New York State Department of Health
Title V Maternal and Child Health Services Block Grant Five-Year State Action Plan 2021-2025

Domain: Women and Maternal Health
Objective WMH-1: Increase the percent of women, ages 18 through 44, with a preventive medical visit in the past year by 5%, from 79.6% in 2018 to 83.6% in 2022. (Behavioral Risk Factor Surveillance System)
Objective WMH-2: Reduce the maternal mortality rate by 10%, from 17.8 deaths per 100,000 live births in 2014-2018 to 16 deaths per 100,000 live births in 2018-2022. (National Vital Statistics System)
Objective WMH-3: Reduce the rate of severe maternal morbidity per 10,000 delivery hospitalizations by 5%, from 83.5 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2017 to 79.3 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2021. (Healthcare Cost and Utilization Project-State Inpatient Databases)
Objective WMH-4: Reduce the percent of women who have depressive symptoms after birth by 5%, from 13% in 2017 to 12.4% in 2021. (Pregnancy Risk Assessment Monitoring System)
Associated National Outcome Measures (NOM): NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations NOM 3: Maternal mortality rate per 100,000 live births NOM 4: Percent of low-birth-weight deliveries (<2,500 grams) NOM 5: Percent of preterm births (<37 weeks gestation) NOM 6: Percent of early term births (37,38 weeks gestation) NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births NOM 10: Percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy NOM 11: The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth
Associated National Performance Measure (NPM): NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Associated Evidence-Based Strategy Measure (ESM): ESM WMH-1: Percent of MICHC program participants engaged prenatally who have created a birth plan during a visit with a Community Health Workfer ESM WMH-2: Percent of female Family Planning Program clients with a documented comprehensive medical exam in the past year

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Strategy WMH-1 Alignment with Needs Assessment Priorities*: Health Care, Poverty, Awareness of Resources, Transportation, Community Services, Parenting & Family Support, and Social Support & Cohesion
Strategy WMH-1: Integrate specific activities across all relevant Title V programs to promote the health and wellness of people of child-bearing age, including enrollment in health insurance, routine well visits, pregnancy planning and prevention, prenatal, and postpartum care through coordination and linkages across systems of care (hospital to community).
Activity WHM-1.2: RPCs and affiliate hospitals enhance capacity to provide perinatal telehealth services and subspecialty providers with an emphasis on rural communities and those with disproportionate access to services. **Activity WMH-1.3:** Through the Perinatal and Infant Community Health Collaborative and the Maternal, Infant, and Early Childhood Home Visiting programs, integrate use of virtual home visiting services to increase acceptance and support of services for families that have been hard to reach. **Activity WMH-1.4:** Perinatal and Infant Community Health Collaborative programs support Community Health Workers to conduct outreach to find and engage high-risk pregnant and postpartum families in consistent, comprehensive preventive and primary care services, including prenatal, interconception, and postpartum care. **Activity WMH-1.5:** Family Planning Program support delivery of comprehensive reproductive health services. **Activity WMH-1.6:** Support prevention and response services for victims of sexual violence. **Activity WMH-1.7:** Train Perinatal and Infant Community Health Collaborative and Maternal, Infant, and Early Childhood Home Visiting programs on CDC's *Learn the Signs Act Early* campaign. Collaborate with the NYS Council for Children and Families on the Early Childhood Comprehensive Systems grant which supports dissemination of *Learn the Signs Act Early* materials. **Activity WMH-1.8:** Direct American Rescue Plan Act funds to Maternal, Infant, and Early Childhood Home Visiting funded Healthy Families New York and Nurse Family Partnership programs to support program staffing (including hazard pay), staff training and diaper bank coordination, as well as assisting eligible families in obtaining emergency supplies, technology to support virtual home visits, and prepaid grocery cards. **Activity WMH-1.9:** Conduct public awareness campaigns to promote messages about maternal warning signs to educate pregnant and postpartum women about when to seek help for untoward conditions associated with perinatal complications.
Strategy WMH-2 Alignment with Needs Assessment Priorities*: Health Care, Poverty, Awareness of Resources, Community Services, Parenting & Family Support, Social Support & Cohesion
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.
Activity WMH-2.1: Collaborate with birthing hospitals and Regional Perinatal Centers to support new regulations requiring referral and support for mental health, substance use treatment and other ancillary services. **Activity WMH-2.2:** Improve coordination with birthing hospitals and increase bilateral referrals through utilization of best practices
Strategy WMH-3 Alignment with Needs Assessment Priorities*: Health Care Poverty, Parenting & Family Support
Strategy WMH-3: Apply public health surveillance and data analysis findings to improve services and systems related to maternal and women's health care.

