Maternal and Child Health Services Title V Block Grant

New York

FY 2023 Application/ FY 2021 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

August 5, 2022

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 2023 Maternal and Child Health Services Block Grant Application and FFY 2021 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: January31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

The Title V Maternal and Child Health Services Block Grant (MCHSBG) is the Nation's oldest Federal-State partnership to ensure the health of individuals of reproductive age, children, and youth, including children and youth with special health care needs (CYSHCN) and their families. Administered by the Health Resources and Services Administration Maternal and Child Health Bureau (MCHB), Title V MCHSBG provides core funding to states for Maternal and Child Health (MCH) public health activities.

States submit an annual application and report in accordance with MCHB guidance. This year's NYS application reflects our continued leadership and commitment to protect and promote equity and support the health of individuals of reproductive age, individuals who are pregnant, infants, children, 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 with a priority to serve communities disproportionally impacted by systemic barriers, such as racism and sexism. Building on last year's application, this year's application reflects the many ways in which NYS has continued to lead and meet its MCH commitments throughout the arc of the ongoing and evolving COVID-19 pandemic.

The State's action plan for the upcoming year represents our ongoing commitment to address the objectives, strategies, and performance measures to address our 2021-25 Action Plan priorities across the Block Grant's five MCH population health domains: women's and maternal health (WMH), perinatal and infant health (PIH), child health (CH), adolescent health (AH), and children and youth with special health care needs (CYSHCN). Despite the ongoing challenges presented by COVID-19, NYS'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 wellbeing. It emphasizes understanding and addressing social determinants of health to address health disparities and reflects a concerted effort to build a more comprehensive system of supports for CYSHCN and their families.

Within NYSDOH, Title V MCHSBG activities are led by the Division of Family Health (DFH). As the Title V program, DFH provides NYSDOH-wide leadership on MCH, directly oversees many MCH programs and initiatives, and collaborates with other key MCH-serving programs outside the DFH. A critical role of NYS's Title V Program is to ensure the needs of the MCH population are addressed through key policy initiatives as reflected throughout the application.

In keeping with a commitment to ensure NYS's supports and services align with the needs of communities, the Title V MCHSBG program continues to obtain community input to inform activities. Input was obtained from the Title V MCHSBG Advisory Council, Parent to Parent of NY, Schuyler Center for Advocacy and Analysis, American Academy of Pediatrics, Association of Regional Perinatal Programs and Networks, MCH Committee of the New York State Association of County Health Officials, New York State Perinatal Association, community listening forums, providers, and key stakeholders.

Under Title V MCHSBG leadership, NYS continued to build on its previous work to supplement and further refine its 2021-25 Needs Assessment and State Action Plan. This included continued engagement of stakeholders to provide input and feedback on MCH outcomes in the State, ongoing collection and analysis of relevant MCH health data, and opportunities for community member input. Feedback and insight gained through this process was used to refine activities during the previous year and further develop our upcoming State Action Plan.

Recognizing the collaborative and cross-programmatic nature of our work, DFH 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 DFH

are assigned to work on cross-disciplinary teams centered around each of the five MCH population domains. Leaders for each team were identified based on their primary area of focus in their daily work and were tasked with ensuring that work and activities for their subsequent domain, as outlined in the most recent Title V application, were completed. Despite the many unique and transformative challenges for NYS's Title V program over the past two years, domain teams have continued this approach through virtual meetings and expanded use of an online platform (Microsoft Teams), to share information, work on shared documents, and regularly meet virtually whether working in the office or remotely. This platform and structure helped to foster increased collaboration between team members and continues to be essential as staff have transitioned to hybrid remote and in-office work arrangements.

Below are the NYS National Performance Measures (NPM) and State Performance Measures (SPM) with the cross-cutting, community and data-informed Title V MCHSBG priorities.

Title V State MCH Priorities and Performance Measures, 2021-2025

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

Level III+ NICU • SPM1: Percent of samples received at the lab within 48 hours of collection <u>Child Health</u> • NPM 8.1: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day <u>Adolescent Health</u> • NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year <u>Children and Youth with Special Health Care Needs (CYSHCN)</u> • 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 MCH Needs Assessment (NA) Summary and the five-year State Action Plan were developed based on community input and analysis of MCH performance measures and investments. Below is a summary by domain of the key findings and priorities identified in our full five-year NA Summary.

Domain 1 – Maternal/Women's Health

The preventive medical visit measure was selected for this domain, because it is foundational to women's health throughout the life course, population health data demonstrate a need for its continued improvement, and it relates directly to several 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 well-woman 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, mental and behavioral health, oral health, and other supports and services. NYS's 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/Infant's Health

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, NYS's Title V MCHSBG program views this indicator as part of a continuum of supports, services, and systems of care for infants, mothers, families, and service providers. This broader approach aligns with several priorities voiced by families in 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. Strategies include promoting early prenatal care and increasing awareness of community resources, supports, and services through Title V MCHSBG funded programs.

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

Domain 3 – Child Health

The physical activity measure was selected for this domain because it is responsive to concerns voiced directly by families in NYS and reinforced by state-specific population health 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 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

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 NYS. Preventive medical visits are one part of overall wellness, based on community input and population data, need to include social-emotional wellbeing and preparation for taking on the responsibilities of adulthood. Adolescence is often a very challenging stage in a person's life, during which there is immense physical, cognitive, social-emotional, and sexual development. Supporting adolescents' health and development and helping them prepare for their futures can have a lasting impact throughout the life course. Adolescent Health strategies focus on

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

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

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

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

Measuring transitions to adult health care was selected because it was voiced as a key priority by youth with special health care needs and their families, reinforced by state-specific population health data. Families reported that only 13% of CYSHCN receive care in a well-functioning system, and less than 19% of youth aged 12-17 with special health care needs received services necessary to make transitions to adult health care. This is consistent with experiences described by YSCHN and their families throughout the state. CYSHCN strategies include engaging youth with special health care needs and their families in our efforts to improve systems and practices supporting this population, including care coordination and transition support.

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

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

NYS is committed to ensuring the health and wellbeing of the MCH population. Due to generous Medicaid benefits, insurance availability through the NYS of Health, and significant state appropriations for MCH, Title V MCHSBG funds support an infrastructure within the NYSDOH that ensures the work of the Title V Program and provides additional funding to support public health infrastructure for priority efforts to augment state investments. For example, Title V MCHSBG funds augment State investments to support family planning and adolescent health services. In addition, Title V MCHSBG funds support quality improvement efforts through grants to the Regional Perinatal Centers (RPC) for quality improvement activities to NYS's 120 obstetrical hospitals to improve maternal and infant mortality and morbidity. Grants are provided to local health departments to support information and referral services for CYSHCN. NYS's Title V application illustrates the extensive resources offered to NYS's MCH population. NYS's MCH programs and initiatives are complex. NYS's Title V application provides an overview that demonstrates NYS's ongoing commitment to ensure the health and wellness of all NYS's people of reproductive age, children, and families.

III.A.3. MCH Success Story

As detailed in last year's application, NYS's Title V Program addressed the challenges created by the COVID-19 public health emergency, while integrating and strengthening relationships with stakeholders to create collaborations that will build and sustain public health programs. Major accomplishments of the past year include the integration of oral health into School-Based Health Center medical programs, an increased focus on children's mental health, and integrating home visiting referrals into the New York State Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Integration of Oral Health into School-Based Health Centers:

NYS's Title V Program's strong partnership and collaboration with the HRSA Oral Health Workforce Grant furthered the NYS Title V interest in the integration of oral health into the School-Based Health Center medical clinics (SBHCs) by providing training on fluoride varnish application and billing. This training provided the SBHCs with the knowledge and education needed to integrate oral health within the medical setting across NYS. The HRSA Oral Health Workforce Grant also provided fluoride varnish and oral health kits (toothbrushes, toothpaste, floss) to SBHCs, as well as local health department Children and Youth with Special Health Care Needs programs, to further these oral health integration efforts. Integration with Children's Mental Health:

Increased Focus on Child and Adolescent Mental Health

Significant work has been done to increase collaboration and integration with program partners for medical SBHCs. The School Health Unit (SHU) regularly engages with the Office of Mental Health (OMH) to promote access and utilization of behavioral and mental health resources across New York State. Plans are being created to expand OMH's Project TEACH, which provides mental health consultation and referral services to pediatric primary care providers and their patients, to increase linkage and utilization in the SBHC setting. SHU staff is also working with OMH to help identify where SBHCs are located and how they can be utilized as part of the network of services for school-age children.

Additional collaborations focused on children's mental health include working with the Bureau of Immunization to address COVID-19 vaccinations for the pediatric population and the Bureau of Women, Infant, and Adolescent Health to promote relevant initiatives to the SBHC patient population.

Collaboration with the WIC Program

The COVID-19 public health emergency resulted in a change in the WIC program from in-person visits to pregnant and parenting families to virtual visits. This change in program delivery contributed to a sharp decrease in referrals to home visiting programs. NYS's Title V Program collaborated with the NYS WIC program, the HRSA Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative, and the NYS Office of Children and Families Services (OCFS) to increase bi-lateral referrals between local WIC agencies and home visiting programs, using internal and external stakeholder feedback. This was accomplished by the creation of a common referral form desk guide, and referral reminder to ensure pregnant and parenting families are connected to the services they require. This integration of these tools into the NYS WIC program provided a user-friendly system for local WIC agency staff, increased collaboration, and strengthened the relationship between partners.

III.B. Overview of the State

According to population estimates from the 2020 US Census, New York State is the fourth most populous state in the country, housing more than 20 million people (20,201,249). Within the state, approximately 45% of the population, or almost 9 million people (8,804,190), 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 2020 Census, 22.4% of New York State's population is foreign born.

Of New York State's 20,201,249 residents, approximately 54.7% of individuals identify as White alone, 19.5% identify as Hispanic or Latino, 17.6% identify as Black or African American, 9.3% identify as Asian alone, 1.0% identify as American Indian or Alaska Native, and 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

2020 Census estimates indicate that 22.4% of New York State's population (4,372,167) is foreign born. Among this group, 58.4% (2,551,469) are naturalized citizens while 41.6% (1,820,698) are non-citizens. The largest percentage of foreign-born individuals migrated from the Americas (49.6%), Asia (29.5%), and Europe (15.9%). In addition to counties surrounding NYC, Long Island, and the Hudson Valley, counties with larger population centers, including Buffalo, Rochester, and Albany, have higher percentages of foreign-born residents.

Households and Families

According to five-year estimates from the 2020 American Community Survey, there are 7,417,224 households in New York State, with an average of 2.55 people per household. Of these households, 44% (3,259,898) are married couple families, and 56% (4,157,326) are non-family households. Approximately 29% (2,147,352) of all households have at least one child under the age of 18.

Income and Poverty

Five-year estimates from 2020 American Community Survey reveal that the median household income in New York State is $71,117. Counties with the highest income levels are heavily concentrated in NYC, Long Island, and Mid-Hudson. Nassau County, in particular, ranks highest in the state with a median household income level above $100,000.

Median household income has increased steadily since 2010 ($54,047). However, income levels vary significantly by race. The average median household income is $70,712 for Whites, $68,567 for Asians, $43,997 for Blacks or African Americans, $43,889 for Hispanics or Latinos, and $40,043 for American Indians and Alaska Natives.

Income inequality has also increased over time in the state. The Gini coefficient has risen from 0.499 in 2010 to 0.516 in 2017. According to 2020 Census Bureau estimates, New York State ranks highest among all states in terms of income inequality.

According to 2020 estimates from the American Community Survey, 12.7% of New York State's population is living below the federal poverty line. Counties with the highest percentage of families falling below the threshold are concentrated in the

NYC region, particularly in Bronx County (26.76%) and Kings County (17.87%).

Age Distribution

The median age in New York State is 39. Approximately 21% (4,071,142) of the population is under 18 years of age, and roughly 16.5% (3,221,702) 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 in 2020.

Women of Childbearing Age

Estimates from the 2020 American Community Survey indicate that there are 4,667,868 women of childbearing age (15-50 years), representing 46% of the total female population.

Children

Of New York State's 20,201,249 residents, 5.8% of the population is under the age of 5 and 20.9% of the population is under the age of 18. According to 2019 estimates from the Kids Count Data Center, approximately 18% of all children in the state are living with families below the federal poverty line. Further, 12% of children are living with families where no parent has regular, full-time employment.

Education

According to 2020-21 school year data published by the New York State Department of Education, 2,512,973 children are enrolled in K-12 public schools. Approximately 41% (1,036,391) of public school students are White, 28% (715,474) are Hispanic, and 16% (413,883) are Black or African American.

The high school graduation rate for all public school students is 86%. However, graduation rates vary significantly by ethnicity. While 90% of white students graduate, only 80% of Black or African American and Hispanic or Latino students graduate from high school. Additionally, graduation rates differ based on migrant status. The graduation rate for migrant is 63%, compared to 86% for not migrant.

In terms of educational attainment of adults (ages 25 and over), approximately 25.5% of the population has a high school diploma or GED, 20.9% of the population has a bachelor's degree, and 16.5% of the population has a graduate degree. The percentage of individuals with a bachelor's or graduate degree has increased over the past decade while the percentage of individuals with a high school diploma or less has decreased.

Language

According to five-year estimates from the 2020 American Community Survey, approximately 69% of the population over the age of 5 (12,799,886) speaks only English. Of the 5,574,294 residents that speak a language other than English, 14.7% speak Spanish, 8.7% 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 5.4% of the non-elderly population (ages 0-64) in New York State has no health insurance. Estimates from the 2020 American Community Survey reveal that uninsured rates vary significantly by ethnicity. While only 3.9% of Whites are uninsured, 10.3% of Hispanics, 11.6% of American Indians or Alaska Natives, 6.6% of Asians, 9.3% of Native Hawaiian and Pacific Islanders, and 6.1% of Blacks 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 PA 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 MCHSBG staff directed the update in the PA 2019-2024 related to Promoting Healthy Women, Infants and Children and worked to ensure the alignment with NYS's Title V MCHSBG State Action Plan. The vision for the 2019-2024 PA highlights a Health in All Policies approach and a focus on healthy aging.

III.C. Needs Assessment
FY 2023 Application/FY 2021 Annual Report Update

Our FY21 application presented a comprehensive five-year Needs Assessment (NA) summary of state's MCH needs, strengths, capacity, and partnerships. The NA 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. Our subsequent FY22 NA update focused primarily on the impact of COVID-19. This year's FY23 NA update reflects the continued impact of the pandemic, along with other persistent and emerging themes for our MCH populations and service systems.

Throughout this NA update, relevant Title V domains *[WMH, PIH, CH, AH, CYSHCN*] are referenced for selected examples. Please refer to the FY21 five-year NA summary for descriptions of MCH programs referenced in this update.

Ongoing NA Activities:

This year Title V staff led a variety of activities that inform our ongoing assessment of MCH population and system needs. As noted last year, a combined approach of formal structured NA activities with more ad hoc ongoing open communication has proven essential throughout the public health emergency and continuing to present.

Population Health Data

In addition to monitoring Title V performance and outcome measures, we periodically review population data from a variety of sources to assess status, trends, and disparities for key MCH indicators. These data are shared with partners and are used to inform program strategies and allocation of funds. Examples from the past year include:

- In collaboration with the state's multidisciplinary NYS Maternal Mortality Review Board (MMRB), DFH leads a comprehensive process to identify and review all maternal deaths. The focus is on describing the scope and distribution of maternal deaths and identifying key contributing factors and preventability. The first MMRB report for the 2018 cohort was released in April 2022 *[WMH].*
- Title V funds were allocated to conduct an over-sample of National Survey of Children's Health (NSCH) data for NYS, with enhanced sampling of Black/African American, Hispanic, and CYSHCN. A project sampling plan was finalized this project period, to be implemented in 2022, with data available in 2023 *[CH, AH, CYSHCN].*
- Title V staff review data from relevant national surveys including Pregnancy Risk Assessment Monitoring System (PRAMS), Behavioral Risk Factor Surveillance System (BRFSS), NSCH, and Youth Risk Behavior Survey (YRBS) at least annually *[All].*
- In fall 2021, we updated the Adolescent Sexual Health Needs Index (ASHNI), which is a multi-dimensional ZIP code level indicator incorporating adolescent sexual health outcomes with demographic and community level predictive factors and which is used to prioritize available resources to the highest need communities. The updated ASHNI will be used for the 2022 Comprehensive Adolescent Pregnancy Prevention (CAPP) and Personal Responsibility Education Program (PREP) procurements *[AH*].

Program Utilization & Outcome Data

Data collection, management, and analysis is integrated across Title V-funded programs. In addition to supporting local program management, these data provide important insights to MCH population needs, service capacity/utilization, and selected outcomes. Examples from the past year include:

- A new PICHC data management information system (DMIS) for the Perinatal & Infant Community Health Collaborative (PICHC) was launched in April 2021, and a new five-year DMIS vendor contract will be awarded to begin September 2022 *[WMH, PIH].*
- The state's Growing Up Healthy Hotline maintains data on information and resource needs based on calls received

[WMH, PIH, CH].

- A new data system for the School-Based Health Center (SBHC) program is under development. It will allow for more streamlined and accurate reporting, including new performance measures related to physical activity and nutrition aligned with Title V priorities *[CH, AH, CYSHCN].*
- A web-based data system for local health department (LHD)-based CYSHCN programs was launched in October 2021 through the state's Health Commerce System to streamline and improve the accuracy of data collection, analysis, and reporting.

Communication with Local Providers

As a fundamental requirement of grant funding, Title V-funded local providers are expected to engage with their communities and continuously assess community and client needs. Title V staff also communicate continuously with local partners through grant reports, regular scheduled provider calls, webinars, and ongoing ad hoc communication. All of these are critical vehicles for learning about ongoing and emerging MCH needs, challenges, and successes. Examples of ongoing, continuous communication include:

- Review and discussion of quarterly or bi-annual contractor reports., regular monthly convene monthly or quarterly calls with local grantees to share information, review data and performance measures, ad hoc discussion to address emerging issues. *[All].*
- The Title V-funded Assets Coming Together (ACT) for Youth Center for Community Action (CCA) engages in continuous ongoing communication with local adolescent health grantee programs about their training and technical assistance (T&TA) needs. *[AH, CYSHCN].*
- ~~Regional Perinatal Centers (RPC) assessed the needs of rural affiliate birthing hospitals related to technology, training, and interests for telehealth services *[WMH, PIH].*~~

Quality Improvement & Evaluation Initiatives

Title V staff lead and participate in a range of special initiatives and projects to learn about service and system needs and effectiveness. These range from focused literature reviews to formal evaluation projects and to extensive continuous quality improvement (CQI) initiatives that integrate ongoing assessment of MCH outcomes and services with testing and implementation of specific improvement strategies matched to the issue. Examples from the past year include:

- The Newborn Screening Program is engaged in an ongoing CQI initiative to reduce collection and processing time for labs, improve blood spot specimen quality, reduce false positive screening results, and improve timeliness in screening for time-critical conditions *[PIH, CYSCHCN].*
- The NYS Perinatal Quality Collaborative is leading an interdisciplinary learning collaborative focused on implicit bias in birthing care, following the model of our numerous successful NYSPQC projects. *[WMH, PIH].*
- The Bureau of Women, Infants, and Adolescent Health (BWIAH) within DFH, with support from several Title V-funded MCH Catalyst Program graduate student interns, carried out special projects to strengthen engagement of families in MCH home visiting, enhance collaboration between MCH home visiting programs and birthing hospitals, and develop data collection instruments for evaluating sexual violence prevention programs *[WMH, PIH, AH].*

Enhanced Strategies for Assessing the Needs of CYSHCN & Their Families

Direct input from CYSHCN and their families is a special priority for NYS's Title V Program. We have allocated Title V and other funds to support an array of NA activities, integrated within other family supportive services. These include:

- **Regional Family Liaisons.** DFH has allocated funding to support contracts with three Regional Support Centers (RSCs), which are HRSA designated University Centers of Excellence in Developmental Disabilities, to support families and provide T&TA to Local Health Department (LHD) CYSHCN programs. Each RSC is required to employ a Family Liaison (FL) as a requirement of the funding opportunity. The FL are parents of CYSHCN whose lived

experience and knowledge informs RSC activities.

- **Family Engagement Sessions.** The regional FL are responsible for conducting family engagement sessions with CYSHCN families. These sessions use standardized questions to assess the needs of CYSHCN families, including questions about the impact of COVID-19. From 2019-2021, over 300 parents and caregivers of CYSHCN from 51 NYS counties participated in 63 small group sessions and 104 individual family interviews (primarily virtual).
- **County Needs Assessment Surveys.** RSCs also conduct surveys with each county to gather feedback and determine local gaps, barriers, resources, and T&TA needs. Counties are invited to develop tailored improvement and TA plans to help meet their community engagement goals with TA from the RSCs.
- **County Family and Community Engagement Requirements.** LHD CYSHCN programs are required to engage CYSHCN families in work groups, committees, task forces, and advisory committees to improve the system of care for CYSHCN. Families are engaged in local planning activities such as the county Community Health Assessment (CHA), and their input informs training and TA for the local programs.
- **Other Surveillance and Program Data.** Title V staff routinely review available public data sources to monitor trends and identify emerging needs for CYSHCN, including NSCH data and NYS Medicaid Health Home for Children data. In 2021, we issued the *New York State Profile of Children and Youth with Special Health Care Needs, 2018-2019*, an annual state report synthesizing demographic, health status, and service needs of NYS's CYSHCN population.

Health Status & Needs of the State's MCH population

Findings from Analysis of Population & Performance Data

Population health data and other specific performance measures collected from Title V-funded programs provide key information related to health status and needs of NYS's MCH population and service systems. Notably, we may begin to see the early impact of COVID-19 in this year's analysis, as the measures reported here are for the 2019-20 period.

Analysis of the most recently available data shows continued improvement in maternal mortality rates and stable rates for well-woman visits statewide. However, we observed declines in documented medical exams for women served in NYS Family Planning Program sites and development of birthing plans for pregnant clients served through the MICHC program, (the latter may reflect changes in data reporting) (*WMH*). Delivery of percent of very low birth weight (VLBW) infants in Level III+ birthing hospitals and timeliness of newborn bloodspot sample delivery were stable from the previous year's analysis *(PIH)*. The incidence of elevated blood lead levels among young increased *(CYSHCN),* and daily physical activity among children ages 6-11 declined from the previous year (*CH)*, as did documentation of anticipatory guidance for physical activity and nutrition for children and youth enrolled in School-Based Health Centers (*CH*/*AH*). We observed continued improvement in the percentage of youth serving programs that engage youth in program planning and that provide training for youth on adult preparation topics, but preventive medical visits for adolescents decreased (*AH).* Provision of transition supports for youth with sickle cell disease (SCD) among SCD contractor programs improved, but the overall statewide percentage of youth with special health care needs who received services to support transitions to adult health care declined *(CYSHCN).*

Emerging & Persistent Themes

As emphasized in last year's NA Update, the COVID-19 pandemic laid bare and exacerbated previous health and socioeconomic disparities, while also exposing and creating new needs for families and communities. The 10 crosscutting themes voiced by community members in our five-year NA summary remained salient over the last year, with selected themes described below emerging (or re-emerging) as prominent needs.

Improving the accessibility, quality, and equity of health care services continues to be a high priority for individuals and families in NYS. Telehealth services have emerged as a promising approach for strengthening capacity to provide services, tailored to the needs of urban and rural areas. We have expanded telehealth services for reproductive and family planning services, and as noted above we are working with Regional Perinatal Centers to assess and support needs for telehealth

among birthing hospitals *[WMH, PIH]*.

State and local partners have noted rising needs for mental health and substance use services, demonstrated by an increase in referrals for mental health services overall and specifically for referrals not completed because of limited provider capacity. These unmet needs may result from an inadequate number of providers as well as insufficient ability of existing providers to work with pregnant people and to provide Medication-Assisted Treatment (vs Abstinence-Based Treatment) for people with substance use needs *[WMH]*.

Local partners report continued concerns about children falling behind on routine primary and preventive care *[CH, AH*]. They also note persistent vaccine hesitancy among pregnant people and parents in some communities, and a general distrust of government and public services for many undocumented people *[All]*.

Families describe several key barriers to getting care for CYSHCN. Families in rural areas identified limited access to specialists and lack of high-quality health care facilities for CYSHCN, resulting in delayed diagnoses and lack of continuity for meeting children's needs during key periods of development. Families in urban areas reported other challenges related to transportation and accessibility of services for CYSHCN. Statewide, CYSHCN families who do not speak English or who are Deaf or hearing impaired reported even more difficulties finding services for their children, including translation services and access to bilingual providers. In addition, families noted inadequate family-professional relationships including poor bedside manner, dismissiveness, and insensitivity from providers as frequent concerns *[CYSHCN].*

Families also continue to experience ***challenges in meeting their basic needs***. Among the nearly 8,000 referrals for Title V-funded MICHC CHW clients last year, four of the top five referral categories were for basic needs including clothing and baby care items, housing assistance, food pantries, and WIC *[WMH, PIH]*. Partners report affordability and scarcity of "life supplies" including food and baby formula - due to rising prices, recalls, and supply chain issues - as major concerns for families [*PIH]*. Housing insecurity is also a major worry, as families report being priced out of their neighborhoods with gentrification, struggling to pay for housing due to rising costs and job loss, and rising concerns about eviction with the expiration of moratoriums *[All domains]*.

Social-emotional and mental health continues to rise in prominence as key concerns raised by individuals, families, and service providers across the life course. Data demonstrate increasing rates and racial disparities for depression symptoms, and inadequate mental health services, for pregnant and postpartum people *[WMH].* SBHC staff report growing concerns about mental health among students, resulting in a need for additional mental health staff *[CH, AH, CYSHCN]*. Youth-serving programs continue to report significant challenges in recruiting, engaging, and retaining youth in remote programming, describing a phenomenon of significant "screen-time burnout" and "Zoom Fatigue" that are taking a serious toll on young people's social and emotional well-being *[AH]*. CYSHCN parents and providers report concerns about the impact of COVID-19 on children's social and emotional development and well-being. In addition, parents of CYSHCN themselves report significant levels of stress and anxiety associated with caring and continuously needing to advocate for their children's special health care needs, while foster and adoptive families of CYSHCN described additional challenges in meeting the behavioral and mental health support needs of children with trauma experiences *[CYSHCN]*.

Title V Program & MCH Systems Capacity

Consistent with last year's NA Update, the pandemic continues to have significant impact on the capacity of state and local MCH programs. At the state level, most staff deployments to assist with COVID-19 response have been completed. However there has been a great deal of staff turnover, with many staff retiring from public health or taking new positions outside the Division/Title V Program. Although DFH has been able to pursue recruitments to fill resulting vacancies and some new positions, recruitments have been challenging, and when new staff are hired there are significant extended needs for orientation and training. Current staff are often spread thin to cover existing and emerging work, in the context of significant losses in institutional memory. This dynamic of staffing losses, high turnover, and anticipated prolonged rebuilding of workforce capacity is a theme that spans across nearly all State level Title V units and programs.

A similar dynamic is occurring within local MCH organizations, which are also going through periods of major rebuilding. During the height of the pandemic, many programs experienced significant declines in services and clients because of school and other site closures, transportation limitations, and social distancing requirements. Most programs that discontinued services have now resumed operations, with varying limitations on in-person service delivery. Some programs that closed completely during the pandemic (e.g., one county CYSHCN program, two SBHC sites) are not expected to re-open. We have identified needs for training and re-training of local staff on program fundamentals, from contracting and work plans to specific program activities. We have also taken steps to address workforce equity within Title V-funded programs; as one example, the most recent PICHC RFA required a living wage for all staff.

Two major initiatives have been pursued to help address these workforce challenges. First, NYS launched the New York State Public Health Corps (NYSPHC) to build public health capacity for current and future public health emergencies, bolster the state's public health infrastructure, improve effective public communication and education around public health efforts, and strengthen community level connections and partnerships. In collaboration with community partners, NYSDOH will recruit and train up to 1,000 NYSPHC Fellows, who will serve in state and local agencies, including 9 fellows assigned specifically to DFH/Title V Programs. In addition, NYSDOH was allocated $16 million, which is from a larger $66M federal Public Health Crisis Workforce grant, to support hiring additional clinical staff at School-Based Health Centers for the period through June 2023, with the potential for further extension.

