Maternal and Child Health Services Title V Block Grant

New York

FY 2024 Application/ FY 2022 Annual Report

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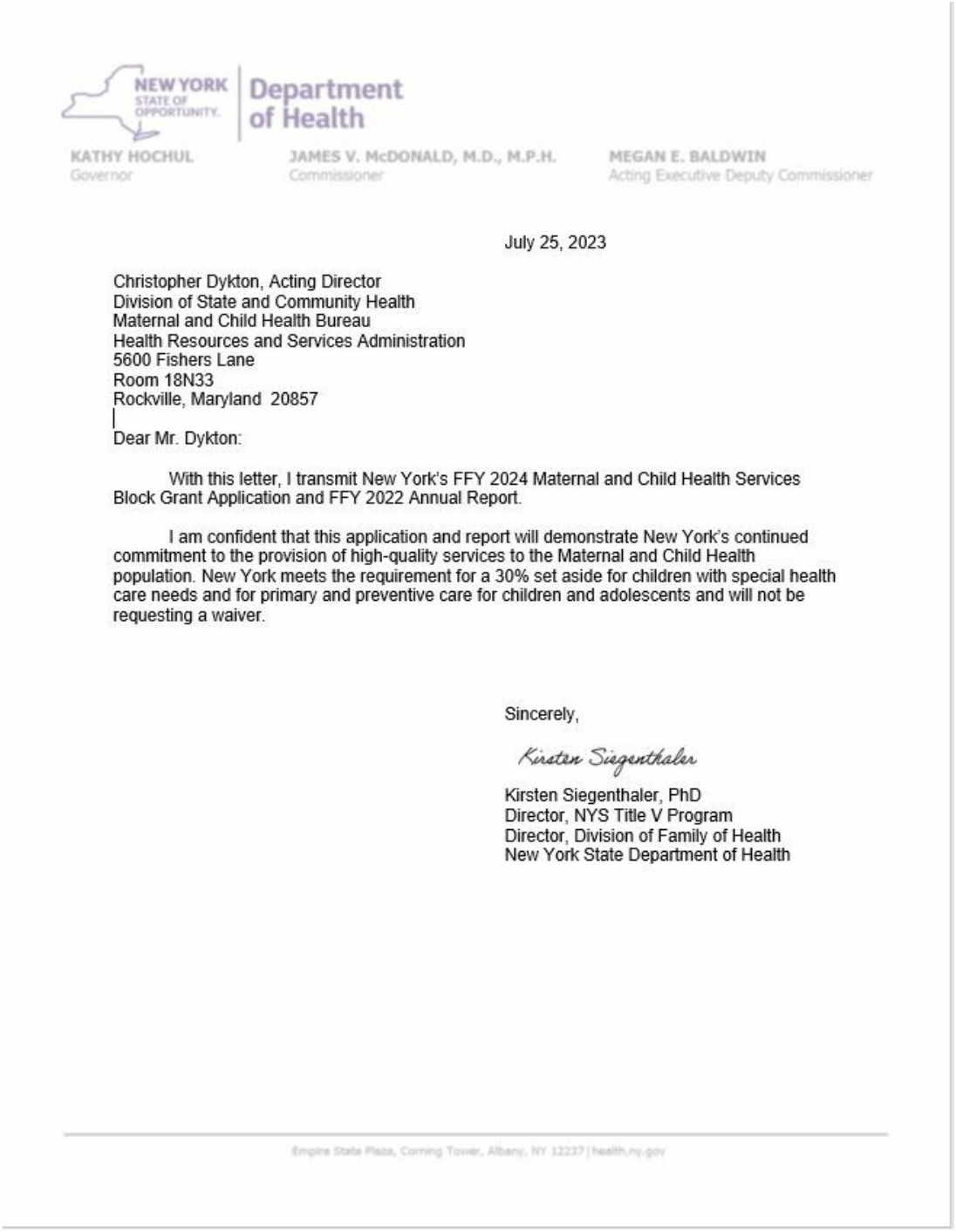
I. General Requirements

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

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

July 25, 2023

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

Dear Mr. Dykton:

With this letter, I transmit New York's FFY 2024 Maternal and Child Health Services Block Grant Application and FFY 2022 Annual Report.

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

Sincerely,

Kirsten Siegenthaler

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

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

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 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: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January 31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

A. Program Overview

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

New York's Title V priorities and 5-year State Action Plan for 2021-2025 were developed based on a comprehensive Needs Assessment designed to assess the state's Maternal and Child Health needs, strengths, capacity, and partnerships. The full Needs Assessment summary was submitted with our FY21 application. This Needs Assessment synthesized data and information from a wide range of sources including community listening forums, population health surveys and data systems, surveys of providers and the public, stakeholder meetings, and an inventory of Maternal and Child Health programs. The Needs Assessment identified ten cross-cutting themes voiced by families and community members. These themes related to social determinants of health including poverty, transportation, housing, biases in health care, environmental and neighborhood safety, family support, social cohesion, and more. Subsequent FY22 and FY23 Needs Assessment updates reinforced the initial ten priorities and highlighted the impact of the COVID-19 pandemic on NY's maternal and child populations and service systems.

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

Our action plan for the FY24 represents our ongoing commitment to address the objectives, strategies, and performance measures for our 2021-25 State Action Plan priorities across five Maternal and Child Health population health domains: women's and maternal health (*WMH*), perinatal and infant health *(PIH*), child health (*CH*), adolescent health (*AH*), and children and youth with special health care needs. NY's application continues to reflect significant input from families, providers, and other key stakeholders across the state, and remains centered on the issues that have been voiced by communities that impact family and community health and well-being. It emphasizes understanding and addressing cross-cutting social determinants of health to reduce health disparities and promote health equity. It also reflects dedication to building a more comprehensive and inclusive system of supports for Children and Youth with Special Health Care Needs and their families.

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

application.

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

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

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

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

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

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

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

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

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

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

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

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

Domain 2 – Perinatal and Infant Health (PIH)

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

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

Domain 3 – Child Health (CH)

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

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

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

Domain 4 – Adolescent Health (AH)

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

promoting routine care related to reproductive, oral, and behavioral health, and resources needed to successfully transition to adulthood.

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

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

Domain 4 – Children and Youth with Special Health Care Needs (CYSHCN)

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

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

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

NYS is committed to ensuring the health and wellbeing of the Maternal and Child Health population. Due to generous Medicaid benefits, insurance availability through the state's health insurance exchange, and significant state appropriations for Maternal and Child Health, Title V funds support an infrastructure within the NYSDOH that ensures the work of the Title V program, and augment other federal grants and state investments to support public health infrastructure for priority efforts such as family planning and adolescent health services. In addition, Title V Maternal and Child Health Services Block Grant staff support the state's Regional Perinatal Centers to implement quality improvement activities with NY's obstetrical hospitals and birthing centers to improve maternal and infant mortality and morbidity. Grants are provided to local health departments to support information and referral services for Children and Youth with Special Health Care Needs, with a further increase in allocation of Title V funds for the current grant cycle. NY's Title V application illustrates the extensive resources offered to NY's Maternal and Child Health population.

NY's Maternal and Child Health programs and initiatives are complex. This application provides an overview that demonstrates NY's ongoing commitment to ensure the health and wellness of all NY's women, children, and families.

III.A.3. MCH Success Story

A strong and diverse Maternal and Child Health workforce is needed to meet the needs of NY's Maternal and Child Health population. This year we have chosen to focus our success story on a key approaches our Title V Program has invested in to cultivate the Maternal and Child Health workforce of today and tomorrow: **our academic-practice partnership with the UAlbany School of Public Health Maternal and Child Health Program.**

The UAlbany School of Public Health Maternal and Child Health Program was established in 2015 with initial grant funding from the federal Health Resources and Services Administration Maternal and Child Health Catalyst initiative to develop an increased focus on Maternal and Child Health within the school and university and to prepare students for Maternal and Child Health careers, with priority for students from underrepresented backgrounds. Under the shared direction of then-Title V Director (now School of Public Health staff) Rachel de Long, MD, MPH and School of Public Health faculty Christine Bozlak, PhD, MPH, the program offers academic Maternal and Child Health courses, a graduate certificate in Maternal and Child Health, Maternal and Child Health-related internships, and a wide array of professional development opportunities for both students and Maternal and Child Health practitioners.

From its inception, the partnership with the state's Title V program, formalized through a Memorandum of Understanding has been a distinguishing strength of the School of Public Health Maternal and Child Health Program. Key elements of our partnership include:

- **Technical Assistance.** Dr. de Long provides technical assistance for the NYS Title V program, meeting regularly with the Title V leadership team and working directly with five domain teams to gather and synthesize information for the annual needs assessment updates and other application components. Both co-directors consult with Division of Family Health and facilitate connections with other faculty related to research and evaluation opportunities.
- **Teaching and professional development**. Title V staff are regular guest presenters in Maternal and Child Health courses, and frequently participate in seminars, networking events, community service projects, and other PD activities hosted by the School of Public Health Maternal and Child Health program. This creates an environment of shared learning and professional development between Title V staff, faculty, and students.
- **Student internships**. The Division of Family Health hosts up to six graduate student interns every semester (up to 18 annually). Through the Memorandum of Understanding, students are hired by School of Public Health and assigned to Division of Family Health staff as project mentors. This allows students to apply what they are learning in the classroom to real-world issues and settings, while developing essential public health skills and contributing to meaningful Maternal and Child Health initiatives. It also expands our program's capacity to advance priority projects and provides Title V staff – many of whom are School of Public Health alumni - with the opportunity to serve as mentors, which is critical to their own professional development. Since 2019 we have mentored 32 graduate students within the Division of Family Health, supporting 20 priority Maternal and Child Health projects. Six of these student interns – one-third of those who graduated prior to Spring 2023 – are now employed in the Division of Family Health or other Maternal and Child Health organizational units at NYSDOH, demonstrating the value of our investment in the future Title V workforce.

This spring we highlighted this partnership in a poster presentation at the 2023 Association of Maternal and Child Health Programs conference, which we are expanding to a full manuscript and an article for the National Maternal and Child Health Workforce Development Center newsletter. Please see ***Supporting Document 2*** and ***Section V.B.ii Maternal and Child Health Workforce Development*** for more details on this mutually successful partnership.

III.B. Overview of the State

According to 5-Year population estimates from the 2021 American Community Survey, New York State is the fourth most populous state in the country, with more than 20 million people (20,114,745). Within the state, approximately 41% of the population (8,335,897) reside in New York City.

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

Diversity

New York State is home to a highly diverse population. Across all states, New York ranks third in terms of having the highest percentage of foreign-born people. According to data from the 2021 Census, 22.5% of New York State's population is foreign born.

Of New York State's 20,114,745 residents, approximately 55.6% of individuals identify as White alone, 19.5% identify as Hispanic or Latino, 14.2% identify as Black or African American, 8.7% identify as Asian alone, 0.6% identify as American Indian or Alaska Native, and less than 0.1% identify as Native Hawaiian or Other Pacific Islander. Compared to national estimates, New York State has a higher percentage of non-Hispanic Black, Asian residents, and Hispanic residents.

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

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

Immigration

2021 Census estimates indicate that 22.5% of New York State's population (4,523,896) is foreign born. Among this group, 58.8% (2,661,793) are naturalized citizens while 41.2% (1,862,103) are non-citizens. The largest percentage of foreign-born individuals migrated from the Latin America (48.4%), Asia (29.4%), and Europe (15.9%). In addition to counties surrounding NYC, Long Island, and the Hudson Valley, counties with larger population centers, including Buffalo, Rochester, Syracuse, Utica, and Albany, have higher percentages of foreign-born residents.

Households and Families

According to five-year estimates from the 2021 American Community Survey, there are 7,530,150 households in New York State, with an average of 2.6 people per household. Of these households, 43.7% (3,293,425) are married couple families. Approximately 29% (2,154,604) of all households have at least one child under the age of 18.

Income and Poverty

Five-year estimates from 2021 American Community Survey reveal that the median household income in New York State is $74,314. Counties with the highest income levels are heavily concentrated in NYC, Long Island, and Mid-Hudson. Nassau County on Long Island ranks highest in the state with a median household income level above $125,000.

Median household income has increased steadily since 2010 ($54,047). However, income levels vary significantly by race. The average median household income is $83,877 for White people, $83,399 for Asian people, $53,697 for Black or African American people, $55,621 for Hispanic or Latino people, and $50,731 for American Indian and Alaska Native people. Income inequality has also increased over time in the state. The Gini coefficient has risen from 0.499 in 2010 to 0.51 in 2021. New York State ranks highest among all states in terms of income inequality.

According to 2021 estimates from the American Community Survey, 13.9% 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 (26.4%) and Kings County (19.2%).

Age Distribution

The median age in New York State is 39.8. Approximately 21% (4,217,396) of the population is under 18 years of age, and roughly 16.6% (3,330,159) of the population is 65 years or older. The median age has increased over the past decade, rising from 37.7 in 2007 to 39.8 in 2021.

Women of Childbearing Age

Estimates from the 2021 American Community Survey indicate that there are 4,774,828 women of childbearing age (15-50 years), representing 46.4% of the total female population.

Children

Of New York State's 20,114,745 residents, 5.7% of the population is under the age of 5 and 21.0% of the population is under the age of 18. According to 2021 American Community Survey 5-Year estimates, approximately 18.4% of all children in the state are living with families below the federal poverty line. Further, 12.6% of children are living with families where no parent has regular, full-time employment.

Education

According to 2021-22 school year data published by the New York State Department of Education, 2,448,537 children are enrolled in K-12 public schools. Approximately 41% (1,003,496) of public-school students are White, 29% (706,423) are Hispanic, and 16% (394,838) are Black or African American.

The high school graduation rate for all public-school students is 87%. However, graduation rates vary significantly by ethnicity. While 91% of white students graduate, only 82% of Black or African American and 81% of Hispanic or Latino students graduate from high school. Additionally, graduation rates differ based on migrant status. The graduation rate for migrant is 54%, compared to 87% for not migrant.

In terms of educational attainment of adults (ages 25 and over), approximately 25.2% of the population has a high school diploma or GED, 21.3% of the population has a bachelor's degree, and 16.8% 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 2020 American Community Survey, 69.5% of the population over the age of 5 (13,177,639) speaks only English. Of the 5,782,730 residents that speak a language other than English, 14.8% speak Spanish, 8.8% speak other Indo-European languages, and 5.1% speak Asian and Pacific Island languages. Approximately 13.1% of the population who speaks a language other than English report that they speak English less than "very well."

Health Care

Approximately 6.1% of the non-elderly population (ages 0-64) in New York State has no health insurance. Estimates from the 2021 American Community Survey reveal that uninsured rates vary significantly by ethnicity. While only 3.2% of White people are uninsured, 10.0% of Hispanic people, 12.1% of American Indian or Alaska Native people, 6.1% of Asian people, 25.0% of Native Hawaiian and Pacific Islander people, and 5.9% 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, was created 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 (PA) that was developed in conjunction with the Public Health Committee of the NYS Public Health and Health Planning Council (PHHPC), and in partnership with more than 140 organizations across the state. The Prevention Agenda focuses on eliminating the profound health disparities across all priority areas including preventing chronic diseases; promoting a healthy and safe environment; promoting healthy women, infants, and children; promoting wellbeing and preventing mental and substance use disorders; and preventing communicable diseases. Title V Maternal and Child Health Services Block Grant staff directed the update in the Prevention Agenda 2019-2024 related to Promoting Healthy Women, Infants and Children and worked to ensure the alignment with NYS's Title V Maternal and Child Health Services Block Grant State Action Plan. The vision for the 2019-2024 Prevention Agenda highlights a Health in All Policies approach and a focus on healthy aging.

III.C. Needs Assessment
FY 2024 Application/FY 2022 Annual Report Update

Our FY21 comprehensive five-year Needs Assessment detailed the state's Maternal and Child Health needs, strengths, capacity, and partnerships. It identified ten cross-cutting themes voiced by families and community members related to social determinants of health including poverty, transportation, housing, health care, environmental and neighborhood safety, family support, social cohesion, and more. Subsequent Needs Assessment updates highlighted the impact of COVID-19 on Maternal and Child Health populations and services. This year's Needs Assessment update reflects the continued impact of the pandemic and other persistent and emerging themes. Relevant Title V domains *[WMH, PIH, CH, AH, CYSHCN*] are referenced; refer to the FY21 five-year Needs Assessment summary for program descriptions.

Title V staff continued to lead many activities that inform our assessment of Maternal and Child populations and systems. A combination of formal structured Needs Assessment activities and ongoing open communication is essential to this effort.

Population Health Data In addition to monitoring Title V measures, we review data sources to assess status, trends, and disparities for Maternal and Child Health indicators. Data are shared with partners and the public and inform program strategies and allocation of funds. Examples include:

- Title V staff review national survey data including Pregnancy Risk Assessment Monitoring System, Behavioral Risk Factor Surveillance System, National Survey of Children's Health, and Youth Risk Behavior Surveillance System annually *[All].*
- NYSDOH maintains a Maternal and Child Health (MCH) data dashboard, updated in February 2023 *[All]*
- Title V staff lead a comprehensive maternal death and morbidity review process with the NYS Maternal Mortality Review Board. This period we completed reviews for 2019 and 2020 cohorts and released a statewide report on the 2018 cohort and an issue brief on perinatal mental health. Analysis of severe maternal morbidity, previously deferred due to pandemic redeployments, is underway *[WMH]*
- Title V staff completed a draft report *Infant Mortality in New York State, 2016-2019*, released in June 2022 [*PIH*]
- Title V funded an over-sample of the National Survey of Children's Health for NYS, with enhanced sampling of Black, Hispanic, and Children and Youth with Special Health Care Needs. Data will be available in 2023-24 *[CH, AH, CYSHCN]*

Local Program Data Data collection and reporting are required for all Title V programs. These data support local program management and provide important insights to needs, services, and selected outcomes. Local providers are required to engage with their communities to assess community and client needs, which they share with Title V staff through grant reports, provider calls, and webinars. Examples include:

- All Title V local programs submit quarterly or bi-annual reports with both quantitative and narrative information on program activities, capacity, successes, challenges, and training and technical assistance needs. State staff review and discuss reports with local providers *[All]*
- Title V program staff convene monthly or quarterly calls with grantees to share information, review performance data, and discuss emerging and ongoing needs, challenges, and solutions *[All]*
- John Snow Inc. (JSI), the new Perinatal and Infant Community Health Collaborative training and technical assistance contractor, conducted a comprehensive assessment of resource and training needs for local programs, and is launching a dedicated website for current and new training resources [*WMH, PIH*]
- The state's Growing up Health Hotline maintains data on information and resource needs based on calls received *[WMH, PIH, CH]*
- A new School Based Health Center data system is being developed, with system testing this year. The new system will streamline reporting, including Title V aligned performance measures *[CH, AH, CYSHCN]*
- The ACT for Youth Center for Community Action communicates with local adolescent health (AH) grantees about their training and technical assistance needs *[AH, CYSHCN]*

- Adolescent Health programs implementing evidence-based sexual health programs complete surveys, report on attendance, reach, and dosage of their selected curricula bi-annually through the ACT for Youth Center for Community Action's online reporting system *[AH]*
- A web-based data system for the Children and Youth with Special Health Care Needs programs launched in 2021 and is now fully operational. Reports are being developed. *[CYSHCN]*

Quality Improvement & Evaluation Initiatives Title V staff lead numerous projects to learn about specific service and system needs, capacity, and effectiveness, from focused literature reviews to evaluation projects to intensive continuous quality improvement initiatives. Examples include:

- The Division of Family Health's Bureau of Perinatal, Reproductive, and Sexual Health evaluated relationships between local home visiting programs (Perinatal and Infant Community Health Collaborative and Maternal, Infant, and Early Childhood Home Visiting) and birthing hospitals and developed a new referral tracking tool *[WMH, PIH]*
- The NYS Perinatal Quality Collaborative continued learning collaboratives with birthing hospitals on birth equity and one on opioid use disorder and neonatal abstinence syndrome *[WMH, PIH]*
- The Family Planning Program collected and analyzed survey data from local providers to assess partnerships with Syringe Exchange Programs and conducted a qualitative analysis of Family Planning Program annual reports *[WMH]*
- The Newborn Screening Program continued a continuous quality improvement initiative to improve lab collection and processing times, blood spot specimen quality, false positive screening results, timeliness in screening, and data completeness *[PIH, CYSCHCN]*
- The Early Hearing Detection and Intervention program is leading an ongoing project to use surveillance data to improve screening and follow-up *[PIH, CYSHCN]*
- Title V staff partnered with the Medicaid Health Home Serving Children to survey care managers about awareness of new eligibility criteria for Sickle Cell Disease, which will inform training and informational materials [*CYSHCN*]

Advisory Groups Title V staff convene and participate in many formal bodies that facilitate input from state, regional, and local partners including families and youth. Examples include:

- Division of Family Health convenes the NYS Title V Advisory Council. With representation from Local Health Departments, community-based organizations, parent groups, and advocates, the council meets three times each year on a range of issues and initiatives *[All]*
- NYSDOH convenes the NYS Advisory Council on Lead Poisoning Prevention to provide input on the prevention and elimination of childhood lead poisoning [*CH, CYSHCN*]
- Staff are establishing a statewide Home Visiting Parent Advisory Committee. *[WMH, PIH]*
- Title V staff serve on the state Early Childhood Advisory Council and advises the Governor on early childhood issues *[PIH, CH, CYSHCN*|
- Title V staff participate in an inter-agency Adverse Childhood Experiences workgroup *[CH, AH, CYSHCN]*
- Title V staff are longstanding members of the NYS Youth Development Team. Plans for reconvening the team, which has not met since pre-pandemic, are under discussion *[AH]*
- Title V staff are exploring the development of a Youth Advisory Council. Initially the Youth Advisory Council will support an adolescent mental health campaign with plans for an ongoing partnership to advise on Adolescent Health topics [*AH]*
- Title V staff are members of the NYS Developmental Disabilities Planning Council and its Individuals and Families Committee, Policy Work Group, and Transitions Community of Practice [*CYSHCN*]
- Title V leadership participate in the inter-agency Deputy Commissioners' Cross-Systems Work Group to focus on care coordination for and placement of youth with developmental disabilities [*CYSHCN*]

Assessing Children and Youth with Special Health Care Needs & their Families' Needs Direct input from Children and Youth with Special Health Care Needs and their families is a special priority for NY's Title V Program. We support many

Needs Assessment activities integrated within other family supportive services:

- **Regional Family Liaisons.** The NYS Department of Health contracts with three Regional Support Centers, which are required to employ Family Liaisons who are parents of Children and Youth with Special Health Care Needs. This year Family Liaisons helped to develop a Health Conditions guide, social media flyer, and Resource Directory.
- **Family Engagement Sessions.** From 2019-21, Family Liaisons conducted 63 family engagement sessions and 104 individual interviews with over 300 parents with Children and Youth with Special Health Care Needs and caregivers from 51 counties. The results were compiled in a Family Engagement Report that was shared with participant families in their preferred language, presented to Local Health Department Children and Youth with Special Health Care Needs programs, and informs family support activities.
- **County Needs Assessment Surveys.** Regional Support Centers survey all Local Health Departments to determine local gaps, barriers, resources, and training and technical assistance needs. Regional Support Centers develop tailored improvement and technical assistance plans to meet their community engagement goals, and the findings inform statewide training and technical assistance planning.
- **County Family Engagement Requirements.** Local Health Departments are required to engage families with Children and Youth with Special Health Care Needs in work groups, committees, and task forces to improve the system of care for Children and Youth with Special Health Care Needs. Families engage in local planning activities and their input informs training and technical assistance for the local programs.
- **Parent representation in Advisory Groups.** A parent representative from *Parent to Parent of NYS* serves on the Title V Advisory Council. Parents with experience navigating state systems are being added to the Commissioner's Cross-Systems Work Group led by the NYS Office of Children and Families.
- **Other Surveillance and Program Data.** Title V staff review available data sources to monitor trends and emerging needs for Children and Youth with Special Health Care Needs, including data from the National Survey of Children's Health, Local Health Department Children and Youth with Special Health Care Needs programs, and NYS Medicaid Health Homes Serving Children program. The *New York State Profile of Children and Youth with Special Health Care Needs* is updated annually and shared with partners.

Health Status & Needs of the State's Maternal and Child Health population

Title V performance and outcome measures provide key information on health status and needs of NY's Maternal and Child Health population and service systems. The impact of COVID-19 is now seen in 2020-21 data measures.

Analysis compared to last year's application shows declines in primary and preventive health care for 2020-21, including well-woman visits [*WMH*], adolescent preventive visits *[AH*], transition support services *[CYSHCN*], and anticipatory guidance for children in School Based Health Centers [*CH*], although annual exams for Family Planning Program clients improved *[WMH, AH]*. Delivery of very low birth weight (VLBW) infants in Level III+ birthing hospitals and timeliness of newborn bloodspot screening samples were stable *[PIH]*. Maternal mortality continued to improve, but striking racial disparities persist *[WMH]*.

All youth-serving programs report providing training for youth on adult preparation topics, and engagement of youth in local program planning and implementation increased [*AH*]. We saw improvements in developing birthing plans for Perinatal and Infant Community Health Collaborative clients working with Community Health Workers [*WMH*] and transition supports for youth with Sickle Cell Disease [*CYSHCN*]. Daily physical activity among children increased after declining last year [*CH]*, while the incidence of childhood lead poisoning improved *[CYSHCN].*

As noted in past Needs Assessment Updates, the COVID-19 pandemic exacerbated previous disparities, while exposing and creating new needs. The 10 crosscutting themes voiced by community members in our five-year Needs Assessment summary remain salient. Providers report continued housing insecurity and related needs for training and technical assistance. Among the 19,000+ referrals made by Perinatal and Infant Community Health Collaborative programs this year, the top five categories were for clothing and baby care items, referrals to the Supplemental Nutrition Assistance Program for

Women, Infants, and Children (WIC), food pantries, dental care, and housing *[WMH, PIH]*. Downstate providers identified basic support needs for the influx of people seeking asylum. In response, Title V programs have helped raise awareness and link client families to many community resources for breastfeeding and doula support, domestic violence and substance use, parenting education and support, health insurance enrollment, WIC, prenatal visits, job placement, financial literacy, and basic needs such as cribs, car seats, food, and housing.

While nearly all NYS children are insured, families with Children and Youth with Special Health Care Needs continue to experience special financial challenges for children's health needs. Among children receiving the Children and Youth with Special Health Care Needs Support Services funding in 2022, the most common services funded included durable medical equipment, orthodontia, enteral formula and specialty foods, medications, medical-surgical services, and physician visits *[CYSHCN]*. Providers report that transportation and access to OB-GYN, mental health, and dental providers are barriers, especially in rural areas *[All*].

Mental health continues to be a prominent emerging theme. With staff reporting increasingly complex concerns among home visiting clients involving domestic violence, substance use, and social service involvement [*WMH, PIH]*. Our Maternal Mortality Review Board study found that 15% of 2018 pregnancy related deaths were due to mental health conditions *[WMH].* Providers describe lingering social-emotional and mental health impacts of the pandemic among children and youth, with increasing behavioral issues, school absences, students feeling isolated and disconnected, and difficulties adjusting back to in-person learning *[CH, AH, CYSHCN].*

Title V Program & Maternal and Child Health Systems Capacity

In the wake of the pandemic, Maternal and Child Health programs and organizations are in a period of rebuilding. There has been significant staff turnover from retirements or staff taking new positions, resulting in staffing gaps and loss of institutional memory and challenges in recruiting, hiring, and training new staff. For example, although the Perinatal and Infant Community Health Collaborative program increased Community Health Workers' salary requirements to a living wage, recruitment and retention has been challenging as staff seek higher wages and more flexible remote options for better work/life balance. A provider survey identified Community Health Worker staff burnout and emotional wellness among the top training needs for Perinatal and Infant Community Health Collaborative grantees. See ***Section V.B.ii*** for further discussion of NYS Maternal and Child Health workforce development.

Despite significant challenges, there have been accomplishments in capacity-building in the past year with key themes and examples below.

Expanding & enhancing Maternal and Child Health-serving programs. Several key programs grew in number, reach, scope, inclusiveness, or other key elements this project year. For example:

- The Family Planning Program re-entered the national Title X network in 2022. Family Planning Program expanded their network to three new organizations and increased funding for all providers [*WMH, AH].*
- The Maternal and Infant Community Health Collaboratives program was renamed Perinatal and Infant Community Health Collaborative, reflecting a more inclusive approach to serving all pregnant and birthing people *[WMH, PIH].*
- Perinatal and Infant Community Health Collaborative and Maternal, Infant, and Early Childhood Home Visiting programs continued to successfully integrate virtual home visiting services, initially developed during the pandemic, to supplement in-person visits. Virtual visits accounted for nearly 60% of home visits in FY21. *[WMH, PIH].*
- The Division received a five-year pediatric mental health grant that connects School Based Health Centers with Project TEACH, a statewide training, education, and consultation initiative to enhance primary care providers' mental health care capacity overseen by the state's Office of Mental Health [*CH, AH, CYSHCN].*
- The School-Based Dental Home program expanded the scope from the former dental sealant program to establish a consistent source of dental care for children including biannual examinations, screenings, preventive services, anticipatory guidance, referrals, and follow-up of untreated dental disease *[CH, AH*].

- The Comprehensive Adolescent Pregnancy Prevention program increased funding levels and expanded program requirements for youth-led programming to promote social-emotional well-being, alternatives to early sexual activity, and skills for successful transition to healthy adulthood *[AH].*
- Annual grants to Local Health Department Children and Youth with Special Health Care Needs programs were increased significantly, with corresponding increases in minimum program staffing and an increase from 49 to 52 participating Local Health Departments (of the state's 58 total). Regional Support Centers developed a new internal web portal to support staff training needs. *[CYSHCN]*

Data, Training, and Technical Support. NYS Title V Program has invested strategically in this area to facilitate effective implementation of Maternal and Child Health initiatives. Examples include:

- The Perinatal and Infant Community Health Collaborative program procured for a data management information system and new training and technical assistance provider [*WMH, PIH].*
- NYS Perinatal Quality Collaborative disseminated the NYS Obstetric Hemorrhage Project Toolkit to support practices that reduce obstetric hemorrhage within birthing hospitals *[WMH].*
- The Rape Prevention and Education program created Regional Profiles for each of the 17 counties covered its six regional centers, with county-level data to support data-informed sexual violence prevention work *[WMH].*
- A perinatal psychiatrist was appointed to the Maternal Mortality Review Board to provide expertise for recommendations to reduce mental health-related maternal mortality *[WMH].*
- A supplemental one-year federal Telehealth grant from the Office of Population Affairs supported training, technical assistance, and infrastructure building for family planning telehealth services *[WMH, AH].*
- With support from one-time grant funding, Title V staff worked with the Regional Perinatal Centers and networks of affiliate birthing hospitals to enhance capacity for perinatal telehealth services and subspecialty care, focused on rural and other communities with reduced access to care [*WMH, PIH].*
- Title V staff facilitated training for Perinatal and Infant Community Health Collaborative and Maternal, Infant, and Early Childhood Home Visiting home visiting staff on *CDC's Learn the Signs Act Early* campaign [*PIH, CH, CYSCN].*
- A new web-based data management and information system for Local Health Department Children and Youth with Special Health Care Needs programs was launched to support needs assessment, program management, and quality improvement *[CYSHCN].*

Program Standards, Monitoring, and Improvement. Clear and up to date regulatory frameworks, standards, and guidelines are essential to facilitating effective program implementation, oversight, and improvement. NY's Title V program plays a key role in these efforts. Examples include:

- In collaboration with the NYSDOH Office of Primary Care and Health Systems Management, Title V staff are implementing new state legislation to approve operating certificates for midwifery birth centers that are accredited by recognized national organizations *[WMH, PIH].*
- Title V staff updated eligibility requirements for the Infertility Reimbursement Program to align with state insurance law that requires all large cap insurance plans to provide three cycles of in vitro fertilization and fertility preservation services and prevents discrimination based on disability, age, sex, sexual orientation, marital status, gender identity, and other characteristics *[WMH].*
- In 2020, NYS legalized compensated gestational surrogacy. Title V staff with other NYSDOH areas review and approve applicants and update guidance documents. There was an increase from 12 to 30 in the number of licensed surrogacy matching programs *[WMH, PIH].*
- Through the NYS Perinatal Quality Collaborative, implementation of universal protocols for opioid use disorder screening, assessment, and follow-up within birthing hospitals increased dramatically. The NYS Perinatal Quality Collaborative Birth Equity collaborative gathered data from birthing hospitals about patient experience and use of stratified data to inform improvement activities aimed at reducing disparities *[WMH, PIH]*
- The Newborn Screening Program reviews baseline data with each hospital during site visits and is expanding its monitoring plan to add updated performance summaries 6-8 months post-visit to assess improvement [*PIH,*

CYSHCN].

- Among Title V youth-serving programs, 100% reported providing training on adult preparation subjects to support transition to adulthood, and 78% reported engaging youth in program planning and implementation, an increase from the prior year *[AH]*.

Health communication and education capacity. Social media and other communication platforms increase the potential to reach large, diverse populations. We incorporate a science-based health messaging approach to develop social media campaigns and cultivate partnerships with other agencies to disseminate information. Examples include:

- Statewide implementation of CDC's *Hear Her* Campaign to reduce maternal morbidity and mortality *[WMH*]
- A state-developed public awareness campaign on Perinatal Mood and Anxiety Disorders *[WMH]*
- Re-launch of a media campaign for black and Hispanic male youth on drinking water vs sugar-sweetened beverages *[AH]*
- Collaboration with the NYS Council on Children and Families to promote a targeted media campaign to reach pregnant and newly parenting New Yorkers in counties with low home visiting program enrollment through their *NYS Parent Portal* [*WMH, PIH, CH*]

Workforce development. See ***Section V.B.ii*** for additional information.

Title V Partnerships & Collaborations

Partnership and collaboration are core to our work. Below are examples to highlight the range of partnerships and collaborations:

- Staff from the Bureaus of Perinatal, Reproductive, Sexual and Adolescent Health and the Bureau of Child Health collaborated on a *Sexual Health Education Programming to Youth with Special Needs* roundtable which was well-attended and positively received *[AH, CYSHCN]*.
- School Based Health Center and Asthma program staff facilitated a webinar, resulting in nine School Based Health Center operators (22 clinic sites) joining the project, with nearly 50 staff trained, and 225 students served to date *[CH, AH, CYSCHN].*
- Within NYSDOH, Title V staff are collaborating to address significant increases in Congenital Syphilis, with the goal of developing and implementing a statewide strategic plan. Title V staff presented at the 2022 NYS Perinatal Association meeting. *[WMH, PIH, CYSHCN*]
- Title V staff continue to provide subject matter expertise to NYS Medicaid Program to implement care coordination and transition support services for Children and Youth with Special Health Care Needs through Medicaid Health Home Serving Children, including the addition of Sickle Cell Disease as a single qualifying condition. Staff assist with virtual Medicaid Health Home Serving Children site visits, communicate updates to Local Health Departments, and participate in a committee about the new Sickle Cell Disease criterion [*CYSHCN]*.
- As part of ongoing strategic efforts to increase referrals for home visiting, staff collaborated with the NYS Office of Children and Family Services and the NYS Council on Children and Families on a Title V-funded media campaign about the *NYS Parent Portal*. Based on focus groups with home visiting-eligible parents, *NYS Parent Portal* language was revised from "home visiting" to "parenting support" to reduce stigma and perceived connection with Child Protective Services. The campaign directed pregnant and newly parenting New Yorkers in counties with low home visiting program enrollment to the portal for resources including childcare, home visiting, and afterschool programs. The three-month campaign resulted in over 100,000 clicks, with additional evaluation currently in process *[WMH, PIH].*
- Title V staff continue a longstanding collaboration with the Health Resources and Services Administration-funded *Leadership Education in Neurodevelopmental and related Disabilities* program based at Westchester Institute of Human Development. Title V staff participated in the May 2022 *Leadership Education in Neurodevelopmental and related Disabilities* virtual poster session [*CYSHCN].*

Operationalizing Needs Assessment Activities & Findings

Needs Assessment activities are operationalized within routine program systems and activities:

- Review existing population health surveys and surveillance systems annually
- Develop, maintain, and improve data management systems for local programs
- Integrate data reporting requirements in grant contracts with regular meetings and ongoing communication to discuss trends or emerging needs in local providers' reports
- Integrate community engagement requirements, including community listening forums, in procurement processes
- Supporting statewide and regional centers that assess needs of priority populations and local providers and use those assessments to inform ongoing statewide and program-specific training and technical assistance activities
- Establish formal data sharing agreements with programs and agencies.

In turn, our program systematically applies findings from these and other Needs Assessment activities to a wide range of public health actions. For example:

- Community Health Workers use results of client assessments to develop individualized client care plans, and grantees use input gathered through their participation in community action boards to develop local strategies for addressing needs, including social determinants of health *[WMH, PIH].*
- NYSDOH issued a Health Advisory and accompanying patient educational materials (in multiple languages) on the importance and safety of COVID-19 vaccination for preconception, pregnant, postpartum and breastfeeding people *[WMH].*
- The Comprehensive Adolescent Pregnancy Prevention program and Personal Responsibility Education Program procurements applied the Adolescent Sexual Health Needs Index, a multi-dimensional zip code level indicator, to guide selection of priority communities, expanded the focus on social-emotional development and health equity, and included engagement of youth stakeholders in scoring applications *[AH].*
- The 2021 Family Engagement Report, based on input from families with Children and Youth with Special Health Care Needs, directly informs development of training and technical assistance resources, educational materials and resources for families, and county-specific family engagement plans. Regional Support Centers facilitated a webinar on accessible recreation, including opportunities to partner with the NYS Department of Environmental Conservation, which resulted in local projects to install a wheelchair charging station and add accessible swings in playgrounds. *[CYSHCN*]
- Health equity is a prominent foundational theme in our needs assessment. The Division of Family Health's Racial Justice and Health Equity Team reviews all Division Requests for Applications and consults with program teams to incorporate revisions as needed [*All].*

Organizational Changes

The Program had several key organizational and leadership-level staffing changes:

- Shaunna L. Escobar, MD, MPH, CPH, EMHL, FAAFP was appointed Associate Medical Director for the Division of Family Health.
- The former Bureau of Women, Infant and Adolescent Health was renamed to Bureau of Perinatal, Reproductive, Adolescent and Sexual Health to support diversity, equity, and inclusion. Ben Wise, MS, CHES was appointed Associate Director, Joanne Gerber, MS, RN was appointed Assistant Director for Healthcare Based Perinatal Health, and Raemie Swain, MS was appointed Assistant Director for Reproductive Health.
- A new Bureau of Health Equity and Community Engagement was created to address disparities highlighted in the COVID-19 pandemic and build a foundation for future epidemic responses. The bureau focuses on expanding and developing mitigation and prevention resources and services for pandemic response, improving data collection and reporting, and building infrastructure for cross-sector partnerships to align public health, healthcare, and social care interventions. Jennifer Post was appointed as Director.
- A new Bureau of Data Analytics, Research and Evaluation was created to support research and data needs across the Division. Solita Jones, DrPH, MS was appointed as Bureau Director, with three Assistant Directors: Jo-Yu Chin,

PhD (Population Health and Equity), Joanne Guo (Perinatal Health Surveillance and Quality Improvement), and Eileen Shields (Perinatal, Reproductive, and Sexual Health Analytics).

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

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$38,909,810	$32,378,022	$38,909,810	$39,701,635
State Funds	$29,285,355	$29,285,355	$29,285,355	$29,285,355
Local Funds	$55,483,224	$35,333,319	$55,602,278	$36,848,150
Other Funds	$0	$0	$0	$0
Program Funds	$22,224,404	$25,288,886	$16,735,967	$22,078,647
SubTotal	$145,902,793	$122,285,582	$140,533,410	$127,913,787
Other Federal Funds	$65,608,665	$48,210,047	$49,308,573	$44,826,458
Total	$211,511,458	$170,495,629	$189,841,983	$172,740,245

	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$38,909,810	$37,088,652	$38,909,810	
State Funds	$29,285,355	$29,285,355	$29,285,355	
Local Funds	$35,897,127	$36,881,701	$36,138,659	
Other Funds	$0	$0	$0	
Program Funds	$21,713,525	$26,235,808	$24,571,358	
SubTotal	$125,805,817	$129,491,516	$128,905,182	
Other Federal Funds	$61,858,217	$49,502,087	$62,282,555	
Total	$187,664,034	$178,993,603	$191,187,737	

	2024	
	Budgeted	Expended
Federal Allocation	$38,909,810	
State Funds	$29,285,355	
Local Funds	$47,389,317	
Other Funds	$0	
Program Funds	$18,762,687	
SubTotal	$134,347,169	
Other Federal Funds	$66,910,483	
Total	$201,257,652	

III.D.1. Expenditures

Federal Fiscal Year (FY) 22 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 Maternal and Child Health population are fully outlined and described in the FY 2022 report and FY 2024 application.

Title V Maternal and Child Health Service 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, ACT for Youth Center for Community Action, and Family Planning Program, promote primary and preventive health care, preconception and interconception health, and physical, social, and emotional health and wellness for all individuals served. Programs such as the School Based Health Center program 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. Title V Maternal and Child Health Services Block Grant funding is provided to NYS's Regional Perinatal Centers to ensure all pregnant women and newborns have access to high quality, appropriate level of perinatal care to improve birth outcomes. 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, Maternal and Infant Community Health Collaboratives (which was renamed to the Perinatal and Infant Community Health Collaborative), 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 the Family Planning Program, School Based Health Centers, 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, including the overarching priority to promote health equity. NYS's Part C of the Individuals with Disabilities Education Action (also known as the Early Intervention Program) funding supports the administration of one of the largest Early Intervention Program in the nation. Grants such as Maternal, Infant, and Early Childhood Hove Visiting support evidence-based home visiting and efforts to engage women and families into health insurance, interconception health, breastfeeding, parenting support, and a range of other supports and services. Funding provided through the Personal Responsibility Education Program and Pregnancy Assistance Fund allows an expansion of adolescent programming to support the growth and development of children and adolescents. The Health Resources and Services Administration Universal Newborn Hearing Screening and the Center for Disease Control and Prevention's Early Hearing Detection and Intervention 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. in 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 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 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 Children and Youth with

Special Health Care Needs, NYS's Title V Program also oversees services specifically designed to serve Children and Youth with Special Health Care Needs and their families. For example, Title V Maternal and Child Health Services Block Grant funds support forty-eight county Local Health Departments and the five counties served by the NYC Department of Health and Mental Hygiene (NYCDOHMH) to provide information and referral services to Children and Youth with Special Health Care Needs and their families. 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 Children and Youth with Special Health Care Needs. 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 School Based Health Centers provide services to children, including Children and Youth with Special Health Care Needs that can result in decreased absenteeism, improved school performance, and better health outcomes. As stated in NYS's application, NYS's Title V Maternal and Child Health Services Block Grant program continues to focus improving supports and services for Children and Youth with Special Health Care Needs and their families. Information obtained from Children and Youth with Special Health Care Needs and their families will assist NYS's Title V Program to improve and enhance supports and services for Children and Youth with Special Health Care Needs in the coming years.

To calculate data on priority populations served by group (pregnant women, infants under one year of age, children ages 1-21 years, Children and Youth with Special Health Care Needs and others) and by level of the Maternal and Child Health 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 Children and Youth with Special Health Care Needs Supports and Services NYS's direct care expenses remain less than 1%.

NYS's commitment to the Maternal and Child Health population is evidenced by the substantial State appropriation that is devoted to supports and services for NYS's women, children, including Children and Youth with Special Health Care Needs 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 Maternal and Child Health population.

Overall, the actual expenditures for FY 22 appear less than originally projected. This is because multiple Maternal and Child Health 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 22 application reflected a budget of over $21 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 Maternal and Child Health 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 Children and Youth with Special Health Care Needs and families across NYS.

III.D.2. Budget

This Federal Fiscal Year (FY) 2024 budget reflects NYS's commitment to Title V Maternal and Child Health Services Block Grant programs and services. NYS will continue to use FY 2024 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, 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 Maternal and Child Health 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 disparities, social-emotional development in children and adolescents, and will promote and support efforts to ensure all NYS's children have the opportunity for healthy development. Information obtained through systems/care mapping has been used to develop enhanced systems for Children and Youth with Special Health Care Needs and their families. The Title V Program is increasing its investment in the Local Health Department Children and Youth with Special Health Care Needs program to provide more support to local staff who can connect with and support Children and Youth with Special Health Care Needs and their families. The Title V Program will also continue to invest in three regional technical assistance centers at the state's University Centers of Excellence in Developmental Disabilities. In NYS, the University Centers of Excellence in Developmental Disabilities are the Westchester Institute for Human Development in Valhalla, Rose F. Kennedy Center at Montefiore Medical Center in New York City, and the Strong Center for Developmental Disabilities at the University of Rochester. These entities are federally designated by Health Resources and Services Administration and established federally through a competitive application process to work with people with disabilities, family members, state and local government agencies, and community providers in projects that provide training, technical assistance, service, research, and information sharing. This investment will continue to assist NYS's Title V Maternal and Child Health Services Block Grant program to improve and enhance supports and services for Children and Youth with Special Health Care Needs 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 Children and Youth with Special Health Care Needs, and many other supports and services discussed throughout NYS's application. Paramount to the plan is the promotion of health equity for all across the life course.

Financially, the Title V Administrative budget of $2.8 million remains below the 10% limit for these costs. As in prior years, the NYS share for Maternal and Child Health services will continue to be considerable and will more than meet the requirements for state match. Expenditures for FY24 are expected to utilize the full allocation of $38,909,810. NYS continues to be fully committed to the health and wellness of all New Yorkers and will move forward in the comprehensive work as outlines in the Title V State Action Plan.

III.E. Five-Year State Action Plan

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

State: New York

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

NYS's Title V Maternal and Child Health Services Block Grant program builds on years of Maternal and Child Health leadership and public health investments. As a large state with well-developed health care, public health insurance, and public health systems, New York addresses the needs of the Maternal and Child Health population through a robust mix of public health programs, policy initiatives, and partnerships. Partnerships encompass collaboration with other public health programs, other state agencies, and a broad array of external organizations ranging from large, sophisticated hospital and health care systems to small, grassroots community-based organizations.

Like other large states, NYS does not provide direct services. Rather, our Title V Maternal and Child Health Services Block Grant program works to improve supports and services and to deliver public health strategies and programs through contracts and community partnerships to address the state's large and extremely diverse Maternal and Child Health population. Title V Maternal and Child Health Services Block Grant funding supports internal state public health infrastructure and systems, and, in combination with other state and federal funding sources, supports gaps in services and programs to maximize outcomes for Maternal and Child Health populations. Key programs and partnerships are described in the *Title V Program Capacity* and *Title V Program Partnerships, Collaboration, and Coordination* sections of the five-year Needs Assessment Summary and the Needs Assessment Update in this year's application.

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

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

Organizationally, much of this work continues to be led by cross-programmatic Title V 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 NYSDOH, such as perinatal health, child health and Children and Youth with Special Health Care Needs. As evidenced in the Annual Report and Application section, NYS's Title V Program continues to make substantial progress in carrying out defined strategies, despite the significant challenges of the past two years at all levels. This is accomplished through direct oversight and administration of key Maternal and Child Health public health programs, as well as Title V Maternal and Child Health Services Block Grant roles as a convener and collaborator. We seek to engage external partners at all levels to enrich the Maternal and Child Health programs administered through Title V Maternal and Child Health Services Block Grant, while simultaneously seeking to bring a Maternal and Child Health perspective and voice to initiatives led outside the Title V Maternal and Child Health Services Block Grant program.

