New York State Action Plan Table 2025 Application/2023 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					
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	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)	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.	ESM WWV.1 - Percent of Maternal and Infant Community Health Collaboratives (MICHC) program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker (CHW) ESM WWV.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year	NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

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					NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression,

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					Formerly NOM 24) - PPD
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.	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)	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.	ESM WWV.1 - Percent of Maternal and Infant Community Health Collaboratives (MICHC) program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker (CHW) ESM WWV.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year	NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
					NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression, Formerly NOM 24) - PPD
Address equity, bias, quality of care, and barriers to access in	Increase the percentage of individuals receiving postpartum visits: a) establish baseline percentage and propose a percentage increase for	The NYS Title V Program is working to ensure postpartum visits through a number of our current strategies and activities. The work to review current initiatives, identify gaps, and develop strategies and activities to improve postpartum visits is just beginning in the current grant. We will report on more robust strategies and activities in next year's application.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023	NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B)	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.

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health care services for women and families, especially for communities of color and low-income communities	individuals who attended a postpartum checkup within 12 weeks after giving birth; and b) similarly for individuals who attended a postpartum checkup and received recommended care components.		annual report.	Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV	
Perinatal/Infant Health					
Address transportation barriers for individuals and families.	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)	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.	ESM RAC.1 - Percent of birthing hospitals with final level of perinatal care designation, in accordance with updated regulations and standards	NPM - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) (Risk-Appropriate Perinatal Care, Formerly NPM 3) - RAC	NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related
Increase awareness of resources and services in the community	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	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.		SPM 1: Percent of samples received by the State Newborn Screening lab within 48 hours of collection	

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among families and the providers who serve them.	samples received within 48 hours of collection by September 2023. (Newborn Blood Spot data)				
Child Health					
Increase access to affordable fresh and healthy foods in communities.	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).	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.	ESM PA-Child.1 - Percent of children and youth enrolled in School Based Health Centers (SBHCs) who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a SBHC within the past year.	NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day (Physical Activity, Formerly NPM 8.1) - PA-Child	NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS
Address community and environmental safety for children, youth, and families.	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	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	ESM PA-Child.1 - Percent of children and youth enrolled in School Based Health Centers (SBHCs) who have documentation of anticipatory guidance that includes physical	NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day (Physical Activity, Formerly NPM 8.1) - PA-Child	NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

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	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).	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.	activity and nutrition during a visit to a SBHC within the past year.		(Obesity, Formerly NOM 20) - OBS
Enhance supports for parents and families, especially those with children with special health care needs, and inclusive of all family members and caregivers	Establish baseline percentage and propose a percentage increase of children with and without special health care needs, ages 0 through 17, who have a medical home.	The NYS Title V Program is working to ensure postpartum visits through a number of our current strategies and activities. The Child Health Domain Team will review data from the five (5) National Survey of Children's Health components that inform the Medical Home NPM: usual source of sick care, personal doctor or nurse, family-centered care, no problems getting referrals, and effective care coordination when needed. Upon review, annual objectives and strategies will be identified for the FY 2026 Application. Where possible, these activities will align with the Blueprint for Change.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Adolescent Health					
Cultivate and enhance social support and social cohesion opportunities for individuals and families who experience	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	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"	ESM AWV.1 - Percent of youth-serving programs that provide training on adult preparation subjects, such as accessing health insurance, maintaining their routine preventive medical visits, healthy	NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle

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isolation as a result of systemic barriers including racism, across the life course	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)	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.	relationships, effective communication, financial literacy, etc. ESM AWV.2 - Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation		NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu

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					NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB
Children with Special Health Care Needs					
Enhance supports for parents and families, especially those with children with special health care needs, and inclusive of all family members and caregivers	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	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	ESM TR.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	NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

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	care in a well-functioning system by 5%, from 15.2% in 2017-2018 to 16% in 2021-2022 (NSCH)	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.	appointment.		
Increase the availability and quality of affordable housing.	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)	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.		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	
Promote awareness and enhance availability, accessibility and coordination of services for families and youth, including CYSHCN, with a focus on areas impacted by	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	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	ESM TR.1 - Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.	NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

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systemic barriers, including racism	16% in 2021-2022 (NSCH)	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.			
Enhance supports for parents and families, especially those with children with special health care needs, and inclusive of all family members and caregivers	Establish baseline percentage and propose a percentage increase of children with special health care needs, ages 0 through 17, who have a medical home.	The NYS Title V Program is working to ensure Medical Homes for children visits through a number of our current strategies and activities. The Child and Youth with Special Health Care Needs Domain Team will review data from the five (5) National Survey of Children's Health components that inform the Medical Home NPM: usual source of sick care, personal doctor or nurse, family-centered care, no problems getting referrals, and effective care coordination when needed. Upon review, annual objectives and strategies will be identified for the FY 2026 Application. Where possible, these activities will align with the Blueprint for Change.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.