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Activity WMH-3.1: Summarize, share, and discuss findings of the Maternal Mortality Review Board with key stakeholders, including the Maternal Mortality and Morbidity Advisory Council, to inform and guide statewide prevention strategies. **Activity WMH-3.2:** Issue and disseminate a biennial Maternal Mortality Report to provide data that can be used to improve maternal outcomes. **Activity WMH-3.3:** Identify cases of Severe Maternal Morbidity through hospital discharge data and conduct an analysis using linked birth data and hospital discharge data to define the major causes of maternal morbidity. **Activity WMH-3.4:** Promote the NYS Perinatal Quality Collaborative quality improvement activities that support the NYS Birth Equity Improvement Project, a comprehensive interdisciplinary quality improvement project focused on reducing implicit bias and improving birth equity. **Activity WMH-3.5:** Collaborate with NYSDOH AIDS Institute and the New York City Department of Health and Mental Hygiene on efforts to address significant increases in the number and rate of congenital syphilis among NYS females of childbearing age
Strategy WMH-4 Alignment with Needs Assessment Priorities*: Health Care, Poverty, Awareness of Resources, Transportation, Community Services, Parenting & Family Support, Social Support & Cohesion, Community & Environmental Safety, Housing, Healthy Food
Strategy WMH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact women's health and use of health care across the life course.
Activity WMH-4.1: Perinatal and Infant Community Health Collaborative contractors conduct community mobilization and engagement activities to identify issues and develop strategies that address barriers impacting maternal and infant health **Activity WMH-4.2:** Through NYSDOH funded home visiting programs (Perinatal and Infant Community Health Collaborative, Healthy Families NY, and Nurse Family Partnership programs), provide supports to individual clients and their families to address social determinants of health and improve outcomes. **Activity WMH-4.3:** Collaborate with internal partners including NYS Perinatal Quality Collaborative and Perinatal and Infant Community Health Collaborative program, and external partners including Prevent Child Abuse New York, the Schuyler Center for Advocacy and Analysis, NYS Office of Mental Health, and the Office of Children and Families. **Activity WMH-4.4:** Collaborate with NYS Perinatal Quality Collaborative on the NYS Birth Equity Improvement Project. **Activity WMH-4.5:** Through the Infertility Reimbursement Program, provide reimbursement for out-of-pocket costs associated with in vitro fertilization (IVF) and fertility preservation services to individuals who meet eligibility criteria. **Activity WMH-4.6:** Improve uptake of the COVID-19 vaccination among people who are pregnant, in the postpartum period and/or lactating, and of those people's families, with an emphasis on equity and those populations disproportionately affected by the COVID-19 pandemic. **Activity WMH-4.7:** Update and improve the NYS Sexual Assault Victim's Bill of Rights **Activity WMH-4.8:** Through Breastfeeding Grand Rounds webcasts, provide education on current breastfeeding health issues with both clinical and public health significance. **Activity WMH-4.9**: Develop and deliver a health equity training to staff within the Bureau of Perinatal, Reproductive, and Sexual Health, and more broadly across the Division of Family Health through the Racial Justice and Health Equity Workgroup.

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Activity WMH-4.10: Improve reproductive healthcare for the substance use population through NYS Family Planning Program collaboration with the AIDS Institute's Office of Drug User Health by addressing disparities and creating partnerships and strong referrals between Family Planning Programs and Syringe Exchange Programs to strengthen reproductive healthcare and primary care. **Activity WMH-4.11:** Provide resources for birthing people to find their voice and communicate effectively with health care providers **Activity WMH-4.12**: Engage with Maternal, Infant, and Early Childhood Home Visiting programs (Healthy Families NY and Nurse Family Partnership) and the Perinatal and Infant Community Health Collaborative program providers to promote the availability of diapers through the NY Cares/Baby2Baby Diaper Bank

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Objective PIH-1: Increase or maintain the percent of very low birth weight infants born in a hospital with a Level III+ NICU by 2.4%, from the 2017 level of 91.2% to 93.4% by 2021. (NYS Vital Statistics Birth Data)
Objective PIH-2: Decrease the infant mortality rate by 2.6%, from 4.6 deaths per 1,000 live births in 2017 to 4.49 deaths per 1,000 live births in 2021 (National Vital Statistic System)
Objective PIH-3: Improve the timeliness of Newborn Blood Spot samples received at the NYSDOH Wadsworth Laboratory from 74.34% to greater than 85% of samples received within 48 hours of collection by September 2023. (Newborn Blood Spot data)
Associated National Outcome Measures (NOM): NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births
Associated National Performance Measures (NPM): NPM 3: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
Associated Evidence-Based Strategy Measure (ESM): ESM PIH-1: Percent of birthing hospitals with final level of perinatal care designation, in accordance with updated regulations and standards.
Strategy PIH-1 Alignment with Needs Assessment Priorities*: Transportation, Awareness of Resources, Community Services, Poverty, Parenting & Family Support, Social Support & Cohesion, Health Care
Strategy PIH-1: Integrate specific activities across all relevant Title V programs to promote access to early prenatal care, birthing facilities appropriate to one's needs, postpartum care, and infant care.
Activity PIH-1.2: Through the PICHC and Maternal, Infant, and Early Childhood Home Visiting programs, integrate use of a birth plan including a discussion of appropriate level of care for childbirth. **Activity PIH-1.3:** In collaboration with the NYS Office of Health Insurance Programs (i.e., the state's Medicaid program), support funded Community Health Worker programs to become Medicaid-enrolled providers for reimbursement.