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

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

A strong and diverse Maternal and Child Health workforce is needed to meet the needs of NY's Maternal and Child Health population. The rapidly evolving United States health care and public health system, mass retirements in the maternal and child health workforce, persistent disparities in key Maternal and Child Health population health outcomes, and commitment to balancing equity-driven inclusive approaches with evidence-based practice all emphasize the need for a diverse, well-trained, and flexible Maternal and Child Health workforce. Title V programs must continuously consider the needs of the current workforce while simultaneously investing in developing the workforce of tomorrow.

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

As noted elsewhere in this application, the COVID-19 pandemic created unique workforce challenges as staff rapidly shifted the focus of programs to address new needs and barriers for Maternal and Child Health populations, adjusted to remote work environments, and in many cases were redeployed to participate in direct COVID-19 public health efforts. As we transition from the public health emergency phase of the pandemic, we are managing many staff vacancies due to retirement and staff taking new positions and the accompanying loss of institutional memory, alongside staff adjusting to a new hybrid work environment. While we are successfully backfilling vacancies and securing approval for new staff positions, there have been challenges in recruiting people to fill these positions and significant time and attention are needed to orient, train, and integrate new staff. Although this has created many challenges, it also has facilitated many unique professional development opportunities for staff to apply and expand their public health and leadership skills, and we are exceptionally proud of how our staff have embraced and excelled in meeting these challenges to support the health of New Yorkers.

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

Supporting professional development of the current Maternal and Child Health workforce. Within NYSDOH, our Title V program prioritizes recruiting, retaining, and supporting the continuous professional development of a diverse and competent staff. All new Division of Family Health staff complete a series of virtual orientation modules focused on the Title V program and role of each organizational unit within the Division. Through their day-to-day work and active involvement in collaborative cross-program domain teams, staff are engaged in planning and implementing all steps of our Title V process, from ongoing needs assessment activities to strategic plan development and implementation to monitoring and evaluating funded programs and initiatives. We encourage staff to participate in a NYSDOH-wide mentoring initiative and notify staff of all promotional opportunities including job postings and civil service test announcements. Title V funds support staff training and attendance at national and regional conferences, such as the Association of Maternal and Child Health Programs and NYS Perinatal Association to stay up to date on best practices, build expertise, and make and maintain connections with federal partners and other states and Maternal and Child Health organizations. We encourage Title V-funded local programs to include similar professional development activities in their grant budgets to support their staff.

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

understanding, and practices to advance health equity across all staff, programs, and policies. In 2018 Division of Family Health established an internal Health Equity team, which identified four courses focused on different aspects of health equity. These have been packaged into a comprehensive health equity curriculum with pre- and post-evaluation modules hosted on the NYSDOH learning management system. All existing and incoming staff from entry level and support staff through top management are required to complete the series, and success is monitored and reported to leadership. In addition, Title V staff participate in an interagency Racial Justice Workgroup within the Center for Community Health, which includes Division of Family Health as well as the Divisions of Nutrition, Chronic Disease Control and Prevention, and Epidemiology. The Center for Community Health Racial Justice Workgroup is leading a multi-year effort to translate our shared commitment to racial justice into action, including a range of innovative training interventions to build the capacity of health and human services providers, health care facilities, community-based organizations, and larger communities to employ a health equity framework for improving health outcomes. NYS Department of Health staff also joined the Government Alliance on Race and Equity (GARE) in 2019 and participated in their training. In July 2022, NYSDOH established a new Office of Health Equity and Human Rights. This new office will address health disparities and work to improve diversity, equity, and inclusion within the Department, and will be a resource for programs across the entire Department to achieve common goals of equitable health for all New Yorkers.

Statewide Centers of Excellence. To augment the support provided by state Title V staff, we have established statewide Centers of Excellence to provide training and technical assistance to local programs in key areas, including family planning, perinatal health, lead poisoning prevention, adolescent health, and Children and Youth with Special Health Care Needs. These centers support access to current and archived informational resources and practice support tools, facilitate ongoing access to experts in the field, provide training and technical assistance, lead structured quality improvement projects, and translate emerging research and best practices to support effective implementation of Maternal and Child Health programs and services. The Centers of Excellence serve as invaluable resources to both local and state Maternal and Child Health staff. For example, as highlighted elsewhere in this application, the Regional Support Centers for Children and Youth with Special Health Care Needs have created a portal for Local Health Department Children and Youth with Special Health Care Needs staff to house program-specific trainings and other resources and work directly with each Local Health Department to develop and develop and update their county specific family engagement plan goals and action steps. The ACT for Youth Center for Community Action provides training, technical assistance, and evaluation for adolescent health initiatives, including maintaining detailed implementation toolkits for Comprehensive Adolescent Pregnancy Prevention program and Personal Responsibility Education Program providers.

CDC Foundation State-Funded Project. Another important strategy we have leveraged to augment our current state Maternal and Child Health workforce capacity is a partnership with the CDC Foundation. The CDC Foundation is an independent not for profit organization, established by Congress, that helps the Centers for Disease Control and Prevention (CDC) work more effectively with partners through philanthropic and private sector resources. This support allows for accelerated research, cost effective innovative and high impact programs, and a wider reach in partnership for health protection work. In 2021, the Foundation established a State-Funded Projects (SFP) program to assist health departments across the country in rapidly mobilizing state responses to address the ever-changing demands of emergency response. The Division of Family Health is fortunate to have secured one fellow, Cora Mann, through the SFP program. Cora is assisting with maternal morbidity and mortality data collection and analysis to understand the scope, trends, causes, demographics, and geographical differences of maternal morbidity through sophisticated analysis of hospital discharge data in the Statewide Planning and Research Cooperative System (SPARCS) and birth data. She is leading Division of Family Health's efforts to examine the data and prepare reports and presentations that will be used to inform policy and program activities.

NYS Public Health Corps Fellowship. The New York State Public Health Corps (NYSPHC) Fellowship Program was established in 2021 by Governor Hochul to build public health capacity and support during the COVID-19 operations and increase preparedness for future public health emergencies. It helps to create an effective public health workforce, both by increasing our workforce capacity today and by investing in the development of promising emerging public health professionals for the long term. In working with the NYSDOH and their community partners, up to 1,000 fellows were

recruited and deployed to participate and use their talents and expertise to help advance the State's public health agenda while serving their communities. Fellows work in specific assigned projects and have many opportunities to participate in educational webinars, networking, mentorship, summits, and seminars as they grow as public health professionals.

The Division of Family Health is currently hosting two NYSPHC fellows. Cecelia Guthrie is working on communication efforts for the New York State Perinatal Quality Collaborative. In this role, Cecelia develops a variety of resources such as presentations, newsletters, and educational materials for stakeholders including pregnant people and their providers to further support positive health outcomes. Projects additionally focus on birth equity, Opioid Use Disorder in Pregnancy and Neonatal Intensive Care Unity (NICU) equity. Avinash Lekram is working as a Health Education Outreach Specialist to support the Bureau of Perinatal Reproductive Adolescent and Sexual Health. In this role Avinash focuses on reproductive health and perinatal health to help advance equity as a public health foundation. Some of their projects include updating a bill of rights for people who have experienced sexual assault and assisting with the planning of a first of its kind reproductive justice symposium. Both Cecelia and Avinash are recent graduates of the University at Albany (UAlbany) School of Public Health, where they both earned their Master of Public Health (MPH) degrees and Certificates of Graduate Study in Maternal and Child Health.

Fellowship in Applied Public Health. This year our Title V program partnered with the Fellowship in Applied Public Health (FAPH), a leadership development initiative jointly sponsored by NYSDOH and University at Albany School of Public Health. Fellows are physicians and other advanced licensed health care professionals seeking to transition from clinical to public health practice and leadership roles. In addition to completing all requirements for the MPH degree, fellows spend a full year doing intensive practicum placements within NYSDOH and a local health department. The Division of Family Health hosted fellow Tristan Sharratt, FNP for a 3-month practicum in the Bureau of Perinatal, Reproductive, Adolescent, and Sexual Health, where he worked with the Family Planning Program team on a special project focused on strengthening justice, equity, diversity, and inclusion across Family Planning programs, specifically on addressing the unique reproductive and sexual health needs of people identifying as LGBTQ+ and people with disabilities. Tristan's work included developing and implementing a survey of clinical, health education, and administrative family planning staff, which in turn informed the distribution of a guide to inclusive practice for family planning programs. This work has been submitted for presentation at the upcoming American Public Health Association Fall 2023 conference.

Empire State Fellows Program. The Empire State Fellow Program is a full-time 2-year leadership training program that prepares the next generation of talented professionals for careers as New York State policy makers. While taking part in the work of government, Empire Fellows participate in educational and professional development programs that will help them to serve as effective and ethical government leaders. Work assignments offer Fellows unparalleled experience collaborating with senior officials and participating in the policy-making process.
The NYSDOH currently hosts Kerline Destin as an Empire Fellow in the Division of Family Health within the Office of Public Health. Kerline is currently leading a project to develop a communication guide for birthing people to improve their interactions with providers. This work includes chairing a small working group to move this project forward. Kerline will also be taking the lead on a state measure for the Title V Maternal and Child Health Services Block Grant action plan that includes work on the communication guide. In addition, Kerline is an active member on the Division of Family Health Social and Emotional Workgroup and participates in ongoing work in the Bureau of Health Equity and Community Engagement.

Academic-Practice Partnership with UAlbany School of Public Health. The UAlbany School of Public Health was jointly founded by UAlbany and NYSDOH nearly 40 years ago. In 2015, as an outgrowth of this foundational partnership, School of Public Health established a Maternal and Child Health program with initial grant funding from the federal Health Resources and Services Administration Maternal and Child Health Catalyst initiative. Rachel de Long, M.D., M.P.H., clinical School of Public Health faculty and then the NY Title V Maternal and Child Health Services Block Grant Director, and Christine Bozlak, PhD, MPH, a full-time School of Public Health faculty, serve as co-directors for the School of Public Health Maternal and Child Health Program. Consistent with the federal Maternal and Child Health Catalyst Program goals, the School of Public Health program seeks to develop an increased focus on Maternal and Child Health within the school and university and to prepare students for Maternal and Child Health careers, with priority for students from underrepresented backgrounds. The

program offers academic Maternal and Child Health courses, funds Maternal and Child Health-related internships for School of Public Health students, supports student and faculty travel to Maternal and Child Health conferences, and facilitates a wide array of professional development opportunities for both students and Maternal and Child Health practitioners. A new certificate of graduate studies in Maternal and Child Health launched in the 2019-20 academic year, with 44 graduates to date and 30 students enrolled as of June 2023.

From its inception, the partnership with the state's Title V Maternal and Child Health Services Block Grant program has been a distinguishing strength of the School of Public Health Maternal and Child Health Program. Since Dr. de Long transitioned from her former role as Title V Director to a full-time position at School of Public Health, the Maternal and Child Health and Title V programs have continued to strengthen and expand the collaboration, most recently under Dr. Siegenthaler's leadership. In 2018 we established a Memorandum of Understanding to implement a one-time Women's Health Initiative funded by the state legislature. That Memorandum of Understanding was extended in 2019 to support faculty and student assistance with the Title V 5-year Needs Assessment and several related priority Maternal and Child Health projects, and in 2021 we established our current 5-year Memorandum of Understanding, detailed further below. This academic-practice partnership was highlighted in a poster presentation at the 2023 Association of Maternal and Child Health Programs conference. We are currently working on a full manuscript for peer review, and have been invited to submit an article for the National MCH Workforce Development Center's Academic-Practice Partnership newsletter.

The Academic-Practice Partnership between NYS Title V and UAlbany School of Public Health Maternal and Child Health Program encompasses several key approaches to support development of both the current and future Maternal and Child Health workforce:

- **Technical Assistance.** Dr. de Long dedicates a portion of her time, supported through our Memorandum of Understanding, to providing ongoing and annual technical assistance for the state's Title V grant application. She participates in overall application framing and planning, works directly with the five Title V domain teams to gather and synthesize information for the 5-year Needs Assessment and annual Needs Assessment updates, and assists in writing other sections of the application. Throughout the year, both co-directors consult with the Division of Family Health on a variety of topics as needed and facilitate connections with other faculty related to applied research and evaluation opportunities. For example, this year Dr. de Long led an in-service webinar and discussion with child health and Children and Youth with Special Health Care Needs staff on *Bright Futures* to support their Title V action plan strategies on anticipatory guidance and health education.

- **Teaching and professional development**. Title V staff and students interact regularly, both in and out of the classroom. The Title V Director and other Maternal and Child Health staff regularly provide guest lectures in Maternal and Child Health courses at School of Public Health. The co-directors incorporate options for student project topics related to state Title V priorities, and, with student permission, share the products with Title V staff to inform their work. In addition, Title V staff are invited and regularly participate in seminars, networking events, community service projects, and other professional development activities hosted by the School of Public Health Maternal and Child Health program, and in turn invite Maternal and Child Health program staff to join relevant sessions convened by NYSDOH. This approach creates an environment of shared learning and professional development, in which Title V staff, faculty, and students are engaged in professional development alongside one another, with different partners 'in the lead' for different activities and often functioning as both teachers and learners at the same time.

- **Student internships**. Applied field experience is a cornerstone of public health professional training. Both MPH and DrPH students at UAlbany are required to complete 720 hours of internships or practicums, providing a critical opportunity to expose them to state level Maternal and Child Health work and career opportunities within Title V. Through the Memorandum of Understanding, the Division of Family Health hosts up to six graduate student interns every semester (up to 18 annually). Through the Memorandum of Understanding, students are hired by School of Public Health and assigned to Division of Family Health staff as project mentors. This allows students to apply what they are

learning in the classroom to real-world issues and settings, while developing essential public health skills and contributing to meaningful initiatives and products. It also expands the capacity of our Title V program to advance priority projects and provides Title V staff – many of whom are themselves School of Public Health graduates - with the opportunity to serve as mentors, which is critical to their own professional development. In addition to their respective core projects, students receive orientation to Title V and the Division, have opportunities to network with other students and staff, and benefit from direct guidance on how to pursue employment within the Division of Family Health and NYSDOH through both civil service and grant-funded opportunities.

Since 2019 we have funded and mentored 32 graduate students within the Division of Family Health, supporting 20 distinct priority Maternal and Child Health projects across all five Title V domains. Six of these students were co-mentored by Dr. de Long and Dr. Siegenthaler (Title V Director) together over two semesters for a system mapping project to create logic models for our Title V State Action Plan and develop a crosswalk to analyze how we are integrating health equity across our programs. Six of the student interns we have hosted – a full one-third of those who had graduated prior to Spring 2023 – are now employed in the Division of Family Health or other Maternal and Child Health-related organizational units at NYSDOH, demonstrating the value of our investment in the future Title V workforce. We will host six students in Summer 2023, focusing on projects that include Communication Strategies for Reproductive Health and Adolescent Mental Health, strengthening health equity within local Children and Youth with Special Health Care Needs programs, and analysis and evaluation of NYS Perinatal Quality Collaborative's health equity collaborative.

See ***Supporting Document 2*** for our Academic-Practice Partnership presented in the Association of Maternal and Child Health Program conference poster, a complete list of Title V-funded internships (2019-2023), and selected products of student internships, including the logic models drafted by student interns.

As we look forward, our Title V program will continue to prioritize development of the current and future Maternal and Child Health workforce development through our staff development activities and partnerships.

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

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

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

NYS's Children and Youth with Special Health Care Needs Program requires the three University Centers of Excellence in Developmental Disabilities (UCEDDs), which are the state's Resource Support Centers that provide technical support and assistance to counties, employ a parent/family member/caregiver of a child or youth with a special health care need to ensure that families can talk to a trusted messenger and that the programs' supports and services meet family's needs. The Local Health Department Children and Youth with Special Health Care Needs Program work plan requires that they provide program outreach and awareness regarding the local Children and Youth with Special Health Care Needs Program, gap-filling programs, and community resources. The goal of these activities is to empower families of Children and Youth with Special Health Care Needs and youth/young adults with special health care needs to navigate the systems of care. All 49 local contractors are required to report quarterly on their activities in this area.

NYS's Early Intervention Program ensures there is a family voice through the State Systemic Improvement Program quality improvement teams. This quality improvement initiative aims to improve family outcomes in the Early Intervention Program service delivery system. The State Systemic Improvement Program work is highlighted in the Children with Special Health Care Needs section. In addition to the State Systemic Improvement Program, the Early Intervention Program supports the Family Initiatives Coordination Services Project that coordinates the development and implementation of a variety of family initiatives including training and support for parents involved in the Early Intervention Program to become advocates for special needs children at local, state, and national levels continues.

The NYS Advisory Councils often include a family voice. Parents are members of the Early Intervention Coordinating Council as well as the Maternal and Child Health Services Block Grant Advisory Council and provide valuable input to guide policy and practice. Michelle Juda, executive director of Parent to Parent of NY has been designated as a member of NYS's Maternal and Child Health Services Block Grant Advisory Council and NYS's family representation to the Association of Maternal and Child Health Programs. The Early Childhood Advisory Council, oversee by the NYS Council on Children and Families, has recruited and is supporting parents/caregivers as members of the Council and to provide guidance and review of State-led Maternal and Child Health programs.

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

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

Maternal and Child Health data are critical to the effective, efficient, and equitable implementation and improvement of Maternal and Child Health programs, services, and policies. Descriptions of the data systems and sources that inform NYS's Title V Maternal and Child Health Services Block Grant work are provided in Section 2b.iii.c. The Division of Family Health relies on a strong workforce comprised of data analysts, epidemiologists, evaluation specialists, program research specialists, programmers, and research scientists to develop, maintain, and utilize our various Maternal and Child Health data systems, to evaluate and improve our programs and to monitor ongoing and emerging priorities. This workforce includes both staff within the Division of Family Health and partners in other NYSDOH organizational units. While staff are funded by different funding sources, including Title V Maternal and Child Health Services Block Grant, State Systems Development Initiative, other federal grants, and state funds, data staff collaborate with other data staff as well as program staff to meet the needs of our Title V Maternal and Child Health Services Block Grant Program and NYSDOH's Maternal and Child Health initiatives overall.

As of June 2022, NYS's Maternal and Child Health epidemiology workforce within the Division of Family Health included 24 staff with the titles and funding sources outlined in the table below. As a result of promotions and individuals leaving NYSDOH, there are vacancies in Maternal and Child Health epidemiology-related positions within the Division of Family Health at the time of this report. The Division is working to fill vacancies.

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

	Funding Source				
Maternal and Child Health Epidemiology-related Titles	Title V	State Systems Develop. Initiative	Other Federal Funding	Contractor	Total
Data Analyst				4	4
Evaluation Specialist				1	1
Program Research Specialist	2	1	5	1	9
Programmer				1	1
Project Manager				1	1
Research Scientist	4		3	1	8
Total	6	1	8	9	24

Beyond the Division of Family Health, there are staff with similar titles throughout NYSDOH that support programs receiving Title V Maternal and Child Health Services Block Grant funds, such as Newborn Bloodspot Screening in the Wadsworth Laboratory, Office for Public Health Practice which oversees the Maternal and Child Health Dashboard and the NYSDOH Prevention Agenda Dashboard (that includes the 'Promote Healthy Women, Infants, and Children' section) as well as data surveillance systems like the Pregnancy Risk Assessment Monitoring System, the Lead Poisoning Prevention Program in the Center for Environmental Health, and Comprehensive Services and Health Systems Approaches to Improve Asthma Control in Division of Community Chronic Disease Prevention. Examples of NYSDOH staff outside of the Division of Family Health that support Maternal and Child Health efforts but are not Title V Maternal and Child Health Services Block Grant funded include data staff who are located organizationally in the NYSDOH's Office of Quality and Patient Safety and who manage critical data sources, such as vital statistics, Medicaid claims, and hospital discharge data.

Other state agency partners outside of NYSDOH support Maternal and Child Health epidemiological efforts. The NYS Council on Children and Families developed the Kids' Well-being Indicators Clearinghouse (www.nyskwic.org), which aims to advance the use of children's health, education, and well-being indicators as a tool for policy development, planning, and accountability. NYSDOH is a member agency of the Kids' Well-being Indicators Clearinghouse and provides data to the

clearinghouse. Programmers contracting with NYS Office of Information Technology update, fix, and test NYS's Vital Records data systems.

The COVID-19 pandemic presented a period of both immense challenges as well as opportunities for the Maternal and Child Health epidemiology workforce in the Division of Family Health. Nearly all staff were reassigned to COVID-19 response tasks, sometimes for short-term discrete projects or at times for months-long deployments. Some assignments were done in addition to usual duties while others required 100% effort, removing staff completely from their usual duties and leaving other staff to cover. Response efforts strained all data staff, both those who were reassigned and those who continued all usual duties. But this was also an opportunity to forge new relationships with staff throughout NYSDOH that can be fostered and leveraged into the future and to gain new skills and experiences that can be applied to Maternal and Child Health and Title V Maternal and Child Health Services Block Grant work specifically.

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

One of the main objectives of the State Systems Development Initiative is to build and expand NYS 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. The importance of NYSDOH data capacity is recognized as critical to identifying the population's Maternal and Child Health needs, including the impact of structural racism. Improving data integration and utilization allows for greater ability to assess trends in outcomes, including health disparities. With the changing landscape of NYS's population, services, and resources, coupled with health reform changes that seek to improve outcomes and reduce disparities while not increasing costs, there is an increased demand for quality data that is available to Maternal and Child Health decision makers, program administrators, and staff who are monitoring and evaluating programs and their impact.

i. Contributions of the State Systems Development Initiative grant in building and supporting accessible, timely & linked Maternal and Child Health data systems, as documented on Form 12

NYS has a strong commitment to data systems development and invests in infrastructure to promote data linkages and timely reporting. The following data sources are provided by partners to allow the State Systems Development Initiative and other Title V staff to assess, monitor, and evaluate Title V programming in NYS: Newborn Screening Program data; Vital Records (births, deaths); New York City Vital Records; Statewide Perinatal Data System (SPDS); Children and Youth with Special Health Care Needs database; Early Intervention Program Data; Behavioral Risk Factor Surveillance System; Centers of Disease Control and Prevention (CDC) Pregnancy Risk Assessment Monitoring System; Immunization Information System; Medicaid; Quality Assurance Reporting; Statewide Planning and Research Cooperative System; National Survey of Children's Health; Early Hearing Detection Intervention; CDC Breastfeeding Report Card; National Immunization Survey; Sexually Transmitted Disease Surveillance; United States Current Population Survey; National Pediatric Nutrition Surveillance System; National Survey of Children with Special Healthcare Needs; Statewide Health Information Network in New York; Psychiatric Services and Clinical Knowledge Enhancement System; and United States Census data.

The State Systems Development Initiative Principal Investigator, who is the Division of Family Health Medical Director, the State Systems Development Initiative Program Research Specialist, and other Division of Family Health research scientists have initiated several efforts to increase data capacity and advance the development and utilization of linked information systems between key Maternal and Child Health datasets in NYS to improve access to electronic Maternal and Child Health data. Various data linkage projects are listed below, detailed updates on the projects can be found in *Supporting Document 3: Maternal and Child Health Data Systems*.

- NY and NYC Linked Birth and Infant Death Data
- Statewide Perinatal Data System (SPDS)
- NYS and NYC Linked Birth, Death and Hospital Discharge Data for Maternal Mortality and Morbidity
- Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES)
- All Payer Database
- Linked NY Early Intervention Program and Children and Youth with Special Health Care Needs
- Early Hearing Detection and Intervention-Information System (EHDI-IS)
- Pregnancy Risk Assessment Monitoring System (PRAMS) Data Linked to NYS Birth Data
- Prevention Agenda Dashboard
- Maternal and Child Health Dashboard

ii. The role the State Systems Development Initiative plays in enabling ongoing Title V Program assessment, monitoring, and reporting.

The State Systems Development Initiative Principal Investigator, the Program Research Specialist, and other program research scientists guide the collection and analysis of the data that forms the basis for the Five-Year Needs Assessment

and the State Action Plan. Collectively these describe NYS's priority needs, key strategies and activities, and National Outcome Measures (NOMs), National Performance Measures (NPMs), State Performance Measures (SPMs), and Evidence-Based or -Informed Strategy Measures (ESM). Staff partners with stakeholders to review and discuss relevant Maternal and Child Health data and recommend structural and process measures used to monitor progress in all Maternal and Child Health population domains.

In 2021, Title V staff guided the development, selection, refinement and/or tracking of data and performance measures that are associated with the Maternal and Child Health Services Block Grant priorities for the purpose of ascertaining progress towards achieving reported goals. The State Systems Development Initiative and other Title V analytic staff assisted with the coordination of data collection of NOMs, NPMs, SPMs, and ESMs 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 Maternal and Child Health Services Block Grant Application/Annual Report. These activities support Title V Maternal and Child Health Services Block Grant analysis of the NPMs and related structural/process objectives as part of the Maternal and Child Health Services Block Grant Application/Annual Report.

Staff have been assisting with a plan to improve data linkages across the five-year State Systems Development Initiative funding cycle. In 2021, staff continued to perform a gap analysis based on amended or added Core/State Dataset (CDS) elements, but efforts were slowed by COVID-19 priorities and staffing turnover. New York State is currently reporting seven of the Core/National Dataset elements and six of the CDS elements as part of the Maternal and Child Health Services Block Grant.

Additionally, the State Systems Development Initiative Program Research Specialist assisted with the development of a survey to evaluate the utility of safe sleep materials (sleeping safely starter kits and cotton/fleece sleep sacks) that were purchased by NYSDOH and distributed to NYS-funded home visiting programs to aid in the promotion of safe infant sleep practices.

iii. Key State Systems Development Initiative program activities, including any products or resource materials that were developed, which served to support State Title V Program efforts

NYS Perinatal Quality Collaborative (NYSPQC)

The State Systems Development Initiative Program Research Specialist assists with data collection and analysis for the NYS Perinatal Quality Collaborative's Opioid Use Disorder and Neonatal Abstinence Syndrome project with 47 birthing hospitals from diverse geographic areas and representing all levels of NYSDOH perinatal designations. The project's goal of improving the identification and treatment of pregnant women with Opioid Use Disorder is being achieved by delivering provider and patient education; implementing universal verbal screening; improving the management of patients during labor, delivery, and immediately postpartum; coordinating discharge care; and collaborating across hospital teams to share and learn. The project's goal of improving the care of infants with neonatal abstinence syndrome is being achieved by delivering provider and patient education; improving early identification of infants at risk; improving the management of patients using standardized neonatal abstinence syndrome treatment protocols, including pharmacological and non-pharmacological management; coordinating discharge care; and collaborating across hospital teams to share and learn.

The NYS Perinatal Quality Collaborative conducted the NYS Obstetric Hemorrhage Project between November 2017 and June 2021, in collaboration with the American College of Obstetricians and Gynecologists District II NY, Healthcare Association of New York State, and Greater New York Hospital Association, with support from the National Institute for Children's Health Quality. Eighty-three NYS birthing hospitals from all levels of perinatal regionalization participated. The project aligned with the national Alliance for Innovation on Maternal Health led by the American College of Obstetricians and Gynecologists.

The NYS Perinatal Quality Collaborative's Birth Equity Improvement Project was launched to all NYS birthing hospitals and

centers in January 2021. The project assists facilities to identify how individual and systemic racism impacts birth outcomes at the facility level and identify actions to improve both the experience of care and perinatal outcomes for Black birthing people in the communities they serve. This project was implemented at the recommendation of the NYS Taskforce on Maternal Mortality & Disparate Racial Outcomes. To date, 70 NYS birthing hospitals and centers are participating in the project.

Participating hospitals are collecting and submitting a Patient Reported Experience Measure which is a self-directed, anonymous survey of birthing people, available in 12 languages. Facility-specific QR code/link has been provided to access the survey, and answers go directly to NYSDOH for analysis. Survey questions were drawn from validated patient experience tools and developed with input from an advisory group. Questions focus on shared decision making, feeling treated differently due to demographics, and feeling treated with respect and compassion. Demographic information collected includes primary language, race/ethnicity, age, sexual orientation, and gender identity. Monthly facility level data reports are stratified by race/ethnicity.

Participating facilities have reported the following since project data collection began:

- Facilities with written policies and procedures addressing equitable care increased 24%, from 41.8% in Q2 2021 to 51.9% in Q4 2021
- Facilities with any type of anti-racism education program in place for staff increased 35% from 56.4% in Q2 2021 to 75.9% in Q4 2021
- Facilities with the Patient Reported Experience Measure survey implemented and offered to every birthing person increased 45%, from 30.9% in Q2 2021 to 75.9% in Q4 2021
- Facilities that are reviewing perinatal data stratified by race and ethnicity to develop activities intended to address inequities in care increased 8.1% from 34.5% in Q2 2021 to 42.6% in Q4 2021.

NYS Safe Sleep Infant Mortality Collaborative Improvement and Innovation Network (CoIIN)

Title V Maternal and Child Health Services Block Grant staff and seven community-based organizations (CBOs) (e.g., Healthy Start and Maternal and Infant Community Health Collaboratives), participated in the second national Safe Sleep IM CoIIN. Under the leadership of the National Institute for Children's Health Quality, NYS and several other states worked to reduce disparities in infant mortality due to unsafe sleep. Between July 2018 and May 2020, the CBOs provided safe sleep information to caregivers and administered a survey 30-60 days postpartum. Completed surveys were submitted to NYSDOH monthly for quality improvement purposes. Run charts were provided to the organizations to identify areas to focus their tests of change and assess whether the changes they made resulted in improvement.

Although the NYS IM CoIIN has ended, the Title V Program continues partnerships with CBOs and providers to reduce infant deaths related to unsafe sleep practices. Title V Program staff is collecting data on the distribution of safe sleep materials to hospitals and community-based home visiting programs.

Products or Resource Materials Developed:

- New York State Report on Pregnancy-Associated Deaths in 2018 Link to Published Report
- NYSDOH Patient Education Brochure: Protect Yourself, Your Family, and Your Baby: Get the COVID-19 Vaccine! Covid-19 Vaccine Brochure
- NYSDOH Patient Education Poster: Protect Yourself, Your Family, and Your Baby: Get the COVID-19 Vaccine Covid-19 Vaccine Poster
- Hear Her Palm Cards for Pregnant or Recently Pregnant Persons (in 11 languages) Palm Card for Pregnant or Recently Pregnant Persons in English
- Hear Her Palm Cards for Partners, Friends, and Family (in 11 languages) Palm Card for Partners Friends and Family in English
- Pregnant or Just Had a Baby? Know When to Call for Help – Fast! Pamphlet Know When to Call for Help – Fast!

Pamphlet

- Information for Patients After Giving Birth During Covid-19 Pandemic – Fact Sheet Information for Patients After Giving Birth Factsheet
- NYSPQC Patient Resource - Neonatal Abstinence Syndrome: What You Need to Know NAS: What You Need to Know
- Patient Education - Your Pregnancy & Substance Use: Four Ways to Get and Stay Healthier #0737_NAS_4Things_YourPregnancySubstanceUse_101420 (albany.edu)
- Provider Education - Perinatal Substance Use: Five Ways You Can Improve Care During Pregnancy & Beyond #0735_NAS_5Ways_SubstanceUse_101420 (albany.edu)
- Provider Education - Opioids & Neonatal Abstinence Syndrome: Language Matters #0732_NAS_LanguageMatters_101420 (albany.edu)
- Provider Education - How to Care for a Baby with Neonatal Abstinence Syndrome #0733 How to Care for a Baby with Neonatal Abstinence Syndrome

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

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

Data and information systems that inform Title V Maternal and Child Health Services Block Grant and Maternal and Child Health efforts overall are administered within the Division of Family Health or are administered by other NYSDOH organizational units and Division of Family Health staff maintain strong partnerships and formal data use agreements to access needed data.

Within the Division of Family Health, the following systems are maintained:

- The Division of Family Health 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 aligned with the Pediatric Mental Health Care Access (PMHCA) initiative which is working with School Based Health Centers; Adolescent Pregnancy Prevention Programs; Sexual Violence Prevention Programs; and the NYS Perinatal Quality Collaborative. Data particular to each program are collected for program monitoring and evaluation.
- For population surveillance for newborn hearing screening and follow-up, the 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 New York State Immunization Information System (NYSIIS) in 2018. It allows hospitals, audiologists, and primary care practitioners to document all hearing screening, diagnoses, and referrals to early intervention for all infants who are born in NYS.
- In addition, the Division of Family Health oversees the NYS Early Intervention Program under Part C of Individuals with Disabilities Education Act (often referred to as IDEA). Data from the NYS Early Intervention Program are linked with the Early Hearing Detection and Intervention Information System (EHDI-IS) to confirm referral of infants to the program when they have suspected and/or identified hearing loss. The NYS Early Intervention Program utilizes the New York Early Intervention System, which is a centralized, web-based system that electronically manages Early Intervention Program administrative tasks and provides for the exchange of information among municipalities, program providers and State administrators. The New York Early Intervention System is going to be replaced by the EI-Hub, which is a new solution designed specifically for the New York State Early Intervention Program. The EI-Hub will allow users across New York State 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 will be able to capture and report on child information from referral (intake) to transition, including managing provider data, provider management, claims creation, billing, and payments.

The systems outside of the Division of Family Health that staff access via partnership or formal agreements are:

- Vital Records (VR), two separate systems for NYS excluding NYC and for NYC
    - Core Electronic Birth Certificate: The Statewide Perinatal Data System (SPDS) is an electronic maternal and newborn data collection system which was established and is currently maintained by NYSDOH with the purpose of improving prenatal, obstetric, and newborn care for mothers and infants in NYS. The Statewide Perinatal Data System was developed to make data available for NYSDOH and hospitals for monitoring and quality improvement. Web-based and modular in design, the Statewide Perinatal Data System includes the Core Electronic Birth Certificate that captures birth data in hospitals outside of NYC, and the Neonatal Intensive Care Unit (NICU) module (see below). 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. In addition to meeting National Center for Health Statistics standards for collection of electronic birth data, the Core Electronic Birth Certificate Module also includes quality improvement variables.
    - NYS Electronic Death Registration System is a secure web-based system for electronically registering deaths for NYS hospitals, excluding NYC. The NYS 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 used to identify pregnancy-related deaths.
    - NYC vital records system, eVital, allows all NYC hospitals to electronically submit birth and death registrations using mobile devices and facial recognition security. The eVital birth module captures the same birth data as the Statewide Perinatal Data System, using National Center for Health Statistics standards supplemented by the set of quality improvement variables, but does not provide NYC hospitals with access to the same statistical summary reports and data extraction capabilities as are available for upstate hospitals.
    - NYS Office of Mental Health Project TEACH and Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) data.
- Neonatal Intensive Care Unit (NICU) Module is a module of the Statewide Perinatal Data System that captures detailed clinical information from all hospitals, including NYC, certified to provide specialty or intensive care to high-risk neonates, i.e., those designated as Level II, III or Regional Perinatal Center. The NICU Module captures data for all neonates admitted to special and intensive care nurseries for longer than four hours and includes information on newborns who die in the delivery room, or in transit to or within the neonatal special or intensive care units. Data include demographics for the infant and birthing person and diagnoses and treatments for the infant.
- Statewide Planning and Research Cooperative System (SPARCS) is a comprehensive all payer data reporting system established in 1979. It collects patient level detail on patient characteristics, diagnoses and treatments, services, and charges for each hospital inpatient stay and outpatient (ambulatory surgery, emergency department, and outpatient services) visit; and each ambulatory surgery and outpatient services visit to a hospital extension clinic and diagnostic and treatment center licensed to provide ambulatory surgery services.
- All Payor Database 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 the Statewide Planning and Research Cooperative System (SPARCS) 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.
- Newborn Screening Laboratory Information Management System (LIMS) is maintained by the Wadsworth Laboratory to record bloodspot samples received, demographics, results for the 50 different disorders tested, and follow-up.
- New York State Immunization Information System (NYSIIS) is the system where health care providers report all immunizations administered to persons less than 19 years of age and their immunization histories. It aims to establish a complete, accurate, secure, real-time immunization medical record that is easily accessible and promotes public health by fully immunizing all individuals appropriate to age and risk.
- Statewide Health Information Network for New York (SHIN-NY) facilitates the electronic exchange of clinical information and connects healthcare professionals statewide to improve patient outcomes, reduce unnecessary and avoidable tests and procedures, and lower costs. It ensures access to a patient's electronic medical records wherever and whenever they need it. Health records are not publicly accessible. Only a patient decides who can see their records and may opt out at any time.
- Electronic Clinical Laboratory Reporting System (ECLRS) provides laboratories that serve NYS with a single electronic system for secure and rapid transmission of reportable disease information to NYSDOH, local health departments, and the New York City Department of Health and Mental Hygiene. It enhances public health surveillance by providing timely reporting; improving completeness and accuracy of reports; and generally facilitating the

identification of emergent public health problems by monitoring communicable diseases, lead poisoning, HIV/AIDS, and cancer. The Electronic Clinical Laboratory Reporting System was particularly critical during the COVID-19 pandemic to record test results; public health law was changed to mandate reporting of SARS-CoV-2.

- LeadWeb is a NYSDOH-maintained system used by 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. As such, the system provides a real-time database of blood lead tests and follow-up activities.
- The Pregnancy Risk Assessment Monitoring System is an ongoing mail/telephone survey of mothers who have recently given birth to a live born infant, designed by the CDC. It collects information from mothers about behaviors and experiences before, during, and after pregnancy that are not available from other data sources. The goal of the Pregnancy Risk Assessment Monitoring System project is to make data available to inform policy and program investments to improve the health of mothers and infants by reducing adverse outcomes such as low birth weight, infant mortality and morbidity, and maternal morbidity. The Pregnancy Risk Assessment Monitoring System 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 is an annual statewide random telephone and cellular surveillance survey designed by the CDC. The survey monitors modifiable risk behaviors and other factors contributing to the leading causes of morbidity and mortality in the population. Data from the Behavioral Risk Factor Surveillance System are useful for planning, initiating, and supporting health promotion and disease prevention programs at the state and federal level, and monitoring progress toward achieving health objectives for the state and nation. NYS's Behavioral Risk Factor Surveillance System sample is representative of the non-institutionalized civilian adult population, aged 18 years and older.
- The Youth Risk Behavior Surveillance System, 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 Youth Risk Behavior Survey 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 in NYS on behalf of the NYS Education Department.

The Division of Family Health has partnered with NYSDOH'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's Title V Maternal and Child Health Services Block Grant application. It was built to support the assessment of needs, monitor progress towards improving the health of NYS Maternal and Child Health populations, and reducing health disparities. It provides an interactive visual presentation of state and county data and for select measures, socio-demographic data. Where available, the most current data are compared to previous year data to monitor performance at both state and county levels. Trend graphs, tables, maps, and bar charts are available from the state and county homepage dashboard views. The Dashboard was updated in February 2023.

The Division of Family Health has a strong commitment to data systems development and utilizes Title V and State Systems Development Initiative funding to invest in infrastructure to promote data linkages and timely reporting.

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

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

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

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

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

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

NYSDOH staff at the state Emergency Operation Center or within NYSDOH 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 program staff, as needed for any Maternal and Child Health planning before or during a disaster.

The NYSDOH 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 NYSDOH leadership as identified.

Title V Program staff helped identify key resources for training as part of the Health Emergency Preparedness and Response Plan Pediatric Surge plan. Additionally, Title V Maternal and Child Health Services Block Grant program staff were

part of the development group that created the NYSDOH Pediatric and Obstetric Emergency Preparedness Toolkit, a guide for emergency preparedness planning, training, and practice, including clinical and operational information for emergencies.

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

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

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

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

As required by Health Resources and Services 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 NYSDOH, as is the NYS Medicaid Program. The NYS Medicaid program, which is administered by the NYSDOH Office of Health Insurance Programs, is part of the larger organizational structure of the NYSDOH along with the NYS Title V Maternal and Child Health Services Block Grant program.

Among the many advantages of being part of the same agency, the Title V Maternal and Child Health Services Block Grant and the Medicaid program have been able to establish a strong relationship designed to enhance the services for the Maternal and Child Health population within NYS. This intra-agency relationship enables Title V staff to support the use of the Medicaid program and funding 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 NYSDOH Office of Health Insurance Programs (i.e., state's Medicaid program) and NYSDOH Title V Maternal and Child Health Services Block Grant staff regularly work together on various Maternal and Child Health initiatives, readily share data on Maternal and Child Health populations and outcomes and collaborate to improve systems of care for NYS residents.

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

State Action Plan Introduction

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

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

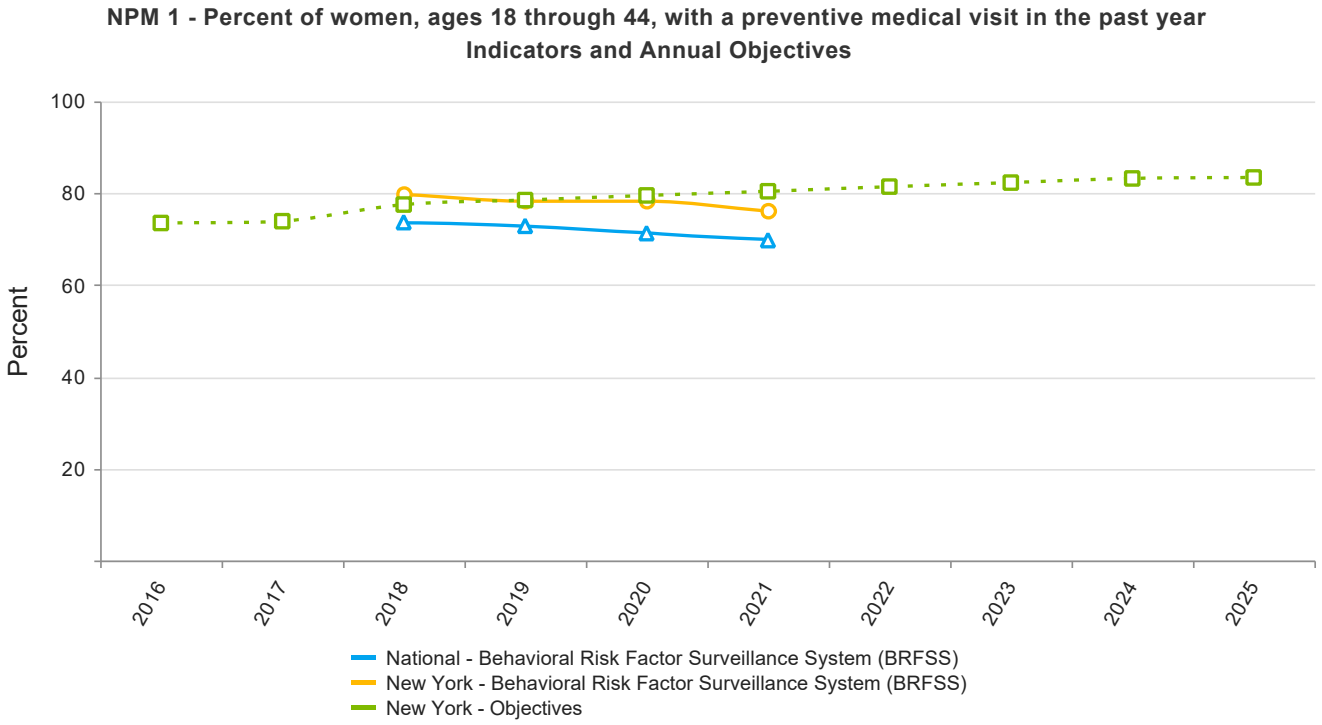
This approach continued to develop New York's five-year State Action Plan. The plan is anchored by the 10 broad crosscutting priorities and the seven specific performance measures. The action plan responds to this question: *what strategic public health approaches and specific program activities can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

The resulting State Action Plan serves to link the broad, crosscutting priorities identified by families and community members with the specific outcomes encompassed in the selected national and state performance measures. The State Action Plan table presents the strategic public health approaches identified to address each of the national or state performance measures, highlights selected activities and action steps to carry out that strategic approach, and shows how each strategic approach aligns with the crosscutting priorities.
Evidence-based strategy measures (ESMs) were developed for each domain to capture the reach and effectiveness of these strategies for the relevant populations directly served through the Title V Maternal and Child Health Services Block Grant program. Specific objectives with measurable improvement targets were developed for each domain to further operationalize the strategies and measures. Wherever possible, these objectives and measures were aligned with the NYS Prevention Agenda to reinforce consistency and synergy with the Title V State Action Plan.

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

Women/Maternal Health

National Performance Measures



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective			79.4	81.3	81.3
Annual Indicator		79.6	78.3	75.9	75.9
Numerator		2,826,660	2,737,695	2,698,183	2,698,183
Denominator		3,550,054	3,498,639	3,553,627	3,553,627
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2021	2021

Previous NPM-1 BRFSS data for survey year 2017 that was pre-populated under the 2018 Annual Report Year is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	82.2	83.1	83.3

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percent of Maternal and Infant Community Health Collaboratives (MICHC) program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker (CHW)

Measure Status:	Active

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

Annual Objectives			
	2023	2024	2025
Annual Objective	61.0	64.1	67.3

ESM 1.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			37.5	37.7
Annual Indicator	37.3	36.2	29.7	32.9
Numerator		92,136	58,264	66,886
Denominator		254,718	195,847	203,468
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
Data Source Year	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	37.9	38.2	38.2

State Action Plan Table

State Action Plan Table (New York) - Women/Maternal Health - Entry 1

Priority Need

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

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

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

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

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

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

Strategies

Strategy WMH-1: Integrate specific activities across all relevant Title V programs to promote the health and wellness of people of child-bearing age, including enrollment in health insurance, routine well visits, pregnancy planning and prevention, prenatal, and postpartum care through coordination and linkages across systems of care (hospital to community). Please see Supporting Document 3 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy WMH-2: Strengthen coordination between birthing hospitals, outpatient health care providers, and other community services to make support for birthing parents and their families more comprehensive and continuous. Please see Supporting Document 3 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

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

Strategy WMH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact women’s health and use of health care across the life course. Please see Supporting Document 3 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

ESMs	Status
ESM 1.1 - Percent of Maternal and Infant Community Health Collaboratives (MICHC) program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker (CHW)	Active
ESM 1.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year	Active

NOMs
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)
NOM 6 - Percent of early term births (37, 38 weeks)
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 women who drink alcohol in the last 3 months of pregnancy
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations
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

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

Priority Need

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

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

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

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

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

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

Strategies

Strategy WMH-1: Integrate specific activities across all relevant Title V programs to promote the health and wellness of people of child-bearing age, including enrollment in health insurance, routine well visits, pregnancy planning and prevention, prenatal, and postpartum care through coordination and linkages across systems of care (hospitals to community). Please see Supporting Document 3 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy WMH-2: Strengthen coordination between birthing hospitals, outpatient health care providers, and other community services to make support for birthing parents and their families more comprehensive and continuous. Please see Supporting Document 3 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

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

Strategy WMH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact women’s health and use of health care across the life course. Please see Supporting Document 3 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

ESMs	Status
ESM 1.1 - Percent of Maternal and Infant Community Health Collaboratives (MICHC) program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker (CHW)	Active
ESM 1.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year	Active

NOMs
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)
NOM 6 - Percent of early term births (37, 38 weeks)
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 women who drink alcohol in the last 3 months of pregnancy
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations
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

Women/Maternal Health - Annual Report

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

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

The New York State Maternal Mortality Review Board has identified increasing access to comprehensive, high quality, and equitable health care services as a key element of efforts to eliminate the striking racial and ethnic disparities in mortality and morbidity outcomes. NYS is ranked 23rd in the nation for the rate of maternal mortality. While NYS's overall maternal mortality rate has declined from its peak, racial disparities in maternal deaths persist, with maternal deaths being 4.6 times more likely for Black women compared to White women during the 2017-2019 timeframe. Severe maternal morbidity also affects the lives of people who give birth, as well as their newborns, families, and health care provider teams, in profound and sometimes life-altering ways. Severe maternal morbidity can result in prolonged hospital stays, substantial medical costs, higher life-long burden of health problems, physical and emotional stress, and interference with maternal-newborn bonding. Additionally, severe maternal morbidity is associated with an increased risk for maternal death. Perinatal depression is among the most common morbidities during pregnancy and the postpartum period, with significant implications for the health and well-being of the entire family. During listening sessions, NYS women and families consistently highlighted maternal depression as a challenge requiring more attention and supports.

