Massachusetts State Action Plan Table 2026 Application/2024 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
1. Maternal/Parental/Reproductive Health: Ensure all MA residents who are pregnant and give birth, and their families live the healthiest life, supported by strong public health and healthcare systems	1. By 2030, all Massachusetts birthing facilities will adhere to Department of Public Health (DPH) regulations specific to risk appropriate perinatal care including having formal transfer protocols in place. 2. By 2030, increase the number of families served by a home visiting program from 6,000 to 10,000 per year. 3. By 2030, increase the annual number of registrations for all trainings offered by the Massachusetts Sexual and Reproductive Health (MASRH) Training Center (virtual, in-person, and asynchronous) from 842 to 1010. 4. By 2030, increase by 10% (from 13.5% in 2022) the percentage of postpartum depression (PPD) screenings completed per the maternal health law. 5. By 2028, reach at least 20 clinical (and/or other	Focus Area 1. Promote the implementation of risk-appropriate care for people who give birth 1.1 Increase awareness of levels of care among obstetric providers and people who give birth to enable implementation of revised regulations 1.2 Ensure safe and timely transport across levels of care (including community birth) by developing a toolkit, standardized systems, data collection and quality improvement methods 1.3 Promote awareness of how to access community birth among women Focus Area 2. Expand home visiting to serve all towns and cities in MA 2.1 Expand universal one-time postpartum home visiting program statewide 2.2 Expand evidence-based and evidence-informed home visiting to serve more families in MA 2.3 Increase postpartum visit attendance amongst families enrolled in home visiting 2.4 Establish insurance reimbursement for home visiting programs Focus Area 3. Promote health care provider assessment of need for contraceptive, preconception, and or infertility care	ESM PPV.1 - Post-partum visit frequency for Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program participants	NPM - Postpartum Visit	**Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety

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	professional) maternal health/obstetrical staff and community-based organization staff with Paid Family and Medical Leave tools and/or resources to support knowledge of, access to, and uptake of the benefit for families served. 6. By 2030, MDPH will design and implement a comprehensive survey on fatherhood experiences during pregnancy, birth, and the postpartum period —including cases of infant loss. The findings will be analyzed to inform strategies for more meaningful engagement and support, ensuring fathers are empowered as essential partners in maternal and child health.	3.1 Promote Contraceptive Access campaigns to increase knowledge of MA Contraceptive Access Laws and support informed decision-making as they apply to contraceptive care provided by pharmacists and health-center-based providers, and to the public seeking contraceptive care 3.2 Provide technical assistance and training among prenatal and postpartum providers to address the emerging needs of patients related to birth planning 3.3 Increase the sustainability of the sexual and reproductive health service delivery network in Massachusetts Focus Area 4. Improve access to maternal mental health services and supports 4.1 Work collaboratively with state and community partners (including Perinatal-Neonatal Quality Improvement Network (PNQIN) and MassHealth) to improve screening, assessment, and referral for treatment of perinatal mood and anxiety disorders 4.2 Provide technical assistance and training among prenatal and postpartum providers and families to raise awareness of perinatal mood and anxiety disorders 4.3 Conduct surveillance of perinatal mood and anxiety disorders (PMADs) including post-traumatic stress disorder (PTSD), PPD, Anxiety, Obsessive-Compulsion Disorder (OCD), and psychosis Focus Area 5. Expand knowledge of, access to, and uptake of economic supports and mobility opportunities for families in MA 5.1 Develop new and/or enhance existing tools, resources, and infrastructure to support increased knowledge of Paid Family Medical Leave (PFML) for health care providers, community providers, and families to increase support with and uptake of the PFML benefit			

