Maternal and Child Health Services Title V Block Grant

New York

FY 2017 Application/ FY 2015 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

NEW YORK STATE OF OPPORTUNITY. | Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

July 15, 2016

Michele Lawler, MS, RD, Director
Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Administration
Room 5C-26, Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

Dear Ms. Lawler:

With this letter, I transmit New York's FFY 2017 Maternal and Child Health Services Block Grant Application and FFY 2015 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,

Lauren J. Tobias
Director, NYS Title V Program and
Director, Division of Family 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 C of the 2015 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 "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

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

Each year, states submit an application and report in accordance with MCHB guidance. This year's application from NYS reflects our continued leadership and commitment to protect and promote the health of women, infants, children and families, within the context of a changing health care landscape, the continued adoption of a life course perspective and a focus on data-driven, evidence-based public health interventions. As an interim application, this application reflects a more in-depth analysis of State and National data as well as evidence-based and promising strategies to refine NY's Title V State Action Plan. The Action Plan for 2016-20 submitted in this application reflects significant work over the past year to develop measurable objectives, defined strategies, National Performance and Outcome Measures, Evidence-Informed Strategy Measures and State Performance Measures as required for the eight core MCH priorities across six MCH population health domains: maternal and women's health, perinatal and infant health, child health, adolescent health, children with special health care needs and cross-cutting life course. NY's application reflects the ongoing commitment of NY's Title V program, DOH and key MCH partners as well as significant input from families, providers and other key stakeholders across NYS.

The eight priorities selected by NYS include:

1. Reduce maternal mortality & morbidity
2. Reduce infant mortality & morbidity
3. Support and enhance social-emotional development and relationships for children and adolescents
4. Increase supports to address the special health care needs of children and youth
5. Increase the use of preventive health care services across the life course
6. Promote oral health and reduce tooth decay across the life course
7. Promote supports and opportunities that foster healthy home and community environments.
8. Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH populations

Within the NYSDOH, Title V activities are led by the Division of Family Health (DFH). As the Title V program, DFH provides 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 NY's Title V program is to ensure the needs of the MCH population are addressed through key policy initiatives, including the implementation of the Affordable Care Act (ACA) and Medicaid Redesign in NYS, as reflected throughout the application.

Under Title V leadership, a comprehensive process was convened to refine NY's MCH needs assessment and action plan. Cross functional teams from across the DFH were formed for each of NY's MCH priorities. Using NY's Interim State Action Plan as a starting point, the teams conducted in-depth analyses of data to enhance an understanding of the selected MCH priority areas, identified baseline data and refined targets for NY's Title V priorities; and, identified evidence based practice and recommendations for strategies to achieve the selected objectives. The teams presented their findings to a larger DOH work facilitated discussions to refine the State Action Plan.

A unique aspect of this process was a partnership with the HRSA-funded National MCH Development Center at the University of North Carolina that served as an invaluable resource to identify information, tools and resources to gain a better understanding of MCH needs and priorities as well as potential strategies to address these priorities. The Center also worked with Title V to develop and enhance skills in Title V staff to build NY's "MCH Leaders of Tomorrow" to support and promote MCH leaders of the future in NYS.

To further strengthen NY's State Action Plan, input was obtained from the MCHSBG Advisory Council, Parent to Parent of NYS and other key partners including the Schuyler Center for Advocacy and Analysis (SCAA), American Academy of Pediatrics (AAP); American Congress of Obstetricians and Gynecologists (ACOG); Prevent Child Abuse NY, Docs for Tots, New York State Association of County Health Officials, and others providers and key stakeholders.

Key products of the process described above include a MCH NA Summary Update and a 5-year MCH Action Plan for NYS. Key elements including accomplishments and emerging issues, challenges and plans are highlighted below for each of the six MCH population domains.

Domain 1 – Maternal/Women's Health

Health care coverage is a significant factor in making health care accessible and available to women. Through the NY State of Health, the state's official health plan Marketplace, NY continued its efforts to enroll all New Yorkers into comprehensive health care coverage. All Title V programs also prioritize engaging all women into health care coverage.

Title V leads efforts to improve the health of women in NYS with an essential element of this being women's ability to control their reproductive health. NYS has had a long-standing commitment to ensuring all women have access to comprehensive reproductive health care through programs such as the comprehensive system of family planning services and generous health benefits such as the Family Planning Benefit Program that includes presumptive eligibility. NY is a leader in increasing access to Long Acting Reversible Contraception (LARC), the most effective means of birth control through quality improvement efforts with family planning providers and through efforts such as NY's Infant Mortality COIIN project as well as NY's participation in CDC's 6/18 initiative to promote health and prevent unintended pregnancies.

NY has made great strides in improving birth outcomes, but striking disparities remain. Key outcomes of concern are high rates of unintended pregnancy and short birth intervals, stagnant rates of early prenatal care, and high rates of maternal mortality/morbidity. Improving preconception/ interconception health, including pregnancy planning and prevention, are key to achieve further improvements. Successes include robust surveillance systems, generous Medicaid coverage, a statewide maternal mortality review system, effective clinical quality improvement models, evidence-based community health initiatives, strong partnerships with key stakeholders and ongoing involvement with health reform initiatives. NY's State Action Plan addresses priority areas, building on strong partnerships, to strengthen and expand maternal mortality/morbidity reviews and develop improved mechanisms to apply findings to address key factors identified, improving the health of women including engaging women into health insurance, integrating preconception/interconception health into routine women's health care, developing strategies to address NY's increasing opioid use epidemic and developing collaborative strategies to address maternal depression.

Domain 2 – Perinatal/Infant's Health

Infant mortality has been steadily declining, but striking disparities remain. An ongoing concern for infant health is increasing rates of neonatal abstinence syndrome resulting from opiate abuse. In addition, developing strategies for new and emerging public health issues such as zika virus challenges the system. Key accomplishments include a statewide system of regionalized perinatal care, strong community-based perinatal services including evidence-based home visiting, clinical quality improvement initiatives with birthing hospitals, involvement in the national COIIN initiative to decrease infant mortality, involvement with health care reform and strong partnerships to promote improved health outcomes. NY's Action Plan includes Title V leadership to update perinatal regionalization standards to enhance the quality of care provided in these facilities and ensuring the system is facile enough to evolve in the changing health care landscape in NYS, develop performance measures to promote quality improvement and ongoing assessment of levels of perinatal care, increasing access to evidence-based home visiting services, among others. Collaborative efforts will be enhanced or developed to improve important perinatal practices such as improving clinical quality of care, and to address new and emerging health issues such as maternal opioid use improve perinatal outcomes.