Despite these significant challenges, there have been many accomplishments related to capacity-building across NYS's Title V Program during the past year. Selected examples include:

- **Adaptation of services to virtual and hybrid environments.** Going back to the first peak of the pandemic in NYS in spring 2020, MCH programs and providers have demonstrated tremendous creativity, resilience, and compassion for the communities and people they serve. As routine in-person programming came to an abrupt halt, programs developed strategies for engaging and supporting clients remotely. For example, MICHC and MIECHV replaced in-person home visits with remote visits, phone, and email communications [*WMH, PIH]*. Some SBHCs offered telemedicine services [*CH, AH, CYSHCN]* and the ACT CCA worked with local CAPP, PREP & Sexual Risk Avoidance Education (SRAE) programs to help them adapt and implement evidence-based programs with fidelity within the confines of a virtual environment [*AH].* SBHCs are also using telehealth to supplement in-person mental health services, which has provided additional options for patient engagement, offers a better understanding of student's home environments, and appears to be associated with a decrease in missed or canceled appointments *[CH, AH, CYSHCN].*

- **New program data systems**. As noted, in the past year we have invested in improved data management information systems for several key Title V-funded programs, including MICHC/PICHC *[WMH, PIH*], SBHCs [*CH, AH, CYSHCN]*, and LHD CYSHCN programs [*CYSHCN]*. These systems will expand the scope of data collected from local providers while improving the quality, accuracy, and efficiency of data collection, management, and analysis.

- **Quality Improvement Initiatives/ Learning Collaboratives.** As described, we are leading a growing portfolio of quality improvement projects (See ***Ongoing NA Activities***). In addition to enhancing our understanding of the needs and effectiveness of MCH services, these initiatives strengthen state and local organizational capacity for identifying, testing, disseminating, and institutionalizing best practices across a wide range of MCH service settings. *[WMH, PIH]*.

- **Prioritizing investments in Maternal, Perinatal & Infant Health programs.** The recent PICHC RFA resulted in a net increase of three local providers, expanding both the geographic coverage and number of clients to be served through the program. Title V staff have provided significant subject matter expertise this year to support a home

visiting pilot in four counties, as part of the state's First 1000 days Medicaid initiative, through which managed care organizations support staffing Obstetrician and Pediatric offices with mental health social workers and peer navigators to engage, screen, and refer high-risk patients to home visiting services, which include partnerships with Title V PICHC programs. This year's state budget included an increase in funding for RPCs, which will support a 38% increase in funding over the prior year, building on previously described work to enhance telehealth capacity across birthing hospitals *[WMH, PIH].*

- **Expanding service capacity of SBHCs to meet the existing and emerging needs of children and youth.** The Division recently received a new five-year HRSA grant to expand access to pediatric mental health care. The goal for NYS's grant is to connect SBHCs with OMH's Project TEACH, which is a statewide training, education, and consultation initiative that works to strengthen and support primary care providers' ability to diagnose and manage mild-to-moderate mental health concerns. A Request for Applications (RFA) was completed this year (expected release later in 2022) to support the establishment of dental homes in SBHCs, which in turn will increase capacity for providing dental services and enhancing oral health promotion and prevention activities. *[CH, AH]*.

Title V Partnerships & Collaborations

Partnership and collaboration are core to the work of our Title V Program. Collaboration occurs at every level – across organizational units and programs within the Title V Program, with other MCH-serving state programs within NYSDOH and other state agencies, and with a wide array of stakeholders. We have selected one example for each domain to highlight as part of this year's NA update:

- To strengthen collaboration across all DFH youth-serving programs, meetings to learn about the backgrounds and current work of staff in other programs were established. , In August 2021, staff from numerous youth-serving programs (CAPP, PREP, SRAE, SBHC, Family Planning, CYSHCN, and others) were invited to a series of ACT CCA-hosted webinars on youth mental health.
- Within the Title V Program, the Bureau of Child Health (DFH) is partnering with the Asthma Guidance Team (Division of Chronic Disease Prevention) and the American Lung Association to enhance SBHC engagement in an Asthma Self-Management Education Pilot project. [*CH]*.
- Building on the longstanding partnership between our state Title V and Medicaid programs to support the development and implementation of Medicaid Children's Health Homes (CHH), this year Title V staff joined a multidisciplinary NYS Medicaid Redesign Team focused on improving outcomes for people with Sickle Cell Disease (SCD). Based on the team's recommendations, NYS pursued adding SCD as a single qualifying condition for enrollment in CHH, which would strengthen care coordination to promote effective treatment, reduce symptoms, prolong life, and improve well-being for children, youth, and young adults with SCD. [*CYSHCN]*.
- Our Home Visiting Team includes staff from MICHC/PICHC (Community Health Staff from MICHC/PICHC) and MIECHV funded programs continued a collaboration with the WIC Program (NYSDOH Division of Nutrition) and Healthy Families NY (NYS Office of Children and Family Services) to improve referrals to home visiting programs from WIC local agencies. [*PIH].*
- Title V staff are collaborating with the NYS Office of Addiction Services and Supports (OASAS) to support a new OASAS overdose prevention grant that includes pregnant people, new parents, and survivors of sexual and domestic violence among its priority populations. In addition, we are engaging OASAS in meetings with Title V-funded programs/partners to strengthen those relationships [*WMH]*

Operationalizing Needs Assessment Activities & Findings

Our Title V Program continues multiple approaches to operationalize NA activities and findings. As demonstrated above,

most of the methods we use to gather input and information are operationalized within routine program activities. These include:

- Reviewing existing population health surveys and surveillance systems annually.
- Developing, maintaining, and improving data management systems for local Title V-funded programs.
- Integrating requirements for routine data reporting in grant contracts for all Title V-funded programs.
- Integrating requirements for community engagement, including community listening forums, in our procurement processes.
- Supporting statewide and regional centers that assess needs of priority populations to inform ongoing statewide and program-specific T&TA activities.
- Applying findings from all these assessment activities to the design and ongoing improvement of MCH programs and initiatives.

Please refer to ***Ongoing NA Activities*** above for further detail on these approaches.

Organizational & Leadership Changes

Our Title V Program had several key leadership-level staffing changes this year:

- Kirsten Siegenthaler, PhD, was promoted to Director of the Division of Family Health and Title V Director, having served as the Associate Director for three years.
- Emily DeLorenzo, PhD, joined as Associate Director of the Division of Family Health, which was vacant following Dr. Siegenthaler' s promotion to Division and Title V Director.
- Christopher Kus, MD, MPH, Associate Medical Director for the Division/Title V Program, retired from NYSDOH.
- Ann-Margret Foley, MSW, was appointed Director of the Bureau of Women, Infant, and Adolescent Health (BWIAH).
- Rae Ann Augliera, MS, was appointed Associate Director of BWIAH, following the retirement of Michael Acosta.
- Raymond Pierce was appointed Director of the Bureau of Early Intervention, following the retirement of Connie Donohue.
- Claire Rudolph was appointed Assistant Director of the Bureau of Child Health.

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

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$37,671,810	$25,616,759	$38,909,810	$32,378,022
State Funds	$29,285,356	$29,285,356	$29,285,355	$29,285,355
Local Funds	$122,324,435	$57,532,053	$55,483,224	$35,333,319
Other Funds	$0	$0	$0	$0
Program Funds	$30,303,017	$22,258,095	$22,224,404	$25,288,886
SubTotal	$219,584,618	$134,692,263	$145,902,793	$122,285,582
Other Federal Funds	$47,470,052	$53,655,287	$65,608,665	$48,210,047
Total	$267,054,670	$188,347,550	$211,511,458	$170,495,629

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

	2023	
	Budgeted	Expended
Federal Allocation	$38,909,810	
State Funds	$29,285,355	
Local Funds	$36,138,659	
Other Funds	$0	
Program Funds	$24,571,358	
SubTotal	$128,905,182	
Other Federal Funds	$62,282,555	
Total	$191,187,737	

III.D.1. Expenditures

FY 21 Expenditures, including Title V MCHSBG, State appropriations, and other grant funding, demonstrate NYS's commitment to providing supports and services to NYS's women, children, and families. The State Allocation Plan is described in Section 504, Use of Allotment of Funds, and Section 505, Application for Block Grant Funds.

Expenditures, reflected in Form 2, confirm that NYS has continued to comply with the 30%-30%-10% requirements, as specified in Section 504(d) and Section 505(a)(3). The scope and comprehensiveness of services for NYS's MCH population are fully outlined and described in the FY 2021 report and FY 2023 application.

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

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

Supports and services to NYS's Children and Youth with Special Health Care Needs (CYSHCN) and their families are an essential component of NYS's Title V services. Through the Children and Youth with Special Health Care Needs Support Services (CYSHCN-SS) funding is provided for medical assessment of children with suspected health issues where there is no other source of financial support. Although all primary and preventive health care programs provide services to CYSHCN, NYS's Title V Program also oversees services specifically designed to serve CYSHCN. For example, Title V MCHSBG funds support forty-eight county Local Health Departments (LHDs) and the five counties served by the NYC Department of Health and Mental Hygiene (NYCDOHMH) to provide information and referral services to CYSHCN and their families. This funding supports staff in LHDs to respond to inquiries by families related to issues such as insurance coverage, assistance with services, family support and needed items for their CYSHCN. Support is provided to NYS's

Wadsworth Center Laboratory that administers the statewide Newborn Metabolic Screening Program as well as specialty centers for individuals with genetic diseases and disabilities. NYS's Lead Poisoning Prevention Program focuses on environmental changes as well as identifying and supporting potentially lead poisoned children and their families. Programs such as NYS's SBHC provide services to children, including CYSHCN that can result in decreased absenteeism, improved school performance, and better health outcomes. As stated in NYS's application, NYS's Title V MCHSBG program continues to focus improving supports and services for CYSHCN and their families. Information obtained from CYSHCN and their families will assist NYS's Title V Program to improve and enhance supports and services for CYSHCN in the coming years.

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

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

Overall, the actual expenditures for FY 21 appear more than originally projected. This is because multiple MCH grants are spent in the same time period due to the two-year spending period. Each award value remains fully obligated and will be fully dispersed by the liquidation deadline at the end of each year.

NYS's FY 21 application reflected a budget of over $55 million in Local funds, but actual expenditures were less than anticipated. This is likely related to the timing of the reporting by LHDs rather than an actual decrease in expenditures.

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

III.D.2. Budget

This FY 2023 budget reflects NYS's commitment to Title V MCHSBG programs and services. NYS will continue to use FY 2023 Title V funds to support the implementation of NYS's Title V State Action Plan. Title V MCHSBG funds, in addition to State appropriation, Federal Medical Assistance Program (FMAP), and federal grant funds will continue to support programs and initiatives across all domains as described in the application section. This includes the development of substantial data analyses and reports to guide NYS's services for the MCH population. Support for efforts such as maternal and infant mortality and morbidity surveillance and quality improvement efforts to avoid these devastating outcomes is a priority. Enhancing NYS's efforts to identify those factors that result in maternal mortality and morbidity and addressing those factors will continue to be of importance in NYS's Title V MCHSBG program. NYS's Title V MCHSBG will continue interagency efforts to address maternal depression.

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

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

Financially, the Title V Administrative budget of $2.6 million remains below the 10% limit for these costs. As in prior years, the NYS share for MCH services will continue to be considerable and will more than meet the requirements for state match. Expenditures for FY23 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 MCHSBG program builds on years of MCH 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 MCH 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 MCHSBG 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 MCH population. Title V MCHSBG 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 MCH 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 (NA) Summary and the NA Update in this year's application.

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

NYS's SAP 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 MCHSBG 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 CYSHCN. 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 MCH public health programs, as well as Title V MCHSBG roles as a convener and collaborator. We seek to engage external partners at all levels to enrich the MCH programs administered through Title V MCHSBG, while simultaneously seeking to bring an MCH perspective and voice to initiatives led outside the Title V MCHSBG 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 MCH workforce is needed to meet the needs of NYS's MCH population. As stated previously, at the community level, most services and programs are implemented by local partners including local health departments (LHDs), universities and academic medical centers, hospitals and clinics, and community-based organizations.

To best meet the training and technical assistance needs of these providers, Center for Community Action (CCA) have been established that provide information and education to major Title V MCHSBG funded provider groups, including CCA for adolescent health, family planning, reproductive health, oral health, lead poisoning prevention, and children and youth with special health care needs (CYSHCN). This allows the Title V MCHSBG program to provide maximum support to this MCH workforce including facilitating access to experts in the field, research, updates on new and emerging evidence to guide practice, and technical assistance to improve practice. The family planning and reproductive health CCA is also facilitating performance improvement efforts within the network of family planning providers. The CCAs not only provide opportunities for current practice improvement efforts but serve to provide MCH program staff with expertise in the science of improvement to lead quality efforts in the future.

MCH providers also use funds provided by the Title V MCHSBG program to access qualified and competent staff, participate in training and conferences and other activities to improve the quality of the workforce providing services. Title V MCHSBG supports staff participation to attend national conferences (virtually since 2020) to continue to build expertise in the MCH arena and make connections on the federal level as well as develop partnerships between states to continue to improve NYS's approach to improving the health and wellness of the MCH population.

As previously discussed, NYS's Title V MCHSBG program also leads various efforts with health care providers, hospitals, and other professionals throughout NYS to enhance practice. These include, but are not limited to, the improvement initiatives through New York State Perinatal Quality Collaborative (NYSPQC) and training and information provided to and through professional organizations (topics include the identification of children with an autism spectrum disorder (ASD), developmental screening, the identification and treatment of hypertension during pregnancy, and screening and referral of children for oral health services). Staff are integrated into the regional perinatal center re-designation process, offering professional staff development opportunities, as high-level medical professionals work together to modernize the state's system of care in birthing hospitals throughout NYS.

Title V MCHSBG continues to foster the growth of the MCH workforce by encouraging staff to access the Association of Maternal and Child Health Programs' (AMCHP) educational opportunities to network and grow in the field of MCH. An AMCHP representative regularly presents at the NYS MCHSBG Advisory Council meetings to ensure NYS has the most current information from the federal level.

The Division of Family Health (DFH), in which the Title V MCHSBG Program and other MCH programs are located organizationally, is committed to improving health equity for all New Yorkers. In order to further this agenda, DFH staff have been engaging in educational opportunities and integrating this knowledge into policies and practices. DFH established a 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. 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. Through this workforce development initiative, leadership aims to sensitize and educate staff on the issues of health equity, which impacts all aspects of Title V work. Involvement in work related to health equity including Racial Justice Workgroup within the Center for Community Health (CCH), which includes DFH as well as the Divisions of Nutrition, Chronic Disease Control and Prevention, and Epidemiology. The CCH Racial Justice Workgroup began in 2018 and continues to focus work on turning commitment to racial justice into action. A Racial Justice Work Group was formed, comprised of diverse representatives focused on achieving racial justice principles. In addition, a range of innovative training interventions are being implementing to build the capacity of health and human services providers, health care facilities, community-based organizations (CBOs) and larger communities to employ a health equity framework to improve health outcomes.

As an outgrowth of the partnership between the State University of New York at Albany School of Public Health (SPH) and NYSDOH, and with initial grant funding from the federal HRSA MCH Catalyst initiative, SPH established an MCH program starting in 2015. Consistent with the federal MCH Catalyst Program goals, the program at SPH seeks to develop an increased focus on MCH within the school and university and to prepare students for MCH careers, with priority for students from underrepresented backgrounds. Rachel de Long, M.D., M.P.H., the former NYS Title V MCHSBG Director, and Christine Bozlak, PhD, MPH, a full-time SPH faculty, serve as co-directors for the SPH MCH Program. The program offers both academic coursework in MCH, funds MCH-related internships for SPH students, supports student and faculty travel to MCH conferences, and facilitates a wide array of professional development opportunities for both students and MCH practitioners. A new graduate certificate in MCH launched in the 2019-20 academic year, with over 30 students enrolled as of May 2022. The partnership with the state's Title V MCHSBG program is a distinguishing strength of the school's MCH Program, formalized through a formal Memorandum of Understanding (MOU) established in January 2021. This MOU supports technical assistance from the SPH MCH Program for the annual Title V NA Update and other priority projects, including funding up to 18 graduate public health student internships within the Title V Program annually. To date, 16 students have completed (or are currently completing) paid internships or assistantships within NYSDOH Title V Program.

Of note, several of the mentors for these students are themselves alumni of the UAlbany SPH.

Title V MCHSBG will continue to make workforce development a priority and promote internal and external efforts to address these needs.

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

The NYS Title V MCHSBG Program has a long history of partnering with consumers, including families and family organizations to ensure family voice across the state's MCH initiatives.

The NYS Title V MCHSBG Program ensures there is a family voice represented in the State's MCH services and programs, through our local partners including local health departments (LHDs), universities and academic medical centers, hospitals and clinics, and community-based organizations. When procuring services, the Division of Family Health (DFH) requires local partners that receive contracts to ensure ongoing involvement and feedback is received from consumers who represent the diverse MCH 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 (CYSHCN) Program requires the three University Centers of Excellence in Developmental Disabilities (UCEDDs), which are the state's Resource Support Centers that provide technical support and assistance to counties, employ a parent/family member/caregiver of a child or youth with a special health care need to ensure that families can talk to a trusted messenger and that the programs' supports and services meet family's needs. The LHD CYSHCN Program work plan requires that they provide program outreach and awareness regarding the local CYSHCN Program, gap-filling programs, and community resources. The goal of these activities is to empower families of CYSHCN 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's (EIP) ensures there is a family voice through the State Systemic Improvement Program (SSIP) quality improvement teams. This quality improvement initiative aims to improve family outcomes in the EIP service delivery system. The SSIP work is highlighted in the Children with Special Health Care Needs section. In addition to the SSIP, the EIP 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 EIP 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 MCHSBG 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 MCHSBG Advisory Council and NYS's family representation to AMCHP. The Early Childhood Advisory Council, oversee by the NYS Council on Children and Families (CCF), has recruited and is supporting parents/caregivers as members of the Council and to provide guidance and review of State-led MCH programs.

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

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

MCH data are critical to the effective, efficient, and equitable implementation and improvement of MCH programs, services, and policies. Descriptions of the data systems and sources that inform NYS's Title V MCHSBG work are provided in Section 2b.iii.c. DFH 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 MCH data systems, to evaluate and improve our programs and to monitor ongoing and emerging priorities. This workforce includes both staff within DFH and partners in other NYSDOH organizational units. While staff are funded by different funding sources, including Title V MCHSBG, State Systems Development Initiative (SSDI), 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 MCHSBG Program and NYSDOH's MCH initiatives overall.

As of June 2022, NYS's MCH epidemiology workforce within DFH 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 MCH epidemiology-related positions within DFH at the time of this report. The Division is working to fill vacancies.

Division of Family Health Staff with MCH Epidemiology-related Titles by Funding Source.

	Funding Source				
MCH Epidemiology-related Titles	Title V	SSDI	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 DFH, there are staff with similar titles throughout NYSDOH that support programs receiving Title V MCHSBG funds, such as Newborn Bloodspot Screening in the Wadsworth Laboratory, Office for Public Health Practice which oversees the MCH Dashboard and the NYSDOH Prevention Agenda Dashboard (that includes the 'Promote Healthy Women, Infants, and Children' section) as well as data surveillance systems like PRAMS, 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 DFH that support MCH efforts but are not Title V MCHSBG funded include data staff who are located organizationally in the Office of Quality and Patient Safety (OQPS) and who manage critical data sources, such as vital statistics, Medicaid claims, and hospital discharge data.

Other state agency partners outside of NYSDOH support MCH epidemiological efforts. The NYS Council on Children and Families developed the Kids' Well-being Indicators Clearinghouse (KWIC; 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 KWIC 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 MCH epidemiology workforce in DFH. 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 MCH and Title V MCHSBG work specifically.

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

One of the main objectives of the State Systems Development Initiative (SSDI) is to build and expand NYS MCH data capacity to support Title V MCHSBG program activities and contribute to data-supported decision making in MCH programs, including assessment, planning, implementation, and evaluation. The importance of New York State Department of Health (NYSDOH) data capacity is recognized as critical to identifying needs of the MCH population, 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 MCH decision makers, program administrators, and staff who are monitoring and evaluating programs and their impact.

I. Contributions of the SSDI grant in building and supporting accessible, timely & linked MCH 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 SSDI and other Title V staff to assess, monitor, and evaluate Title V programming in NYS: Newborn Screening Program data; Vital Records (births, deaths); New York City Vital Records; Statewide Perinatal Data System (SPDS); Children and Youth with Special Health Care Needs 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 SSDI Principal Investigator (PI), who is the DFH Medical Director, the SSDI Program Research Specialist (PRS), and other DFH research scientists have initiated several efforts to increase data capacity and advance the development and utilization of linked information systems between key MCH datasets in NYS to improve access to electronic MCH health data. A listing of the various data linkage projects are listed below, detailed updates on the projects can be found in *Supporting Document 3: MCH 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 (APD)**
- **Linked NY Early Intervention Program (EIP) and Children and Youth with Special Health Care Needs (CYSHCN)**
- **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 SSDI plays in enabling ongoing Title V Program assessment, monitoring, and reporting.

The SSDI PI, the SSDI PRS, 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 MCH data and recommend structural and process measures used to monitor progress in all MCH 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 MCHSBG priorities for the purpose of ascertaining progress towards achieving reported goals. SSDI and other Title V analytic staff assisted with the coordination of data collection of NOMs, NPMs, SPMs, and ESMs both within and outside the DFH; contributed to ad hoc data analyses; and wrote summaries of data analyses relevant to the MCH population for the MCHSBG Application/Annual Report. These activities support Title V MCHSBG analysis of the NPMs and related structural/process objectives as part of the MCHSBG Application/Annual Report.

Staff have been assisting with a plan to improve data linkages across the five-year SSDI funding cycle. 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 MCHSBG.

Additionally, the SSDI PRS 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 SSDI 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 SSDI PRS is assisting with data collection and analysis for the NYSPQC'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 OUD 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 NAS is being achieved by delivering provider and patient education; improving early identification of infants at risk; improving the management of patients using standardized NAS treatment protocols, including pharmacological and non-pharmacological management; coordinating discharge care; and collaborating across hospital teams to share and learn.

The NYSPQC conducted the NYS Obstetric Hemorrhage Project between November 2017 and June 2021, in collaboration with the American College of Obstetricians and Gynecologists (ACOG) District II, Healthcare Association of New York State, and Greater New York Hospital Association, with support from the National Institute for Children's Health Quality (NICHQ). 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 ACOG.

The NYSPQC's NYS Birth Equity Improvement Project (BEIP) was launched to all NYS birthing hospitals and centers in January 2021. The project assists facilities to identify how individual and systemic racism 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 (PREM) 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 PREM 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 IM Collaborative Improvement and Innovation Network (CoIIN)

Title V MCHSBG staff and seven community-based organizations (CBOs) (i.e., Healthy Start and Maternal and Infant Community Health Collaboratives), participated in the second national Safe Sleep IM CoIIN. Under the leadership of NICHQ, 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 MCHSBG program relies on a number of robust data and information systems to inform priority setting, monitor health outcomes and disparities, and assess programs and policies. These systems include population-level data (e.g., vital statistics), representative surveys (e.g., Behavioral Risk Factor Surveillance System, Pregnancy Risk Assessment Monitoring System), and program data systems. The various data sources augmented 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 MCHSBG and MCH efforts overall are administered within DFH or are administered by other NYSDOH organizational units and DFH staff maintain strong partnerships and formal data use agreements to access needed data. Within DFH are the following systems:

- Early Hearing Detection and Intervention System (EHDI-IS 2.0) 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.
- New York Early Intervention System (NYEIS) is a centralized, web-based system that electronically manages Early Intervention Program (EIP) administrative tasks and provides for the exchange of information among municipalities, EIP providers and State administrators. The system is designed to support the EIP's service delivery, provider approval, financial, administration, and management activities at both the local and state levels by recording all EIP activities, including initial intake, evaluation, eligibility determination, Individualized Family Service Plan development, service provision, collection of third party insurance information (Medicaid and Commercial Insurers) and entry of claims from providers requesting reimbursement for EIP services provided.
- Individual program data systems (e.g., Family Planning Program; Maternal, Infant, and Early Childhood Home Visiting program; School-Based Health Centers; Adolescent Pregnancy Prevention Programs; NYS Perinatal Quality Collaborative) where data particular to each program are collected for program monitoring and evaluation.

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

- Vital Records (VR), two separate systems for NYC and Rest of State (ROS)
    - Core Electronic Birth Certificate (EBC): The Statewide Perinatal Data System (SPDS) is an electronic maternal and newborn data collection system which was established and is currently maintained by NYSDOH with the purpose of improving prenatal, obstetric, and newborn care for mothers and infants in NYS. The SPDS was developed to make data available for NYSDOH and hospitals for monitoring and quality improvement. Web-based and modular in design, SPDS includes the Core EBC that captures birth data in hospitals outside of NYC, and the NICU module (see below). The EBC provides near-real-time data for use in vital records birth registration, rapid enrollment of eligible newborns in Medicaid, and maternal/child public health surveillance of hospitals and communities. In addition to meeting National Center for Health Statistics (NCHS) standards for collection of electronic birth data, the Core EBC Module also includes quality improvement (QI) variables.
    - NYS Electronic Death Registration System (EDRS) is a secure web-based system for electronically registering deaths for NYS hospitals, excluding NYC. EDRS simplifies the data collection process and enhances communication between health care providers and medical certifiers, medical examiners/coroners, funeral directors, and local registrars as they work together to register deaths.
    - eVital allows all NYC hospitals to electronically submit birth and death registrations using mobile devices and facial recognition security. The eVital birth module captures the same birth data as the SPDS, using NCHS standards supplemented by the set of QI variables, but does not as yet provide NYC hospitals with access to the same statistical summary reports and data extraction capabilities as are available for upstate hospitals.

- Neonatal Intensive Care Unit (NICU) Module is a module of the SPDS that captures detailed clinical information from all hospitals, including NYC, certified to provide specialty or intensive care to high-risk neonates, i.e., those designated as Level II, III or Regional Perinatal Center. The NICU Module captures data for all neonates admitted to special and intensive care nurseries for longer than four hours, and includes information on newborns who die in the

delivery room, or in transit to or within the neonatal special or intensive care units. Data include demographics for the infant and birthing person and diagnoses and treatments for the infant.

- Statewide Planning and Research Cooperative System (SPARCS) is a comprehensive all payer data reporting system established in 1979. It collects patient level detail on patient characteristics, diagnoses and treatments, services, and charges for each hospital inpatient stay and outpatient (ambulatory surgery, emergency department, and outpatient services) visit; and each ambulatory surgery and outpatient services visit to a hospital extension clinic and diagnostic and treatment center licensed to provide ambulatory surgery services.
- All Payor Database (APD) is a comprehensive health claims and clinical database aimed at improving quality of care, efficiency, cost of care and patient satisfaction available in a self-sustainable, non-duplicative, interactive, and interoperable manner that ensures safeguards for privacy, confidentiality, and security. Currently the APD includes SPARCS hospital discharge data, VR death data, and Medicaid claims and encounter data. Going forward, VR birth data, commercial claims data, and other public health registries and electronic health records will be integrated.
- Newborn Screening laboratory information management system (LIMS) is maintained by the Wadsworth Laboratory to record bloodspot samples received, demographics, results for the 50 different disorders tested, and follow-up.
- New York State Immunization Information System (NYSIIS) is the system where health care providers report all immunizations administered to persons less than 19 years of age and their immunization histories. It aims to establish a complete, accurate, secure, real-time immunization medical record that is easily accessible and promotes public health by fully immunizing all individuals appropriate to age and risk.
- Statewide Health Information Network for New York (SHIN-NY) facilitates the electronic exchange of clinical information and connects healthcare professionals statewide to improve patient outcomes, reduce unnecessary and avoidable tests and procedures, and lower costs. It ensures access to a patient's electronic medical records wherever and whenever they need it. Health records are not publicly accessible. Only a patient decides who can see their records and may opt out at any time.
- Electronic Clinical Laboratory Reporting System (ECLRS) provides laboratories that serve NYS with a single electronic system for secure and rapid transmission of reportable disease information to NYSDOH, local health departments (LHD), and the New York City Department of Health and Mental Hygiene. It enhances public health surveillance by providing timely reporting; improving completeness and accuracy of reports; and generally facilitating the identification of emergent public health problems by monitoring communicable diseases, lead poisoning, HIV/AIDS, and cancer. ECLRS was particularly critical during the COVID-19 pandemic to record test results; public health law was changed to mandate reporting of SARS-CoV-2.
- LeadWeb is a NYSDOH-maintained system used by LHDs to carry out the required case management and follow-up activities for children with elevated blood lead levels (BLL). All BLL test results for children younger than 18 are reported to LeadWeb by laboratories, and LHDs are notified of new cases identified in their county. LeadWeb also collects information on housing-related hazards and environmental follow-up for each child. LHD staff are required to document when follow-up services are provided for each case, which they input directly into LeadWeb. As such, the system provides a real-time database of blood lead tests and follow-up activities.
- Pregnancy Risk Assessment Monitoring System (PRAMS) is an ongoing mail/telephone survey of mothers who have recently given birth to a live born infant, designed by the CDC. It collects information from mothers about behaviors and experiences before, during, and after pregnancy that are not available from other data sources. The goal of the PRAMS project is to make data available to inform policy and program investments to improve the health of mothers and infants by reducing adverse outcomes such as low birth weight, infant mortality and morbidity, and maternal morbidity. PRAMS provides state-specific data for planning and assessing health programs and for describing maternal experiences that may contribute to maternal and infant health.
- Behavioral Risk Factor Surveillance System (BRFSS) is an annual statewide random telephone and cellular surveillance survey designed by the CDC. The survey monitors modifiable risk behaviors and other factors contributing to the leading causes of morbidity and mortality in the population. Data from the BRFSS are useful for planning, initiating, and supporting health promotion and disease prevention programs at the state and federal level,

and monitoring progress toward achieving health objectives for the state and nation. NYS's BRFSS sample is representative of the non-institutionalized civilian adult population, aged 18 years and older.