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		5.2 Disseminate existing tools and resources on economic benefits and mobility opportunities, including but not limited to Paid Family and Medical Leave, Earned Income Tax Credits (EITC), Volunteer Income Tax Assistance sites (VITA), Baby Steps, WIC, SNAP, and Child and Family Tax Credits for MA families. Partner with economic benefit organizations and state agencies to provide quarterly trainings and/or offices hours on economic benefits/mobility opportunities to clinical and community-based professionals who work with pregnant and birthing families and families with young children Focus Area 6. Ensure Title V programs have strategies to improve Fatherhood Engagement 6.1 Analyze the Fatherhood Survey Responses 6.2 Partner with Children's Trust and the Massachusetts Fatherhood Collaborative to support and align engagement activities			
	7. By 2030, increase the percent of participants whose housing status was unstable at intake who gain stable housing during the program from 42% to 55%.	Focus Area 7. Expand engagement of parents under 26 to improve community health factor-related outcomes for families led by young caregivers 7.1 Support expanded parent engagement – Parent Advisories and Parent Ambassadors with the Mass Pregnant and Parenting Teen Initiative (MPPTI) 7.2 Explore sustainability funds for MPPTI and collaborate with other state programs serving parents under 26 7.3 Continue to implement whole family/two-generation approach to provide comprehensive case management to families under 26 addressing community health factors, including housing 7.4 Embed healing centered engagement in MPPTI	ESM HI-Pregnancy.1 - Massachusetts Pregnant Parenting Teen Initiative (MPPTI) participants gaining stable housing	NPM - Housing Instability - Pregnancy	**Linked NOMs:** Severe Maternal Morbidity Maternal Mortality Low Birth Weight Preterm Birth Stillbirth Perinatal Mortality Infant Mortality SUID Mortality Neonatal Abstinence Syndrome Postpartum Depression Postpartum Anxiety
Perinatal/Infant Health					
2. Perinatal/ Infant Health:	1A. By 2030, we will be	Focus Area 1. Improve system of care for infants whose families	ESM BF.1 - Number	NPM - Breastfeeding	**Linked NOMs:**

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Ensure all infants are born healthy and thrive in their first year of life, and reduce/eliminate variation in birth outcomes based on community health factors	collecting data regarding what services families with Infants with Prenatal Substance Exposure (IPSE) are being referred to and evaluating outcomes of those referrals, developing a plan to address gaps in services. All IPSE and their families will be offered a family care plan by the time they are discharged after delivery. 1B. By 2030, develop a cadre of 100 providers (clinicians and non-clinical, including peer workforce) implementing Mothering from the Inside Out, Circle of Security-Parenting, and other relational supports that strengthen parenting capacity alongside recovery capacity. 2. By 2030, increase breastfeeding duration at 6 months by 5% through targeted strategies and in partnership with key collaborators, as described in the Breastfeeding Strategic Plan. 3A. By 2030, have an operational Fetal and Infant Mortality Review (FIMR) conducting reviews of infant and fetal deaths and to draft actionable recommendations	are affected by parental substance use 1.1 Improve system of care for infants whose families are affected by parental substance use 1.2 Implement Infants with prenatal substance exposure (IPSE) learning collaborative 1.3 Building on FIRST (Families In Recovery SupporT) Steps Together, support an attachment-oriented lens within the system of care to promote infant and family safety and well-being Focus Area 2. Improve healthy infant growth and development through breastfeeding 2.1 Implement components of the statewide Breastfeeding Strategic Plan Focus Area 3. Reduce infant mortality and expand access to supports for families experiencing loss 3.1 Develop a Fetal Infant Mortality Review (FIMR) implementation plan, including collaboration with key partners, resources to manage and sustain a FIMR 3.2 Launch a safer sleep communications and training campaign with targeted outreach to parents with a Substance Use Disorder (SUD) 3.3 Increase awareness and access to bereavement support for families that have experienced a fetal or infant loss, as well as implement evidence-based prevention work	of women who receive Massachusetts' Paid Family and Medical Leave (PFML) bonding leave/medical leave for recovery from birth ***Inactive -*** *ESM BF.2 - Percent of WIC participants receiving services from a Breastfeeding Peer Counselor who exclusively breastfed for at least three months*		Infant Mortality Postneonatal Mortality SUID Mortality