Domain 3 – Child Health

The majority of NY's children are in good health, with declining mortality and hospitalization rates and high rates of health insurance coverage. A major priority of Title V is the social-emotional and behavioral health needs of children. In addition, while most children receive annual well child visits, elements of care such as developmental screening need improvement. Key accomplishments include efforts to address the social-emotional needs of children in partnership with key stakeholders such as the Early Childhood Advisory Council and Early Intervention Coordinating Council, generous public health insurance options, rich networks of health care providers including the largest School Based Health Center (SBHC) program in the nation, and strong public health programs to promote physical activity and provide access to nutritious meals. A key challenge to achieve further improvements in child health is to strengthen collaboration across child-serving programs, as these are spread throughout DOH and other State agencies. In addition to continuing support for core programs including home visiting and SBHCs, NY's Action Plan addresses the need to promote and increase development screening for all NY's children, and to develop new collaborative strategies to support children's social-emotional health using a strength-based approach to building on assets, as well as to improve engagement of vulnerable families in high quality primary health care.

Domain 4 – Children with Special Health Care Needs (CSHCN)

Although the majority of NY's children are insured, families of CSHCN continue to report lack of consistent health care coverage, inadequate coverage and lack of care coordination to meet special needs. In addition, adolescents with special needs remain challenged with navigating health care coverage and services as they transition to the adult care system. Key accomplishments include extensive health insurance options, comprehensive early intervention services for infants and toddlers with developmental delays and disabilities, extensive engagement of Title V staff in developing and implementing Health Home for children, family representation on key advisory groups, and funding for local health department-based services for families of CSHCN. However, parents have reported that the myriad of services available to CSHCN and their families are at times challenging to understand and access, while there remains significant gaps in some services or services in areas of NYS. NY's Action Plan highlights a systems-mapping initiative to identify strengths, gaps and barriers in a comprehensive manner in order to set future direction for Title V in this arena, continued strong engagement with Medicaid to support successful implementation of Health Home for children, enhancing policy and supports for children with Autism Spectrum Disorders, focused improvement projects to enhance family support practices within Early Intervention and disseminate best practices to other Title V programs, and seeking ways to enhance bi-directional communication with and from parents of CSHCN and adolescents with special needs to facilitate their transition to the adult health care system.

Domain 5 – Adolescent Health

NY's Title V program has been a national leader in building comprehensive systems for adolescents including access to confidential reproductive health services and delivery of evidence-based programming to improve adolescent health including a strong focus on positive youth development. NY's teen pregnancy rate has reached an all-time low, though disparities remain. The social-emotional well-being of NY's adolescents has been highlighted as a Title V priority, recognizing the stagnant or slightly worsening rates of suicide in the adolescent population. Additionally, health care providers with expertise in adolescent health are limited and utilization rates for preventive health care visits decline in adolescence. Mental health, suicide, sexual violence and bullying are significant persistent and emerging issues for adolescents. Key successes in NYS include strong networks of youth-serving providers including SBHCs and community-based programs, policies that support access to health insurance and confidential health care services, and strong technical support for evidence-based programming through state-academic partnerships/ Centers of Excellence. NY's Action plan includes strengthening partnerships and developing new collaborative strategies to support adolescents' social-emotional health using a strength-based approach to building on assets, to promote healthy relationships, wellness, health literacy and support transition to adult roles in adolescent health initiatives.

Domain 6 – Cross-Cutting/Life Course

Throughout NY's needs assessment, several cross-cutting themes emerged, including oral health, health insurance coverage and use of preventive health care services, community environments that support health and striking disparities in most health outcomes. Key successes include new investments to maintain and expand community water fluoridation, continued funding for school-based preventive dental services, support for "place-based" health promotion initiatives that span MCH, chronic disease and environmental health, including efforts to address social determinants of health.

Throughout this application, racial, ethnic, economic and geographic disparities are highlighted for virtually all MCH outcomes and factors assessed. Disparities is not limited to race and ethnicity. Rather, economic status, geography, language, and other factors such as health literacy can have a significant impact on the health status of NY's MCH population.

NY's Action Plan emphasizes the need for stronger collaborations with partners and stakeholders, and concerted efforts and new approaches to develop and implement new strategies in this area, including engaging partners at the community level to identify and develop lasting changes to address home and community issues as well as promoting health equity to address NY's significant and long-standing health disparities.

II. Components of the Application/Annual Report

II.A. Overview of the State

As of 2015, New York State (NYS) has the fourth largest population after California, Texas and Florida with a population of 19.8 million. NYS is a very diverse state with a substantial portion of its population being members of racial and ethnic minorities. Compared to the national population, in 2014, a larger percentage of NYS' population is Black (17.6% NYS; 13.2% US); Asian (8.5% NYS; 5.4% US); and Hispanic (18.6% NYS: 17.4% US). NYS also has a significantly higher foreign-born population (22.3% NYS: 13.1% US-2010-2014 data), and larger population speaking a language other than English at home (30.2% State: 20.9% US-2010-2014 data). NYS's cultural diversity is both a strength and challenge. Racial and ethnic minorities often have poorer quality health care than white Americans, even when they are able to access insurance. A priority for NYS is to ensure that health care systems meet the needs of diverse populations at all levels to promote equity in health care and eliminate disparities in health access and outcomes.

In 2010-14, the percent of New Yorkers who graduated from high school is slightly below the national level (85.4% versus 86.3% US), while the percentage with a bachelor's degree or higher is higher (33.7% versus 29.3%). NY's per capita income in the past 12 months (2014 dollars – 2010-14) is higher than the national average ($32,829 versus $28,555 US), and NY's median household income for 2010-14 is also higher ($58,687 versus $53,482). However, the State's percentage of persons below the poverty level percent during that same period is less than the national percentage (15.9% versus 14.8%). Educational attainment has a major impact on income and is a significant factor in access and quality of health care. Poverty is also associated with poor health outcomes, especially for women and children. Racial and ethnic minorities are significantly impacted by lower educational attainment and poverty in NYS.