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

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

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

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

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

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

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

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

Through the Maternal and Infant Community Heath Collaboratives, which was renamed in 2022 to the Perinatal and Infant Community Health Collaboratives, community health workers conduct basic health and well-being assessments in the prenatal and postpartum periods using standardized evidence-based and/or validated screening tools to identify and prioritize the needs of the individuals and families they serve. Assessments are completed at enrollment and updated throughout clients' service periods and individualized care plans are developed based on the needs identified. Community Health Workers receive annual training on 1) Communicating with families on difficult and sensitive topics such as mental health and depression, 2) Using a trauma-informed care approach, and 3) Managing emergency situations. Community Health Workers also connect clients and families to needed services and provide enhanced social support. Community Health Workers help ensure early and consistent participation in preventive and primary health care services, including early prenatal care, particularly for those individuals not engaged in care and other supportive services. Community Health Workers also provide health information to increase clients' knowledge and their ability to self-advocate and make informed health care decisions with the goal of helping families achieve optimal health, self-sufficiency, and overall well-being.

Perinatal and Infant Community Health Collaborative programs coordinated outreach and engagement activities work with other home visiting programs serving the same communities including programs supported by New York's funding from the Health Resources and Services Administration for the Maternal, Infant, and Early Childhood Home Visiting initiative. The Maternal, Infant, and Early Childhood Home Visiting initiative provides funds to promote and improve the health, development and well-being of children and families, who are most impacted by systemic barriers and at risk for not receiving services, through evidence-based home visiting programs. The Perinatal and Infant Community Health Collaborative and Maternal, Infant, and Early Childhood Home Visiting 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 Maternal and Infant Community Health Collaboratives program formally ended June 30, 2022 and was replaced with the new Perinatal and Infant Community Health Collaborative initiative, whose name is more inclusive in language and reflects all people who are pregnant. Through a competitive award process, a total of 26 awards were made for a five-year period beginning July 1, 2022-June 30, 2027.

The goal of the Perinatal and Infant Community Health Collaborative initiative is to improve perinatal health outcomes and eliminate racial, ethnic, and economic disparities in those outcomes. Funded programs will 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. Perinatal and Infant Community Health Collaborative programs are required to implement individual-level strategies to address perinatal health behaviors, and community-level strategies to address the social determinants which impact health outcomes. The core individual-level strategy is the use of Community Health Workers to outreach and provide supports to high-need, low income, Medicaid-eligible individuals at risk for, or with a

previous history of, adverse birth outcomes. Community-level strategies will involve collaboration with diverse community partners, including community residents, to mobilize community action to address the social determinants impacting perinatal health outcomes. A companion competitive procurement for a Perinatal and Infant Community Health Collaborative training and technical assistance provider was released during the reporting period and awarded to John Snow Inc. (JSI) for a five-year period beginning October 1, 2022 – September 30, 2027. JSI will support Perinatal and Infant Community Health Collaborative programs on 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 Community Health Workers and their Supervisors.

In addition, a new data management information system vendor contract was awarded to the Research Foundation of the State University of New York for a five-year period September 1, 2022 – August 30, 2027 to collect and monitor Perinatal and Infant Community Health Collaborative program data.

The NYS Family Planning Program awarded funds to three new Family Planning Program organizations in August of 2022. The Family Planning Program now supports 37 health facilities that are regulated by NYSDOH under Article 28 of NYS Public Health Law (these include hospitals, clinics, health departments, federal qualified health centers) that operate 164 family planning clinic sites across the state.

The NYS Family Planning Program reentered the Title X network in April 2022 and, as a result, all funded NYS Family Planning Program contracts re-entered the Title X network. With this influx of funding, the NYS Family Planning Program was able to expand their network to include the three new Family Planning Program organizations mentioned above and to announce additional funding for all NYS Family Planning Program providers 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 NYS Family Planning Program applied for and was awarded a one-year Telehealth grant (7/15/22-5/31/23) from the Office of Population Affairs to provide funds to rural Family Planning Program providers to support telehealth infrastructure, improve access to telehealth services, and support training and technical assistance for the Family Planning Program providers. Ensuring continued access to these core primary and preventive services is essential.

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

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

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

Staff promoted the Growing up Health Hotline across all these programs as well as the NYS Early Intervention Program. During FFY22, the Growing up Health Hotline handled nearly 14,000 calls, most of which resulted in a referral to local

agencies that oversee the Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC). Other callers were referred to the NYS Marketplace for health insurance coverage or local departments of health for early intervention services. During the formula shortage, the Growing up Health Hotline provided callers who participate in the Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC) with the contact information for local agencies that oversee the Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC) to assist with locating formula in their area. The Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC) continues to promote the Growing up Health Hotline in brochures and via the online chat service “Wanda” when respondents are Spanish speaking.

WMH-1.2 Through the Regional Perinatal Centers and networks of affiliate birthing hospitals, support and enhance capacity to provide high quality perinatal telehealth services and perinatal subspecialty providers, particularly to rural communities and communities with disproportionate access to such services.

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

WMH-1.3 Through the Perinatal and Infant Community Health Collaborative and Maternal, Infant, and Early Childhood Home Visiting programs, integrate virtual home visiting services to increase acceptance and support of services for hard-to-reach families.

Virtual home visits conducted in the context of the response to COVID-19 have helped to maintain communication and allow for essential Community Health Worker and home visiting services to continue including providing health information, support and referral and follow-up for preventive and prenatal care visits. The use of virtual tools for home visiting, outreach, education, and further social supports continued to be integrated as a supplement to safe, in-person services during the on-going COVID-19 pandemic. During the reporting period, Perinatal and Infant Community Health Collaborative programs conducted 24,198 visits with clients, of which 59% (14,331) were virtual visits. Community Health Workers and home visitors continuously disseminated guidance from reputable sources, such as the NYSDOH, on COVID-19 and perinatal health as it became available.

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

The Perinatal and Infant Community Health Collaborative programs supported Community Health Workers to conduct outreach to find and engage high-risk pregnant and postpartum families in consistent and comprehensive preventive and primary care services, including preconception, prenatal, and postpartum care. From October 1, 2021, to September 30, 2022, a total of 5,101 clients were enrolled in the Maternal/Perinatal and Infant Community Health Collaborative programs. Community Health Workers routinely screened clients for health insurance enrollment and health care engagement, assisted them in getting care through referrals as needed, and provided ongoing social support and reinforcement for health care utilization. They also provided clients with health information and social support to increase their knowledge and ability to self-advocate and make informed health care decisions, including help developing birth plans. During this period from October 1, 2021, to September 30, 2022, Community Health Workers engaged 1,303 prenatal clients to create a birth plan.

Community Health Workers also issued a total of 19,215 referrals, with the top five referral categories overall being clothing/baby care items, referrals to Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC), food pantry, dental services, and housing assistance.

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 Family Planning Program work. An example was an additional one-time federal grant award to continue supporting telehealth services in rural service areas beyond the COVID 19 pandemic, as well as continued support for dispensing 12-month supplies of contraceptives when appropriate. Family Planning Providers continue to assist uninsured clients in enrolling in the most appropriate health insurance plans including Medicaid, Family Planning Benefit Program, and Family Planning Extension Program.

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

***New* WMH-1.7** Continue to provide training to Train Perinatal and Infant Community Health Collaborative and Maternal, Infant, and Early Childhood Home Visiting programs on the Centers for Disease Control and Prevention's (CDC) *Learn the Signs Act Early* campaign and collaborate with the NYS Council on Children and Families on the Early Childhood Comprehensive Systems grant, which supports dissemination of *Learn the Signs Act Early* materials.

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

***New* WMH-1.8** Through the Maternal, Infant, and Early Childhood Home Visiting Initiative, direct American Rescue Plan Act (ARPA) Act funds to Maternal, Infant, and Early Childhood Home Visiting -funded programs.

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

***New* 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.

NYSDOH implemented the Hear Her Campaign on media statewide to build public awareness of the importance of recognizing early urgent maternal warning signs for pregnant and recently pregnant people. The simple message is that listening and acting quickly could save a life. The campaign ran twice (9/20/21 through 10/20/21 and 7/5/22 through 8/14/22). The goals of the Hear Her Campaign are to raise awareness of potentially life-threatening warning signs during and after pregnancy and to improve communication between patients and their healthcare providers. The NYSDOH utilized social media platforms (Facebook, Instagram, and Snapchat) to convey information to pregnant people and their partners, friends, and family about pregnancy-related complications. The NYSDOH also employed two palm cards developed by CDC – one for pregnant and recently pregnant persons and one for partners, friends, and family. These palm cards were co-branded, printed, and distributed to home visiting programs in NYS to disseminate to their clients. The palm cards were translated into the ten languages most commonly-spoken in NYS and are available on the NYSDOH website at NYS Hear Her Campaign (ny.gov) for downloading and printing, or they can be ordered from the NYSDOH distribution warehouse free of charge.

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

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

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. Perinatal and Infant Community Health Collaborative programs routinely coordinated with a wide variety of community-based organizations that provide health and social support services to address needs related to both physical and mental health, and social determinants of health such as safe housing, transportation, poverty, and nutrition. Birthing hospitals in NYS are required to provide similar referral services through support and social services. As noted above, telehealth services have emerged as a promising approach to delivering clinical care that can be tailored to the needs of each region and community, both urban and rural. Strengthening the connection between the Perinatal and Infant Community Health Collaborative providers and individual birthing hospitals ensures that pregnant New Yorkers, including those with high-risk pregnancies and chronic conditions, are connected to the highest quality of birthing services and support services, including timely postpartum care.

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

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

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

WMH-2.2 Collaborate with Perinatal and Infant Community Health Collaborative; Maternal, Infant, and Early Childhood Home Visiting; Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC); local health and social service programs; midwives; doulas; as well as state and national organizations such as American College of Obstetricians and Gynecologists, the Academy of Pediatrics, Society for Maternal-Fetal Medicine, hospital associations and the NYS Association of Licensed Midwives on messaging and strategies to promote birthing options appropriate for anticipated level of care, and safety of birthing hospitals, especially during health emergencies.

Title V funds will support a Perinatal Mood and Anxiety Disorder campaign and CDC *Hear Her* campaign. This work will continue in subsequent program years,

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

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

Title V staff mentored two Master's in Public Health student interns, one each in the Spring 2022 and Fall 2022 semesters. These interns examined existing relationships between home visiting programs and birthing hospitals via Survey Monkey questionnaires and evaluation of responses. The Spring 2022 intern used Maternal and Infant Community Health Collaboratives, Nurse Family Partnership programs, and Healthy Families New York referral data and created a referral monitoring tool in Excel to track trends in referrals made. With guidance from Title V staff, the intern ascertained best practices for improving referral relationships by survey analysis and evaluation of current data trends, and she presented on her findings to Maternal and Infant Community Health Collaboratives and Maternal, Infant, and Early Childhood Home Visiting-funded programs in April 2022. The Fall 2022 intern developed a survey for birthing hospitals, based on the previous

questionnaire; their work was completed outside of this reporting period. Title V staff will continue to share best practices for established home visiting-birthing hospital partnerships with key provider groups across the state to encourage and strengthen ongoing collaboration.

***New* WMH-2.4** Implement a Vaccine Hesitancy Media Campaign.

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

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

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

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

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

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

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

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

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

***New* WMH-3.2a:** Appoint a perinatal psychiatrist to the Maternal Mortality Review 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 Maternal Mortality Review to enable recommendations and strategies to reduce maternal mortality related to mental health conditions in pregnant and postpartum women.

During the reporting period, the Maternal Mortality Review met virtually six times (11/21, 1/22, 3/22, 5/22, 7/22, and 9/22) to perform the maternal death case reviews. The Maternal Mortality Review assessed the causes of death, factors leading to the death, and preventability for each maternal death reviewed. Staff developed a written report of the findings and recommendations for the 2018 maternal death cohort to prevent future deaths and reduce the risk resulting from racial, economic, or other disparities. In April 2022, the findings of the 2018 maternal death case reviews and related recommendations were published in the *New York State Report on Pregnancy-Associated Deaths in 2018*. The Maternal Mortality and Morbidity Advisory Council recommendations for preventability are in the process of being translated into action through collaboration with the Maternal Mortality and Morbidity Advisory Council, the American College of Obstetricians and Gynecologists District II NY, and other key stakeholders, including the development of issue briefs, factsheets, webinars, media campaigns, printed materials, and quality improvement projects through the NYS Perinatal Quality Collaborative. A statewide report on maternal mortality with data and recommendations to improve maternal outcomes was released in April 2022 and can be found at *NYS Report on Pregnancy-Associated Deaths in 2018*. During the reporting period, Maternal Mortality and Morbidity Advisory Council members also developed an issue brief on the Management of Behavioral Health Medications During Pregnancy. It was approved and will be published and posted on the NYSDOH website during the next reporting period. (See Strategy PIH- 2.6 for more detail on NYS Perinatal Quality Collaborative and equitable care.)

The NYC Maternal Mortality and Morbidity Review Committee (M3RC) published findings and recommendations from its 2016-2018 review of NYC maternal deaths and presented this information during a citywide webinar on October 28, 2021.

A two-page factsheet presenting the highlights of the NYS Report on Pregnancy-Associated Deaths in 2018 was developed during the reporting period. The fact sheet will be released and posted on the NYSDOH website near the start of the next reporting period.

Title V staff developed dedicated Maternal Mortality pages which were deployed to the NYSDOH website and can be found at Maternal Mortality (nys.gov).

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.

The planned severe maternal morbidity analysis that was deferred while two analytic staff were deployed to assist in the COVID-19 pandemic efforts is now underway. Analytic staff have been working to identify cases of severe maternal morbidity through hospital discharge data and to perform an analysis using linked birth data and hospital discharge data to define the major causes of maternal morbidity. This project will culminate in the development of a statewide report on severe maternal morbidity, spanning a decade of data.

WMH-3.4: Through the New York State Perinatal Quality Collaborative, continue work with birthing hospital teams and community-based organizations, through the NYS Opioid Use Disorder in Pregnancy and Neonatal Abstinence Syndrome

(NAS) Project. This learning collaborative, which kicked-off in September 2018, was initially conducted as a pilot with 14 NYS birthing hospitals participating. The project was expanded in Fall 2020 to include a total of 39 NYS birthing hospitals. The project seeks to identify and manage the care of pregnant and birthing people with Opioid Use Disorder during pregnancy, and to improve the identification, standardization of therapy, and coordination of aftercare of infants with neonatal abstinence syndrome. NYS participates in the national Alliance for Innovation on Maternal Health (AIM) through this project

The NYS Perinatal Quality Collaborative continued to work with birthing hospitals and outpatient prenatal care clinics through the NYS Opioid Use Disorder in Pregnancy and Neonatal Abstinence Syndrome Project. This learning collaborative, which kicked-off in September 2018 with 14 birthing hospitals serving as pilot sites, expanded in the fall of 2020 to include a total of 43 birthing hospitals. The project seeks to identify and manage the care of people with Opioid Use Disorder during pregnancy, as well as to improve the identification, standardization of therapy, and coordination of aftercare of infants with neonatal abstinence syndrome. NYS participates in the national Alliance for Innovation on Maternal Health (AIM) through this project.

The NYS Perinatal Quality Collaborative 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 that can be found at Opioid Overdose Prevention. The posters are available in English and Spanish, and the brochures are available in the top 11 languages spoken in NYS.

WMH-3.5: Through the New York State Perinatal Quality Collaborative, NYS birthing hospitals and centers have been engaged in a comprehensive interdisciplinary hospital quality improvement project focused on implicit bias through the NYS Birth Equity Improvement Project

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

In addition, the NYS Perinatal Quality Collaborative finalized and disseminated the NYS Obstetric Hemorrhage Project Toolkit, which contains presentations, tools, resources, and data forms created by hospital teams. The toolkit will assist birthing hospitals that participated in the project with continued efforts and sustainability related to obstetric hemorrhage. It will also provide resources to non-participating hospitals. The project website will continue to be available to project participants interested in referencing archived materials.

***New* WMH-3.6:** Collaborate with NYSDOH AIDS Institute and the New York City Department of Health and Mental Hygiene on efforts to address significant increases in the number and rate of infectious (primary, secondary, and early latent) syphilis among NYS females of childbearing age.

***New* WMH-3.7:** The Rape Prevention and Education Program will create 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 will be 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 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. Four regional profiles were completed and shared with partner agencies on the Healthy Nightlife Initiative, the Healthy Schools Initiative, Health data, and census data. Each profile contains multiple data sources specific to each county served to make data-informed decisions for preventing sexual violence in their community. Training and technical assistance was provided to each regional centers to help describe the profile and how to use the data.

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

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

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

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

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

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

Community Health Workers conduct enhanced outreach, perform intake screening assessments using evidence-based tools, issue referrals and follow-up for needed services, work with clients to develop birth and postpartum plans, and connect or provide support groups for clients on topics related to breast/chest feeding, parenting/childbirth classes, Doula

support, financial and health literacy resources, translation services and referral to English as a New Language (ENL) classes and grief support groups for families who have lost a parent or infant/child.

On a community-level, Perinatal and Infant Community Health Collaborative programs are required to conduct community mobilization, engagement and advocacy activities which include:

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

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

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

- Actively participated in local community advisory boards, consortiums, or coalitions to address issues impacting perinatal and infant health and identify effective strategies for addressing the social determinants impacting those outcomes.
- Engaged and partnered with diverse stakeholders from a wide array of community sectors including community residents, grassroots organizations, community-based service organizations, health care providers, local government, local foundations, and local businesses. This included working with over 4,227 community partners at more than 1,057 coordinated outreach events.
- Worked collaboratively with community partners to address relevant community issues such as safe housing, availability and accessibility of resources and services (e.g., health care, mental health, substance abuse services, home visiting, family support resources), social norms (e.g., related to use of preventive care services, breastfeeding, or personal health behaviors), and community mobilization to effectively identify and address community problems. Community Health Workers issued more than 19,215 health care and social support referrals to Perinatal and Infant Community Health Collaborative clients. The top five social support referrals are clothing and baby care items, the Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC); food pantry; housing assistance; and food stamps.

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

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

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

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

Title V staff continued to collaborate with partners, including the NYS Office of Mental Health's Project TEACH, the American College of Obstetricians and Gynecologists NY, home visiting programs, and other community-based organizations to address mental health in pregnant and postpartum people by increasing screening and follow-up support. A webinar was conducted on October 6, 2021, which focused on the impact of social determinants of health on maternal mental health, and, specifically, a collaborative multidisciplinary approach to maternal mental health with a focus on Black and Latinx populations. The panelist of speakers included staff from NYS birthing hospitals and community-based organizations. Announcement of these webinar opportunities were shared with all NYS birthing facilities and Perinatal and Infant Community Health Collaborative Program Managers directly, as well as by email distribution. Recipients include Perinatal and Infant Community Health Collaborative program staff such as Community Health Workers and their Supervisors, staff of Healthy Start home visiting programs, local health department staff, and NYSDOH staff located in Albany and in Regional Offices.

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

The Title V Program, in collaboration with its NYS Perinatal Quality Collaborative, began a comprehensive learning collaborative project, the NYS Birth Equity Improvement Project in 2021 which will continue through October 2022. Seventy-three New York State birthing hospitals and centers have joined the project, which seeks to assist birthing facilities in identifying how individual and systemic racism impacts birth outcomes at their organizations and taking action to improve both the experience of care and perinatal outcomes for Black birthing people in the communities they serve. Monthly data collection and analysis for the project began in April 2021. Participating facilities have taken part in educational opportunities focused on anti-racism and the impact of bias in perinatal health care, developed new and/or improved existing policies related to birth equity to better meet the needs of their community, and worked to ensure they are centering the experience of Black people who are giving birth through the implementation of a Patient Reported Experience Measure. The Patient Reported Experience Measure, which was implemented in July 2021, is administered to birthing people prior to their discharge from participating hospitals. As of September 30, 2022, more than 25,000 patient-reported surveys have been submitted. The data collected through the Patient Reported Experience Measure survey is analyzed by Title V staff and reported back to facilities.

WMH-4.5 Support gestational surrogacy regulations, including licensure of and collaborations with gestational surrogacy programs.

Title V staff continued to review gestational surrogacy program application sections relevant to the Division of Family Health areas of expertise, including gestational surrogacy programs policies and procedures for screening of potential gestational surrogates (per NYSDOH 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 related to above elements.

In 2020, NYS passed a law legalizing compensated gestational surrogacy. Title V staff, in partnership with other Department colleagues continue to review and approve new applicants, as well as review any updated guidance documents as agencies apply for their annual licensure renewal. During the program year, the Department approved an additional 12 applicants, bringing the number of licensed surrogacy matching programs to 30.

New **WMH-4.6** Monitor Infertility Reimbursement Program contracts and provide guidance and ongoing support to contractors and the public.

NYSDOH has awarded six contractors (one upstate and 5 downstate) to participate in the Department's Infertility Reimbursement Program, formerly known as the Infertility Demonstration Program, for the award period of 10/1/2022 – 9/30/2024. Title V staff updated eligibility requirements for the new program to align with new state insurance law, effective January 1, 2020, that requires all large cap insurance plans to provide three cycles of in vitro fertilization (IVF) and fertility preservation services (FPS) as well as adding requirements that prevent discrimination based on an individual's expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions, or personal characteristics, including age, sex, sexual orientation, marital status, or gender identity. The new law also includes a new state definition of infertility. Based on these changes to the law, the Department developed new criteria for patient and provider participation in the Infertility Reimbursement Program, in consultation with expert stakeholders, including the American College of Obstetricians and Gynecologists and the Association of Reproductive Medicine, using the CDC's Assisted Reproductive Technology 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.

New **WMH-4.7** Improve uptake of the COVID-19 vaccination among people who are pregnant, in the postpartum period and/or lactating, and of those people's families, with an emphasis on equity and those populations disproportionately affected by the COVID-19 pandemic. This will include hosting educational webinars for perinatal care providers, assisting NYS birthing facilities with the development and/or updating of their COVID-19 vaccination policies, and developing resources geared towards providers and/or patients.

Title V staff continued work to support the improved uptake of the COVID-19 vaccination among pregnant and parenting individuals and their families, with an emphasis on equity and those populations disproportionately affected by the COVID-19 pandemic. A series of webinars were hosted on these topics, including two titled: COVID-19 Vaccination During the Perinatal Period and COVID-19 Vaccines for Black Birthing Women/People. These webinars offered free continuing education (CE) credits and the recordings were archived on the NYS Perinatal Quality Collaborative webpage. The NYS Perinatal Quality Collaborative project team led the development of a COVID-19 vaccination and pregnancy brochure and poster. The brochure and poster were created in collaboration with the NYSDOH's Vaccine Confidence Workgroup and other bureaus within the NYSDOH to encourage and provide information to pregnant women/people about the COVID-19 vaccine. A PDF copy of the brochure and poster have been uploaded on the NYSDOH website for public use and can be found here: https://health.ny.gov/publications/19647.pdf and here: https://health.ny.gov/publications/19656.pdf.

The brochure and poster in PDF version, as well as information for ordering hard copies, was also distributed to all NYS birthing facilities, all NYS Perinatal Quality Collaborative participating hospitals and centers, and to all Perinatal and Infant Community Health Collaborative programs. The brochure was translated into 10 additional languages and is available to order from our distribution warehouse free of charge to all NYS providers. The poster was translated into Spanish and is also available to order at our distribution warehouse free of charge to all NYS providers. Resources on screening, treatment, referral, or other services related to COVID-19 and maternal mental health for providers were collected. The resources were collected from the American College of Obstetricians and Gynecologists, Society for Maternal-Fetal Medicine, CDC, and other states' Perinatal Quality Collaboratives and organizations. The resources were posted on the NYS Perinatal Quality Collaborative webpage and shared with our birthing facilities and providers. and providers.

New **WMH-4.8** Improve the New York State Sexual Assault Victim's Bill of Rights. The Sexual Assault Victim's Bill of Rights

was developed in 2019. The Bill of Rights will be updated to improve health literacy and translated into the 10 most common languages in New York State.

The New York State Sexual Assault Victim's Bill of Rights was developed in 2019. The plan was to update the Bill of Rights to improve health literacy and translate the Bill of Rights into the 10 most common languages in New York State. This work was delayed due to staffing vacancies. New staff members were onboarded within the Sexual Violence Prevention Unit in the fall of 2022 to oversee the Sexual Assault Forensic Examiner Program and the Rape Crisis Program. The work will be carried forward into the next program year.

***New* WMH-4.9** Collaborate with the Office of Drug User Health to addressing disparities in family planning/reproductive health in the substance use population, creating partnerships between Family Planning Program and their Syringe Exchange Programs to strengthen reproductive healthcare and primary care. Spring 2023 regional meeting will be planned to strengthen relationships and referrals between Syringe Exchange Programs and Family Planning Programs.

The Family Planning Program has begun working with the NYSDOH AIDS Institute Office of Drug User Health to address disparities in reproductive and sexual health care in the substance using population. This population is in high need of family planning services, and family planning clinics have the unique position to help de-stigmatize substance use disorders and address sexual and reproductive health needs from a harm reduction perspective. The goal of this work is to strengthen collaboration between Family Planning Programs and Syringe Exchange Programs to increase access to reproductive and primary healthcare. A survey will be sent out in October 2022 to Family Planning Program providers outside of NYC to gauge their knowledge of Syringe Exchange Programs in counties that the Family Planning Program serves, their current partnership status, and their interest in strengthening partnerships with the Syringe Exchange Programs.

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

Within the Division of Family Health, a new Bureau of Health Equity and Community Engagement was created to address disparities highlighted in the COVID-19 pandemic and build a foundation for future epidemic responses. The bureau focuses on expanding and developing mitigation and prevention resources and services for pandemic response, improving data collection and reporting, and building infrastructure for cross-sector partnerships to align public health, healthcare, and social care interventions. More information about this new bureau in future annual reports and applications for the 2022-23 program year.

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

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

Data for this measure is obtained from monthly reports submitted by Maternal/Perinatal and Infant Community Health Collaborative contractors (note: Maternal and Infant Community Health Collaboratives transitioned to Perinatal and Infant Community Health Collaborative in 2022). The baseline value for this measure, taken from 6-month program period of 10/1/19-3/31/20, is 52.7%. For the time period of 10/1/2021 to 9/30/2022, there was a slight decline to 51.7%. We believe that the decline is due to the implementation of a new web-based data management system on 4/1/2021. Program uptake

of the new data system impacted data completeness and quality. Title V staff are working closely with Perinatal and Infant Community Health Collaborative programs to ensure participants have a birth plan created.

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

Data for this measure will come from Family Planning Program clinic visit record data. For the time period from 10/1/2021 to 9/30/22, 38.7% of Family Planning Program clients had a documented comprehensive medical exam. This is an improvement from the 25.6% of Family Planning Program clients reported in the prior annual report and exceeded the one year set goal of improving by 5%.

Women/Maternal Health - Application Year

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

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

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

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

Objective WMH-1: Increase the percent of women, ages 18 through 44, with a preventive medical visit in the past year by 5%, from 79.6% in 2018 to 81.3% 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 17.7 deaths per 100,000 live births in 2016-2020. (National Vital Statistics System)

Objective WMH-3: Reduce the rate of severe maternal morbidity per 10,000 delivery hospitalizations by 1%, from 93.2 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2015 to 92.2 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2019. (Healthcare Cost and Utilization project-State Inpatient Database)

Objective WMH-4: Reduce the percent of women who have depressive symptoms after birth by 23%, from 13.0% in 2017 to 10.0% in 2020. (Pregnancy Risk Assessment Monitoring System)

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

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

Improving the health of people of child-bearing age requires a life course approach to be most effective. Preventive medical visits are a key opportunity for delivering health education and reinforcing health-promoting behaviors. Preventive visits help to identify chronic conditions, such as hypertension and diabetes, in child-bearing people that could contribute to maternal morbidity and mortality. Family planning and reproductive health visits ensure that people of child-bearing age have access to contraception for prevention of pregnancy, and counseling on reproductive life planning, appropriate birth spacing, and preconception health. Title V programs also provide enabling services, such as social support and referrals/linkages to a wide range of community services, to holistically address health and wellness, including mental health and social

determinants of health, for people of child-bearing age. Incorporating specific activities across programs leverages the public health infrastructure and capacity supported through previous and ongoing Title V investments.

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

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

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

As reinforced by community forums, increasing awareness of available resources among both consumers and providers is critical. The use of social media messages enhances awareness of the state's Growing Up Healthy Hotline service, which in turn provides callers with linkages to local community resources, supports, and services including Supplemental Nutrition Program for Women, Infants and Children (WIC), Medicaid, Family Planning, prenatal care, and the NYS Early Intervention Program. Social media and other emerging communication forums online have the potential to reach large and diverse populations. When messages are developed using science-based health messaging, social media can be a communication medium that can educate and influence health decision making.

The NYS Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2023-24 year:

- **Activity WMH-1.1**: Across all Title V programs, enhance promotion of the NYS Growing up Health Hotline to increase awareness of available community resources, supports, and services including Supplemental Nutrition Assistance

Program for Women, Infants, and Children (WIC); Medicaid; family planning; and prenatal care.
    - Title V including Perinatal and Infant Community Health Collaborative and Maternal, Infant, and Early Childhood Home Visiting staff will continue to promote the Growing up Health Hotline through presentations to Title V programs and partners, broadly share the Growing up Health Hotline flyer available in multiple languages on the Department's website and provide updates to the Growing up Health Hotline as available resources emerge or change.
- **Activity WMH-1.2:** Through the Regional Perinatal Centers and networks of affiliate birthing hospitals, support and enhance capacity to provide high-quality perinatal telehealth services and perinatal subspecialty providers, particularly to rural communities and those with disproportionate access to such services.
    - Title V staff will continue to engage with these providers and other perinatal/neonatal telehealth initiative providers and support relevant collaborations across the Department to support telehealth initiatives, including the Department's Office of Health Insurance Program's maternity telehealth workgroup.
- **Activity WMH-1.3:** Through the Perinatal and Infant Community Health Collaborative and Maternal, Infant, and Early Childhood Home Visiting programs, integrate use of virtual home visiting services to increase acceptance and support of services for families that have been hard to reach.
    - Recent experience suggests that virtual home visits conducted in the context of the response to COVID-19 have helped to maintain communication and allow for essential Community Health Workers and home visiting services to continue including providing health information, support and referral and follow-up for preventive and prenatal care visits. As we enter into the endemic phase of COVID-19, and vaccinations are more widely available and accepted in some marginalized communities, home visiting programs have begun to slowly transition to modified in-person visits and continue to use the virtual option as needed to ensure at risk individuals and families continue to receive supportive services.
- **Activity WMH-1.4:** Through the Perinatal and Infant Community Health Collaborative program, continue to support Community Health Workers to conduct outreach to find and engage high-risk pregnant and postpartum families in consistent, comprehensive preventive and primary care services, including prenatal, interconception, and postpartum care.
    - Community Health Workers will routinely screen clients for health insurance enrollment and health care engagement, assist them in obtaining care if needed, provide ongoing social support and reinforcement for health care utilization, and provide clients with health information and social support to increase knowledge and ability to self-advocate and make informed health care decisions, including assistance to develop birth and postpartum plans. Community Health Workers will initiate (or coordinate with Obstetric providers) the development of a birth plan with all prenatal clients and monitor the number of birth plans initiated through the Perinatal and Infant Community Health Collaborative data management information system.
- **Activity WMH-1.5:** Through the NYS Family Planning Program, continue to support the delivery of comprehensive, confidential reproductive health services for individuals of reproductive age who are low income and uninsured or underinsured at our 160 family planning clinic locations across the state.
    - Barriers to accessing reproductive health care will remain a priority and be addressed through continued use of telehealth services and dispensing a 12-month supply of contraceptives. Family Planning providers will continue to implement sliding fee schedules to ensure cost is never a barrier to care, partner with and refer to other medical and social services to meet the needs of their patients, conduct outreach and education to ensure community members know where they can access comprehensive and affordable services and assist uninsured clients in enrolling in the most appropriate health insurance plans including Medicaid, Family Planning Benefit Program, and Family Planning Extension Program.
- **Activity WMH-1.6:** The Sexual Violence Prevention Unit will continue to support prevention and response services for sexual violence through three programs: Rape Prevention and Education; Rape Crisis; and Sexual Assault Forensic Examiners.
    - NYS's Rape Prevention and Education program consists of six Regional Centers for Sexual Violence Prevention to implement evidence-based/informed primary prevention strategies in 17 counties across NYS

with the highest average number of reported forcible rapes over a five-year period. To support survivors of sexual violence, 53 NYSDOH approved Rape Crisis Programs provide support and advocacy services. The Sexual Assault Forensic Examiners Program consists of 49 hospital programs, seven training programs, and 524 examiners to respond to survivors of sexual assault and collect forensic evidence.

- **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.
    - A letter of agreement covering the period 10/1/21-9/30/24 is in place for this training.
- **Activity WMH-1.8:** Through the Maternal, Infant, and Early Childhood Home Visiting Initiative, direct American Rescue Plan Act (ARPA) funds to Healthy Families New York through a Memorandum of Understanding with the NYS Office for Children and Family Services which oversees the Healthy Families New York program, and through contracts with the Nurse Family Partnership programs overseen by NYSDOH. Per statute, ARPA funds can be utilized for emergency supplies for families, technology for families to support virtual home visits, home visitor staffing, home visitor training, prepaid grocery cards, diaper bank coordination, and/or hazard pay for staff. Round 1 ARPA funding expires 9/30/23 and Round 2 funding expires 9/30/24.
- **Activity 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.
    - The Department's webpage about the Hear Her Campaign promotes messages to consumers about urgent maternal warning signs. Hear Her. You Can Help Save Her Life. (ny.gov). Links on the webpage to print materials that providers may offer birthing people and their partners/families about urgent maternal warning signs will continue to be available.

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

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

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2023-24 year:

- **Activity WMH-2.1**: Collaborate with birthing hospitals and Regional Perinatal Centers to support new regulatory requirements related to providing referral and support for ancillary services, including mental health, alcohol and substance use treatment and other services.

- Title V staff will continue to coordinate NYSDOH's response to public comments and adopt regulations related to perinatal services in hospitals, as well as the state's regional perinatal network, including midwifery and physician-led birth centers as the first level of care. Following adoption of these regulations, work with Island Peer Review Organization (IPRO), which has a contract with NYSDOH to support this work, to develop and implement a redesignation survey based on the new regulations. Each birthing hospital will complete the survey of their intended level of care (which may mean hospitals requesting to increase or decrease a level of care). These surveys will be reviewed, and a portion of the applicants (20% of birth centers, Level 1 and Level 2 birthing hospitals, and all Level 3 and Regional Perinatal Center applicants) will have an on-site visit with IPRO staff and contracted neonatologists and/or maternal-fetal medicine specialists, to verify that the applicant meets the regulatory requirements and can provide appropriate care. Title V staff will also coordinate and support Regional Perinatal Centers as they work with their affiliate birthing facilities to meet the new regulatory requirements related to providing referral and support for ancillary services, including mental health, alcohol and substance use treatment, and other services which are not requirements under current regulations.
  (See Activity PIH-2.1 for additional details.)

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

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

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

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

findings of the state and city boards. The council, known as the Maternal Mortality and Morbidity Advisory Council, is authorized to develop recommendations on policies, best practices, and strategies to prevent maternal mortality and morbidity.

Title V staff will continue to implement a comprehensive review process with the multidisciplinary NYS Maternal Mortality Review Board for the purpose of reviewing maternal deaths and maternal morbidity. The Maternal Mortality and Morbidity Advisory Council will continue to meet virtually, about four to six times per year, to enable timely maternal death reviews. NYS has an established a public health surveillance process in place to identify and review cases of maternal death through multiple sources of public health data and chart reviews. The Maternal Mortality and Morbidity Advisory Council will assess the causes of deaths, factors leading to the deaths, preventability for each maternal death reviewed, and develop recommendations to reduce the risk of maternal mortality and morbidity, including risk resulting from racial, economic, or other disparities. Recommendations based on the review of the 2018 maternal death cohort have been presented to the Maternal Mortality and Morbidity Advisory Council. The Maternal Mortality and Morbidity Advisory Council is meeting to develop their own recommendations with anticipated release of those recommendations in the fall of 2023. The Maternal Mortality and Morbidity Advisory Council recommendations for preventability will be translated into action through collaboration with the Maternal Mortality and Morbidity Advisory Council, the American College of Obstetricians and Gynecologists District II NY, and other key stakeholders, including the development of issue briefs, webinars, and quality improvement projects through the NYS Perinatal Quality Collaborative. *(See Strategy PIH-3 for additional details.)*

In 2023, the Department has been assessing the implementation of 2018 Maternal Mortality and Morbidity Advisory Council recommendations and will continue to direct its efforts at implementation of recommendations with partners through policy development and quality improvement work.

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

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

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2023-2024 year:

- **Activity WMH-3.1:** Summarize, share, and discuss findings of the Maternal Mortality and Morbidity Advisory Council with key partners, including the Maternal Mortality and Morbidity Advisory Council, to inform statewide prevention strategies as described above.
    - Title V staff will continue to meet with the Maternal Mortality and Morbidity Advisory Council at least twice annually to share and discuss findings of the Maternal Mortality and Morbidity Advisory Council and obtain Maternal Mortality and Morbidity Advisory Council recommendations on statewide prevention strategies. They will also continue to create and publish at least one issue brief annually on a key topic identified by the Maternal Mortality and Morbidity Advisory Council that can inform prevention strategies.
- **Activity WMH-3.2:** Issue and disseminate a maternal mortality report and an Executive summary to provide data and information that can be used to improve maternal outcomes.

    - Title V staff will conduct analysis of maternal mortality data for the 2018-2020 cohort. The anticipated publication date is 12/31/2023.
- **Activity WMH-3.3:** Identify cases of severe maternal morbidity through hospital discharge data to conduct an analysis assessing severe maternal morbidity trends, major causes, and disparities during the 2011-2021 period.
    - Title V staff are in the process of developing a surveillance report of severe maternal morbidity, with a target publication date of 12/31/2023.
- **Activity WMH-3.4:** Through the NYS Perinatal Quality Collaborative, continue work on the NYS Birth Equity Improvement Project, a comprehensive interdisciplinary quality improvement project focused on implicit bias and birth equity *(see Strategy WMH-4 below for further detail).*
- **Activity WMH-3.5:** Collaborate with NYSDOH AIDS Institute and the New York City Department of Health and Mental Hygiene on efforts to address significant increases in the number and rate of infectious (primary, secondary, and early latent syphilis among NYS females of childbearing age *(See Activity PIH-3.5 for additional details and activities*).

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

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

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

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2023-24 year:

- **Activity WMH-4.1:** Through the Perinatal and Infant Community Health Collaborative programs, continue to work with diverse community stakeholders including community residents to identify and collaboratively address issues and barriers impacting perinatal and infant health outcomes at the community level, including to the following activities:
    - Actively facilitate/participate in community advisory boards, consortiums, or coalitions to address issues impacting perinatal and infant health and identify effective strategies for addressing the social determinants impacting those outcomes.
    - Engage and partner with diverse stakeholders from a wide array of community sectors including community residents, grassroots organizations, community-based service organizations, health care providers, local government, local foundations, and local businesses.
    - Work collaboratively to address relevant community issues such as safe housing, availability and

accessibility of resources and services (e.g., health care, mental health, substance abuse services, home visiting, family support resources), social norms (e.g., related to use of preventive care services, breastfeeding, or personal health behaviors), and community mobilization to effectively identify and address community problems.

- **Activity WMH-4.2:** The Perinatal and Infant Community Health Collaborative programs' Community Health Workers, as well as Maternal, Infant, and Early Childhood Home Visiting's NYSDOH-led Nurse Family Partnership and NYS Office of Children and Family Services-led Healthy Families New York programs, continue to provide supports to individual clients and their families to address behavioral and social determinants of health outcomes, including the following specific program activities:
    - Provide information on available community resources for needs related to housing, food, employment and job training, transportation, and other basic needs. Perinatal and Infant Community Health Collaborative program policy was developed (per the recommendations of the NYS Expert Panel on Postpartum Care.) to support Perinatal and Infant Community Health Collaborative contractors to continue functioning as Stress-Free Zones (to the extent possible), creating a community in which birthing people have access to essential wraparound and care coordination services.
    - Routinely screen for health insurance enrollment, and assist clients with enrollment as needed, including referral to enrollment Navigators and Community Health Advocates.
    - Conduct screenings using standardized, evidence-based, or validated tools for domestic violence, substance use, smoking, and depression, and make referrals for follow-up as needed. Perinatal and Infant Community Health Collaborative, Nurse Family Partnership and Healthy Families New York program data will be collected and monitored via a web-based data management and information system.
    - Help families connect and use or enroll in enhanced social support resources and programs including parenting classes, peer support groups, childbirth education and resources, breastfeeding education, and directly support clients to develop birth and postpartum care plans.
    - To best support and empower the work of Community Health Workers, the Perinatal and Infant Community Health Collaborative program established policy to ensure Community Health Workers are fairly compensated with a salary comparable to a living wage. Title V staff will continue to assess the salary and ensure Community Health Workers have a livable wage in light of inflation and other factors.
    - Through a new Perinatal and Infant Community Health Collaborative training and technical assistance contractor, John Snow Inc. (JSI), effective 10/1/22, will provide professional development support for Community Health Workers to delivery these services, including annual training on how to talk with families about difficult topics like mental health and depression, using a trauma informed care approach, and how to manage emergency situations. Training and technical assistance will include assessing the training needs of funded grantees and providing appropriate technical assistance, developing/conducting web-based and in-person trainings, ensuring competencies of Community Health Workers and supervisors, standardization of best practice strategies, promoting/conducting Continuous Quality Improvement activities, and conducting an annual learning collaborative. JSI will also host a Perinatal and Infant Community Health Collaborative website/page, providing access to available trainings, resources, and opportunity for Perinatal and Infant Community Health Collaborative programs to communicate their training needs.
- **Activity WMH-4.3:** Collaborate with partners, including:
    - Prevent Child Abuse New York, the NYS Office of Children and Family Services, and the Schuyler Center for Advocacy and Analysis (SCAA) Home Visiting Workgroup to integrate parent engagement and leadership into state level home visiting efforts. In 2024, Maternal, Infant, and Early Childhood Home Visiting staff have proposed to initiate and implement a statewide parent advisory committee, which will consist of parents who are current or former home visiting clients. Through parent engagement and leadership, the parent advisory committee will provide input on matters of interest to state agency partners and develop professional skills. Title V and Maternal, Infant, and Early Childhood Home Visiting staff will share lessons learned with Perinatal and Infant Community Health Collaborative programs to enhance their community member participation on

Community Advisory Boards.

- NYS Office of Mental Health's Project TEACH, American College of Obstetricians and Gynecologists District II NY, home visiting programs and other community-based organizations, will work together to continue to address mental health in pregnant and postpartum people by increasing screening and follow-up support.
- The NYS Perinatal Quality Collaborative has worked in collaboration with Project TEACH, and American College of Obstetricians and Gynecologists District II NY to host a series of five webinars to date focused on maternal mental health. Specifically, these webinars have focused on perinatal mood and anxiety disorders; developing an integrated maternal mental health/obstetrics practice; the integration of maternal mental health in obstetrics using an employee-based insurance model; maternal mental health disparities and steps for achieving equity; and the impact of social determinants of health on maternal mental health with an emphasis on Black and Latinx populations. The NYS Perinatal Quality Collaborative continues to meet with staff from Project TEACH and American College of Obstetricians and Gynecologists District II NY on a quarterly basis to plan for the development of new webinar topics.
- The Perinatal and Infant Community Health Collaborative program will be updating the data management information system to add an additional postpartum depression screening within three months of giving birth (in addition to at initial intake) for all birthing clients. Community Health Workers will continue to assist individuals with the development of a postpartum care plan and provide information, guidance, support, and referrals to needed services. Perinatal and Infant Community Health Collaborative program staff will be continuously trained and updated on postpartum care and available resources through the dedicated Perinatal and Infant Community Health Collaborative training website provided by JSI.

- **Activity WMH-4.4:** Collaborate with NYS Perinatal Quality Collaborative on the NYS Birth Equity Improvement Project.
    - The Title V Program, in collaboration with the NYS Perinatal Quality Collaborative, will continue the work of the NYS Birth Equity Improvement Project to assist birthing facilities in identifying how individual and systemic racism impacts birth outcomes at their organizations and to take action to improve both the experience of care and perinatal outcomes for Black people who give birth in the communities they serve. Monthly data collection and analysis for the project will continue through the application period. Participating facilities will continue to participate in educational opportunities focused on anti-racism and the impact of bias in perinatal health care as well as reducing primary cesarean births for low-risk birthing people (i.e., Nulliparous, Term, Singleton, Vertex, or NTSV, deliveries), develop new and/or improved existing policies related to birth equity to better meet the needs of their community, and work to ensure they are centering the experience of Black birthing people through the ongoing administration of the Patient Reported Experience Measure.
- **Activity WMH-4.5** Through the Infertility Reimbursement Program, provide reimbursement for out-of-pocket costs associated with in vitro fertilization (IVF) and fertility preservation services to individuals who meet eligibility criteria.
    - The Infertility Reimbursement Program was developed to align with NYS insurance law effective 1/1/2020, which requires all large cap insurance plans to provide three cycles of in vitro fertilization (IVF), fertility preservation services, and added requirements that prevent discrimination based on an individual's expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, or other health conditions, or based on personal characteristics, including age, sex, sexual orientation, marital status, or gender identity. The new law also includes a state definition of infertility that is more equitable. Infertility Reimbursement Program patient participation is inclusive of Medicaid recipients, making the program more accessible to individuals with limited income, the unemployed, or those lacking health insurance through their employer. Title V staff will provide guidance, monitor activities, and collect data from six contractors awarded funding for a two-year period from 10/1/22-9/30/24. Staff will also monitor the program's public mail log and respond to questions received about how to access infertility services in NYS.
- **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. Title V staff will:

- Host educational webinars for perinatal care providers, assist NYS birthing facilities with the development and/or updating of their COVID-19 vaccination policies, and develop resources geared towards providers and/or patients
- Develop multi-media campaigns on vaccine hesitancy for individuals of reproductive age. In collaboration with the NYSDOH's Bureau of Marketing and Creative Communications, NYS recently launched the COVID-19 and Pregnancy Media Campaign. Promotional materials were developed to increase vaccination uptake for pregnant and postpartum people and their families. Phase 1 of the campaign launched in Fall 2022 and focused on promoting COVID-19 vaccination during the perinatal period with the development and dissemination of promotional materials such as Facebook posts, bus flyers, and other social media. During December, Phase 2 of the campaign launched and focused on sharing testimonials from perinatal providers on their experience with COVID-19 vaccination during pregnancy. Two perinatal providers were identified who were interested in participating in the COVID-19 and Pregnancy Media Campaign. One of the providers identified was from the University of Rochester Medical Center and the other from Northwell Health. The providers' testimonials included their experience with receiving the COVID-19 vaccination during pregnancy and the benefits of the vaccine. Title V staff will continue to promote these materials to partners.