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Activity PIH-1.4: Support new and ongoing messaging, educational, and social marketing campaigns to promote perinatal and infant health. Campaigns and messaging will be tailored to individuals who are pregnant, neonates/infants, their parents/caregivers, and families; campaign topics will be determined based on emergent needs and opportunities. **Activity PIH-1.5:** Through the Regional Perinatal Centers and networks of affiliate birthing hospitals, support and enhance capacity to provide high quality perinatal telehealth services and perinatal subspecialty providers, particularly to rural communities and communities with disproportionate access to such services. **Activity PIH-1.6:** Through the Perinatal and Infant Community Health Collaboratives and Maternal, Infant, and Early Childhood Home Visiting programs, integrate use of virtual home visiting services to increase acceptance and support of services for hard-to-reach families. (Policy, Equity focus) **Activity PIH-1.7:** Through the Perinatal and Infant Community Health Collaboratives and Maternal, Infant, and Early Childhood Home Visiting programs, support community health workers to engage high-risk pregnant and postpartum families in consistent, comprehensive preventive and primary care services, including newborn care, screening, and assisting families in enrolling in health insurance, and providing families with social support to enhance health literacy and use of health care. **Activity PIH-1.8 (New to 2023-24):** Support distribution of free diapers to families in need through the NY Cares/Baby2Baby. Diaper Bank program. The Perinatal and Infant Community Health Collaboratives and Maternal, Infant, and Early Childhood Home Visiting programs, and other maternal and infant health-serving programs will be encouraged to obtain diapers from the Diaper Bank and distribute them enroll potential clients as appropriate. **Activity PIH-1.9**: Through the American Indian Health program, continue to support direct health care and supporting services to ensure access to health care. **Activity PIH-1.10**: Through the Migrant and Seasonal Farmworker programs, continue to support direct health care and supporting services to ensure access to health care. **Activity PIH-1.11**: Through all Title V programs, offer, and provide opportunities for training and technical assistance related to clinical and community topics related to perinatal and infant health.
Strategy PIH-2 Alignment with Needs Assessment Priorities*: Transportation, Health Care, Awareness of Resources, Community Services, Parenting & Family Support, Social Support & Cohesion
Strategy PIH-2: Implement updated perinatal regionalization standards, designations, and structured clinical quality improvement initiatives in birthing hospitals and centers.
Activity PIH-2.1: Establish regulations to require birthing hospitals to provide referral and support for ancillary services, including mental health, alcohol and substance use treatment and other services. **Activity PIH-2.2:** Assess perinatal designation surveys and site visit findings, communicate with birthing hospital staff on identified issues, and issue final designations for perinatal levels of care. **Activity PIH-2.3:** To improve coordination and increase bilateral referrals between birthing hospitals and home visiting programs **Activity PIH-2.3e (New to 2023-24):** Title V staff will engage with Essex County Department of Health to support implementation of a universal light touch home visiting program reaching all birthing people and families within the county regardless of income or other need criteria. (Policy, Equity focus)

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Activity PIH-2.4: Continue collaboration with other NYSDOH units to support the programmatic review to establish midwifery-led birthing centers through national accreditation and streamlined Certificate of Need application, and support integration of these facilities into the regional perinatal system as a critical foundation for obstetrical and neonatal patients who are at low risk. **Activity PIH 2.5:** Collaborate with stakeholders to educate OB-GYN and family practice providers about changes to local birthing hospitals' level of perinatal care designation.
Strategy PIH-3 Alignment with Needs Assessment Priorities*: Transportation, Health Care, Awareness of Resources, Community Services, Parenting & Family Support
Strategy PIH-3: Apply public health surveillance and data analysis findings to improve services and systems related to perinatal and infant health care.
Activity PIH-3.1: Collaborate with the Office of Children and Family Services (Healthy Families NY), Nurse Family Partnership programs, PICHC, and local Supplemental Nutritional Assistance Program for Women, Infant, and Children (WIC) programs on the WIC Referral Project and the State Maternal, Infant, and Early, Childhood Home Visiting continuous quality improvement project to improve bi-directional referrals between local WIC sites and local home visiting programs. **Activity PIH-3.2:** Lead quality improvement projects through the NYS Perinatal Quality Collaboratives, with birthing hospital teams and community-based organizations. (Policy, Equity focus) **Activity PIH-3.5:** Collaborate with NYSDOH AIDS Institute and the New York City Department of Health and Mental Hygiene on efforts to address significant increases in the number and rate of infectious (primary, secondary, and early latent) syphilis among New York State females of childbearing age, and number and rate of congenital syphilis cases (Equity focus)
Strategy PIH-4 Alignment with Needs Assessment Priorities*: Transportation, Health Care, Awareness of Resources, Community Services, Poverty, Parenting & Family Support, Social Support & Cohesion, Community & Environmental Safety, Housing, Healthy Food
Strategy PIH-4: Address social determinants identified by community members that impact infant health and use of perinatal and infant health care and support services.
Activity PIH-4.2: Through the Perinatal and Infant Community Health Collaboratives programs, work with diverse community stakeholders including community residents to identify and collaboratively address issues and barriers impacting maternal and infant health outcomes at the community level (Equity focus). **Activity PIH-4.3:** Through the Perinatal and Infant Community Health Collaboratives and Maternal, Infant, and Early Childhood Home Visiting programs, provide supports to individual clients and their families to address social determinants of health. Provide information on community resources, screen and assist families in enrolling in health insurance and health care, work directly with families to strengthen health literacy, self-care, and advocacy skills, and provide and enroll families in enhanced social supports and educational opportunities **Activity PIH-4.4:** Through the NYS Perinatal Quality Collaborative, continue to develop and lead a new quality improvement project with birthing hospital teams and community-based organizations, to improve outcomes for all infants admitted to Neonatal Intensive Care Units (NICUs) and their families by focusing on racial justice and birth equity (Equity focus).