NYS' population is dense; in 2010 there were 411 persons per square mile in NYS, compared to 87 in the US. New Yorkers are more likely to live in urban areas than residents of other states. 64 % of NYS's population live in the NY Metropolitan area; 43% in New York City (NYC) alone. NYS is also geographically diverse; population density varies widely, from 69,467 persons per square mile in Manhattan to only three persons per square mile in Hamilton County in the Adirondack Mountain Range; NYC is 104 times more densely populated than the rest of the state. Population density often determines the number and types of health services in an area.

NYS has a rich system of health care. NYS has the fourth-highest ratio of physicians to residents in the nation, with approximately 360 physicians per 100,000 residents, compared to a national average of 271 per 100,000. NYS also has 40% more specialists per capita than other states and 22% more primary care physicians per capita than average. NYS is home to more than 2,500 outpatient hospital and free standing health clinics, including over 60 FQHCs with approximately 600 sites throughout NYS; 226 school-based health center clinics; and 178 family planning clinic sites. In addition, NY has over 220 hospitals. Despite the substantial health care resources, many areas of the state lack access to needed services due to a maldistribution of resources. As of April 2016, there were 179 primary care Health Professional Shortage Areas (HPSAs) in NYS, 133 dental HPSAs; and 152 mental health HPSAs. Of the total HPSAs, about 38% of HPSAs are located in metropolitan areas; 62% are in rural or mostly rural (non-metropolitan) areas.

At the inception of the Medicaid Redesign efforts, NYS's Medicaid (MA) Program, once the nation's largest, was spending nearly $53 billion to serve five million people, which is twice the national average when compared on a per recipient basis. There was increasing recognition that payment reform was necessary to shift the payment incentives from expensive facility-based care to keeping people healthy, including management of chronic diseases in ambulatory settings. To better serve patients in the right setting at the right price, NYS has invested in hospital programs, including outpatient clinics, ambulatory surgery, and emergency room; physicians' fees; primary care; freestanding programs; and mental hygiene enhancements.

In 2011, Governor Cuomo launched the Medicaid Redesign Team (MRT), an innovative effort to collaborate with stakeholders and implement reform of NY's MA program to reduce costs while simultaneously improving quality of

care. In doing so, NYS embraces the Center for Medicare and Medicaid (CMS) services triple aim for delivery reform, including improving the quality of care; improving health by addressing root causes of poor health; and reducing per capita costs. The MRT utilized an intensive stakeholder engagement process to develop a plan to reduce costs in NY's MA program while also focusing on improving quality and implementing reforms. The mission, scope and expertise of the Title V program well positions staff to provide leadership, subject matter expertise and engage key MCH stakeholders to ensure that the needs of NY's most vulnerable population including mothers, children and families are addressed through policy reforms.
The MRT plan includes:

- Care Management for All: NY is moving away from a fee-for-service payment structure that is volume driven to more value driven payment and coordination of care. As a result, the MRT has set NY on a multiyear path to "care management for all." The state has expanded enrollment in the MA Managed Care Program (MMCP) by requiring many of the high need populations which were previously exempted or excluded, to enroll in managed care plans. The MMCP provides an organized system of care, an accountable entity and the ability to coordinate and manage care. The Title V program has provided significant support to OHIP to plan for the transition of MCH services into managed care including MA waiver programs for children, medically fragile children, children in foster care and school-based health services.

- Health Homes: a care management model that will be initiated in 2016 that serves high-need/high-cost MA populations with expanded care coordination capabilities.

- Global MA Spending Cap: established a two-year state-share dollar cap and a four-year state-share spending cap, monitoring MA expenditures more closely than ever before. A global spending report is published to the MRT website monthly so the public can track performance.

Over 230 separate reform initiatives of MRT have been or are still being implemented. The Title V program developed several MRT proposals to enhance services for the MCH population and partners with OHIP to support MCH-related implementation issues, including an intensive collaboration to develop a children's health home initiative to provide enhanced care coordination for children with chronic physical and behavioral health needs. Since the inception of MRT in 2011, per recipient spending has been reduced by approximately 10 %, bringing spending in line with 2003 levels. Overall spending has been held virtually flat during a period of enrollment growth driven by a weak labor market and the Affordable Care Act. Savings have been reinvested into the health care system, thereby improving quality of care even as enrollment in Medicaid continues to grow. The MRT of NYS has been chosen as a Finalist in 2015 for the prestigious Innovations in American Government Awards.
On April 14, 2014, the Governor announced that NY has finalized terms and conditions with the federal government for a groundbreaking waiver that will allow the state to reinvest $8 billion in federal savings generated by MRT reforms. The waiver amendment dollars will address critical issues throughout the state and allow for comprehensive reform through a Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program will promote community-level collaborations and focus on system reform, specifically a goal to achieve a 25 % reduction in avoidable hospital use over five years. Safety net providers will be required to collaborate to implement innovative projects focusing on system transformation, clinical improvement and population health improvement.
NY's Title V program continues to partner with OHIP to ensure the "voice" of the MCH population is heard and policies, practices and systems are developed to best meet their needs.
As a result, increased support for community health navigators, clinical perinatal improvement projects, establishment or expansion of the evidence-based maternal-infant home visiting programs and Community Health Worker programs and population health projects to reduce preterm births, are part of the DSRIP initiative.
Changes in MA have proven they can drive the broader health care system-wide innovations. Building on previous successes, the Governor seeks to align the entire health care system, including private insurance, to further improve

quality, keep costs low, and improve the health of all New Yorkers. NY was recently awarded a four-year, nearly $100 million State Innovations Model Testing (SIM) grant by the federal Center for Medicare and MA Innovation, which will support the Governor's State Health Innovation Plan (SHP), a five-year strategic blueprint that works to give New Yorkers access to high quality, coordinated care. NY developed the Plan and the SIM grant application with the support of numerous stakeholders. The state's official project period of the grant began on February 1, 2015 and will continue for four years.
The SHIP works toward the development and implementation of innovative health service delivery and payment models premised on a strong foundation of advanced primary care that is supported by both public and private payers in all regions of the state. Updated health information technology, quality measurement, integration with population health, and enhanced transparency will reduce costs and better enable consumers to make wiser healthcare choices. The SHIP will improve coordination and integration of care from primary care to long-term care, specialists and community supports, creating a continuum of care that links physicians and community-based resources to help promote the state's Prevention Agenda which is described below and MA reform efforts.
Expanding access to health care by making affordable health insurance available is one of the critical accomplishments of the Governor's health care agenda. NYS has also aggressively responded to implementation of the ACA. The NYS 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. As of January 2016, more than 2.7 million New Yorkers were enrolled in coverage and 92 % of those enrolled reported being uninsured at the time of application. Of those enrolled, 260,000 are enrolled in private qualified health plans (QHPs); 356,000 are enrolled in the state's new Essential Plan (a Basic Health Program); 210,000 are enrolled in Child Health Plus (CHP); and, 1.9 million are enrolled in Medicaid. New York's uninsured rate has fallen to less than 6 % as of June 2015 - its lowest point in decades. Fifteen insurers – double the national average – are offering plans in the state's individual marketplace for 2016. Additionally, the health insurance premium rates for individuals for 2014 and 2015 were 50 percent lower than what individuals would have paid before creation of the marketplace in October 2013.

