

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
<b>Women/Maternal Health</b>					
<p>Support the health and well-being of women throughout pregnancy and postpartum periods</p>	<p>Objective WMH-1: Increase the percent of women who attended a postpartum checkup within 12 weeks of giving birth by 4%, from 91.3% in 2025 to 95% in 2030. (PRAMS)</p> <p>Objective WMH-2: Increase the percent of women who attended a postpartum checkup and received recommended care components from by 10%, from 67.2% in 2025 to 74.2% in 2030. (PRAMS)</p>	<p>Strategy WMH-1: Support perinatal home visiting services for pregnant and postpartum women.</p> <p>Strategy WMH-2: Support comprehensive, confidential family planning reproductive health services before and after pregnancy.</p> <p>Strategy WMH-3: Support Sexual Violence programs that prevent and respond to sexual violence as a key factor that affects women’s health and well-being.</p> <p>Strategy WMH-4: Provide pregnant and postpartum women, their families, and community members with accurate information to promote preconception, prenatal, and postpartum health and use of health care services, including mental health and reproductive health care.</p> <p>Strategy WMH-5: Maintain and enhance a statewide perinatal regionalization system to ensure that pregnant, intrapartum, and postpartum women and newborns receive high quality, risk-appropriate care, including a specific focus on maternal health, morbidity, and mortality.</p> <p>Strategy WMH-6: Through the Perinatal Quality Collaborative (NYSPQC), engage birthing facilities and other partners in structured quality improvement projects to improve health care services and outcomes for pregnant, intrapartum, and postpartum women.</p> <p>Strategy WMH-7: Convene, facilitate, and/or participate in partnerships to improve postpartum visits, health, and well-being.</p> <p>Strategy WMH-8: Apply population health data to support clinical and public health actions that promote maternal health.</p>	<p>ESM PPV.1 - Percent of regular Big 6 Postpartum Visit peer learning meetings attended with active participation in presenting and/or responding to peer discussions.</p> <p>ESM PPV.2 - Percent of Perinatal and Infant Community Health Collaboratives (PICHC) clients who attended a postpartum visit within 12 weeks after giving birth.</p>	<p>NPM - Postpartum Visit</p>	<p><b>Linked NOMs:</b>                      Maternal Mortality                      Neonatal Abstinence Syndrome                      Women's Health Status                      Postpartum Depression                      Postpartum Anxiety</p>

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<b>Perinatal/Infant Health</b>					
Ensure risk-appropriate care for infants	Objective PIH-1: Increase or maintain the percent of very low birth weight infants born in a hospital with a Level III+ NICU by 1%, from 92.3% in 2025 to 93.4% by 2030.	<p>Strategy PIH-1: Support perinatal home visiting services for families with infants and young children.</p> <p>Strategy PIH-2: Provide families with accurate information to promote infant health, development, and use of health care services.</p> <p>Strategy PIH-3: Maintain and enhance the statewide perinatal regionalization system to ensure that pregnant women and newborns receive high quality, risk-appropriate care, including a specific focus on infant morbidity and mortality.</p> <p>Strategy PIH-4: Maintain robust statewide population-based Newborn Bloodspot Screening and Newborn Hearing Screening Programs.</p> <p>Strategy PIH-5: Through the Perinatal Quality Collaborative (NYSPQC), engage birthing facilities and other partners in structured quality improvement projects to improve health care services and outcomes for infants.</p> <p>Strategy PIH-6: Convene, facilitate, and/or participate in cross-sector and interdisciplinary partnerships to enhance coordination of services and improve health outcomes for infants and their families.</p> <p>Strategy PIH-7: Apply population health data to support clinical and public health actions that promote infant health.</p>	ESM RAC.1 - Percent of birthing hospitals re-designated with updated standards	NPM - Risk-Appropriate Perinatal Care	<p><b>Linked NOMs:</b></p> <p>Stillbirth</p> <p>Perinatal Mortality</p> <p>Infant Mortality</p> <p>Neonatal Mortality</p> <p>Postneonatal Mortality</p> <p>Preterm-Related Mortality</p>
<b>Child Health</b>					
Promote healthy play and nutrition for all children	Objective CH-1: Increase the percent of NYS children age 6-11 who are physically active at least 60 minutes per day by 5%, from 24.3% in 2025 to 25.5% in 2030. (NSCH)	Strategy CH-5: Through the SBHC program, implement both clinical practices and community partnerships that promote healthy active play and physical activity.	<i>Inactive - ESM PA-Child.1 - Percent of children and youth enrolled in School Based Health Centers (SBHCs) who have documentation of anticipatory guidance</i>	NPM - Physical Activity - Child	<p><b>Linked NOMs:</b></p> <p>Children's Health Status</p> <p>Child Obesity</p>