- The Youth Risk Behavior Survey (YRBS), coordinated by the CDC, monitors students' health risks and behaviors in several categories, including weight and diet, physical activity, injury and violence, tobacco use, alcohol, and other drug use, and sexual behaviors. The YRBS is conducted every two years among a representative group of NYS students in grades 9–12. The NYS Center for School Health conducts the YRBS in NYS on behalf of the NYS Education Department.

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

DFH partnered with OQPS to begin building a Perinatal Data Warehouse, which will house linked VR birth and death data and SPARCS hospital discharge data and provide summary reports of priority birthing outcomes to birthing facilities and DFH. The warehouse and its reports will aid the quality improvement efforts of the NYSPQC, with the broader aim of addressing health disparities in birth outcomes, particularly maternal mortality and morbidity. This project is ongoing after being delayed March 2020-April 2022 due to staff reassignment for COVID-19 pandemic response.

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

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

The NYSDOH written EOP is called the Health Emergency Preparedness and Response Plan (HEPRP) and is coordinated through the NYSDOH Office of Health Emergency Preparedness (OHEP). It includes input from major NYSDOH Programs, including the Center for Community Health and Division of Family Health's Title V MCHSBG Program. The HEPRP is reviewed every three years or as needed after major events or identified changes.

Both the NYS CEMP and the NYSDOH HEPRP includes annexes which specifically look at the needs of the MCH populations. Under the NYS CEMP, NYSDOH participates in the Emergency Support Function (ESF) 6 with OCFS and other human service agencies, and in other ESFs, to identify methods of serving various populations, including the MCH population, when responding to an emergency impacting NYS.

Under the NYSDOH HEPRP, MCH 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 OHEP staff participate in the ESF meetings where NYSDOH is a member agency and other NYS CEMP meetings, and coordinate with NYSDOH program subject matter experts, including Title V MCHSBG 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 CEMP and HEPRP.

Title V MCHSBG program staff, specifically Dr. Marilyn Kacica, who is the Medical Director, was a key expert in providing information and identifying pediatric resources for the HEPRP Pediatric Surge annex.

NYSDOH staff at the state Emergency Operation Center (EOC) 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 MCHSBG program staff, as needed for any MCH planning before or during a disaster.

The NYSDOH Incident Management System (IMS) is a flexible and scalable structure based on the needs of the incident. In an incident where MCH concerns are identified, Title V MCHSBG leadership would be activated within the IMS 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 MCHSBG leadership will also be included for situational awareness on any department wide IMS 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 HEPRP Pediatric Surge plan. Additionally, Title V MCHSBG 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 health outcomes for the MCH population in NYS is an essential part of the NYS Title V MCHSBG program. Title V MCHSBG 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 MCH population in NYS has access to high quality health care services. These collaborations are highlighted throughout the Needs Assessment, Title V MCHSBG application and report, and include partnerships with other public health programs, state and local agencies, private sector partnerships, families, and consumers. A summary of major partnerships is included in *Supporting Document 1*.

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

As required by HRSA, the NYS Title V MCHSBG 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. Operated by the NYSDOH Office of Health Insurance Programs (OHIP) the NYS Medicaid program is part of the larger organizational structure of the NYSDOH along with the NYS Title V MCHSBG program.

Among the many advantages of being part of the same agency, the Title V MCHSBG and OHIP programs have been able to establish a strong relationship designed to enhance the services for the MCH population within NYS. This intra-agency relationship enables Title V staff to support the use of OHIP programs and funding whenever possible, ensuring that the Title V MCHSBG 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, OHIP and Title V MCHSBG staff regularly work together on various MCH initiatives, readily share data on MCH 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 priorities for the current five-year grant cycle were driven by this fundamental question: *how can we be responsive to the themes voiced by families and communities, within the context of the program infrastructure and resources we have, and with consideration for the national priorities and specific performance measures established by HRSA?*

From this question, we endorsed ten crosscutting priorities for NYS's Title V State Action Plan. These priorities align directly with the ten crosscutting themes identified from family and community members through the NA process described in our NA 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 MCHSBG 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.

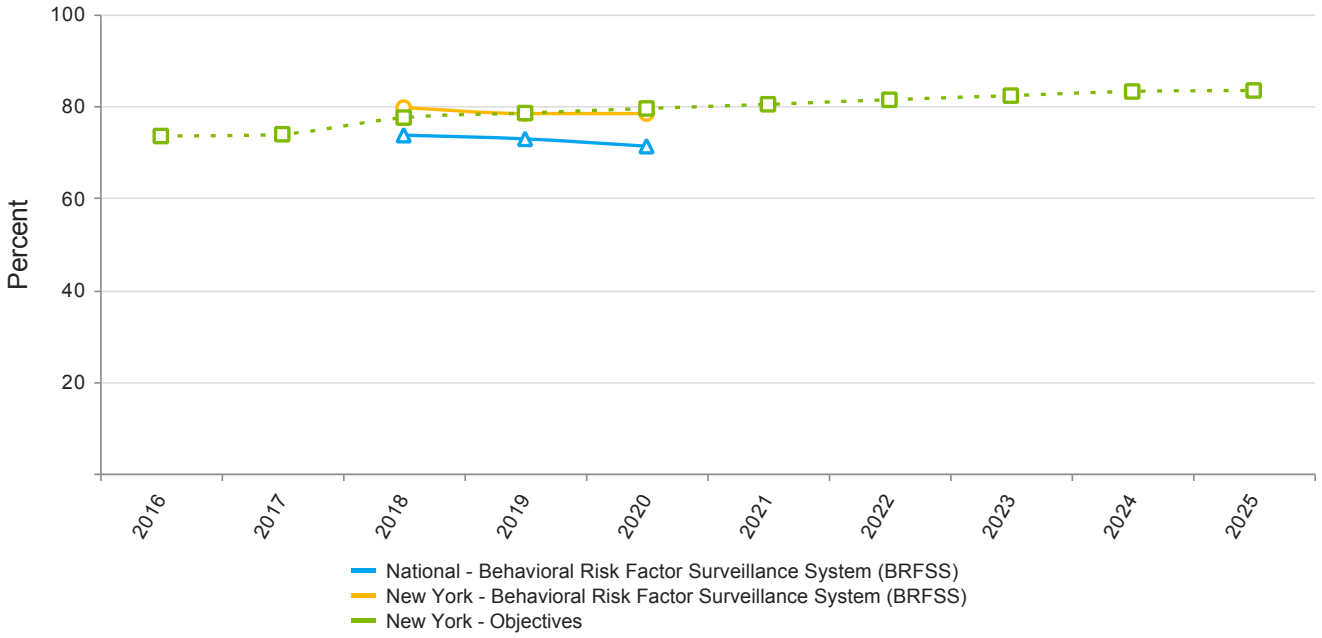
Evidence-based strategy measures (ESMs) were developed for each domain to capture the reach and effectiveness of these strategies for the relevant populations directly served through the Title V MCHSBG program. Specific objectives with measurable improvement targets were developed for each domain to 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

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



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective				79.4	80.3
Annual Indicator			79.6	78.3	78.3
Numerator			2,826,660	2,737,695	2,703,220
Denominator			3,550,054	3,498,639	3,451,509
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

Previous NPM-1 BRFSS data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	81.3	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
Annual Objective			55.3
Annual Indicator	52.7	63.4	40.1
Numerator		2,068	573
Denominator		3,260	1,430
Data Source	MICHC Program Data	MICHC Program Data	MICHC Program Data
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	58.1	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
Annual Objective			37.5
Annual Indicator	37.3	36.2	29.7
Numerator		92,136	58,264
Denominator		254,718	195,847
Data Source	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
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	37.7	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 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

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

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

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

ESMs	Status
ESM 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 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

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

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

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

ESMs	Status
ESM 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.** This NPM was selected because 1) Preventive medical visits for individuals of reproductive age are foundational to health throughout the life course, 2) it is supported by population health data demonstrating a need for continued improvement, and 3) it relates directly to priorities voiced by women and families at community listening forums held across NYS. During the community listening sessions, women and families expressed priority needs including awareness and access of community resources, quality health care, transportation, and social support. 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 includes preconception, reproductive and sexual health, family planning, prenatal, and postpartum care and encompasses a full spectrum of medical, mental/behavioral health, oral health, dietary/nutritional, and other supports and services.

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. NYS is ranked 23rd in the nation for the rate of maternal mortality. While NYS's maternal mortality rate has been declining, racial disparities in maternal deaths are persistent, with maternal deaths being three to four times more common among Black women compared to White women. Severe maternal morbidity also fundamentally affects the lives of people who give birth, newborns, families, and health care provider teams. It 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, and is associated with an increased risk for maternal death. Perinatal depression is among the most common morbidities during pregnancy and postpartum periods, with significant implications for the health and well-being of the entire family. 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. (BRFSS)

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

Objective WMH-3: Reduce the rate of severe maternal morbidity per 10,000 delivery hospitalizations by 5%, from 80 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2017 to 76 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2021. (HCUP-SID)

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

Four strategic public health approaches were identified to accomplish these objectives. These strategies are presented in the 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, 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 and 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 (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 1) Communicating with families on difficult and sensitive topics such as mental health and depression, 2) Using a trauma-informed care approach, and 3) Managing emergency situations. CHWs also connect clients and families to needed services and provide enhanced social support. CHWs help ensure early and consistent participation in preventive and primary health care services, including early prenatal care, particularly for those individuals not engaged in care and other supportive services. CHWs provided 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.

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

On July 28, 2021, a competitive request for applications (RFA) was released for the next iteration of MICHC, known as the Perinatal and Infant Community Health Collaborative (PICHC) initiative. A total of 26 awards were made for a five-year period beginning July 1, 2022 - June 30, 2027. The goal of the PICHC 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. PICHC programs are required to implement individual-level strategies to address perinatal health behaviors, and community-level strategies to address the social determinants which impact health outcomes. The core individual-level strategy is the use of CHWs 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 RFA for a PICHC training and technical assistance provider was developed during the reporting period and released on December 14, 2021. Applications were received and scored in spring of 2022. The grant award package is pending review with the Office of the State Comptroller (OSC). Upon receiving OSC approval, a contractual agreement will be initiated for the five year period October 1, 2022 – September 30, 2027.

Current MICHC contracts were extended for 9-months through June 30, 2022, to prevent a gap in services while the new RFA was released, applications were received, and contracts were executed. During this extension period, MICHC

programs received a one-time funding increase to support 1) salary increases for CHWs to ensure they are compensated equitably with a living wage according to the U.S. Department of Labor standards; 2) implementation of mandatory staff training focused on cultural humility, anti-racism, and equity in perinatal care which will better enable program staff to provide supportive services which improve health and behavioral outcomes especially for people who are pregnant or recently gave birth and are from communities disproportionally impacted by systemic barriers such as racism; and 3) subcontracts with community partners to address service gaps, in response to community input and needs assessments.

In addition, a new data management information system (DMIS) was launched April 1, 2021, to collect and monitor MICHC program data. The current DMIS vendor contract is in place through August 30, 2022. A competitive request for proposals (RFP) was developed and released on August 13, 2021. A new PICHC DMIS vendor contract will be awarded for a five-year period September 1, 2022 – August 30, 2027.

The NYS Family Planning Program (FPP) supports 34 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 over 150 family planning clinic 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, 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 the MIECHV Needs Assessment community forums, increasing awareness of available resources among both consumers and providers is critical. Home visiting programs are encouraged to promote use of the state's Growing Up Healthy Hotline service which in turn provides callers with linkages to local community resources, supports, and services including Supplemental Nutrition Program for Women, Infants and Children (WIC), Medicaid, Family Planning, prenatal care, and the NYS Early Intervention Program. Social media and other emerging communication forums online 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 2020-21 reporting period:

- Across all programs, enhanced promotion of the NYS Growing Up Healthy Hotline (GUHH) to increase awareness of available community resources, supports, and services including WIC, Medicaid, family planning, prenatal care, and the NYS Early Intervention Program. In March-June 2021, an overview of GUHH was presented for multiple audiences: WIC local agencies, the statewide home visiting workgroup, local health departments, and other home visiting partners at the Home Visiting Coordination Initiative. A GUHH flyer for use by programs was translated into multiple languages and posted to the NYSDOH website in January 2021. The translations were prompted by an Executive Order (EO) directing all state agencies that provide direct public services to offer language assistance services (translation and interpretation) to people with limited English proficiency (LEP). While the GUHH flyer is not a vital document and falls outside the EO, Title V staff recognized the importance of translating this flyer to improve recruitment and engagement of MICHC and MIECHV priority populations.
- Through the Regional Perinatal Centers (RPCs) and networks of affiliate birthing hospitals, support and enhance capacity to provide high quality perinatal telehealth services and perinatal subspecialty providers, particularly to rural communities and communities with disproportionate access to such services. Telehealth services will be tailored based on regional assessments of provider and affiliate hospital needs, to include routine prenatal and postpartum care and/or specialty care such as maternal-fetal medicine, radiology, and genetic counseling.
- Through the MICHC and MIECHV programs, successfully integrated use of 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 CHW 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-gong COVID-19 pandemic. CHWs continuously disseminated guidance on COVID-19 and perinatal health, as it became available.

- Through the MICHC program, supported CHWs to conduct outreach to find and engage high-risk pregnant and postpartum families in consistent, comprehensive preventive and primary care services, including preconception, prenatal, and postpartum care. From April 1, 2021, to March 31, 2022, a total of 4,688 clients were enrolled in the MICHC program. CHWs 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 April 1, 2021, to March 31, 2022, CHWs engaged 914 clients prenatally to create a birth plan. CHWs also issued a total of 17,011 referrals, with the top five referral categories being clothing/baby care items, housing assistance, SNAP, food pantry and WIC.
- Through the FPP, continued to support the delivery of comprehensive, confidential reproductive health services for women and men of reproductive age who are low-income and who are uninsured or underinsured. Addressing barriers to accessing reproductive health continues to be a priority of all FPP work. An example was the expansion in the availability of telehealth services, especially in response to the COVID-19 pandemic Including continued support to dispense a 12-month supply 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 (FPBP), and Family Planning Extension Program (FPEP).

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. MICHC 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 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 MICHC 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 led the following specific program and policy activities to advance this strategy during the 2020-21 reporting period:

- 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.
- Collaborated with MICHC, MIECHV, WIC, local health and social service programs, midwives, doulas, as well as state and national organizations such as the American College of Obstetricians and Gynecologists (ACOG), American Academy of Pediatrics (AAP), 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. A multimedia statewide campaign (in English and Spanish) was launched January 2021 through May 2021. Messaging was

developed to address four key areas:

- Emphasize the safety of and rebuild confidence in maternity care at all certified birthing facilities
- Explain infection control practices in each type of birthing facility
- Increase patient understanding of different levels of maternity care and types of birthing facilities as well as how to work with providers to select the appropriate patient-centered delivery
- Support the mental health and wellbeing of pregnant and birthing people and their families.

Media outlets included digital, streaming video and radio, social media, and search optimization. Radio Public Service Announcements (PSA) were aired in New York City and major metropolitan areas in Upstate NY/Long Island. Print advertisement boards were placed in metropolitan community locations such as salons, laundromats, and corner stores. Throughout the campaign, advertisements and campaign materials were seen or heard over 35.6 million times, resulting in nearly 75,000 clicks to the Department's website.

- Collaborated with NYS WIC to improve referrals from WIC local agencies to home visiting programs (MICHC, Nurse Family Partnership (NFP) and Healthy Families New York (HFNY). Both home visitors and WIC local agency staff were surveyed about referral patterns and barriers to referring to home visiting. Survey results indicated that home visiting agencies who are co-located with WIC, and those who have WIC on their community advisory board, reported the most referrals from WIC. Almost half of staff from WIC local agencies had not referred to home visiting in the past six months. WIC staff commonly indicated they lacked knowledge of home visiting programs and could benefit from a script to use with participants. These survey results were utilized to create a referral desk guide for WIC staff, which contained some scripting, and informed presentations on referrals given to home visiting programs and WIC local agencies. The home visiting team meets with NYS WIC to discuss bidirectional referral data quarterly to facilitate coordination and communication across the programs.
- The Regional Perinatal Centers (RPCs) and networks of affiliate birthing hospitals, continued to 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 were tailored based on regional assessments of provider and affiliate hospital needs, to include routine prenatal and postpartum care and/or specialty care such as maternal-fetal medicine, radiology, and genetic counseling. Each of the five upstate RPCs that serve a significant rural population identified needs and capacity. Several of the RPCs 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. *(See Strategy PIH-1 for more detail on Telehealth Services for Neonatal Services).*
- As part of the effort to improve coordination and increase bilateral referrals between birthing hospitals and MICHC and MIECHV home visiting programs, Title V staff collaborated with the NYS Council on Children and Families (CCF) to develop a flyer for their new NYS Parent Portal, which includes information on childcare and home visiting options by county, to promote the website and increase awareness of home visiting services and supports available in NYS. In March 2021, this flyer was shared with NYS birthing hospitals and community-based programs serving pregnant and parenting families with the goal of directing more MICHC and MIECHV clients to the NYS Parent Portal. The flyer was also translated into the ten most common non-English languages spoken by Limited English Proficiency (LEP) individuals in NYS. As a result of this effort, CCF data (comparing March 2020 to March 2021) showed a 459% increase in number of clicks to the Childcare Locator (which includes the home visiting locator) and a 601% increase in number of clicks to the Parent Portal. Subsequent data comparing April 2020 to April 2021 showed a 442% increase in number of clicks to the Childcare Locator and a 154% increase in number of clicks to the Parent Portal.
- Title V staff also held multiple brainstorming sessions and developed a student internship project for the spring 2022 semester that will examine existing relationships between home visiting programs and birthing hospitals via a Survey Monkey questionnaire and evaluation of responses. The intern will also use current MICHC, NFP, and HFNY referral data and create a referral monitoring tool in Excel to track trends in referrals made. Best practices to improve referral

relationships will be determined by survey analysis and evaluation of current data trends. Title V staff will share best practices with established home visiting-birthing hospital partnerships across the state to encourage and strengthen on-going collaboration.

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 raise awareness, empower community action, and facilitate quality improvement efforts at all levels.

Title V staff have implemented a comprehensive review process with the multidisciplinary NYS Maternal Mortality Review Board (MMRB) for the purpose of reviewing maternal deaths and maternal morbidity. NYS has an established public health surveillance process in place to identify and review cases of maternal death through multiple sources of public health data and chart reviews. The cases are identified within one year of the date of the maternal death and the case reviews are completed within two years of the date of death. The 2018 maternal death cohort was completed by the end of calendar year 2020. The 2019 maternal death cohort review was initiated in 2019 and is on track for completion by the end of 2021.

During the reporting period, the MMRB met virtually six times (11/20, 12/20, 2/21, 5/21, 7/21 and 9/21) to perform the maternal death case reviews. The MMRB assessed the causes of deaths, factors leading to the deaths, and preventability for each maternal death reviewed. Staff has developed a written report of the findings and recommendations for the 2018 maternal death cohort that will be used to prevent future deaths and reduce the risk resulting from racial, economic, or other disparities. In September 2021, the findings of the 2018 maternal death case reviews and related recommendations were shared with the Maternal Mortality and Morbidity Advisory Council (MMMAC). The MMRB recommendations for preventability will be translated into action through collaboration with the MMMAC, ACOG District II) and other key stakeholders, including the development of issue briefs, webinars, and quality improvement projects through the New York State Perinatal Quality Collaborative (NYSPQC).
(See Strategy PIH- 2.4 for more detail on NYSPQC and equitable care.)

Analysis of NYSPQC project data provided by participating birthing hospitals helps to improve services and systems related to maternal health care. The NYSPQC, ACOG-NY, Healthcare Association of New York State (HANYS) and Greater New York Healthcare Association (GNYHA), with support from the National Institute for Children's Health Quality (NICHQ), will continue to lead specific improvement projects related to opioid use disorder in pregnancy and birth equity, two important areas related to maternal mortality and morbidity. (See Strategy PIH- 4.1 for more detail on improvement projects.)

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 policy 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 NYSPQC projects, Title V staff have been collecting and doing 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 2020-21 reporting period:

- Summarized, shared, and discussed findings of the MMRB with key partners, including the MMMAC, to inform statewide prevention strategies as described above. Data from the 2018 maternal death cohort and findings from the

MMRB case reviews was compiled and analyzed.

- A statewide report on maternal mortality with data and information to improve maternal outcomes was released in April 2022 and can be found at: maternal_mortality_review_2018.pdf (ny.gov).
- A planned Severe Maternal Morbidity (SMM) analysis was deferred while two analytic staff were deployed to assist in the COVID-19 pandemic efforts. Efforts of remaining analytic and program staff centered on continuing the MMRB meetings and writing the statewide report of the 2018 maternal death cohort. As time allows, staff will continue to identify cases of SMM through hospital discharge data and conduct an analysis using linked birth data and hospital discharge data to define the major causes of maternal morbidity.
- The three-year NYS Obstetric Hemorrhage Project closed in June 2021. Through this project, the NYSPQC worked with birthing hospital teams to improve the assessment, identification, and management of maternal hemorrhage, one of the leading causes of maternal morbidity and mortality in NYS. A participating birthing hospital provided this feedback on the project, “It was a great support to be part of this collaborative and have our site make so many improvements during our engagement in the project.” During the coming reporting period, the NYSPQC will finalize and disseminate the NYS Obstetric Hemorrhage Project Toolkit, which contains presentations, tools and resources created by hospital teams, data forms, and other items to all NYS birthing hospitals. 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 for their use and information. The project website will continue to be available to project participants interested in referencing archived materials.
- The NYSPQC continued to work with birthing hospital teams and community-based organization through the NYS Opioid Use Disorder (OUD) in Pregnancy & Neonatal Abstinence Syndrome (NAS) 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 OUD during pregnancy, and improve the identification, standardization of therapy, and coordination of aftercare of infants with NAS. NYS participates in the national Alliance for Innovation on Maternal Health (AIM) through this project.
- Through the NYSPQC, with the support of collaborative partners, a new comprehensive interdisciplinary hospital quality improvement project, the New York State Birth Equity Improvement Project (NYSBEIP), 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 birthing people in the communities they serve. (See Strategy WMH-4 below for further detail.)

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’s and Maternal Health outcomes are impacted by the social determinants of health (SDOH), or the conditions in which people are born, live, work, play, learn, and age. SDOH include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of power and resources due to racism and other biases are root causes of inequities in access, availability of services, and quality of clinical care. All ten priorities that emerged from community members' input during the needs’ assessment revolve around SDOH 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 SDOH. 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; the development of supports, opportunities and social norms that promote and facilitate healthy behaviors across the lifespan; involving community members in program implementation and policy; 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 Title V Program led the following specific program and policy activities to advance this strategy during the 2020-21 reporting period:

- Through the MICHC program, contracted staff including CHWs 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 1,500 community partners at more than 200 coordinated outreach events.
    - Worked collaboratively with community partners to address relevant community issues such as safe housing, availability and accessibility of resources and services (e.g., health care, mental health, substance abuse services, home visiting, family support resources), social norms (e.g., related to use of preventive care services, breastfeeding, or personal health behaviors) and community mobilization to effectively identify and address community problems. CHWs issued more than 12,610 health care and social support referrals to MICHC clients.
- Through the MICHC program, provided supports to individual clients and their families to address behavioral SDOH outcomes, including:
    - Provided 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.
    - Helped 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.
    - Provided professional development support for CHWs 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; how to manage emergency situations; and cultural humility, anti-racism, and equity in perinatal care.
- On a policy level through a contractual agreement, Title V staff worked to ensure CHWs are compensated with a living wage and afforded promotional opportunities. With the additional funds being provided in the nine-month extension period (10/1/2021-6/30/2021) as highlighted above, not only are CHW salaries intended to increase, but the requirements for the CHW Supervisor position have been updated to allow for a pathway for experienced CHWs to advance to a CHW supervisory role. To achieve this, MICHC programs that have identified a potential candidate must submit a staff development plan that includes the CHWs resume, a one-year probation period and additional training on Mental Health First-Aid, Case Management, Identification of Child Abuse and Maltreatment, Crisis Intervention, and Identification of Intimate Partner and Domestic Violence.
- Through the Enough is Enough (EiE) program, (which supports 48 projects across the state to work with local colleges and universities to support sexual violence prevention and education efforts) Title V funding supported costs associated with training EiE programs on the Safer Bars Curriculum to train bar proprietors and their staff on what is sexual violence, how to observe and assess situations for signs of sexual violence, bystander intervention skills building; policy change assistance, and environmental assessments. Trainings were initially scheduled for Fall 2020. However, due to the COVID-19 pandemic, NYSDOH collaborated with the training agency (Cicatelli Associates, Inc.) and the developer (Dr. Elise Lopez, University at Arizona) to modify the training-of-trainers to fit a virtual delivery model. Trainings were provided in early 2021. Due to the COVID-19 pandemic and the impact on alcohol-serving establishments (closures and limited capacity once reopened), EIE programs with support from the NYSDOH decided to pause implementation of the Safer Bars programs until it was reasonable to resume. As part of the 2021-

2022 enacted state budget, the Department transferred the EiE program to the NYS Office for the Prevention of Domestic Violence (OPDV), effective April 1, 2021. NYSDOH staff continue to collaborate with OPDV on the Safer Bars curriculum implementation.