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Activity PIH-4.5: Title V staff will collaborate with the Division's Bureau of Health Equity and Community Engagement to share resources with stakeholders and funded programs serving pregnant and birthing people and their families, as well as to establish or strengthen connections between community partners and Title V-funded programs. **Activity PIH-4.6**: Through all Title V programs, provide opportunities for training and technical assistance related to providing services equitably, addressing social determinants of health, health disparities, and promoting racial and reproductive justice. **Activity PIH-4.7**: Issue a procurement to establish a statewide Parent Advisory Committee, beginning in 2024, consisting of parents who are current/former home visiting clients and other stakeholders. Through parent engagement and leadership, the Parent Advisory Committee will provide input on matters of interest to state agency partners and develop professional skills. Title V and Maternal, Infant, and Early Childhood Home Visiting staff will share lessons learned with home visiting programs to enhance their community member participation on Community Advisory Boards. **Activity PIH-4.8**: Support the Department's various breastfeeding/chestfeeding activities, including collaboration with intra-agency workgroups and planning and promoting breastfeeding grand round meetings.
Associated State Performance Measure (SPM): SPM1: state-wide improvement from 74.34% to greater than 85% of samples received at the lab within 48 hours of collection
Strategy PIH-5 Alignment with Needs Assessment Priorities*: Awareness of Resources, Health Care
Strategy PIH-5: Maintain and strengthen a robust statewide population-based Newborn Screening Program.
Activity PIH-5.1: Conduct virtual and in-person (when appropriate) site visits with birthing facilities to provide education about NBS regulation and compliance. **Activity PIH-5.2:** Continue implementation of a hospital late collection (>120hr) follow-up process to ensure timely collection and mitigate risks of hospital staff oversight. **Activity PIH-5.4 (New to 2023-24):** Through the NYS Early Hearing Detection and Intervention program, provide monthly data reports to birthing hospitals identifying infants born at their facility that failed an initial hearing screening test and do not have a reported follow-up test within three months of birth, and provide technical support as appropriate. **Activity PIH-5.5:** The NY Early Hearing Detection and Intervention program will collaborate with the Newborn Screening program to enhance identification and linkage to care for infants with Congenital Cytomegalovirus (cCMV) Infection who may be at risk for hearing loss.

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Objective CH-1: Increase the percent of NYS children age 6-11 who are physically active at least 60 minutes per day by 3.7%, from 27% in 2017-2018 to 28% in 2021-2022 (National Survey of Children's Health).
Objective CH-2: Decrease the percent of NYS children age 10-17 who are obese (BMI at or above the 95th percentile) by 2.8%, and from 14.4% of children age 10-17 in 2017-2018 to 14% in 2021-2022 (National Survey of Children's Health).
Associated National Outcome Measures (NOM): NOM 19: Percent of children, ages 0 through 17, in excellent or very good health

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NOM 20: Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)
Associated National Performance Measures (NPM): NPM 8.1: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
Associated Evidence-Based Strategy Measures (ESM): ESM CH-1: Percent of children and youth enrolled in School Based Health Center 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.
Strategy CH-1 Alignment with Needs Assessment Priorities*: Healthy Food, Community & Environmental Safety, Awareness of Resources, Community Services, Health Care, Parenting & Family Support
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.
Activity CH-1.1: Provide guidance and add quarterly reporting requirements for all funded School Based Health Centers to increase provision of 1) age-appropriate anticipatory guidance regarding physical activity and nutrition and 2) routine assessment for indicators of overall health, one of which will be weight status, but it will not be the sole factor. Data from quarterly reports will be reviewed and reports will be generated for feedback to School Based Health Centers to assess progress and drive improvements in these practices. **Activity CH-1.2:** Promote the use of the American Academy of Pediatrics' Bright Futures model for anticipatory guidance in School Based Health Centers and seek opportunities to engage the American Academy of Pediatrics for assistance to promote this resource.
Strategy CH-2 Alignment with Needs Assessment Priorities*: Healthy Food, Community & Environmental Safety, Transportation, Community Services, Parenting & Family Support, Social Support & Cohesion
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.
Activity CH-2.1: Collaborate with the NYSDOH Division of Chronic Disease Prevention to implement multi-pronged strategies to enhance the work of Creating Healthy Schools and Communities grantees (as available), and other initiatives aimed at increasing children's physical activity. **Activity CH-2.2:** Facilitate partnerships between 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 through Complete Streets implementation, including Safe Routes to School programs. **Activity CH-2.3:** Collaborate with the Division of Chronic Disease Prevention's Asthma Control Program to promote asthma self-management education with School Based Health Centers to improve asthma management outcomes and increase students' participation in physical activity.
Strategy CH-3 Alignment with Needs Assessment Priorities*: Healthy Food, Community & Environmental Safety, Transportation, Community Services, Poverty, Social Support & Cohesion, Housing
Strategy CH-3: Apply public health surveillance and data analysis findings to improve services and systems related to