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	3B. By 2030, have a set of up-to-date trainings and communication materials promoting safer sleep that are integrated and distributed through other Title V MCH initiatives 3C. By 2026, have a website that increases awareness of pregnancy loss resources, and establish baseline view counts; by 2030, increase views to the website by 10%.				
Child Health					
3. Child Health: Optimize the healthy development of all children so they can flourish and reach their full potential through safe, stable, and nurturing relationships and environments	1. By 2030, increase the percentage of children with and without special health care needs, ages 0 through 17, who have a medical home from 47.5% (2022-2023 data) to 57.5%.	Focus Area 1. Improve the capacity of the pediatric medical home and the community system of supports to provide a high-quality and integrated continuum of family centered care 1.1 Support integration of infant early childhood mental health (IECMH) services into pediatric primary care (i.e. training/professional development and resources to support IECMH, role of family partner, support building out of integrated care teams) 1.2 Increase connection between Medical Home & MCH programs (focus on home visiting and/or Early Intervention (EI), as well as early education and care via the in-development Child Care Health and Safety Consultation program, and services for children with special health needs.) 1.3 Promote Positive Childhood Experience (PCEs) and reduce Adverse Childhood Experiences (ACEs) for young children through data surveillance, linkage, and community engagement approaches to inform prevention strategies	ESM MH.1 - Capacity building of pediatric medical home, integrated into the community system of supports, to promote safe, stable, nurturing relationships and environments for children and their families	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
	2A. By 2030, Childhood Lead Poisoning Prevention Program	2. Reduce gaps in incidence of children and infants who experience elevated blood lead levels or lead poisoning	No ESMs were created by the State.	SPM 1: Financial resources for deleading	

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	(CLPPP) will leverage additional financial resources for deleading projects in high-risk communities by 15%.	2.1 Increase financial resources in high-risk communities for deleading homes	ESMs are optional for this measure.		
	2B. By 2030, lead testing increased by 5% in rural clusters.	2.2 Increase lead testing capacity in rural areas	No ESMs were created by the State. ESMs are optional for this measure.	SPM 2: Blood lead level testing in all rural clusters	
3. Child Health: Optimize the healthy development of all children so they can flourish and reach their full potential through safe, stable, and nurturing relationships and environments	3. By 2030, pediatric (ages 0-17) emergency department visits, hospitalizations, and deaths for unintentional poisonings decrease by 5%. 4. By 2030, the infrastructure for the MA Children's Vision Initiative will be established including integration into existing DPH MCH initiatives, initiation of a data surveillance plan, and shared priority setting with cross-state agency partners.	Focus Area 3. Expand awareness and sustainability of the Regional Poison Control Center to assist in the prevention, diagnosis, and management of poisoning 3.1 Design, implement and evaluate Poison Control Center community education offerings to the public and external partners that increase awareness of poison risks and poison center services by piloting trainings and gathering feedback from various MCH stakeholders 3.2 Integrate Poison Control Center community education initiatives into DPH programs serving MCH populations to ensure providers and care givers are aware of best practices to prevent and address accidental ingestion of toxins by children 3.3 Engaging partners to facilitate long-term program planning for and sustainability of the Poison Control Center Focus Area 4. Develop infrastructure to address gaps in children's vision outcomes 4.1 Build DPH capacity (staffing, funding, infrastructure) to establish a MA Children’s Vision initiative 4.2 Develop a plan to create a statewide vision surveillance / registry system 4.3 Create a cross-state agency collaboration focused on children's vision including (not limited to) partners such as MDPH, the Department of Elementary and Secondary Education			