- Title V staff continued to collaborate with partners, including but not limited to, the Office of Mental Health's Project TEACH, American College of Obstetricians and Gynecologists (ACOG-NY), home visiting programs and other community-based organizations, to address mental health in pregnant and postpartum people by increasing screening and follow-up support. Two maternal mental health training webinars were hosted during the reporting period. The first, in February 2021, focused on integrating maternal mental health into obstetrics and featured presentations by Mary D'Alton, MD, Chair of the Department of OB/Gyn and Catherine Monk, MD, Director of Women's Mental Health Obstetrics and Gynecology at Columbia University Irving Medical Center. The second webinar took place on October 6, 2021, which focused on the impact of SDOH 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 MICHC Program Managers directly, as well as on the MICHC listserv. Recipients include but are not limited to MICHC program staff such as CHWs and CHW Supervisors, staff of Healthy Start home visiting programs, LHD staff, and NYSDOH staff located in Albany and in regional office.
- The Title V Program, in collaboration with its NYSPQC, began a comprehensive learning collaborative project, the NYS Birth Equity Improvement Project (BEIP) 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 participated 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 (PREM). The PREM, which was implemented in July 2021, is administered at project participating facilities to birthing people prior to their discharge. As of October 6, 2021, more than 3,500 PREMs were submitted by people as they were being discharged from a participating hospital. The data collected through the PREM is analyzed by Title V staff and reported back to facilities.
- In 2020, NYS passed a law legalizing compensated gestational surrogacy. Title V staff, in partnership with other Department colleagues, worked to establish regulations, guidance documents and a Surrogates' Bill of Rights to support the licensure of Gestational Surrogacy Programs (GSP). This comprehensive law (effective February 15, 2021) and regulations transformed NYS from one of the last states to allow gestational surrogacy to establishing the most comprehensive gestational surrogacy and ova donation program in the country. Gestational surrogacy provides New Yorkers', including people who identify as LGBTQIA+, with the ability to start or expand their families. Title V staff developed and implemented internal policies and procedures to review GSP applications. Between February 15, 2021, and September 30, 2021, Title V staff reviewed 18 applications, approving 12 for licensure and requesting additional or clarifying information in alignment with GSP requirements.
- Title V staff updated eligibility requirements of the Department's Infertility Reimbursement Program (IRP), formerly known as the Infertility Demonstration Program, to align with new state insurance law effective January 1, 2020, which requires all large cap insurance plans to provide three cycles of in vitro fertilization (IVF), fertility preservation services (FPS) and adds 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 new state definition of infertility. Based on these changes to the law, the Department has developed new criteria for patient and provider participation in the IRP, in consultation with expert stakeholders (ACOG and the Association of Reproductive Medicine), using the Centers for Disease Control and Prevention (CDC)

Assisted Reproductive Technology (ART) Success Rate Report, to obtain objective performance data on provider eligibility. Patient participation will now include Medicaid recipients, making the program more accessible to individuals with limited income, the unemployed or those lacking insurance through their employer. Per the new criteria, NYSDOH has identified 24 infertility providers in NYS who meet provider eligibility requirements. NYSDOH released a solicitation of interest (SOI) for the IRP in early 2022. It is anticipated that contracts resulting from this SOI will be for a two-year period from 10/1/22-9/30/24.

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 MICHC program participants engaged prenatally who have created a birth plan during a visit with a CHW.

Data for this measure is obtained from monthly reports submitted by MICHC contractors. The baseline value for this measure, taken from 6-month program period of 10/1/19-3/31/20, is 52.7%. Since the baseline data collection period, a new web-based data management system was implemented on 4/1/2021. Uptake of the new data system impacted data completeness and quality, resulting in a value of 43.4% for the time period of 4/1/2021 to 3/31/2022. The program has set a one-year improvement target of 5%, to 45.6% of participants, for 2022.

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

Data for this measure will come from FPP clinic visit record (CVR) data. Current FPP data for program year 2018 shows 25.6% of FPP clients had a documented comprehensive medical exam. The FPP program has set a one-year improvement target of 5%, to 26.9% of clients in 2022.

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.

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. A recent report ranked New York State (NYS) 23rd in the nation for the rate of maternal mortality. While NYS's maternal mortality rate has been declining, racial disparities in maternal deaths are persistent, with maternal deaths being three to four times more likely among Black women compared to White women. Severe maternal morbidity also fundamentally affects the lives of birthing persons, newborns, families, and health care provider teams. It 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, and is associated with an increased risk for maternal death. Perinatal depression is among the most common morbidities during pregnancy and postpartum periods, with significant implications for the health and well-being of the entire family. 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 performance measure:

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

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.

As noted in the FY21 Report, the previous Maternal and Infant Community Heath Collaboratives (MICHC) program has segued to the current Perinatal and Infant Community Health Collaboratives (PICHC) program (July 1, 2022 - June 30, 2027) via a competitive Request for Applications (RFA) process. Through the RFA process, and with additional state funding to reduce maternal mortality, three additional programs were approved (total 26 statewide). The goal of the PICHC initiative is to improve perinatal health outcomes and eliminate racial, ethnic, and economic disparities in those outcomes. As the core individual-level strategy, PICHC programs will utilize community health workers (CHWs) 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 will be completed at enrollment and updated throughout clients' service periods and individualized care plans will be developed based on the needs identified. CHWs will receive annual training from the PICHC Training/Technical Assistance provider 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. CHWs will also connect clients and families to needed services and provide enhanced social support. CHWs will 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. CHWs will 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.

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

The NYS Family Planning Program (FPP) supports 34 health facilities that are regulated by NYSDOH under Article 28 of NYS Public Health Law (these include hospitals and clinics) that operate over 150 family planning service sites across the state. Through these service sites, the FPP 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 (GUHH) 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 2022-23 year:

- **Activity WMH 1.1**: Across all Title V programs, enhance promotion of the NYS GUHH to increase awareness of available community resources, supports, and services including WIC, Medicaid, family planning, and prenatal care.
    - Title V including PICHC and MIECHV staff will continue to promote the GUHH through presentations to Title V programs and partners, broadly share the GUHH flyer available in multiple languages on the Department's website and provide updates to GUHH as available resources emerge or change.
- **Activity WHM 1.2:** Through the Regional Perinatal Centers (RPCs) and networks of affiliate birthing hospitals, support and enhance capacity to provide high-quality perinatal telehealth services and perinatal subspecialty providers, particularly to rural communities and 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.
    - Capital funds initially identified in the New York State of the State 2019 will be distributed to RPCs specifically to support perinatal telehealth costs. Through the Department's Office of Primary Care and Health Systems Management and the *Statewide Health Care Transformation III Grant* RFA, applications will be reviewed prior to the start of the 2022-23 program year, but up to $5M in state allocations will be used by RPCs on capital costs such as equipment, construction, training on equipment, etc.
- **Activity WMH 1.3:** Through the PICHC and MIECHV programs, integrate use of virtual home visiting services to increase acceptance and support of services for hard-to-reach families.
    - 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 CHW and home visiting services to continue including providing health information, support and referral and follow-up for preventive and prenatal care visits. As COVID-19 vaccinations become more widely available and accepted in some marginalized communities, we anticipate home visiting programs 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 PICHC program, continue to support CHWs 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.
    - CHWs 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. CHWs will initiate (or coordinate with Obstetric provider) the development of a birth plan with all prenatal clients and monitor the number of birth plans initiated through the PICHC data management information system (DMIS).
- **Activity WMH 1.5:** Through the FPP, continue to support the delivery of comprehensive, confidential reproductive health services for individuals of reproductive age who are low income and uninsured or underinsured.
    - 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 assist uninsured clients in enrolling in the most appropriate health insurance plans including Medicaid, Family Planning Benefit Program (FPBP), and Family Planning Extension Program (FPEP).
- **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 6 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 Program consists of hospital programs, training programs, and examiners to respond to survivors of sexual assault and collect forensic evidence.

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

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

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

- **Activity 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.
  - 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 move up or down 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 (RPC) 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:** Collaborate with PICHC, MIECHV, WIC, local health and social service programs, midwives, doulas, as well as state and national organizations, such as the American College of Obstetricians and Gynecologists (ACOG), American Academy of Pediatrics (AAP), 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 staff will:

- Periodically present to PICHC and MIECHV home visiting programs on the Perinatal Regionalization system and on effective strategies for guiding clients to the birthing hospital with the appropriate level of care for their clients.
- Continue to collaborate with state and local stakeholders on COVID-19 messaging to address relevant issues such as vaccine safety for pregnancy and vaccine hesitancy as needed.

- **Activity WMH 2.3**: Improve coordination and increase bilateral referrals between birthing hospitals and home visiting programs. Title V staff will:
  - Continue to assist in connecting PICHC programs with their local birthing hospitals and support formal meetings where possible. Resources will be shared with programs and evaluation surveys conducted to determine use and effectiveness of resources. PICHC program data will 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 PICHC, MIECHV, WIC, and the Office of Children and Family Services (OCFS) on the WIC Referral Project and the State MIECHV continuous quality improvement (CQI) project, to improve bi-directional referrals between local WIC sites and local PICHC and MIECHV home visiting programs.

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

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

The Title V staff have implemented and will continue a comprehensive review process with the multidisciplinary NYS Maternal Mortality Review Board (MMRB) for the purpose of reviewing maternal deaths and maternal morbidity. During the COVID-19 pandemic, the MMRB has continued to meet virtually, about four to six times per year, to enable timely maternal death reviews. NYS has an established public health surveillance process in place to identify and review cases of maternal death through multiple sources of public health data and chart reviews. The MMRB 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 scored and ranked by MMRB members and the themes of these recommendations have been presented to the Maternal Mortality and Morbidity Advisory Council (MMMAC). The MMRB recommendations for preventability will be translated into action through collaboration with the MMMAC, ACOG District II of NY (ACOG-NY) and other key stakeholders, including the development of issue briefs, webinars, and quality improvement projects through the NYS Perinatal Quality Collaborative (NYSPQC).
(See Strategy PIH-3 for additional details.)

Analysis of NYSPQC project data provided by participating birthing hospitals helps to improve services and systems related to maternal health care. The NYSPQC, in collaboration with ACOG-NY, Healthcare Association of New York State (HANYS), and Greater New York Healthcare Association (GNYHA), and with support from the National Institute for Children's Health Quality (NICHQ), will continue to lead an improvement project focused on opioid use disorder in pregnancy as an important cause of maternal mortality and morbidity.

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 focused on birth equity and anti-racism. The Birth Equity Improvement Project (BEIP) learning collaborative, which launched in January 2021, has engaged birthing hospital staff from clinical, administrative, and executive levels to analyze hospital policy and procedures that may contribute to bias and develop strategies to improve outcomes. As with all NYSPQC projects, Title V staff will 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.

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

- **Activity WMH 3.1:** Summarize, share, and discuss findings of the MMRB with key partners, including the MMMAC, to inform statewide prevention strategies as described above.
- **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.
- **Activity WMH 3.3:** Identify cases of Severe Maternal Morbidity (SMM) through hospital discharge data, conduct an analysis using linked birth data and hospital discharge data to define the major causes of maternal morbidity.
- **Activity WMH 3.4:** Through NYSPQC, continue to work with birthing hospital teams' participating in the NYS Opioid Use Disorder (OUD) in Pregnancy & Neonatal Abstinence Syndrome (NAS) Project.
    - This learning collaborative, which kicked-off in September 2018 with 14 pilot site birthing hospitals, was expanded in 2020 to include a total of 43 birthing hospitals. The project seeks to identify and manage the care of people with OUD during pregnancy, and improve the identification, standardization of therapy, and coordination of aftercare of infants with NAS. NYS participates in the national Alliance for Innovation on Maternal Health (AIM) through this project.
- **Activity WMH 3.5:** Through the NYSPQC, continue work on the NYS BEIP, a comprehensive interdisciplinary quality improvement project focused on implicit bias and birth equity *(see Strategy WMH-4 below for further detail).*
- **Activity 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 (P/S/EL) syphilis among NYS females of childbearing age *(See Activity PIH-3.5 for additional details and activities*).

- **Activity WMH 3.7**: Through the Rape Prevention and Education Program, create Regional Profiles that will serve as living documents of publicly available data across 17 counties covered by 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, NYS Education Department and the U.S. Census.

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's and Maternal Health outcomes are impacted by the social determinants of health (SDOH), or the conditions in which people are born, live, work, play, learn, and age. SDOH 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 SDOH 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 SDOH. Strategies focus on 1) improving outreach to women, who have been disproportionally impacted by systemic barrier 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.

Additionally, in response to the recently enacted Child-Parent Security Act (CPSA), which allows gestational surrogacy in New York, regulations were enacted in early 2020, and gestational surrogacy programs (GSPs) may now apply for licensure. The CPSA outlines the requirements of GSPs (also known as 'matching programs'), assisted reproductive technology service providers, and ova donation programs (a subset of tissue banks). The CPSA and GSPs provide opportunities for New Yorkers to start or expand their families when pregnancy and childbirth are not feasible options. Title V staff will continue to be directly involved in the program, now coordinated through the Office of Primary Care and Health Systems Management (OPCHSM).

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

- **Activity WMH 4.1:** Through the PICHC programs, continue to work with diverse community stakeholders including community residents to identify and collaboratively address issues and barriers impacting maternal 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:** Through the PICHC program's CHWs, continue to provide supports to individual clients and their families to address behavioral SDOH 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.
    - Routinely screen for health insurance enrollment, and assist clients with enrollment as needed, including referral to enrollment Navigators and Community Health Advocates.
    - Conduct screenings using standardized, evidence-based, or validated tools for domestic violence, substance use, smoking, and depression, and make referrals for follow-up as needed. PICHC program data will be collected and monitored via a web-based data management and information system (DMIS).
    - 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.
    - Through a new training and technical assistance (TA) contractor, provide professional development support for CHWs 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 TA will include assessing the training needs of funded grantees and providing appropriate TA, developing/conducting web-based and in-person trainings, ensuring competencies of CHWs and supervisors, standardization of best practice strategies, promoting/conducting CQI activities, and conducting an annual learning collaborative.

- **Activity WMH 4.3:** Collaborate with partners, including but not limited to:
    - Prevent Child Abuse New York, OCFS, and the Schuyler Center for Advocacy and Analysis (SCAA) Home Visiting Workgroup to integrate parent engagement and leadership into state level home visiting efforts. MIECHV staff have proposed to initiate and implement a statewide parent advisory committee (PAC) beginning October 1, 2022, which will consist of parents who are current or former home visiting clients. 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 MIECHV staff will share lessons learned with PICHC programs to enhance their community member participation on Community Advisory Boards.
    - Office of Mental Health's (OMH) Project Teach, ACOG-NY, home visiting programs and other community-based organizations, to address mental health in pregnant and postpartum people by increasing screening and follow-up support. A Title V funded-media campaign to encourage pregnant and newly parenting individuals to seek help for mental health concerns will re-launch in the Spring of 2022. Title V staff will coordinate efforts on the campaign with OMH and the Postpartum Resource Center of NYS, a non-profit organization which educates the public and provides a helpline for individuals with symptoms of perinatal mood and anxiety disorders.
- **Activity WMH 4.4:** Collaborate with NYSPQC on the NYS BEIP.
    - The Title V Program, in collaboration with NYSPQC, will continue the work of the BEIP to assist birthing facilities to identify 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, 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 (PREM).
- **Activity WMH 4.5**: Support gestational surrogacy regulations, including licensure of and collaborations with GSPs.
    - The CPSA and associated regulations and guidance support gestational surrogacy for surrogates living in NYS. This includes establishment of a Surrogates' Bill of Rights, clinical screening guidelines for prospective surrogates and intended parent(s), informed consent requirements, voluntary surrogacy and ova donor registries, and conflict of interest requirements for gestational surrogacy providers and assistive reproductive therapy service providers.
    - Title V staff will continue to review GSP applications for the required documentation (https://health.ny.gov/community/pregnancy/surrogacy/program_license.htm) through the secure NYS Health Commerce System. Completed applications will be reviewed by the Department's internal GSP (housed within OPCHSM), the Division of Legal Affairs, and Title V Division of Family Health staff to ensure that the legal and regulatory requirements are met, background checks are conducted and appropriate, address identified deficiencies, and ensure there are no contraindicators that would deny an applicant licensure.
- **Activity WMH 4.6**: Through the Infertility Reimbursement Program (IRP), provide reimbursement for out-of-pocket costs associated with in vitro fertilization (IVF) and fertility preservation services to individuals who meet eligibility criteria.
    - IRP contracts beginning October 1, 2022 will 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 (FPS), and adds 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. Patient participation will now include 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 monitor activities and data for these contracts for a two-year period from 10/1/22-9/30/24.

- **Activity 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. 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 a multi-media campaign on vaccine hesitancy for individuals of reproductive age.
- **Activity WMH 4.8:** Improve the NYS Sexual Assault Victim's Bill of Rights (BORs).
  - The Sexual Assault Victim's BORs was developed in 2019. The BORs will be updated to improve health literacy and translated into the 10 most common languages in NYS.

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

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

Data for this measure will come from monthly reports submitted by local PICHC contractors in the new DMIS. The baseline value for this measure, taken from the 12-month program period of 4/1/21-3/31/22, is 43.4.7%. The program has set an improvement target of 5% annually, to 50.2% 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 come from FPP clinic visit record (CVR) data. Current FPP data for the time period 10/1/2020 - 9/30/2021 shows 36.2% 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.

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					
	2017	2018	2019	2020	2021
Annual Objective	91	93.4	93.7	93	92.4
Annual Indicator	92.7	92.5	91.2	92.2	91.6
Numerator			2,782	2,626	2,610
Denominator			3,052	2,849	2,850
Data Source	NYS VS	NYS VS	NYS VS	NYS VS	NYS VS
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	92.6	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
Annual Objective			0
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	NYS Data	NYS Data	NYS Data
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	0.0	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
Annual Objective			75
Annual Indicator	70	68	70
Numerator			
Denominator			
Data Source	Newborn Blood Spot data	Newborn Blood Spot data	Newborn Blood Spot data
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	77.0	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 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.	
Strategy PIH-2: Implement updated perinatal regionalization standards, designations, and structured clinical quality improvement initiatives in birthing hospitals and centers. Please see Supporting Document 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.	
Strategy PIH-3: Apply public health surveillance and data analysis findings to improve services and systems related to perinatal and infant health care. Please see Supporting Document 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.	
Strategy PIH-4: Address social determinants identified by community members that impact infant health and use of perinatal and infant health care and support services. Please see Supporting Document 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.	
ESMs	**Status**
ESM 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 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Perinatal/Infant Health - Annual Report

For Perinatal and Infant Health (PIH), New York's Title V Program selected **NPM 3: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ NICU.** This NPM was selected because of its relevance to quality and systems of care for infants who are at high risk for poor outcomes. While NPM 3 specifically measures 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, and fostering community engagement and empowerment.

In addition, New York's Title V Program established one **SPM for this domain, state-wide improvement from 74.34% to greater than 85% of newborn bloodspot screening (NBS) samples received at the lab within 48 hours of collection.** This SPM was developed to reflect the state's continued commitment to ensure that every newborn in the state receives 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 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 (13.3%) than non-Hispanic white infants (6.3% and 7.7%, respectively). NYS has improved the proportion of pregnant people entering prenatal care during the first trimester to 80.6%, but again there are disparities with only 71.8 of non-Hispanic Black and 74.7% of Hispanic pregnant women beginning early prenatal care compared to 85.7% of non-Hispanic white pregnant women. 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 NPM3 and other related measures to ensure that quality of care and key health outcomes are maintained or improved.

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

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

Objective PIH-1: Increase or maintain the percent of very low birth weight infants born in a hospital with a Level III+ NICU by 2.4%, from the 2017 level of 91.2% to 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).

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)

Five strategic public health approaches were identified to accomplish these objectives over the next five years. These are presented in the 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 and 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 programs, including Maternal & Infant Community Heath Collaboratives (MICHC), Newborn Bloodspot Screening (NBS), New York State Perinatal Quality Collaborative (NYSPQC), and Regional Perinatal Centers (RPCs), play a direct role in promoting comprehensive health and wellness of neonates through population-based systems, public health interventions, and delivering or linking people to health care services.

The Title V Program made progress or completed the following specific program and policy activities to advance this strategy throughout the 2020-21 year:

- PIH 1.1: The Department implemented a multimedia educational campaign that promoted the safety of birthing hospitals, maternity care options (levels of care and types of care providers), and infection control, and supported mental and emotional health of birthing people and families, to strengthen community awareness and advocacy for obtaining prenatal and postpartum care at appropriate level of care.
    - This campaign was informed by experts and community members in response to the COVID-19 Maternity Task Force recommendations (available at https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/042920_CMTF_Recommendations.pdf).
    - Campaign images and messages and ad placements were tailored to reach Black and Hispanic/Latinx pregnant people aged 15-50, an audience estimated at over 83,700 people (American Community Survey 2018, US Census Bureau).
    - In addition to messages on NYSDOH social media and partner agencies and providers, print media was placed in metropolitan markets while internet advertisements (banner ads, streaming video, and streaming and broadcast audio) and search optimization were statewide. Ads and audio were available in English and Spanish.
    - Over 35 million estimated impressions (the number of times the campaign was seen or heard) were delivered, resulting in nearly 75,000 clicks to the campaign website (not including broadcast/streaming radio and print media).
- PIH 1.2: 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 WIC, Medicaid, family planning, prenatal care, and the NYS Early Intervention Program.
- PIH 1.3: Through the Regional Perinatal Centers (RPCs) and networks of affiliate birthing hospitals, support and enhance capacity to provide high quality perinatal telehealth services and perinatal subspecialty providers, particularly to rural communities and communities with disproportionate access to such services. *(See Domain 1 WMH for additional details on obstetrical telehealth initiatives.)*
    - The Title V-funded Rural Perinatal Telehealth Initiative provides funding to five upstate RPCs that serve rural communities. Starting in the 2019-20 program year and continuing through the current program year, RPCs 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.
    - Based on identified needs, each RPC developed a telehealth service plan, determined the best approach to obtaining telehealth equipment (mobile carts, stethoscopes, etc.), and established formal relationships with affiliate partners to provide telehealth services.
    - 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).
    - Logistical issues, including global silicon chip shortages, high telehealth equipment demand, overtaxed hospital IT departments and legal/contractual delays, all five projects were extended beyond the initial 1/1/20-12/31/20 contract period, and are slated to end 12/31/21. Due to these issues, process and outcome measure data are not available at the time of reporting.
- PIH 1.4: Through the Maternal and Infant Community Health Collaboratives (MICHC) and Maternal, Infant, and Early Childhood Home Visiting (MIECHV) programs, integrate use of virtual home visiting services to increase acceptance and support of services for hard-to-reach families *(See Domain 1 WMH for details).*
- PIH 1.5: Through the MICHC and Maternal, Infant, and Early Childhood Home Visiting (MIECHV) programs, support community health workers (CHWs) 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 Domain 1 WMH for details).*
- PIH 1.6: Through the American Indian Health Program (AIHP) and Migrant and Seasonal Farmworker (MSFW) Programs, continue to support direct health care and supporting services to ensure access to health care.
- PIH 1.7: Through the NYSPQC, provide educational opportunities and implement structured quality improvement

projects with birthing hospitals and centers *(See Strategy PIH-2 below for detail).*

Additionally, a new strategy was identified and completed during the progress period.

- PIH 1.8: To increase public awareness of urgent maternal warning signs for pregnant and postpartum people, the Division of Family Health engaged in two activities:
    - The Division of Family Health launched a one-month, social media campaign, entitled the *Hear Her* campaign, to build public awareness of early urgent maternal warning signs for pregnant and recently pregnant people, as well as their support persons. Six social media messages linked back to the Department's webpage for additional information and to a materials order form for print materials. Printed cards translated into the 10 most common languages spoken in NYS detail urgent maternal warning signs as a conversation starter for consumers with health care providers. With permission, NYS utilized the CDC's *Hear Her*™ campaign materials and linked back to a NYS campaign landing page on the NYSDOH website.
    - The Division of Family Health also collaborated with the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) to distribute training licenses for the POST-BIRTH Warning Signs evidence-based initiative to all birthing hospitals, and to distribute take-home magnets for each birthing person who delivered at a birthing hospital. Each birthing hospital was offered a site license to train 10 nurses in obstetrics or other related fields on implementing the POST-BIRTH Warning Signs initiative. Additionally, the Department purchased and distributed POST-BIRTH Warning Signs magnets, to be provided for each birthing parent upon discharge as part of the program implementation. As of September 30, 2021, 68 birthing hospitals had registered for the program, distributing 720 licenses and over 142,000 magnets.

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

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

Working within this statewide system of perinatal regionalization, NYS's Title V Program implements the NYSPQC. The NYSPQC aims to provide the best, safest, and 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 NYSPQC has adapted the Institute for Healthcare Improvement (IHI) model for Idealized Perinatal Care and Breakthrough Series Methodology as a framework to guide improvement. Key NYSPQC 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 (QI) activities
- Providing topic-specific, intensive QI 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 NYSPQC are implemented by all participating NYS birthing hospitals and centers to improve outcomes of perinatal care. Analysis of NYSPQC project data provided by participating birthing hospitals and centers helps to improve services and systems related to perinatal health care.

The Title V Program led the following specific program and policy activities to advance this strategy through the 2020-21 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 late 2020, DFH submitted a regulatory reform package designed to strengthen the perinatal regionalization system and update regulations related to hospital-based perinatal services, physician- and midwifery-led birth centers.
    - 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.
- PIH 2.2: Collaborated 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.
    - Two physician-led birthing centers (PLBC) were approved in the 2019-20 program year under COVID-19 emergency authorization. These PLBCs applied for permanent authorization through the Department's Certificate of Need (CON) process. One has received approval and is completing construction; the other applicant has had challenges with meeting architectural and life safety standards and continues to work with the Department.
    - During the 2020-21 program year, two applications for establishment of midwifery-led birth centers were received through the CON process. One applicant ultimately withdrew due to financial issues. The other applicant's parent midwifery practice is the subject of an ongoing NYS State Education Department professional conduct investigation; as such, the CON application is paused until the outcomes are provided and reviewed.
- PIH 2.3: Collaborate with stakeholders to educate OB/GYN and family practice providers about changes to hospitals' levels of perinatal care in their communities.
    - This activity is on hold pending regulations noted above.
- PIH 2.4: Led quality improvement projects through the NYSPQC, with birthing hospital and center teams and community-based organizations, to improve obstetric and neonatal outcomes in specific areas including:
    - Reducing maternal morbidity and mortality by improving the assessment, identification and management of obstetric hemorrhage (project completed in June 2021).
        - Between March 2018, and March 2021, hospital teams reported an improvement in the percent of maternity patients with a documented hemorrhage risk assessment, including:
            - A 26% improvement on admission to labor and delivery (75.5% to 94.7%)
            - A 106% improvement during the post-partum period (41.3% to 84.4%).
        - Adoption of quantitative measurement of blood loss (QBL) increased from 41% of participants in Q1 2019 to 90% in Q1 2021.
        - By the end of the project, participants reported:
            - 99% had a unit policy and procedure(s) on OB hemorrhage (updated in the last 2-3 years) in place
            - 100% had OB hemorrhage supplies readily available, typically in a cart or mobile box
            - 100% had STAT (immediate) access to hemorrhage medications.
    - Identifying and managing the care of pregnant and postpartum people with opiate use disorder (OUD) during pregnancy.
    - Improving the identification, standardization of therapy and coordination of aftercare of infants with neonatal abstinence syndrome (NAS).
    - Improving infant outcomes, with a focus on equity in the NICU (project under development).
    - Improving outcomes for all NYS birthing people by focusing on racial justice and birth equity.
- PIH 2.5: To improve coordination and increase bilateral referrals between birthing hospitals and home visiting programs, Title V staff will assist in connecting MICHC and MIECHV-funded home visiting 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.
    - Due to priorities related to COVID-19 and limited staff resources, this project was largely on hold during the reporting period. A new staff person (Public Health Program Nurse) was hired July 2021 and was assigned a leadership role for this project. We anticipate major progress on this activity in the 2021-22 program year.

Strategy PIH-3: Maintain and strengthen a robust statewide population-based Newborn Screening Program.

New York's Newborn Screening Program (NBS) 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 NBS 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 NBS programs. The program ensures that every newborn in the state receives newborn bloodspot screening as a public health service, with no fee for testing. The program also performs follow-up case management to ensure newborns with a positive screening result receive appropriate diagnostic testing and treatment. Specialty Care Centers are certified and monitored to ensure newborns have access to specialty care for disease-specific testing and management. In addition, the NBS program receives separate funding from HRSA to support each of the state's 10 Inherited Metabolic Disease (IMD) Specialty Care Centers to enroll patients with an IMD diagnosis identified by newborn screening for long-term follow-up in the NYS Newborn Screening Patient Registry. These IMD Specialty Care Centers are responsible for entering and tracking for consented patients annually, and for attending an annual meeting to discuss long-term follow-up data. Patients are monitored until age 18, when the individual must consent to continue participation until age 21. In 2020, the program screened 211,203 infants, 99.97% of all NYS resident infants born that year (See Form 4 for further details).

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

PIH 3.1: The Title V Program collaborated with the Newborn Blood Spot Program on the following activities to advance this strategy during the 2020-21 program year:

- Provided comprehensive newborn bloodspot screening for every newborn born in NYS.
- 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
        - Non-NICU specimen quality
        - 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.
    - The NBS 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.
- Expanded 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 NBS implemented a post-site visit monitoring plan to further enhance the impact of virtual site visits, as described above.