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children's health and health care.
Activity CH-3.1: Collaborate with the US Census Bureau to conduct an over-sample of NYS 2022 National Survey of Children's Health for enhanced sampling of Black/African-American, Hispanic, and Children and Youth with Special Health Care Needs. **Activity CH-3.2:** Design and implement a School Based Health Center data collection system that allows School Based Health Centers to identify, track, and address disparities within the School Based Health Center. **Activity CH-3.4:** Explore collaborative opportunities with Division of Chronic Disease Prevention's Bureau of Chronic Disease Evaluation and Research to review and share information on student weight status assessments to inform School Based Health Center work in this area.
Strategy CH-4 Alignment with Needs Assessment Priorities*: Healthy Food, Community & Environmental Safety, Transportation, Community Services, Poverty, Social Support & Cohesion, Housing
Strategy CH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact children's health and well-being.
Activity CH-4.1: Design the new School Based Health Center data collection system with a racial justice and health equity lens, building a reporting tool that allows School Based Health Centers to identify, track, and address disparities within the School Based Health Center (site or provider level). **Activity CH-4.2:** Partner with key stakeholders such as the Community Health Care Association of New York State and New York School Based Health Alliance to identify and share best practices for School Based Health Centers to address racial justice and health equity.

Domain: Children and Youth with Special Health Care Needs
Objective CYSCHN-1: Increase the percent of NYS adolescents with special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 17.8% in 2017-2018 to 18.7% in 2021-2022 (National Survey of Children's Health)
Objective CYSCHN-2: Increase the percent of children and youth with special health care needs, 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 CYSCN-3: Reduce the incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months by at least 5%, from 3.7 per 1000 children tested in 2016 to below 3.0 in 1000 children tested in 2022 (NYS Child Health Lead Poisoning Prevention Program Data)
Associated National Outcome Measures (NOM): NOM 17.2: Percent of children with special health care needs, ages 0 through 17, who receive care in a well-functioning system
Associated National Performance Measures (NPM): NPM 12: Percent of adolescents with and without special health care needs, ages 12-17, who received services necessary to make transitions to adult health care
Associated Evidence-Based Strategy Measure (ESM): ESM CYSHCN-1: Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed,

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among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.
Strategy CYSHCN-1 Alignment with Needs Assessment Priorities*: Community Services, Parenting & Family Support, Awareness of Resources, Social Support & Cohesion, Health Care
Strategy CYSHCN-1: Engage youth with special health care needs and their families in state and local efforts to improve systems and practices for supporting youth with special health care needs.
Activity CYSHCN-1.1: Maintain at least one dedicated family representative on the state's Title V Maternal and Child Health Services Block Grant Advisory Council and engaged all Council members in updates and discussions related to Children and Youth with Special Health Care Needs program activities. **Activity CYSHCN-1.2:** Collaborate with advocacy groups like Parent to Parent to understand the needs of Children and Youth with Special Health Care Needs and their families, facilitated information sharing, and promoted Local Health Department Children and Youth with Special Health Care Needs programs. **Activity CYSHCN-1.3:** Support Regional Support Centers to employ parents of Children and Youth with Special Health Care Needs as family/parent liaisons. 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. **Activity CYSHCN-1.4:** Support Regional Support Centers to develop a Children and Youth with Special Health Care Needs Resource Directory Guide that will be made available online to provide families and health care providers with current information about services and supports. **Activity CYSHCN-1.5:** Support Local Health Department Children and Youth with Special Health Care Needs programs to involve Children and Youth with Special Health Care Needs 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 Children and Youth with Special Health Care Needs to develop training for Local Health Department staff and providers. **Activity CYSHCN-1.6:** Engage the New York State Association of County Health Officials to promote and bolster Local Health Department Children and Youth with Special Health Care Needs programs to raise awareness of Children and Youth with Special Health Care Needs services and reach and serve more families. **Activity CYSHCN-1.7:** Support Sickle Cell Disease programs in three Hemoglobinopathy Centers to provide supports by and for youth with SCD, including peer support groups, system navigation supports, and self-care services. **Activity CYSHCN-1.8:** Collaborate with other Title V and Division of Family Health adolescent-serving programs, including School-Based Health Centers, Comprehensive Adolescent Pregnancy Prevention, and ACT for Youth Center for Community Action to identify additional opportunities to meaningfully engage adolescents in program and policy development that impacts Children and Youth with Special Health Care Needs. **Activity CYSHCN-1.9:** Serve on the NYS Developmental Disabilities Planning Council and its Individuals and Families Committee, to promote inclusion of Children and Youth with Special Health Care Needs-specific focus to the Council's agenda and policy portfolio.