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		(DESE), the Department of Children and Families (DCF), the Department of Transitional Assistance (DTA), the Department of Developmental Services (DDS), the Department of Early Education and Care (EEC), and MassHealth 4.4 Develop and implement policy agenda to support children's vision infrastructure including identifying regulations to update to address gaps in vision care and improve care coordination 4.5 Integrate children's vision care into existing MCH systems initiatives (Child Care Health and Safety Consultation Program, pediatric care, primary care, CYSHN initiatives, home visiting, school health centers and services, public health nurses etc.) by training providers on screening referrals (including rescreening), referral resources for eye exams, information about linkages with eye care providers 4.6 Increase public awareness on children's vision care (communication with families around vision screening and follow-up care); coordination among pediatric primary care providers and school systems)			
Adolescent Health					
4. Adolescent Health: Enhance strengths, skills, and supports to promote positive youth development and ensure youth are healthy and thriving	1. By 2030, increase the percentage of all high school students who were tested for a sexually transmitted disease (STD) other than HIV during the 12 months before the Youth Risk Behavior Survey (YRBS) from 5.6% (2023 data) to 15%. 2. By 2030, increase the percentage of School-Based Health Centers (SBHC) meeting the recommended number of behavioral health visits from 30% to 50%.	Focus Area 1. Improve sexual and reproductive health and well-being for adolescents 1.1 Adolescent Sexuality Education (ASE) program will focus re-procurement on embedding protective factors/Positive Youth Development (PYD)/mental health/caregiver engagement into programming and include key populations at risk for poor health outcomes 1.2 Sexual and Reproductive Health Program (SRHP) funded agencies serve adolescents with contraceptive counseling and STI testing/treatment 1.3 School-based health centers serve adolescents with preventive medical visits	ESM MHT.1 - School-Based Health Centers (SBHC) meeting recommended number of behavioral health (BH) visits	NPM - Mental Health Treatment	**Linked NOMs:** Adolescent Mortality Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Children's Health Status Adolescent Depression/Anxiety CSHCN Systems of Care Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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	3. By 2030, increase the percentage of division of Child/Adolescent Health and Reproductive Health (CARH) programs integrating youth voice into programming from 25% to 75%.	1.4 Support the Department of Elementary and Secondary Education's (DESE) rollout of the Comprehensive Health and Physical Education curriculum framework Focus Area 2. Improve youth mental health and substance use outcomes 2.1: Improve access to mental health and substance use services via several programs (School tele-behavioral health pilot; SBHCs; School Behavioral Health Workforce and Service Expansion (SBHE) grants; collaboration with MDPH's Office of Youth and Young Adult Services (OYYAS) within the Bureau of Substance and Addiction Services (BSAS) that will embed protective factors/positive youth development/mental health/caregiver engagement into programming and include key populations at risk for poor health outcomes 2.2 Ensure quality services through provider training, technical assistance and professional development for key populations at risk for poor health outcomes 2.3 Integrate and increase referrals for social services that address community health factors of mental health and substance use 2.4 Evaluate school behavioral health grant programs and develop a feedback mechanism for schools 2.5 School health manual revision and launch, which includes addressing mental/behavioral health issues in schools as well as information about mandated screenings (vision, hearing, height/weight, postural, substance use) 2.6 Partner with the attorney general's office to reduce cell phone use in schools to protect mental health and to collaborate on bullying prevention in schools to promote institutional excellence			

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		2.7 Support schools to improve school climate and foster belonging Focus Area 3. Strengthen systems for integrating youth voice into programming and implementing youth-led programming 3.1 Increase youth participation in program planning and evaluation through youth advisory board (YAB) and youth leadership opportunities and incorporate feedback loop with youth leaders			
Children with Special Health Care Needs					
5. Children and Youth with Special Health Needs: Strengthen systems of care for Children and Youth with Special Health Needs and their families	1. By 2030, increase the percentage of CYSHN who receive services to prepare for transition from 21.7% (NSCH, 2022-2023) to 30%	Focus Area 1. Support smooth transition from pediatric to adult health care 1.1 Work with providers to support CYSHN through transition 1.2 Establish and launch a marketing/outreach campaign to promote supportive transition to adult healthcare for youth/young adults with special needs 1.3 Integrate the voices of young adults with special health needs into the formation and maintenance of programs that serve CYSHN and adolescents across DPH.	ESM TAHC.1 - The CCATER Center will measure the percentage of enrolled providers who participate in a number of different transition-related activities including receiving TA, receiving resources and education, joining group discussions and collaboratives ***Inactive -*** *ESM TAHC.2 - Percent of youth ages 14 and older receiving services from the DPH Care Coordination Program who receive health transition information and support from their Care Coordinator*	NPM - Transition To Adult Health Care	**Linked NOMs:** CSHCN Systems of Care