Strategy PIH-4: Apply public health surveillance and data analysis findings to improve services and systems related to perinatal and infant health care.

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

The Title V Program led the following specific program and policy activities to advance this strategy over the course of the 2020-21 year:

- PIH 4.1: Led quality improvement projects through the NYSPQC, 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 OUD during pregnancy, and improving the identification, standardization of therapy and coordination of aftercare of infants with NAS; and improving outcomes for all NYS birthing people by focusing on racial justice and birth equity.
    - The NYSPQC's OUD-NAS 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 Strategy WMH-3 for more detail on these projects.*

- PIH 4.2: Summarize, share, and discuss findings of the Maternal Mortality Review Board (MMRB) with key stakeholders, including the Maternal Mortality and Morbidity Advisory Council (MMMAC) and ACOG-NY, to inform statewide prevention strategies to improve maternal outcomes. This includes the development of issue briefs, webinars, and quality improvement projects through the NYSPQC, and a maternal mortality report.
    - *See Strategy WMH-3 for more detail on the MMRB and MMMAC.*
- PIH 4.3: 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 was placed 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 2021-22 reporting period.

Strategy PIH-5: 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 (SDOH), or the conditions in which people are born, live, work, play, learn, and age. SDOH 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 SDOH 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 2020-21 year:

- PIH 5.1: Through the MICHC programs, Title V staff 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.
    - *See Strategy WMH-4 for further details.*
- PIH 5.2: Through the MICHC and MIECHV-funded programs, Title V staff provided supports to individual clients and their families to address behavioral social determinants of health outcomes. Programs provided 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 Strategy WMH-4 for further details.*
- PIH 5.3: Through the NYSPQC, continue to lead a quality improvement project with birthing hospital teams and community-based organizations, to improve outcomes for all NYS birthing people and infants by focusing on racial justice and birth equity.
    - *See Strategy WMH-3 for further details.*
- PIH 5.4: Through the Infant Safe Sleep Initiative, the Department made safe sleep educational materials (brochures, posters, anatomical diagrams, mirror clings, etc.) that are translated into multiple languages available to hospitals and home visiting programs for distribution to infant caregivers. Additionally, 43 NYS-funded home visiting programs and Level 1 and 2 perinatal intensive care hospitals were provided books for distribution to infant caregivers that convey safe sleep messages in a story format. In 2021-2022, the DFH will continue implementation of this initiative by distributing pack-n-plays, sleep sacks, and onesies to NYS-funded home visiting programs so that infant caregivers have the resources that enable them to practice safe sleep.

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 from IPRO/NYSDOH 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 2021. The program has set a goal to visit an additional 40 birthing hospitals by September 2023. This initiative is funded through non-Title V HRSA 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 74.34% to greater than 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.

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 not changed for years; racial and ethnic disparities continue. Non-Hispanic Black infants represent significantly more low birth weight births (13.3%) and preterm births (13.3%) than non-Hispanic white infants (6.3% and 7.7%, respectively). NYS has improved the proportion of pregnant people entering prenatal care during the first trimester to 80.6%, but disparities persist with only 71.8% of non-Hispanic Black and 74.7% of Hispanic pregnant people beginning early prenatal care compared to 85.7% of non-Hispanic White pregnant people. 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. 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 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.

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

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

Objective PIH-1: Increase or maintain the percent of very low birth weight infants born in a hospital with a Level III+ NICU by 2.4%, from the 2017 level of 91.2% to 93.4% by 2022. (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 2022 (NVSS).

Objective PIH-3: Improve the timeliness of Newborn Blood Spot samples received at the NYSDOH Wadsworth Laboratory from 74.3% to greater than 85% of samples received within 48 hours of collection by September 2023. (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 above 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 Maternal and Infant Community Heath Collaboratives (MICHC) (ended 6/30/22); Perinatal and Infant Community Health Collaboratives (PICHC; began 7/1/22); and the NYS Perinatal Quality Collaborative (NYSPQC), 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 (NSP) and Regional Perinatal Centers (RPCs). The RPC grant program was funded by Title V until April 2022, when a state appropriation was passed in the 2022-23 state budget.

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-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 PICHC and Maternal, Infant, and Early Childhood Home Visiting (MIECHV) 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 OPCHSM, review and approve applications to establish midwifery-led and physician-led birth centers across New York State (see *Domain 1 Women and Maternal Health (WMH) for details)*.
- **Activity PIH-1.4:** Support new and ongoing messaging, educational, and social marketing campaigns to promote perinatal and infant health, such as messages related to the safety of birthing hospitals, maternity care options (levels of care and types of care providers), perinatal mood and anxiety disorders, and vaccine promotion tailored to individuals who are pregnant, neonates/infants, their parents/caregivers, and families.
- **Activity PIH-1.5:** Through the Regional Perinatal Centers (RPCs) and networks of affiliate birthing hospitals, support and enhance capacity to provide high quality perinatal telehealth services and perinatal subspecialty providers, particularly to rural communities and communities with disproportionate access to such services. Title V staff will

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 PICHC and MIECHV 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 PICHC and MIECHV programs, support community health workers (CHWs) 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).*

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. In May 2021, a Midwifery Birth Center Accreditation bill was passed by both houses of the legislature and signed by Governor Hochul on December 30, 2021. A subsequent Chapter Amendment to incorporate accreditation into the Certificate of Need process and require additional perinatal regionalization-related requirements beyond the scope of birth center accreditation was passed by both houses and signed by Governor Hochul in early March 2022. This bill caused unanticipated delays as adoption as written would have affected the regulatory package's MBC section significantly. At time of writing, the full regulatory package has been resubmitted for NYSDOH and external approval and submission for publication in the State Register (anticipated Summer 2022) and anticipates adoption of regulations by December 2022.

Working within this statewide system of perinatal regionalization, NYS's Title V Program implements the NYSPQC, which aims to provide the best, safest, and most equitable care for pregnant and birthing people and infants in NYS by collaborating with birthing hospitals, perinatal care providers, and other key stakeholders to prevent and minimize harm through the translation of evidence-based guidelines to clinical practice. The NYSPQC has adapted the Institute for Healthcare Improvement (IHI) model for Idealized Perinatal Care and Breakthrough Series Methodology as a framework to guide improvement. Key NYSPQC 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 (QI) activities
- providing topic-specific, intensive QI 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 NYSPQC are implemented by all participating NYS birthing hospitals and partners to improve outcomes for perinatal care. Analysis of NYSPQC project data provided by participating birthing hospitals helps to improve services and systems related to perinatal health care.

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 PICHC and MIECHV 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 PICHC, MIECHV, WIC and OCFS on the WIC Referral Project and the State MIECHV CQI project, to improve bi-directional referrals between local WIC sites and local MICHC and MIECHV home visiting programs.
- **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 OPCHSM and the Division of Legal Affairs to review, update and promulgate MBC-specific regulations following enactment of New York's MBC Accreditation Law (anticipated March 2022). These regulations or guidelines are separate from the perinatal regionalization and perinatal services regulations mentioned previously, although they encompass overlapping parts of regulation.
- **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 (MCH). 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 MCH programs and policy work. Sharing data with stakeholders, including providers and community members, is critical to raise awareness, empower community action, and facilitate quality improvement efforts at all levels.

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 Office of Children and Family Services, PICHC, MIECHV and local WIC programs on the WIC Referral Project and the State MIECHV CQI 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 NYSPQC, 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 OUD (*see Activity WMH 3.4 for additional details)*.
  - **3.2b:** Improving the identification, standardization of therapy, and coordination of aftercare for infants with NAS.
  - **3.2c:** Improving infant outcomes, with a focus on those in the 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).*
  - **3.2e:** Increasing provider knowledge and birthing hospital protocols related to the COVID-19 vaccination for the perinatal population and their families.
- **Activity PIH-3.3:** Summarize, share, and discuss findings and recommendations of the Maternal Mortality Review Board (MMRB) with key stakeholders, including the Maternal Mortality and Morbidity Advisory Council (MMMAC) and American College of Obstetricians and Gynecologists District II of New York (ACOG-NY), to inform statewide prevention strategies to improve maternal outcomes. This will include the development of issue briefs webinars, quality improvement projects through the NYSPQC, 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 (P/S/EL)) syphilis among New York State females of childbearing age, and number and rate of congenital syphilis (CS) cases.
  - **3.5a:** Support the develop a statewide CS 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 P/S/EL syphilis and CS 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 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 (SDOH), or the conditions in which people are born, live, work, play, learn, and age. SDOH 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 SDOH 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 distribute a Parent Portal resources flyer, developed by the NYS Council on Children and Families to birthing hospital/center obstetrical, neonatal, and social work/patient discharge planning teams. Evaluation will include development of follow-up to assess usage of the resource by institutions, as well as monitoring referrals from birthing hospitals to PICHC as reported via the DMIS.
- **Activity PIH-4.2:** Through the PICHC 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 PICHC and MIECHV 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 NYSPQC, continue to develop and lead a new quality improvement project with birthing hospital teams and community-based organizations, to improve outcomes for all infants admitted to Neonatal Intensive Care Units (NICUs) and their families by focusing on racial justice and birth equity.

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

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

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

COVID-19 presented unique challenges and barriers to the NBSP, including challenges related to site visits at hospitals during this public health emergency, as well as system-wide delays in shipping that affected the ability to meet the state performance measures of samples being received within 48 hours of collection. To address and reduce the impact of these barriers, the NBS program continued to use established protocols for conducting virtual site visits developed in early 2020, to conduct virtual site visits. Despite these challenges, the NBSP anticipates that these issues will not affect the 2022-23 program year and has identified several activities to continue to support efforts to meet the SPM.

The Title V Program will collaborate with the NBS program on the following activities to advance this strategy over the upcoming 2022-23 year:

- **Activity PIH-5.1:** NBSP 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 (CQI) 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 CQI initiative at the 10 Inherited Metabolic Disease (IMD) Centers for Short-term Follow-up compliance. Individual quality reports with the following outcome measures will be provided to each of the 10 IMD 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).

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

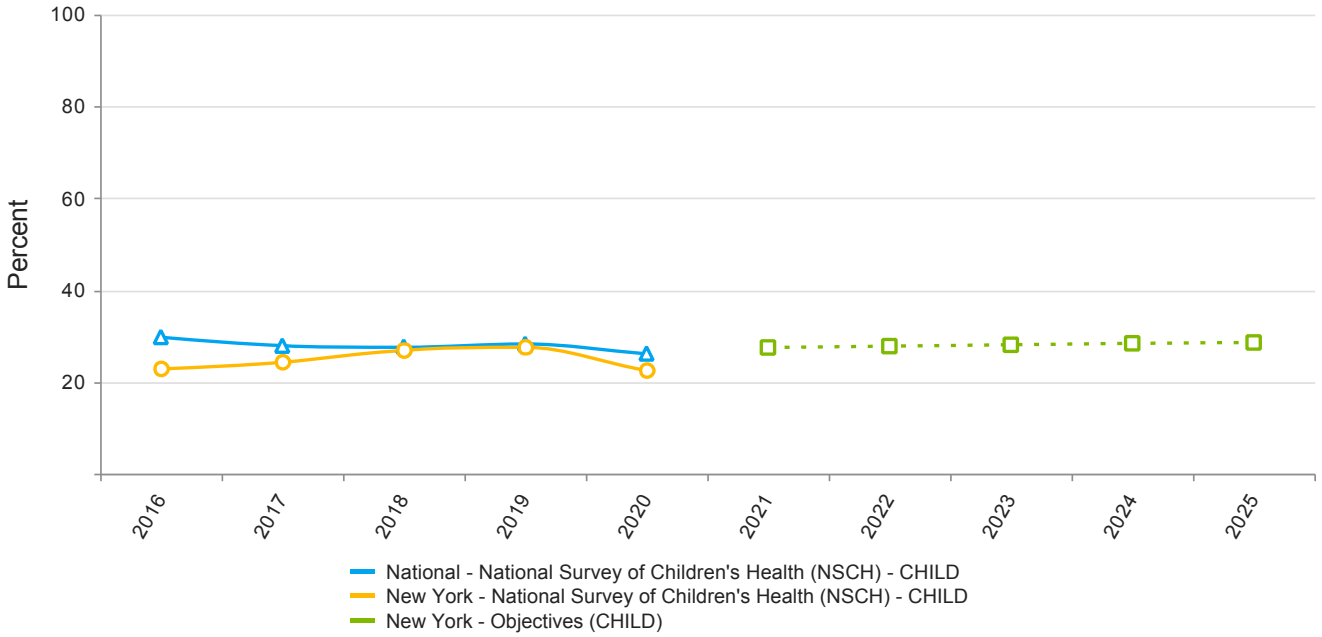
ESM PIH-1: Percent of birthing hospitals with final level of perinatal care designation, in accordance with updated regulations and standards.

Data for this measure will come 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.

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**
Annual Objective			27.5
Annual Indicator	27.0	27.4	22.4
Numerator	369,498	316,874	272,297
Denominator	1,370,994	1,158,167	1,213,091
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	27.8	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
Annual Objective			51.6
Annual Indicator		51.6	43
Numerator		98,941	74,325
Denominator		191,920	172,751
Data Source		SBHC quarterly report	SBHC quarterly report
Data Source Year		2018-2019	2019-2020
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	51.6	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 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.	
Strategy CH-2: Promote home, school, and community environments that support developmentally appropriate active play, recreation, and active transportation for children of all ages and abilities. Please see Supporting Document 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.	
Strategy CH-3: Apply public health surveillance and data analysis findings to improve services and systems related to children's health and health care. Please see Supporting Document 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.	
Strategy CH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact children's health and well-being. Please see Supporting Document 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.	
ESMs	**Status**
ESM 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 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

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

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

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

ESMs	Status
ESM 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)

For Child Health (CH), New York's Title V Program selected **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, reinforced by state-specific population health data. Over 14% of NYS children ages 10-17 are obese, and only 27% of NYS children ages 6-11 years are physically active for at least 60 minutes daily. NYS families identified the availability and accessibility of amenities that support children's safe, active play and access to healthy foods as top priority needs, alongside priorities for community and environmental safety for children and community transportation. Supporting healthy, active play and recreation for children and youth of all ages 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 (SBHC) 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. SBHCs 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 SBHC medical and dental programs and how it affected the operators' ability to meet their performance goals. Many of the SBHC medical programs closed when schools closed in March 2020 and many of the schools in NYS remained closed or had intermittent in-person schooling during this reporting period. Additionally, all SBHC dental clinics were required to close in accordance with the state's mandatory closure guidance of all dental practices and were kept closed for a longer period than other practices once the guidance was lifted due to concerns over exposure to children. Some providers were not able to maintain staffing levels to keep their clinics open and performance measures could not be met at all. Some providers, who had the resources and ability to provide care through telehealth, were able to provide some services to children and adolescents.

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 (NSCH).

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 (NSCH).

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 (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. This reporting period, Title V staff worked 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. 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 2020-21 year.

The Title V Program worked to provide guidance and add quarterly reporting requirements for all 48 School-Based Health Center (SBHC) 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 SBHCs. During this reporting period, the Title V Program worked to formulate a plan for determining baseline and annual targets to review using the current SBHC data system and quarterly reports. These baseline and annual targets are further detailed in the Evidenced-based Strategy Measure (ESM-CH1) section at the end of this report. The CH domain team met and made some progress on defining age-appropriate anticipatory guidance including physical activity and nutrition and type of guidance to be provided utilizing the current reporting. There was much discussion on the current data system and its limitations with age-appropriate anticipatory guidance being one example.

The current SBHC 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 has been received from Health Research, Inc. (HRI) to replace the current data system. The goal of the new data project is to develop and support a SBHC data system that receives and integrates data for all SBHCs, 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 planned 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 SBHCs, since the anticipatory guidance provided in the report and corresponding field guide does not currently address physical activity and nutrition. Once the new SBHC data system is launched, a new quarterly data report will be automatically generated for each SBHC. It is anticipated that the new system will begin to be tested with a small group of SBHCs early in 2022 and fully implemented by the end of 2022.

Data from quarterly reports using the current data system was reviewed and feedback was provided to each SBHC. This is part of routine contract management where contractors ensure strategies are developed and implemented to improve provider performance on quality indicators.

To promote the use of the American Academy of Pediatrics (AAP) Bright Futures™ model for anticipatory guidance in SBHCs and to seek opportunities to engage AAP for assistance to promote this resource, DFH 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 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 SBHCs.

The Title V Program also worked to incorporate guidance, reporting, and tracking to support SBHCs 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 work with SBHCs to ensure that enrolled students have an established dental home to promote optimal oral and overall health, the Title V Program developed a 2022-2027 School-Based Dental Home RFA to be released in 2022 to establish dental homes in SBHCs and include anticipatory guidance that includes physical activity and nutrition. During this reporting period, the concept proposal and RFA package for the School-Based Dental Home RFA was developed along with a workplan and performance measures. Organizations funded through this RFA will comprise the School-Based Dental Home Programs 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 SBHC 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.

Staff explored opportunities to collaborate with New York School-Based Health Alliance (NYSBHA) to support SBHCs' increased efforts to promote physical activity. A plan is being developed to collaborate with NYSBHA to host a webinar with subject matter experts from NYSBHA and/or the national chapter as co-presenters for SBHCs. Staff are in the process of developing ideas for topics most closely related to our objectives.

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, Bureau of Child Health staff collaborated with the Adolescent Health Unit (AHU) within DFH. This collaboration provided learning opportunities for SBHCs on topics of interest related to adolescents. ACT for Youth, the AHU Center of Excellence, presented a 3-part webinar series on Adolescent Mental Health in August 2021 including: Youth Mental Health 2021 Return to Normal; You Can Help A Student: Recognizing When Adolescent Students Are Struggling and How to Help; and The Cutting Edge: Understanding and Addressing Non-Suicidal Self-Injury in Youth.

DFH staff also collaborated with the NYSDOH Division of Nutrition (DON) to determine ways to incorporate public health nutrition messaging with physical activity guidance across child health programs, including SBHC and CYSHCN programs.

The DFH 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, including several programs. The School-Based Sealant Program and Drinking Water Fluoridation (DWF) 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 (SBSP) 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, 23 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, SBSPs 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. The contract period for this program is 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 (DWF) 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 (CWF). Title V funds a contract with the NYRWA (August 2018-July 2023) to provide technical assistance (TA) to public water systems (PWS) via onsite visits and operator trainings, to help ensure fluoridated PWS are maintained and operated in compliance with all laws, rules, and regulations. The DWF Program also provides TA to local and regional health departments, elected officials, and local, state, and national CWF stakeholders and champions, including the benefits, risks, effectiveness, and cost-effectiveness of CWF, along with the legal requirements to meet NYS Public Health Law §1100-a. During this reporting period, Title V staff monitored eight state-funded grants awarded to public water systems through the DWF Grant Program. Also, 29 public water systems received financial and/or technical support from New York Rural Water Association (NYRWA) to maintain or initiate community water fluoridation. Five trainings were provided to public water system operators during this time period, with a total of 88 operators receiving the training from NYRWA. A total of 71.2% of NYS residents served by community water systems have optimally fluoridated water, which is an improvement from previous reports. (2018 data captured by the Safe Drinking Water Information System (SDWIS) as of April 2020, which is an Environmental Protection Agency (EPA) 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. This reporting period, DFH staff began to collaborate with the Asthma Guidance Team, led by the NYSDOH Division of Chronic Disease Prevention (DCDP), to improve asthma control in NYS and management of asthma in schools by planning a meeting with DCDP to discuss Asthma Self-Management Education in SBHCs. 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 DCDP to discuss their partnering with SBHCs for asthma self-management training services to SBHC patients. The plan discussed would potentially include a group of 5-10 SBHCs, to start. A webinar is being developed to introduce this project to the SBHCs and discuss what the expectations will be. Through the SBHC 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.

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 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 NYSDOH Creating Healthy Schools and Communities (CHSC) program. Title V staff worked to develop strong relationships with this program and integrate SBHC 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 2020-21 reporting period.

Collaboration with the NYSDOH DCDP helps to implement multi-pronged strategies to enhance the work of CHSC grantees and other initiatives aimed at increasing children's physical activity. In June 2021, CHSC funding was approved for 26 contracts. The funding period is 6/1/21-5/31/26. Meetings were held to identify potential areas for collaboration including SBHC representation on the school wellness committees and collaboration on the upcoming virtual CHSC Grantee meeting being planned for February 2022 with DCDP's Nutrition and Physical Activity Center of Excellence (COE). A series of meetings are being scheduled to reconnect and formulate a plan for collaboration and to share updates on the status of the Title V Child Health Domain and the CHSC grants. This collaboration will facilitate partnerships between local Creating Healthy Schools and Communities grantees and SBHCs 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. While Title V staff actively participated in DCDP's Pediatric Obesity Prevention Work Group and contributed to the direction of the group as well as assist with establishing mutually beneficial priorities in the past, no meetings were held this reporting period due to competing priorities from the COVID-19 public health emergency.

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 MCH. Across all Title V programs, continuous effort is needed to enhance the collection, analysis, and sharing of data to inform the planning and implementation of MCH programs and policy work. Sharing data with stakeholders, including providers and community members, is critical to raise awareness, empower community action, and facilitate quality improvement efforts at all levels. The Title V Program led several specific program and policy activities to advance this strategy over this 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 data for NYS to allow for enhanced sampling of Black/African-American, Hispanic, and CYSHCN populations. During this reporting period, the sampling plan was developed and finalized. The document has been reviewed and Title V funds will be used to conduct the oversample in 2022 (data available in 2023).

As mentioned in Strategy CH-1, Title V staff are working to design and implement a new SBHC data collection system. The current system does not allow SBHCs to identify, track, and address disparities within the SBHC. During this reporting period, Title V staff met with HRI staff to discuss how to engage and survey stakeholders to identify, track, and address disparities within the SBHC. This work will be addressed in the following years of the Title V grant.

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, MCH outcomes are impacted by social determinants of health (SDOH), or the conditions in which people are born, live, work, play, learn, and age. SDOH 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 2020 Title V Needs Assessment revolve around SDOH and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities.

SBHCs 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. SBHC 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 began to discuss some program and policy activities to advance this strategy over this reporting period including the new SBHC data collection system and partnering with key stakeholders to address racial justice and heath equity. In discussions of building the new SBHC data collection system, as mentioned above, Title V staff discussed 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 began internal discussions on how to collaborate and partner with key stakeholders such as the Community Health Care Association of New York State (CHCANYS) and New York School-Based Health Alliance (NYSBHA) to identify and share best practices for SBHCs 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 SBHCs who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a SBHC within the past year.**

Title V staff met to discuss this measure including its wording and data collection and made progress on the anticipatory guidance and the type of guidance to be provided to SBHCs. The modified phrasing reflects the work of the SBHCs. Data for this measure comes from the SBHC quarterly reports. The baseline of 51.6% has been established based on 2018-2019 SBHC 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 the SBHCs 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, NYS'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 NYS and reinforced by state-specific population health data.

11.5% of NYS adolescents ages 10-17 are obese, and only 22.4% of NYS children ages 6-11 years are physically active for at least 60 minutes daily (2019-2020 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 (SBHC) 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. SBHCs 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, NSCH).

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 (NSCH).

Four strategic public health approaches were identified to accomplish these objectives over the next five years. These are presented in the State Action Plan (SAP) 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 (SBHCs) are an important source of primary and preventive health 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. 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 2022-23 year:

- Activity CH-1.1: Provide guidance and add quarterly reporting requirements for all funded School-Based Health Centers (SBHCs) 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 SBHCs to assess progress and drive improvements in these practices.
- Activity CH-1.2: Promote the use of the American Academy of Pediatrics' (AAP) Bright Futures™ model for anticipatory guidance in SBHCs and seek opportunities to engage AAP for assistance to promote this resource.
- Activity CH-1.3: Incorporate guidance, reporting, and tracking to support SBHCs 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 SBHCs 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 (NYSBHA) to support SBHCs' 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 SBHC and CYSHCN 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.

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 SBHC 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 2022-23 year:

- Activity CH-2.1: Collaborate with the NYSDOH Division of Chronic Disease Prevention (DCDP) 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: Facilitate partnerships between local Creating Healthy Schools and Communities grantees (as available) and SBHCs to engage and educate community partners, families, and community residents on the benefits of physical activity through Complete Streets implementation, including Safe Routes to School programs.
- Activity CH-2.3: Actively participate in DCDP'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 2022-23 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 CYSHCN populations.
- Activity CH-3.2: Design and implement a SBHC data collection system that allows SBHCs to identify, track, and address disparities within the SBHC.
- Activity CH-3.3: Engage and survey stakeholders to identify, track, and address disparities within the SBHC.
- Activity CH-3.4: Explore collaborative opportunities with DCDP's Bureau of Chronic Disease Evaluation and Research to review and share information on student weight status assessments to inform SBHC 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 (SDOH), or the conditions in which people are born, live, work, play, learn, and age. SDOH 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 SDOH and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities.

SBHCs 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. SBHC 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 2022-23 year:

- Activity CH-4.1: Design the new SBHC data collection system with a racial justice and health equity lens, building a reporting tool that allows SBHCs to identify, track, and address disparities within the SBHC (site or provider level).
- Activity CH-4.2: Partner with key stakeholders such as the Community Health Care Association of New York State (CHCANYS) and NYSBHA to identify and share best practices for SBHCs 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 SBHCs who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a SBHC within the past year.**

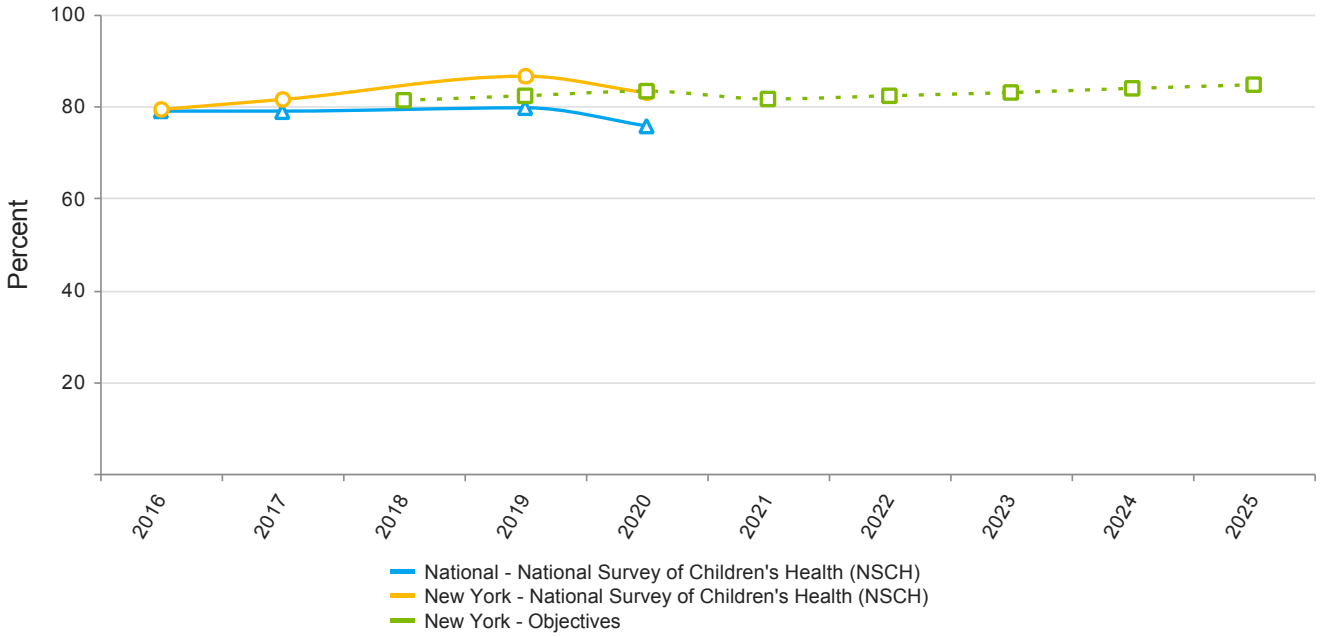
Data for this measure come from the SBHC quarterly reporting system. The baseline for 2021 (51.6%) was established using program year 2018-2019 data. Targets have been established to achieve a 2% increase each year, except for 2022 as the first year is primarily a planning year and an increase in anticipatory 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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		81.2	82.2	83.2	81.5
Annual Indicator	79.2	81.3	81.3	86.3	82.9
Numerator	1,103,856	1,081,532	1,081,532	1,367,654	1,218,475
Denominator	1,393,274	1,331,106	1,331,106	1,583,876	1,469,455
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2016_2017	2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	82.2	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
Annual Objective			96.3
Annual Indicator		96.3	100
Numerator		52	52
Denominator		54	52
Data Source		Survey of CAPP and PREP Programs	Survey of CAPP and PREP Programs
Data Source Year		2020	2021
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	96.3	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
Annual Objective			68.7
Annual Indicator		68.7	78.1
Numerator		46	50
Denominator		67	64
Data Source		Survey of CAPP, PREP, and SRAE Programs	Survey of CAPP, PREP, and SRAE Programs
Data Source Year		2020	2021
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	70.1	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 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

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

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

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

ESMs	Status
ESM 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 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
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Adolescent Health - Annual Report

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 for Youth Center for Community Action (ACT CCA), 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 Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Survey (YRBS), 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 (NSCH)

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 (NSCH)

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 (NSCH)

Four strategic public health approaches were identified to accomplish these objectives over the next five years. These are presented in the 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 (CAPP), Sexual Risk Avoidance Education (SRAE), Children & Youth with Special Health Care Needs (CYSHCN), School-Based Health Centers (SBHC), Family Planning Program, and Sexual Violence Prevention programs. Assets Coming Together for Youth Center for Community Action (ACT CCA) at Cornell University works with the Adolescent Health Unit (AHU) to provide technical assistance, training, and evaluation services for the CAPP, PREP, and SRAE programs.