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Activity CYSHCN-1.10: Collaborate with internal NYSDOH partners, such as Early Intervention, the Division of Chronic Disease Prevention, and Office of the Aging (NY Connects), and external partners such as Office of Children and Family Services to identify and utilize additional resources.
Strategy CYSHCN-2 Alignment with Needs Assessment Priorities*: Community Services, Parenting & Family Support, Awareness of Resources, Transportation, Social Support & Cohesion, Health Care
Strategy CYSHCN-2: Enhance care coordination, including transition support services, for children and youth with special health care needs.
Activity CYSHCN-2.1: Provide funding and program guidance to Local Health Department Children and Youth with Special HealthCare Needs 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 Children and Youth with Special Health Care Needs from pediatric to adult health care. Local Health Departments will provide timely and appropriate information and referrals to insurance, health services, transportation, and community resources to support transition and other services for Children and Youth with Special Health Care Needs. **Activity CYSHCN-2.2:** Continue to support three HRSA-designated University Centers of Excellence for Developmental Disabilities (UCEDDs), which are referred to as Regional Support Centers, to support youth, families, and Local Health Department Children and Youth with Special Health Care Needs programs. Regional Support Centers will identify resources and develop a comprehensive Resource Directory 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 Children and Youth with Special Health Care Needs and their families. As described in the previous strategy, families and youth are deeply involved in guiding this work. **Activity CYSHCN-2.3:** In collaboration with the Regional Support Centers, facilitate professional development and information sharing between Local Health Department programs related to transition, including a webinar on Got Transition®'s Six Core Elements. **Activity CYSHCN-2.4:** Administer Children and Youth with Special Health Care Needs Support Services. **Activity CYSHCN-2.5:** Provide grant funding, evidence-based strategies (Got Transition®) and technical assistance to Hemoglobinopathy Centers to support successful transition to adult services for young adults with Sickle Cell Disease, including but not limited to transition policy, tracking and monitoring, transition readiness and planning, transfer of care, and transition feedback and completion. **Activity CYSHCN-2.6:** Support care coordinators at Hemoglobinopathy Specialty Care Centers to help patients with Sickle Cell Disease with appointments, scheduling, education, peer support and other health care transition services. **Activity CYSHCN-2.7:** Facilitate collaboration between Title V programs serving youth. **Activity CYSHCN-2.8:** Provide subject matter and technical support to NYS Medicaid Program to implement enhanced care coordination and transition support services for Children and Youth with Special Health Care Needs through Medicaid's Health Home Serving Children.

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Activity CYSHCN-2.9: Provide representation, subject matter expertise, and policy implementation support for the Health Home Managed Care Organization subcommittee focused on Sickle Cell Disease.
Associated State Performance Measure (SPM): SPM 2: Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months.
Strategy CYSHCN-3 Alignment with Needs Assessment Priorities*: Community Services, Parenting & Family Support, Transportation, Poverty, Social Support & Cohesion, Health Care, Community & Environmental Safety, Housing, Healthy Food
Strategy CYSHCN-3: Support comprehensive public health efforts to prevent, identify, and manage childhood lead poisoning
Activity CYSHCN-3.1: Provide continued grant funding to local health department Lead Poisoning Prevention Programs and a statewide network of Regional Lead Resource Centers to support enhanced regional and local efforts to reduce the prevalence of elevated blood lead levels in children birth to 18 years. **Activity CYSHCN-3.2:** Work with Lead Poisoning Prevention Programs, Regional Lead Resource Centers, and other partners to ensure that all blood lead test results, including testing done in permitted/registered laboratories and point of service testing conducted in health care provider offices, are reported to the NYSDOH within the timeframes required. **Activity CYSHCN-3.3:** Through the Regional Lead Resource Centers, support the provision of outreach and education to health care provider and families, technical assistance to providers and Local Health Department programs, individual case consultation, and treatment of lead poisoning among children, pregnant women, and newborns, including chelation treatment where indicated. **Activity CYSHCN-3.4:** Through the Local Health Department Lead Poisoning Prevention Programs and Regional Lead Resource Centers, promote clinical prevention and screening practices in accordance with state requirements. **Activity 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. **Activity CYSHCN-3.6:** Through the Regional Lead Resource Centers, increase capacity and sustainability in local health care and public health systems by engaging health care providers and professional medical groups in leadership roles within regional or community coalitions focused on the prevention and elimination of lead poisoning.
Strategy CYSHCN-4 Alignment with Needs Assessment Priorities*: Housing, Awareness of Resources, Community Services, Health Care, Community & Environmental Safety
Strategy CYSHCN-4: Apply public health surveillance and data analysis findings to improve services and systems related to health and health care for children and youth with special health care needs.
Activity CYSHCN-4.1: Complete a careful analysis of the revised National Survey of Children's Health when available to assess available measures, trends, and other updates related to Children and Youth with Special Health Care Needs in NYS. **Activity CYSHCN 4.2:** Collaborate with the U.S. Census Bureau to conduct an over-sample of NYS 2022 National Survey of Children's Health for NYS to allow for enhanced sampling of Black/African-American, Hispanic, including CYSHCN. **Activity CYSHCN 4.3:** Analyze and report on available Children and Youth with Special Health Care Needs data for NYS, including data from the National Survey of Children's Health, share reports with Local Health Departments and other

