exchange to accomplish a shared objective and measure. This learning collaborative model is supported by evidence from quality improvement and implementation science research and has become a best practice in clinical and public health systems change. For example, a recent systematic review of learning collaboratives (Gotham et al, 2022) found that there is evidence of effectiveness for both traditional clinical and behavioral health-focused learning collaboratives to improve practices and health outcomes.<br>3) This strategy directly impacts the ESM by documenting NYS Title V Program participation in Big 6 Postpartum Visit peer learning meetings. |
| **Significance:** | This ESM directly measures participation of Title V Big 6 Medical Home for Postpartum Visits peer learning meetings. The strategy measures fidelity of implementation of this strategy in both qualitative (defined active participation) and quantitative (percent of meetings with participation) terms. It is important to hold ourselves accountable to consistent and active participation in the peer learning meetings to benefit from the collaboration, as the cited review by Gothamet al (2022) noted that approaches with greater fidelity to the learning collaborative model are most effective. |

**ESM PPV.2 - Percent of Perinatal and Infant Community Health Collaboratives (PICHC) clients who attended a postpartum visit within 12 weeks after giving birth.**
**NPM – A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components - PPV**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase the percentage of Perinatal and Infant Community Health Collaboratives (PICHC) clients that attend a postpartum visit within 12 weeks through continuous quality improvement projects. |
| **Definition:** | **Unit Type:** Percentage<br>**Unit Number:** 100<br>**Numerator:** The number of Perinatal and Infant Community Health Collaboratives (PICHC) clients that attend a postpartum visit within 12 weeks after giving birth.<br>**Denominator:** The number of Perinatal and Infant Community Health Collaboratives (PICHC) clients who gave birth. |
| **Data Sources and Data Issues:** | Perinatal and Infant Community Health Collaboratives (PICHC) Program data |
| **Evidence-based/informed strategy:** | ESM: Increase the percentage of Perinatal and Infant Community Health Collaboratives (PICHC) clients that attend a postpartum visit within 12 weeks through continuous quality improvement projects.<br>1) This ESM directly aligns Strategy WMH-1: Support perinatal home visiting services for pregnant and postpartum women. This ESM mirrors NPM on Postpartum Visit; and applies to the Perinatal and Infant Community Health Collaboratives (PICHC) Program, a community-health worker home visiting model.<br>2) The MCH Evidence Center lists home visiting as having moderate evidence, which is the strongest category of interventions for this measure, to influence postpartum visit performance.<br>3) The state's home visiting programs have the ability to reach many people and, with the state's existing infrastructure funding a training and technical assistance center, we can support our home visiting program to implement. Lessons learned can be shared more broadly with the state's other home visiting programs. |
| **Significance:** | This ESM measures Postpartum Visit for the Perinatal and Infant Community Health Collaboratives (PICHC) Program, a community-health worker home visiting model. This ESM will measure the state's success on this NPM among a subset of individuals. As we review data and work to improve performance, we can share lessons learned with the state's other home visiting programs. |

**ESM RAC.1 - Percent of birthing hospitals re-designated with updated standards**
**NPM – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) - RAC**

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Update NYS perinatal regionalization standards and designations and implement updated performance measures for Regional Perinatal Centers and affiliate birthing hospitals.</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>NYS Title V Program records – current list of birthing facilities and updated list as birthing hospitals are re-designated.<br>As noted in the State Action Plann narrative, the re-designation cannot begin until updated standards are adopted in state regulations.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>ESM: Percent of birthing hospitals re-designated with updated standards.<br>1) This ESM is aligned with Strategy 3 in the Perinatal and Infant Health domain application: Maintain and enhance the statewide perinatal regionalization system to ensure that pregnant women and newborns receive high quality, risk-appropriate care, including a specific focus on infant morbidity and mortality.<br>2) The MCH Evidence Center indicates that this is an evidence-based intervention with moderate evidence to support improving risk appropriate perinatal care.<br>3) The strategy to formally redesignate hospitals will provide an opportunity to ensure all New York perinatal hospitals are functioning in accordance with current standards of care for both maternal and infant outcomes.</td></tr>
<tr><td>Significance:</td><td>This ESM measures birthing hospitals with a perinatal care designation matches their capacity and that the people giving birth are seen in the location that best meets their needs. Evidence supports that there will be better outcomes if perinatal hospitals are functioning in accordance with current standards of care for both maternal and infant outcomes.</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 - PA-Child**