Due to the ongoing 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 CCA 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. Additionally, Title V staff working on adolescent health initiatives were assigned to work on COVID19 related response efforts. This caused a temporary suspension of focused work on the Social-Emotional Wellness team and limited the ability for staff to interact with their program providers. All Title V Adolescent Health Unit (AHU) staff who had been assigned to COVID-19 projects returned full time to the AHU as of September 2021.

Program providers developed virtual implementation plans with the assistance of ACT CCA. Most program delivery was virtual during this time period. Program providers reported challenges in recruiting, engaging, and retaining youth who often spent the entire school day online and were experiencing screen-time burnout. CAPP, PREP and SRAE program providers developed numerous strategies for establishing and maintaining a virtual presence with their communities, including workshops, informational campaigns, community outreach, and PSA-type videos. Providers often developed creative solutions to bring youth more readily into the virtual environment, including youth “game nights.” Programs that typically hosted annual conferences for youth audiences continued to do so virtually with multiple presentations and guest speakers.

The Title V Program established the following specific program and policy activities to advance this strategy over the 2020-21 year:

- Through PREP and CAPP, provide information to adolescents and parents on the offering and arranging of adolescent sexual health reproductive services.
    - Through PREP and CAPP grants, programs provide education and conduct outreach to youth and parents about how to access adolescent sexual health reproductive services. Programs provide and arrange referrals for services when needs are identified as appropriate and outreach and education to youth and parents is reported biannually by programs. AHU 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.
    - Evidence-based programming was completed for 13,759 youth during this reporting period for CAPP and PREP programs.
- Through SRAE, provide medically accurate and complete sexuality health education services to youth.
    - SRAE programs implement medically accurate and complete evidence-based education to youth. Programs report on attendance, reach and dosage of the curriculum implemented biannually. Programs also conduct entry and exit surveys with each cycle implemented. AHU staff review biannual program reports, provide feedback to programs and follow-up with programs as needed.
    - Evidence-based programming was completed for 568 youth during this reporting period for SRAE programs.
- Through CAPP, PREP and SRAE, increase access to health care services for adolescents through a referral process that includes confirmation as permitted while ensuring confidentiality.
    - CAPP, PREP and SRAE increase access to health care services by directly referring youth internally within their organization or through a Memorandum of Understanding (MOU) with clinical providers and other providers. SRAE programs report biannually the number of adolescents referred for comprehensive health care 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 are reported biannually. AHU staff review biannual reports, provide feedback to programs and follow-up as needed.
- DFH 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 AHU 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 CCA. AHU staff review biannual reports, provide feedback, and follow-up as needed.

- In May 2021, the Bureau of Women, Infants and Adolescent Health (BWIAH) held a three-day virtual Provider Meeting. The main theme of the conference was Adverse Childhood Experiences (ACEs) and Trauma & Resiliency, with keynote speaker Dr. Filetti, one of the lead research scientists on the original ACEs study. Conference sessions included skills-building for staff and addressed topics such as social-emotional wellness, youth development, health equity, technology and social media, and self-care. All AHU programs were required to have staff attend. Presentations were recorded and were posted on the ACT CCA website.
- ACT CCA hosted a series of three webinars on Youth Mental Health topics in August 2021, including:
  - You Can Help a Student: Recognizing When Adolescent Students Are Struggling and How to Help
  - The Cutting Edge: Understanding and Addressing Non-Suicidal Self-Injury in Youth
  - Youth Mental Health 2021 Return to "Normal?"

- Within the Title V program, enhance collaboration between adolescent serving programs, including CAPP, SRAE, SBHC, and CYSHCN, 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.
  - ACT CCA hosted a series of webinars on Youth Mental Health in August 2021 (listed above). The webinars were attended not only by AHU program providers, but also by School-Based Health Centers (SBHCs), Family Planning providers, Home Visiting Programs, Children and Youth with Special Health Care Needs (CYSCHN) programs, Youth Health Advocates, Sexual Violence Prevention Programs, and other Title V NYSDOH staff. Response to this webinar series was overwhelmingly positive. All the webinars were recorded and posted on the ACT CCA website at http://www.actforyouth.net/publications/mental-health-webinars.cfm; information on how to access those recordings was disseminated to Title V staff. More webinars on this topic are being scheduled for 2022 and will be offered to all Title V staff and their programs.
  - CYSHCN and Child Health staff exchanged resources with AHU staff on their program backgrounds and work, as well as training and webinar opportunities for adolescent health topics.
  - AHU forwarded resource information and webinar opportunities to other Title V staff when appropriate, including presentations by our federal grantors.
- 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. AHU staff attend quarterly HPV Coalition meetings and receive informational updates. HPV vaccination information resources were also disseminated to AHU program providers and ACT CCA. Participation in NYS HPV Coalition and contact with other organizations is ongoing.
  - Title V staff began to attend quarterly NYS HPV Coalition meetings during this reporting period and emailed HPV information to adolescent-serving providers.
- Refer adolescent parents to family planning providers for contraception and birth planning, including SBHCs, where available.
  - All CAPP and PREP programs 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 (MOU) with an Article 28 regulated facility to provide these services to youth. At a minimum, on a biannual basis, AHU discusses with each provider their interaction and relationship with their designated family planning providers and SBHCs if applicable.
- Promote access to confidential reproductive health care services and preventive medical visits for adolescents, including through SBHCs, where available. Family planning providers provide counseling and services related to contraception, promotion of healthy relationships, preventive medical care, and preconception/interconception health.
  - CAPP and PREP programs that are not at Article 28 regulated facilities are required to have an MOU in place with a family planning program to provide these services. A list of CAPP/PREP programs located in schools with SBHCs was developed and shared with Title V staff.
  - As noted by Child Health domain staff, many SBHC medical programs closed when schools closed due to COVID-19 in March 2020. This situation affected some schools and SBHCs through this reporting period. Staff shortages also affected SBHCs' ability to keep clinics open.
- 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 LGBTQIA+ 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.
  - CAPP, PREP and SRAE programs incorporate healthy relationship education and skills building.
  - AHU 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 AHU by all program providers.
    - Some providers prioritize engaging LGBTQIA+ populations in their catchment area, offering educational opportunities and support resources.
    - AHU program providers partner with community youth-serving organizations to share resources and collaborate on community outreach efforts.
- Promote adolescents' social-emotional wellness and positive developmental assets through established Title V programs.
    - All AHU 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 2021 provider day which focused on themes of overcoming Adverse Childhood Experiences and Resiliency to trauma.
    - ACT CCA offered educational and training opportunities to AHU 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 2020-21 reporting period:

- 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.
    - AHU providers are required to have a mechanism in place to refer youth for services when needs are identified. AHU programs have MOUs in place for youth referrals to partner agencies. Referrals for services are reported biannually. Biannual reports are reviewed by AHU program staff, providing feedback and follow up as needed.
- Refer adolescent parents to family planning providers or SBHC for contraception and birth planning.
- All CAPP and PREP 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 MOU with an Article 28 regulated facility to provide these services to youth. At a minimum, AHU staff will discuss with each provider biannually their interaction and relationship with their designated Family Planning Program providers and SBHC if applicable. In addition, several CAPP 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.
    - Where available AHU programs will refer pregnant and birthing adolescents to Perinatal and Infant Community Health Collaborative (PICHC) programs, Home Visiting programs including Nurse Family Partnership (NFP), Healthy Families NY (HFNY), and Community Health Worker Programs (CHWP). AHU programs are aware of the supporting programs available within their catchment area.
    - Through collaboration with Maternal Infant and Early Childhood Home Visiting (MIECHV) Program, provided updated Growing Up Healthy information (flyer and online resources) to all AHU program providers.
- 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 CAPP and PREP 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 MOU with an Article 28 regulated facility to provide these services to youth. At a minimum, AHU staff will discuss with each provider biannually their interaction and relationship with their designated Family Planning Program providers and SBHC if applicable.
- 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 PREP programs and several CAPP programs include adult preparation topics, ACT CCA provides training, webinars, and workgroups to programs in support of delivering adult preparation subjects.
- In addition to delivery of EBP course curriculum, AHU program providers offer workshops and other events that address adult preparation topics. During this reporting period, programs continued to offer education virtually through websites and online meeting platforms (e.g., Zoom).
- Some PREP providers delivered individually designed summer programs, separate from EBP 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 were identified through collaboration with Title V CYSCHN staff.

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 MCH. Across all Title V programs, continuous effort is needed to enhance the collection, analysis, and sharing of data to inform the planning and implementation of MCH programs and policy work. Sharing data with stakeholders, including providers and community members, is critical to raise awareness, empower community action, and facilitate quality improvement efforts at all levels.

The combination of public survey data gleaned from sources such as the National Survey of Children's Health (NSCH) and the Youth Risk Behavior Surveillance System (YRBS) 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 2020-21 year:

- Collaborate with the U.S. Census Bureau and HRSA 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 CYSHCN populations.
    - AHU staff collaborated with CYSHCN to discuss this oversampling initiative. Implementation of this project is scheduled to begin in the Spring of 2022.
- 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 will be used for development of new CAPP and PREP procurements in 2022. Introductory information about the new ASHNI was shared with broader Title V staff and with ACT CCA to explore additional ways the ASHNI can be used throughout Title V programs.
- Through ACT CCA trainings, webinars, and web posts, provide information and education to youth-serving organizations.
    - ACT CCA provided training and informational opportunities to AHU program providers throughout this period. In addition to training on 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 CCA offers monthly webinars focusing on a myriad of adolescent health-related topics. Through their website, ACT CCA maintains an on-going blog/discussion group that addresses additional focus areas regarding today's youth.
- Explore collaborative opportunities with Division of Chronic Disease Prevention (DCDP) Bureau of Surveillance to review and share information gathered through the YRBS.
    - AHU staff participated in meeting with DCDP Bureau of Chronic Disease Evaluation and Research about ongoing collaboration to support data analysis and better understand the behaviors and issues facing adolescents using BRFSS and YRBS data elements. There is now updated BRFSS survey data for 2019, including ACEs, health disparities, and chronic conditions.

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.

MCH outcomes are impacted by the social determinants of health (SDOH), or the conditions in which people are born, live,

work, play, learn, and age. SDOH 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 SDOH 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 2020-21 year:

- Collaborate with other state agencies and youth-serving organizations on adolescent-centered priorities through the Youth Development Team (YDT). The YDT includes representation from NYSDOH, Office of Children and Family Services (OCFS), Council on Children and Families (CCF) and the Developmental Disabilities Planning Council (DDPC) in coordination with youth-led organizations.
    - Reestablishing the YDT has been delayed due to the ongoing COVID-19 pandemic.
- Ensure that NYSDOH health equity teams review materials before being widely disseminated to youth and youth-serving organizations
    - Currently the Health Equity Team reviews RFAs through a Health Equity lens. RFAs for CAPP and PREP will be issued in 2022.
- Collaborate with youth through focus groups and community forums for direct input with state initiatives and special projects.
    - Upcoming procurements for CAPP and PREP will incorporate youth stakeholder input to identify program opportunities for social-emotional wellness.
    - Upcoming media campaigns to support adolescents' mental health will engage youth to develop the campaign collaboratively.
- Involve stakeholders, who represent the populations most impacted by racism and health inequities, in programmatic decisions.
    - Upcoming procurements for CAPP and PREP will incorporate youth stakeholder input to identify program opportunities for social-emotional wellness.
- Through NYSDOH adolescent providers, issue information on locally available resources and provide referrals specific to addressing the SDOH with adolescents from populations impacted by disparities.
    - Title V staff are in discussion with ACT CCA regarding a presentation on Racial Justice/Health Equity training for program providers that is focused on adolescents in the upcoming reporting period.

All members of the Division of Family Health's 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 (PICHC) and Dental Fluoridation RFAs to ensure a health equity lens was incorporated during development.

Shortly after the end 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 is training to ensure staff understand health equity, health disparities and social determinants of health. Title V 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 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. Data collection is underway to update this measure.

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. Data collection is underway to update this measure.

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.

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 social-emotional wellbeing and preparation for taking on the responsibilities of adulthood. As indicated in the Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Survey (YRBS), over 30% of 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. 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. Only 16.4% of adolescents without special health care needs received services necessary to transition to adult health care. And 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.

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 2022-2023 (National Survey of Children's Health, NSCH).

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 (NSCH).

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 (NSCH).

Four strategic public health approaches were identified to accomplish these objectives over the next five years. These are presented in the State Action Plan (SAP) 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' 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 (CAPP) Program, Sexual Risk Avoidance Education (SRAE), Personal Responsibility Education Program (PREP), Children and Youth with Special Health Care Needs (CYSHCN), School-Based Health Centers (SBHC), Family Planning Program, and Sexual Violence Prevention (SVP) programs.

The NYS Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2022-2023 year:

- Activity AH1.1: Through CAPP, 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 (PREP) also provides this information, in partnership with the Title V program.
- Activity AH1.2: Through SRAE, provide medically accurate and complete sexuality health education services to youth.
- Activity AH1.3: Through CAPP, PREP and SRAE, increase access to health care services for adolescents through a referral process that includes confirmation as permitted while ensuring confidentiality.
- Activity AH1.4: 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 AH1.5: Within the Title V program, enhance collaboration between adolescent serving programs, including CAPP, SRAE, SBHC, SVP, and CYSHCN, 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 AH1.6: Collaborate with internal partners, including NYSDOH AIDS Institute and Bureau of Immunization, and external partners, such as the NYS HPV Coalition, to promote HPV vaccination with clinical providers.
- Activity AH1.7: Refer adolescent parents to family planning providers for contraception and birth planning, including SBHCs, where available.
- Activity AH1.8: Promote access to confidential reproductive health care services and preventive medical visits for

adolescents, including through SBHCs, where available. Family planning providers deliver counseling and services related to contraception, promotion of healthy relationships, preventive medical care, and preconception/interconception health.

- Activity AH1.9: 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 LGBTQIA+ persons.
- Activity AH1.10: 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 2022-2023 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 SBHC for contraception and birth planning.
- Activity AH-2.3: Support pregnant and birthing adolescent parents in attending prenatal, postpartum, and well-baby appointments.
- Activity AH-2.4: Promote access to confidential reproductive health care services and preventive medical visits for adolescents. Family planning providers provide counseling and services related to contraception, promotion of healthy relationships, preventive medical care, and preconception/interconception health.
- Activity AH-2.5: Ensure adolescent-serving programs provide training on Adulthood Preparation Subjects (APS), 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 PREP programming includes APS subjects. Some current CAPP grants include an optional component incorporating APS training; the forthcoming procurement for CAPP will require APS training be done by all contractors.

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 NSCH and the Youth Risk Behavior Survey (YRBS) 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 2022-2023 year:

- Activity AH-3.1: Collaborate with the US Census Bureau and HRSA to conduct an over-sample of NYS National Survey of Children's Health (NSCH), for NYS to allow for enhanced sampling of Black/African-American, Hispanic, and CYSHCN populations during the 2022 data collection period.
- Activity AH-3.2: Title V staff will continue to use publicly available and internal surveillance data to identify adolescent needs and/or health behavior trends to support optimum adolescent health and development and determine funding areas for NYSDOH adolescent health procurements.
- Activity AH-3.3: Through ACT CCA 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 (DCDP) Bureau of Chronic Disease Evaluation and Research (BCDER), which works with the NYS Education Department, to review and share information gathered through the YRBS.

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 (SDOH), or the conditions in which people are born, live, work, play, learn, and age. SDOH 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 SDOH 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 2022-2023 year:

- Activity AH-4.1: Collaborate with other state agencies and youth-serving organizations on adolescent-centered priorities through the Youth Development Team (YDT). The YDT includes representation from NYSDOH, Office of Children and Family Services (OCFS), Council on Children and Families (CCF) and the Developmental Disabilities Planning Council (DDPC) 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 SDOH 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 7/1/2020 – 12/31/20, is 96.3%. The program has set an improvement target of 100% by 2025. For the most recent reporting period, the value is 100% (1/1/21 – 12/31/21, note: two of 54 programs have missing data).

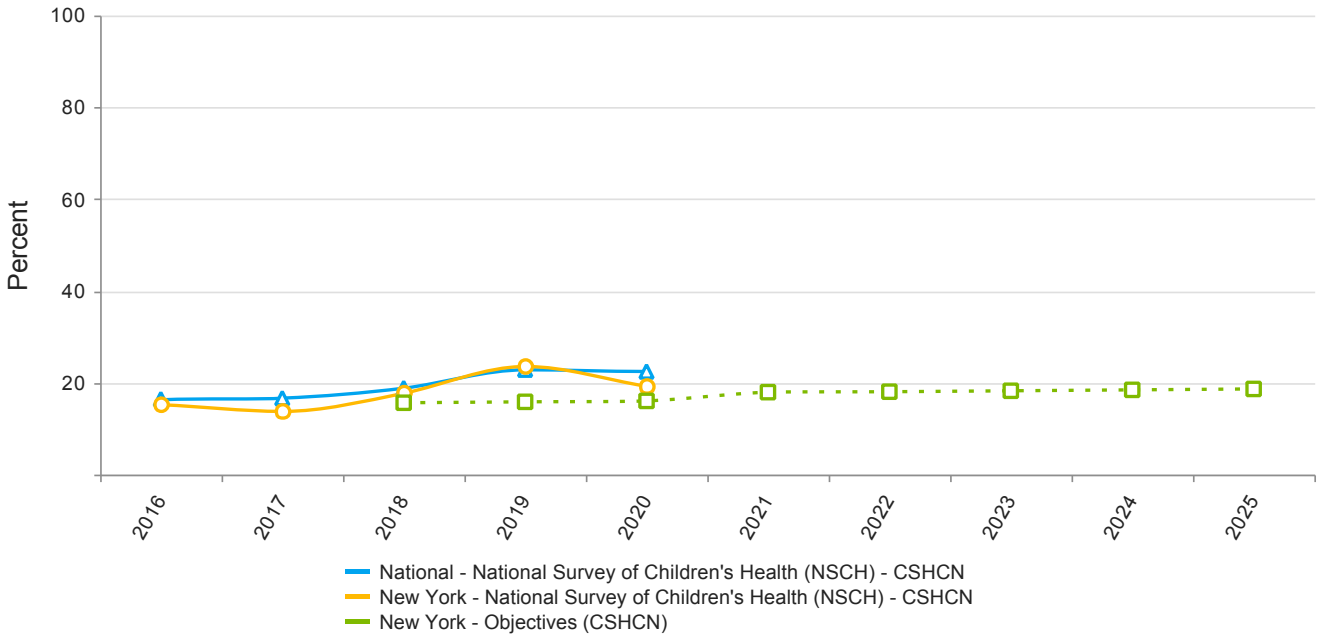
ESM AH-2: Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation.

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 78.1% (1/1/21 – 12/31/21, note: two of 66 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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		15.7	15.9	16.1	18
Annual Indicator	15.3	13.7	17.8	23.6	19.1
Numerator	48,081	34,736	48,580	87,040	73,058
Denominator	314,730	253,092	273,067	369,539	381,623
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	18.1	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
Annual Objective			40.3
Annual Indicator	40.3	62.4	66.1
Numerator		295	323
Denominator		473	489
Data Source	Contractor Reports	Contractor Reports	Contractor Reports
Data Source Year	2018-2019	2019-2020	2020-2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	41.1	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
Annual Objective			3.6
Annual Indicator		3.6	12.1
Numerator		1,772	6,063
Denominator		498,946	502,219
Data Source		NYS Child Health Lead Poisoning Prevention Program	NYS Child Health Lead Poisoning Prevention Program
Data Source Year		2018	2019
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	12.1	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 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.	
Strategy CYSHCN-2: Enhance care coordination, including transition support services, for children and youth with special health care needs. Please see Supporting Document 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.	
Strategy CYSHCN-3: Apply public health surveillance and data analysis findings to improve services and systems related to health and health care for children and youth with special health care needs. Please see Supporting Document 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.	
Strategy CYSHCN-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact the health and well- being of children and youth with special health care needs. Please see Supporting Document 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.	
ESMs	**Status**
ESM 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 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

Strategy CYSHCN-2: Enhance care coordination, including transition support services, for children and youth with special health care needs. Please see Supporting Document 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

Strategy CYSHCN-3: Apply public health surveillance and data analysis findings to improve services and systems related to health and health care for children and youth with special health care needs. Please see Supporting Document 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

Strategy CYSHCN-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact the health and well- being of children and youth with special health care needs. Please see Supporting Document 2 " State Action Plan Table" and domain narrative sections for specific activities related to each strategy.

ESMs	Status
ESM 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 2 “ State Action Plan Table” and domain narrative sections for specific activities related to each strategy.

Children with Special Health Care Needs - Annual Report

For Children and Youth with Special Health Care Needs (CYSHCN), New York'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 CYSHCN receive care in a well-functioning system, and less than 18% of youth ages 12-17 with special health care needs received services necessary to make transitions to adult health care. 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. This NPM also aligns directly with NYS Prevention Agenda goals and interventions related to support for CYSHCN.

In addition, New York'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 (NSCH).

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 (NSCH).

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 YSHCN.

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 CYSHCN-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 (RSCs), to provide training and technical assistance to local health department (LHD)-based CYSHCN programs and to conduct family engagement. The RSCs are required to employ a family/parent liaison that is a CYSHCN parent, a critical component of the RSC work with CYSHCN families and LHDs. Family liaisons bring firsthand experience, perspective, and knowledge of barriers and gaps in care to all aspects of RSC 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 CYSHCN families and they use this feedback to inform educational materials and trainings for LHDs. 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 LHDs. Information from that Report was also used to present to CYSHCN LHD programs on a quarterly call in 2022. RSCs 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 RSCs.

In addition, the 2020-2025 LHD CYSHCN program contract period includes deliverables to address family and community engagement at many levels. LHDs involved families of CYSHCN in work groups, committees, task forces or advisory committees to improve the system of care for CYSHCN, involve families and CYSHCN in local planning activities, such as the Community Health Assessment (CHA), and use feedback from families of CYSHCN to develop training for CYSHCN staff and providers.

Sickle cell disease (SCD) grantees at three (3) Hemoglobinopathy Specialty Care (HSC) Centers work directly and exclusively with youth in support services. HSCs conducted peer support groups to gauge barriers to care and transition for youth and young adults with SCD. Transition Navigators at HSCs engaged youth with SCD to ensure compliance with care regimens and to understand what barriers youth experience in caring for themselves. During this reporting period, additional funding through Legislative Add-Ons became available to five SCD organizations – three HSCs with existing State funding and two community-based organizations (CBO). One of the CBOs is the Sickle Cell Thalassemia Patient Network (SCTPN) who also recently received a five-year HRSA grant that asks them to work with their local Title V agency. Title V staff are looking forward to future collaborations with them, including their annual meeting in 2022.

Title V staff engaged with the Office of Health Insurance Programs (OHIP), our Medicaid office, on a Medicaid Redesign Team for sickle cell disease outcomes, including community partners, clinicians, and experts in SCD. The team generated a list of recommendations for Medicaid to reduce costs and hospitalizations for SCD patients. The most feasible and potentially impactful of those was regarding care coordination for sickle cell disease to be a single qualifying condition for enrollment into Children Health Homes (CHHs) which promote effective treatment that can reduce symptoms, prolong life, and improve well-being for children, youth, and young adults with SCD. Sickle cell disease was not a single qualifying condition for management through a Medicaid Health Home, but instead required a second condition, typically chronic pain in this case. However, since not all sickle cell disease patients have a second qualifying condition, many were not able to receive care coordination through a Health Home. NYSDOH worked with OHIP to request through a State Plan Amendment that SCD be designated as a single qualifying condition. That approval came in early 2022.

Having served its purpose, the Medicaid Redesign Team disbanded. Soon after, OHIP established the Sickle Cell Disease Health Home Managed Care Organization (HHMCO) Subcommittee with intention of following the State Plan Amendment progress as well as troubleshoot and plan for implementation, including promotion of Health Homes and addressing capacity issues. Title V staff serve on that Subcommittee.

The Title V Director and CYSHCN Director also serve on a Commissioners' Cross-Systems Work Group that looks at 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.