Domain: Children and Youth with Special Health Care Needs
stakeholders, and post on the Department of Health's public website. **Activity CYSHCN 4.4:** Develop and implement plans for updating the current data reporting methods (quarterly and annual reports) of Local Health Department Children and Youth with Special Health Care Needs programs and Sickle Cell Disease care transition programs to NYSDOH Title V program. Analyze and share relevant data collected from programs to improve services and inform larger program and policy work related to Children and Youth with Special Health Care Needs. **Activity CYSHCN-4.5:** Use the data gathered from the Children and Youth with Special Health Care Needs programs to identify specific areas for further improvement and to inform improvement activities. **Activity CYSHCN-4.6:** Use the data combined from the Local Health Department quarterly narrative and data reports to accurately reflect the population served.
Strategy CYSHCN-5 Alignment with Needs Assessment Priorities*: Healthy Food, Community & Environmental Safety, Transportation, Community Services, Poverty, Social Support & Cohesion, Housing
Strategy CYSHCN-5: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact the health and well-being of children and youth with special health care needs.
Activity CYSHCN-5.1: Support local Children and Youth with Special Health Care Needs programs based in Local Health Department, with coverage increasing from 49 to 52 counties beginning October 2022. **CYSHCN-5.2:** Work with the Regional Support Centers and Local Health Department Children and Youth with Special Health Care Needs programs to integrate health equity into written materials, communication, outreach, and referrals. **Activity CYSHCN-5.3**: Develop and implement data collection systems that allows Local Health Department Children and Youth with Special Health Care Needs programs and Sickle Cell Disease care transition grantees to identify, track, and address disparities. **CYSHCN-5.4** Partner with key stakeholders such as Parent to Parent, Local Health Departments, and Regional Support Centers to identify and share best practices to address racial justice and health equity.

Domain: Adolescent Health
Objective AH-1: Increase the percent of adolescents, ages 12-17, with a preventive medical visit in the past year by 5%, from 81.3% in 2016-2017 to 85.4% in 2022-2023. (NSCH)
Objective AH-2: Increase the percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling by 5%, from 53.5% in 2017-2018 to 56.2% in 2022-2023. (NSCH)
Objective AH-3: Increase the percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine by 8%, from 67.3% in 2018 to 72.7% in 2023. (NIS)
Objective AH-4: Increase the percent of NYS adolescents without special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 16.4% in 2017-2018 to 17.2% in 2022-2023. (NSCH)
Associated National Outcome Measure (NOM): NOM 16.1: Adolescent mortality rate, ages 10 through 19, per 100,000 NOM 16.2: Adolescent motor vehicle mortality rate ages 15 through 19 per 100,000

Domain: Adolescent Health
NOM 16.3: Adolescent suicide rate ages 15 through 19 per 100,000 NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 20: Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (Body Mass Index (BMI) at or above the 95th percentile) NOM 22.2: Percent of children, 6 months through 17 years, who are vaccinated annually against seasonal influenza NOM 22.3: Percent of adolescents, ages 13 through 17, who have received at least one dose of the Human Papilloma Virus (HPV) vaccine NOM 22.4: Percent of adolescents, ages 13 through 17, who have received at least one dose of the tetanus, diphtheria, and pertussis (TDAP) vaccine NOM 22.5 Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine NOM 23 Teen birth rate, ages 15 through 19, per 1,000 females
Associated National Performance Measure (NPM): NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Associated Evidence-Based Strategy Measure (ESM): ESM AH-1: Percent of youth-serving programs that provide training on adult preparation subjects, such as accessing health insurance, 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. ESM AH-2: Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation.
Strategy AH-1 Alignment with Needs Assessment Priorities*: Social Support & Cohesion, Awareness of Resources, Transportation, Community Services, Poverty, Health Care, Community & Environmental Safety
Activity AH-1.1: Through Comprehensive Adolescent Pregnancy Prevention program, provide information to adolescents and parents on the offering and arranging of adolescent sexual health reproductive services. The federally funded Personal Responsibility and Education Program also provides this information, in partnership with the Title V program. **Activity AH-1.2:** Through the Sexual Responsibility Avoidance Education program, provide medically accurate and complete sexuality health education services to youth. **Activity AH-1.3:** Through the Comprehensive Adolescent Pregnancy Prevention program, the Personal Responsibility and Education Program and Sexual Responsibility Avoidance Education program, increase access to health care services for adolescents through a referral process that includes confirmation as permitted while ensuring confidentiality. **Activity AH-1.4**: NYSDOH staff, including Title V funded staff, and community youth-serving organizations provide trauma-informed education and training on social emotional wellness and positive youth development for children and adolescents. **Activity AH-1.5**: Within the Title V program, enhance collaboration between adolescent serving programs.