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	2. By 20230, increase the percentage of children approved for short-term respite who received respite care in a pediatric skilled nursing facility-based (PSNF) setting from 62.9% (MRT program data FY24) to 70%.	Focus Area 2. Build a comprehensive system for pediatric respite for caregivers and families with CYSHN and children with medical complexity (CMC) 2.1 Increase the supply of pediatric short term & emergency respite beds as well as long term care beds in pediatric skilled nursing facilities (PSNFs) that meets the needs of CMC 2.2 Work with state elder and adult caregiver work groups and coalitions to expand their scope to include pediatrics, including those with comorbid CMC and behavioral/emotional dysregulation needs 2.3 Expand the respite care provider workforce	No ESMs were created by the State. ESMs are optional for this measure.	SPM 3: Percent of children approved for short-term respite who received respite care in a pediatric skilled nursing facility-based (PSNF) setting	
5. Children and Youth with Special Health Needs: Strengthen systems of care for Children and Youth with Special Health Needs and their families	3. By 2030, increase the percentage of children with autism who receive care in a well-functioning system of care from 2.7% (95% CI 0.00, 6.64) to 10%. 4. By 2030. reduce the percentage of caregivers who reported it was somewhat or very difficult to obtain the mental health treatment or counseling they needed for their child from 63.4%.	Focus Area 3. Shape a continuum of care (from evaluation to services to transition) for children with autism spectrum disorder and their families 3.1 Establish a coordinated and strategic approach to support children/youth with autism and their families within DPH 3.2 Establish a coordinated and strategic approach to support children/youth with autism and their families with sister agencies to examine larger system across the state Focus Area 4. Improve access to mental health supports and services for CYSHN 4.1 Increase resources that promote mental health and wellbeing 4.2 Strengthen mental health workforce for CYSHN 4.3: Advance the state's understanding of and response to CYSHN with Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections and Pediatric Acute Neuropsychiatric Syndrome (PANDAS/PANS) and Fetal Alcohol Spectrum Disorder (FASD) and their medical and mental/behavioral health needs			
5. Children and Youth with	5. By 2030, increase the	Focus Area 5. Ensure comprehensive and wrap-around services	ESM MH.1 -	NPM - Medical Home	**Linked NOMs:**

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Special Health Needs: Strengthen systems of care for Children and Youth with Special Health Needs and their families	percentage of CYSHN who receive care in a well-functioning system of care from 14.2% (NSCH, 2022-2023) to 20%.	for CYSHN and their families through a suite of interventions, including policy, technical assistance, referrals and enhanced care coordination. 5.1 Provide education, resources and connection to services and family supports for CYSHN, young adults, families, and community partners serving CYSHN, including strengthening collaboration with sister state agencies supporting these children including but not limited to DESE, EEC, Department of Mental Health (DMH), DCF, DDS, Department of Youth Services (DYS). 5.2 Provide enhanced care coordination services to CYSHN, including children with medical complexity 5.3 Advocate for access to appropriate durable medical equipment and technology	Capacity building of pediatric medical home, integrated into the community system of supports, to promote safe, stable, nurturing relationships and environments for children and their families		Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Cross-Cutting/Systems Building					
6. Cross-Cutting: Strengthen the MCH workforce to ensure families and communities are supported by high-quality providers that reflect the communities they serve across the MCH ecosystem	1. By 2030, DPH will develop a baseline of the number of births where a doula was present and provided support. 2. By 2028, 30 professionals working in programs that serve families seeking child care will receive up to date and comprehensive education on the licensed family child care model as a high quality child care option for families. 3. By 2030, develop a system for tracking the breadth and scope of behavioral health workforce for MCH populations. 4A. By 2030, maintain CHW	Focus Area 1. Community Birth Workforce 1.1: Expand the community birth workforce by launching education and continued education options in the state 1.2: Strengthen the lactation workforce by: supporting implementation of International Board Certified Lactation Consultant (IBCLC) licensure, improving lactation training for our WIC nutrition and paraprofessional staff, and development of community peer lactation counselors 1.3: Launch the Doula certification program and expand the number of certified doulas in MA Focus Area 2. Child Care workforce 2.1 Expanding knowledge of, access to, and economic empowerment for licensed family child care options Focus Area 3. Behavioral Health Workforce	No ESMs were created by the State. ESMs are optional for this measure.	SPM 4: Number of new home visitors trained	