For 2016, NYSOH has introduced an even more affordable health insurance option for New Yorkers whose income is at or below 200 % of the Federal Poverty Level, or $40,180 for a family of three - the new Essential Plan. The Essential Plan lowers premiums to $20 or less a month (with no deductibles and low co-pays) and provides comprehensive benefits for hundreds of thousands of New Yorkers. This innovative Basic Health Program (BHP) is one of only two programs nationwide (Washington State is the other.) to receive federal approval under the ACA.

Individuals, families and small businesses can use the Marketplace to help them compare insurance options, calculate costs and select coverage online, in-person, over the phone or by mail. In addition, New Yorkers may obtain MA and CHP coverage through the Marketplace. NYSOH has trained and certified almost 9,000 navigators, brokers and Certified Application Counselors to provide free, in-person enrollment assistance to apply for coverage. NYSOH features a state-of-the-art website where New Yorkers can shop and enroll in coverage and a customer service center to answer questions and enroll people into coverage. NYSOH has also continued to expand its outreach efforts to ensure that every New Yorker knows that affordable health care options are available.
QHP enrollment is only available to applicants who experience a qualifying event, although Native Americans can enroll in QHPs year-round. Applicants who are eligible for the Essential Plan, Medicaid, or CHP can enroll at any point in the year. Under federal ACA rules, a baby's birth triggers a qualifying event, but pregnancy does not. Legislation was enacted in NY in January 2016 that makes pregnancy a qualifying event through the state-run exchange, making NY the first state in the nation where the commencement of pregnancy allows a woman to enroll in a plan through the exchange.

NYS has benefitted from the receipt of ACA funding. Over $18 million in Personal Responsibility Education Program (PREP) funding supports programs designed to educate adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted infections. Over $16 million in Abstinence Education Grant Program (AEGP) funds, an initiative to implement mentoring, counseling and adult-supervised activities designed to delay the

initiation of sexual activity in young people ages 9-12 residing in high-need communities. Over $42 million in Maternal, Infant and Early Childhood (MIECHV) funding is being used to implement evidence-based home visiting programs. Over $4 million in ACA funds have been used to improve immunization rates, practices and the NYS Immunization Information System (NYSIIS). Over $17 million in ACA funds have been used to support chronic disease prevention programs, including smoking cessation; evidence-based cancer screening and detection programs; implementation of comprehensive population-based strategies in community and health systems setting to prevent obesity, diabetes, heart disease and stroke, and to reduce health disparities among adults. Overall, ACA funding has provided NYS with tremendous opportunities to improve and enhance NY's MCH services and eliminate disparities.

MCH programs continue to be relatively successful in maintaining State funding levels. In addition, the Governor continues to support significant legal, economic and health efforts that will have a positive impact upon the MCH population, including:

- NY has successfully boosted pay for tipped workers and increased the minimum wage to $15 for all fast food workers, 10,000 state workers and 28,000 SUNY employees. In 2013, the Governor successfully secured an increase in the state's minimum wage for all workers to $9.00. As a next step, the Governor is proposing to increase the minimum wage to $15, which would be the highest statewide minimum wage in the nation.
- The Governor has reintroduced ambitious legislation to address gender inequality. The Governor's 10-point Women's Equality Act proposed amending state law to: prohibit employers from denying work or promotions to workers simply because they have children; protect workers from sexual harassment regardless of the size of the workplace; create a specific protection in the Human Rights Law requiring employers to provide reasonable accommodations for pregnancy-related conditions; provide further protections of victims of domestic violence; strengthen human trafficking laws; and, protect Freedom of Choice by amending NYS law to codify the *Roe v. Wade* decision and to revise the law to further protect the woman's health if serious complications develop late in pregnancy; legally, the woman is only protected if her life is deemed to be in danger. Nine out of the 10 components of the law, excluding the abortion related provisions, have been passed. Title V staff were actively engaged in the development of this law.
- In order to protect New Yorkers' job security and earnings during new and unexpected life events, the Governor has proposed a comprehensive paid family leave program that will provide 12 full weeks of job protected leave and cover all employees, regardless of business size. NY's paid leave program will be funded through nominal employee contributions.
- As of February, there were ten positive cases of Zika virus infection among NYS residents. All of the infected patients are returning travelers from countries where Zika virus is ongoing. The Governor has directed DOH to expand the free Zika virus testing program for all pregnant women who have traveled to areas where the infection is ongoing, regardless of whether they exhibit symptoms. Additionally, DOH has issued a health advisory to local health departments, health care providers and hospitals to further coordinate Zika response efforts in NYS. The state will be testing mosquito pools for Zika as well as West Nile and EEE viruses.

II.B. Five Year Needs Assessment Summary

2016 Five-Year Needs Assessment Summary

II.B.1. Process

Over the past year, considerable effort was devoted to refine NY's State Action Plan. Cross functional teams were formed from across the DFH for each of NY's MCH priorities. The teams: conducted in-depth analyses of data to enhance an understanding of MCH issues; refined baseline and targets for NY's Title V priorities; and, identified evidence based or promising practice. To further strengthen NY's State Action Plan, input was obtained from the MCHSBG Advisory Council, Parent to Parent of NYS and other key partners including the Schuyler Center for Advocacy and Analysis (SCAA), American Academy of Pediatrics; American Congress of Obstetricians and Gynecologists (ACOG); Prevent Child Abuse NY, Docs for Tots, New York State Association of County Health Officials, and others providers and key stakeholders. .