- **Activity WMH-4.7:** Update and improve the NYS Sexual Assault Victim's Bill of Rights.
  - The Sexual Assault Victim's Bill of Rights was developed in 2019. The Bill of Rights will be updated to improve health literacy and translated into the 10 most common languages in NYS. The new Bill of Rights will include improved design features that make it easier for victims/survivors to understand the information and bring the document home safely. Most importantly, the new Bill of Rights will update necessary language on changes to Public Health Law since 2019 that improve access to HIV post-exposure prophylaxis for minors.
- **Activity WMH-4.8:** Breastfeeding Support
  - Title V staff will participate in the Breastfeeding Grand Rounds planning committee in collaboration with Division of Chronic Disease and Division of Nutrition. Breastfeeding Grand Rounds webcasts are created for public health and health care professionals and feature clinical experts paired with public health experts to provide education on current breastfeeding health issues with both clinical and public health significance.
- **Activity WMH-4.9:** Develop and deliver a health equity training to staff within the Bureau of Perinatal, Reproductive, and Sexual Health, and Division of Family Health staff who participate on the Racial Justice Workgroup.
  - The Sexual Violence Prevention Unit's Rape Prevention and Education Program has hired a consultant to develop and deliver a training series on *Antiracist Health Equity* for 50 internal Bureau of Perinatal, Reproductive, and Sexual Health staff. This training will be held in Fall 2023 and will consist of six live, two-hour virtual trainings. The consultant will also submit a final report of evaluations from each individual training and an aggregate assessment of the combined trainings with recommendations for potential future training and/or reinforcement of antiracism approaches within the Bureau.
- **Activity WMH-4.10:** Improve reproductive healthcare for the substance use population.
  - The NYS Family Planning Program is collaborating with the AIDS Institute's Office of Drug User Health to address disparities in family planning/reproductive health in the substance use population, creating partnerships and strong referrals between Family Planning Program and their Syringe Exchange Programs to strengthen reproductive healthcare and primary care.
- **Activity WMH-4.11**: Provide resources for Black birthing people to advocate and communicate effectively with healthcare providers.
  - In 2018, the Department conducted seven community listening sessions with birthing people and other stakeholders. Poor communication with health care providers (e.g., feeling providers were not listening to them, that they were not given enough time with providers, and that few providers reflected their lived experience) was reported as a barrier to receiving optimal prenatal care. As one strategy to address this barrier, a communication guide for birthing people to promote effective communication with their health care provider is being developed and will be disseminated to partner organizations, including home visiting programs. Development plans for the

draft guide, titled “My Voice Matters” was presented on 11/16/22 to an internal Department planning committee. The purpose of the guide is to improve birth outcomes by empowering and encouraging all birthing people and their advocates to speak up and participate in their antenatal care and decision-making and improve communication between providers and all birthing people. A planning subcommittee will meet monthly to develop the guide. The planning committee will supervise and provide feedback on the development of the guide to the subcommittee. The proposed timeline for release of the guide is January 2024.

- **Activity WMH-4.12:** Engage with Maternal, Infant, and Early Childhood Home Visiting (Healthy Families New York and Nurse Family Partnership) and Perinatal and Infant Community Health Collaborative providers to promote the availability of diapers through the NYCARES/Baby2Baby Diaper Bank.
    - Title V staff will collaborate internally and with state partners at the Office of Temporary Disability and Assistance (OTDA) to coordinate access to free diapers for families served by NYS home visiting programs.

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

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

Data for this measure will be obtained from monthly reports submitted by local Perinatal and Infant Community Health Collaborative contractors in the data management information system. The baseline value for this measure, taken from the 12-month program period of 4/1/21-3/31/22, is 43.4%. The Perinatal and Infant Community Health Collaborative program has set an objective of 64.1% of participants by 2024.

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

Data for this measure will be obtained from Family Planning Program clinic visit record data. For the program period 10/1/20-9/30/21, 32.8% of female Family Planning Program clients had a documented comprehensive medical exam. The Family Planning Program has set an objective of 38.2% in 2024.

Perinatal/Infant Health

National Performance Measures

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Indicators and Annual Objectives

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

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	93.4	93.7	93	92.4	92.6
Annual Indicator	92.5	91.2	92.2	91.6	91.3
Numerator		2,782	2,626	2,610	2,437
Denominator		3,052	2,849	2,850	2,668
Data Source	NYS VS	NYS VS	NYS VS	NYS VS	NYS VS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	92.8	93.1	93.4

Evidence-Based or –Informed Strategy Measures

ESM 3.1 - Percent of birthing hospitals with final level of perinatal care designation, in accordance with updated regulations and standards

Measure Status:	Active

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

Annual Objectives			
	2023	2024	2025
Annual Objective	50.0	75.0	100.0

State Performance Measures

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

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			75	77
Annual Indicator	70	68	70	70.6
Numerator				
Denominator				
Data Source	Newborn Blood Spot data	Newborn Blood Spot data	Newborn Blood Spot data	Newborn Blood Spot data
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	79.0	81.0	85.0

State Action Plan Table

State Action Plan Table (New York) - Perinatal/Infant Health - Entry 1	
Priority Need	
Address transportation barriers for individuals and families.	
NPM	
NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	
Objectives	
Objective PIH-1: Increase or maintain the percent of very low birth weight infants born in a hospital with a Level III+ NICU by 2.4%, from the 2017 level of 91.2% to 93.4% by 2021. (NYS Vital Statistics Birth Data)	
Objective PIH-2: Decrease the infant mortality rate by 2.6%, from 4.6 deaths per 1,000 live births in 2017 to 4.49 deaths per 1,000 live births in 2021 (NVSS)	
Strategies	
Strategy PIH-1: Integrate specific activities across all relevant Title V programs to promote access to early prenatal care, access to birthing facilities appropriate to one's needs, postpartum care, and infant care. Please see Supporting Document 3 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.	
Strategy PIH-2: Implement updated perinatal regionalization standards, designations, and structured clinical quality improvement initiatives in birthing hospitals and centers. Please see Supporting Document 3 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.	
Strategy PIH-3: Apply public health surveillance and data analysis findings to improve services and systems related to perinatal and infant health care. Please see Supporting Document 3 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.	
Strategy PIH-4: Address social determinants identified by community members that impact infant health and use of perinatal and infant health care and support services. Please see Supporting Document 3 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.	
ESMs	**Status**
ESM 3.1 - Percent of birthing hospitals with final level of perinatal care designation, in accordance with updated regulations and standards	Active

NOMs

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

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

Priority Need

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

SPM

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

Objectives

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

Strategies

Strategy PIH-5: Maintain and strengthen a robust statewide population-based Newborn Screening Program. Please see Supporting Document 3 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Perinatal/Infant Health - Annual Report

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

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

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

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

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

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

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

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

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

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

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

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

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

Consistent with a life course perspective, improving birth outcomes for infants requires attention to health and health care services for both babies, parents, and people of reproductive age (see the MWH Domain for additional discussion). New York State has made significant strides to reduce infant mortality and morbidities, but more work is still required. Timely and comprehensive prenatal and postpartum medical visits are essential to providing prevention education and anticipatory guidance, screening for risk factors that may negatively affect the health of the neonate, managing chronic conditions and pregnancy complications, and connecting families with a wide array of community services and social supports to holistically address the health and wellness needs of pregnant people, neonates, and new families. Several Maternal and Child Health programs, including Maternal and Infant Community Heath Collaboratives, which was renamed to the Perinatal and Infant Community Health Collaborative in 2022, Newborn Bloodspot Screening, New York State Perinatal Quality Collaborative, and Regional Perinatal Centers, play a direct role in promoting comprehensive health and wellness of neonates through population-based systems, public health interventions, and delivering or linking people to health care services.

The Title V Program made progress or completed the following specific program and policy activities to advance this strategy throughout the 2021-22 year:

PIH-1.1: Across all Title V programs, enhance promotion of the NYS Growing Up Healthy Hotline to increase awareness of available community resources, supports, and services including Supplemental Nutrition Assistance Program for Women, Infants, and Children, Medicaid (WIC); family planning; prenatal care; and the NYS Early Intervention Program. During the reporting period, Title V-funded programs and other NYSDOH programs promoted the Growing up Health Hotline in a variety of ways, including through social media posts and in print media. During the baby formula shortage, the Growing up Health Hotline provided a critical link between consumers and WIC. In a press release by Governor Kathy Hochul on May 12, New Yorkers were directed to contact their local WIC clinic. The weblinks included in the press release feature the Growing up Health Hotline as a resource for people to call. See *WMH-1.1* for additional details.

PIH-1.2: Through the Perinatal and Infant Community Health Collaborative and Maternal, Infant, and Early Childhood Home Visiting programs, integrate use of a birth plan including a discussion of appropriate level of perinatal care (for higher risk pregnancy/childbirth). See *WMH-1.*4 for details.

PIH-1.3: In collaboration with the Office of Primary Care and Health Systems Management (OPCHSM), review and approve applications to establish midwifery-led and freestanding birth centers across New York State. Title V staff continued to work with our partners within NYSDOH in the Office of Primary Care and Health Systems Management (OPCHSM) related to midwifery and freestanding birth centers.

In December 2021, Governor Hochul signed the Midwifery Birth Center Accreditation Act. Subsequently, a Chapter Amendment was drafted, passed, and signed into law in February 2022, which addressed several technical issues and conflicting requirements of the original Act. The Midwifery Birth Center Accreditation Act provides a mechanism for applicant Midwifery Birth Centers that are accredited through a national accrediting organization recognized by the Commissioner (e.g., the Commission for the Accreditation of Birth Centers), to meet certain requirements of New York's Midwifery Birth Center accreditation process. The act also establishes specific requirements that the applicant Midwifery Birth Center must meet related to its' establishment process through a Certificate of Need review. To implement regulations and procedural changes to meet the new law, the Department had to pause its' movement on the perinatal services and perinatal regionalization regulations (see *PIH- 2.1*). During the project period, the Department engaged with additional midwifery stakeholders, including representatives from the national and state chapters of Commission for the Accreditation of Birth Centers, as well as NYS Midwifery leadership, the state chapter of the American Association of Birth Centers, to discuss further adaptations to the regulations. Work to finalize the regulations continues into FY23.

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

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

The NYS Perinatal Quality Collaborative project team, in collaboration with other programs within the NYSDOH including the Bureau of Perinatal, Reproductive, and Sexual Health and the Bureau of Marketing and Creative Communications, launched the COVID-19 Vaccination and Pregnancy Media Campaign in Fall 2022. Phase 1 of the campaign focused on promoting COVID-19 vaccination during the perinatal population with the development of promotional materials such as Facebook posts, bus flyers, and other social media. Planning for Phase 2 began during the project period and was launched in December and will focus on sharing testimonials from perinatal providers on their experience with COVID-19 vaccination. The NYS Perinatal Quality Collaborative identified two perinatal providers who were pregnant and interested in promoting vaccination to the perinatal population for the COVID-19 media campaign. One of the providers is from University of Rochester Medical Center and the other from Northwell Health. The providers reported their testimonials on receiving the COVID-19 vaccination during pregnancy and the benefits of the vaccine.

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

The Title V-funded Rural Perinatal Telehealth Initiative provides funding to five upstate Regional Perinatal Centers that serve rural communities. These contracts were extended into the program period due to COVID-19-related delays. Four of five programs ended by December 2021, with the final program ending in June 2022. As part of the programs, Regional Perinatal Centers were charged with conducting a technology, training, and interest-based Needs Assessment of rural affiliate birthing hospitals; community-based Obstetric, pediatric, and family medicine providers were also a potential

partner.

Projects related to perinatal and infant health included increased access to real-time video-consultation with neonatologists and neonatal subspecialty providers; and increasing local access to neonatal ophthalmology to assess retinopathy of prematurity (with the goals of reducing patient/parent travel time and increasing timely clinical assessment).

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 Regional Perinatal Centers involved in the project spent considerable time discussing potential workarounds, 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 Regional Perinatal Center directly engaging with the patient is not a billable service.

Two Regional Perinatal Centers adopted an “on-call” payment structure which allocated a flat fee for physicians to be available for a 24-hour period, with additional reimbursement for teleconsultations that weren’t billable to insurance. One Regional Perinatal Center modified their program to provide telemedicine coverage during daytime and evening hours, reverting to telephonic consultation and transfer as had been done. The remaining two Regional Perinatal Centers either were able to maintain 24/7 coverage or had engaged in specialty telemedicine projects that did not require 24/7 coverage (e.g., telehealth services to patients/families in need of pediatric ophthalmology visits for retinopathy of prematurity and other eye conditions).

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

PIH-1.7: Through the Maternal and Infant Community Health Collaboratives and Maternal, Infant, and Early Childhood Home Visiting programs, support community health workers to engage high-risk pregnant and postpartum families in consistent, comprehensive preventive and primary care services, including newborn care, screen and assist families in enrolling in health insurance, and provide families with social support to enhance health literacy and use of health care. *See WMH-1.4* for details*.*

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

Two new activities implemented during the program year:

PIH-1.10: Through the Act Early project, train Maternal and Infant Community Health Collaboratives and Maternal, Infant, and Early Childhood Home Visiting programs on CDC’s *Learn the Signs Act Early* campaign. Collaborate with the Bureau of Early Intervention to facilitate orders for free *Learn the Signs Act Early* materials from CDC website to programs. See *WMH-1.7* for details.

PIH-1.11: Provide support to birthing families and community-based organizations to address nationwide shortages of infant formula. On Feb 17, 2022, the U.S. Food and Drug Administration warned consumers not to use potentially contaminated products from Abbott Nutrition's Sturgis MI facility, prompting a voluntary recall initiated. Supply shortages started to escalate, receiving local and national media and policymaker attention. Maternal, Infant, and Early Childhood Home Visiting and Title V-funded programs were provided with guidance and resources from the NYS Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC), U.S. Department of Health and Human Services, the U.S. Department of Agriculture, and the Governor’s Office for locating formula and appropriate formula substitutions. By the Summer of 2022, the Abbott manufacturing facility was reported to be back online, and complaints of formula shortages greatly declined.

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

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

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

Key NYS Perinatal Quality Collaborative activities include:

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

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

The Title V Program led the following specific program and policy activities to advance this strategy through the 2021-22 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. In May

2021, a Midwifery Birth Center Accreditation bill passed both the NYS Senate and Assembly (S1414-A/A259-A). This bill has major potential implications on the midwifery birth center section of the proposed regulations. As such, approval was paused in June 2021. As noted above in PIH- 1.3, the law was signed by Governor Hochul in December 2021, with a subsequent Chapter Amendment signed in February 2022 to address significant issues with the law. Progress was made on updating the regulations, and the proposed changes to regulations were published on May 31, 2023 for public comment. Activities supporting this work will be reported in next year's annual report and application.

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 PIH- 1.3 above, the regulations for perinatal regionalization were placed on hold during the program year. No significant progress was made during the program year. Subsequent to this reporting period, progress on the regulations was made and the proposed changes to regulations were published on May 31, 2023 for public comment. Activities supporting this work will be reported in next year's annual report and application.

PIH-2.3: Improve coordination and increase bilateral referrals between birthing hospitals and home visiting programs. Title V staff will assist in connecting Perinatal and Infant Community Health Collaborative and Maternal, Infant, and Early Childhood Home Visiting-funded programs with their local birthing hospital(s) and support formal meetings. Additionally, Title V staff shared promising and best practices from established home visiting-birthing hospital partnerships across the state to encourage collaboration. In January 2022, the Division hosted a graduate student intern from the University at Albany School of Public Health. The intern conducted a brief literature review, developed, distributed, and analyzed a survey of home visiting programs, and conducted key informant interviews with several programs to identify barriers and promising practices for bilateral referrals with birthing hospitals. Results of the survey were shared with home visiting programs in May 2022. Additionally, in September 2022, the Division hosted a second graduate student intern to conduct a similar survey for birthing hospitals. The survey was near completion at the end of the reporting year, and data analysis is ongoing. Staff intend to develop and share promising practices resources for birth hospitals and home visiting programs. See *WMH 2.4* for additional details.

PIH-2.4: Collaborate with other NYSDOH 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 OB-GYN and family practice providers about changes to hospitals' level of perinatal care in their community. As noted above, redesignation of birthing hospitals was not completed during the project period. This remains a long-term goal following adoption of perinatal regulations and subsequent redesignation activities.

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

- Identifying and managing the care of pregnant and postpartum women/people with opioid use disorder during pregnancy. Of the 15 birthing hospitals and birth centers that started this project in 2018, the cohort increased the implementation of a universal Opioid Use Disorder screening protocol in place from 20% at Quarter 1of 2019 to 87% at Quarter 3 of 2022. Additionally, participant sites established a protocol or process flow to assess and link pregnant patients with Opioid Use Disorder to supportive services, from 33% in Quarter 1 of 2019 to 87% by Quarter 2 of 2022. Of the additional 24 birthing facilities that joined the project as an expansion phase ("expansion cohort"), the number of facilities with a universal Opioid Use Disorder screening protocol in place increased from 40% in Quarter 4 of 2020 and Quarter 3 of 2022. Expansion sites also implemented protocols or process flows to assess and link pregnant patients with Opioid Use Disorder to support services, increasing from 20% in Quarter 4 of 2020 to 83% in Quarter 3 of 2022.
- Improving the identification, standardization of therapy and coordination of aftercare of infants with neonatal

abstinence syndrome. By the end of this reporting period, all pilot hospitals will have put in place standardized pharmacologic and non-pharmacologic guidelines for newborns with opioid exposure. Of the expansion phase hospitals, 83% put in place standardized pharmacologic guidelines and 88% have non-pharmacologic guidelines for newborns with opioid exposure.

- Improving infant outcomes, with a focus on equity in the neonatal intensive care unit (NICU). This project is under development.
- Assisting NYS birthing facilities in identifying how individual and systemic racism impacts birth outcomes at their organizations and taking action to improve both the experience of care and perinatal outcomes for Black birthing people in the communities they serve. 54% of hospitals and birthing centers have policies and procedures in place to address equitable care. 82% of facilities have implemented a Patient Reported Experience Measure survey that is offered to every birthing person prior to discharge. 88% of facilities are collecting race and ethnicity data for birthing people; and 50% are using perinatal data stratified by race and ethnicity to develop targeted actions. A new outcome and balancing measures report was developed for facilities' use. As of Q3 2022, the Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean birth rate was 29.6% for all project participants.

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

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

The Title V Program led the following specific program and policy activities to advance this strategy over the course of the 2021-22 year:

PIH-3.1: Collaborate with the NYS Office of Children and Family Services to implement a PDSA-style quality improvement initiative with the goal of increasing referrals from the Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC) to Home Visiting programs including Maternal/Perinatal and Infant Community Health Collaborative and those receiving Maternal, Infant, and Early Childhood Home Visiting funding. Efforts to increase referrals from WIC to Home Visiting programs were completed in previous reporting periods, and this project is in a maintenance phase. During the reporting period, Title V staff updated county-specific program tools for WIC programs to use.

PIH-3.2: Led quality improvement projects through the NYS Perinatal Quality Collaborative, with birthing hospital and center teams and community-based organizations, with a focus on reducing maternal morbidity and mortality by improving the assessment, identification, and management of obstetric hemorrhage; identifying and managing the care of pregnant and postpartum people with Opioid Use Disorder during pregnancy, and improving the identification, standardization of therapy and coordination of aftercare of infants with Neonatal Abstinence Syndrome; and improving outcomes for all NYS birthing people by focusing on racial justice and birth equity. The NYS Perinatal Quality Collaborative's Opioid Use Disorder in Pregnancy and Neonatal Abstinence Syndrome project, which began as a pilot in 2018, was expanded to a statewide project in October 2020, bringing the total number of participating birthing hospitals to 45. See *PIH-2.6* and *WMH-3.3-8* for more detail on these projects.

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

Advisory Council.

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

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

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

- **3.5a**: Develop a statewide Congenital Syphilis Strategic Plan and support the implementation of priority activities. This activity is led by the NYSDOH AIDS Institute. A workgroup continues to be developed. Meetings had not yet started during the reporting period. Title V staff will continue to engage with the NYSDOH AIDS Institute on this workgroup and will report on progress in future applications.
- **3.5b**: Issue locally tailored and statewide health advisories to alert health care professionals of primary, secondary, and early latent syphilis and Congenital Syphilis surveillance trends, screening requirements and recommendations, and appropriate treatment regimens. This activity is led by the AI. During the reporting period, no advisories were issued by NYSDOH. Title V staff will continue to engage with the NYSDOH AIDS Institute on this workgroup and will report on progress in future applications.
- **3.5c**: Promote clinical education opportunities to birthing hospital staff, provided through NYSDOH-supported Clinical Education Initiative and other CDC-funded provider training initiatives. During the reporting period, Title V staff presented at the New York State Perinatal Association's annual meeting (June 2022), and shared Congenital Syphilis-related information provided from NYSDOH and NYCDOHMH's Sexually Transmitted Infection (STI) programs. As a result of this training, a Regional Perinatal Center Coordinator from the State University of New York (SUNY) Stony Brook requested a presentation on Congenital Syphilis at their annual conference serving the Long Island clinical community. Title V staff collaborated with NYSDOH AIDS Institute staff to provide this training.
- **3.5d**: Provide periodic updates and resources for community-based providers that engage with pregnancy clients, to promote awareness of STIs that can affect pregnancy, fertility, and the health of a fetus or newborn. In June 2022, Title V staff presented at the New York State Perinatal Association's annual meeting. This meeting brings together clinical and community-based providers to discuss and learn about topics of interest. Title V staff presented during a plenary session which included a brief presentation of NYC and Rest of State (ROS) syphilis surveillance trends, recent awareness events and resources, and several policy initiatives in development.

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

In addition to the updates above, the Division of Family Health through the Title V program is advancing public health surveillance and data analysis to improve services and systems related to perinatal and infant health care. A new Bureau of Data Analytics, Research, and Evaluation was created to support research and data needs across the Division of Family Health. The consolidation of data and analytic staff into one Bureau under the direction of a new Bureau Director with a

DrPH in Epidemiology will create efficiencies and cross training as well as provide professional development opportunities to further advance the use of data in Maternal and Child Health programs and policy decisions.

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

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

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

The Title V Program led the following specific program and policy activities to advance this strategy in the 2021-22 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 Perinatal and Infant Community Health Collaborative as reported via the HV program data management information systems. Incorporation of the Parent Portal as a resource for web-based and print materials has become commonplace for the Department's efforts. The Portal served as a landing page for a brief home visiting media campaign, directing pregnant and newly parenting New Yorkers in counties with low home visiting program enrollment to the portal. During the campaign (August – October 2022), the Parent Portal received over 100,000 clicks. Further campaign evaluation is ongoing. In addition, the Division engaged with two graduate public health students in the Spring and Fall 2022 semesters to conduct and analyze data from surveys of home visiting programs and birthing hospitals. See *PIH-2.3* and *WMH-2.4* for additional information.

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

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

PIH-4.4: Through the NYS Perinatal Quality Collaborative, continue to lead a quality improvement project with birthing hospital teams and community-based organizations, to improve outcomes for all NYS birthing people and infants by focusing on racial justice and birth equity. See *WMH-4.4* for further details. Additionally, NYS Perinatal Quality Collaborative is in the process of developing a Equity Improvement Project in the neonatal intensive care unit (NICU). This progress on this new project will be reported in next year's annual report and application.

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

PIH-4.5: Title V staff worked to develop a statewide Home Visiting Parent Advisory Committee procurement proposal. The Department issued a Solicitation of Interest to gauge capacity and interest for community-based programs to support a Home Visiting Parent Advisory Committee. As a result of the Solicitation of Interest, the Department is in the process of developing and issuing a procurement for services.

PIH-4.6: Provide information and guidance to providers regarding federal Child Abuse Prevention and Treatment Act (CAPTA)/ Comprehensive Addiction and Recovery Act (CARA) legislation and implementation of Plans of Safe Care. A series of webinars was presented and posted on the NYSDOH 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 CAPTA/CARA and development and use of Plans of Safe Care.

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

As described in the Women and Maternal Health section, a new Bureau of Health Equity and Community Engagement was created within the Division of Family Health to address disparities highlighted in the COVID-19 pandemic and build a foundation for future epidemic responses. More information about this new bureau in future annual reports and applications for the 2022-23 program year.

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

New York's Newborn Screening Program is a population-based program and public health system that identifies infants who may have one of several rare, but treatable diseases through bloodspot screening shortly after birth. Within NYSDOH, the Newborn Screening Program is housed and administered by the Wadsworth Center, NYS's public health laboratory, with direct support from Title V and several other state and federal funding sources. The program currently performs laboratory testing for 50 diseases, following national recommendations for Newborn Screening programs. The program ensures that every newborn in the state receives newborn bloodspot screening as a public health service, with no fee for testing. The program also performs follow-up case management to ensure newborns with a positive screening result receive appropriate diagnostic testing and treatment. Specialty Care Centers are certified and monitored to ensure newborns have access to specialty care for disease-specific testing and management. In addition, the Newborn Screening program receives separate funding from the Health Resources and Services Administration to support each of the state's 10 Inherited Metabolic Disease Specialty Care Centers to enroll patients with an Inherited Metabolic Disease diagnosis identified by newborn screening for long-term follow-up in the NYS Newborn Screening Patient Registry. These Inherited Metabolic Disease Specialty Care Centers are responsible for entering and tracking for consented patients annually, and for attending an annual meeting to discuss long-term follow-up data. Patients are monitored until age 18, when the individual

must consent to continue participation until age 21. In 2021, the program screened 211,203 infants, 99.97% of all NYS resident infants born that year (See Form 4 for further details).

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

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

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

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

- Performed a quality improvement project to ensure hospitals are meeting benchmarks. During the program year, nine (of 121) virtual hospital site visits were conducted, representing approximately 14% of total specimens submitted to the Newborn Screening Program. Site visits are intended to engage birthing hospital staff to improve compliance with five key performance measures:
    - Collection time (within 36 hours of life)
    - Turn-around time (received by lab within 48 hours of collection)
    - Overall specimen quality
    - Specimen quality from samples taken outside of the neonatal intensive care unit (NICU)
    - Completeness of data (including demographic variables).
- Baseline data are presented during the site visit for discussion. Although all five performance measures are addressed on site visits, focus is placed on turn-around time, as most NYS birthing hospitals struggle to improve this metric.
- Newborn Screening program is developing a post-site visit monitoring plan with each hospital, to provide an updated hospital performance summary within 6-8 months post-site visit to evaluate improvement. For example, one hospital engaged with a private courier service to supplement UPS shipping, resulting in a 12.6% improvement in turn-around time and meeting a goal of 80% of specimens received within 48 hours of collection.
- Expand the number of hospital site visits (conducted virtually) made by NYSDOH staff. Due to the ongoing COVID-19 pandemic and priorities within NYSDOH and birthing hospitals, focus on expanding the number of hospital site visits was not feasible. Rather, the Newborn Screening program implemented a post-site visit monitoring plan to

further enhance the impact of virtual site visits, as described above.

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

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

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

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

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

Perinatal/Infant Health - Application Year

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2023-24 year:

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

neonates/infants, their parents/caregivers, and families; campaign topics will be determined based on emergent needs and opportunities

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

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

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

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

The NYSDOH submitted the regulatory package for approval in September 2020. Several delays beyond the control of Title V staff have affected the state's ability to adopt regulations and begin the process of redesignating birthing hospitals. In

February 2023, the draft regulations were presented to the NYS Public Health and Health Planning Council (PHHPC) for information. The regulations were resubmitted to the Governor's Executive Office for final approval and were posted in the New York State Register for a 60-day public comment period starting on May 31, 2023. Further activities related to this project are described below.

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

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

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

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

The NYS Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2022-23 year:

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

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

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

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

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

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

The NYS Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2022-23 year:

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

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

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

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

Efforts to improve infant health outcomes must focus directly on addressing longstanding and persistent racial and ethnic disparities in infant health. This persistence of disparities in most of our major health indicators clearly shows that while

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

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2022-23 year:

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

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

The NYS Newborn Screening program is a population-based program and public health system that identifies infants who may have a rare, but treatable disease through bloodspot screening shortly after birth. Within NYSDOH, the Newborn

Screening program is housed and administered by the Wadsworth Center, NYS's public health laboratory, with direct support from Title V and several other state and federal funding sources. The Newborn Screening program currently performs laboratory testing for 50 diseases, following national recommendations for Newborn Screening programs. The program ensures that every newborn in the state receives newborn bloodspot screening as a public health service, with no fee for testing. The program also performs follow-up case management to ensure newborns with a positive screening result receive appropriate diagnostic testing and treatment. Specialty Care Centers are certified and monitored to ensure newborns have access to specialty care for disease-specific testing and management. In addition, the Newborn Screening program contracts with each of the state's 10 Inherited Metabolic Disease Specialty Care Centers to enroll patients with an Inherited Metabolic Disease diagnosis identified by newborn screening in the NYS Newborn Screening Patient Registry. These Inherited Metabolic Disease Specialty Care Centers are responsible for entering and tracking for consented patients annually and for attending an annual meeting to discuss long-term follow-up data. Patients are monitored until age 18, when the individual must consent to continue participation until age 21. In 2021, the program screened 211,203 infants, 99.97% of all NYS resident infants born that year (See Form 4 for further details).

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

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

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

The Title V Program will support the Newborn Screening and the NYS Early Hearing Detection and Intervention programs on the following activities to advance this strategy over the upcoming 2023-24 year:

- **Activity PIH- 5.1:** Newborn Screening program staff will continue to conduct virtual site visits and in-person visits when appropriate with birthing facilities and hospitals to provide education to the hospital staff about Part 69-1, newborn screening regulation and compliance. The site visits are part of a birth hospital continuous quality improvement initiative supported by the Association of Public Health Laboratories to improve pre-analytic turnaround times (from collection of newborn dried blood specimens to receipt of specimens by the Program).
- **Activity PIH- 5.2:** Continue implementation and evaluation of a hospital late collection (>120hr) follow-up process with birth hospitals, to ensure timely collection and mitigate any risks of hospital staff oversight.
- **Activity PIH- 5.3:** Continue supporting the ongoing continuous quality improvement initiative at the 10 Inherited Metabolic Disease Centers for Short-term Follow-up compliance. Individual quality reports with the following

outcome measures will be provided to each of the 10 Inherited Metabolic Disease Center Directors: total number of referrals for center, percentage/number of referrals closed more than 90 days, percentage/number of referrals lost-to follow-up, and the NYS overall averages in each category. Standard operating procedures for follow-up practices at the Centers will be requested and reviewed. A similar project was completed with the Endocrine Specialty Care Centers in the past (2019-2020).

- **Activity PIH- 5.4:** Through the Early Hearing Detection and Intervention program, provide monthly data reports to birthing hospitals identifying infants born at their facility that failed an initial hearing screening test and do not have a reported follow-up test within three months of birth, and provide technical support to birthing hospital staff and audiologists as appropriate. The NYS Early Hearing Detection and Intervention program generates aggregated monthly reports for 120 birthing hospitals and 72 audiology practices that serve young children in New York State to support monitoring and surveillance activities. These reports assess the completeness and timeliness of newborn hearing screening and follow-up. Additionally, The NYS Early Hearing Detection and Intervention staff sends monthly child lists and run charts to hospitals and audiology practices that are missing newborn hearing screening and follow-up results or referrals to the NYS Early Intervention Program.
- **Activity PIH-5.5**: The NYS Early Hearing Detection and Intervention program will collaborate with the Newborn Screening program to enhance identification and linkage to care for infants with Congenital Cytomegalovirus (cCMV) Infection who may be at risk for hearing loss.

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

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

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

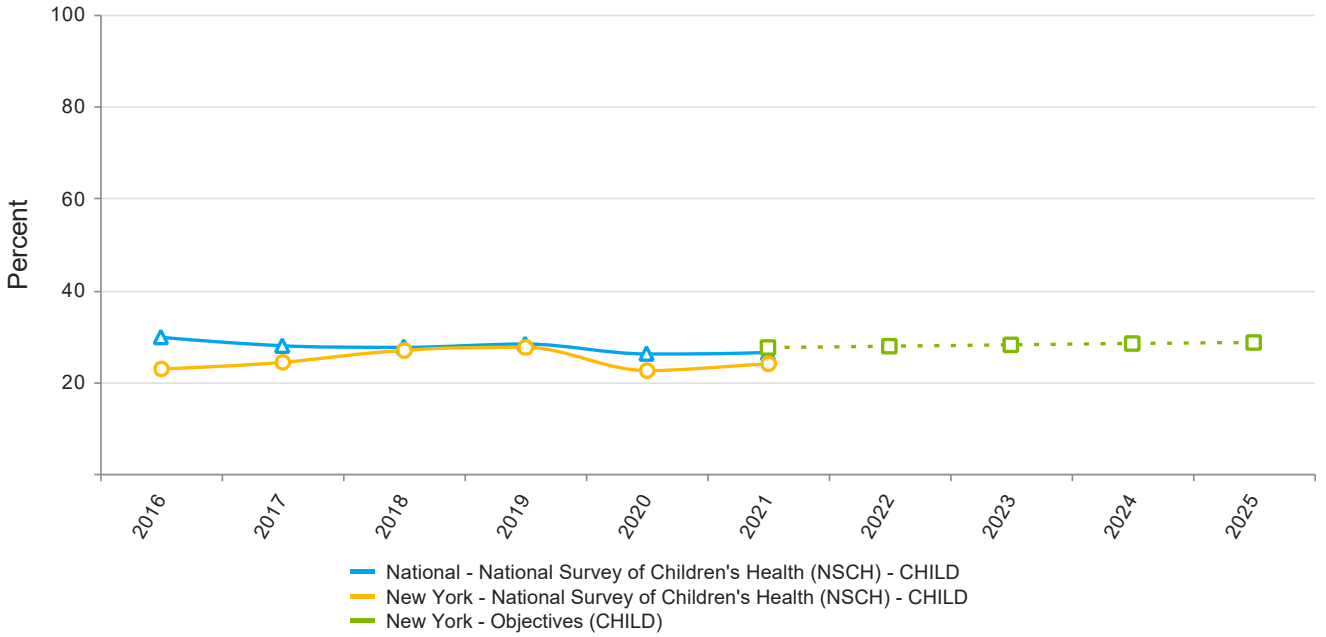
ESM PIH-2: Increase the percentage of the birthing hospitals that received site visits from NYSDOH staff to evaluate the process of collecting and transmitting Newborn Blood Spot samples to ensure samples are received by the NYSDOH Wadsworth Laboratory within 48 hours of collection.

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

Child Health

National Performance Measures

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
Indicators and Annual Objectives



Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CHILD				
	2019	**2020**	**2021**	**2022**
Annual Objective			27.8	27.8
Annual Indicator	27.0	27.4	24.1	24.1
Numerator	369,498	316,874	308,176	308,176
Denominator	1,370,994	1,158,167	1,278,404	1,278,404
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2017_2018	2018_2019	2020_2021	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	28.1	28.4	28.6

Evidence-Based or –Informed Strategy Measures

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.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			51.6	51.6
Annual Indicator		51.6	43	35.1
Numerator		98,941	74,325	54,615
Denominator		191,920	172,751	155,443
Data Source		SBHC quarterly report	SBHC quarterly report	SBHC quarterly report
Data Source Year		2018-2019	2019-2020	2020-2021
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	52.6	53.6	54.7

State Action Plan Table

State Action Plan Table (New York) - Child Health - Entry 1	
Priority Need	
Increase access to affordable fresh and healthy foods in communities.	
NPM	
NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day	
Objectives	
Objective CH-1: Increase the percent of NYS children age 6-11 who are physically active at least 60 minutes per day by 3.7%, from 27% in 2017-2018 to 28% in 2021-2022 (NSCH).	
Objective CH-2: Decrease the percent of NYS children age 10-17 who are obese (BMI at or above the 95th percentile) by 2.8%, and from 14.4% of children age 10-17 in 2017-2018 to 14% in 2021-2022 (NSCH).	
Strategies	
Strategy CH-1: Promote evidence-based and family-centered health care for children to promote healthy behaviors and to prevent, identify, and manage chronic health issues so that children can be healthy and active. Please see Supporting Document 3 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.	
Strategy CH-2: Promote home, school, and community environments that support developmentally appropriate active play, recreation, and active transportation for children of all ages and abilities. Please see Supporting Document 3 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.	
Strategy CH-3: Apply public health surveillance and data analysis findings to improve services and systems related to children's health and health care. Please see Supporting Document 3 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.	
Strategy CH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact children’s health and well-being. Please see Supporting Document 3 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.	
ESMs	**Status**
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.	Active

NOMs

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 (BMI at or above the 95th percentile)

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

Priority Need

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

NPM

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Objectives

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

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

Strategies

Strategy CH-1: Promote evidence-based and family-centered health care for children to promote healthy behaviors and to prevent, identify, and manage chronic health issues so that children can be healthy and active. Please see Supporting Document 3 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

Strategy CH-2: Promote home, school, and community environments that support developmentally appropriate active play, recreation, and active transportation for children of all ages and abilities. Please see Supporting Document 3 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

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

Strategy CH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact children's health and well-being. Please see Supporting Document 3 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

ESMs	Status
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.	Active

NOMs

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 (BMI at or above the 95th percentile)

Child Health - Annual Report

For Child Health (CH), New York's Title V Program selected **National Performance Measure (NPM) 8.1: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day.** This NPM was selected because it is responsive to concerns voiced directly by families in New York State (NYS) and reinforced by state-specific population health data. According to the National Survey of Children's Health, during the 2020-2021 reporting period over 17% of NYS children ages 10-17 were obese (5.5% increase compared to 2019-2020 data), and only 24.1% of NYS children ages 6-11 years were physically active for at least 60 minutes daily (2.1% decrease compared to 2019-2020 data). NYS families identified the availability and accessibility of amenities that support children's safe, active play and access to healthy foods as top priority needs, alongside priorities for community and environmental safety for children and community transportation. Supporting healthy, active play and recreation for children and youth of all ages and abilities is critical to promoting healthy weight as well as general physical and mental health during childhood and throughout the life course. In addition, this measure provides opportunities to be responsive to the Title V priorities for health care access and quality, social support, and social cohesion. This NPM aligns directly with NYS Prevention Agenda goals for physical activity and chronic disease prevention.

NYS's Title V Program has the capacity to address these priorities through its School-Based Health Center program and through collaboration with the New York State Department of Health (NYSDOH) Creating Healthy Schools and Communities program to enhance environmental infrastructure and supports, both in schools and in the community, to support physical activity. School Based Health Centers serve NYS's 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. We would be remiss not to mention the impact of the COVID-19 public health emergency on the School Based Health Center medical and dental programs and how it affected the operators' ability to meet their performance goals.

For this reporting period, many of the School Based Health Center medical programs that closed in March 2020 had reopened. Some providers were not able to maintain staffing levels to keep their clinics open and performance measures could not be met. There were opportunities for some other providers to work with Local Health Departments to run clinics to immunize children against COVID. In November 2021, Title V staff presented on the importance of mental health assessment and referrals during one of the School Based Health Center medical and dental program quarterly calls and introduced the Pediatric Mental Health Care Access (PMHCA) grant, also managed by the Division of Family Health. Then in the summer of 2022, Title V staff discussed the PMHCA grant on a Title V Advisory Council meeting to strengthen the support for mental health access in School Based Health Centers. A key strategy of the PMHCA grant is a partnership with the Office of Mental Health and that office's Project TEACH (which stands for Training and Education for the Advancement of Children's Health) which is aimed at enhancing primary care provider capacity to provide mental health services. Project TEACH has been actively reaching out to all the School Based Health Centers and creating relationships to engage the School Based Health Centers in Project TEACH training and one on one consultation 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 95th percentile) by 2.8%, and from 14.4% of children ages 10-17 in 2017-2018 to 14% in 2021-2022 (National Survey of Children's Health).

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

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

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

School-Based Health Centers are an important source of primary and preventive care services for thousands of NYS children and have the opportunity and capacity to holistically address children's needs. During this reporting period, Title V staff worked with School Based Health Centers statewide to ensure anticipatory guidance to promote proper nutrition and daily physical activity, weight status assessment, and attention to overall health promotion and chronic disease management, as part of routine primary and preventive care for children. In addition, the Title V Program continued to support an array of core public health programs that address children's health and wellness and access to primary and preventive health care services. The Title V Program led the following specific program and policy activities to advance this strategy in the 2021-22 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 46 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. During this reporting period, the Title V Program continued to work on formulating a plan to update the School Based Health Center data system and quarterly reports. There was much discussion on the current data system and its limitations with age-appropriate anticipatory guidance being one example and plans to build a new School Based Health Center data system continued.

As mentioned in the last reporting period, the current School Based Health Center data system is outdated and needs to be replaced. Reports are generated manually and there is no trend reporting capability. There is no way to easily compare operator performance. A grant was received in 2019 from Health Research, Inc. (HRI) to replace the current data system. The goal of the new data project is to develop and support a School Based Health Center data system that receives and integrates data for all School Based Health Centers, meets the needs of the state and includes performance metrics that will generate reliable reports, empowering the NYSDOH to assess operators' performance and support quality improvement efforts. This system will provide the NYSDOH 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. During this reporting period, Title V staff continued to plan out the necessary steps needed to build the new data system. One of the elements of the new data system that was discussed was the inclusion of updated guidance on providing anticipatory guidance to children and adolescents to address physical activity and nutrition. Crafting this language will be a change in operation for the School Based Health Centers, since the anticipatory guidance provided in the report and corresponding field guide does not currently address physical activity and nutrition. The new data system continues to be in the development stage, specifically utilizing the recommended platform for the new system to be housed. Once the new School Based Health Center data system is launched, a new quarterly data report will be automatically generated for each School Based Health Center. It is anticipated that the new system will begin to be tested with a small group of School Based Health Centers in the next reporting period.

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 contractors ensure strategies are developed and implemented to improve provider performance on quality indicators.

CH-1.2: Promote the use of the American Academy of Pediatrics' Bright Futures™ model for anticipatory guidance in School Based Health Centers and seek opportunities to engage the Academy of Pediatrics for assistance to promote this resource.

To promote the use of the American Academy of Pediatrics Bright Futures™ model for anticipatory guidance in School Based Health Centers and to seek opportunities to engage the Academy of Pediatrics for assistance to promote this resource, NYSDOH Division of Family Health staff met to develop a plan. It was determined that the first step is to build internal capacity regarding Bright Futures™. This will include what it is, who developed it, how it is used in the field, and what it says about anticipatory guidance. This internal training was delayed and will take place in the next reporting period. After the internal training, use of the Bright Futures™ model for provision of age-anticipatory guidance will be promoted with the School Based Health Centers.

CH-1.3: Incorporate guidance, reporting, and tracking to support School Based Health Center 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 also 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 developed a 2023-2028 School-Based Dental Home Request for Application that was released on August 9, 2022, to establish dental homes in School Based Health Centers and include anticipatory guidance that includes physical activity and nutrition. Applications were due on October 12, 2022. Organizations funded through this Request for Application will comprise the School Based Dental Home Program and support the program's overarching goals to establish a consistent source of dental care for children, improve oral health outcomes, engage families to support their health goals, and reduce racial and ethnic disparities in children's oral health outcomes. The services provided through the School Based Dental Home Program will be delivered through School Based Health Center dental clinics. School-Based Dental Home funded programs will deliver high-quality, accessible dental services in the school setting to children, with a focus on serving low-income, uninsured, and underinsured individuals. Services provided by funded programs include biannual examinations/screenings, preventive services, anticipatory guidance, referrals for needed oral health services, follow-up on any untreated dental disease, and ensuring quality and continuity of care.

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

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

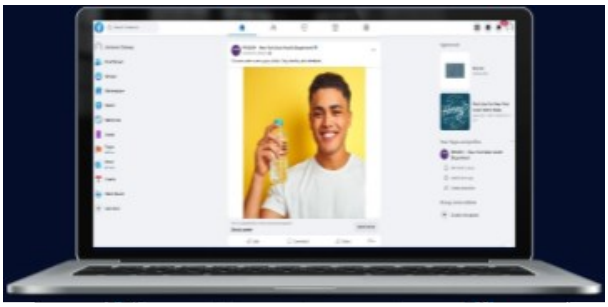
CH-1.5: Within the Title V program, strengthen collaboration between child- and adolescent-serving programs to enhance promotion of physical activity through established programs that focus on adult-led activities and social-emotional wellness

To strengthen collaboration between child- and adolescent-serving programs to enhance promotion of physical activity through established programs that focus on adult-led activities and social-emotional wellness, staff working in the child health domain continued to collaborate with the staff focused on adolescent health domain work. Staff from the two domains meet internally to explore opportunities for School Based Health Centers on topics of interest related to adolescents.

CH-1.6: Collaborate with the NYSDOH Division of Nutrition to incorporate public health nutrition messaging with physical activity guidance across child health programs, including School Based Health Center and Children and Youth with Special Health Care Needs programs.

In July and August of 2022, Title V staff re-ran a Sugar-Sweetened Beverage media and out-of-home campaign, originally developed in 2018 to promote drinking water instead of sugar-sweetened beverages, especially sports drinks. The campaign messages and ads were developed in collaboration with the Division of Chronic Disease Prevention's staff/programs addressing obesity, since these drinks impact oral health and weight gain. Title V staff also distributed posters to School Based Health Centers across NYS to use throughout their schools.

The media campaign was statewide and included over-the-top, Display Banners, social media, and search ads geared toward Black and Hispanic Males ages 12-17 and their caregivers. Over-the-top placements ran to reach households where both the children and parents may be using the devices, thus reaching both audiences. Over-the-top delivered approximately 6.5 million impressions and close to 6.3 million video completes. Display Banner ads served more than 10 million impressions and over 10,000 clicks to the website. The social media advertisements were made up of 10 second videos, images, and text and were used to drive awareness to the NYSDOH website for education and information about sugar-sweetened beverages and their effect on oral health and obesity. Facebook, Instagram and Snapchat were chosen based on indexing among the target audience, as well as their targeting capabilities. These social reach ads drove more than 3.8 million impressions. Estimated Reach by platform included Facebook (40,800), Instagram (104,352), Snapchat Traffic (243,600), and Snapchat Reach (537,112). The social traffic ads drove more than 3.2 million impressions and over 31,000 clicks to the website. Google and Bing Search ads drove more than 92,000 impressions and approximately 5,800 clicks to the website.