In addition, the Title V Program led the following specific program and policy activities to advance this strategy over the 2020-21 reporting period:

- Maintain at least one dedicated family representative on the state's Title V MCHSBG Advisory Council and engaged all Council members in updates and discussions related to CYSHCN program activities.
    - There is one parent representative from Parent to Parent on the Title V MCHSBG Advisory Council. CYSHCN Program engage council members in updates and discussion related to program activities._
    - On June 30, 2021, the CYSHCN Director presented CYSHCN updates to the MCHSBG Title V Advisory Council meeting.
    - On October 12, 2021, CYSHCN staff presented to the NYS MCHSBG Advisory Council about the overview of our CYSHCN data for years 2018-2019 findings.
- Collaborate with advocacy groups like Parent to Parent to understand the needs of CYSHCN and their families, facilitated information sharing, and promoted LHD CYSHCN programs.
    - On September 29, 2020, the RSCs had a webinar on Family Professional Partnerships with Michele Juda from Parent to Parent who presented to the LHDs.
    - On December 17, 2020, the Regional Support Centers (RSCs) held a webinar "Serving Families with Mental Health Needs During COVID-19" with the National Alliance on Mental Illness (NAMI) for the LHDs to share with individuals and families.
    - On March 2, 2021, the NYSDOH Growing Up Healthy Hotline (GUHH) presented to the LHDs, and the recording was sent to the LHDs. Also, the GUHH link was added to our CYSHCN website.
    - Information about a free webinar on Living with Fetal Alcohol Spectrum Disorders was sent to the LHDs that was presented by NYS Parent to Parent on May 12, 2021.
- Support RSCs to employ parents of CYSHCN as family/parent liaisons. RSCs 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 TA for LHD programs.
    - The family specialists for the RSCs 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 worked to develop family engagement plans for LHDs.
    - The family specialists collaborated to develop resources for CYSHCN families such as: back-to-school resources, a CYSHCN Profile template for families, and a manual that outlines the 27 most common special health care needs conditions (according to NSCH) that will assist local health departments in understanding some of the health conditions that qualify under the CYSHCN program while providing credible resources for more information on these conditions.
    - Family specialists also supported the RSCs in developing a CYSHCN Resource Directory that will be made available online to provide families, LHDs, and health care providers with current information about services and supports. Resource Directories are available on each of the RSC's websites and are continually updated to ensure they are a reliable source of information.
    - Delays in posting the Resource Directory on the NYSDOH website occurred due to COVID-19 with staff being re-assigned and because the proper platform has not been identified. RSCs and Title V staff are steadfast on finding an interactive, user-friendly option with mapping and printing capabilities at the very least.
- Support LHD CYSHCN programs to involve CYSHCN and their families in work groups, committees, task forces or advisory committees, local health assessment and planning activities, and other systems development work. Used

feedback from families of CYSHCN to develop training for CYSHCN staff and providers.
    - NYS CYSHCN Program keeps track of LHDs quarterly reports involving CYSHCN and their families in work groups, committees, task forces or advisory committees and other LHD assessment and planning activities. Some of these activities have been delayed at LHDs due to their role in COVID-19 response.
    - Title V staff provided regular and as-needed technical assistance to LHDs throughout the reporting period.
- Engage the New York State Association of County Health Officials (NYSACHO) to promote and bolster LHD CYSHCN programs to raise awareness of LHD CYSHCN services and reach and serve more families.
    - CYSHCN Director met with NYSACHO on October 27, 2020, to review CYSHCN program progress and needs of counties.
    - RSCs presented to the NYSACHO MCH committee on December 4, 2020, to discuss the role of RSCs in county CYSHCN programs.
    - The CYSHCN Director shared the CYSHCN COVID-19 resources with NYSACHO and Parent to Parent on March 10, 2021.
- Support sickle cell disease (SCD) programs at three Hemoglobinopathy Specialty Care Centers (HSCs) to provide supports by and for youth with SCD, including peer support groups, system navigation supports, and self-care services.
    - On October 1, 2020, NYSDOH presented “Coordinating Care and Supporting Transition for Children, AYA with Sickle Cell Disease: 2018-2020 Data Summary” to the three HSCs.
    - The three HSCs shared information through their quarterly reports, including family feedback and changes occurring due to the pandemic. Telehealth has been a very positive experience for clients and families. Families were grateful to have telehealth appointments as an option. There was better compliance with keeping appointments, self-management with medication regimes and pain management through the telehealth visits since the clients were staying home.
    - There was greater attendance at social supports via virtual gatherings in which the attendees were interactive.
    - The HSCs participated in a virtual full-day conference with the Sickle Cell Advisory Consortium of NY (SCAC) for professionals, clients, and families. Title V staff drafted a PowerPoint presentation for SCAC’s annual meeting and received approval to present about NYSDOH Sickle Cell Disease program activities (presentation occurred in November 2021, after this reporting period).
- Collaborate with other Title V and Division of Family Health adolescent-serving programs, including School-Based Health Centers, Comprehensive Adolescent Pregnancy Prevention, and ACT for Youth Center for Community Action to identify additional opportunities to meaningfully engage adolescents in program and policy development that impacts CYSHCN.
    - On May 6, 2021, the Office of the Medical Director presented at the Leadership Education in Neurodevelopmental and related Disabilities (LEND), Westchester Institute of Human Development (WIHD) virtual learning poster session. Title V Staff spoke about the challenges that families and children have faced during the pandemic and the updates on the CYSHCN Program and the RSC activities. The purpose of this learning poster session was to have the LEND trainees meet with NYSDOH Title V Program directors, staff, and other state agencies to learn about team research projects that impact children with disabilities and their families.
    - The Title V CYSHCN Director presented to LEND Fellows as a Community Partner on October 8, 2020.
    - The Title V CYSHCN Director presented a poster about the Regional Support Center work at the May 2021 Association of Maternal and Child Health Programs (AMCHP) virtual annual conference. NYS Title V staff and RSCs have engaged stakeholders, including families, to identify the challenges, gaps, and barriers to care and develop solutions to address them. This poster presented the key findings from caregivers/families and professionals, the changes undertaken based on community feedback, and feedback from the CYSHCN community.
    - ACT for Youth presented a 3-webinar series on Adolescent Mental Health in August 2021. All 3 webinars were recorded. On August 18, 2021, the first of the webinar was “You can help a student: Recognizing when Adolescent student are struggling and how to help them”. On August 25, 2021, ACT for Youth presented “The Cutting Edge: Understanding and Addressing Non-Suicidal Self-Injury in Youth”. The last of the three webinars on Adolescent Mental Health were presented on August 31, 2021, and the topic was “Youth Mental Health 2021 Return to “Normal?”
- Engage a youth representative in work with the NYSDOH Office of Health Insurance Programs/Medicaid Program on the Medicaid Redesign Team (MRT) II work group regarding best practices for transition care.
    - A young adult from one of the HSCs was invited but did not participate in this group. The group is now defunct.
- Serve on the New York State Developmental Disabilities Planning Council (DDPC) and the Individuals and Families Committee to promote inclusion of CYSHCN-specific focus to the DDPC’s agenda and policy portfolio. DDPC membership includes parents of CYSHCN from around New York State who are directly involved in decision-making regarding funding opportunities and policy development.
    - The Title V CYSHCN Director attended three DDPC and four Individuals and Families Committee meetings to

promote the inclusion of CYSHCN-specific focus for the DDPC's agenda and policy portfolio.
    - In 2021, the Title V CYSHCN Director participated in the DDPC Decision-Making Toolkit Work Group and reviewed the Request for Applications (RFA) for potential projects.

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 2018-2019 National Survey of Children's Health data for NYS show that about 69.6% of all children, and 57.2% of CYSHCN age birth to 17 years who needed care coordination services received effective services. Preparing for and supporting the transition from youth to adulthood is especially important for CYSHCN and their families. Only 23.6% 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 64.8% of adolescents with SHCN had a chance to speak to their health care provider alone at their last preventive check-up. While 78.7% of adolescents with SHCN 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 16.2% reported that their doctors discussed the shift to a provider who treats adults, if needed.

Title V staff identified supports to help youth and families coordinate care, including a specific focus on transition services, to improve efficiency, quality, health outcomes and patient satisfaction. CYSHCN often require specialty medical services across multiple providers and service settings and may experience multiple transitions as they develop and "age out" of specific programs or services, move across service and community settings, and become more independent growing from children to youth to adults. Care coordination services and more informal transition supports can be critical for CYSHCN and their families to manage their health and family needs during key periods of change and over time.

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

- Provide funding and program guidance to Local Health Department (LHD)-based CYSHCN programs to work with medical providers, childcare providers, and local school systems to improve communications between service providers to assist families with the referral process and support the transition of CYSHCN from pediatric to adult health care.
    - Community outreach was not possible for most counties due to their role in COVID-19 response.
    - For the CYSHCN database that was created in the Health Commerce System, there were weekly meetings to discuss the details of this CYSHCN survey.
    - On October 5, 2020, the NYSDOH CYSHCN staff did an overview of the CYSHCN program for year 2020-2025, including information about contracts with the RSCs and the CYSHCN database.
    - On September 13, 2021, staff from the Office of the Medical Director collaborated with the director of the Special Olympics, to present to the NYSDOH CYSHCN staff about the sports program and how LHDs can become involved.
    - On October 4, 2021, Leanne Fusco and Linsey Coyle, directors from Special Olympics New York (SONY) shared information with the LHDs about SONY sports programs events as well as health initiative and local volunteer opportunities.
    - Collaborated with OHIP to identify trainings for LHDs. OHIP staff will present to LHDs about Health Homes in early 2022.
    - In January 2021, the Bureau of Child Health received approval to re-design the Health Information Document (H.I. Doc.) which enables Children and Youth with Special Health Care Needs (CYSHCN) and families to collect, maintain and organize health information that can be shared with health care providers and other professionals. CYSHCN and families have indicated a need for a health summary tool that is written in plain, understandable language; able to be completed and updated by the family; portable; discreet and comprehensive for health care and social service needs; and readily available. The images that were chosen on this updated document represent racial diversity. NYSDOH translates important health related materials into the 10 most commonly spoken languages in New York State. In addition, this tool will be printed in English and Spanish and available on the CYSHCN website to print in any of the other 10 languages.
    - On March 24, 2021, the Regional Support Center, Einstein, presented a webinar titled "Supporting Youth Through Health Care Recreation & Employment Transitions" to 27 LHDs and CYSHCN families.
    - The NYS CYSHCN Program engaged youth and their families in state and local efforts to improve the systems and practices for supporting CYSHCN. As part of these efforts, on January 25, 2021, two young adult ambassadors presented on their journey of transitioning from pediatric to adult care to the Sickle Cell Disease providers.
    - On May 11, 2021, Got Transition® presented a webinar on Got Transition's Six Core Elements of Health Care Transition™ to our LHDs.
    - In July 2021, the NYSDOH CYSHCN Program collaborated with the National Alliance and requested a review of Got Transition® information on our website. They reviewed the information that was on our webpage and

provided feedback. We then updated our webpage with the suggestions.
    - In September 2021, the Office of Health Insurance Programs presented a Sickle Cell Disease (SCD) webinar given by Dr. Viswanathan to their Child and Adult Care Management Agencies. She spoke on how SCD may soon be eligible as a single qualifying condition for the Health Home population.
- Administered CYSHCN Support Services (CYSHCN-SS), a gap-filling supplemental program that provides reimbursement for specialty health care services for severe chronic illness or physically handicapping conditions in children who meet county financial and medical eligibility criteria.
- While most of NYS's children are insured, families continue to experience financial challenges meeting the needs of their CYSHCN. The Title V Program provides funding for direct services through the Children and Youth with Special Health Care Needs Support Services Program (CYSHCN-SS). In 2021, sixty-three (63) children received an evaluation and 34 received treatment services funded through CYSHCN-SS. Services included orthodontia (24%), enteral formula and specialty foods (18%), medications (21%), hearing aids (10%), physician office (6%) and hospital inpatient (7%).
- Facilitated collaboration between Title V programs serving youth, including SBHC and CAPP programs, to inclusively address broader health needs of CYSHCN including social emotional health, oral health, healthy relationships, and sexual reproductive health.
    - On June 23, 2021, CYSHCN staff attended NYSDOH AIDS Institute course on Sexual Orientation and Gender Identify: Why this is important working with adults and children in Health Homes.
- Provided subject matter and technical support to NYS Medicaid Program to implement enhanced care coordination and transition support services for CYSHCN through Medicaid Children's Health Home (CHH), including integration of eligible children also receiving services through the Early Intervention Program, referral of CYSHCN to Health Homes, and transition from Children's to Adult Health Homes. CYSHCN staff provided technical support in reviewing the policy and procedures of all the following CHH.
    - In 2020, the Title V Program participated with OHIP staff on site visits to twelve designated CHH agencies. There were five anticipated visits remaining that were to take place in the Summer 2020 before the pandemic struck 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.
    - The following site visits took place in 2021: the week of January 25, 2021, Niagara Falls Memorial Center (NFMMC); Children's Health Home of Upstate New York (OSHEI) the week of February 1, 2021; Children's Health Home of Upstate New York (CHHUNY) the week of February 8, 2021; Collaborative for Children and Families (CCF) the week of February 22, 2021; Greater Rochester Health Homes Network LLC (GRHHN) the week of March 8, 2021; St. Mary's Health Home (SMHH) the week of March 22, 2021; Coordinated Behavioral Care (CBC), aka Pathways to Wellness, the week of May 17, 2021; Bronx Accountable Healthcare Network (BAHN) the week of August 23, 2021; and Community Care Management Partners (CCMP) Health Home was scheduled for October 18, 2021.
    - Enrollment data is for the time period of 10/1/2020-9/30/2021: the number of children enrolled in CHH for this time period is reported to be 43,285 unique members, an increase from the 39,045 children enrolled in CHH 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 IQ; 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. New York has more pre-1950 housing containing lead paint than any other state in the nation, with approximately 43% 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 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 2020-21 year:

- Provides continued grant funding to local health department Lead Poisoning Prevention Programs (LPPP) and a statewide network of Regional Lead Resource Centers (RLRCs) 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 RLRC's are as follows: Kaleida Health/Oishei Children's Hospital sub-contracted with University of Rochester Medical Center (Western Region), SUNY Upstate Medical University sub-contracted with Albany Medical Center (Central/Eastern Region), and the Children's Hospital at Montefiore (Metro/Hudson Valley Region).
- Worked with LPPPs, RLRCs, 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 RLRCs 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 NYSDOH LPPP.
    - During educational sessions, guidelines and regulations are discussed to confirm understanding of reporting expectations and what the data reported is used for by LHDs.
    - RLRCs connecting labs/HCPs to NYSDOH LPPP to enroll for reporting.
    - LHDs reach out with lab issues to NYSDOH LPPP.
    - Supported the provision of outreach and education to health care provider and families, technical assistance to providers and LHD programs, individual case consultation, and treatment of lead poisoning among children, pregnant women, and newborns, including chelation treatment where indicated.
    - The three RLRC's provided outreach and education to over 350 physician practices during the 2020-2021 program year, technical assistance to providers and LHD programs, individual case consultation and treatment of lead poisoning was conducted over 840 times, and chelation treatment was performed 72 times.
- Through the LHD LPPPs and RLRCs, 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.
- Through the LHD LPPPs and RLRCs, 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.
- Through the RLRCs, increased 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 2020-2021 program year, the three RLRC's participated in over 100 regional and community-based lead poisoning prevention coalition meetings.

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 CYSHCN. A recently drafted summary document titled "New York State Profile of Children and Youth with Special Health Care Needs, 2018-2019", which updates the program's current 2017-2018 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 CYSHCN population, determines the impact that having special health care needs has on children and families, and identifies areas in most need of improvement to ensure NYS CYSHCN 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 CYSHCN grantees, partner organizations like Parent to Parent and NYSACHO.

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

- Completed a careful analysis of the revised 2018-2019 National Survey of Children's Health (NSCH) when available to assess available measures, trends, and other updates related to CYSHCN in NYS.
    - Key findings included that 45.3% of CYSHCN live in households with income below 200% of the federal poverty level. About 12% of CYSHCN have their daily activities greatly affected by their health condition(s); 16.4% of CYSHCN ages 6-17 missed 11 or more school days in a year, compared to 3.5% of NYS children without SHCN; and nearly half (49%) of CYSHCN ages 6-17 had trouble making or keeping friends.
    - Families of CYSHCN report higher out-of-pocket medical expenses, have trouble paying medical bills, spend more time coordinating their child's health care, and report reducing or stopping work due to their child's health.
    - In 2018–2019 the five key components indicating a child meets medical home criteria showed only 35.5% of care met the criteria, compared to 48.8% of children without SHCN.
- Collaborated with the U.S. Census Bureau to plan 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 CYSHCN populations.
    - Due to delays caused by COVID-19 response among Title V staff, this oversampling will occur in 2022 and data will be available in 2023.
- Analyzed and reported on available CYSHCN data for NYS, including data from the National Survey of Children's Health, share reports with LHDs and other stakeholders, and post on the Department's public website.
    - 2018-2019 New York State Profile of Children with Special Health Care Needs report is posted (https://www.health.ny.gov/community/special_needs/docs/cshcn_profile_2018-19.pdf)
- Developed and implemented plans for updating the current data reporting methods (quarterly and annual reports) of LHD CYSHCN. Analyzed and shared relevant data collected from programs to improve services and inform larger program and policy work related to CYSHCN.
    - NYSDOH CYSHCN continues to collect data from LHDs; however, several months ago the team decided to use the HCS for the new data collection. All NYSDOH CYSHCN staff received training on the HCS. Reviews and modifications of the CYSHCN questions were completed. A data submission guide and training materials for the LHDs were written and continually updated. Also, LHD trainings were conducted on 9/20/21, 9/28/21, and 9/30/21 before the new data collection went live on the HCS on October 1, 2021. Also, a FAQ was designed and is continually updated as more questions come in.
    - CYSHCN program staff and data team staff conducted one-on-one trainings with LHDs to answer questions and review the CYSHCN data collection survey. Staff used the data gathered from the CYSHCN programs to identify specific areas for further improvement and to inform improvement activities.
    - An analysis of the LHD CYSHCN data for 2018-2019 program data demonstrated that of the 1,661 CYSHCN children were served, 49.91% had Medicaid, 26.07% had commercial insurance, 8.31% had Child Health Plus (CHP), 12.88% had other insurance, and 2.83% had no insurance reported.
      Additionally, 6% of children had Supplemental Security Income (SSI).
    - Sixty-five percent of CYSHCN served were White, 12.16% African American, 1.63% Asian or Pacific Islander, 0.42% American Indian or Alaska Native, 4.76% more than one race, 0.54% other race, and 15.59% had unknown race (i.e., did not respond); 13.18% of children were Hispanic.
    - The percent of children reported to have a primary care provider was 98.43%, which is an improvement from the 97.7% in 2017-2018 data.
    - An optional data field for type of financial assistance needed by families for aspects of care was added. Among those served, there was information for 6.56% of CYSHCN, and 53.21% needed assistance for a service not covered by insurance, 26.61% for a service exceeding the limit of the benefit package, 11.93% needed help with co-pays, 4.59% for deductible costs, and 3.67% for premium costs.
    - In addition, information about referrals from the state's IDEA Part C Early Intervention Program was included. Approximately 25.34% of CYSHCN were referred by Early Intervention Program which is a 6.76% increase from last year.
    - There were 33 children referred to HH in 2018-2019, compared to 22 children the year before.
    - The annual CYSHCN data that is collected from all the LHDs was compiled and corrected for errors. A webinar was held August 30, 2021, to report on the statewide CYSHCN findings and how to read their individual report once received. This report can be used for program quality improvement as well. On September 8, 2021, each of the LHDs received their individual data for 2018-2019. The CYSHCN data profile report showed the monies allocated, how much was used, the estimated number of CYSHCN percent and actual number of children served. In this webinar, staff also included that Health Homes is waiting for approval for sickle cell disease to be a single qualifying condition for Health Home eligibility. Lastly, the RSCs 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, MCH outcomes are impacted by the social determinants of health (SDOH), or the conditions in which people are born, live, work, play, learn, and age. SDOH 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 SDOH and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities.

Many NYS families of CYSHCN are struggling with poverty, transportation, access to care (including availability of specialists), and sometimes employment, as many caregivers reported having to decrease hours worked or leaving jobs altogether to care for their children and 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 LHDs or RSCs. NYSDOH, RSCs and LHDs need to meet people where they are, provide multiple methods and means for CYSHCN and their families to engage, and ensure that a diverse population is being recruited and retained by LHDs.

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

- Support local CYSHCN programs based in local health departments (LHDs), with coverage increasing from 49 to 50 counties beginning October 2020.
    - In the fall of 2020, LHDs were provided guidance on funding spending during COVID-19. One of those suggestions was to purchase antibacterial wipes and face masks for staff working with CYSHCN families.
    - An email was sent on May 6, 2021, to the LHDs inviting them to a NYSDOH-sponsored free continuing education training for LHDs staff on the topic of Fluoride Varnish Health Detailing (PHD). The purpose of this training was to enhance the capacity of LHD staff to conduct PHD to medical health care providers on how to perform oral health screening and fluoride varnish applications to child in the medical setting to reduce tooth decay. This was done with the BCH Oral Health Unit. In addition to this training, the Oral Health Unit granted an opportunity for the LHDs to receive oral hygiene kits.
    - The pandemic had a serious impact on Title V CYSHCN staff's ability to support local CYSHCN programs. All CYSHCN 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 (Point of Dispensing) in Albany. Also, many LHD CYSHCN staff were pulled into COVID-19 response thus making them unavailable to administer the CYSHCN programs.
    - CYSHCN and their families have been tremendously affected by this pandemic. For example, LHDs feel that COVID-19 has placed so many restrictions on getting needed resources to families in an in-person manner that their outreach was limited. Information was still provided as best as possible through mailings or Facebook or telephonically. Many families did not take their children to doctor appointments until recently and now we see an increase of referrals to Early Intervention and Comprehensive Preschool Special Education services.
    - 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 LHD websites out of concern for the community.
    - Parents in NYC reported having problems finding housing or having issues paying for their rent due to COVID-19 related job loss and facing issue of losing their housing. One LHD created two platforms during their current COVID-19 pandemic to share a plethora of educational supports in our community. Title V staff have shared daily virtual educational and recreational videos, printable teaching supports, Crisis and Emergency Essential Needs Service Providers links, important things to know about COVID-19 for people with disabilities, virtual support groups and more.
    - Worked with the RSCs and LHD CYSHCN programs to integrate health equity into written materials, communication, outreach, and referrals for CYSHCN and families. 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. NYSDOH translates important health related materials into the 12 most commonly spoken languages in New York State – Spanish, Chinese, Russian, Yiddish, Bengali, Korean, Haitian Creole, Italian, Arabic, Polish, French and Urdu.
    - On June 16, 2021, the Regional Support Center (RSC), Einstein presented a webinar "Breaking Down the Walls: Support Healthy Sexuality for LGBTQ People with Intellect Developmental Disabilities" with 27 LHDs attendees.
    - On August 5, 2021, the Regional Support Center, Einstein, hosted a one-hour webinar: Effective Communication for Diverse Individual and Family Styles. Attendees and staff learned 6 common communication challenges and simple strategies to improve communication with neuro-diverse people and allies. There was a total of 23 LHD attendees.
    - On June 7, 2021, there was a training on Advocacy (English): Supporting parents/caregivers of Youth with

Special Health Care Needs and there were 30 attendees.
    - September 28, 2021: Parent Advocacy 家長倡導 Webinar. This one-hour webinar, in Mandarin, featured professionals and parents from the Chinese American Planning Council (CPC) and focused on how to best support other parents/caregivers of youth with special health care needs. This webinar provided a variety of advocacy information and tips. There were at total of 16 attendees: 14 parents and 2 professionals.
    - August 26, 2021: Presentación Sobre la Abogacía. This one-hour webinar, in Spanish, focused on various forms of advocacy and provided perspectives from a community-based organization leader and a parent. This webinar provided a platform to understand changes in inclusion, changes in educational policies and services for people with disabilities. There was a total of 19 attendees: 12 parents and 7 professionals.
    - September 16, 2021: Finding Meaningful and Sustainable Direction as a Family. The Einstein RSC and Open the Lid hosted a one-hour family support webinar, in English, in which participants learned simple strategies to navigate challenging behaviors. The webinar covered creating (1) long-term plans, (2) achievable short-term goals, and (3) coping strategies for the journey. There was a total of 10 attendees: 5 parents and 5 professionals. September 28, 2021: Encontrar Una Dirección Significativa Y Sostenible Como Familia. The Einstein RSC and Open the Lid hosted a one-hour family support webinar, in Spanish, in which participants learned simple strategies to navigate challenging behaviors. The webinar covered creating (1) long-term plans (2) achievable short-term goals, and (3) coping strategies for the journey. There was a total of 15 attendees: 13 parents and 2 professionals.
- Develop and implement data collection systems that allows LHD CYSHCN 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 CYSHCN Health Commerce System data submission for the LHDs. In conjunction with a live demonstration of the database, this webinar provided information on CYSHCN survey questions, data entry, and questions that were added or modified.
    - A new CYSHCN data collection tool has been developed using the Person-based Electronic Response Data System (PERDS) application in the NYSDOH's Health Commerce System (HCS). This CYSHCN data collection tool new was rolled out on October 1, 2021. Trainings and technical assistances are provided to LHDs 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 NYS 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 HCS PERDS is a secure online system supporting the exchange of health information by LHD CYSHCN program staff. State program managers and LHD CYSHCN program staff can access data in a timely manner to identify, track, and address disparities among CYSHCN.
    - For Sickle Cell Disease care transition grantees, an updated quarterly tool was completed. Conference calls with grantees on the updated tool and data summary were completed.
- Partnered with key stakeholders such as Parent to Parent, LHDs and RSCs to identify and share best practices to address racial justice and health equity.
    - The RSCs produce a biweekly newsletter for LHD CYSHCN Program staff and partners called CYSHCN Clips. The newsletter features professional development opportunities, upcoming events, and recent research. Examples include:
        - August 20, 2021: Children's Home and Community Based Services Brochure; VAX Facts; Invitation to CYSHCN Project: Advocacy Webinar for Spanish Speaking Parents; Tips on Helping Your Child Return to In-Person School; Learn to Lead Relationship and Sexuality Workshops for Parents of Kids with I/DD; SPARK Study at RFK CERC/CHAM; NEW: CDC COVID-19 Materials for People with Intellectual and Developmental Disabilities and Care Providers
        - August 24, 2021: LHD Webinar #6: Effective Communication for Diverse Individual and Family Styles (recording)
        - September 3, 2021: resources from Association of Maternal & Child Health Programs (AMCHP): MCH Essential Series - asynchronous training modules on variety of topics (cultural competency, youth empowerment, life course perspective, using data to inform programs, evidence and equity, MCH history/systems, etc.); and Lead Poisoning Toolkit
        - 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
        - September 17, 2021, CYSHCN Clips: Agency 101: Connecting Individuals with Disabilities to Adult Services(webinar); NICHQ (National Institute for Children's Health Quality presents Connecting Providers and Community-Based Organizations to Improve SCD Appointment Attendance

        - 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
        - September 20, 2021, CYSHCN Clips included Agency 101: Connecting Individuals with Disabilities to Adult Services; Encontrar Una Dirección Significativa y Sostenible Como Familia
- Racial Justice Work Group
    - All members of 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, New York State Birth equity improvement project and the Together We Can Inclusion project. During this time staff reviewed some NYSDOH RFAs 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, is 40.3%. The program has set an improvement target of 5% for 2022, to 42.3%.

Children with Special Health Care Needs - Application Year

For Children and Youth with Special Health Care Needs (CYSHCN), 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 CYSHCN receive care in a well-functioning system, and less than 18% of youth ages 12-17 with special health care needs received services necessary to make transitions to adult health care. 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 CYSHCN.

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 this performance measure:

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, NSCH).

Objective CYSHCN-2: Increase the percentage of children and youth with special health care needs (CYSHCN), 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).

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 12.1 per 1,000 children tested in 2019. (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 (SAP) 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.

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. As described in the Needs Assessment summary, families expressed a lack of awareness of resources and services in the community, barriers accessing transportation, challenges in finding and accessing services and amenities in their communities, and needs for better social supports, social cohesion, and specific supports for parents and families. Directly involving family members, including youth, in the design, implementation, and

evaluation of programs and services is critical to ensuring that those programs and services meet their needs and are delivered in ways that are empowering, respectful, accessible, culturally competent, and effective. Families of CYSHCN face unique challenges and bring knowledge, experience, and strengths that are a tremendous asset; they are the experts about their needs and care. This is a theme woven into all CYSHCN-serving Title V programs.

For example, the Title V Program contracts with three HRSA-designated University Centers for Excellence in Developmental Disabilities (UCEDDs), knowns as Regional Support Centers (RSCs), to provide training and technical assistance to local health department (LHD)-based CYSHCN programs and to conduct family engagement. The RSCs each have a family liaison who is a parent/caregiver of a CYSHCN. The family liaison role is seen as a critical component of the RSC work with families, CYSHCN, and LHDs. Family liaisons bring firsthand experience, perspective, and knowledge of barriers and gaps in care to all aspects of RSC activities, including meeting with families and resource gathering. Family liaisons are involved in all cross functional teams including educational, data, technical assistance to LHDs, and Resource Directory and are responsible for conducting family engagement sessions with a prescribed set of questions to gauge the needs of CYSHCN families. Meetings are all virtual, and not in-person as intended, due to the COVID-19 public health emergency. In addition, RSCs continue to conduct 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. Some counties have established work plans/family engagement plans regarding engaging their CYSHCN communities that the RSCs will continue to provide support on.

In addition, the NYSDOH has established contracts with LHDs to administer the CYSHCN 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. LHDs will involve families of CYSHCN in work groups, committees, task forces or advisory committees to improve the system of care for CYSHCN, involve families and CYSHCN in local planning activities, such as the Community Health Assessment (CHA), and use feedback from families of CYSHCN to develop training for CYSHCN staff and providers.

Sickle cell disease (SCD) grantees at three Hemoglobinopathy Specialty Care (HSC) Centers work directly and exclusively with youth in transition support services. HSCs conduct peer support groups to gauge barriers to care and transition for youth and young adults with SCD. Transition navigators at HSCs engage youth with SCD 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 2022-23 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 CYSHCN program activities.
- Activity CYSHCN 1.2: Collaborate with advocacy groups like Parent to Parent of NYS to understand the needs of CYSHCN and their families, facilitate information sharing, and promote LHD CYSHCN programs.
- Activity CYSHCN 1.3: Support RSCs to employ parents of CYSHCN as parent liaisons. Work with the RSCs 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 LHD programs.
- Activity CYSHCN 1.4: Support RSCs to develop a CYSHCN Resource Directory that will be made available online to provide families, LHDs and health care providers with current information about services and supports.
- Activity CYSHCN 1.5: Support LHD CYSHCN programs to involve CYSHCN and their families in work groups, committees, task forces or advisory committees, local health assessment and planning activities, and other systems development work. Use feedback from families of CYSHCN to develop training for CYSHCN staff and providers.
- Activity CYSHCN 1.6: Engage the New York State Association of County Health Officials (NYSACHO) to promote and bolster LHD CYSHCN programs to raise awareness of LHD CYSHCN services and reach and serve more families.