II.B.2 Findings

II.B.2.a. MCH Population Needs

This section reflects any updates or enhanced analysis in support of NY's MCH priority issues.

Domain 1: Maternal & Women's Health

A priority for this domain was a more complete analysis of factors impacting maternal mortality and morbidity. NYS Maternal Mortality (MM) Review Report - 2006-2008, comprised of a review of 125 maternal deaths, determined that Black women comprised 46% of the pregnancy-related deaths, followed by White (18%) and Asian (10%); 30% were obese (BMI of 30 or more); and, the leading causes of death were hemorrhage (23%), hypertension (23%), embolism (17%), and cardiovascular problems (10%). Various key stakeholders, including the Partnership for Maternal Health, and others stressed the importance of addressing MM by ensuring women are healthy before they become pregnant, increasing inter-pregnancy spacing, and ensuring information regarding maternal deaths is shared on a timely basis and in a manner to promote clinical learning and improvement efforts.

Title V also looked more closely at opioid abuse, a growing public health issue. Opioid abuse in pregnancy includes the use of heroin and the misuse of prescription opioid analgesic medications. According to the National Survey on Drug Use and Health, an estimated 4.4% of pregnant women reported illicit drug use in the past 30 days. Whereas 0.1% of pregnant women were estimated to have used heroin in the past 30 days, 1% of pregnant women reported nonmedical use of opioid-containing pain medication. ACOG, regional perinatal centers and other key stakeholders supported a greater focus on this significant issue.

As stated in last year's application, maternal depression is the most common morbidity among postpartum women, affecting 10-20% of women during or within 12 months of pregnancy. It impacts the health of the woman, infant and the entire family. Stakeholders strongly support addressing this issue, including increasing screening of pregnant and postpartum women for depression and identifying and expanding resources for treatment and support.

Domain 2: Perinatal and Infant Health

Although NY continues to surpass the HP 2020 target for VLBW infants delivered in hospitals with Level III-IV NICUs at 92.3% in 2014, with the changing landscape of health care in NYS including the implementation of the ACA and DSRIP, as well as changes in hospital affiliations and standards of perinatal care, key stakeholders such as the MCHSBG Advisory Council, ACOG and others have stressed the need for NY to revisit perinatal regionalization, incorporating updated standards and ensuring the system is created in synergy with the evolving health care system. All stakeholders have expressed support to continue and enhance clinical quality improvement efforts to improve perinatal outcomes.

Opioid use impacts infants and children as well as adults in NYS. Rates of drug-related discharges for newborns increased by 60% since 2008, with increases both upstate and in NYC and across all racial and ethnic groups, and

higher rates outside NYC and among black infants. The rate of Neonatal Abstinence Syndrome has doubled outside of NYC since 2008 to 4.5 per 1000 delivery hospitalizations, primarily among white infants. Addressing the opioid epidemic has been emphasized as a NYS interagency priority within and outside of DOH.
Universally, the continued development of evidence-based home visiting services has been stressed as essential to provide support to the MCH population by the MCHSBG Advisory Council, Schuyler Center for Analysis and Advocacy and other key stakeholders to continue to improve health outcomes in this population as well as children and families.

Domain 3: Child Health

A greater emphasis for the NA process has been on social-emotional development. The National Survey of Children's Health 2011-2012 report that 33.2% of NY's children 4 months to 5 years are determined to be at moderate or high risk for developmental or behavioral problems as compared with 26.2% on the National level. Of equal concern are findings from the same survey that found that only 21.3% of NY's children 10 months to 5 years received a standardized developmental screening as compared to 21.3% on the national level and 64.4% of children age 2-27 with problems requiring counseling who received mental health care as compared to 61% on the National level.
Childhood experiences, both positive and negative, have a tremendous impact on future violence victimization and perpetration, and lifelong health and wellness and therefore, early experiences are a priority public health issue. Much foundational research has been done related to Adverse Childhood Experiences (ACEs). In the ACE module of the BRFSS, nationally 23.6% of all individuals experienced one ACE, 13.6% two, 8.1% three and 14.3% four or more ACE. NY's NA processes over the past year included reviewing the evidence to determine a process to focus on the positive rather than negative behaviors of children, namely asset building processes.
In all stakeholder groups including the MCHSBG Advisory Council, parent representatives, Early Childhood Advisory Council, EICC among others, the need to ensure all children received comprehensive primary and preventive care including standardized developmental screening as well as appropriate assessment and supports for mental health and other developmental problems was underscored as a priority for Title V.

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

Assessment of this domain throughout the past year has reinforced the need for a more comprehensive approach to collecting and analyzing data for CSHCN in NYS. In addition, input from Parent to Parent of NYS, key stakeholders and others also emphasized the fragmentation of the service system for CSHCN, complexity of accessing the myriad of available services, and the fact that some families receive supports and services as needed while others go without regardless of health insurance status. As stated in the annual report section of this application, Title V staff are directly involved in the development of Health Home for Children (HH). Parents stressed ensuring a smooth transition into HH and ongoing assessment of the comprehensiveness of case management that occurs through HH. In addition, Parent to Parent also stressed the need to focus on those CSHCN who are not eligible for HH but nonetheless require supports and services. Parents also emphasized the need for bidirectional information to ensure they were aware of changes and updates in the service system and Title V continues to hear their voices.

In all stakeholder groups, an emphasis was placed on Title V ensuring routine developmental screening for all children, ensuring children with autism are diagnosed early and receive appropriate supports and services throughout their life span, and that adolescents with special needs receive comprehensive information and supports to transition to the adult health care system without negative impact on their health and well-being. Ensuring statewide services for CSHCN including in rural areas as well as neighborhoods in poverty where there may be safety concerns for the family and/or provider was also expressed as priorities in conversations with parents.

The qualitative information obtained throughout the past year has clarified and strengthened NY's Title V State Action Plan related to CSHCN and will serve as framework for future Title V policy and program development.

Domain 5: Adolescent Health

As with the child domain, an emphasis was placed on the social-emotional wellness of NY's adolescents over the past year. The rate (per 100,000) of suicide deaths among youth aged 15-19 increased from 4.2 in 2013 to 5.1 in

2014. In NYS, vital statistics data demonstrate that suicide is the leading cause of injury death for children ages 10 to 14 years and the fourth leading cause for children ages 15 to 19 years. Young males are less likely to seek help or talk about their feelings.