To reach this audience effectively, multiple out-of-home media types were utilized. Transit media (bus interiors and exteriors) and street furniture (bus shelters) were placed to reach those relying on public transportation as well as passing vehicle and foot traffic simultaneously. The geographic target for the out-of-home campaign was selected based on statewide obesity and oral health data and included Bronx, Erie, Essex, Franklin, Greene, Kings, Lewis, Monroe, New York, and St. Lawrence counties. This strategy reaches the target audience multiple times, while they are waiting for the bus, boarding the bus, and inside while they are riding the bus. Convenience store 1-sheets and cooler clings were also implemented to reach those shopping for essentials, delivering this important message while entering the store as well as on the refrigerator at the point of beverage selection. English and Spanish creative was utilized to reach different ethnic groups. Spanish placements were

allocated in-line with population distribution of speakers throughout the target markets. Approximately 108,395,642 impressions were delivered from the placement of 1,502 ad units. Additionally, static media received, on average, two bonus weeks of media after the paid campaign end date.

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 sealant and community water fluoridation programs to promote children's oral health and reduce dental caries as key contributors to children's overall health and well-being.
- Comprehensive Services and Health Systems Approaches to Improve Asthma Control in New York State to improve the quality and availability of guidelines-based asthma care.

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

The NYS-funded School Based Sealant Program aims to reduce the prevalence of dental caries among New York State's children by providing dental sealants to first molars of second and third grade children through School Based Health Centers. School-based dental sealant delivery programs are recommended by the U.S. Department of Health and Human Services' Community Preventive Services Task Force based on strong evidence of effectiveness in preventing tooth decay.

Currently, 21 contractors that are health facilities regulated by NYSDOH under Article 28 of NYS Public Health Law are funded to provide dental sealants to second and third graders in schools across the state. These programs prioritize supporting schools with a higher percentage of children eligible for the federal free or reduced-price school lunch program. In addition to applying sealants, School Based Sealant Programs are expected to provide the full array of services including outreach and education, dental screening, education and anticipatory guidance, sealant retention assessment, and referrals and follow-up care. Title V staff worked to ensure the School Based Sealant Program was extended 12 months to align with the start of the School Based Dental Home Program that begins July 1, 2023. The contract period for the School Based Sealant Program is now July 1, 2017-June 30, 2023.

In partnership with the Title V program, Title V staff assisted with the contract development and monitoring of the NYSDOH Drinking Water Fluoridation grant. The purpose of this grant is to provide NYS residents access to optimally fluoridated water to prevent tooth decay and promote good oral health, which is important to maintaining overall health. The grant focuses on providing technical and financial support to communities to initiate and maintain Community Water Fluoridation. Title V funds a contract with the New York Rural Water Association (August 2018-July 2023) to provide technical assistance to public water systems via onsite visits and operator trainings, to help ensure fluoridated public water systems are

maintained and operated in compliance with all laws, rules, and regulations.

The Drinking Water Fluoridation Program also provides technical assistance to local and regional health departments, elected officials, and local, state, and national Community Water Fluoridation stakeholders and champions, including the benefits, risks, effectiveness, and cost-effectiveness of Community Water Fluoridation, along with the legal requirements to meet NYS Public Health Law §1100-a. During this reporting period, Title V staff monitored ten state-funded grants awarded to public water systems through the Drinking Water Fluoridation Grant Program. Also, 22 public water systems received financial and/or technical support from New York Rural Water Association to maintain or initiate community water fluoridation. Four trainings were provided to public water systems operators during this period, with a total of 101 operators receiving the training from the New York Rural Water Association. A total of 71.1% of NYS residents served by community water systems have optimally fluoridated water, which is a slight decrease from previous reports, based on 2019 data captured by the Safe Drinking Water Information System as of August 2021, which is an Environmental Protection Agency database managed by the NYSDOH Center for Environmental Health.

The Comprehensive Services and Health Systems Approaches to Improve Asthma Control in New York State aims to improve the quality and availability of guidelines-based asthma care. During this reporting period, Division of Family Health staff continued to collaborate with the Asthma Guidance Team, led by the NYSDOH Division of Chronic Disease Prevention, to improve asthma control in NYS and management of asthma in schools by meeting with Division of Chronic Disease Prevention to discuss Asthma Self-Management Education in School Based Health Centers. Because exercise-induced asthma is common in adolescents, the asthma action plan includes the importance of exercise being managed in schools so that students can fully participate. Treatment with prescribed medications before vigorous activity or exercise can prevent symptoms. This reporting period also included collaborating with the Division of Chronic Disease Prevention to discuss continued partnering with School Based Health Centers for asthma self-management training services to School Based Health Center patients. A promotional opportunity webinar was developed and presented to introduce this project to the School Based Health Centers in February 2022 by the American Lung Association with Asthma Control Program and discuss what the expectations of the projects are. Through the School Based Health Centers education with the students, the students will be better able to manage their asthma symptoms, decrease asthma complications and exercise-induced asthma so they can participate more fully in physical activity in/outside of schools. Eight School Based Health Center operators and 16 School Based Health Center sites are participating in the project and are in various stages of implementation. Some sites have completed their first and second visits and have submitted flip chart data. The flip chart is an asthma education tool. The asthma facilitator uses this to educate their students and they keep a roster of students who receive education with the use of the flipchart. Pre and post test scores are collected and then submitted for data collection by the American Lung Association.

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 NYSDOH Division of Chronic Disease Prevention to implement multi-pronged strategies to enhance the work of Creating Healthy Schools and Communities grantees, and other initiatives.

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

Program led many program and policy activities to advance this strategy over the 2021-22 reporting period.

CH-2.2: Facilitate partnerships between local Creating Healthy Schools and Communities grantees (as available) and School Based Health Centers to engage and educate community partners, families, and community residents on the benefits of physical activity through Complete Streets implementation, including Safe Routes to School programs. Collaboration with the NYSDOH Division of Chronic Disease Prevention helps to implement multi-pronged strategies to enhance the work of Creating Healthy Schools and Communities grantees and other initiatives aimed at increasing children's physical activity. In June 2021, Creating Healthy Schools and Communities funding was approved for 26 contracts through May 2026. Title V staff met with Division of Chronic Disease Prevention staff to finalize a plan to encourage collaboration among School Based Health Centers and Creating Healthy Schools and Communities grantees. This collaboration is aimed at facilitating partnerships between local Creating Healthy Schools and Communities grantees and School Based Health Centers to engage and educate community partners, families, and community residents on the benefits of physical activity including through Complete Streets implementation and Safe Routes to School programs. Title V staff worked to develop a list of schools and school districts that have a School Based Health Center and are a Creating Healthy Schools and Communities grantee. This list was used to share a collaboration webinar opportunity to introduce and familiarize Creating Healthy Schools and Communities grantees and School Based Health Centers with each other as well as identify overlap and discuss potential collaboration ideas. The collaboration webinar was held in May 2022 and subsequent information was sent to the list with contact information for the School Based Health Center and Creating Healthy Schools and Communities grantees and collaboration webinar slide deck. During the webinar, several School Based Health Centers and Creating Healthy Schools and Communities grantees expressed excitement with the connection made with new partners. Title V staff and Division of Chronic Disease Prevention staff will continue to check in on School Based Health Center and Creating Healthy Schools and Communities grantees to determine collaboration and connections made and determine how else State level staff can help assist them in these efforts.

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

The Pediatric Obesity Prevention Work Group was interrupted by the COVID-19 pandemic. Staff from Division of Chronic Disease Prevention are assessing the direction for this work.

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

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

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

Last reporting period, Title V staff collaborated with the U.S. Census Bureau to develop a plan to conduct an over-sample of National Survey of Children's Health in NYS to increase the number of samples for Black/African-American, Hispanic, and Children and Youth with Special Health Care Needs populations. During this reporting period, the sampling plan was being implemented and will continue to be implemented into the next reporting period. The data will be available in the 2023-2024 reporting period.

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

As mentioned in Strategy CH-1, Title V staff are working to design and implement a new School Based Health Center data collection system. The current system does not allow School Based Health Centers to identify, track, and address disparities within the School Based Health Centers. During this reporting period, Title V staff continued to meet with staff funded on the Health Research, Inc. grant to discuss how to engage and survey stakeholders to identify, track, and address disparities within the School Based Health Centers. This work will be addressed in the following years of the Title V grant.

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

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

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

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

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

CH-4.1: Design the new School Based Health Center data collection system with a racial justice and health equity lens, building a reporting tool that allows School Based Health Centers to identify, track, and address disparities within the School Based Health Centers (site or provider level).
School Based Health Centers are located in the areas of NYS that have been most impacted by systemic barriers and, therefore least likely to gain access to high-quality services and most at risk for poor health outcomes. The communities are disadvantaged economically and disproportionately impacted by key social determinants of health such as housing, transportation, employment, access to health care, and sources of healthy food. Families facing day-to-day challenges of poverty and racism may be less able to prioritize or take advantage of opportunities for recreational physical activity.

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

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

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

As described in the Women and Maternal Health section, a new Bureau of Health Equity and Community Engagement was created within the Division of Family Health to address disparities highlighted in the COVID-19 pandemic and build a foundation for future epidemic responses. More information about this new bureau in future annual reports and applications for the 2022-23 program year.

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

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

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

Targets are as follows:

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

Child Health - Application Year

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

15.6% of NYS adolescents ages 10-17 are obese, and only 24.1% of NYS children ages 6-11 years are physically active for at least 60 minutes daily (2020-2021 National Survey of Children's Health). NYS families identified the availability and accessibility of amenities that support children's safe, active play and access to healthy foods as top priority needs, alongside priorities for community and environmental safety for children and community transportation. Supporting healthy, active play and recreation for children and youth of all ages is critical to promoting healthy weight as well as general physical and mental health during childhood and throughout the life course. In addition, this measure provides opportunities to be responsive to the Title V priorities for health care access and quality, social support, and social cohesion. This NPM aligns directly with NYS Prevention Agenda goals for physical activity and chronic disease prevention.

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

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

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

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

Four strategic public health approaches were identified to accomplish these objectives over 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 CH-1: Promote evidence-based and family-centered health care for children to promote healthy behaviors and to prevent, identify, and manage chronic health issues so that children can be healthy and active.

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

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

Program will continue to support an array of core public health programs that address children's health and wellness and access to primary and preventive health care services.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2023-24 year:

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

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

To achieve state goals related to increasing children's physical activity, children and their families need safe, appealing, and accessible places to play and be active – at home, in school, and in their neighborhoods and communities. Across the

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

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2023-24 year:

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

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

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

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2023-24 year:

- **Activity CH-3.1**: Collaborate with the U.S. Census Bureau to conduct an over-sample of NYS 2022 National Survey of Children's Health for NYS to allow for enhanced sampling of Black/African American, Hispanic, and Children and Youth with Special Health Care Needs populations.
- **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 Centers.
- **Activity CH-3.3**: Engage and survey stakeholders to identify, track, and address disparities within the School Based Health Centers.
- **Activity CH-3.4**: Explore collaborative opportunities with Division of Chronic Disease Prevention's Bureau of Chronic Disease Evaluation and Research to review and share information on student weight status assessments to inform School Based Health Center work in this area.

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

Child health outcomes are impacted by social determinants of health, or the conditions in which people are born, live, work, play, learn, and age. The social determinants of health include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of

power and resources due to racism and other biases are root causes of inequities in access, availability of services, and quality of care. All ten priorities that emerged from community members' input during the Title V Needs Assessment revolve around the social determinants of health and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities.

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

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

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2023-24 year:

- **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 Centers (site or provider level).
- **Activity CH-4.2**: Partner with key stakeholders such as the Community Health Care Association of New York State and the New York School-Based Health Alliance to identify and share best practices for School Based Health Centers to address racial justice and health equity.

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

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

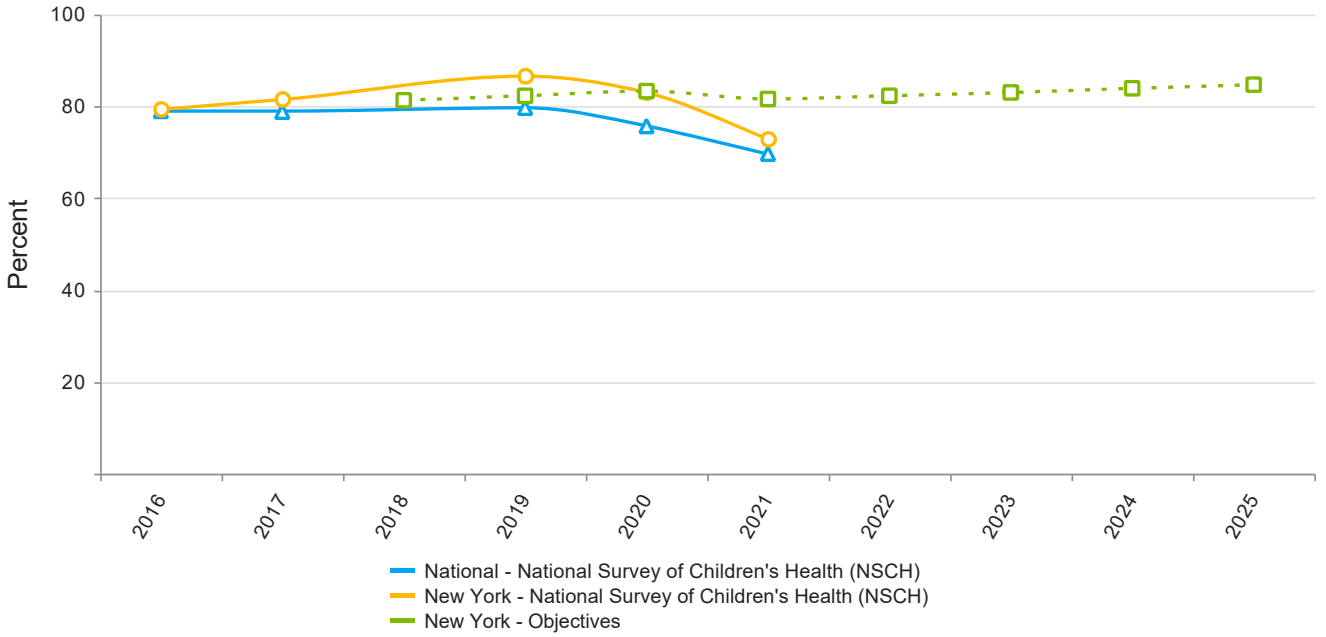
Data for this measure come from the School Based Health Center quarterly reporting system. The baseline for 2021 (51.6%) was established using program year 2018-2019 data. Targets have been established to achieve a 2% increase each year, except for 2022 as the first year is primarily a planning year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

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

Adolescent Health

National Performance Measures

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	81.2	82.2	83.2	82.2	82.2
Annual Indicator	81.3	81.3	86.3	72.8	72.8
Numerator	1,081,532	1,081,532	1,367,654	976,520	976,520
Denominator	1,331,106	1,331,106	1,583,876	1,341,167	1,341,167
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2016_2017	2019	2020_2021	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	82.9	83.8	84.6

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Percent of youth-serving programs that provide training on adult preparation subjects, such as accessing health insurance, maintaining their routine preventive medical visits, healthy relationships, effective communication, financial literacy, etc.

Measure Status:	Active

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

Annual Objectives			
	2023	2024	2025
Annual Objective	98.2	100.0	100.0

ESM 10.2 - Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			68.7	70.1
Annual Indicator		68.7	78.1	79.4
Numerator		46	50	50
Denominator		67	64	63
Data Source		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
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	71.6	73.1	74.0

State Action Plan Table

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

Priority Need

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

NPM

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

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

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

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

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

Strategies

Strategy AH-1: Incorporate specific activities to promote the wellness of adolescents across all Title V programs, including promoting and facilitating routine well visits, reproductive health care, oral health, and behavioral health. Please see Supporting Document 3 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy AH-2: Promote supports for adolescents to gain the knowledge, self- efficacy, and resources they need to prepare for and transition to adulthood. Please see Supporting Document 3 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

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

Strategy AH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact adolescents’ health and well-being. Please see Supporting Document 3 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

ESMs	Status
ESM 10.1 - Percent of youth-serving programs that provide training on adult preparation subjects, such as accessing health insurance, maintaining their routine preventive medical visits, healthy relationships, effective communication, financial literacy, etc.	Active
ESM 10.2 - Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation	Active

NOMs
NOM 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
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
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 (BMI at or above the 95th percentile)
NOM 22.2 - Percent of children, ages 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 HPV vaccine
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the 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

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For Adolescent Health, New York's Title V Program selected NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year. This NPM was selected because it aligns with both population health data indicators and concerns voiced directly by adolescents in New York State (NYS). Most teens (ages 12-17) had a preventive medical (86.3%) and preventive dental (89.1%) visit in 2019, but NYS continues to work towards increasing the total number of adolescents who have obtained annual preventive medical and dental visits as well as reducing current disparities. 86.0% of Hispanic adolescents had a preventive medical visit compared to 89.3% of non-Hispanic White adolescents and only 78.2% of adolescents on Medicaid had an annual visit compared to 91.5% adolescents with private insurance.

In a series of adolescent focus groups conducted in 2019 by NYSDOH through the Assets Coming Together (ACT) for Youth Center for Community Action, adolescents across the state discussed that their medical providers lack compassion and respect for their young patients, and that youth would prefer visiting providers who are more affirming and reflective of the youth themselves. The importance of social support and the need for more people to talk to positive mentors were frequently mentioned by adolescents. They discussed feeling socially isolated and wanting opportunities for community engagement or building a sense of belonging. Beyond assuming responsibility for their own health care, adolescents voiced a desire for education about financial literacy, healthy cooking, navigating relationships, and other aspects of adulthood.

Preventive medical visits are one component of overall wellness, but data and community input point to other areas such as social emotional development and adult preparation that could assist with adolescents' proper growth and development. As indicated in the 2019 Youth Risk Behavior Surveillance System, over 30% of New York high school students reported feeling sad or hopeless for more than two weeks in the past year and over 10% reported that they attempted suicide. Hispanic students are more likely to report depression symptoms and suicide attempts, and there are dramatic disparities based on sexual identity as well, with 60% of students identifying as gay, lesbian, or bisexual reporting depression symptoms and 26% reporting a suicide attempt. Only 16.4% of adolescents without special health care needs received services necessary to transition to adult health care.

Adolescence is often a very challenging stage in a person's life. During this time, adolescents experience growth through physical development, cognitive development, social-emotional development, identity, and sexual development. Supporting adolescents' health and development and helping them prepare for their futures can have a lasting impact throughout the life course. The multifaceted nature of adolescent development and wellness means the selected NPM and its associated strategies are responsive to most of the priority areas, particularly health care, social support and cohesion, community services and amenities, and awareness of resources. This NPM also aligns directly with established priorities encompassed in the NYS Prevention Agenda goals to support and enhance children and adolescents' social-emotional development and relationships, strengthen opportunities to build well-being and resilience across the lifespan, facilitate supportive environments that promote respect and dignity for people of all ages, and other Prevention Agenda goals related to mental health and substance use, including prevent underage drinking and excessive alcohol consumption by adults, prevent opioid and other substance misuse and deaths, prevent and address adverse childhood experiences (ACEs), reduce the prevalence of major depressive disorders, prevent suicides, and reduce the mortality gap between those living with serious mental illness and the general population. (New York State Prevention Agenda 2019-2024 https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/ship/overview.pdf)

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

Objective AH-1: Increase the percentage of adolescents, ages 12-17, with a preventive medical visit in the past year by 5%, from 81.3% in 2016-2017 to 85.4% in 2021-2022. (National Survey for Children's Health (National Survey of Children's Health)

Objective AH-2: Increase the percentage of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling by 5%, from 53.5% in 2017-2018 to 56.2% in 2021-2022 (National Survey of Children's Health)

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

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

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

Strategy AH-1: Incorporate specific activities to promote the wellness of adolescents across all Title V programs, including promoting and facilitating routine well visits, reproductive health care, oral health, and behavioral health.

Adolescence is a critical stage of development when children grow physically, cognitively, emotionally, and socially to become adults. The lifestyle choices, behaviors, and relationships established during this time can affect an adolescent's current and future health. Routine well visits during adolescence are recommended by the American Academy of Pediatrics and Bright Futures™ as one way to foster health in the present and build a foundation for wellness into the future. They are an opportunity to promote healthy behaviors, discuss risky behaviors, provide important vaccinations, and address conditions that can interfere with healthy development. Likewise, comprehensive, and inclusive reproductive health care and education are opportunities to help adolescents avoid or mitigate risky sexual behaviors. Title V Programs also provide enabling services to adolescents, such as referrals to and linkages with community services and social supports to holistically address health and wellness, including mental health and social determinants of health.

The key programs that work to support adolescent wellness and help connect adolescents to needed services include Comprehensive Adolescent Pregnancy Prevention program, Personal Responsibility Education Program, Sexual Risk Avoidance Education, Children & Youth with Special Health Care Needs, School-Based Health Centers, Family Planning Program, and Sexual Violence Prevention programs. ACT for Youth Center for Community Action at Cornell University works with the Department of Health to provide technical assistance, training, and evaluation services for the Comprehensive Adolescent Pregnancy Prevention program, Personal Responsibility Education Program, and Sexual Risk Avoidance Education programs.

During the height of the COVID19 pandemic, Kindergarten through 12th grade schools and youth-serving locations throughout the state experienced closures; transportation options were limited; and social distancing protocols were introduced. This reduced the ability for programs to meet the youth in a consistent manner. The ACT for Youth Center for Community Action worked with programs to ensure that the evidence-based programs they were implementing were be adapted with fidelity within the confines of a new virtual environment. Significantly less youth were served across the state compared to time periods prior to the emergence of COVID19.

However, as noted by the CDC, schools and community programs play critical roles in promoting equity in learning and health, particularly for groups disproportionately affected by COVID-19. People living in rural areas, people with disabilities, immigrants, and people who identify as American Indian/Alaska Native, Black or African American, and Hispanic or Latino have been disproportionately affected by COVID-19. These disparities were also observed among children. School administrators and public health officials can promote equity in learning and health by demonstrating to families, teachers, and staff that comprehensive prevention strategies are in place to keep students, staff, families, and school communities safe and provide supportive environments for in-person learning.

The Title V Program established the following specific program and policy activities to advance this strategy over the 2021-

22 year:

AH-1.1: Through the Personal Responsibility Education Program and Comprehensive Adolescent Pregnancy Prevention program, provide information to adolescents and parents on the offering and arranging of adolescent sexual health reproductive services.

The Comprehensive Adolescent Pregnancy Prevention program and the Personal Responsibility Education Program support the delivery of evidence-based programs to youth. These evidence-based programs are curriculums that **have been rigorously tested in controlled settings, proven effective, and translated into practical models that are widely available to community-based organizations. Evidence**-based programming on reproductive and sexual health was completed for 23,073 youth during this reporting period through the Comprehensive Adolescent Pregnancy Prevention program and the Personal Responsibility Education Program.

The Comprehensive Adolescent Pregnancy Prevention program funds youth-serving organizations to work with adolescents, ages 10-21 that lack social and economic opportunities to develop their full potential. This includes (but is not limited to): racial/ethnic minorities, youth from socioeconomic disadvantaged communities, youth living in foster care, youth who identify as lesbian, gay, bisexual transgender and questioning, youth who are homeless, and youth involved in the juvenile justice system. The Comprehensive Adolescent Pregnancy Prevention program provides evidence-based programs to youth to reduce the adolescent pregnancy rate and the rate of unintended pregnancy by practicing health promotion and risk-reduction behaviors and ensuring access to confidential reproductive health care and family planning services for adolescents.

The Personal Responsibility Education Program is similar to the Comprehensive Adolescent Pregnancy Prevention program but is fully federally funded. It supports implementation of evidence-based program models and educates youth on at least three of the following six adult preparation subjects: Healthy Relationships, Adolescent Development, Financial Literacy, Parent-Child Communication, Educational and Career Success, and/or Healthy Life Skills. The Personal Responsibility Education Program also promotes activities to ensure youth access to comprehensive reproductive health care and family planning services.

Programs provide and arrange referrals for services identified as appropriate and outreach and education to youth and parents is reported biannually by programs. Department of Health staff review biannual reports, provide feedback and follow-up as needed. Programs use social media to promote programming, access to services, and education and programs collaborate with community partners to promote education and access to services. Many Comprehensive Adolescent Pregnancy Prevention program and Personal Responsibility Education Program providers promote their resources on social media platforms popular with youth, such as Instagram, Snapchat, and occasionally TikTok and Facebook. For example, Community Healthcare Network's Comprehensive Adolescent Pregnancy Prevention program and Personal Responsibility Education Program used an innovative youth-as-partners model to involve peer educators in the creation of five social media campaigns and PSAs every year on their Instagram and Facebook pages. They can provide educational content featuring authentic youth voice and connect youth to Community Healthcare Network's programming and sexual health services via these platforms.

A new Request for Applications was issued for the Comprehensive Adolescent Pregnancy Prevention program in 2022, with an enhanced focus on health equity. The Request for Application required applicants to "[a]pply a health equity lens to activities to address social determinants of health and reduce disparities that impact adolescents' health and well-being." The programs work to increase the percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, (including racial and social injustice) in program planning and implementation. The Comprehensive Adolescent Pregnancy Prevention Program Request for Application asked applicants how they had engaged youth in the design of this aspect of the program and how they would continue to increase youth voice.

AH-1.2: Through the Sexual Risk Avoidance Education program, provide medically accurate and complete sexuality health

education services to youth.

The Sexual Risk Avoidance Education program focuses efforts on youth ages 10-13 living in resource poor communities, and, like the Personal Responsibility Education Program, is also federally funded. The Sexual Risk Avoidance Education program has three components. The first provides sexual risk avoidance education with an evidence-based approach based on adolescent learning and developmental theories for the age group receiving the education. The education includes medically accurate and complete information and normalizes the optimal health behavior of avoiding sexual activity. The second component focuses on adult-supervised activities with the youth. These activities stimulate cognitive, social, physical and/or emotion 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 391 youth during this reporting period for the Sexual Risk Avoidance Education programs.

AH-1.3: Through the Comprehensive Adolescent Pregnancy Prevention program, Personal Responsibility Education Program, and Sexual Risk Avoidance Education program, increase access to health care services for adolescents through a referral process that includes confirmation as permitted while ensuring confidentiality.

The Comprehensive Adolescent Pregnancy Prevention program, Personal Responsibility Education Program, and Sexual Risk Avoidance Education program increase access to health care services by directly referring youth internally within their organization or through a Memorandum of Understanding with clinical providers and other providers. The Comprehensive Adolescent Pregnancy Prevention program, Personal Responsibility Education Program, and Sexual Risk Avoidance Education program report biannually the number of adolescents referred for comprehensive health care services. A total of 342 comprehensive health care services were made in 2022, of which 92 referrals were from reproductive health services. Programs ensure confidentiality through continuous staff trainings and by providing education to the public, communities, and community-based organizations (CBOs). Outreach and education efforts, including community events, presentations, and social media posts. are reported biannually. Department of Health staff review biannual reports, provide feedback to programs and follow-up as needed.

AH-1.4: Division of Family Health staff and community youth-serving organizations provide trauma-informed education and training on social emotional wellness and positive youth development for children and adolescents.

All adolescent health programs provide programming using positive youth development and a trauma-informed approach. On-going trainings to providers on trauma-informed approach and social-emotional wellness are provided to program providers through ACT for Youth Center for Community Action. ACT for Youth Center for Community Action hosted webinars on positive youth development and trauma-informed care, including: Puberty!; Mindfulness-Based Programs for Stress and Health; Using a Trauma-Informed Approach, Positive Youth Development. ACT for Youth Center for Community Action also provided in person training at two locations on Positive Youth Development. Department of Health staff review biannual reports, provide feedback, and follow-up as needed.

In July 2022, the Bureau of Women, Infants and Adolescent Health, which was renamed to the Bureau of Perinatal, Reproductive, and Sexual Health, held a three-day virtual Provider Meeting. The main theme of the conference was Building on Community Strengths for Health and Justice. Keynote speakers included Dr. Rachel Hardemen, PhD, MPH, on Centering Antiracism to Achieve Reproductive Justice; Dr. Kenneth Ginsberg, MD, MSEd on Integrating Self-Care with Our Real Lives; and several providers and community advocates from Central New York on Building Trust and Community Engagement. Conference sessions focused on centering community voices and creating action; building capacity for diversity, equity, inclusion, and justice; and building organizational strengths. All adolescent health programs were required

to have staff attend. Presentations were recorded and were posted on the ACT for Youth Center for Community Action website.

The 2022 Comprehensive Adolescent Pregnancy Prevention Program Request for Application included an enhanced focus on social-emotional wellness. The goal of the program is to increase percentage of adolescents who live in supportive and cohesive communities, implement multi-dimensional educational, vocational, economic, and recreational opportunities for youth on multiple health and developmental related topics that introduce them to new situations, ideas and people, and challenge them to build or learn skills.

AH-1.5: Within the Title V program, enhance collaboration between adolescent serving programs, including the Comprehensive Adolescent Pregnancy Prevention program, the Sexual Risk Avoidance Education program, School Based Health Centers, and Children and Youth with Special Health Care Needs programs, to promote holistic adolescent health through provision of comprehensive physical exams and anticipatory guidance, including BMI, behavioral health, oral health, and reproductive health, for adolescents with and without special health care needs.

Title V staff working in the Children and Youth with Special Health Care Needs, Child Health and Adolescent Health exchanged resources about their programs as well as training and webinar opportunities for adolescent health topics.

Division of Family Health staff in the Adolescent Health and Children and Youth with Special Health Care Needs domains collaborated on a roundtable discussion for the 2022 the Bureau of Women, Infants and Adolescent Health held a Conference at which all of the programs overseen by the Bureau attended. Members of both the Adolescent Health and Children and Youth with Special Health Care Needs domains, along with Adolescent Health providers, presented “Beginning a Discussion: Delivering Sexual Health Education Programming to Youth with Special Needs.” The panel examined existing resources for youth with special needs, discussed why sexual health programming is important for this population, and shared lessons learned in delivering an evidence-based sexual health program to for youth on the autism spectrum.

Staff in the Adolescent Health domain forwarded resource information and webinar opportunities to other Title V staff when appropriate, including presentations by our federal grantors: Teaching Students with Intellectual or Developmental Disabilities (I/DD) about Sexuality and Healthy Relationships; Misinformation and Public Health - Implications, Innovative Practices for Providing Sexual Health Education and Services in Schools; and Training for Parents, Caregivers, and Families on the Mental Health of Children.

AH-1.6: Collaborate with internal and external stakeholders, including AIDS Institute, Bureau of Immunization, and the NYS Human Papilloma Virus (HPV) Coalition to promote HPV vaccination with clinical providers.

Title V staff met with representatives of the AIDS Institute, the Bureau of Immunization, and the NYS HPV Coalition, including sharing resources and contacts among organizations. Staff supporting the Adolescent Health domain attend quarterly HPV Coalition meetings and receive informational updates. HPV vaccination information resources were 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.

Title V staff attended quarterly NYS HPV Coalition meetings during this reporting period and emailed HPV information to adolescent-serving providers.

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 program and Personal Responsibility Education Program are required to provide access to family planning. Programs that are not located in health facilities that are regulated by NYSDOH 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. At a minimum, on a biannual basis, staff discusses with

each provider their interaction and relationship with their designated family planning providers and School Based Health Centers if applicable.

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 an 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.

As noted by Child Health domain staff, many School Based Health Center medical programs closed when schools closed due to COVID-19 in March 2020. However, they have reopened during this reporting period.

AH-1.9: Promote healthy relationships and sexual violence prevention using policy change, protective environment strengthening, healthy social norms reinforcement, and skill-building to address individual, relationship, community, and societal risk and protective factors. Focus on groups experiencing disproportionate burden of sexual violence, including communities of color, adolescents and young adults, domestic violence victims, those experiencing low income, people affected by alcohol and drug abuse, and LGBTQ+ persons.

Through use of the Adolescent Sexual Health Needs Index (ASHNI), adolescent-serving programs identify priority populations – youth lacking social and economic opportunities that can enable them to develop to their full potential.

The Comprehensive Adolescent Pregnancy Prevention program, Personal Responsibility Education Program, and Sexual Risk Avoidance Education program incorporate healthy relationship education and skills building. The Comprehensive Adolescent Pregnancy Prevention program programs must include youth-led, multi-dimensional (educational, social, vocational, economic, and recreational) opportunities for adolescents to provide alternatives to sexual activity and to develop skills that can support a successful transition into healthy young adults. The Personal Responsibility Education Program requires each provider to teach at least three Adulthood Preparation Subjects such as healthy relationships, including positive self-esteem and relationship dynamics, friendships, dating, romantic involvement, marriage, and family interactions; adolescent development, such as the development of healthy attitudes and values; educational and career success, such as developing skills for employment preparation; and healthy life skills, such as goal-setting, decision making, negotiation, communication, interpersonal skills, and stress management. The Sexual Risk Avoidance Education program must teach youth the benefits associated with personal responsibility, self-regulation, goal setting, healthy decision-making, healthy relationships, avoiding poverty, resisting sexual coercion and dating violence, and other youth risk behaviors, such as drug and alcohol usage.

Adolescent Health program providers make referrals as needed for physical, social, emotional, educational, and developmental support or services, including mental health, social-emotional wellness, substance abuse counseling, interpersonal violence prevention, nutrition (e.g., food pantry), and employment services. Referrals are noted in biannual reports submitted to the Department of Health by all program providers.

Some providers prioritize engaging LGBTQ+ populations in their catchment area, offering educational opportunities and support resources. All Personal Responsibility Education Programs and Comprehensive Adolescent Pregnancy Prevention programs must consider the needs of LGBTQ youth and identify how their programs will be inclusive of and non-stigmatizing toward such participants as part of the application process. In addition to this standard, some programs identify LGBTQ+ youth as a priority population. For example, the Hetrick-Martin Institute is dedicated to serving LGBTQ+ youth.

Their Comprehensive Adolescent Pregnancy Prevention program ensures that LGBTQ+ youth can learn about sexual health in a safe and inclusive environment and have access to LGBTQ+ supports and services through the organization's wrap-around service model. The AIDS Community Resources Comprehensive Adolescent Pregnancy Prevention program regularly provides workshops to youth and partners on LGBTQ+ health topics. They delivered a webinar, "Affirming Puberty Conversations for Transgender and Gender Diverse Youth" at the Center for Sex Education's 2022 National Sex Ed Conference.

Adolescent health program providers partner with community youth-serving organizations to share resources and collaborate on community outreach efforts. For example, the State University of New York (SUNY) Downstate Personal Responsibility Education Program is part of the Brooklyn Association of Teen Educators (BATES) Network, a collaboration of 18 community partners, which has conducted an annual conference for 29 years. In addition, in the development of the Comprehensive Adolescent Pregnancy Prevention program and Personal Responsibility Education Program applications, the respondents were asked to identify community resources and which stakeholders were involved.

AH-1.10: Promote adolescents' social-emotional wellness and positive developmental assets through established Title V programs.

All adolescent health programs incorporate a positive youth development framework, a holistic approach to adolescent health – social-emotional wellness, youth development, engaging parents and community providers, and providing resources to youth for their health care needs within their communities.

Title V staff continue to stress the importance of social-emotional wellness and positive youth development during regular contact with adolescent-serving providers, this includes the 2022 Bureau of Women, Infants and Adolescent Health provider meeting described above which offered several workshops on trauma-informed care, adolescent well-being, and centering youth voices.

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 2021-22 reporting period:

AH-2.1: Ensure adolescent providers have a mechanism in place to provide adolescent-related health care service referrals to other providers of health care services, including substance abuse (e.g., alcohol, tobacco cessation), mental health issues, and intimate partner violence.

Adolescent health providers are required to have a mechanism in place to refer youth for services when needs are identified. Adolescent health programs have Memoranda of Understanding in place for youth referrals to partner agencies. Referrals for services are reported biannually. A total of 342 comprehensive health care services were made in 2022, of which 92 referrals were for reproductive health services. Biannual reports are reviewed by Department of Health staff, providing feedback and follow up as needed.

AH-2.2: Refer adolescent parents to family planning providers or School Based Health Center 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 of Health staff will discuss with each provider biannually their interaction and relationship with their designated Family Planning Program providers and School Based Health Centers if applicable. In addition, several Comprehensive Adolescent Pregnancy Prevention programs implement an adult role model parent/parent peer education program designed to provide parents with the information and skills they need to become the primary sexuality educators of their children. This education includes information regarding family planning services. Support pregnant and birthing adolescent parents in attending prenatal, postpartum, and well-baby appointments.

AH-2.3: Support pregnant and birthing adolescent parents in attending prenatal, postpartum, and well-baby appointments.

Where available, adolescent health programs will refer pregnant and birthing adolescents to Perinatal and Infant Community Health Collaborative programs, Home Visiting programs including Nurse Family Partnership, Healthy Families NY, and Community Health Worker Programs. Adolescent health programs are aware of the supporting programs available within their catchment area.

AH-2.4: Promote access to confidential reproductive health care services and preventive medical visits for adolescents. Family planning providers provide counseling and services related to contraception, promotion of healthy relationships, preventive medical care, and preconception/interconception health.

All Comprehensive Adolescent Pregnancy Prevention programs and Personal Responsibility Education Programs are required to provide access to family planning. Programs that are not located in an Article-28 regulated facility are required to have an on-going Memorandum of Understanding with an Article-28 regulated facility to provide these services to youth. At a minimum, Department of Health staff will discuss with each provider biannually their interaction and relationship with their designated Family Planning Program providers and School Based Health Center if applicable.

AH-2.5: Ensure adolescent-serving programs provide training on adulthood preparation subjects, such as healthy relationships, effective communication, career and education opportunities, health care transition, and financial literacy for adolescents with and without special health care needs to prepare them for a transition into adulthood.

All Personal Responsibility Education Programs and several 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. ACT for Youth Center for Community Action provides training, webinars, and workgroups to programs in support of delivering adult preparation subjects. In addition to delivery of evidence-based program course curriculum, adolescent health program providers offer workshops and other events that address adult preparation topics. During this reporting period, programs have moved to more in-person delivery of programming, but some continue to offer education virtually through websites and online meeting platforms (e.g., Zoom).

Some Personal Responsibility Education Program providers delivered individually designed summer programs, separate from evidence-based practice courses. Specifically, programs included job training, a conference on bias and working with people from diverse backgrounds, and education on civic participation and community advocacy.

Transitioning to adulthood resources available from Got Transition® were identified through collaboration with Title V CYSCHN staff. Got Transition® is a federally funded national resource center on health care transition from pediatric to adult health care providers.

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

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

The combination of public survey data gleaned from sources such as the National Survey of Children's Health and the Youth Risk Behavior Surveillance System with data from the AHSNI, 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 2021-22 year:

AH-3.1: Collaborate with the U.S. Census Bureau and the Health Resources and Services Administration to conduct an over-sample of NYS 2021 National Survey of Children's Health for NYS to allow for enhanced sampling of Black/African-American, Hispanic, and Children and Youth with Special Health Care Needs populations.

Department of Health staff collaborated with Children and Youth with Special Health Care Needs to discuss this oversampling initiative. Implementation of this project is scheduled to begin in the Spring of 2022. The survey has been completed but data are not anticipated to be ready and available for review until the second half of 2024.

AH-3.2: Division staff will continue to use publicly available and internal surveillance data to identify adolescent needs and/or health behavior trends to support optimum adolescent health and development and determine funding areas for NYSDOH adolescent health procurements.

The Adolescent Sexual Health Needs Index (ASHNI) was updated in September 2021. The ASHNI is an indicator, calculated at the ZIP code level, to provide a single, multidimensional measure related to adolescent pregnancy and Sexually Transmitted Infections (STIs). ASHNI takes into consideration of key factors related to these outcomes, including size of the adolescent population, actual number of adolescent pregnancies and number of adolescents diagnosed with an STI, and specific of demographic and community factors (education, economic, race/ethnicity) associated with sexual health outcomes. ASHNI supports the State's ability to prioritize public health resources to areas with the poorest health outcomes and with the least access to services with the goal of reducing disparities. The ASHNI was used for development of the new Comprehensive Adolescent Pregnancy Prevention program and Personal Responsibility Education Program procurements in 2022. Introductory information about the new ASHNI was shared with broader Title V staff and with ACT for Youth Center for Community Action to explore additional ways the ASHNI can be used throughout Title V programs.

AH-3.3: Through ACT for Youth Center for Community Action trainings, webinars, and web posts, provide information and education to youth-serving organizations.

ACT for Youth Center for Community Action provided training and informational opportunities to adolescent health program providers throughout this period. In addition to training on evidence-based programs (EBPs), webinars addressed positive youth development, trauma and trauma-Informed approaches, STI education and prevention, youth mental health, diversity and cultural differences, provider collaboration forums, civic engagement, social media, healthy relationships, and a variety of trainings on working virtually. ACT for Youth Center for Community Action hosted webinars on positive youth development and trauma-informed care, including: Puberty!; Mindfulness-Based Programs for Stress and Health; Using a Trauma-Informed Approach, Positive Youth Development.

ACT for Youth Center for Community Action offers monthly webinars focusing on a myriad of adolescent health-related topics. Through their website, ACT for Youth Center for Community Action maintains an on-going blog/discussion group that addresses additional focus areas regarding today's youth. The ACT for Youth Center for Community Action website includes resources such as: Adolescent Development Toolkit: Youth Mental Health: Understanding Positive Youth Development; Adolescent Health and Development.

AH-3.4: Explore collaborative opportunities with Division of Chronic Disease Prevention's Bureau of Chronic Disease Evaluation and Research to review and share information gathered through the Youth Risk Behavior Surveillance System.

Title V data staff attended Bureau of Chronic Disease Evaluation and Research surveillance meetings to discuss 2019 Youth Risk Behavior Surveillance System data, and staff will continue to attend future meetings.

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

Maternal and Child Health outcomes are impacted by the social determinants of health, or the conditions in which people are born, live, work, play, learn, and age. The social determinants of health include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of power and resources due to racism and other biases are root causes of inequities in access, availability of services, and quality of care. All ten priorities that emerged from community members' input during the Needs Assessment revolve around the social determinants of health and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities. Adolescents who participated in the listening sessions and focus groups were aware of how things such as quality housing, safe communities, employment, and community services affect their health and well-being and that of their families and were aware of the inequities in the access and quality for their communities. They discussed seeing their parents struggle and wanting change for their parents and for themselves as they near adulthood. Strategies focus on involving stakeholders who represent the populations impacted by health inequities, particularly engaging and collaborating with youth, to inform program planning and implementation and policy development.

The Title V Program established the following specific program and policy activities to advance this strategy over the 2021-22 year:

AH-4.1: Collaborate with other state agencies and youth-serving organizations on adolescent-centered priorities through the Youth Development Team. The Youth Development Teams includes representation from NYSDOH, NYS Office of Children and Family Services, the NYS Council on Children and Families, and the NYS Developmental Disabilities Planning Council in coordination with youth-led organizations.

Reestablishing the Youth Development Team has been delayed due to the ongoing COVID-19 pandemic.

AH-4.2: Ensure that NYSDOH health equity teams review materials before being widely disseminated to youth and youth-serving organizations

Currently the Division of Family Health's cross-division Racial Justice and Health Equity Team reviews Request for Applications through a Health Equity lens. As a result, both the Comprehensive Adolescent Pregnancy Prevention program and Personal Responsibility Education Program Request for Applications included language that indicated NYSDOH's dedication to improving health outcomes and advancing health equity, directly asking applicants to focus on the health and racial disparities among youth in their communities, placing an emphasis on the inequities of historically marginalized populations, such as Black, Indigenous, and People of Color and LGBTQ+ populations) and how they plan to address through our programming. In addition, applicants were asked to account for the disproportionate numbers of youth affected

by issues of systemic racism within their communities (i.e., lack of transportation, inadequate healthcare, and food deserts) and ways to collaborate with partner agencies to meet the needs of the impacted youth. The Request for Application for Comprehensive Adolescent Pregnancy Prevention program was issued on September 30, 2022, and the Personal Responsibility Education Program Request for Application was released in early 2023.

AH-4.3: Collaborate with youth through focus groups and community forums for direct input with state initiatives and special projects.

NYSDOH is exploring the formation of a Youth Advisory Council to provide youth from across NYS an opportunity to weigh in on NYSDOH policies and programs, including an adolescent mental health campaign for the new pediatric mental health grant, with plans for an ongoing partnership to advise Division of Family Health on other Adolescent Health topics.

NYSDOH will ensure that the council will be geographically and demographically diverse to ensure that youth from communities impacted by health inequities are represented. The goal is to improve equity by ensuring that youth have a voice in regard to sexual and reproductive health issues.

NYSDOH is developing a multimedia Mental Health Campaign to promote the availability of School Based Health Center mental health services for underserved youth while addressing the stigma associated with needing and accessing care. Materials developed will be culturally sensitive and available in English and Spanish to ensure the messaging reaches important high-need populations.

AH-4.4: Involve stakeholders, who represent the populations most impacted by racism and health inequities, in programmatic decisions.

The upcoming procurement for the Comprehensive Adolescent Pregnancy Prevention program will incorporate youth stakeholder input to identify program opportunities for social-emotional wellness. The Comprehensive Adolescent Pregnancy Prevention program providers increase the percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, (including racial and social injustice) in program planning and implementation Increase the percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, (including racial and social injustice) in program planning and implementation.

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.

In collaboration with our Perinatal Regionalization Unit the Adolescent Health Unit participated in the development of adolescent health pamphlets on pelvic exam and heavy menstrual bleeding. These health promotion initiatives will educate female adolescents on the importance of self-monitoring as it relates to vaginal health and checkups with a health care provider.

The Jewish Organization of Women's Medical Association (JOWMA) created and designed a pamphlet on puberty for adolescent females of all races to inform this young and growing population on things to look for, who to talk to, and what to do during this stage of life. The Department of Health supports this organizations initiative by providing printing and translation services for pamphlet distribution.

All members of the Division of Family Health's cross-division Racial Justice and Health Equity Team were assigned to COVID-19 activities during 2020 and 2021. During that time many of the members were conducting health equity activities as it relates to COVID-19. They were in involved in the contact tracing community support response, vaccine equity task force, training of the contact tracing workforce on equity and diversity, New York State Birth Equity improvement project and the Together We Can Inclusion project. During this time the Health Equity Team reviewed the Perinatal and Infant Community Health Collaboratives, and Dental Fluoridation Request for Applications to ensure a health equity lens was

incorporated during development. In the beginning of this reporting period in October 2021, the Division's Racial Justice and Health Equity Team reconvened, collectively to resume efforts within the Division and is currently re-establishing itself after staff transitioned out of the Division and NYSDOH and will be recruiting new members. With so many new staff, the Team's first focus was training to ensure staff understand health equity, health disparities and social determinants of health. Early in 2022 several Health Equity Team members left the Division; new members joined the Team later in the reporting period. Title V staff are currently seeking to work with the NYSDOH AIDS Institute Health Equity Coordinator to collaborate efforts and learn from one another.

It is important to note, the NYS Title V Program established two Evidence-Based Strategy Measures (ESMs) to track the programmatic investments and inputs designed to impact NPM 10.

ESM AH-1: Percent of youth-serving programs that provide training on adult preparation subjects, such as healthy relationships, effective communication, financial literacy, and adult health care for adolescents with and without special health care needs to prepare them for a transition into adulthood.