| | |
|---|---|
| **Measure Status:** | Inactive - Replaced |
| **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<br>**Unit Number:** 100<br>**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<br>**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 PA-Child.2 - Percent of School Based Health Centers (SBHCs) operators that have 3 or more partnerships to promote physical activity.**
**NPM – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | 100% of School Based Health Centers (SBHCs) operators will have 3 or more partnerships to promote physical activity. |
| **Definition:** | **Unit Type:** Percentage<br>**Unit Number:** 100<br>**Numerator:** The number of School Based Health Centers (SBHCs) operators with 3 or more partnerships to promote physical activity.<br>**Denominator:** The number of School Based Health Centers (SBHCs) operators |
| **Data Sources and Data Issues:** | SBHC Survey |
| **Evidence-based/informed strategy:** | ESM: Percent of SBHC operators that have 3 or more partnerships to promote physical activity<br>1) This ESM directly aligns with Strategy CH-5: Through the SBHC program, implement both clinical practices and community partnerships that promote healthy active play and physical activity.<br>2) As described under Strategy CH-1, SBHCs are a critical part of the public health infrastructure for providing primary and preventive health care to children in NYS. There is good evidence to support individual patient-centered counseling by health care providers to positively influence health behaviors as one aspect of overall approaches to promoting physical activity among youth. Moreover, SBHCs' location and relationship with schools provides a unique opportunity to explore partnerships that go beyond individual care to encompass other evidence-based and emerging family, school, and community interventions, including the new investment in Community Health Workers linked to SBHCs. The MCH Evidence Center's online resources provide multiple evidence-based activities in school settings. Since the schools are different in their structure and population, there will not be one correct model. We will work with the SBHCs to share the evidence then support them to implement. Partnerships will be required to be successful in any of these models.<br>3) Strategy CH-1 directly impacts the ESM by facilitating establishment of new partnerships and/or enhancement of existing partnerships between SBHCs and other community agencies or organizations to promote age-appropriate physical activity. |
| **Significance:** | This ESM measures SBHC program partnerships to promote physical activity. SBHC operators can link students to existing opportunities and/or work collaboratively with community partners to create new opportunities for activities that promote physical activity within and outside of school. Measuring the establishment of such partnerships through the ESM holds SBHCs accountable to completing and reporting this foundational activity. Setting the bar at three or more partnerships encourages more robust work in this area by grantees. |

**ESM MHT.1 - Percent of DFH-funded adolescent-serving programs that receive mental health-related trainings and resources.**
**NPM – Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling - MHT**

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>100% of DFH-funded adolescent-serving programs will receive mental health-related trainings and resources.</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>DFH-funded adolescent-serving programs that received mental health-related trainings and resources</td></tr>
<tr><td>Denominator:</td><td>DFH-funded adolescent-serving programs</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Source: Adolescent health program data<br>As noted in the State Action Plan narrative for Strategy AH-3, DFH-funded adolescent-serving programs included in the numerator and denominator for this measure include: School-Based Health Centers (SBHCs), Comprehensive Adolescent Pregnancy Prevention (CAPP), Personal Responsibility Education Program (PREP), Sexual Risk Avoidance Education (SRAE), Children and Youth with Special Health Care Needs (CYSHCN), Family Planning, and Sexual Violence Prevention programs</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>ESM AH-1: Percent of DFH-funded adolescent-serving programs that receive mental health-related trainings and resources.<br>1) This ESM directly aligns with Strategy AH-2: Partner with the NYS Office of Mental Health Project TEACH program to enhance primary care provider capacity for providing mental health services in SBHCs and other youth-serving programs statewide and Strategy AH-3: Incorporate information and resources to promote the physical, mental, and behavioral health and wellness of adolescents across all youth-serving Title V programs.<br>2) Training is a widely recognized and utilized implementation support strategy from translational research/ implementation science. Evidence to support training specific to influencing provider mental health practices and collaborative care for the management of depression (comparable to Project TEACH) is summarized in the HRSA-funded Strengthening the Evidence for MCH Evidence Tools.<br>3) Providing training to a broad scope of Title V-funded clinical and public health providers will influence the performance measure by positively influencing their practices related to educating, screening, referring, and treating youth for needed mental health treatment or counseling, including through social support to de-stigmatize mental health challenges and treatment."</td></tr>
<tr><td>Significance:</td><td>This ESM measures outreach and dissemination of training and related resources to frontline providers in SBHCs and other youth-serving program in NYS. These are necessary initial steps to connect providers with such resources, and thus appropriate for measuring progress in this new strategy as part of planning and early implementation phases. Over time, the ESM can be modified to reflect subsequent impact at later phases.</td></tr>
</table>