Adolescents are particularly sensitive to environmental influences including family, peers, school and neighborhood environment that can either support or challenge their health and well-being. Supporting positive development of young people fosters healthy behaviors and helps to ensure a healthy and productive future adult population. NY's NA processes over the past year included reviewing the evidence to determine a process to focus on the positive rather than negative behaviors of adolescents, namely asset building processes.

In all stakeholder groups including the MCHSBG Advisory Council, parent representatives, and other key groups, the need to ensure adolescents receive comprehensive primary and preventive care rather than sporadic care for health issues, as well as appropriate assessment and supports for mental health issues was underscored as a priority for Title V.

Domain 6: Cross-Cutting & Life Course

Throughout NY's NA process, several recurring themes continue to emerge that cut across all MCH populations and life course. Oral health is a key health issue across the life course. 23% of children 2-5 years of age have had dental caries that includes 18% white children and 29% black children. The 3rd Grade Survey 2009-2012 in NYS indicates significant disparities between low and high income children with regards to caries experience, untreated caries and sealants.

All MCH stakeholder groups, emphasized the significance of improving oral health in NYS, and promoting healthy home and community environments to promote the health and wellness of NY families. Through a review of evidence and input from the field, Title V recognized the importance of addressing the social determinants of health through the lens of impacted communities to promote changes in that community to improve health equity and access to healthy lifestyle choices, health care and social services and other essentials supports such as quality housing, employment among others.

Throughout this application, racial, ethnic, economic and geographic disparities are highlighted for virtually all MCH outcomes and factors assessed. As evidenced in Vital Records data in NYS, black women die at an earlier age than white women and women of other races and ethnicity, and disparities exist in maternal mortality, infant mortality, and other key MCH health indicators. Native Americans in NYS experience significant chronic diseases and death at an earlier age than other populations. Disparities is not limited to race and ethnicity. Rather, economic status, geography, language, and other factors such as health literacy can have a significant impact on the health status of NY's MCH population.

Although significant work has been done over the past year to develop a deeper understanding of this very complex issue, more work is left to be done. This will require closer collaboration with programs and entities within DOH as well as externally to ensure a community-based focus to address this Title V priority.

II.B.2.b. Title V Program Capacity

II.B.2.b.i. Organizational Structure

Organizational changes occurring within the Office of Public Health (OPH) over the past year include the retirement of Dr. Guthrie Birkhead as director of the OPH and replaced by Bradley Hutton, the former director of the Center for Community Health (CCH). In addition, Adrienne Mazeau assumed the position of in the CCH. Lauren J. Tobias replaced Rachel de Long as director of the DFH and NY's Title V program. See Attachment 2 for an organizational chart.

II.B.2.b.ii. Agency Capacity

NY's commitment to ensuring the health and well-being of the MCH population is manifest in an extraordinary array of resources. The extensive list of internal and external partnerships is contained in Attachment 1. The following

sections contains updates to NY's supports and services by domain. Unless otherwise specified, the services contained in FFY 2016 application remain intact and are reported on in IIF Annual Report.

Domain 1: Women's & Maternal Health No updates

Domain 2: Perinatal & Infant Health

CDC's 6/18 Initiative – Title V staff and OHIP are participating this initiative, specifically related to the high-burden health condition of unintended pregnancy focusing on administrative systems, supports and financing to increase access to LARC and prevent unintended pregnancies.

Domain 3: Child Health No updates

Domain 4: Children with Special Health Care Needs No updates

Domain 5: Adolescent Health

Enough is Enough is a Governor's initiative to address and prevent sexual violence on college campuses using strategies to help college faculty, staff and students learn to identify sexual assault and safely intervene in the prevention of relationship violence and stalking.

Domain 6: Cross-cutting & Life Course

II.B.2.b.iii. MCH Workforce Development and Capacity

Over the past year the workforce remains relatively stable though three significant changes occurred in Title V in NYS. Lauren J. Tobias recently assumed the position of Title V director with Rachel de Long's departure. Dionne Richardson, D.D.S., M.P.H., assumed the role of the Title V Dental Director. Phillip Passero assumed the role of Director of the Bureau of Administration. All other key staff remained the same (see *Appendix* for staff biographies):

A unique aspect of this process was a partnership with the HRSA-funded National MCH Development Center at the University of North Carolina that served as an invaluable resource to identify information, tools and resources used by Title V in NYS to gain a better understanding of MCH needs and priorities as well as potential strategies to address these priorities. The Center also worked with Title V to develop and enhance skills in Title V staff to build NY's "MCH Leaders of Tomorrow".

II.B.2.c. Partnerships, Collaboration, and Coordination

NY's Title V Program has extensive partnerships to meet the needs of NY's MCH population. See Attachment 1 for highlights of key collaborations.

Five-Year Needs Assessment Summary (Submitted on July 15, 2015)

II.B.1. Process

The DOH engaged in an extensive needs assessment (NA) process to identify the needs and strengths of NYS's MCH population and service system. This NA served as the basis for the state's MCH priorities (*II.C*) and 5-year MCH Action Plan (*II.F*)

The NA was planned with input from key DFH staff, NY's MCHSBG Advisory Council and other MCH partners. This NA builds on other recent NA processes for the state's Prevention Agenda, MIECHV state plan, maternal and infant health and adolescent health program redesigns and local Community Health Assessments. An internal leadership group was convened with key staff from DFH and other MCH programs in nutrition, chronic disease, environmental health, injury and immunization. Teams jointly led by program and research staff for each population health domain gathered and analyzed public health surveillance data and relevant information on DOH programs and evidence-based practices. Both the leadership group and MCHSBG Advisory Council provided feedback and recommendations throughout the process.

Quantitative data analysis focused on national priority areas and additional state priorities. A rich variety of data sources were utilized, see Attachment 1. Literature was reviewed to identify key contributing factors and evidence-based/ -informed strategies. A unique aspect of this NA was a partnership with the MCH elective class at SUNY Albany School of Public Health, through which student teams assessed selected emerging MCH topics such as maternal depression, neonatal abstinence syndrome and use of preventive health services by young men. Student reviews focused on the epidemiology, impact, contributing factors and evidence base for their selected topics; Title V staff attended team presentations and received copies of student papers to incorporate in this NA. This innovative partnership led to the development of a successful MCH Catalyst Grant application (see *II.B.2.b.iii*).