Data for this measure will be obtained from biannual reports and annual data requests submitted by local adolescent health providers. The baseline value for this measure, taken from a six-month program period of 7/1/2020 – 12/31/2020, is 96.3%. The program has set an improvement target of 75% by 2025. For the period of 1/1/2021 – 12/31/2021, the value of this measure was 100% (with data for 2 of 54 programs missing).

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

Data for this measure will be obtained from biannual reports and annual data requests submitted by adolescent health providers. The baseline value for this measure, taken from a six-month program period of 7/1/2020 – 12/31/2020, is 68.7%. The program has set an improvement target of 75% by 2025. For the period of 1/1/2021 – 12/31/2021, the value of this measure was 78.1% (with data for 2 of 66 programs missing).

Adolescent Health - Application Year

For Adolescent Health, New York's Title V Program selected **the National Performance Measure (NPM) 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.** This NPM was selected because it aligns with both population health data indicators and concerns voiced directly by adolescents in NYS. Most adolescents ages 12-17 had a preventive medical (86.3%) and preventive dental (89.1%) visits in 2019, but there is room for improvement and disparities persist – only 86.0% of Hispanic adolescents had a preventive medical visit compared to 89.3% of non-Hispanic White adolescents and only 78.2% of adolescents on Medicaid had their annual visit compared to 91.5% with private insurance. Adolescents across the state discussed that their medical providers lack compassion and respect for their young patients and that youth would prefer visiting providers who are more affirming and reflective of the youth themselves. As the NPM's are self-reported the actual data measures may be lower than indicated.

As detailed above in the annual report, preventive medical visits are one part of overall wellness, but data and community input point to other areas that could help adolescents thrive, such as building healthy relationships, social-emotional wellbeing, and preparation for taking on the responsibilities of adulthood. There are dramatic disparities based on sexual identity as well. The importance of social support and the need for more people to talk to positive mentors were frequently mentioned by adolescents. Adolescents voiced a desire for education about financial literacy, healthy cooking, navigating relationships, and other aspects of adulthood. https://www.cdc.gov/healthyyouth/data/yrbs/index.htm

As mentioned in the annual report, adolescence is often a very challenging stage in a person's life. The multifaceted nature of adolescent development and wellness means the selected NPM and its associated strategies are responsive to most of the priority areas, particularly health care, social support and cohesion, community services and amenities, and awareness of resources. This NPM also aligns directly with established priorities encompassed in the NYS Prevention Agenda goals.

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

Objective AH-1: Increase the percentage of adolescents, ages 12-17, with a preventive medical visit in the past year by 5%, from 81.3% in 2016-2017 to 85.4% in 2022-2023 (National Survey of Children's Health).

Objective AH-2: Increase the percentage of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling by 5%, from 53.5% in 2017-2018 to 56.2% in 2022-2023 (National Survey of Children's Health).

Objective AH-3: Increase the percentage of adolescents, ages 13 through 17, who have received at least one dose of the Human Papilloma Virus (HPV) vaccine by 8%, from 67.3% in 2018 to 72.7% in 2023 (NIS).

Objective AH-4: Increase the percentage of NYS adolescents without special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 16.4% in 2017-2018 to 17.2% in 2022-2023 (National Survey of Children's Health).

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

Strategy AH-1: Incorporate specific activities to promote the wellness of adolescents across all Title V programs, including promoting and facilitating routine well visits, reproductive health care, oral health, and behavioral health.

The lifestyle choices, behaviors, and relationships established during adolescence can affect their current and future health. Routine well visits during adolescence are recommended by the American Academy of Pediatrics' Bright Futures™ as one way to foster health in the present and build a foundation for wellness into the future. Well visits are an opportunity to

promote healthy behaviors, discuss risky behaviors, provide important vaccinations, and address conditions that can interfere with healthy development. Comprehensive and inclusive reproductive health care and education are opportunities to help adolescents avoid or mitigate risky sexual behaviors. Title V funded programs also provide enabling services to adolescents, such as referrals to and linkages with community services and social supports to holistically address health and wellness, including mental health and social determinants of health.

The key programs that work to support adolescent wellness and help connect adolescents to needed services include Comprehensive Adolescent Pregnancy Prevention program, Sexual Risk Avoidance Education program, Personal Responsibility Education Program, Children and Youth with Special Health Care Needs programs, School Based Health Centers, Family Planning Program, and Sexual Violence Prevention program.

A new Comprehensive Adolescent Pregnancy Prevention program procurement was issued September 2022. Forty-one awards were made for a new five- year period, which begins 7/1/2023. A new Personal Responsibility Education Program procurement was issued January 2023, and as of March 2023 submitted Personal Responsibility Education Program applications are under review. It is anticipated that approximately between seven to ten awards will be made for a new five-year period, beginning on 10/1/2023. A new Sexual Risk Avoidance Education program procurement is being developed for contracts to begin 7/1/2024. The Sexual Risk Avoidance Education program procurement will be issued in 2023.

The NYS Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2023-2024 year:

- **Activity AH-1.1**: Through the Comprehensive Adolescent Pregnancy Prevention program, provide information to adolescents and parents on the offering and arranging of adolescent sexual health reproductive services. The federally funded Personal Responsibility and Education Program also provides this information, in partnership with the Title V program.
- **Activity AH-1.2**: Through the Sexual Risk Avoidance Education program, provide medically accurate and complete sexuality health education services to youth.
- **Activity AH-1.3**: Through the Comprehensive Adolescent Pregnancy Prevention program, Personal Responsibility Education Program, and Sexual Risk Avoidance Education program, increase access to health care services for adolescents through a referral process that includes confirmation as permitted while ensuring confidentiality.
- **Activity AH-1.4**: NYSDOH staff, including Title V funded staff, and community youth-serving organizations provide trauma-informed education and training on social emotional wellness and positive youth development for children and adolescents.
- **Activity AH-1.5**: Within the Title V program, enhance collaboration between adolescent serving programs, including the Comprehensive Adolescent Pregnancy Prevention program, Sexual Risk Avoidance Education program, School Based Health Center, Sexual Violence Prevention program, and Children and Youth with Special Health Care Needs programs, to promote holistic adolescent health through provision of comprehensive physical exams and anticipatory guidance, including body mass index (BMI), behavioral health, oral health, and reproductive health, for adolescents with and without special health care needs.
- **Activity AH-1.6**: Collaborate with internal partners, including NYSDOH AIDS Institute and Bureau of Immunization, and external partners, such as the NYS Humans Papilloma Virus (HPV) Coalition, to promote HPV vaccination with clinical providers.
- **Activity AH 1.7**: Refer adolescents and their parents to family planning providers for contraception and birth planning, including School Based Health Centers, where available.
- **Activity AH-1.8**: Promote access to confidential reproductive health care services and preventive medical visits for adolescents, including through School Based Health Centers, where available. Family planning providers deliver counseling and services related to contraception, promotion of healthy relationships, preventive medical care, and preconception/inter-conception health.
- **Activity AH-1.9**: Promote healthy relationships and sexual violence prevention using policy change, protective environment strengthening, healthy social norms reinforcement, and skill-building to address individual, relationship,

community, and societal risk and protective factors. Focus on groups experiencing disproportionate burden of sexual violence, including communities of color, adolescents and young adults, domestic violence victims, those experiencing low income, people affected by alcohol and drug abuse, and LGBTQ+ persons. Staff supporting the Adolescent Health domain will work with staff in the Sexual Violence Prevention unit to ensure that providers are implementing effective and informative programming regarding healthy and safe relationships.

- **Activity AH-1.10**: Promote adolescents' social-emotional wellness and positive developmental assets through established Title V programs.

Strategy AH-2: Promote supports for adolescents to gain the knowledge, self-efficacy, and resources they need to prepare for and transition to adulthood.

For young adults, with or without special health care needs, the transition to adulthood is a crucial time in their development. Young adults may move away from their parents, transition to adult health care, become increasingly sexually active, continue their education, and/or start a career. Navigating these transitions can be difficult for youth as their independence continues to grow. Often, an increased sense of independence can lead to an increase of unhealthy risky behaviors. Title V programs will provide youth with support to help prepare for and navigate this transition.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2023-2024 year:

- **Activity AH-2.1**: Ensure adolescent providers have a mechanism in place to provide adolescent-related health care service referrals to other providers of health care services, including substance abuse (e.g., alcohol, tobacco cessation), mental health issues, sexual violence, and intimate partner violence.
- **Activity AH-2.2**: Refer adolescent parents to family planning providers or School Based Health Centers for contraception and birth planning.
- **Activity AH-2.3**: Support pregnant and birthing adolescent parents in attending prenatal, postpartum, and well-baby appointments.
- **Activity AH-2.4**: Promote access to confidential reproductive health care services and preventive medical visits for adolescents. Family planning providers provide counseling and services related to contraception, promotion of healthy relationships, preventive medical care, and preconception/inter-conception health.
- **Activity AH-2.5**: Ensure adolescent-serving programs provide training on Adulthood Preparation Subjects, such as, healthy relationships, effective communication, career and education opportunities, health care transition, and financial literacy for adolescents with and without special health care needs to prepare them for a transition into adulthood. All Personal Responsibility Education Program programming includes Adult Preparation Subjects. Some current Comprehensive Adolescent Pregnancy Prevention programs include an optional component incorporating Adult Preparation Subject training; the Comprehensive Adolescent Pregnancy Prevention program procurement issued in September 2022 requires Adulthood Preparation Subjects training be done by all contractors. All 41 Comprehensive Adolescent Pregnancy Prevention program contractors awarded under this procurement include Adulthood Preparation Subject training for these programs that start 7/1/2023.
- **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: Apply public health surveillance and data analysis findings to improve services and systems related to children's health and health care.

Data-driven, evidence-based practice is essential to achieving public health goals for NYSDOH and the NYS Title V program. Across all Title V funded programs, continuous effort is needed to enhance the collection, analysis, and sharing of data to inform the planning and implementation of programs and policies. Sharing data with stakeholders, including

providers and community members, is critical to raise awareness, empower community action, and facilitate quality improvement efforts at all levels.

The combination of public survey data gleaned from sources like National Survey of Children's Health and the Youth Risk Behavior Surveillance System with data from NYS's Adolescent Sexual Health Needs Index (ASHNI), Vital Statistics and other data systems provide information to identify areas throughout the state with the most pressing health needs for youth.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2023-2024 year:

- **Activity AH-3.1**: Collaborate with the US Census Bureau and the Health Resources and Services Administration to conduct an over-sample of NYS National Survey of Children's Health, for NYS to allow for enhanced sampling of Black/African-American, Hispanic, and Children and Youth with Special Health Care Needs populations during the 2022 data collection period. This survey has been completed and work is underway to make data available in 2024.
- **Activity AH-3.2**: Title V staff will continue to use publicly available and internal surveillance data to identify adolescent needs and/or health behavior trends to support optimum adolescent health and development and determine funding areas for NYSDOH adolescent health procurements.
- **Activity AH-3.3**: Through ACT for Youth Center for Community Action trainings, webinars, and web posts, provide information and education to youth-serving organizations.
- **Activity AH-3.4**: Explore collaborative opportunities with the NYSDOH Division of Chronic Disease Prevention's Bureau of Chronic Disease Evaluation and Research, which works with the NYS Education Department, to review and share information gathered through the Youth Risk Behavior Surveillance System.

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

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

These factors and inequities impact the health outcomes of both individuals and entire communities. Adolescents who participated in the listening sessions and focus groups were aware of how things like quality housing, safe communities, employment, and community services affect their health and well-being and that of their families and were aware of the inequities in the access and quality for their communities. They discussed seeing their parents struggle and wanting change for their parents and for themselves as they near adulthood. Strategies focus on involving stakeholders who represent populations impacted by health inequities, particularly engaging and collaborating with youth, to inform program planning and implementation and policy development.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2023-2024 year:

- **Activity AH-4.1**: Collaborate with other state agencies, within the Department of Health, and with youth-serving organizations on adolescent-centered priorities through the Youth Development Team. The Youth Development team includes representation from NYSDOH, NYS Office of Children and Family Services, the NYS Council on Children and Families, and the NYS Developmental Disabilities Planning Council in coordination with youth-led organizations.
- **Activity AH-4.2**: Ensure that NYSDOH health equity teams review materials before being widely disseminated to youth and youth-serving organizations.
- **Activity AH-4.3**: Collaborate with youth through focus groups and community forums for direct input with state

initiatives and special projects.

- **Activity AH-4.4**: Involve stakeholders that are representative of the populations most impacted by racism and health inequities in programmatic decisions.
- **Activity AH-4.5**: Through NYSDOH adolescent providers, issue information on locally available resources and provide referrals specific to addressing the social determinants of health with adolescents from populations impacted by disparities.

The NYS Title V Program established two Evidence-Based Strategy Measures (ESMs) to track the programmatic investments and inputs designed to impact NPM 10:

ESM AH-1: Percent of youth-serving programs that provide training on adult preparation subjects, such as accessing health insurance, maintaining their routine preventive medical visits, healthy relationships, effective communication, financial literacy, and adult health care for adolescents with and without special health care needs to prepare them for a transition into adulthood.

Data for this measure will come from annual surveys of adolescent health providers. The baseline value for this measure, taken from a six-month program period of 7/1/2021 – 12/31/22, is 100%. The program has set an improvement target of 100% by 2025. For the most recent reporting period, the value is 100% (1/1/21 – 12/31/22, note: one of 53 programs had missing data).

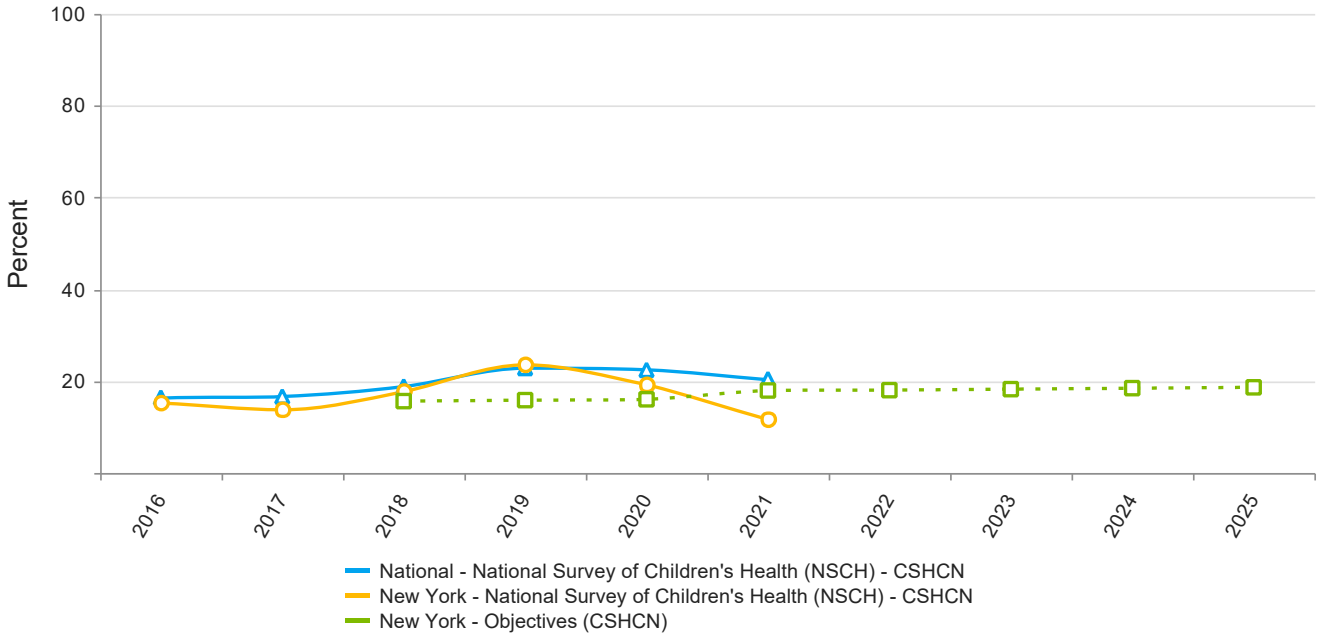
ESM AH-2: Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation.

Data for this measure will come from annual surveys of adolescent health providers. The baseline value for this measure, taken from a six-month program period of 7/1/2020 – 12/31/20, is 68.7%. The program has set an improvement target of 75% by 2025. For the current most recent reporting period, the value is 79.4% (1/1/22 – 12/31/22, note: three of 65 programs have missing data).

Children with Special Health Care Needs

National Performance Measures

NPM 12 - 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
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	15.7	15.9	16.1	18.1	18.1
Annual Indicator	13.7	17.8	23.6	11.8	11.8
Numerator	34,736	48,580	87,040	40,243	40,243
Denominator	253,092	273,067	369,539	340,705	340,705
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2020_2021	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	18.3	18.5	18.7

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.

Measure Status:			Active	
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			40.3	41.1
Annual Indicator	40.3	62.4	66.1	74.8
Numerator		295	323	450
Denominator		473	489	602
Data Source	Contractor Reports	Contractor Reports	Contractor Reports	Contractor Reports
Data Source Year	2018-2019	2019-2020	2020-2021	2021-2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	41.5	41.9	42.3

State Performance Measures

SPM 2 - Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			3.6	12.1
Annual Indicator		3.6	12.1	10.4
Numerator		1,772	6,063	4,443
Denominator		498,946	502,219	428,592
Data Source		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
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	12.0	11.9	11.8

State Action Plan Table

State Action Plan Table (New York) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Enhance supports for parents and families, especially those with children with special health care needs, and inclusive of all family members and caregivers	
NPM	
NPM 12 - 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	
Objectives	
Objective CYSCHN-1: Increase the percent of NYS adolescents with special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 17.8% in 2017-2018 to 18.7% in 2021-2022 (NSCH)	
Objective CYSCHN-2: Increase the percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system by 5%, from 15.2% in 2017-2018 to 16% in 2021-2022 (NSCH)	
Strategies	
Strategy CYSHCN-1: Engage youth with special health care needs (YSHCN) and their families in state and local efforts to improve systems and practices for supporting YSHCN. Please see Supporting Document 3 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.	
Strategy CYSHCN-2: Enhance care coordination, including transition support services, for children and youth with special health care needs. Please see Supporting Document 3 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.	
Strategy CYSHCN-3: Apply public health surveillance and data analysis findings to improve services and systems related to health and health care for children and youth with special health care needs. Please see Supporting Document 3 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.	
Strategy CYSHCN-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact the health and well- being of children and youth with special health care needs. Please see Supporting Document 3 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.	
ESMs	**Status**
ESM 12.1 - Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (New York) - Children with Special Health Care Needs - Entry 2

Priority Need

Promote awareness and enhance availability, accessibility and coordination of services for families and youth, including CYSHCN, with a focus on areas impacted by systemic barriers, including racism

NPM

NPM 12 - 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

Objectives

Objective CYSCHN-1: Increase the percent of NYS adolescents with special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 17.8% in 2017-2018 to 18.7% in 2021-2022 (NSCH)

Objective CYSCHN-2: Increase the percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system by 5%, from 15.2% in 2017-2018 to 16% in 2021-2022 (NSCH)

Strategies

Strategy CYSHCN-1: Engage youth with special health care needs (YSHCN) and their families in state and local efforts to improve systems and practices for supporting YSHCN. Please see Supporting Document 3 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Strategy CYSHCN-2: Enhance care coordination, including transition support services, for children and youth with special health care needs. Please see Supporting Document 3 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

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

Strategy CYSHCN-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact the health and well- being of children and youth with special health care needs. Please see Supporting Document 3 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

ESMs	Status
ESM 12.1 - Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (New York) - Children with Special Health Care Needs - Entry 3

Priority Need

Increase the availability and quality of affordable housing.

SPM

SPM 2 - Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months

Objectives

Objective CYSHCN-3: Reduce the incidence of confirmed high blood lead levels at 5 micrograms per deciliter or greater per 1,000 tested children aged less than 72 months, with baseline incidence and benchmarks established in 2020-21 program year. The current incidence of confirmed blood lead levels at 10 micrograms per deciliter or greater is 3.7 per 1,000 children tested in 2016. (NYS Child Health Lead Poisoning Prevention Program Data)

Strategies

Strategy CSHCN-5: Support comprehensive public health efforts to prevent, identify, and manage childhood lead poisoning. Please see Supporting Document 3 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Children with Special Health Care Needs - Annual Report

For Children and Youth with Special Health Care Needs, New York (NY)'s Title V Program selected **NPM 12: Percent of adolescents with special health care needs, ages 12-17, who received services necessary to make transitions to adult health care.** This NPM was selected because it was voiced as a key priority by youth with special health care needs and their families, reinforced by state-specific population health data. Families reported that only 15% of Children and Youth with Special Health Care Needs receive care in a well-functioning system, and less than 18% of youth ages 12-17 with special health care needs received services necessary to make transitions to adult health care. This is consistent with findings from NY's Care Mapping process conducted in 2017-2018, and with findings from the community listening forums conducted for this application. This NPM also aligns directly with NYS Prevention Agenda goals and interventions related to support for Children and Youth with Special Health Care Needs.

In addition, NY's Title V Program established one SPM for this domain, **SPM 2: Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months**. This SPM was developed to reflect the state's longstanding commitment to eliminating childhood lead poisoning as a key public health problem in NYS. It is responsive to cross-cutting priorities voiced by families related to safe and healthy environments to support children's development, and access to comprehensive, high quality health care services. It is also responsive to specific concerns shared by families regarding challenges in accessing and coordinating medical care and related services for 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 CYSHCN-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 CYSHCN-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 CYSHCN-3: Reduce the incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months by at least 5%, from 3.55 per 1,000 children tested in 2018 to below 2.89 in 1,000 children tested in 2022 (NYS Child Health Lead Poisoning Prevention Program Data).

Strategy CYSHCN-1: Engage youth with special health care needs (YSHCN) and their families in state and local efforts to improve systems and practices for supporting Children and Youth with Special Health Care Needs.

Families and youth need to be directly involved in program and policy planning and implementation in meaningful roles at all levels. This is consistent with the Title V program's longstanding commitments to family-centered care/family-professional partnerships and positive youth development. This is a theme woven into all Children and Youth with Special Health Care Needs-serving Title V programs.

For example, the Title V Program contracts with three federally designated University Centers for Excellence in Developmental Disabilities (UCEDDs), or Regional Support Centers, to provide training and technical assistance to Local Health Department Children and Youth with Special Health Care Needs programs and to conduct family engagement. The Regional Support Centers are required to employ a family/parent liaison that is a parent with a Child with Special Health Care Needs, a critical component of the Regional Support Centers' work with families with Children and Youth with Special Health Care Needs 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 Children and Youth with Special Health Care Needs and they use this feedback to inform educational materials and trainings for Local Health Departments.

In addition, the 2020-2025 Local Health Department Children and Youth with Special Health Care Needs program contract period includes deliverables to address family and community engagement at many levels. The Local Health Department staff involved families of Children and Youth with Special Health Care Needs in work groups, committees, task forces, and/or advisory committees to improve the system of care for Children and Youth with Special Health Care Needs, involve families and Children and Youth with Special Health Care Needs in local planning activities, such as the Community Health Assessment, and use feedback from families of Children and Youth with Special Health Care Needs to develop training for Children and Youth with Special Health Care Needs staff and providers.

Finally, the state's sickle cell disease contractors at three Hemoglobinopathy Specialty Care Centers work directly and exclusively with youth with Sickle Cell Disease and their families to provide support services. This includes 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 provider, ensure compliance with appointments and medication, self-management, and preventive health care including non-medical mechanism 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 2021-22 reporting period:

CYSHCN-1.1: Maintain at least one dedicated family representative on the state's Title V Maternal and Child Health Services Block Grant Advisory Council and engaged all Council members in updates and discussions related to Children and Youth with Special Health Care Needs program activities.

There is one parent representative from Parent to Parent on the Title V Maternal and Child Health Services Block Grant Advisory Council. Children and Youth with Special Health Care Needs Program engage council members in updates and discussion related to program activities. On April 7th the Children and Youth with Special Health Care Needs Program shared the Health Information Document with NYS Parent to Parent. On June 9th, the three Coordinating Care and Supporting Transition for Children, Adolescents and Young Adults with Sickle Cell Disease contractors presented to the Title V Maternal Child Health Services Block Grant Advisory Council. On October 12, 2021, Children and Youth with Special Health Care Needs staff presented to the NYS Maternal and Child Health Services Block Grant Advisory Council about the overview of our Children and Youth with Special Health Care Needs data for years 2018-2019 findings.

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.

Title V Program leadership, Kirsten Siegenthaler, Title V Director, and Suzanne Swan, Children and Youth with Special Health Care Needs Director, participate quarterly in the Council on Children and Families Commissioners' Cross-Systems Work Group. The Cross-Systems Work Group reviews care coordination for and placement of youth with developmental disabilities. The group focuses on managing extreme cases of long hospital stays, youth placement in care settings outside the home, and increasing efficiencies in the process where possible. In 2022, parents and caregivers who have navigated the process will be added to these meetings on a quarterly basis.

Children and Youth with Special Health Care Needs staff attended the 2021 NY State Birth to Five (NYSB5) Virtual

Conference held October 15, 2021. They had over 115 individual attendees, 6 presentations and a kick-off with keynote speaker, Richard Gonzales is the federal project officer who is responsible for the Preschool Development Grant Birth through Five (PDGB5) projects nationwide.

Information about free webinar on “Question and Answers Discussion Group for parents of children and adults with Fetal Alcohol Syndrome Disorder” presented by NYS Parent to Parent on January 21. 2022 and March 28, 2022, was shared with Local Health Department Children and Youth with Special Health Care Needs staff.

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.

The family specialists for the Regional Support Centers continued to work in 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 Children and Youth with Special Health Care Needs staff.

The family specialists collaborated to develop resources for Children and Youth with Special Health Care Needs families such as: a Health Conditions guide which outlines the 27 most common special health care needs conditions (according to the National Survey for Children’s Health) intended to provide technical assistance and resources for local health departments to serve families of Children and Youth with Special Health Care Needs.

In addition, the Regional Support Centers staff developed a social media flyer for the Local Health Department staff to adapt and share in their county. Family specialists also supported the Regional Support Centers in the development of a Children and Youth with Special Health Care Needs Resource Directory that will be made available online to provide families, Local Health Departments, and health care providers with current information about state-wide services and supports. Resource Directories are available on each of the three Regional Support Centers’ websites and are continually updated to ensure they are a reliable source of information.

CYSHCH-1.4: Support Regional Support Centers to develop a Children and Youth with Special Health Care Needs Resource Directory that will provide families and health care providers with current information about services and supports.

Title V staff supports the Regional Support Centers staff in the development and accessibility of the Resource Directory to the public. NYSDOH Title V staff met with the Council of Children and Families staff to discuss opportunities for collaboration. We are developing a Memorandum of Understanding with the NYS Council on Children and Families to add the Children and Youth with Special Health Care Needs directory to their Multiple System Navigator. Title V staff 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. Regional Support Centers staff used feedback from families of Children and Youth with Special Health Care Needs to develop training for Children and Youth with Special Health Care Needs staff and providers.

NYS Children and Youth with Special Health Care Needs Program keeps track of Local Health Departments’ quarterly reports involving Children and Youth with Special Health Care Needs and their families in work groups, committees, task forces or advisory committees and other Local Health Department assessment and planning activities. Some of these activities have been delayed at Local Health Departments due to their role in COVID-19 response.

Title V staff provided regular and as-needed technical assistance to Local Health Departments throughout the reporting period.

- On May 12, 2022, a Back-to-Basics webinar was presented to the Local Health Department, Regional Support

Centers, and NYSDOH Regional Office staff. A follow up email with the Back-to-Basics webinar slides, recording and fiscal contract documents, updated Questions and Answers was sent on June 16, 2022.

- The Regional Support Centers presented on the Family Engagement Report on June 21, 2022, focusing on the Lessons Learned from the families of Children and Youth with Special Health Care Needs.
- On September 21, 2022, Children and Youth with Special Health Care Needs staff presented on the statewide NYS Children and Youth with Special Health Care Needs data for 2019-2020.
- The Regional Support Center staff presented a webinar about monkeypox in September 2022 in response to requests from families of Children and Youth with Special Health Care Needs.

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 Children and Youth with Special Health Care Needs staff and providers.

As described above, the Title V Program contracts with the state's three UCEDDs, which are referred to as the Regional Support Centers, to provide training and technical assistance to Local Health Department Children and Youth with Special Health Care Needs programs and to conduct family engagement. The Regional Support Centers employ a family/parent liaison that is a parent with a Child with Special Health Care Needs.

During this reporting year, these meetings were all virtual, and not in-person as intended, due to the COVID-19 public health emergency. Qualitative data from family sessions was compiled and presented to families and a Family Engagement Report was made available to all Local Health Departments. Information from that Report was also used to present to Local Health Department Children and Youth with Special Health Care Needs programs on a quarterly call in 2022. Regional Support Centers also conducted Needs Assessment surveys with each county, as available, to gather feedback and determine gaps and barriers, type of technical assistance needed, and what resources are available in each community. Counties then had the option to establish work plans to help meet their community engagement goals with assistance from the Regional Support Centers.

Local Health Department Children and Youth with Special Health Care Needs program contract period includes deliverables to address family and community engagement at many levels. The Local Health Department staff involved families of Children and Youth with Special Health Care Needs in work groups, committees, task forces, and/or advisory committees to improve the system of care for Children and Youth with Special Health Care Needs, involve families and Children and Youth with Special Health Care Needs in local planning activities, such as the Community Health Assessment, and use feedback from families of Children and Youth with Special Health Care Needs to develop training for Children and Youth with Special Health Care Needs staff and providers

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.

The Children and Youth with Special Health Care Needs Director shared the Health Information Document resources with the New York State Association of County Health Officials in April 2022 and they in turned shared with the Local Health Departments. The Children and Youth with Special Health Care Needs Director shared information about the increase in funding for the Children and Youth with Special Health Care Needs program with staff from the New York State Association of County Health Officials to encourage local health departments that have not historically participated in the program to consider the opportunity for their community. The Children and Youth with Special Health Care Needs Director met with the New York State Association of County Health Officials Executive Director to provide an orientation to the state's Children and Youth with Special Health Care Needs program on June 1, 2022.

CYSHCN-1.7: Support Sickle Cell Disease programs at three Hemoglobinopathy Specialty Care Centers to provide supports by and for youth with Sickle Cell Disease, including peer support groups, system navigation supports, and self-care services.

As described above, the state's three Sickle Cell Disease contractors support youth with Sickle Cell Disease and their families. They provide peer support groups, system navigation supports, and self-care services. Hemoglobinopathy Specialty Care Centers conduct peer support groups to gauge barriers to care and transition for youth and young adults with Sickle Cell Disease. Peer support groups also provide opportunity for advocacy and linkages with other individuals and families living with Sickle Cell Disease. Transition Navigators at Hemoglobinopathy Specialty Care Centers engage youth with Sickle Cell Disease to promote and support the transition from pediatric to adult care provider, ensure compliance with appointments and medication, self- management, and preventive health care including non-medical mechanism 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 information posted on the NYS Children and Youth with Special Health Care Needs website page was reviewed by their staff: Patience White and Peggy McManus. They provided feedback in October 2021and minor changes were made based on their recommendations.

Children and Youth with Special Health Care Needs staff attended the webinar "Improving Health Care Transition through Tele-Transition Services" on October 26, 2021. The webinar highlighted a new video and social story about how to engage in tele-transition services to help you transition from a pediatric provider to an adult provider.

The Hemoglobinopathy Specialty Care Centers participated in a virtual full-day conference with the Sickle Cell Advisory Consortium of NY for professionals, clients, and families in November 2021.

On March 15th, 2022, Sickle Cell Disease contractors hosted a Sickle Cell Disease Grand Rounds for physicians, nurses, social workers, other health care professionals, and community-based organizations. Updates about bone marrow transplant, hydroxyurea use, and adherence issues were discussed.

On June 9th, 2022, the three contracted Hemoglobinopathy Specialty Care Centers presented about their work and experiences implementing the Coordinating Care and Supporting Transition for Children and Adolescent/Young Adults with Sickle Cell Disease program to Title V Maternal Child Health Services Block Grant Advisory Council meeting.

Information about the updated 2022 transition coding and new pediatric to adult transition counseling code in the ICD-10-CM Codes as well as the reimbursement tip sheet were shared with the Sickle Cell Disease contractors on 6/10/22.

On July 28th, 2022, Department of Health staff met with the staff from the three Hemoglobinopathy Specialty Care Centers to discuss the program and hear about their feedback, successes, and challenges.

A Request for Application for Adolescent Transition Services for Sickle Cell Disease was released on 10/06/2022, with anticipated start date of 10/01/2023.

The three Hemoglobinopathy Specialty Care Centers regularly share information through their quarterly reports on various Performance measures. The three Sickle Cell Disease contractors reported that there was an increased number of clients who were compliant in keeping appointments, medication adherence, self-management, and preventive health care including non-medical mechanisms for pain management. Appointment reminders, flexibility in scheduling, availability of transition navigators, home visits and tele-health visits have positively impacted compliance. In addition, virtual support groups and webinars resulted in greater attendance and an increase in interactions among participants.

During this reporting period, additional funding through special legislative appropriations was available to five Sickle Cell Disease organizations – three Hemoglobinopathy Specialty Care Centers with existing state funding and two community-based organizations (CBO). Title V staff engaged with the NYSDOH Office of Health Insurance Programs (i.e., the state's Medicaid program), on a Medicaid Redesign Team for Sickle Cell Disease outcomes, including community partners, clinicians, and experts in Sickle Cell Disease. The team generated a list of recommendations for Medicaid to reduce costs and hospitalizations for patients with Sickle Cell Disease. The most feasible and potentially impactful recommendation was care coordination for Sickle Cell Disease to be identified as a single qualifying condition for enrollment into Health Homes serving children. This will promote effective treatment that can reduce symptoms, prolong life, and improve well-being for children, youth, and young adults with Sickle Cell Disease. Based on the recommendations of the committee, the Centers for Medicare and Medicaid Services (CMS) State Plan Amendment (SPA) #21-0026, was approved and includes Sickle Cell Disease as a single qualifying condition for Health Homes Serving Adults and Health Homes Serving Children, effective March 24th, 2022. NYS Medicaid has established the Sickle Cell Disease Health Home Managed Care Organization Subcommittee with intention of following the Medicaid State Plan Amendment progress as well as to plan and troubleshoot implementation. The subcommittee's activities also include the development of informational materials, promotion of Health Homes, and identification of capacity issues. Title V staff serve on the subcommittee.

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.

On May 3, 2022, Children and Youth with Special Health Care Needs staff attended "What's Great in the State-A Celebration of Children's Mental Health" at Glens Sanders Mansion. The 2022 What's Great in Our State celebration, honored the individuals, communities, schools, and organizations across NYS that are making a difference in the field of children and youth mental wellness. Along with the awards, the event featured a keynote address Justin Michael Williams. Children and Youth with Special Health Care Needs staff promoted the Health Information Document at this event.

On May 5, 2022, the Office of the Medical Director presented at the *annual Leadership Education in Neurodevelopmental and related Disabilities* meeting, Westchester Institute of Human Development learning poster session which was hosted virtually. The purpose of the poster session was to have the *Leadership Education in Neurodevelopmental and related Disabilities* trainees meet with NYSDOH Title V program directors, staff, and other state agencies to share about their team research projects related to Children and Youth with Special Health Care Needs and their families. On July 20, 2022, the Bureau of Women, Infant and Adolescent Health 2022 hosted a conference at which all the programs overseen by the Bureau attended. The Title V Children and Youth with Special Health Care Needs staff participated in the roundtable presentation, "Beginning a Discussion: Delivering Sexual Health Education Programming to Youth with Special Needs," along with program staff from Staten Island University Hospital's Comprehensive Adolescent Pregnancy Prevention program staff. The presentation was well received. St. Lawrence County Comprehensive Adolescent Pregnancy Prevention program staff, who deliver programming to autistic youth, attended training. Staff participate monthly in the Sickle Cell Disease Health Home Managed Care Organization subcommittee meetings led by the NYSDOH Office of Health Insurance Programs to provide insight and feedback on children and young adults with Sickle Cell Disease. Serve on the NYS Developmental Disabilities Planning Council and the Individuals and Families Committee to promote inclusion of Children and Youth with Special Health Care Needs-specific focus to the NYS Developmental Disabilities Planning Council's agenda and policy portfolio. The NYS Developmental Disabilities Planning Council membership includes parents of Children and Youth with Special Health Care Needs 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 NYSDOH 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 Children's Health Home program, which provides comprehensive care

management services. Title V program includes leadership and youth from the state's three Sickle Cell Disease contractors in this work.

In this reporting period, Title V staff presented to NYS Sickle Cell Advisory Committee on NYSDOH Sickle Cell Disease program, the NYSDOH's Office of Health Insurance'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 the Medicaid Health Home Serving Children in October 2021.

CYSHCN-1.10: 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.

The Title V Children and Youth with Special Health Care Needs Director presents the Children and Youth with Special Health Care Needs program ongoing at the quarterly NYS Developmental Disabilities Planning Council and its Individuals and Families Committee meeting to promote the inclusion of Children and Youth with Special Health Care Needs specific focus for the Council's agenda and policy portfolio.

Strategy CYSHCN-2: Enhance care coordination, including transition support services, for children and youth with special health care needs.

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 2019-2020 National Survey of Children's Health data for NYS show that about 71.7% of all children, and 52.5% of Children and Youth with Special Health Care Needs 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 Children and Youth with Special Health Care Needs and their families. Only 19.1% 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 62.8% 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 76.2% 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 15.9% 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. Children and Youth with Special Health Care Needs 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 Children and Youth with Special Health Care Needs and their families to manage their health and family needs during key periods of change and over time.

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

CYSHCN-2.1: Provide funding and program guidance to Local Health Department Children and Youth with Special Health Care 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.

Community outreach remains an issue for most counties due to their role in COVID-19 response.
The following support and guidance were provided:

- For the Children and Youth with Special Health Care Needs database that was created in the Health Commerce System, there were weekly meetings to discuss the details of the Children and Youth with Special Health Care Needs survey which is the tool the Local Health Department staff utilize to collect about their encounters with Children and Youth with Special Health Care Needs and their families.
- On October 4, 2021, Leanne Fusco and Linsey Coyle, directors from Special Olympics New York shared information with the Local Health Departments about Special Olympics New York sports programs events as well as health initiative and local volunteer opportunities.
- On February 17, 2022, the Children and Youth with Special Health Care Needs program sent out a document of frequently asked questions that came up to a webinar on Health Commerce System data submission to the Local Health Department. included in this email was that went out back in December 2021. Also attached was the NYSDOH Children and Youth with Special Health Care Needs Program Local Health Departments Question and Answer 2021-2022 (Grant Year 2).
- On March 9, 2022, the NYSDOH Office of Health Insurance Programs (i.e., the state's Medicaid program) and the NYS Office for People with Developmental Disabilities (OPWDD) did a presentation on Health Home Serving Children providing the Local Health Departments with information about how to refer a child to the program and answered questions for the Local Health Departments.
- In April 2022, the Bureau of Child Health distributed the re-designed Health Information Document. which enables Children and Youth with Special Health Care Needs and their families to collect, maintain, and organize health information to be shared with health care providers and other professionals. In April 2022, The Health Information Document was also shared with the NYSDOH Office of Health Insurance Programs, Regional Office staff, Lead Program and Adolescent Health programs, the Division of Family Health, and Sickle Cell Disease partners. In April 2022, the Bureau of Child Health is overseeing work to translate the Health Information Document into French and Urdu. The Health Information Document is posted on the Children and Youth with Special Health Care Needs web page and available in thirteen languages.
- On May 12, 2022, the Children and Youth with Special Health Care Needs program staff presented the Back-to-Basics webinar to the Local Health Departments staff and reinforced the engagement of medical providers, schools, and daycare providers.
- On May 30, 2022, the Children and Youth with Special Health Care Needs program staff met with the Regional Office staff to regroup as a team since Regional Office staff have resumed pre-covid routine responsibilities. The team met again, on September 26, 2022, to discuss roles and responsibilities to support the Local Health Departments Children and Youth with Special Health Care Needs staff.
- On June 16, 2022, the Children and Youth with Special Health Care Needs Program staff sent the Children and Youth with Special Health Care Needs data submission training resources to the Department of Health Regional Office Staff.
- On October 6, the Children and Youth with Special Health Care Needs program presented to the Local Health Departments on the Back-to-Basics webinar and reinforcing the engagement of medical providers, schools, and daycare providers.

The Local Health Departments Children and Youth with Special Health Care Needs programs were notified September 14, 2022, that effective October 1, 2022, funding in the amount of 3.2 million dollars for a total of $5.2 million dollars will be provided to Local Health Departments Children and Youth with Special Health Care Needs programs. The enhanced funding will support additional staff time dedicated to the program and related administrative responsibilities, as well as related non-personal services such as travel, space, and operating expenses. The number of Local Health Departments that implement the Children and Youth with Special Health Care Needs program increased from 49 to 52 counties with the 2022-2023 contract year which began October 2022.

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 Children and Youth with Special Health Care Needs 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 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.

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.

The Regional Support Centers presented a webinar Planning for Transition to Adulthood which included two parents sharing their experience with the transition process and their children with additional needs on 12/16/22.

CYSHCN-2.4: Administer Children and Youth with Special Health Care Needs 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. Note: Effective April 2020, NYS public health law was amended to modernize the name of the former Physically Handicapped Children's Program to Children and Youth with Special Health Care Needs Support Services. This change corrects outdated terminology and directly aligns Children and Youth with Special Health Care Needs Support Services with Title V terminology and programs.

While (99%) of NYS's children are insured, according to the New York State Profile of Children and Youth with Special Health Care Needs, 2019-2020 report, families continue to experience financial challenges meeting the needs of their Children and Youth with Special Health Care Needs. The Title V Program provides funding for direct services through the Children and Youth with Special Health Care Needs Support Services. In 2022, nineteen (19) children received an evaluation and 71 received treatment services funded through Children and Youth with Special Health Care Needs Support Services. Services included durable medical equipment (22%), orthodontia (17%), enteral formula and specialty foods (16%), medications (16%), medical surgical (12%) and physician office (8%). The racial distribution for these Children and Youth with Special Health Care Needs are 64 White and 1 Black; and for ethnicity there were 2 Hispanics, 14 Other and 9 Unknown.

CYSHCN-2.5: Provide grant funding, evidence-based strategies (Got Transition®) and technical assistance to Hemoglobinopathy Specialty Care Centers to support successful transition to adult services for young adults with Sickle Cell Disease, including but not limited to transition policy, tracking and monitoring, transition readiness and planning, transfer of care, and transition feedback and completion.

See *CYSHCN Activity-1.7* above for details about activities. State funding is allocated to three Sickle Cell Disease contractors at Hemoglobinopathy Specialty Care Centers. The Sickle Cell Disease contractors utilize Got Transition® which is a federally funded national resource center on health care transition.

CYSHCN-2.6: Support care coordinators at Hemoglobinopathy Specialty Care Centers to help patients with Sickle Cell Disease with appointments, scheduling, education, peer support and other health care transition services.

These providers serve as "transition navigators," to assist the adolescent make a successful transition to an adult hematologist or other adult medical care provider. They also focus on providing these adolescents with the skills they need to successfully transition to adult care as evidenced by evaluation of readiness and follow-up post transition for satisfaction with care.

Title V staff worked to update the quarterly reports and held a call with the three grantees to review new reporting tool and

year data summary. Year 5 of the Coordinating Care and Supporting Transition for Children/Adolescent and Young Adults with Sickle Cell Disease (Grant Period 2018-2023) started on 07/01/2022.

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 Children and Youth with Special Health Care Needs including social emotional health, oral health, healthy relationships, and sexual reproductive health.

Title V staff are working to develop list of Adolescent Health programs located at sites with School Based Health Centers. Adolescent health programs, which include Comprehensive Adolescent Pregnancy Prevention program, Personal Responsibility Education Program, and the Sexual Risk Avoidance Education program, were surveyed to identify sites that overlap with School Based Health Center programs. The survey results were combined with the list of School Based Health Centers to develop a comprehensive list.

NYSDOH has a contract with Cornell University's ACT for Youth Center for Community Action. ACT for Youth presented a three-part webinar series on Adolescent Mental Health in August 2021. The presentation was attended by many programs outside of Adolescent Health Unit, including School Based Health Centers staff. Title V staff are working together to expand access to these opportunities within the various programs and across the NYSDOH, including the Regional Offices.

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, including integration of eligible children also receiving services through the Early Intervention Program, referral of Children and Youth with Special Health Care Needs to Health Homes, and transition from Children's to Adult Health Homes.

In 2020, the Title V Program participated with the NYSDOH Office of Health Insurance Program staff on site visits to twelve designated Health Home Serving Children agencies. There were five anticipated visits remaining that were to take place in the Summer 2020 before the pandemic but were put on hold until January 2021 with a new virtual site visit process in place. A review of agencies' policies and procedures is conducted the week prior to the virtual site visit. Children and Youth with Special Health Care Needs staff will provide technical support in reviewing the policy and procedures of each of the Medicaid Health Homes. Staff has provided subject matter and technical support on enhanced care coordination and transition (i.e., transition, language) support during the review of the records during the site visit.

The following site visits took place in 2022: the week of October 18, 2021, Community Care Management Partners; Sunriver was the week of November 15, 2021; January 10, 2022 was Institute of Family Health; the week of February 2, 2022 was Central New York (CNY); the week of March 7, 2022 is Adirondack Health Institute, and the week for May 23, 2022 is Encompass Health Home and the Greater Rochester Health Home Network was the week of June 6, 2022. Coordinated Behavioral Care (also known as Pathway to Wellness) was the week of September 12, 2022.

The Children and Youth with Special Health Care Needs staff had a webinar on 5/12/22, to provide information the Local Health Departments on Sickle Cell Disease as a single qualifying condition for Medicaid's Health Home Serving Children.

Enrollment data is for the time of 10/1/2021-9/30/2022: the number of children enrolled in Health Home Serving Children for this time period is reported to be 49,945 unique members, an increase from the 43,285 children enrolled in Health Homes Serving Children for the last year.

Strategy CYSHCN-3: Support comprehensive public health efforts to prevent, identify, and manage childhood lead poisoning.

Studies show that no amount of lead exposure is safe for children. Even low levels of lead in blood have been shown to

affect a variety of adverse health effects including reduced growth indicators; delayed puberty; lowered Intelligence Quotient; and hyperactivity, attention, behavior, and learning problems. Children under six years old are more likely to be exposed to lead than any other age group, as their normal behaviors result in them breathing in or swallowing dust from old lead paint that gets on floors, windowsills, and hands, and can be found in soil, toys, and other consumer products. NY has more pre-1950 housing containing lead paint than any other state in the nation, with approximately 43% of all of NY's dwellings containing lead-based paint.

Effective October 2019, NYS Public Health Law (§1370) and regulations (Part 67 of Title 10 of the NY Codes, Rules, and Regulations) were amended to lower the definition of an elevated blood lead level in a child to 5 micrograms per deciliter (µg/dL), from the previous level of 10 µg/dL. Health care providers in NYS are required to assess or test all young children in accordance with public health regulations, to confirm and report test results, and to ensure appropriate follow-up evaluation and management as needed. Local Health Departments are required to ensure follow up including environmental management based on the child's blood lead level. The Title V Program supports supplemental grants for lead poisoning prevention programs in Local Health Departments, as well as Regional Lead Resource Centers based in academic medical centers to provide outreach and education to health care provider and families, technical assistance, individual case consultation and treatment of childhood lead poisoning. These programs are administered by the NYSDOH Center for Environmental Health. These Title V-funded program elements complement other components of the state's comprehensive public health approach that also includes laboratory testing and reporting, surveillance, outreach and education, and neighborhood-based primary prevention and healthy housing initiatives.