**ESM MH.1 - Percent of students attending schools that have School Based Health Centers (SBHCs) who are enrolled in the SBHC program**
**NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | 75% of students attending schools with SBHCs will be enrolled in SBHC |
| **Definition:** | **Unit Type:** Percentage<br>**Unit Number:** 100<br>**Numerator:** The number of students attending schools with SBHCs who are enrolled in SBHC<br>**Denominator:** The number of students attending schools with SBHCs |
| **Data Sources and Data Issues:** | Quarterly reports submitted by SBHC. The numbers are self-reported. |
| **Evidence-based/informed strategy:** | ESM CH-1: Percent of students attending schools that have SBHCs who are enrolled in the SBHC program<br>1) This ESM directly aligns with Strategy CH-1: Support a statewide School-Based Health Center (SBHC) program to provide comprehensive, evidence-based, patient-centered primary and preventive health care services - including medical, mental, and dental care - to children in low-income and underserved communities.<br>2) There is a large body of evidence over several decades to support School-Based health Centers as a strategy for improving student health and educational outcomes. The HRSA-funded Strengthening the Evidence for MCH Evidence Tools rates SBHCs as 'scientifically rigorous' (highest level of evidence) for addressing the Medical Home NPM.<br>3) Enrolling children in SBHCs is a foundational step to providing them with needed medical services and a good measure of reach that is feasible to track and meaningful for SBHC providers. |
| **Significance:** | This ESM measures enrollment of eligible students in SBHCs, which is a key step for SBHCs to be able to provide them with comprehensive services, communciate with other providers, bill insurance, and other routine elements of care. Enrollment is also an important metric for SBHCs to demonstrate the ongoing need for and value of their services to the communities in which they are located. This is a measure already tracked and reported by SBHCs that they recognize as an indicator of performance necessary for other measures of impact. |

**ESM MH.2 - Percent of regular Big 6 medical home for CYSHCN peer learning meetings attended with active participation in presenting and/or responding to peer discussions.**
**NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH**

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Attend 90% of the Title V CYSHCN Big 6 meetings.</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>The number of Title V Big 6 Medical Home for CYSHCN regular peer learning meetings attended.</td></tr>
<tr><td>Denominator:</td><td>The number of Title V Big 6 CYSHCN subgroup meetings plus the number of whole group meetings.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Meeting Minutes</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>ESM: Percent of regular Big 6 Medical Home for CYSHCN peer learning meetings attended with active participation in presenting and/or responding to peer discussions.<br>1) This ESM aligns directly with Strategy CYSHCN-4: Convene, facilitate, and/or participate in collaborative partnerships to advance implementation of the medical home model for children and youth with special health care needs (CYSHCN).<br>2) As described in our SAP narrative for Strategy CYSHCN-4, collaborative partnerships are central to our approach to improving systems of care for CYSHCN. The medical home model is a well-supported, evidence-based approach that improves care coordination, family engagement, and health outcomes for CYSHCN. As part of this work, Title V staff will actively participate in the “Big 6” Medical Home for CYSHCN Peer Learning Collaborative, which brings together the six largest states to strengthen care systems through shared learning and exchange to accomplish a shared objective and measure. This learning collaborative model is supported by evidence from quality improvement and implementation science research and has become a best practice in clinical and public health systems change. For example, a recent systematic review of learning collaboratives (Gotham et al, 2022) found that there is evidence of effectiveness for both traditional clinical and behavioral health-focused learning collaboratives to improve practices and health outcomes.<br>3) This strategy directly impacts the ESM by documenting NYS Title V Program participation in Big 6 Medical Home for CYSHCN peer learning meetings.</td></tr>
<tr><td>Significance:</td><td>This ESM directly measures participation of Title V Big 6 Medical Home for CYSHCN peer learning meetings. The strategy measures fidelity of implementation of this strategy in both qualitative (defined active participation) and quantitative (percent of meetings with participation) terms. It is important to hold ourselves accountable to consistent and active participation in the peer learning meetings to benefit from the collaboration, as the cited review by Gothamet al (2022) noted that approaches with greater fidelity to the learning collaborative model are most effective.</td></tr>
</table>