To further strengthen NY's NA, an extensive process was undertaken to receive input from stakeholders including families and service providers through a combination of listening forums (both in-person and virtual), surveys and interviews tailored to meet the needs of partners. Questions tailored for each group and domain addressed: population health issues, needs, and strengths; successes, gaps and barriers; health care utilization and impact of the ACA; and, recommendations for improvement. Input was received from over 150 health and human service providers and over 250 families and youth. Provides include representatives of: American Academy of Pediatrics; American Congress of Obstetricians and Gynecologists; NYS Academy of Family Physicians; NYS Association of Licensed Midwives; family planning providers; school based health and dental providers; maternal health providers; local health departments; providers and stakeholders in the American Indian Health Program and, Early Childhood Advisory Council. Input directly from families and youth, including youth with special health care needs, was received in collaboration with partner organizations including: home visiting programs, MICHC grantees, Docs for Tots, Parent to Parent of NYS, parent graduates of EI Partners in Policymaking (an EI initiative to build leadership and advocacy skills in parents of children with disabilities) and Hands and Voices (professionals and parents of individuals with hearing impairment).

For each domain, all information was compiled to develop a profile highlighting key findings related to: population health status, trends and disparities; key contributing ecologic factors; population strengths and needs; and, a critical analysis of NYS successes, challenges and gaps and capacity to promote population health. Findings are summarized in *II.B.2*.

II.B.2. Findings

II.B.2.a. MCH Population Needs

Domain 1: Maternal & Women's Health

Most (88%) NYS reproductive age women report that they are in **good or better health** [1]. Health issues for this group include: **overweight and obesity** (46%), **physical inactivity** (24%), **depression** (19%), **binge drinking** (18%), **tobacco use** (17%), **asthma** (11%), **high blood pressure** (9%) and **diabetes** (3%); over 14% report a **physical, mental or emotional disability** [1]. Both **health insurance coverage** (87%) and **preventive health care visits** (69%) are higher for NYS women age 18-44 compared to national averages, but lower than for NYS adult women overall [1]. Only 39% of NYS women report that a **health care provider has ever talked with them about ways to prepare for a healthy pregnancy and baby** [2]. Key factors identified by stakeholders include accessibility of care and insurance coverage, provider diversity and cultural competence, social supports and lack of access to opportunities for physical activity and affordable healthy food [3].

"It takes me too long to see my doctor – I have to work"

Over 50% of NYS pregnancies, and 26% of live births, are **unintended pregnancies**, associated with delayed prenatal care, increased risk of adverse pregnancy outcomes and impacts on women's life course [4]. Poverty, race, class and educational attainment are the greatest indicators, coupled with women's low expectations for their futures. **Short birth intervals** (less than 18 months between a birth and subsequent conception), accounting for 30% of second or subsequent births, are also associated with adverse birth outcomes for women and infants and have implications for maternal life course [4, 5]. Pregnancy planning and prevention are greatly influenced by **use of effective contraception.** Over 25% of women at risk for pregnancy took no steps to avoid pregnancy the last time they had sex, though only 8% wanted a pregnancy at the time [1]. Use of effective contraceptive methods among women at NYS-funded family planning clinics increased from 60% in 2009 to 71% in 2014, with less use by Hispanic and Black women [6]. Barriers cited by stakeholders include: transportation; stigma and confidentiality concerns; language barriers; cost; and, competing life responsibilities [3]. **Early entry into prenatal care** fluctuated over the last decade, declining from 75% of births in 2003 to 73% in 2012, with higher rates of early care by older mothers, white women and those outside NYC [4]. About 2.7% of women report **domestic abuse by a husband or partner** in the 12 months prior to pregnancy, and 2.1% during pregnancy [2]. **Cesarean deliveries among low-risk first births** have declined slightly in NYS from 31% in 2008 to under 30% in 2011 [4]. Rates are higher outside NYC and among older and more educated mothers, but lower among women on Medicaid, Asian and White non-Hispanic women [4]. **Preterm births** increased from 11.4% in 2003 to a high of 12.5% in 2006 then declined to a new low of 10.8% in 2012; rates are lower outside NYC and higher among mothers who are single, teen or >35 years old and Black race [4]. **Early term births** (37-38 weeks gestation) followed similar patterns, declining to a low of 23.6% in 2012 [4]. **Low birth weight** rates have been fairly stable at around 8% since 2003 and with similar disparities [4].

Maternal Mortality is a devastating outcome with dramatic impact on families and communities. NYS maternal mortality peaked at 29.2 deaths/100,000 live births in 2008 and declined to 18.8 in 2012, with rates four times higher among Black women and 1.5 times higher among NYC women [4]. Both mortality rates and racial disparities for NYS are notably higher than national rates. Leading causes include cardiac disorders, hemorrhage, hypertension and

embolism. **Severe or "near miss" maternal morbidity** increased in NYS from 2008-10 then declined, with significant racial, ethnic and economic disparities [7]. Risk factors identified in NYS analyses include: greater maternal age; obesity and chronic medical conditions; multiple pregnancies; delayed or inadequate prenatal care; depression; and, Cesarean delivery. **Maternal depression** is the most common morbidity among postpartum women, affecting 10-20% of women during or within 12 months of pregnancy. Risk increases with low social support, personal or family mental illness, substance abuse and pregnancy or birth complications.

Key successes to build on in NYS include:

- **Robust surveillance and data systems** including SPDS, PRAMS, Family Planning and Home Visiting data systems and Maternal Mortality Review systems. A new partnership with BRFSS provides data on women's preconception health and family planning practices.
- **Promising public awareness and education** work including Text4Baby, media campaign on tobacco use among women of reproductive age and emerging resources on maternal depression for consumers and providers.
- **Highly effective clinical quality improvement strategies** to increase use of contraception among family planning clients, reduce non-indicated elective deliveries and improve management of maternal hemorrhage and hypertension.
- **Integration and expansion of evidence-based/-informed strategies** within community health initiatives including maternal and infant home visiting, community health workers and supports for pregnant and parenting teens.
- **Strong and emerging partnerships with health reform initiatives** including ACA health insurance expansion, Medicaid Redesign, Medicaid Health Home and State Health Innovation Plan/Advanced Primary Care model.