The Title V Program led the following specific program and policy activities to advance this strategy over the 2021-22 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 NYSDOH 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 to the NYSDOH 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 to the NYSDOH 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 to the NYSDOH. Email correspondence is used regularly for follow-up to ensure completion of enrollment process for reporting blood lead 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 NYSDOH Lead Poisoning Prevention Programs to enroll for reporting. Local Health Departments reach out with lab issues to NYSDOH 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 948 physicians during the 2021-2022 program year, technical assistance to providers and Local Health Department programs, individual case consultation and treatment of lead poisoning was conducted over 939 times, and chelation treatment was performed 63 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 2021-2022 program year, the three Regional Lead Resource Centers participated in over 100 regional and community-based lead poisoning prevention coalition meetings. A NYS Lead Advisory Council meeting was held on April 20, 2022. Various topics were discussed including Childhood Lead Poison Prevention, CDC reference value, LeadCare II accuracy at low values, and COVID's impact on lead testing.

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.

Title V staff continue to assess all available data sources to inform public health improvement strategies related to Children and Youth with Special Health Care Needs. A recently drafted summary document titled "New York State Profile of Children and Youth with Special Health Care Needs, 2019-2020", which updates the program's current 2018-2019 summary, may serve as one starting point for additional work in this area. This report explores the demographic, health, and functional difficulty profile of the NYS Children and Youth with Special Health Care Needs population, determines the impact that having

special health care needs has on children and families, and identifies areas in most need of improvement to ensure NYS Children and Youth with Special Health Care Needs receive care in a well-functioning system. As additional data become available, Title V staff will update this report, make it available through the NYSDOH public website, and share it with Children and Youth with Special Health Care Needs 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 2021-22 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 Children and Youth with Special Health Care Needs in NYS.

Title V staff completed a careful analysis of the revised 2019-2020 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. Key findings included that 39% of Children and Youth with Special Health Care Needs live in households with income below 200% of the federal poverty level. About 8.8% of Children and Youth with Special Health Care Needs have their daily activities greatly affected by their health condition(s); 13.3% of Children and Youth with Special Health Care Needs ages 6-17 missed 11 or more school days in a year, compared to 3.3% of NYS children without Special Health Care Needs; and nearly half (45.2%) of Children and Youth with Special Health Care Needs ages 6-17 had trouble making or keeping friends. Families of Children and Youth with Special Health Care Needs 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 2019–2020 the five key components indicating a child meets medical home criteria showed only 40.8% of care met the criteria, compared to 50.6% of children without Special Health Care Needs.

CYSHCN-4.2: Collaborate with the U.S. Census Bureau to conduct an over-sample of NYS 2022 National Survey of Children's Health for NYS to allow for enhanced sampling of Black/African-American, Hispanic, including Children and Youth with Special Health Care Needs.

Title V staff collaborated with the U.S. Census Bureau to conduct an over-sample of NYS 2022 National Survey of Children's Health for NYS to allow for enhanced sampling of Black/African American, Hispanic, and Children and Youth with Special Health Care Needs populations. 2022 survey data will be available in fall 2023.

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 stakeholders, and post on the Department's public website.

Title V staff analyzed and reported 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 stakeholders, and post on the Department's public website. 2019-2020 NYS Profile of Children with Special Health Care Needs report is posted (https://www.health.ny.gov/community/special_needs/docs/cshcn_profile_2019-20.pdf)

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.

Title V staff developed and implemented plans for updating the current data reporting methods (quarterly and annual reports) of Local Health Department Children and Youth with Special Health Care Needs. Analyzed and shared 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.

NYSDOH Children and Youth with Special Health Care Needs continues to collect data from Local Health Departments. A new data collection went live on the Department's Health Commerce System on October 1, 2021. All NYSDOH Children and Youth with Special Health Care Needs staff received training on the Health Commerce System. A data submission guide and training materials for the Local Health Departments were written and updated when indicated. Also, Local Health Department trainings were conducted on 9/20/21, 9/28/21, 9/30/21, 12/13/21, 12/20/21, 1/10/22, 1/25/22, 2/17/22, 2/28/22, 3/17/22, and 4/14/22 before and after launching the data system. In addition, Training topic survey sent to Local Health Departments on 3/4/22 and a FAQ was designed and is continually updated as more questions come in.

Children and Youth with Special Health Care Needs program staff and data team staff conducted one-on-one trainings with Local Health Departments to answer questions and review the Children and Youth with Special Health Care Needs data collection survey. Staff used 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.

An analysis of the Local Health Department Children and Youth with Special Health Care Needs data for 2019-2020 program data demonstrated that of the 1,217 Children and Youth with Special Health Care Needs children were served, 52.42% had Medicaid, 26.29% had commercial insurance, 6.9% had Child Health Plus insurance, 11.42% had other insurance, and 1.81% had no insurance reported. Additionally, 5.34% of children had Supplemental Security Income (SSI). Sixty-five percent of Children and Youth with Special Health Care Needs served were White, 12.9% African American, 2.22% Asian or Pacific Islander, 0.99% American Indian or Alaska Native, 5.01% more than one race, 0.66% other race, and 13.39% unknown race; 11.75% of children were Hispanic. The percent of children reported to have a primary care provider was 98.85%, which is an improvement from the 98.43% in 2018-2019 data. An optional data field for type of financial assistance needed by families for aspects of care was added. Among those responded (n=38, 3.12%), 50% needed assistance for a service not covered by insurance, 23.68% for a service exceeding the limit of the benefit package, 18.42% needed help with co-pays, 5.26% for deductible costs, and 2.63% for premium costs. In addition, information about referrals from the state's Early Intervention Program was included. Approximately 26.48% of Children and Youth with Special Health Care Needs were referred by Early Intervention Program which is similar to last year (26.34%). There were 21 children referred to HH in 2019-2020, compared to 33 children the year before.

The annual Children and Youth with Special Health Care Needs data that is collected from all the Local Health Departments was compiled and corrected for errors. A webinar was held September 21, 2022, to report on the statewide Children and Youth with Special Health Care Needs findings. An individual county data report was sent to each county and the webinar included guidance on how to read the individual report. The report serves as a program quality improvement tool as well. The Children and Youth with Special Health Care Needs data profile report included allocated funds, funds spent, the estimated number of Children and Youth with Special Health Care Needs percent and actual number of children served. In this webinar, staff also informed Local Health Department that Sickle Cell Disease is approved as a single qualifying condition for Health Home eligibility. Lastly, the Regional Support Centers gave an update on their work and family sessions.

Strategy CYSHCN-5: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact the health and well-being of children and youth with special health care needs.

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

Many NYS families of Children and Youth with Special Health Care Needs 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 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. NYSDOH, Regional Support Centers, and Local Health Departments need to meet people where they are, provide multiple methods and means for Children and Youth with Special Health Care Needs and their families to engage, and ensure that a diverse population is being recruited and retained by Local Health Departments.

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

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.

Support local Children and Youth with Special Health Care Needs programs based in Local Health Departments, with enhanced funding in the amount of 3.2 million dollars for a total of $5.2 million dollars. The enhanced funding will support additional staff time dedicated to the program and related administrative responsibilities, as well as related non-personal services such as travel, space, and operating expenses. The number of Local Health Departments that implement the Children and Youth with Special Health Care Needs program increased from 49 to 52 counties (this includes upstate and NYC) with the 2022-2023 contract year which began October 2022.

The pandemic had a serious impact on Title V Children and Youth with Special Health Care Needs staff's ability to support local Children and Youth with Special Health Care Needs programs. Children and Youth with Special Health Care Needs staff were reassigned to COVID-19 response activities including the COVID-19 hotline, negative call center, positive call center and running the Mass Vaccination Site(s) (Point of Dispensing).

Also, many Local Health Department Children and Youth with Special Health Care Needs staff were pulled into COVID-19 response which made them unavailable to administer the Children and Youth with Special Health Care Needs programs and impacted their ability to provide support to Children and Youth with Special Health Care Needs and their families. For example, outreach was limited. Information was still provided as best as possible through mailings or Facebook or telephonically. Information about local free food distributions and mental health support, suggestions on activities to do during COVID-19, and safety information related to COVID-19 were posted on many Local Health Department websites.

The Regional Support Centers' family engagement report highlighted the impact of COVID-19 on families of Children and Youth with Special Health Care Needs. Some of the themes that emerged from families around COVID-19 were disruptions to services and evaluations, increased isolation, increased anxiety and fear, increased exhaustion and stress, mixed experiences with virtual services, lack of staffing, increased mental health needs, financial difficulties, and noted positive outcomes of COVID-19 measures.

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 for Children and Youth with Special Health Care Needs and families, all of which will reflect the ethnicity and diversity of the community, including engagement strategies. Health literacy will be supported by providing information in multiple languages, at appropriate reading levels and abilities, as available.

Worked with the Regional Support Centers and Local Health Department Children and Youth with Special Health Care Needs programs to ensure that health equity is integrated into written materials, communication, outreach, referrals, and engagement strategies and reflects the diversity of the community. Health literacy was supported by encouraging counties to provide information in multiple languages, at appropriate reading levels and abilities, as available.

As stated above, the Health Information Document was updated during this reporting period and posted to the Department

of Health's Children and Youth with Special Health Care Needs web page. The Department of Health translates important health related materials into the 12 most commonly spoken languages in NYS – Spanish, Chinese, Russian, Yiddish, Bengali, Korean, Haitian Creole, Italian, Arabic, Polish, French and Urdu.

"Community Integration Webinar | Children & Youth with Special Health Care Needs" was presented by the Regional Support Centers on 10/7/21. This webinar provides education on how to support Children and Youth with Special Health Care Needs in the community, such as recreational settings.

On December 7, 2021, the Children and Youth with Special Health Care Needs staff attended the Log-in2Learn: School of Hard Knocks: The Impact of the Pandemic on School Children and Their Families. Children and Youth with Special Health Care Needs staff learned learn about issues affecting student mental health and well-being from Donna M. Bradbury and Bonnie Catlin from the NYS Office of Mental Health's Office of Prevention & Health Initiatives.

On 12/8/21 the Regional Support Centers presented a "Children and Youth with Special Health Care Needs Family Forum" by engaging families of Children and Youth with Special Health Care Needs through discussion groups and interviews. The Regional Support Centers learned about families' needs and experiences across NYS to improve Children and Youth with Special Health Care Needs Programs at NYS Local Health Departments.

On December 12, 2021, the Regional Support Centers did an interactive webinar called "What Matters: MI + Quality Improvement to Reduce Assessment Burden" which focused on reducing assessment burden through motivational interviewing and quality improvement strategies. This webinar aims to support Local Health Department staff in completing the Health Commerce System Data Collection Form when communicating with Children and Youth with Special Health Care Needs and their families.

On December 23, 2021, a parent advocacy webinar was conducted by the Regional Support Centers in Spanish on "Barreras a la Integracion Comunitaria" (Barriers to Community Integration).

On January 4, 2022, the Regional Support Centers presented on "Children and Youth with Special Health Care Needs Project – Years 3,4, and 5: Comprehending the Technical Assistance Process and Project Calls" a webinar to understand the Children and Youth with Special Health Care Needs Project technical assistance process and review the different types of calls held through the project. This was presented again on February 7, 2022.

May 12, 2022, the Children and Youth with Special Health Care Needs 2020-2025 workplan was re-introduced to the Local Health Departments during the Back-to-Basics webinar.

In collaboration with the Dental Unit, a survey had been sent to all Local Health Departments that ended 5/13/22 regarding an opportunity to receive oral hygiene kits to families of Children and Youth with Special Health Care Needs.

On June 24, 2022, the Children and Youth with Special Health Care Needs staff attended "Systems of Care & Healthy Mental Development: Effective Strategies to Support Children and Youth with Special Health Care Needs in the Medical Home Episode 1" which featured the Nebraska Partnership for Mental Healthcare Access in Pediatrics and the University of Michigan Child Collaborative Consultation Program. Participants learned how these two programs addressed access to behavioral and mental health care for Children and Youth with Special Health Care Needs, in addition to the key partners and collaborators that support their respective programmatic efforts.

On June 30, 2022, the Children and Youth with Special Health Care Needs staff attended the Episode 2 of the "Systems of Care & Healthy Mental Development: Effective Strategies to Support Children and Youth with Special Health Care Needs in the Medical Home". This episode featured pediatricians Marian Earls, MD, MTS, FAAP and Richard Antonelli, MD, MS, FAAP. They discussed how pediatricians and the medical home can support behavioral and mental health care for Children and Youth with Special Health Care Needs.

On June 29, 2022, Children and Youth with Special Health Care Needs Director and Assistant Director joined the inter-departmental Adverse Childhood Experiences (ACEs) workgroup. This group discussed the high incidence of Adverse Childhood Experiences among Children and Youth with Special Health Care Needs.

September 28,2022 Docs for Tots. Dr. Liz Isakson presented Mental Health and Developmental Milestones webinar.

The Regional Support Centers are developing: Who are Children and Youth with Special Health Care Needs video vignettes.

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.

On September 20, 2021, our data team conducted a training session on the Children and Youth with Special Health Care Needs Health Commerce System data submission for the Local Health Departments. In conjunction with a live demonstration of the database, this webinar provided information on Children and Youth with Special Health Care Needs survey questions, data entry, and questions that were added or modified.

A new Children and Youth with Special Health Care Needs data collection tool has been developed using the Person-based Electronic Response Data System (PERDS) application in the NYSDOH's Health Commerce System. This Children and Youth with Special Health Care Needs data collection tool new was rolled out on October 1, 2021. Trainings and technical assistances are provided to Local Health Departments as needed. In preparation for the new data collection tool, we had many meetings about making minor changes such as adding gender identity options, adding all 10 languages, and asking the parent what their primary language is and what's the child's language is. Also, the transition section was revised to include if the child is between age 14 and 21 and if yes, the skip pattern would take them to 2 other questions on transition: 1) "Did child receive information needed for transition to adult health care?", and 2) "Did your child receive services necessary for transition to adult health care?".

The Person-based Electronic Response Data System on Health Commerce System is a secure online system supporting the exchange of health information by Local Health Department Children and Youth with Special Health Care Needs program staff. State program managers and Local Health Department Children and Youth with Special Health Care Needs program staff can access data in a timely manner to identify, track, and address disparities among Children and Youth with Special Health Care Needs.

For Sickle Cell Disease care transition contractors, a quarterly tool was updated and circulated among the grantees. On quarterly conference calls, grantees were oriented on the updated tool and data summary.

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.

Title V staff partnered with key stakeholders such as Parent to Parent, Local Health Departments, and Regional Support Centers to identify and share best practices to address racial justice and health equity.

The Regional Support Centers produce a newsletter for Local Health Department Children and Youth with Special Health Care Needs Program staff and partners called Children and Youth with Special Health Care Needs Clips. The newsletter features professional development opportunities, upcoming events, and recent research. Some examples include:

- A Roadmap for Collaboration among Title V, Home Visiting, and Early Childhood Systems Information on Disability & Intersectional Identities.
- Habla con especialistas en salud y en discapacidades del desarrollo sobre la vacuna del COVID.
- Multiple Webinars by Parent to Parent of NYS: Grandparents Raising Grandchildren with Special Needs, Residential

Parent Group, and Family Empowerment Program.
- Information on a Workshop on Guardianship & Future Care Planning; ¿VACUNARSE O NO VACUNARSE?; Encontrar Una Dirección Significativa y Sostenible Como Familia: webinar on Parents of Children with Disabilities Join The Legal Battle Over Masks in Schools.

Other work included engaging or participating in:
- Learning from Patients to Provide Accessible Healthcare and Effective Communication for Patients who are Blind or have Low Vision.
- NYS Office for New Americans: Empowering New American Parents in the Early Identification of Disabilities in Children.
- The American Association on Intellectual and Developmental Disabilities (AAIDD) webinars.
- 2022 Statewide Epilepsy Conference.
- Presentation: ADHD Risk Factors - Identified, Explained and Addressed

In October 2021, Title V director attended the Food Insecurity Symposium which aligns with our Title V priorities.

On November 3, 2021, Children and Youth with Special Health Care Needs staff attended the NYS Pyramid Model Visioning Session. This provided the State Leadership Team members, time to review the original vision for the Pyramid Model Initiative and reflect on the accomplishments and lessons learned. It provided an opportunity to explore new and broadening areas of opportunity for the initiative.

The Regional Support Centers had Elevatus Training on Developing an Effective Sexuality Policy for Your Agency on October 18, 2021, to the Local Health Departments. Many NY agencies for Individuals with I/DD do not have sexuality policies that help support professionals to address this topic. Professionals have expressed concerns about whether they can and should communicate with individuals about sexuality or not and if it could cause them to lose their job. This webinar was designed specifically for NY agencies and addressed the importance of a sexuality policy, what needs to be included in a policy, NYS Office for People with Developmental Disabilities (OPWDD) recommendations, strategies for gaining policy buy-in and barriers to buy-in, as well as specific consideration for developing a policy that supports both individuals and the support professionals in their lives.

Information about “Transgender Affirming Primary Care Webinar” held on November 17, 2021, was shared with the Local Health Department staff. Health Resources and Services Administration Region 2 (which is New York, New Jersey, Puerto Rico, and the U.S. Virgin Islands) held the webinar in collaboration with Mt. Sinai NYS HIV Primary Care and Prevention Center of Excellence. The course provides an overview of the most appropriate language, best practices, and key terms to use when providing quality healthcare services to patients that identify as transgender or non-binary. With the use of case studies, audience members were walked through various barriers that impact access to care that is specific to the trans and non-binary communities.

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

As described in the Women and Maternal Health section, a new Bureau of Health Equity and Community Engagement was created within the Division of Family Health to address disparities highlighted in the COVID-19 pandemic and build a foundation for future epidemic responses. More information about this new bureau in future annual reports and applications

for the 2022-23 program year.

The Division of Family Health convenes a cross-division Racial Justice Work Group. All members of the Work Group were assigned to COVID-19 activities during this reporting period. During that time many of the members were conducting health equity activities as it relates to COVID-19. Staff were in involved in the contact tracing community support response, vaccine equity task force, training of the contact tracing workforce on equity and diversity, NYS Birth equity improvement project and the Together We Can Inclusion project. During this time staff reviewed some NYSDOH Request for Applications to ensure a health equity lens was incorporated during development.

In October 2021 the work group reconvened to resume heath equity efforts within the Department and will recruit new members. With so many new staff in the Division of Family Health, the primary focus of the work group will be training all staff to ensure internally we all have a universal understanding of health equity, health disparities and social determinants of health. Staff are currently seeking to work with the NYSDOH AIDS Institute health equity coordinator to collaborate efforts and learn from one another.

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 will come from Sickle Cell Disease Care Transition contractor reports. The baseline value for this measure, from the 2018-19 program grant cycle was 40.3%. The program exceeded the improvement target of 5% for 2022, to reach 42.3%. The data for 2021-22 indicates that 65% had transition readiness assessments completed among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.

Children with Special Health Care Needs - Application Year

For Children and Youth with Special Health Care Needs, the NYS Title V Program selected **National Performance Measure (NPM) 12: Percent of adolescents with special health care needs, ages 12-17, who received services necessary to make transitions to adult health care.** This NPM was selected because it was voiced as a key priority by youth with special health care needs and their families and reinforced by state-specific population health data. Families reported that only 15% of Children and Youth with Special Health Care Needs receive care in a well-functioning system, and less than 18% of youth ages 12-17 with special health care needs received services necessary to make transitions to adult health care. This is consistent with findings from New York's care mapping process conducted in 2017-2018, and with findings from the community listening forums conducted for this application, as detailed in the Needs Assessment summary, and discussed further below. Similar feedback was heard through family sessions conducted by Regional Support Centers in 2020 and 2021. This NPM also aligns directly with NYS Prevention Agenda goals and interventions related to support for Children and Youth with Special Health Care Needs.

In addition, New York's Title V Program established one State Performance Measure (SPM) for this domain, **SPM 2: Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months**. This SPM was developed to reflect the state's longstanding commitment to eliminating childhood lead poisoning as a key public health problem in NYS. It is responsive to cross-cutting priorities voiced by families related to safe and healthy environments to support children's development, and access to comprehensive, high quality health care services. It is also responsive to specific concerns shared by families regarding challenges in accessing and coordinating medical care and related services for children and youth 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 these performance measures:

Objective CYSHCN-1: Increase the percentage of NYS adolescents with special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 17.8% in 2017-2018 to 18.7% in 2021-2022 (National Survey of Children's Health).

Objective CYSHCN-2: Increase the percentage of 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 CYSHCN-3: Reduce the incidence of confirmed high blood lead levels at 5 micrograms per deciliter or greater per 1,000 tested children aged less than 72 months. The current incidence of confirmed blood lead levels at 5 micrograms per deciliter or greater was 10.4 per 1,000 children tested in 2020. (NYS Child Health Lead Poisoning Prevention Program Data)

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

Strategy CYSHCN-1: Engage youth with special health care needs (YSHCN) and their families in state and local efforts to improve systems and practices for supporting YSHCN.

As described above in the annual report, families and youth need to be directly involved in program and policy planning and implementation in meaningful roles at all levels. This is consistent with the Title V program's longstanding commitments to family-centered care/family-professional partnerships and positive youth development. Families of Children and Youth with Special Health Care Needs face unique challenges and bring knowledge, experience, and strengths that are a tremendous

asset; they are the experts about their needs and care.

As described above, the Title V Program contracts with three Health Resources and Services Administration-designated University Centers for Excellence in Developmental Disabilities (UCEDDs), knowns as Regional Support Centers, to provide training and technical assistance to Local Health Department Children and Youth with Special Health Care Needs programs and to conduct family engagement. The Regional Support Centers each have a family liaison who is a parent/caregiver of a Child with Special Health Care Needs. The family liaison role is seen as a critical component of the Regional Support Centers work with families, Children and Youth with Special Health Care Needs, and Local Health Departments. Family liaisons bring firsthand experience, perspective, and knowledge of barriers and gaps in care to all aspects of Regional Support Center activities, including meeting with families and resource gathering. Family liaisons are involved in all cross functional teams including educational, data, technical assistance to Local Health Departments, and Resource Directory and are responsible for conducting family engagement sessions with a prescribed set of questions to gauge the needs of families with Children and Youth with Special Health Care Needs.

In addition, the NYSDOH has established contracts with Local Health Departments to administer the Children and Youth with Special Health Care Needs program locally, with the current contract timeframe from October 2020 to September 2025 and deliverables which include addressing family and community engagement at many levels. Local Health Departments will involve families of Children and Youth with Special Health Care Needs in work groups, committees, task forces or advisory committees to improve the system of care for Children and Youth with Special Health Care Needs, involve families and Children and Youth with Special Health Care Needs in local planning activities, such as the Community Health Assessment, and use feedback from families of Children and Youth with Special Health Care Needs to develop training for Children and Youth with Special Health Care Needs staff and providers.

Sickle cell disease contractors at three Hemoglobinopathy Specialty Care Centers work directly and exclusively with youth in transition support services. Hemoglobinopathy Specialty Care Centers conduct peer support groups to gauge barriers to care and transition for youth and young adults with Sickle Cell Disease. Transition navigators at Hemoglobinopathy Specialty Care Centers engage youth with Sickle Cell Disease to ensure compliance with care regimens and to understand what barriers youth experience in caring for themselves.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2023-24 year:

- **Activity CYSHCN-1.1**: Maintain at least one dedicated family representative on the state's Title V Advisory Council and engage all Council members in updates and discussion related to Children and Youth with Special Health Care Needs program activities.
- **Activity CYSHCN-1.2**: Collaborate with advocacy groups like Parent to Parent of NYS to understand the needs of Children and Youth with Special Health Care Needs and their families, facilitate information sharing, and promote 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 parent liaisons. Work with the Regional Support Centers and their parent liaisons to conduct surveys, family engagement sessions and family forums to assess and share family needs and apply results to inform family resources and technical assistance for Local Health Department programs.
- **Activity CYSHCN-1.4**: Support Regional Support Centers to develop a Children and Youth with Special Health Care Needs Resource Directory that will be made available online to provide families, Local Health Departments and health care providers with current information about services and supports.
- **Activity CYSHCN-1.5**: Support Local Health Department 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 Children and Youth with Special Health Care Needs 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 Local Health Department Children and Youth with Special Health Care Needs services and reach and serve more families. The New York State Association of County Health Officials will provide opportunities for Title V staff to speak directly to their members, participate in calls with Local Health Departments, and help disseminate information and opportunities for Children and Youth with Special Health Care Needs and families.
- **Activity CYSHCN-1.7**: Support Sickle Cell Disease programs in three Hemoglobinopathy Specialty Care Centers to provide transition supports by and for youth with Sickle Cell Disease, including peer support groups, system navigation supports, and self-care services.
- **Activity CYSHCN-1.8:** Collaborate with other Title V and Division of Family Health adolescent-serving programs, including School-Based Health Centers, Comprehensive Adolescent Pregnancy Prevention, and ACT for Youth Center for Community Action to identify additional opportunities to meaningfully engage adolescents in program and policy development that impacts 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. The NYS Developmental Disabilities Planning Council membership includes parents of Children and Youth with Special Health Care Needs from around New York State who are directly involved in decision making regarding funding opportunities and policy development.
    - **Activity CYSHCN-1.9.a**: Participate in the NYS Developmental Disabilities Planning Council Policy Workgroup to inform policy focus areas for the Council; review and help distribute policy papers; review and respond to legislation at state and federal levels; and provide advocacy and information to interested parties.
- **Activity CYSHCN-1.10**: Collaborate with state partners, such as Early Intervention, the Division of Chronic Disease Prevention, Office of Children and Family Services, and Office of the Aging-NY Connects to identify and utilize additional resources.

Strategy CYSHCN-2: Enhance care coordination, including transition support services, for children and youth with special health care needs.

The Institute of Medicine identified care coordination as a key strategy to improve the effectiveness, safety, and efficiency of the U.S. health care system, improving outcomes for patients, providers, and payers. The most recent 2020-2021 National Survey of Children's Health data for NYS show that about 72.2% of all children, and 62.5% of Children and Youth with Special Health Care Needs, ages birth to 17 years who needed care coordination services received effective services. Preparing for and supporting the transition from youth to adulthood is especially important for Children and Youth with Special Health Care Needs and their families. Only 11.8% of youth ages 12-17 with special health care needs received services necessary to make transitions to adult health care, highlighting the need for more specific attention to program and systems improvements in this area. Within this overall measure, there is variation in individual components of transition services. About 60.3% of adolescents with special health care needs had a chance to speak to their health care provider alone at their last preventive check-up. While 75% of adolescents with Special Health Care Needs reported that their health care provider actively worked with them to gain skills to manage their health, health care, and understand changes in health care happening around age 18, only 20.7% reported that their doctors discussed the shift to a provider who treats adults, if needed.

Title V staff will identify supports to help youth and families coordinate care, including a specific focus on transition services, to improve efficiency, quality, health outcomes and patient satisfaction. Children and Youth with Special Health Care Needs 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 Children and Youth with Special Health Care Needs and their families to manage their

health and family needs during key periods of change and over time.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2023-24 year:

- **Activity CYSHCN-2.1**: Provide funding and program guidance to Local Health Department Children and Youth with Special Health Care 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-2.1.a**: Require additional Local Health Department staff using the enhanced funding award from October 10, 2022. For example, county staff went from a required 0.2 full time equivalent (FTE) to a 0.5 FTE and 0.4 FTE to 1.0 FTE.
- **Activity CYSHCN-2.2**: Continue to support three Health Resources and Services Administration-designated UCEDDs, which are known as the Regional Support Centers, to support youth, families, and Local Health Department Children and Youth with Special Health Care Needs programs. Regional Support Centers will identify resources and develop a comprehensive Resource Directory for Local Health Departments and families; provide technical assistance to Local Health Departments; conduct family engagement opportunities; identify webinars or professional development for Local Health Departments; develop training and education materials; facilitate communication among Local Health Departments; and identify barriers, unmet needs and opportunities for 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 information on Got Transition®'s Six Core Elements of Health Care Transition™.
- **Activity CYSHCN-2.4**: Administer the Children and Youth with Special Health Care Needs Support Services, a gap-filling supplemental program that provides reimbursement for specialty health care services for severe chronic illness or physically handicapping conditions in children who meet county financial and medical eligibility criteria.
- **Activity CYSHCN-2.5**: Provide grant funding, evidence-based strategies (NYS uses Got Transition®) and technical assistance to Hemoglobinopathy Specialty Care Centers to support successful transition to adult services for young adults with Sickle Cell Disease, including but not limited to transition policy, tracking and monitoring, transition readiness and planning, transfer of care, and transition feedback and completion.
- **Activity CYSHCN-2.6**: Support care coordinators at three Hemoglobinopathy Specialty Care Centers to help patients with Sickle Cell Disease with appointments, scheduling, education, peer support and other health care transition services. These providers serve as “transition navigators,” to assist the adolescent make a successful transition to an adult hematologist or other adult medical care provider. They also focus on providing these adolescents with the skills they need to successfully transition to adult care as evidenced by evaluation of readiness and follow-up post transition for satisfaction with care.
    - **Activity CYSHCN-2.6a**: Require funded Hemoglobinopathy Specialty Care Centers transition coordinators to proactively coordinate with local health department Children and Youth with Special Health Care Needs Programs to enhance the efficiency of both programs.
- **Activity CYSHCN-2.7**: Facilitate collaboration between Title V programs serving youth, including School Based Health Center and Comprehensive Adolescent Pregnancy Prevention programs, to inclusively address broader health needs of Children and Youth with Special Health Care Needs including social emotional health, oral health, healthy relationships, and sexual reproductive health.
- **Activity CYSHCN-2.8**: Provide subject matter and technical support to NYS Medicaid Program to implement

enhanced care coordination and transition support services for Children and Youth with Special Health Care Needs through Medicaid Children's Health Home, including integration of eligible children also receiving services through the Early Intervention Program, referral of Children and Youth with Special Health Care Needs to Health Homes, and transition from Children's to Adult Health Homes. This includes site visits to Children's Health Homes around NYS where chart reviews are conducted, policies and procedures are reviewed, and feedback is provided to the agencies.

- **Activity CYSHCN-2.9**: Provide representation, subject matter expertise, and policy implementation support for the Health Home Managed Care Organization subcommittee focused on Sickle Cell Disease, which formed following the state's effort to identify Sickle Cell Disease as a single qualifying condition for Health Home enhanced care coordination services. This change makes it easier for individuals with Sickle Cell Disease to gain access to the enhanced care coordination of Medicaid's Health Home.

Strategy CYSHCN-3: **Support comprehensive public health efforts to prevent, identify, and manage activities for children who have confirmed elevated blood lead levels.**

Studies show that no amount of lead exposure is safe for children. Even low levels of lead in blood have been shown to affect a variety of adverse health effects including reduced growth indicators, delayed puberty, and lowered Intelligence Quotient, as well as hyperactivity, attention, behavior, and learning problems. Children under six years old are more likely to be exposed to lead than any other age group, as their normal behaviors result in them breathing in or swallowing dust from old lead paint that gets on floors, windowsills, and hands, and can be found in soil, toys, and other consumer products. New York has more pre-1950 housing containing lead paint than any other state in the nation, with approximately 43 percent of all of New York's dwellings containing lead-based paint.

Effective October 2019, NYS Public Health Law (§1370) and regulations (Part 67 of Title 10 of the New York Codes, Rules, and Regulations) were amended to lower the definition of an elevated blood lead level in a child to 5 micrograms per deciliter (µg/dL), from the previous level of 10 µg/dL. Health care providers in NYS are required to assess or test all young children in accordance with public health regulations, to confirm and report test results, and to ensure appropriate follow-up evaluation and management as needed. Local Health Departments are required to ensure follow up including environmental management based on the child's blood lead level. The Title V Program supports supplemental grants for lead poisoning prevention programs in local health departments, as well as Regional Lead Resource Centers based in academic medical centers to provide outreach and education to health care providers and families, technical assistance, individual case consultation and treatment of childhood lead poisoning. These programs are administered by the NYSDOH Center for Environmental Health. These Title V-funded program elements complement other components of the state's comprehensive public health approach that also includes laboratory testing and reporting, surveillance, outreach and education, and neighborhood-based primary prevention and healthy housing initiatives.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2023-24 year:

- **Activity CYSHCN-3.1**: Provide continued grant funding to local health department Lead Poisoning Prevention Programs and a statewide network of Regional Lead Resource Centers to support enhanced regional and local efforts to reduce the prevalence of elevated blood lead levels in children birth to 18 years.
- **Activity CYSHCN-3.2**: Work with Lead Poisoning Prevention Programs, Regional Lead Resource Centers, and other partners to ensure that all blood lead test results, including testing done in permitted/registered laboratories and point of service testing conducted in health care provider offices, are reported to the NYSDOH within the timeframes required.
- **Activity CYSHCN-3.3**: Through the Regional Lead Resource Centers, support the provision of outreach and education to health care provider and families, technical assistance to providers and Local Health Department

programs, individual case consultation, and treatment of lead poisoning among children, pregnant women, and newborns, including chelation treatment where indicated.

- **Activity CYSHCN-3.4**: Through the Local Health Department Lead Poisoning Prevention Programs and Regional Lead Resource Centers, promote clinical prevention and screening practices in accordance with state requirements, including:
    - Routine blood lead testing for all children at age one year and again at age two years
    - Assessment of all children ages six months to six years at every well visit for risk of lead exposure, with blood lead testing as indicated by risk assessment
    - Provision of anticipatory guidance for all families about lead poisoning prevention as part of routine care.
- **Activity CYSHCN-3.5**: Through the Local Health Department Lead Poisoning Prevention Programs, ensure that all children with elevated blood lead levels receive appropriate evaluation and management, including:
    - Confirmatory venous blood lead testing for capillary screening results ≥ 5 µg/dL
    - A complete diagnostic evaluation that includes a detailed lead exposure assessment, nutritional assessment, and developmental screening
    - Medical treatment, as needed
    - Referral to the appropriate local health department for environmental management.
- **Activity CYSHCN-3.6**: Through the Regional Lead Resource Centers, increase capacity and sustainability in local health care and public health systems by engaging health care providers and professional medical groups in leadership roles within regional or community coalitions focused on the prevention and elimination of lead poisoning.

Strategy CYSHCN-4: Apply public health surveillance and data analysis findings to improve services and systems related to health and health care for children and youth with special health care needs.

As noted in other domains, data-driven, evidence-based practice is essential to achieving public health goals for Children and Youth with Special Health Care Needs. Continuous efforts are needed to enhance the collection, analysis, and sharing of data to inform the planning and implementation of Children and Youth with Special Health Care Needs programs and policy work. Sharing data with stakeholders, including providers, families, youth, and other community members, is critical to raise awareness, empower community action, and facilitate quality improvement efforts at all levels. Title V staff will continue to assess all available data sources to inform public health improvement strategies related to Children and Youth with Special Health Care Needs. A recently published summary document titled “New York State Profile of Children and Youth with Special Health Care Needs, 2019-2020", which updates the program’s 2018-2019 summary, and may serve as one starting point for additional work in this area. This report explores the demographic, health, and functional difficulty profile of the NYS Children and Youth with Special Health Care Needs population, determines the impact that having special health care needs has on children and families, and identifies areas in most need of improvement to ensure NYS Children and Youth with Special Health Care Needs receive care in a well-functioning system. As additional data become available (about annually), Title V staff will update this report, make it available through the NYSDOH public website, and share it with Children and Youth with Special Health Care Needs grantees, partner organizations like Parent to Parent and the New York State Association of County Health Officials.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2023-24year:

- **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 data for NYS to allow for enhanced sampling of Black/African-American, Hispanic, including Children and Youth with Special Health Care Needs populations.

- **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 stakeholders, and post on the Department's public website.
- **Activity CYSHCN-4.4**: Develop and implement plans for updating the current data reporting methods (quarterly and annual reports) of Local Health Department 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: 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.

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

Many NYS families of Children and Youth with Special Health Care Needs are struggling disproportionally with poverty, transportation, access to care which includes availability of specialists in their areas and employment opportunities, caregivers reported having to decrease hours worked or leaving jobs altogether to care for their children and to coordinate their children's care. Families facing day-to-day challenges may be less able to seek and use programs or to even have the time to engage with the State's Children and Youth with Special Health Care Needs programs at the Local Health Department or the State's three Regional Support Centers located at the federally designated Centers of Excellence for Developmental Disabilities (UCEDDs). Recognizing this challenge, NYSDOH, Regional Support Centers, and Local Health Departments need to meet people where they are, provide multiple methods and means for Children and Youth with Special Health Care Needs and their families to engage, and ensure that a diverse population is being recruited and retained by Local Health Departments.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2023-24 year:

- **Activity CYSHCN-5.1**: Support 52 local Children and Youth with Special Health Care Needs programs based in Local Health Departments, including encouraging inclusion and health equity measures in outreach and referrals.
- **Activity CYSHCN-5.2**: Work with the Regional Support Centers and Local Health Department Children and Youth with Special Health Care Needs programs to integrate health equity into written materials, communication, outreach, and referrals for Children and Youth with Special Health Care Needs and families, all of which will reflect the ethnicity and diversity of the community, including engagement strategies. Health literacy will be supported by providing information in multiple languages, at appropriate reading levels and abilities, as available.
- **Activity CYSHCN-5.3**: Develop and implement data collection systems that allows Local Health Department Children and Youth with Special Health Care Needs programs and Sickle Cell Disease care transition contractors to identify, track, and address disparities.
- **Activity CYSHCN-5.4**: Partner with key stakeholders such as Parent to Parent, Local Health Departments, and

Regional Support Centers to identify and share best practices to address racial justice and health equity.

The NYS Title V Program established one Evidence-Based Strategy Measure (ESM) to track the programmatic investments and inputs designed to impact NPM 12:

ESM CYSHCN-1: Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease **Care Transition program and kept a routine medical appointment.**

Data for this measure is from Sickle Cell Disease Care Transition contractor reports. The initial baseline value for this measure from the 2018-2019 program grant cycle was 40.3%; the recent 2021-2022 data reflects an on-going upward trend of 65%. The program improvement target of 5% for 2023 (to 42.3%) has been exceeded. We will aim to be retain the current rate of 65% due to unknown factors during COVID-19 that may have contributed to recent unusual data years.

Cross-Cutting/Systems Building

Cross-Cutting/Systems Builiding - Annual Report

No content was entered for the Cross-Cutting/Systems Building - Annual Report in the State Action Plan Narrative by Domain section.

Cross-Cutting/Systems Building - Application Year

No content was entered for the Cross-Cutting/Systems Building - Application in the State Action Plan Narrative by Domain section.

III.F. Public Input

The mission of the NYS Title V Program is to improve the health and wellness of women, children, and families. Engaging the community to gain a more comprehensive understanding of those factors impacting the health of the community and practical strategies to impact those factors is critical. When the community is engaged, new insights emerge, and ideas staff thought to be true were challenged or refined based on input from those who are directly impacted by the work. Developing approaches to improve health outcomes for all NYS's families requires commitment and partnerships with families, health and human service providers and professionals, organizations, and advocacy groups as well as other key stakeholders.

The NYS Title V Program has always sought public input to ensure the state's Title V strategies and efforts reflected the needs, thoughts, and priorities of all Maternal and Child Health stakeholders. During the reporting period, in addition to the stakeholder group conversations that staff conduct on an on-going basis, a more formal and systematic approach was used to intentionally prioritize specific groups to delve deeply into communities from whom greater understanding of life experience might shed light on disparate health outcomes.

In collaboration with the NYS Maternal, Infant, and Early Child Home Visiting program and a broad network of community-based organizations, forums were hosted across the state with families and community members to facilitate open discussion about individual, family, and community health and services. A total of 37 forums were held in 18 NYS counties and in the Akwesasne Territory of the St. Regis Mohawk Tribe, with over 700 community members. Each forum focused on specific populations including expectant parents and parents of young children, done in partnership with the Maternal, Infant, and Early Childhood Home Visiting program; other adult men and women; adolescents; and families of Children and Youth with Special Health Care Needs. Notes of the discussions were recorded by community partners. Participants were racially diverse and reported primary languages of English, Spanish, Chinese, and Haitian/Creole.

Ten common themes emerged reflecting the voices of forum participants across all population groups and geographic areas. Specific quotes from community members are invaluable in understanding the issues they face. Some powerful examples are included below for each theme.

1. Lack of awareness of resources and services in the community
    - *If it was not for finding myself in a shelter due to a domestic violence situation, I would have not known about resources in my community and I do not feel like that is a good thing. (Expectant or new parent)*
    - *You hear about services too late; you're already struggling. (Expectant or new parent)*
2. Transportation barriers
    - *...here are big gaps in the day when you either have to spend your whole day… go early and spend your whole day waiting for your appointment. So you waste a lot of your day, that you [could] have worked or done something else. (Adolescent)*
    - *I have to let one bill go if I have to go to Buffalo [for medical care]. (Family of a Child with Special Health Care Needs)*
3. Availability and accessibility of services and amenities in the community
    - *There needs to be more after school programs for children and things for them to do so they can use their time. Rather than becoming invested in drugs because they have all this time. (Adolescent)*
    - *Not all providers are a good fit for your child. Due to the limited providers, you have to deal with it not being a good fit if you want your child to receive services because there are no other options. (Family of a Child with Special Health Care Needs)*
4. Poverty and issues of the working poor
    - *If you are in poverty, you are more likely to spend more money because there is this like whole thing of like you pay for something to get it immediately rather than saving up to get something that lasts, so you end up buying something that will break really quick. So you end up spending more money. So really, being poor is expensive. (Adolescent)*

- *Teach children about finances and budgets so they can better manage their futures. (Adult)*
- *If you are making a 'livable wage' you can't qualify for certain services. The system is made for us to fail. If you do improve, you lose services, you fall back. (Expectant or new parent)*

5. Supports for parents and families
   - *I had a c-section and was alone at home. I did not have help. (Expectant or new parent)*
   - *I felt welcome at prenatal visits when they introduced themselves and included me [dad] in the conversation. The doctor let me know as a father how much I can help. Included both of us. (Father)*
   - *I have no family support in this country. (Expectant or new parent)*
6. Social support and social cohesion
   - *Everybody needs to talk even for one second or ten minutes. Even boys. (Adolescent)*
   - *I feel isolated because not everyone is experiencing what I am experiencing. (Family of a Child with Special Health Care Needs)*
   - *Having a village, not doing it alone. (Expectant or new parent)*
7. Health care access, quality, and bias
   - *I've skipped appointments for myself because I can't afford the co-pay. (Adult)*
   - *…you go into the clinic and you see someone different every time. So there's not that relationship with doctors. (Adult)*
   - *If you have a lifestyle, they [providers] don't agree with, they won't respect you. (Adolescent)*
8. Community and environmental safety
   - *I want a community where they can grow up and know that they're safe and can go anywhere they want to go and trust the adults in their community. Right now I am scared for my kids… (Adult)*
   - *I see syringes in the stairs, in the elevators, this is a big need in my building. (Family of a Child with Special Health Care Needs)*
9. Housing
   - *I don't feel there's a system in place to make sure landlords treat you like human beings. (Expectant or new parent)*
   - *My mom waited 3 years for them to put on a door. (Adolescent)*
10. Healthy food
    - *There is never enough to go around. We go to soup kitchen, pantries but there needs to be more. (Adolescent)*
    - *We need more healthy food in the hood all hoods have crappy food. (Expectant or new parent)*

The most common suggestions raised by community members (each mentioned in a quarter of the forums) to help foster healthy, thriving communities included:

- More education for both adolescents and adults about financial literacy and life skills, such as budgeting, taxes, credit, parenting, etc.
- More access to healthy foods through community gardens or farmers markets
- Removing sources of and advertising for unhealthy foods, fast food, bars, and alcohol in communities
- Clean up programs to tidy parks and public spaces.

In addition to the forums, web-based surveys designed for the public and service providers were posted on the NYSDOH website and social media and distributed widely through a broad network of over 20 organizational partner groups. Through a mix of closed- and open-ended questions, providers were asked about what's working and what can be strengthened in their communities; social determinants, root causes, disparities, and health outcomes; community partnerships; population engagement strategies; and to rate a range of potential Maternal and Child Health priorities. Consumer respondents were asked about factors that affect health in their communities, available and needed services, and barriers to and satisfaction with existing services. Over 770 providers and over 320 individual consumers responded, representing all regions of the state.

The Children and Youth with Special Health Care Needs Program sought family feedback through the Regional Support

Centers and their family liaisons by holding meetings with families and resource gathering. Family liaisons are responsible for conducting family engagement sessions with a prescribed set of questions to gauge the needs of Children and Youth with Special Health Care Needs families and they use this feedback to inform educational materials and trainings for Local Health Departments. During this reporting year, these meetings were all virtual, and not in-person as intended, due to the COVID-19 public health emergency. Qualitative data from family sessions was compiled and presented to families and a Family Engagement Report was made available to all Local Health Departments. Information from that Report was also used to present to Local Health Department Children and Youth with Special Health Care Needs programs on a quarterly call in 2022.

Division of Family Health engaged the Title V Maternal and Child Health Advisory Council, which includes the Executive Director of Parent to Parent of NYS and a member from the Schuyler Center for Analysis and Advocacy. The Title V Director and staff reviewed the Needs Assessment and the Maternal and Child Health priorities with the Maternal and Child Health Advisory Council on June 17, 2020. Each year in June, the State's Title V annual report and application are reviewed with the Advisory Council, and their feedback is elicited.

The Division of Family Health is engaging state agencies that serve the Maternal and Child Health population, including the NYS Office for Children and Family Services, the NYS Education Department (NYSED), Office for Temporary and Disability Assistance (OTDA), Council on Children and Families, Office for People with Developmental Disabilities (OPWDD), Office of Mental Health (OMH), Office for Addiction Services and Supports (OASAS), Office of Victim Services (OVS), NYS Parks Department, Department of Agriculture and Markets, Department of Transportation (DOT), NYS Division of Criminal Justice Services (DCJS), Department of State, and the Department of Labor.

The Division of Family Health will continue to seek public input on the Maternal and Child Health Priorities and State Action Plan in the coming year and will further reflect this input in subsequent applications/annual reports.

III.G. Technical Assistance

NYS's Title V Program welcomes opportunities to have periodic teleconferences facilitated by Health Resources and Services Administration staff with other large states focused on specific topics, programs, and initiatives to support Title V outcomes. Several states are focusing on the same of similar priority areas. For example, conversations with the "Big 5" States have been very informative in the development of a more comprehensive approach to supports and services for Children and Youth with Special Health Care Needs and their families as well in planning for the comprehensive Needs Assessment for next year's full five-year application. The Health Resources and Services Administration has supported another collaboration between the states with the biggest populations about maternal mortality. NYS's Title V Program is participating with the other large states on this important topic.