NYSACHO will provide opportunities for Title V staff to speak directly to their members, participate in calls with LHDs, and help disseminate information and opportunities for CYSHCN and families.

- Activity CYSHCN 1.7: Support SCD programs in three Hemoglobinopathy Centers to provide transition supports by and for youth with SCD, including peer support groups, system navigation supports, and self-care services.
- Activity CYSHCN 1.8: Collaborate with other Title V and Division of Family Health adolescent-serving programs, including School-Based Health Centers, Comprehensive Adolescent Pregnancy Prevention, and ACT for Youth Center for Community Action to identify additional opportunities to meaningfully engage adolescents in program and policy development that impacts CYSHCN.
- Activity CYSHCN 1.9: Serve on the New York State Developmental Disabilities Planning Council (DDPC) and the Individuals and Families Committee, to promote inclusion of CYSHCN-specific focus to the DDPC's agenda and policy portfolio. DDPC membership includes parents of CYSHCN from around New York State who are directly involved in decision making regarding funding opportunities and policy development.

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 2019-2020 NSCH data for NYS show that about 71% of all children, and 59% of CYSHCN, 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 CYSHCN 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 63% 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 71% of adolescents with SHCN 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 16% 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. CYSHCN often require specialty medical services across multiple providers and service settings and may experience multiple transitions as they develop and "age out" of specific programs or services, move across service and community settings, and become more independent growing from children to youth to adults. Care coordination services and more informal transition supports can be critical for CYSHCN and their families to manage their health and family needs during key periods of change and over time.

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

- Activity CYSHCN 2.1: Provide funding and program guidance to LHD-based CYSHCN programs to work with medical providers, childcare providers, and local school systems to improve communications between service providers to assist families with the referral process and support the transition of CYSHCN from pediatric to adult health care. LHDs will provide timely and appropriate information and referrals to insurance, health services, transportation, and community resources to support transition and other services for CYSHCN.
- Activity CYSHCN 2.2: Continue to support three HRSA-designated UCEDDs, which are known as the RSCs, to support youth, families, and LHD CYSHCN programs. RSCs will identify resources and develop a comprehensive Resource Directory for LHDs and families; provide technical assistance to LHDs; conduct family engagement opportunities; identify webinars or professional development for LHDs; develop training and education materials; facilitate communication among LHDs; and identify barriers, unmet needs and opportunities for CYSHCN and their families. As described in the previous strategy, families and youth are deeply involved in guiding this work.

- Activity CYSHCN 2.3: In collaboration with the RSCs, facilitate professional development and information sharing between LHD programs related to transition, including information on Got Transition's Six Core Elements of Health Care Transition™.
- Activity CYSHCN 2.4: Administer CYSHCN Support Services (CYSHCN-SS), 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 Centers to support successful transition to adult services for young adults with SCD, 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 Centers to help SCD patients 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 2.7: Facilitate collaboration between Title V programs serving youth, including SBHC and CAPP programs, to inclusively address broader health needs of CYSHCN 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 CYSHCN through Medicaid Children's Health Home, including integration of eligible children also receiving services through the Early Intervention Program, referral of CYSHCN to Health Homes, and transition from Children's to Adult Health Homes.

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 (IQ), 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 (RLRCs) 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

2022-23 year:

- Activity CYSHCN 3.1: Provide continued grant funding to local health department Lead Poisoning Prevention Programs (LPPP) and a statewide network of Regional Lead Resource Centers (RLRCs) 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 LPPPs, RLRCs, 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 RLRCs, support the provision of outreach and education to health care provider and families, technical assistance to providers and LHD 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 LHD LPPPs and RLRCs, 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 LHD LPPPs, ensure that all children with elevated blood lead levels receive appropriate evaluation and management, including:
    - Confirmatory venous blood lead testing for capillary screening results $\geq$ 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 RLRCs, 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 CYSHCN. Continuous efforts are needed to enhance the collection, analysis, and sharing of data to inform the planning and implementation of CYSHCN 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 CYSHCN. A recently published summary document titled “New York State Profile of Children and Youth with Special Health Care Needs, 2018-2019", which updates the program’s current 2017-2018 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 CYSHCN population, determines the impact that having special health care needs has on children and families, and identifies areas in most need of improvement to ensure NYS CYSHCN receive care in a well-functioning system. The NSCH 2019-2020 is available now as well so the Profile will be updated again and posted to the NYSDOH website and shared with partners. 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 CYSHCN grantees, partner organizations like Parent to Parent and NYSACHO.

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

- Activity CYSHCN 4.1: Complete a careful analysis of the revised NSCH when available to assess available measures, trends, and other updates related to CYSHCN 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 CYSHCN populations.
- Activity CYSHCN 4.3: Analyze and report on available CYSHCN data for NYS, including data from the National Survey of Children's Health, share reports with LHDs 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 LHD CYSHCN programs and SCD 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 CYSHCN.
- Activity CYSHCN 4.5: Use the data gathered from the CYSHCN programs to identify specific areas for further improvement and to inform improvement activities.

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, MCH outcomes are impacted by the social determinants of health (SDOH), or the conditions in which people are born, live, work, play, learn, and age. SDOH 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 SDOH and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities.

Many NYS families of CYSHCN 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 CYSHCN programs at the local health departments (LHDs) or the State's three Regional Support Centers (RSCs) located at the federally designated Centers of Excellence for Developmental Disabilities (UCEDDs). Recognizing this challenge, NYSDOH, RSCs, and LHDs need to meet people where they are, provide multiple methods and means for CYSHCN and their families to engage, and ensure that a diverse population is being recruited and retained by LHDs.

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

- Activity CYSHCN 5.1: Support 49 local CYSHCN programs based in LHDs, including encouraging inclusion and health equity measures in outreach and referrals.
- Activity CYSHCN 5.2: Work with the RSCs and LHD CYSHCN programs to integrate health equity into written materials, communication, outreach, and referrals for CYSHCN 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 LHD CYSHCN programs and sickle cell disease care transition grantees to identify, track, and address disparities.
- Activity CYSHCN 5.4: Partner with key stakeholders such as Parent to Parent, LHDs and RSCs 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 (SCD) 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 SCD Care Transition contractor reports. The initial baseline value for this measure from the 2018-2019 program grant cycle was 40.3%; 2019-2020 was 64%. The 2020-2021 data reflects a percentage of 70%. However, the program improvement target of 5% for 2023 (to 42.3%) will be retained due to unknown factors during COVID-19 that may have contributed to 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 (MCH) 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 (MIECHV) 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 MIECHV program; other adult men and women; adolescents; and families of Children and Youth with Special Health Care Needs (CYSHCNs). 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 CYSHCN)*
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 CYSHCN)*
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 CYSHCN)*
   - *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 CYSHCN)*
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 MCH 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 CYSHCN Program sought family feedback by hosting discussion groups and interviews with parents of CYSHCN, ages 0-21, and individuals with SHCN, ages 18-21 throughout the reporting period. They sought to learn about issues families face, how to improve family experiences, and create resource guides and training materials that NYS Local Health

Departments (LHD) can use to help children and youth and their families in the future. There were nearly 200 participants. Highlights from what was shared include parents feel that their children's physicians were dismissive, and they had to make extra effort to get the proper diagnosis to begin services. Most community programs are not inclusive. Adequate childcare is extremely hard to find. Parents are not satisfied with the Department of Education placement process. Most families have been met with financial hardships while trying to get their child(ren) adequate care.

Throughout the reporting period, seven LHDs conducted needs assessments to identify gaps and barriers in supporting CYSHCN and their families and identify the LHDs' technical assistance needs. Among identified issues were understaffing, referral programs for YSHCN transitioning to adulthood, and updated resource guides to direct families to proper care. Learning communities for local CYSHCN programs could help address these issues.

DFH was able to engage the Title V MCH 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 MCH priorities with the MCH 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 current annual report and application was presented to the MCH Advisory Council on June 9, 2022.

DFH is engaging state agencies that serve the MCH population, including the Office for Children and Family Services (OCFS), the NYS Education Department (NYSED), Office for Temporary and Disability Assistance (OTDA), Council on Children and Families (CCF), 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.

DFH will continue to seek public input on the MCH 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 with HRSA and 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 CYSHCN and their families as well in planning for the comprehensive Needs Assessment for next year's full five-year application. HRSA 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 (POSC) 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 HRSA to utilize technology to share and learn rather than in-person meetings or conferences. In particular, 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 MCH 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 HRSA-funded MCH Catalyst program. Our programs have worked closely together for over five years to support mutual goals related to MCH 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 MCH 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 HRSA's MCHB to explore how the Bureau may support this relationship to facilitate future technical assistance support from the University at Albany's MCH 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. State Action Plan.pdf

Supporting Document #03 - 3. MCH Data Systems.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - DOH OPH CCH DFH Org Charts 2022.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: New York

	FY 23 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	$ 13,172,738	(33.8%)
B. Children with Special Health Care Needs	$ 22,527,401	(57.8%)
C. Title V Administrative Costs	$ 2,609,055	(6.8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 38,309,194	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 29,285,355	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 36,138,659	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 24,571,358	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 89,995,372	
A. Your State's FY 1989 Maintenance of Effort Amount $ 58,268,752		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 128,905,182	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 62,282,555	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 191,187,737	

OTHER FEDERAL FUNDS	FY 23 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) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 3,446,426
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)	$ 26,526,888
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Medicaid Match	$ 8,550,496
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning Telehealth	$ 700,000

	FY 21 Annual Report Budgeted		FY 21 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 21 Federal Award: $ 38,366,219)		$ 39,701,635	
A. Preventive and Primary Care for Children	$ 11,857,445	(30.5%)	$ 17,043,233	(42.9%)
B. Children with Special Health Care Needs	$ 14,497,912	(37.3%)	$ 15,830,007	(39.8%)
C. Title V Administrative Costs	$ 2,722,777	(7%)	$ 2,474,173	(6.3%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 29,078,134		$ 35,347,413	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 29,285,355		$ 29,285,355	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 55,602,278		$ 36,848,150	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 16,735,967		$ 22,078,647	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 101,623,600		$ 88,212,152	
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)	$ 140,533,410		$ 127,913,787	
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)	$ 49,308,573		$ 44,826,458	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 189,841,983		$ 172,740,245	

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 2,913,835	$ 2,628,117
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 8,336,421	$ 8,091,436
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 26,180,873	$ 26,180,873
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Sexual Risk Avoidance Education	$ 3,326,948	$ 2,885,769
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Medicaid Match	$ 8,550,496	$ 5,040,263

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:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: NY's FY 21 application reflected a budget of over $11 million in Preventive and Primary Care for Children, but actual expenditures were more than anticipated. This is likely related to the timing of reporting rather than an actual increase in expenditures.	
2.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: NY's FY 21 application reflected a budget of over $55 million in Local funds, but actual expenditures were less than anticipated. This is likely related to the timing of the reporting by LHDs rather than an actual decrease in expenditures.	
3.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: NY's FY 21 application reflected a budget of over $16 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 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 676	$ 4,004,662
2. Infants < 1 year	$ 458,554	$ 4,384,274
3. Children 1 through 21 Years	$ 12,714,184	$ 12,658,959
4. CSHCN	$ 22,527,401	$ 15,830,007
5. All Others	$ 599,940	$ 349,560
Federal Total of Individuals Served	$ 36,300,755	$ 37,227,462

IB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 12,806,878	$ 12,841,059
2. Infants < 1 year	$ 5,430,099	$ 5,756,724
3. Children 1 through 21 Years	$ 36,063,843	$ 21,055,924
4. CSHCN	$ 8,797,063	$ 23,703,260
5. All Others	$ 26,897,488	$ 24,855,185
Non-Federal Total of Individuals Served	$ 89,995,371	$ 88,212,152
Federal State MCH Block Grant Partnership Total	$ 126,296,126	$ 125,439,614

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:	**2023**
	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:	**2021**
	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 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 2,508,910	$ 791,234
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	$ 2,508,910	$ 791,234
2. Enabling Services	$ 21,798,543	$ 21,435,300
3. Public Health Services and Systems	$ 14,602,357	$ 17,475,101
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		$ 791,234
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		$ 791,234
Federal Total	$ 38,909,810	$ 39,701,635

IIB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 16,696,642	$ 12,107,934
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 5,607,582	$ 5,678,681
B. Preventive and Primary Care Services for Children	$ 11,089,060	$ 6,429,253
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 47,794,388	$ 46,561,410
3. Public Health Services and Systems	$ 14,528,833	$ 14,715,885
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		$ 12,107,934
Direct Services Line 4 Expended Total		$ 12,107,934
Non-Federal Total	$ 79,019,863	$ 73,385,229

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIB. - Other - Other**
	Fiscal Year:	**2023**
	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: 211,269 **Data Source Year: 2021**

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	211,203 (100.0%)	1,900	370	370 (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 1	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	211,203 (100.0%)	296	0	0 (0%)
Tyrosinemia, type 2, 3	211,203 (100.0%)	5	0	0 (0%)
Spinal Muscular Atrophy	211,203 (100.0%)	11	11	11 (100.0%)
GAMT deficiency	211,203 (100.0%)	3	1	1 (100.0%)
Krabbe disease	211,203 (100.0%)	11	2	2 (100.0%)
Short-chain acyl-CoA dehydrogenase deficiency/IBCD	211,203 (100.0%)	19	5	5 (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:	**2021**
	Column Name:	**Other Newborn**
	Field Note: NA	
2.	**Field Name:**	**HIV - Total Number Referred For Treatment**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**
	Field Note: NA	

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 2021

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	150,863	46.0	0.0	53.0	1.0	0.0
2. Infants < 1 Year of Age	209,128	46.0	0.0	53.0	1.0	0.0
3. Children 1 through 21 Years of Age	293,991	39.0	0.0	58.0	3.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	154,463	46.0	0.0	53.0	1.0	0.0
4. Others	271,932	22.0	0.0	72.0	6.0	0.0
Total	925,914					

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	209,338	No	205,713	100.0	205,713	150,863
2. Infants < 1 Year of Age	209,073	No	209,128	100.0	209,128	209,128
3. Children 1 through 21 Years of Age	4,737,107	Yes	4,737,107	68.4	3,240,181	293,991
3a. Children with Special Health Care Needs 0 through 21 years of age^	976,742	Yes	976,742	45.1	440,511	154,463
4. Others	14,378,697	Yes	14,378,697	5.6	805,207	271,932

^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:	**2021**

Field Note:
Data for Form 5a were aggregated from reports provided by specific Maternal and Child Health programs that are either funded by Title V or funded by state and other funds but with Title V funded staff support for subject matter expertise.

The following MCH serving programs were included in Form 5a for Pregnant Women:
+ Comprehensive Adolescent Pregnancy Prevention and ACT for Youth Center of Excellence
+ Family Planning Program
+ Regional Perinatal Centers
+ Community Water Fluoridation
+ Maternal and Infant Community Health Collaborative (MICHC) Programs
+ Maternal, Infant, and Early Child Home Visiting (MIECHV) Programs - Nurse Family Partnership and Healthy Families
+ Immunization

Estimates for the Primary Source of Coverage were provided by HRSA.

2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2021**

Field Note:
All NYS infant receive Title V funded or supported services as a result of investments in the state's Newborn Metabolic Screening Program for the screening, as well as Newborn Hearing Screening, services through the perinatal system, and home visiting.

Estimates for the Primary Source of Coverage were provided by HRSA.

3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2021**

Field Note:
Data for Form 5a were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by Title V or funded by state and other funds but with Title V funded staff support for subject matter expertise.

The following MCH serving programs were included in Form 5a for Children 1-21 years old:
+ Asthma Program
+ Child Lead Poisoning Prevention Program
+ Local Health Department Children with Special Healthcare Needs Programs
+ Comprehensive Adolescent Pregnancy Prevention Program and ACT for Youth Center of Excellence
+ School Based Health Center Program
+ Family Planning Program
+ Enough Is Enough Program
+ Maternal, Infant, and Early Child Home Visiting (MIECHV) Programs - Nurse Family Partnership and Healthy Families
+ Sickle Cell Disease Transition Grants to Hemoglobinopathy Centers
+ Physically Handicapped Children Program (PHCP)
+ Immunization

Estimates for the Primary Source of Coverage were provided by HRSA.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2021**

Field Note:
Data for Form 5a were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by Title V or funded by state and other funds but with Title V funded staff support for subject matter expertise. Children and Youth with Special Healthcare Needs (CYSHCN) counts are a subset of the counts for Infants under 1 and Children ages 1-21 years old.

The following MCH serving programs were included in Form 5a for CYSHCN:
+ Asthma Program
+ Child Lead Poisoning Prevention Program
+ Local Health Department Children with Special Healthcare Needs Programs
+ School Based Health Center Program
+ Maternal, Infant, and Early Child Home Visiting (MIECHV) Programs - Nurse Family Partnership and Healthy Families
+ Migrant Health
+ Family Planning Program
+ Sickle Cell Disease Transition Grants to Hemoglobinopathy Centers
+ Physically Handicapped Children Program (PHCP)
+ Immunization

Estimates for the Primary Source of Coverage were provided by HRSA.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2021**

Field Note:
Data for Form 5a were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by Title V or funded by state and other funds but with Title V funded staff support for subject matter expertise.

The following MCH serving programs were included in Form 5a for Other Populations:
+ Asthma Program
+ Family Planning Program
+ Enough is Enough Program
+ Migrant Health Program
+ Maternal and Infant Community Health Collaborative (MICHC) Programs
+ Maternal, Infant, and Early Child Home Visiting (MIECHV) Programs - Nurse Family Partnership and Healthy Families
+ Immunization

Estimates for the Primary Source of Coverage were provided by HRSA.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2021**

Field Note:
All pregnant women in NYS benefit from Title V funding as a result of investments in training and quality improvement initiatives with the Regional Perinatal Centers and birthing hospitals as well as work with other medical and healthcare providers.

Data for Form 5b for pregnant women served are reported based on NYS Vital Statistics data report in Form 6 of the Title V application.

2.	**Field Name:**	**Pregnant Women Denominator**
	Fiscal Year:	**2021**

Field Note:
All pregnant women in NYS benefit from Title V funding as a result of investments in training and quality improvement initiatives with the Regional Perinatal Centers and birthing hospitals as well as work with other medical and healthcare providers.

Data for Form 5b for pregnant women served are reported based on NYS Vital Statistics data report in Form 6 of the Title V application.

3.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2021**

Field Note:
All NYS infants receive Title V funding as a result of investments in the state's Newborn Metabolic Screening Program for the screening, as well as Newborn Hearing Screening, services through the perinatal system, and home visiting.

Data for Form 5b for infants < 1 year of age served are reported based on NYS Vital Statistics data report in Form 6 of the Title V application.

4.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2021**

Field Note:
All NYS infants receive Title V funding as a result of investments in the state's Newborn Metabolic Screening Program for the screening, as well as Newborn Hearing Screening, services through the perinatal system, and home visiting.

Data for Form 5b for infants < 1 year of age served are reported based on NYS Vital Statistics data report in Form 6 of the Title V application.

5.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**

Field Note:
Data for Form 5b were aggregated from reports provided by MCH programs directly funded by Title V or funded by state/other funds but with Title V funded staff support for subject matter expertise.

The following MCH serving programs were included in Form 5b for Children 1-21 years old:
+ Asthma Program
+ Child Lead Poisoning Prevention Program
+ Local Health Department Children with Special Healthcare Needs Programs
+ Comprehensive Adolescent Pregnancy Prevention Program and ACT for Youth Center of Excellence
+ School Based Health Center Program
+ Family Planning Program
+ Enough Is Enough Program
+ Maternal, Infant, and Early Child Home Visiting (MIECHV) Programs - Nurse Family Partnership and Healthy Families
+ Sickle Cell Disease Transition Grants to Hemoglobinopathy Centers
+ Physically Handicapped Children Program (PHCP)
+ Community Water Fluoridation
+ Immunization
+ Medicaid Performance Improvement Project (PIP)**

** Footnote: Since approximately 50% of NYS children have Medicaid coverage and would be counted in the Medicaid PIP, the other MCH serving programs were reduced by 50% to reduce the potential for overcounting or double counting of children served by Title V.

6.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**

Field Note:
Data for Form 5b were aggregated from reports provided by MCH programs directly funded by Title V or funded by state/other funds but with Title V funded staff support for subject matter expertise.

The following MCH serving programs were included in Form 5b for CYSHCN:
+ Asthma Program
+ Child Lead Poisoning Prevention Program
+ Local Health Department Children with Special Healthcare Needs Programs
+ Comprehensive Adolescent Pregnancy Prevention Program and ACT for Youth Center of Excellence
+ School Based Health Center Program
+ Maternal, Infant, and Early Child Home Visiting (MIECHV) Programs - Nurse Family Partnership and Healthy Families
+ Migrant Health
+ Family Planning Program
+ Sickle Cell Disease Transition Grants to Hemoglobinopathy Centers
+ Physically Handicapped Children Program (PHCP)+ Immunization
+ Medicaid Performance Improvement Project (PIP)**

** Footnote: Since approximately 50% of NYS children have Medicaid coverage and would be counted in the Medicaid PIP, the other MCH serving programs were reduced by 50% to reduce the potential for overcounting or double counting of children served by Title V.

7.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2021**

Field Note:
Data for Form 5b were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by Title V or funded by state and other funds but with Title V funded staff support for subject matter expertise.

The following MCH serving programs were included in Form 5b for Other Populations:
+ Asthma Program
+ Family Planning Program
+ Enough is Enough Program
+ Maternal and Infant Community Health Collaborative (MICHC) Programs
+ Maternal, Infant, and Early Child Home Visiting (MIECHV) Programs - Nurse Family Partnership and Healthy Families
+ Community Water Fluoridation
+ Immunization

Data Alerts:

1.	Infants Less Than One Year, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: New York

Annual Report Year 2021

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	205,713	101,930	29,323	47,629	354	20,158	1,113	3,178	2,028
Title V Served	205,713	101,930	29,323	47,629	354	20,158	1,113	3,178	2,028
Eligible for Title XIX	101,828	35,818	18,788	33,944	237	9,939	279	1,666	1,157
2. Total Infants in State	209,128	103,729	29,930	48,287	359	20,399	1,128	3,234	2,062
Title V Served	209,128	103,729	29,930	48,287	359	20,399	1,128	3,234	2,062
Eligible for Title XIX	103,327	36,360	19,170	34,368	242	10,038	280	1,693	1,176

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	2023 Application Year	2021 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 522-5066	(800) 522-5006
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"		13,909

B. Other Appropriate Methods	2023 Application Year	2021 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	(518) 474-6968
Extension	
Email	Kirsten.Siegenthaler@health.ny.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Suzanne Swan, MPH
Title	Director, Bureau of Child Health
Address 1	New York State Department of Health
Address 2	Corning Tower Rm 878
City/State/Zip	Albany / NY / 12237
Telephone	(518) 474-1961
Extension	
Email	Suzanne.Swan@health.ny.gov

3. State Family or 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 2023

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
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
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**
2016_2020	17.7	1.3	198	1,121,135
2015_2019	18.4	1.3	211	1,149,071
2014_2018	17.8	1.2	208	1,166,305

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2021
Annual Indicator	13.1
Numerator	
Denominator	
Data Source	
Data Source Year	

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
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**
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
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
2020/Q3-2021/Q2	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 %			
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
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
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
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
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
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**
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
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
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
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**
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
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
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
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
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
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
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
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
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
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
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 <50 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
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
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**
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
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
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
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
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
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
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
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
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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective				79.4	80.3
Annual Indicator			79.6	78.3	78.3
Numerator			2,826,660	2,737,695	2,703,220
Denominator			3,550,054	3,498,639	3,451,509
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

Previous NPM-1 BRFSS data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	81.3	82.2	83.1	83.3

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
annual objectives adjusted following review of data

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					
	2017	2018	2019	2020	2021
Annual Objective	91	93.4	93.7	93	92.4
Annual Indicator	92.7	92.5	91.2	92.2	91.6
Numerator			2,782	2,626	2,610
Denominator			3,052	2,849	2,850
Data Source	NYS VS	NYS VS	NYS VS	NYS VS	NYS VS
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	92.6	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**
Annual Objective			27.5
Annual Indicator	27.0	27.4	22.4
Numerator	369,498	316,874	272,297
Denominator	1,370,994	1,158,167	1,213,091
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	27.8	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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		81.2	82.2	83.2	81.5
Annual Indicator	79.2	81.3	81.3	86.3	82.9
Numerator	1,103,856	1,081,532	1,081,532	1,367,654	1,218,475
Denominator	1,393,274	1,331,106	1,331,106	1,583,876	1,469,455
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2016_2017	2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	82.2	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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		15.7	15.9	16.1	18
Annual Indicator	15.3	13.7	17.8	23.6	19.1
Numerator	48,081	34,736	48,580	87,040	73,058
Denominator	314,730	253,092	273,067	369,539	381,623
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	18.1	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
Annual Objective			75
Annual Indicator	70	68	70
Numerator			
Denominator			
Data Source	Newborn Blood Spot data	Newborn Blood Spot data	Newborn Blood Spot data
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	77.0	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**
Annual Objective			3.6
Annual Indicator		3.6	12.1
Numerator		1,772	6,063
Denominator		498,946	502,219
Data Source		NYS Child Health Lead Poisoning Prevention Program	NYS Child Health Lead Poisoning Prevention Program
Data Source Year		2018	2019
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	12.1	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).

3.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**

Field Note:
To ensure a valid comparison, 2022 Objective has been updated to reflect the latest definition of the measure. Previously, the measure was set at >=10 ug/dL with 2022 Objective at 3.4. As of test year 2019, this is now updated to >=5 ug/dL with 2022 Objective at 12.1.

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.

The Y2023 - Y2026 annual objectives, and now including Y2022, used Y2019 EBLL >= 5 ug/dL as a reference baseline (12.1 per 1000 tested children).

2016-2019 NYS Child Health Lead Poisoning Prevention Program Data as of September 2021 from Community Health Indicator Reports (CHIRS).

Goal is an 1% decrease each year for five years.

4.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
Update incidence of confirmed (>=5 ug/dL) high blood lead levels per 1,000 tested children aged less than 72 months.
Goal is an 1% decrease each year for five years.
The Y2023 - Y2026 annual objectives, and now including Y2022, used Y2019 EBLL >= 5 ug/dL as a reference baseline (12.1 per 1000 tested children).

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

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	58.1	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
Annual Objective			37.5
Annual Indicator	37.3	36.2	29.7
Numerator		92,136	58,264
Denominator		254,718	195,847
Data Source	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
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	37.7	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
Annual Objective			0
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	NYS Data	NYS Data	NYS Data
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	0.0	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	

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
Annual Objective			51.6
Annual Indicator		51.6	43
Numerator		98,941	74,325
Denominator		191,920	172,751
Data Source		SBHC quarterly report	SBHC quarterly report
Data Source Year		2018-2019	2019-2020
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	51.6	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.	

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

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	96.3	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)

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
Annual Objective			68.7
Annual Indicator		68.7	78.1
Numerator		46	50
Denominator		67	64
Data Source		Survey of CAPP, PREP, and SRAE Programs	Survey of CAPP, PREP, and SRAE Programs
Data Source Year		2020	2021
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	70.1	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).	

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
Annual Objective			40.3
Annual Indicator	40.3	62.4	66.1
Numerator		295	323
Denominator		473	489
Data Source	Contractor Reports	Contractor Reports	Contractor Reports
Data Source Year	2018-2019	2019-2020	2020-2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	41.1	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	

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>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.</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 MICHC participants engaged prenatally who have created a birth plan during a visit with a CHW</td></tr>
<tr><td>Denominator:</td><td>Number of MICHC participants engaged prenatally with a CHW</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data for this measure will come from quarterly and annual reports submitted by local MICHC contractors.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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 2021

	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