**ESM TAHC.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 transition to adult health care - TAHC**

| | |
|---|---|
| **Measure Status:** | Inactive - Replaced |
| **Goal:** | Increase the percent of individuals ages 14 to 21, with sickle cell disease, who had subsequent transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical |
| **Definition:** | **Unit Type:** Percentage<br>**Unit Number:** 100<br>**Numerator:** Individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed<br>**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:** | Program quarterly reports. |
| **Evidence-based/informed strategy:** | Planning for Transition and Care Coordination by providing planning, transfer assistance, and care coordination to prepare adolescents for the transition from pediatric to adult health care services. |
| **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. |

**ESM TAHC.2 - Percent of individuals ages 14-21 with sickle cell disease who had subsequent 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 transition to adult health care - TAHC**

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percent of individuals ages 14 to 21, with sickle cell disease, who had subsequent transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical</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>Individuals who had subsequent transition readiness assessments completed.</td></tr>
<tr><td>Denominator:</td><td>Individuals ages 14 to 21 who have sickle cell disease and were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Sickle Cell Disease Care Transition Program quarterly reports.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>ESM:Percent of individuals ages 14-21 with sickle cell disease who had subsequent transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.<br>1) This ESM directly aligns directly with Strategy CYSHCN-7: Support local and regional programs to support transition of youth with special health care needs, based on the evidence-based Got Transition® model.<br>2) Evidence from the MCH Evidence Center and the Blueprint for Change underscores that structured, comprehensive transition programs reduce gaps in care, lower emergency department use, and increase patient and family satisfaction. Structured intervention that incorporate the six core elements of transition (including then Got Transition® model) were among the highest-rated evidence base for achieving the Transition NPM in the MCH Evidence Center review.<br>3) Strategy CYSHCN-7 directly impacts the ESM by providing education and implementation support local SCD programs to incorporate and document transition readiness assessments among youth served through their programs.</td></tr>
<tr><td>Significance:</td><td>This ESM measures completion and documentation of transition readiness assessments completed for youth with SCD served through NYSDOH-funded Sickle Cell Disease Care Transition Programs. Measuring actual changes in practice is a rigorous intermediate outcome (practice/systems change) that is appropriate given that these programs have been funded for several years and thus in ongoing implementation/ maintenance phase of this work.</td></tr>
</table>

## Form 10
## Evidence-Based or -Informed Strategy Measure (ESM) (2021-2025 Needs Assessment Cycle)

**2021-2025: 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.**
**2021-2025: NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - 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>Evidence-based/informed strategy:</td><td>Strategy is to provide training on adult preparation subjects to adolescence to prepare them transition to adults setting.</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>

**2021-2025: ESM AWV.2 - Percent of youth-serving programs that engage youth in program planning and implementation**
**2021-2025: NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - 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 68.7%. The program has set an improvement target of 75% 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 engage youth in program planning and implementation</td></tr>
<tr><td>Denominator:</td><td>Number of youth-serving programs</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 adolescent health providers.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Strategy is to engage youths in program planning and implementation</td></tr>
<tr><td>Significance:</td><td>This ESM is to engage youths in program planning and implementation to promote their health.</td></tr>
</table>

**2021-2025: 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)**
**2021-2025: NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year - 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:** | <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 MICHC participants engaged prenatally who have created a birth plan during a visit with a CHW</td></tr><tr><td>**Denominator:**</td><td>Number of MICHC participants engaged prenatally with a CHW</td></tr></table> |
| **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. |

**2021-2025: ESM WWV.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year**
**2021-2025: NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year - 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<br>**Unit Number:** 100<br>**Numerator:** Number of Family Planning Program clients with a documented comprehensive medical exam in the past year<br>**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. |

## 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 2024**

| | 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<br>• Infant Birth and Death<br>• 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 | Annually | 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 2024**

Products and Publications information has not been provided by the State.