Domain: Adolescent Health
Activity AH-1.6: Collaborate with internal partners, including NYSDOH AIDS Institute and Bureau of Immunization, and external partners, such as the NYS Humans Papilloma Virus (HPV) Coalition, to promote HPV vaccination with clinical providers. **Activity AH 1.7**: Refer adolescents and their parents to family planning providers for contraception and birth planning, including School Based Health Centers, where available. **Activity AH-1.8**: Promote access to confidential reproductive health care services and preventive medical visits for adolescents, including through School Based Health Centers, where available. **Activity AH-1.9**: Promote healthy relationships and sexual violence prevention using policy change, protective environment strengthening, healthy social norms reinforcement, and skill-building to address individual, relationship, community, and societal risk and protective factors. **Activity AH-1.10**: Promote adolescents' social-emotional wellness and positive developmental assets through established Title V programs.
Strategy AH-2 Alignment with Needs Assessment Priorities*: Social Support & Cohesion, Awareness of Resources, Transportation, Community Services, Poverty, Parenting & Family Support, Health Care, Community & Environmental Safety, Housing, Healthy Food
Strategy AH-2: Promote supports for adolescents to gain the knowledge, self-efficacy, and resources they need to prepare for and transition to adulthood.
Activity AH-2.1: Ensure adolescent providers have a mechanism in place to provide adolescent-related health care service referrals to other providers of health care services, including substance abuse (e.g., alcohol, tobacco cessation), mental health issues, sexual violence, and intimate partner violence. **Activity AH-2.2**: Refer adolescent parents to family planning providers or School Based Health Centers for contraception and birth planning. **Activity AH-2.3**: Support pregnant and birthing adolescent parents in attending prenatal, postpartum, and well-baby appointments. **Activity AH-2.4:** Promote access to confidential reproductive health care services and preventive medical visits for adolescents. Family planning providers provide counseling and services related to contraception, promotion of healthy relationships, preventive medical care, and preconception/interconception health. **Activity AH-2.5**: Ensure adolescent-serving programs provide training on Adulthood Preparation Subjects. **Activity AH-2.6**: Work collaboratively with units inside and outside of the Department of Health to gain insight into ways to practice the most effective methods to support all aspects of adolescent health – emotional, mental, and physical – as they transition into adulthood.
Strategy AH-3 Alignment with Needs Assessment Priorities*: Social Support & Cohesion, Community Services, Poverty, Health Care, Community & Environmental, Safety
Strategy AH-3: Apply public health surveillance and data analysis findings to improve services and systems related to children's health and health care.

Domain: Adolescent Health
Activity AH-3.1: Collaborate with the US Census Bureau and Health Resources and Services Administration to conduct an over-sample of NYS National Survey of Children's Health for NYS to allow for enhanced sampling of Black/African-American, Hispanic, and Children and Youth with Special Health Care Needs during the 2022 data collection period. **Activity AH-3.2**: Title V staff will continue to use publicly available and internal surveillance data to identify adolescent needs and/or health behavior trends to support optimum adolescent health and development and determine funding areas for NYSDOH adolescent health procurements. **Activity AH-3.3:** Through ACT for Youth Center for Community Action trainings, webinars, and web posts, provide information and education to youth-serving organizations. **Activity AH-3.4**: Explore collaborative opportunities with the NYSDOH Division of Chronic Disease Prevention's Bureau of Chronic Disease Evaluation and Research, which works with the NYS Education Department, to review and share information gathered through the Youth Risk Behavior Surveillance System.
Strategy AH-4 Alignment with Needs Assessment Priorities*: Social Support & Cohesion, Awareness of Resources, Transportation, Community Services, Poverty, Parenting & Family Support, Health Care, Community & Environmental Safety, Housing, Healthy Food
Strategy AH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact adolescents' health and well-being.
Activity AH-4.1: Collaborate with other state agencies, within the Department of Health, and with youth-serving organizations on adolescent-centered priorities through the Youth Development Team. **Activity AH-4.2**: Ensure that NYSDOH health equity teams review materials before being widely disseminated to youth and youth-serving organizations. **Activity AH-4.3**: Collaborate with youth through focus groups and community forums for direct input with state initiatives and special projects. **Activity AH-4.4**: Involve stakeholders that are representative of the populations most impacted by racism and health inequities in programmatic decisions. **Activity AH-4.5**: Through NYSDOH adolescent providers, issue information on locally available resources and provide referrals specific to addressing the social determinants of health with adolescents from populations impacted by disparities.

***Priorities Key:**

1. **Health Care**: Address equity, bias, quality of care, and barriers to access in health care services for women and families, especially for communities of color and low-income communities.
2. **Community Services**: Promote awareness of and enhance the availability, accessibility, and coordination of community services for families and youth, including children and youth with special health care needs and their families, with a focus on communities most impacted by systemic barriers including racism.
3. **Parenting and Family Support**: Enhance supports for parents and families, especially those with children with special health care needs, and inclusive of all family members and caregivers.
4. **Social Support and Cohesion**: Cultivate and enhance social support and social cohesion opportunities for individuals and families

who experience isolation as a result of systemic barriers, including racism, across the life course.

5. **Healthy Food**: Increase access to affordable fresh and healthy foods in communities.
6. **Community & Environmental Safety**: Address community and environmental safety for children, youth, and families.
7. **Poverty**: Acknowledge and address the fundamental challenges faces by families in poverty and near-poverty, including the "working poor" as a result of systemic barriers, including racism.
8. **Awareness of Resources**: Increase awareness of resources and services in the community among families and the providers who serve them.
9. **Housing:** Increase the availability and quality of affordable housing.
10. **Transportation:** Address transportation barriers for individuals and families.