NYS would benefit from focused discussions on efforts related to perinatal regionalization including the development of metrics and processes for ongoing quality improvement, strategies to best engage birthing hospitals to participate in quality improvement work with limited funding, telehealth models to improve access to health care supports and services, state efforts to identify and address maternal mortality and morbidity, specifically related to efforts to address the impact of racism on perinatal health outcomes. Other topics of importance are supporting pregnant and parenting individuals experiencing substance use disorders in the development and implementation of Plans of Safe Care while mitigating the impact of racism and bias in child welfare reporting. Discussions with colleagues in other large states on establishing policy to promote systems change, identifying evidence-based or evidence-informed practices on an ongoing basis, modifying evidence-based programs to better fit the needs of certain populations, and addressing public health issues in more rural areas where the burden is not as great, and resources are limited are just a few additional examples of areas that may be of benefit to discuss in a forum with large states.

In addition, significant travel restrictions continue for staff in the NYSDOH. This may continue to impact the ability of NYS's Title V staff to participate in State or National Conferences and in-person meetings. It would greatly benefit states such as NYS for the Health Resources and Services Administration to utilize technology to share and learn rather than in-person meetings or conferences. It would be helpful if this were the primary mode of transmitting essential information. In addition, the inability to travel to national meetings can impact NYS sharing valuable experiences and showcasing accomplishments with federal and state representatives.

As described in the Maternal and Child Health Workforce Development section, New York's Title V Program has a strong established collaborative relationship with the University at Albany School of Public Health's Health Resources and Services Administration-funded Maternal and Child Health Catalyst program. Our programs have worked closely together for over five years to support mutual goals related to Maternal and Child Health workforce development, including efforts to engage and train students and to support the professional development of current Title V staff. The University at Albany's Maternal and Child Health Catalyst Program has provided technical assistance to the Title V Program for several major projects, including extensive support to plan, implement, and document the comprehensive five-year Needs Assessment and state action plan for this application. The Catalyst Program Co-Directors' strong working knowledge of New York's Title V Program and larger state systems, as well as the geographic proximity of the programs (especially in light of current and anticipated travel restrictions), make this a uniquely strong approach to technical assistance for our program. In the upcoming year and beyond, NYS's Title V Program is interested in working with the Health Resources and Services Administration Maternal and Child Health Bureau to explore how the Bureau may support this relationship to facilitate future technical assistance support from the University at Albany's Maternal and Child Health Catalyst Program.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Intra Agency Agreement between Title V and Medicaid.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - 1. Public and Private Partnerships.pdf

Supporting Document #02 - 2. DOH UAlbany SPH AAP.pdf

Supporting Document #03 - 3. State Action Plan 2024.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - DOH OPH CCH DFH Org Charts 2023.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: New York

	FY 24 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 38,909,810	
A. Preventive and Primary Care for Children	$ 13,769,335	(35.3%)
B. Children with Special Health Care Needs	$ 21,713,203	(55.8%)
C. Title V Administrative Costs	$ 2,814,956	(7.3%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 38,297,494	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 29,285,355	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 47,389,317	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 18,762,687	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 95,437,359	
A. Your State's FY 1989 Maintenance of Effort Amount $ 58,268,752		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 134,347,169	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 66,910,483	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 201,257,652	

OTHER FEDERAL FUNDS	FY 24 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 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
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)	$ 27,142,871
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 3,446,426
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Medicaid Match	$ 13,262,441

	FY 22 Annual Report Budgeted		FY 22 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 38,909,810 (FY 22 Federal Award: $ 38,284,721)		$ 37,088,652	
A. Preventive and Primary Care for Children	$ 17,773,716	(45.7%)	$ 11,288,221	(30.4%)
B. Children with Special Health Care Needs	$ 14,393,781	(37%)	$ 19,293,232	(52%)
C. Title V Administrative Costs	$ 3,366,617	(8.7%)	$ 2,596,237	(7.1%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 35,534,114		$ 33,177,690	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 29,285,355		$ 29,285,355	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 35,897,127		$ 36,881,701	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 21,713,525		$ 26,235,808	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 86,896,007		$ 92,402,864	
A. Your State's FY 1989 Maintenance of Effort Amount $ 58,268,752				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 125,805,817		$ 129,491,516	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 61,858,217		$ 49,502,087	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 187,664,034		$ 178,993,603	

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 2,841,081	$ 1,903,436
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 8,407,073	$ 7,627,187
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 26,271,804	$ 26,271,804
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Sexual Risk Avoidance Education	$ 2,906,486	$ 2,768,883
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Medicaid Match	$ 8,550,489	$ 5,445,881
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > American Rescue Plan Act Funding for Home Visiting	$ 1,398,700	$ 437,835
US Department of Education > Office of Special Education Programs > Individuals with Disabilities Act-Special Education/American Rescue Plan Act of 2021	$ 11,482,584	$ 5,047,061

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2022**
	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, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2022**
	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:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2022**
	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.	
4.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: NY's FY 22 application reflected a budget of over $21 million in Program Income, but actual expenditures were more than anticipated. This is likely related to the timing of the reporting by LHDs rather than an actual increase in expenditures.	

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 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 689	$ 3,851,243
2. Infants < 1 year	$ 521,407	$ 3,825,696
3. Children 1 through 21 Years	$ 13,247,928	$ 7,462,524
4. CSHCN	$ 21,713,203	$ 19,293,232
5. All Others	$ 611,627	$ 59,720
Federal Total of Individuals Served	$ 36,094,854	$ 34,492,415

IB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 17,147,140	$ 13,612,755
2. Infants < 1 year	$ 7,671,198	$ 6,001,597
3. Children 1 through 21 Years	$ 36,610,171	$ 23,040,937
4. CSHCN	$ 10,674,415	$ 17,314,096
5. All Others	$ 23,334,435	$ 32,433,480
Non-Federal Total of Individuals Served	$ 95,437,359	$ 92,402,865
Federal State MCH Block Grant Partnership Total	$ 131,532,213	$ 126,895,280

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:	**2024**
	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:	**2022**
	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 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 2,173,253	$ 1,728,560
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	$ 2,173,253	$ 1,728,560
2. Enabling Services	$ 21,207,780	$ 24,794,331
3. Public Health Services and Systems	$ 15,528,777	$ 10,565,761
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		$ 1,728,560
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		$ 1,728,560
Federal Total	$ 38,909,810	$ 37,088,652

IIB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 22,000,536	$ 13,698,947
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 8,888,654	$ 6,299,242
B. Preventive and Primary Care Services for Children	$ 13,111,882	$ 7,399,705
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 45,813,782	$ 46,891,842
3. Public Health Services and Systems	$ 15,442,818	$ 15,835,407
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		$ 13,698,947
Direct Services Line 4 Expended Total		$ 13,698,947
Non-Federal Total	$ 83,257,136	$ 76,426,196

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIB. - Other - Other**
	Fiscal Year:	**2024**
	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: 208,514 **Data Source Year: 2022**

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	208,408 (99.9%)	1,467	315	315 (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)	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)	Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia	S,S Disease (Sickle Cell Anemia)
Severe Combined Immunodeficiences	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	208,408 (99.9%)	258	0	0 (0%)
Tyrosinemia, type 2, 3	208,408 (99.9%)	11	0	0 (0%)
Spinal Muscular Atrophy	208,408 (99.9%)	5	5	5 (100.0%)
GAMT deficiency	208,408 (99.9%)	7	0	0 (0%)
Krabbe disease	208,408 (99.9%)	19	1	1 (100.0%)
Short-chain acyl-CoA dehydrogenase deficiency/IBCD	208,408 (99.9%)	23	9	9 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Infants in NY are followed until we receive a confirmatory diagnosis. We have begun a long term follow-up program for some of the inherited metabolic diseases with limited funding from NYS to pay the Centers to enter data. Uptake has been slow. We have worked with Centers on progress reports and getting Institutional Review Board approvals at all 10 sites. The plan is to enroll children until age 18 and re-consent enrollees at that age until age 21. We have worked with the Newborn Screening Translational Research Network and their Longitudinal Pediatric Data Resource to create a series of common data elements to be collected. We are in the process of applying for additional funding to move this work forward as there are limited staff within the newborn screening program at present to conduct this work and the necessary follow-up with providers. We are expecting a new module to be added to our Laboratory Information Management System that will allow Centers for easier data entry.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**HIV - Total Number Confirmed Cases**
	Fiscal Year:	**2022**
	Column Name:	**Other Newborn**
	Field Note: Not available. This information cannot be reported.	
2.	**Field Name:**	**HIV - Total Number Referred For Treatment**
	Fiscal Year:	**2022**
	Column Name:	**Other Newborn**
	Field Note: Not available. This information cannot be reported.	

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 2022

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	142,437	46.0	0.0	53.0	1.0	0.0
2. Infants < 1 Year of Age	211,565	46.0	0.0	53.0	1.0	0.0
3. Children 1 through 21 Years of Age	331,485	41.0	0.0	56.0	3.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	154,431	52.0	0.0	47.0	1.0	0.0
4. Others	216,135	24.0	0.0	70.0	6.0	0.0
Total	901,622					

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	210,742	No	208,093	100.0	208,093	142,437
2. Infants < 1 Year of Age	211,541	No	211,565	100.0	211,565	211,565
3. Children 1 through 21 Years of Age	4,903,677	Yes	4,903,677	67.5	3,309,982	331,485
3a. Children with Special Health Care Needs 0 through 21 years of age^	951,373	Yes	951,373	44.8	426,215	154,431
4. Others	14,721,005	Yes	14,721,005	1.8	264,978	216,135

^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:	**2022**

Field Note:
Data for Form 5a were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by the Title V program or are funded by state or other funds but with Title V funded staff support for subject matter expertise and oversight.

The following Maternal and Child Health serving program were included in Form 5a for Pregnant Women:
• Regional Perinatal Centers
• NYS Comprehensive Family Planning Program
• Perinatal and Infant Community Health Collaborative
• Nurse Family Partnership
• Healthy Families New York

Estimates for the Primary Source of Coverage were provided by HRSA.

2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2022**

Field Note:
All NYS infants receive Title V funded or supported services as a result of investments in the state's Newborn Metabolic Screening Program, the Regional Perinatal Centers, the Newborn Hearing Screening Program, and home visiting.

Estimates for the Primary Source of Coverage were provided by HRSA.

3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2022**

Field Note:
Data for Form 5a were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by the Title V program or are funded by state or other funds but with Title V funded staff support for subject matter expertise and oversight.

The following Maternal and Child Health serving program were included in Form 5a for Children 1 through 21 Years of Age:
• School Based Health Centers medical and dental programs
• Child Lead Poisoning Prevention Program
• Community Water Fluoridation
• Local Health Department Children and Youth with Special Health Care Needs Program, including diagnosis and treatment services
• Sickle Cell Disease Program
• Comprehensive Adolescent Pregnancy Prevention and ACT for Youth Center for Community Action
• Family Planning Program
• Nurse Family Partnership
• Healthy Families New York
• Migrant Health Program

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:	**2022**

Field Note:
Data for Form 5a were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by the Title V program or are funded by state or other funds but with Title V funded staff support for subject matter expertise and oversight.

The following Maternal and Child Health serving program were included in Form 5a for Children and Youth with Special Health Care Needs:
• School Based Health Centers medical and dental programs
• Child Lead Poisoning Prevention Program
• Local Health Department Children and Youth with Special Health Care Needs Program, including diagnosis and treatment services
• Sickle Cell Disease Program
• Comprehensive Adolescent Pregnancy Prevention and ACT for Youth Center for Community Action
• Family Planning Program
• Nurse Family Partnership
• Healthy Families New York
• Migrant Health Program

Estimates for the Primary Source of Coverage were provided by HRSA.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2022**

Field Note:
Data for Form 5a were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by the Title V program or are funded by state or other funds but with Title V funded staff support for subject matter expertise and oversight.

The following Maternal and Child Health serving program were included in Form 5a for Other Populations:
• Migrant Health
• Asthma Program
• Perinatal and Infant Health Community Health Collaborative
• Family Planning Program
• Nurse Family Partnership
• Healthy Families New York

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:	**2022**

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 work with 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:	**2022**

Field Note:
Denominator 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:	**2022**

Field Note:
All NYS infants are served by Title V funding as a result of investments in the state's Newborn Metabolic Screening Program, the Newborn Hearing Screening Program, the Regional Perinatal Centers and birthing hospitals, 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:	**2022**

Field Note:
Denominator 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:	**2022**

Field Note:
Data for Form 5b were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by the Title V program or are funded by state or other funds but with Title V funded staff support for subject matter expertise and oversight.

The following Maternal and Child Health serving program were included in Form 5b for Children 1 through 21 Years of Age:
• Medicaid Program
• School Based Health Centers medical and dental programs
• Child Lead Poisoning Prevention Program
• Comprehensive Adolescent Pregnancy Prevention and ACT for Youth Center for Community Action
• Local Health Department Children and Youth with Special Health Care Needs Programs
• Family Planning Program
• Nurse Family Partnership
• Healthy Families New York

Note: Since approximately 50% of NYS children have Medicaid coverage and were included in the count of children served by Title V leadership and subject matter expertise, the other Maternal and Child Health serving programs were reduced by 50% to reduce the potential for overcounting or double counting children served by Title V funding.

6.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**

Field Note:
Data for Form 5b were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by the Title V program or are funded by state or other funds but with Title V funded staff support for subject matter expertise and oversight.

The following Maternal and Child Health serving program were included in Form 5b for Children with Special Health Care Needs:
• School Based Health Centers medical and dental programs
• Child Lead Poisoning Prevention Program
• Comprehensive Adolescent Pregnancy Prevention and ACT for Youth Center for Community Action
• Family Planning Program
• Nurse Family Partnership
• Healthy Families New York

Note: Since approximately 50% of NYS children have Medicaid coverage and were included in the count of children served by Title V leadership and subject matter expertise, the other Maternal and Child Health serving programs were reduced by 50% to reduce the potential for overcounting or double counting children served by Title V funding.

7.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2022**

Field Note:
Data for Form 5b were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by the Title V program or are funded by state or other funds but with Title V funded staff support for subject matter expertise and oversight.

The following Maternal and Child Health serving program were included in Form 5b for Other Populations:
• Family Planning Program
• Asthma Program
• Migrant Health
• Perinatal and Infant Community Health Collaborative
• Nurse Family Partnership
• Healthy Families New York

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 2022

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	208,093	102,859	27,676	48,953	309	19,415	1,119	3,575	4,187
Title V Served	208,093	102,859	27,676	48,953	309	19,415	1,119	3,575	4,187
Eligible for Title XIX	101,691	34,914	18,000	34,709	216	9,253	279	1,742	2,578
2. Total Infants in State	211,565	104,662	28,253	49,624	315	19,675	1,136	3,636	4,264
Title V Served	211,565	104,662	28,253	49,624	315	19,675	1,136	3,636	4,264
Eligible for Title XIX	103,216	35,407	18,382	35,170	217	9,366	284	1,768	2,622

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: New York

A. State MCH Toll-Free Telephone Lines	2024 Application Year	2022 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 522-5066	(800) 522-5066
2. State MCH Toll-Free "Hotline" Name	Growing Up Healthy Hotline	Growing Up Healthy Hotline
3. Name of Contact Person for State MCH "Hotline"	Cindi Dubner	Cindi Dubner
4. Contact Person's Telephone Number	(518) 474-6968	(518) 474-6968
5. Number of Calls Received on the State MCH "Hotline"		10,507

B. Other Appropriate Methods	2024 Application Year	2022 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address		
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form 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	5184746968
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	5184741961
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	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: New York

Application Year 2024

No.	Priority Need
1.	Address equity, bias, quality of care, and barriers to access in health care services for women and families, especially for communities of color and low-income communities
2.	Promote awareness and enhance availability, accessibility and coordination of services for families and youth, including CYSHCN, with a focus on areas impacted by systemic barriers, including racism
3.	Enhance supports for parents and families, especially those with children with special health care needs, and inclusive of all family members and caregivers
4.	Cultivate and enhance social support and social cohesion opportunities for individuals and families who experience isolation as a result of systemic barriers including racism, across the life course
5.	Increase access to affordable fresh and healthy foods in communities.
6.	Address community and environmental safety for children, youth, and families.
7.	Acknowledge and address the fundamental challenges faced by families in poverty and near-poverty, including the “working poor” as a result of systemic barriers, including racism.
8.	Increase awareness of resources and services in the community among families and the providers who serve them.
9.	Increase the availability and quality of affordable housing.
10.	Address transportation barriers for individuals and families.

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Address equity, bias, quality of care, and barriers to access in health care services for women and families, especially for communities of color and low-income communities	New
2.	Promote awareness and enhance availability, accessibility and coordination of services for families and youth, including CYSHCN, with a focus on areas impacted by systemic barriers, including racism	New
3.	Enhance supports for parents and families, especially those with children with special health care needs, and inclusive of all family members and caregivers	New
4.	Cultivate and enhance social support and social cohesion opportunities for individuals and families who experience isolation as a result of systemic barriers including racism, across the life course	New
5.	Increase access to affordable fresh and healthy foods in communities.	New
6.	Address community and environmental safety for children, youth, and families.	New
7.	Acknowledge and address the fundamental challenges faces by families in poverty and near-poverty, including the “working poor” as a result of systemic barriers, including racism.	New
8.	Increase awareness of resources and services in the community among families and the providers who serve them.	New
9.	Increase the availability and quality of affordable housing.	New
10.	Address transportation barriers for individuals and families.	New

Form 10
National Outcome Measures (NOMs)

State: New York

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	80.7 %	0.1 %	165,046	204,508
2020	80.6 %	0.1 %	164,090	203,541
2019	81.3 %	0.1 %	175,882	216,241
2018	80.9 %	0.1 %	177,826	219,882
2017	80.6 %	0.1 %	180,884	224,372
2016	80.7 %	0.1 %	185,073	229,239
2015	80.3 %	0.1 %	184,418	229,561
2014	79.1 %	0.1 %	182,737	231,024
2013	75.4 %	0.1 %	173,442	230,047
2012	74.5 %	0.1 %	173,825	233,372
2011	73.7 %	0.1 %	172,588	234,324
2010	73.9 %	0.1 %	174,690	236,300
2009	74.1 %	0.1 %	174,327	235,200

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	26.5 %	0.1 %	55,657	210,396
2020	25.5 %	0.1 %	53,193	208,997
2019	24.7 %	0.1 %	54,745	221,211
2018	23.7 %	0.1 %	53,647	225,904
2017	23.5 %	0.1 %	53,936	229,382
2016	23.4 %	0.1 %	54,862	233,991
2015	22.8 %	0.1 %	54,082	236,998
2014	22.7 %	0.1 %	54,104	238,475
2013	22.9 %	0.1 %	54,190	236,558
2012	23.4 %	0.1 %	56,356	240,504
2011	23.5 %	0.1 %	56,643	240,932
2010	24.2 %	0.1 %	59,001	244,016
2009	24.9 %	0.1 %	61,620	247,770

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021/Q1-2021/Q4	2.0 %			
2020/Q4-2021/Q3	2.0 %			
2020/Q3-2021/Q1	2.0 %			
2019/Q4-2020/Q3	1.0 %			
2019/Q1-2019/Q4	1.0 %			
2018/Q4-2019/Q3	1.0 %			
2018/Q3-2019/Q2	1.0 %			
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	1.0 %			
2017/Q3-2018/Q2	1.0 %			
2017/Q2-2018/Q1	1.0 %			
2017/Q1-2017/Q4	1.0 %			
2016/Q4-2017/Q3	1.0 %			
2016/Q3-2017/Q2	1.0 %			
2016/Q2-2017/Q1	1.0 %			
2016/Q1-2016/Q4	1.0 %			
2015/Q4-2016/Q3	1.0 %			
2015/Q3-2016/Q2	2.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	4.0 %			
2013/Q3-2014/Q2	4.0 %			
2013/Q2-2014/Q1	5.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	6.0 %	1.0 %	6,174	102,639
2019	7.8 %	1.4 %	8,029	102,532
2018	8.4 %	1.3 %	8,636	102,696
2017	7.3 %	1.3 %	7,606	103,903
2016	6.0 %	0.9 %	6,230	104,133
2015	8.3 %	0.7 %	17,596	213,268
2014	9.5 %	0.7 %	20,794	218,296
2013	9.5 %	0.8 %	20,516	216,615
2012	9.9 %	1.0 %	10,943	110,416
2011	8.4 %	0.7 %	18,417	218,407
2010	8.1 %	0.7 %	18,042	222,166
2008	7.3 %	1.0 %	8,464	115,245
2007	8.4 %	0.7 %	19,845	235,020

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

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

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

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

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	11.8 %	1.2 %	447,601	3,803,133
2019_2020	12.0 %	1.4 %	453,042	3,776,792
2018_2019	11.2 %	1.6 %	422,964	3,792,855
2017_2018	11.1 %	1.6 %	428,582	3,870,687
2016_2017	10.3 %	1.4 %	396,968	3,835,834
2016	8.4 %	1.4 %	317,135	3,758,559

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 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2021	5.4	0.4	192	3,537,487
2018_2020	5.6	0.4	196	3,517,371
2017_2019	6.2	0.4	221	3,585,673
2016_2018	6.0	0.4	218	3,647,654
2015_2017	5.4	0.4	201	3,709,210
2014_2016	5.0	0.4	189	3,750,090
2013_2015	4.6	0.4	175	3,792,482
2012_2014	5.2	0.4	201	3,850,581
2011_2013	5.6	0.4	218	3,911,971
2010_2012	5.7	0.4	227	3,998,477
2009_2011	5.2	0.4	212	4,071,307
2008_2010	4.2	0.3	175	4,137,652
2007_2009	3.9	0.3	163	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 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	18.6 %	1.3 %	743,518	3,987,379
2019_2020	19.7 %	1.4 %	791,909	4,019,877
2018_2019	18.4 %	1.6 %	751,706	4,084,608
2017_2018	15.8 %	1.6 %	656,207	4,140,731
2016_2017	16.5 %	1.4 %	689,627	4,169,385
2016	18.3 %	1.7 %	765,082	4,185,517

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 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	11.3 %	2.3 %	84,034	743,518
2019_2020	12.7 %	2.5 %	100,355	791,909
2018_2019	11.0 %	2.3 %	82,499	751,706
2017_2018	15.2 %	3.5 %	99,924	656,207
2016_2017	15.0 %	3.1 %	103,462	689,627
2016	11.0 %	2.7 %	83,973	765,082

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 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	3.1 %	0.7 %	103,700	3,354,575
2019_2020	2.1 %	0.4 %	70,503	3,378,025
2018_2019	2.6 %	0.7 %	88,286	3,332,666
2017_2018	3.1 %	0.8 %	107,077	3,441,661
2016_2017	2.5 %	0.5 %	85,905	3,457,869
2016	2.5 %	0.6 %	83,469	3,349,664

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 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	7.7 %	1.0 %	256,502	3,338,505
2019_2020	7.2 %	1.0 %	243,138	3,377,728
2018_2019	6.0 %	1.0 %	199,467	3,330,834
2017_2018	5.3 %	0.9 %	181,410	3,441,139
2016_2017	6.1 %	0.9 %	209,010	3,435,443
2016	7.5 %	1.3 %	246,377	3,292,586

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 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	52.5 %	5.0 %	228,700	435,932
2019_2020	58.1 %	5.6 %	248,568	427,829
2018_2019	58.1 %	6.6 %	225,173	387,496
2017_2018	53.5 %	7.3 %	149,733	279,615
2016_2017	45.5 %	5.6 %	131,277	288,794
2016	45.2 %	6.7 %	169,907	375,487

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 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	91.6 %	1.0 %	3,627,711	3,959,518
2019_2020	91.8 %	1.2 %	3,670,464	3,999,791
2018_2019	91.4 %	1.3 %	3,721,719	4,071,957
2017_2018	91.2 %	1.3 %	3,768,420	4,131,497
2016_2017	90.0 %	1.3 %	3,731,359	4,144,180
2016	89.3 %	1.6 %	3,694,889	4,139,390

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 19 - Notes:

None

Data Alerts: None

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)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	13.6 %	0.1 %	14,137	103,959
2018	14.0 %	0.1 %	23,080	164,822
2016	13.7 %	0.1 %	25,048	182,401
2014	14.3 %	0.1 %	27,888	195,413
2012	15.1 %	0.1 %	28,760	189,928
2010	16.1 %	0.1 %	30,128	186,760
2008	16.4 %	0.1 %	27,601	168,629

Legends:

Indicator has a denominator <20 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	16.1 %	1.6 %	106,407	661,227
2019	13.4 %	0.9 %	93,266	696,658
2017	12.4 %	0.9 %	86,909	699,950
2015	13.1 %	0.8 %	93,740	713,323
2013	10.6 %	0.5 %	75,265	711,539
2011	11.0 %	0.6 %	85,634	777,042
2009	10.8 %	0.9 %	69,040	639,137
2007	10.8 %	0.6 %	80,363	745,792
2005	10.3 %	0.7 %	78,925	765,158

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2020_2021	15.6 %	2.0 %	267,570	1,712,335
2019_2020	11.5 %	1.8 %	208,680	1,816,786
2018_2019	10.7 %	2.0 %	200,961	1,873,439
2017_2018	14.4 %	2.3 %	267,724	1,853,746
2016_2017	15.3 %	2.2 %	271,153	1,767,904
2016	14.8 %	2.5 %	247,537	1,673,430

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 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	2.7 %	0.2 %	109,214	4,099,187
2019	2.3 %	0.1 %	92,621	4,017,665
2018	2.2 %	0.1 %	91,033	4,060,665
2017	2.7 %	0.2 %	112,728	4,146,346
2016	2.5 %	0.2 %	103,337	4,173,030
2015	2.5 %	0.1 %	105,108	4,203,284
2014	3.4 %	0.2 %	142,448	4,218,611
2013	4.1 %	0.2 %	172,518	4,229,729
2012	4.0 %	0.2 %	170,847	4,255,688
2011	4.4 %	0.2 %	188,067	4,276,363
2010	4.8 %	0.2 %	205,478	4,310,594
2009	4.8 %	0.2 %	211,576	4,422,300

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	70.7 %	2.4 %	156,000	221,000
2017	70.2 %	2.7 %	159,000	226,000
2016	63.8 %	3.1 %	154,000	241,000
2015	66.9 %	2.8 %	157,000	234,000
2014	68.3 %	2.5 %	161,000	236,000
2013	69.7 %	2.5 %	165,000	236,000
2012	66.3 %	2.7 %	158,000	238,000
2011	66.2 %	2.9 %	159,000	241,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	63.4 %	1.1 %	2,352,560	3,712,038
2020_2021	64.7 %	1.4 %	2,431,000	3,757,342
2019_2020	69.6 %	1.1 %	2,645,284	3,800,695
2018_2019	69.6 %	1.3 %	2,682,388	3,852,898
2017_2018	64.9 %	1.4 %	2,540,516	3,914,345
2016_2017	65.9 %	1.2 %	2,577,837	3,909,960
2015_2016	65.6 %	1.3 %	2,586,217	3,943,606
2014_2015	67.0 %	1.4 %	2,665,415	3,975,858
2013_2014	64.5 %	1.3 %	2,569,841	3,983,768
2012_2013	60.9 %	1.4 %	2,443,270	4,014,396
2011_2012	54.8 %	1.8 %	2,235,474	4,081,388
2010_2011	54.3 %	1.8 %	2,196,305	4,044,760
2009_2010	47.8 %	2.4 %	1,749,743	3,660,551

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	75.9 %	2.4 %	836,764	1,101,902
2020	79.1 %	2.0 %	883,063	1,116,158
2019	70.8 %	2.8 %	796,876	1,125,173
2018	67.3 %	2.7 %	774,548	1,151,627
2017	68.5 %	2.2 %	802,423	1,170,574
2016	71.5 %	2.1 %	843,600	1,179,474
2015	61.3 %	2.3 %	730,501	1,192,326

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	87.3 %	1.8 %	962,030	1,101,902
2020	93.0 %	1.3 %	1,038,391	1,116,158
2019	93.4 %	1.2 %	1,050,427	1,125,173
2018	91.7 %	1.3 %	1,056,227	1,151,627
2017	92.9 %	1.1 %	1,087,093	1,170,574
2016	91.2 %	1.3 %	1,075,050	1,179,474
2015	89.0 %	1.5 %	1,061,525	1,192,326
2014	91.5 %	1.5 %	1,101,490	1,204,315
2013	89.5 %	1.5 %	1,079,545	1,206,859
2012	90.3 %	1.5 %	1,098,346	1,216,701
2011	88.5 %	1.3 %	1,096,560	1,238,598
2010	82.9 %	1.8 %	1,041,143	1,255,446
2009	69.2 %	2.4 %	901,124	1,302,154

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	93.8 %	1.3 %	1,033,948	1,101,902
2020	93.7 %	1.2 %	1,045,669	1,116,158
2019	95.0 %	1.1 %	1,068,518	1,125,173
2018	94.9 %	1.2 %	1,092,813	1,151,627
2017	89.3 %	1.5 %	1,045,009	1,170,574
2016	89.2 %	1.5 %	1,052,380	1,179,474
2015	86.2 %	1.6 %	1,028,154	1,192,326
2014	79.6 %	2.1 %	958,880	1,204,315
2013	83.4 %	1.7 %	1,005,909	1,206,859
2012	78.5 %	2.1 %	954,645	1,216,701
2011	74.9 %	1.9 %	927,636	1,238,598
2010	71.2 %	2.3 %	893,640	1,255,446
2009	62.9 %	2.6 %	818,840	1,302,154

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	11.7 %	0.9 %	21,602	184,546
2020	10.0 %	1.0 %	8,396	84,005
2019	12.9 %	1.1 %	25,052	194,416
2018	13.2 %	1.0 %	25,880	196,096
2017	13.0 %	0.9 %	26,713	204,888
2016	13.6 %	0.9 %	28,516	209,969
2015	12.2 %	0.9 %	25,899	212,047
2014	11.4 %	0.8 %	24,427	214,506
2013	11.0 %	0.8 %	23,561	213,692
2012	12.0 %	1.1 %	13,109	109,303

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	3.5 %	0.7 %	138,269	3,948,249
2019_2020	2.6 %	0.6 %	104,480	3,990,306
2018_2019	1.8 %	0.6 %	71,665	4,007,278
2017_2018	2.2 %	0.8 %	87,291	4,015,472
2016_2017	2.1 %	0.7 %	84,929	4,099,217
2016	2.0 %	0.6 %	81,336	4,165,523

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 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: New York

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective			79.4	81.3	81.3
Annual Indicator		79.6	78.3	75.9	75.9
Numerator		2,826,660	2,737,695	2,698,183	2,698,183
Denominator		3,550,054	3,498,639	3,553,627	3,553,627
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2021	2021

Previous NPM-1 BRFSS data for survey year 2017 that was pre-populated under the 2018 Annual Report Year is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	82.2	83.1	83.3

Field Level Notes for Form 10 NPMs:

None

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

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

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	93.4	93.7	93	92.4	92.6
Annual Indicator	92.5	91.2	92.2	91.6	91.3
Numerator		2,782	2,626	2,610	2,437
Denominator		3,052	2,849	2,850	2,668
Data Source	NYS VS	NYS VS	NYS VS	NYS VS	NYS VS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	92.8	93.1	93.4

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
2016 data provided by NYS Vital Statistics as of May 2019

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CHILD				
	2019	**2020**	**2021**	**2022**
Annual Objective			27.8	27.8
Annual Indicator	27.0	27.4	24.1	24.1
Numerator	369,498	316,874	308,176	308,176
Denominator	1,370,994	1,158,167	1,278,404	1,278,404
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2017_2018	2018_2019	2020_2021	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	28.1	28.4	28.6

Field Level Notes for Form 10 NPMs:

None

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	81.2	82.2	83.2	82.2	82.2
Annual Indicator	81.3	81.3	86.3	72.8	72.8
Numerator	1,081,532	1,081,532	1,367,654	976,520	976,520
Denominator	1,331,106	1,331,106	1,583,876	1,341,167	1,341,167
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2016_2017	2019	2020_2021	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	82.9	83.8	84.6

Field Level Notes for Form 10 NPMs:

None

NPM 12 - 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 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	15.7	15.9	16.1	18.1	18.1
Annual Indicator	13.7	17.8	23.6	11.8	11.8
Numerator	34,736	48,580	87,040	40,243	40,243
Denominator	253,092	273,067	369,539	340,705	340,705
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2020_2021	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	18.3	18.5	18.7

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: New York

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

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			75	77
Annual Indicator	70	68	70	70.6
Numerator				
Denominator				
Data Source	Newborn Blood Spot data	Newborn Blood Spot data	Newborn Blood Spot data	Newborn Blood Spot data
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	79.0	81.0	85.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: QI project did not begin until December 2019, snow storm after Thanksgiving caused shipping delays that impact timeliness of the lab receiving samples.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2020 data was significantly impacted by the 2019 snow storm and subsequent holiday shipping delays early in the year and then by the COVID-19 pandemic for the remainder of the year. 2020 data was reported as preliminary in 2022 application and now finalized for 2023 application.	

SPM 2 - Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months

Measure Status:			Active	
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			3.6	12.1
Annual Indicator		3.6	12.1	10.4
Numerator		1,772	6,063	4,443
Denominator		498,946	502,219	428,592
Data Source		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
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	12.0	11.9	11.8

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2021 is the baseline year. Incidence of confirmed (>=10 ug/dL) high blood lead levels per 1,000 tested children aged less than 72 months' is 3.55 for test year 2018.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Update baseline to test year 2019 for incidence of confirmed (>=5 ug/dL) high blood lead levels per 1,000 tested children aged less than 72 months. 2016-2019 NYS Child Health Lead Poisoning Prevention Program Data as of September 2021 from Community Health Indicator Reports (CHIRS).	

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: New York

ESM 1.1 - Percent of Maternal and Infant Community Health Collaboratives (MICHC) program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker (CHW)

Measure Status:	Active

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

Annual Objectives			
	2023	2024	2025
Annual Objective	61.0	64.1	67.3

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Baseline data period for 10/1/19-3/31/20	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data collection period was 10/1/19-9/30/20, note the first half of this period is inclusive of the baseline data period.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numbers reported for program period of 4/1/21- 9/30/21 as new data system was implemented as of 4/1/21. Current measure is updated and more accurate with the use of data system than previous data collection allowed.	

ESM 1.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			37.5	37.7
Annual Indicator	37.3	36.2	29.7	32.9
Numerator		92,136	58,264	66,886
Denominator		254,718	195,847	203,468
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
Data Source Year	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	37.9	38.2	38.2

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Decline in 2020 rates assumed due to COVID

ESM 3.1 - Percent of birthing hospitals with final level of perinatal care designation, in accordance with updated regulations and standards

Measure Status:	Active

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

Annual Objectives			
	2023	2024	2025
Annual Objective	50.0	75.0	100.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Re-designation process still underway, no data to report. Anticipate completion in December 2021.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Re-designation still in process; no data to report	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Re-designation still in process; no data to report	

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.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			51.6	51.6
Annual Indicator		51.6	43	35.1
Numerator		98,941	74,325	54,615
Denominator		191,920	172,751	155,443
Data Source		SBHC quarterly report	SBHC quarterly report	SBHC quarterly report
Data Source Year		2018-2019	2019-2020	2020-2021
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	52.6	53.6	54.7

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data is based on July 1, 2018-June 30, 2019. 10 SBHC sites were excluded because their percentage exceeded 100%. Measure wording changes: ESM 8.1.1 - Percent of children and youth enrolled in School Based Health Centers (SBHCs) who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a SBHC within the past year"	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data is based on July 1, 2019-June 30, 2020. Data notes: 8 SBHC sites were excluded because their percentage exceeded 100%. Many SBHCs closed in March of 2020 due to the COVID-19 public health emergency.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Grant cycle: July 1, 2020-June 30, 2021. Six SBHC sites were excluded because their percentage exceeded 100%.	

ESM 10.1 - Percent of youth-serving programs that provide training on adult preparation subjects, such as accessing health insurance, maintaining their routine preventive medical visits, healthy relationships, effective communication, financial literacy, etc.

Measure Status:			Active	
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			96.3	96.3
Annual Indicator		96.3	100	100
Numerator		52	52	52
Denominator		54	52	52
Data Source		Survey of CAPP and PREP Programs	Survey of CAPP and PREP Programs	Survey of CAPP and PREP Programs
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	98.2	100.0	100.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Baseline data period 7/1/20-12/31/20. Surveyed CAPP &/or PREP providers, those who checked that they did training or education with youth/adolescent participants in the following topics included in numerator: Accessing health insurance, Healthy relationships, Educational and career success, Financial literacy, Healthy life skills, Maintaining routine preventive medical visits, Transitioning to adult health care, and relevant "Other" topics. 100% response rate

2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Data from 1/1/2021 - 12/31/2021.

Surveyed CAPP &/or PREP providers, those who checked that they did training or education with youth/adolescent participants in the following topics included in numerator: Accessing health insurance, Healthy relationships, Educational and career success, Financial literacy, Healthy life skills, Maintaining routine preventive medical visits, Transitioning to adult health care, and relevant "Other" topics. Response rate: 96.3% (52/54)

3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Total of 53 programs, one did not respond (missing data)

ESM 10.2 - Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			68.7	70.1
Annual Indicator		68.7	78.1	79.4
Numerator		46	50	50
Denominator		67	64	63
Data Source		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
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	71.6	73.1	74.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data from 7/1/2020 - 12/31/20. Baseline data period is 7/1/20-12/31/20. Surveyed CAPP, PREP, & SRAE providers, those who responded yes to engaging youth in program planning and implementation included in numerator, 100% response rate	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data from 1/1/2021 - 12/31/21. Surveyed CAPP, PREP, & SRAE providers, those who responded yes to engaging youth in program planning and implementation included in numerator. Response rate: 97.0% (64/66).	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Total of 65 programs, two did not respond (missing data)	

ESM 12.1 - Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.

Measure Status:			Active	
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			40.3	41.1
Annual Indicator	40.3	62.4	66.1	74.8
Numerator		295	323	450
Denominator		473	489	602
Data Source	Contractor Reports	Contractor Reports	Contractor Reports	Contractor Reports
Data Source Year	2018-2019	2019-2020	2020-2021	2021-2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	41.5	41.9	42.3

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Baseline based on 2018-2019 data	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Based on 2019-2020 data.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data from 7/1/2020 - 6/30/2021	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data from July 1, 2021-June 30, 2022	

Form 10
State Performance Measure (SPM) Detail Sheets

State: New York

SPM 1 - Percent of samples received by the State Newborn Screening lab within 48 hours of collection
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	The goal is to achieve state-wide improvement from 74.34% to greater than 85% of samples received at the lab within 48 hours of collection by September 2023
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of samples received within 48 hours of collection **Denominator:** Number of births
Data Sources and Data Issues:	NYS Newborn Blood Spot Data
Significance:	This SPM was developed to reflect the state's continued commitment to ensure that every newborn in the state receives newborn bloodspot screening as a public health service, to identify and support infants with a wide range of medical conditions. As a population-based program, the NBS program is an integral part of NY's public health system for supporting the health and lifelong well-being of newborns and their families. In 2018, the program screened 222,049 infants, 99.98% of all NYS resident infants born that year, and timely receipt of the sample is critical to ensure appropriate care can be provided. The Title V Program will collaborate with the Newborn Blood Spot Program to support the quality improvement initiative to improve timely receipt of newborn blood spot samples.

SPM 2 - Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months
Population Domain(s) – Children with Special Health Care Needs

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Reduce the incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months by at least 5% each year.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Rate</td></tr>
<tr><td>Unit Number:</td><td>1,000</td></tr>
<tr><td>Numerator:</td><td>Number of children ages less than 72 months old with blood lead levels 5.0 micrograms per deciliter or greater</td></tr>
<tr><td>Denominator:</td><td>Number of children ages less than 72 months old with blood lead tests</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Baseline data is based on the confirmed high blood lead levels (>=10 ug/dL) from 2015-2018 NYS Child Health Lead Poisoning Prevention Program Data as of November, 2020.</td></tr>
<tr><td>Significance:</td><td>This SPM was developed to reflect the state’s longstanding commitment to eliminating childhood lead poisoning as a key public health problem in NYS. It is responsive to cross-cutting priorities voiced by families related to safe and healthy environments to support children’s development, and access to comprehensive, high quality health care services. It is also responsive to specific concerns shared by families regarding challenges in accessing and coordinating medical care and related services for children with special health care needs. It builds on critical public health investments and capacity to prevent, identify, and address lead poisoning in NYS, including recent amendments to state public health law</td></tr>
</table>

Form 10
State Outcome Measure (SOM) Detail Sheets

State: New York

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: New York

ESM 1.1 - Percent of Maternal and Infant Community Health Collaboratives (MICHC) program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker (CHW)
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	The baseline value for this measure, taken from 6-month program period of 10/1/19-3/31/20, is 52.7%. The program has set an improvement target of 5% annually, to 67.3% of participants by 2024.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of MICHC participants engaged prenatally who have created a birth plan during a visit with a CHW **Denominator:** Number of MICHC participants engaged prenatally with a CHW
Data Sources and Data Issues:	Data for this measure will come from quarterly and annual reports submitted by local MICHC contractors.
Significance:	Through the Maternal & Infant Community Heath Collaboratives (MICHC) program, community health workers (CHWs) conduct basic health and well-being assessments in the prenatal and postpartum periods, using standardized evidence-based and/or validated screening tools, to identify and prioritize needs of the individuals and families served. Assessments are completed at enrollment and updated throughout clients' service periods and individualized care plans are developed based on the needs identified. CHWs receive annual training on how to talk with families about difficult topics like mental health and depression, using a trauma informed care approach, and including how to manage emergency situations. CHWs also connect clients and families to needed services and provide enhanced social support. CHWs help ensure early and consistent participation in preventive and primary health care services, including early prenatal care, particularly for those individuals not engaged in care and other supportive services. CHWs provide health information to increase clients' knowledge and ability to self-advocate and make informed health care decisions, with the goal of helping families achieve optimal health, self-sufficiency, and overall well-being.

ESM 1.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Current FPP data for program year 2018 shows 37.3% of female FPP clients had a documented comprehensive medical exam. The FPP program has set a five-year improvement target of 2.5%, to 38.2% of clients in 2023.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Family Planning Program clients with a documented comprehensive medical exam in the past year **Denominator:** Number of FPP clients
Data Sources and Data Issues:	Data for this measure will come from FPP clinic visit record (CVR) data.
Significance:	The NYS Family Planning Program (FPP) supports 43 Article 28 health facilities (i.e., hospitals and clinics) that operate 156 family planning service sites across the state. Through these service sites, the FPP delivers comprehensive, confidential reproductive health services for low-income, uninsured and underinsured women and men of reproductive age. Services provided include: contraceptive services; preconception planning and counseling services; pregnancy testing and related counseling; preventive services such as basic health screening, screening for sexually transmitted diseases, HIV counseling and testing, breast and cervical cancer screening; and appropriate referrals and health education.

ESM 3.1 - Percent of birthing hospitals with final level of perinatal care designation, in accordance with updated regulations and standards
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	The baseline value for this measure will be determined after regulations are adopted (anticipated in December 2021). The program has set a target to update designations for 50% of hospitals within one year post-adoption and 100% within three years.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of birthing hospitals with final level of perinatal care designation **Denominator:** Number of birthing hospitals
Data Sources and Data Issues:	Data for this measure will come from hospital surveys and site visit reports from IPRO/NYSDOH staff
Significance:	NYS historically has been a leader in establishing systems of perinatal regionalization, with consistently high performance in this measure. Building on that success, the Title V program is currently engaged in a multi-year effort to expand and update perinatal regionalization standards and designations for the state's birthing hospitals and centers. As this work progresses, it is essential to closely monitor the success of designating birthing hospitals in accordance with updated regulations as well as performance and outcome measures to ensure that quality of care and key health outcomes are maintained or improved.

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.
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	The baseline for 2021 (51.6%) has been established using program year 2018-2019 data. Targets have been established to achieve a 2% increase each year.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Children and youth enrolled in SBHCs who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a SBHC within the past year **Denominator:** Children with a visit to a SBHC within the past year
Data Sources and Data Issues:	Data for this measure comes from the SBHC quarterly reports. Targets have been established to achieve a 2% increase each year, except for 2022 as the first year is primarily a planning year and an increase in anticipatory guidance delivery is not expected.
Significance:	NY's Title V program has important capacity to address these priorities through its School Based Health Center (SBHC) program. SBHCs serve NYS's highest need communities and provide critical access to quality primary care for school-aged children. SBHCs are an important source of primary and preventive care services for thousands of NYS children, and have the opportunity and capacity to holistically address children's needs. Title V staff will work with SBHCs statewide to ensure anticipatory guidance to promote proper nutrition and daily physical activity, weight status assessment, and attention to overall health promotion and chronic disease management, as part of routine primary and preventive care for children.

ESM 10.1 - Percent of youth-serving programs that provide training on adult preparation subjects, such as accessing health insurance, maintaining their routine preventive medical visits, healthy relationships, effective communication, financial literacy, etc.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>The baseline value for this measure, taken from a 6-month program period of 7/1/2020 – 12/31/20, is 96.3%. The program has set an improvement target of 100% by 2025.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of youth-serving programs that provide training on adult preparation subjects for adolescents with and without special health care needs to prepare them for a transition into adulthood</td></tr>
<tr><td>Denominator:</td><td>Number of youth-serving programs that provide training on adult preparation subjects for adolescents with and without special health</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data for this measure will come from biannual reports and annual data requests submitted by local adolescent health providers.</td></tr>
<tr><td>Significance:</td><td>Adolescence is a critical stage of development when children grow physically, cognitively, emotionally, and socially to become adults. The lifestyle choices, behaviors, and relationships established during this time can affect an adolescent’s current and future health. Comprehensive and inclusive reproductive health care and education are opportunities to help adolescents avoid or mitigate risky sexual behaviors. Title V Programs also provide enabling services to adolescents, such as referrals to and linkages with community services and social supports to holistically address health and wellness, including mental health and social determinants of health.</td></tr>
</table>

ESM 10.2 - Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	The baseline value for this measure, taken from a 6-month program period of 7/1/2020 – 12/31/20, is 68.7%. The program has set an improvement target of 75% by 2025.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation **Denominator:** Number of youth-serving programs
Data Sources and Data Issues:	Data for this measure will come from biannual reports and annual data requests submitted by adolescent health providers.
Significance:	Significance needed

ESM 12.1 - 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 12 – 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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>The baseline value for this measure, from the 2018-19 program grant cycle, is 40.3%. The program has set an improvement target of 5% for 2022, to 42.3%.</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 ages 14-21 with sickle cell disease who had transition readiness assessments completed</td></tr>
<tr><td>Denominator:</td><td>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</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Sickle Cell Disease Care Transition contractor reports</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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
MCH Data Access and Linkages

State: New York

Annual Report Year 2022

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Quarterly	3		• Hospital Discharge
2) Vital Records Death	Yes	Yes	Quarterly	3	Yes	• Hospital Discharge • Infant birth and death • Mother death linked to infant birth
3) Medicaid	Yes	No	Quarterly	3	Yes	
4) WIC	No	No	Never	NA	No	
5) Newborn Bloodspot Screening	Yes	No	Annually	12	No	
6) Newborn Hearing Screening	Yes	Yes	Annually	12	Yes	• New York State Immunization Information System
7) Hospital Discharge	Yes	Yes	Quarterly	3	Yes	• Birth and death
8) PRAMS or PRAMS-like	Yes	No	Monthly	12	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None