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	presence in SBHC settings. 4B. By 2030, increase the number of MassHealth Tier 2 and Tier 3 integrated primary care providers who participate in DPH e-learning courses on integrating a lived experience professional within pediatric and family medicine primary care teams serving children birth-five. 5. By 2030, we will train 200 new home visitors to increase supports for families with young children. 6A. By 2030, present to 100% of BSN programs in the state on local public health, including the CYSHN program. 6B. Increase the number of CCATER technical assistance activities provided to MassHEalth CARES for Kids providers from 15 annually (in FY24) to 30 annually. 7A. By 2030, increase LPHs ability to meet community needs for MCH Foundational Public Health Services Foundational Area by 10%. 7B. By 2030, there will be a 10% increase in LPH entities	3.1 Support behavioral health service and workforce expansion by providing funding and technical assistance to schools and community-based providers 3.2 Build healing environments through adoption of program and policy requirements with a special focus on survivors 3.3 Promote service delivery transformation with lived experience professionals (e.g. Family Recovery Support Specialists) by continuing to strengthen the peer recovery workforce amongst the FIRST STEPS Together program 3.4 Improve workforce capacity to support priority populations through professional development Focus Area 4. Primary Care Workforce 4.1 SBHC-Expanded CHW support working in collaboration with the office of the CHW to help support more appropriate supervision and resources for this role 4.2 Develop and implement a strategy to support pediatric primary care practices to integrate a team member who reflects the community they serve to provide a continuum of care to children birth to five Focus Area 5. Home Visiting Workforce 5.1 Develop and implement a strategy to support workforce retention and wellness for home visitors, such as offering opportunities related to cross training (e.g., CLC, recovery coaching, doulas, etc.), IECMH, or supports (e.g., salary) Focus Area 6. CYSHN and caregiver workforce 6.1 The UMass Local Public Health Nurse Consultant Program will be including the Children and Youth with Special Health Needs			

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	reporting a moderate or complete level of expertise in FPHS Capabilities related to workforce development. 7C. By 2030, maintain the number of programs supported with capacity building, training, and technical assistance for organizations serving survivors of sexual and domestic violence (SDV).	Workforce (pedi homecare specialty) into our recruitment strategy of presenting for every Bachelor of Science in Nursing (BSN) student in MA 6.2 In partnership with MassHealth, expand the Care Coordination, Assistance, Training, Education & Resource (CCATER) Center to continue to provide training and technical assistance on an enhanced care coordination model to MassHealth CARES for Kids providers of children with medical complexity and their care coordination teams 6.3 Provide accessible health training resources and education to school nurses to support their capacity to care for students with special healthcare needs 6.4 Expand respite care provider workforce (See Focus Area 2 in FY26 CYSHN Application Year narrative) Focus Area 7. Support increased training and capacity building for the local public health clinical workforce 7.1: Increase skills and knowledge of LPH for implementation of Foundational Public Health Services (FPHS) to work toward achieving the performance standards 7.2 Provide training for all LPH clinical workforce to achieve optimal health for the populations served and improve recruitment and retention of staff serving local communities 7.3 Capacity building programs for organizations serving survivors of sexual and domestic violence (SDV)			
7. Cross-Cutting: Strengthen MA state approach of including MCH needs with emergency preparedness and response efforts and embedding a preparedness lens within MCH programs	1. By 2030, establish a foundational Continuity of Operations Plan (COOP) that will guide DPH response for MCH special populations 2A. By 2023, increase the	Focus Area 1. Establish a MA Title V emergency planning and preparedness workgroup 1.1 Institute Continuity of Operations Plans (COOP) and Disaster Recovery Plans aligned with MDPH and other Program Efforts 1.2 Develop internal and external tools to support families around	No ESMs were created by the State. ESMs are optional for this measure.	SPM 5: Number of MCH serving programs that integrate the MDPH Emergency Continuity of Operations Plans (COOP)	

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	number of families who receive support from MCH population-serving programs 2B. By 2030, continue to fund at least 50 housing stabilization units for survivors of intimate partner violence and their children	emergency preparedness planning. Focus Area 2. Enhance an integrated approach in response to the housing crisis for special MCH populations 2.1 Housing for homeless youth and young adults 2.2 Support Changes to Emergency Assistance (EA) System working with the Executive Office of Housing and Livable Communities (EOHLC) to support changes to EA 2.3 Focus on housing for families with CYSHN (lack of housing and accessible housing) 2.4 Residential and housing stabilization programs for survivors of domestic violence and their children 2.5 Identify opportunities for systems and policy actions to improve housing for special MCH populations			