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			<p>that includes physical activity and nutrition during a visit to a SBHC within the past year.</p> <p>ESM PA-Child.2 - Percent of School Based Health Centers (SBHCs) operators that have 3 or more partnerships to promote physical activity.</p>		
Promote comprehensive patient-centered health care for children	Objective CH-2: Increase the percent of children ages 0 through 17 who have a medical home by 11%, from 45.2% in 2025 to 50.0% in 2030. (NSCH)	<p>Strategy CH-1: Support a statewide School-Based Health Center (SBHC) program to provide comprehensive, evidence-based, patient-centered primary and preventive health care services - including medical, mental, and dental care - to children in low-income communities.</p> <p>Strategy CH-2: Promote health insurance enrollment and primary health care utilization for children through all child-serving Title V Programs.</p> <p>Strategy CH-3: Provide families with accurate information to promote children's health, development, and use of health care services.</p> <p>Strategy CH-4: Apply population and program-specific health data to support clinical and public health actions that promote child health.</p>	<p>ESM MH.1 - Percent of students attending schools that have School Based Health Centers (SBHCs) who are enrolled in the SBHC program</p> <p>ESM MH.2 - Percent of regular Big 6 medical home for CYSHCN peer learning meetings attended with active participation in presenting and/or responding to peer discussions.</p>	NPM - Medical Home	<p><b>Linked NOMs:</b></p> <p>Children's Health Status</p> <p>CSHCN Systems of Care Flourishing - Young Child</p> <p>Flourishing - Child Adolescent - CSHCN</p> <p>Flourishing - Child Adolescent - All</p>

## Adolescent Health

Support physical and mental health and health care for adolescents	Objective AH-1: Increase the percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling by 5%, from 86.8% in 2025 to 91.2% in 2030. (NSCH)	<p>Strategy AH-1: Support a statewide School-Based Health Center (SBHC) program to provide comprehensive, evidence-based, patient-centered primary and preventive health care services - including medical, mental, health, and dental care - to adolescents in low-income communities.</p> <p>Strategy AH-2: Partner with the NYS Office of Mental Health Project</p>	<p>ESM MHT.1 - Percent of DFH-funded adolescent-serving programs that receive mental health-related trainings and</p>	NPM - Mental Health Treatment	<p><b>Linked NOMs:</b></p> <p>Adolescent Mortality</p> <p>Adolescent Suicide</p> <p>Adolescent Firearm Death</p> <p>Adolescent Injury Hospitalization</p> <p>Children's Health Status</p>
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		<p>TEACH program to enhance primary care provider capacity for providing mental health services in SBHCs and other youth-serving programs statewide.</p> <p>Strategy AH-3: Incorporate information and resources to promote the physical, mental, and behavioral health and wellness of adolescents across all youth-serving Title V programs.</p> <p>Strategy AH-4: Establish a Youth Advisory Group to directly inform and participate in Title V youth programs, policies, and initiatives.</p> <p>Strategy AH-5: Analyze and apply quantitative and qualitative data on adolescent health behaviors, service utilization, and outcomes to drive Title V youth-serving initiatives and programs.</p>	resources.		Adolescent Depression/Anxiety CSHCN Systems of Care Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

**Children with Special Health Care Needs**

Promote comprehensive patient-centered care for CYSHCN	Objective CYSCHN-1: Increase the percent of children with special health care needs, ages 0-17, who have a medical home by 5%, from 40.4% in 2025 to 42.44% in 2030	<p>Strategy CYSHCN-1: Support Local Health Department (LHD)-based CYSHCN programs to provide comprehensive assistance to CYSHCN and their families</p> <p>Strategy CYSHCN-2: Work with SBHCs to provide best practice care for children with chronic medical and developmental needs and coordinate with specialty providers as needed.</p> <p>Strategy CYSHCN-3: Through LHD-based Lead Poisoning Prevention Programs and Regional Lead Resource Centers, ensure that children with lead poisoning receive timely and appropriate medical and environmental follow-up services.</p> <p>Strategy CYSHCN-4: Convene, facilitate, and/or participate in collaborative partnerships to advance implementation of the medical home model for children and youth with special health care needs (CYSHCN).</p> <p>CYSHCN-5: Directly engage CYSHCN and their families in state and local efforts to improve practices, services, and systems to support them.</p> <p>Strategy CYSHCN-6: Apply public health surveillance and data analysis findings to improve services and systems related to health and health care</p>	ESM MH.1 - Percent of students attending schools that have School Based Health Centers (SBHCs) who are enrolled in the SBHC program ESM MH.2 - Percent of regular Big 6 medical home for CYSHCN peer learning meetings attended with active participation in presenting and/or responding to peer discussions.	NPM - Medical Home	<b>Linked NOMs:</b> Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
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<p>Support transition for youth with special health care needs to adult roles and care</p>	<p>Objective CYSCHN-2: 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 20.3% in 2025 to 21.3% in 2030. (NSCH)</p>	<p>for CYSHCN.</p> <p>Strategy CYSHCN-7: Support local and regional programs to support transition of youth with special health care needs, based on the evidence-based Got Transition® model.</p> <p>Strategy CYSHCN-8: Facilitate partnerships between the CYSHCN Program and other youth-serving programs and agencies to identify and implement practices for holistically addressing broader health needs of CYSHCN as emerging adults.</p>	<p><i>Inactive - ESM TAHC.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.</i></p> <p>ESM TAHC.2 - Percent of individuals ages 14-21 with sickle cell disease who had subsequent transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.</p>	<p>NPM - Transition To Adult Health Care</p>	<p><b>Linked NOMs:</b> CSHCN Systems of Care</p>