"The family planning learning collaborative provided a platform

to engage in an educated discussion about how to improve

performance regarding contraceptives and LARC"

Emerging needs and opportunities include: **integration of pregnancy planning and contraception in primary care** for all women; expanding surveillance for **severe maternal morbidity**; building health care provider capacity to identify and support **maternal depression**; increasing **enrollment and retention of eligible families in evidence-based programs/services**; utilizing data to fully **integrate performance measurement and improvement** across maternal and women's health programs; and, leveraging **health systems reform initiatives** to scale up evidence-based/-informed practices and interventions.

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Domain 2: Perinatal and Infant Health

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Infant mortality is a fundamental indicator of the health of a nation, state or community. NY's infant mortality rate declined from 5.8/1,000 in 2005 to 5/1,000 in 2012 [4]. Leading causes include preterm birth, birth defects,

sudden unexpected infant death (SUID), accidents and homicide. Important risk factors include lack of prenatal care, short birth intervals, maternal chronic disease or tobacco, alcohol and drug use, chronic stress, interpersonal violence, and injury prevention practices. **Neonatal mortality** (within first month of life), accounting for 70% of all infant deaths, peaked at 4.2 in 2004 and declined to 3.3 in 2012, mirroring a decline in **preterm-related mortality** [4]. Since 2009, 90% of **VLBW infants were delivered in hospitals with Level III-IV NICUs**, with a corresponding decline in VLBW mortality rates [4]. **Post neonatal mortality** has been fairly steady over the last decade at ~1.6/1,000 in 2012, while **sleep-related SUID-related mortality rates** have improved [4]. For all these measures there striking disparities with rates for black infants 2-2.5 times higher than white. Rates are generally lower in NYC, although **fetal death** rates are higher in NYC [7].

Rates of **drug-related discharges for newborns** increased by 60% since 2008, with increases both upstate and in NYC and across all racial and ethnic groups, and higher rates outside NYC and among black infants [7]. The rate of **Neonatal Abstinence Syndrome** has doubled outside of NYC since 2008 to 4.5 per 1000 delivery hospitalizations, primarily among white infants [7]. **Fetal alcohol exposure** among newborns has been steady, with ~8% of women reporting alcohol use in the last three months of pregnancy, and higher rates in NYC [2]. **Tobacco use during pregnancy** has declined steadily since 2000, with higher rates outside of NYC and among younger, lower income and unmarried women [2].

Virtually all infants born in NYS are **screened for heritable disorders**; 97% of those with a positive screening result **received timely follow up** [8]. About 93% of babies born in NYS in 2014 had a **hearing test** documented in the statewide registry, increased from 84% in 2013 [9]. Among NYS babies enrolled in Medicaid, 82% received the recommended number of **well-baby visits** in the first year of life, compared to 90% of commercially insured infants [10].

Breastfeeding has increased, with 84% of babies ever breastfed, 41% exclusively breastfed in the hospital, 83% fed any breastmilk in the hospital and 17% exclusively breastfed at age 6 months [2, 4]. Any breastfeeding is higher in NYC, while exclusive breastfeeding is higher outside NYC. Mothers who are Hispanic or White, have greater than high school education, are not on Medicaid or are married are more likely to breastfeed. **Safe sleep practices** have increased, with over 75% of babies outside NYC and 64% of NYC babies are **placed on their backs to sleep** [2]. Babies whose mothers are Black or Hispanic, on Medicaid, not married or have less education are less likely to be placed on their backs to sleep.

"Mothers need support to be healthy and to keep their

babies healthy; services like home visiting help families"

Families and providers cited needs for increased **capacity and accessibility of key services** including primary care, mental health, substance abuse, home visiting, breastfeeding classes and support groups and parenting classes [3]. **Language and cultural barriers** and **social factors** including **housing, transportation, violence, chronic stress and access to affordable health food** were frequently noted.

"We need to employ more people in front line

positions to reflect the communities we serve"

In addition to those noted for *Domain 1*, **key successes** to build on in NYS include: a mature **statewide system of regionalized perinatal care**; successful hospital- and community-based **breastfeeding** initiatives; and, a strong multi-agency/public-private **partnership mobilized to address infant mortality** through NY's CoIIN initiative. **Emerging challenges and opportunities** include prevention, identification and management of **maternal substance use**; disseminating effective and consistent **safe sleep messages**; and updating standards and designation for **perinatal regionalization**.

Domain 3: Child Health

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Families report that 82-85% of NYS children age 0-11 years are in **excellent or very good health**, which is steady since 2003 [11]. Children with higher family income, private health insurance and white non-Hispanic race are most likely to report good health. The NYS **child mortality** rate for children age 0-9 years declined from 17/100,000 in 2003 to 13.9 in 2012 [4]. Mortality is more than double among children age 1-4 years, black and male children. Leading causes of death include injuries/accidents, cancer, congenital malformations and heart disease, accounting for nearly 75% of all child deaths [4]. **Hospitalization for non-fatal injuries** to children 0-9 declined from 436 per 100,000 in 2003 to 355 in 2012 [7] *(see also Domains 4, 5 & 6).*

Nearly all (97-98%) of NYS children age 0-11 years had **health insurance** in 2012, though 9-10% had **inconsistent insurance coverage** over the year and 78-79% had **coverage adequate for all the services they need** [11]. In national surveys, NYS parents report that 54-55% of children age 0-11 receive care meeting all medical home criteria, and 92-93% had a **preventive medical visit** in the past year, while state quality reporting data from Medicaid and commercial managed care plans indicate that 83-85% of children age 3-6 years had a preventive visit in the past year [10, 11]. The proportion of children age 19-35 months receiving the full **4:3:1:3(4):3:1:4 immunization series** has been stable at about 63% while **influenza vaccination** for children 6 months–17 years increased from 48% in 2010 to 65% in 2014 [12]. Based on parent reports, the percent of children age 10-71 months who had a **developmental screening** using a parent-completed tool increased from 11.7% in 2007 to 21.3% in 2012 [11], still well below national goals and averages. About 54% of children were tested for **blood lead levels at ages one and two** in 2012, which has been fairly stable since 2009 [13].

Parent and provider stakeholders in NYS voiced concerns about children's physical and behavioral health and barriers to healthy lifestyles including **affordable healthy food**, **opportunities for physical activity** and **positive social-emotional relationships** [3] (*see also Domain 6*). NYS data find that nearly one in five school-age children, and one in seven WIC-enrolled younger children are **obese**, and less than 25% of children age 6-11 are **physically active** for at least 20 minutes daily [14-16]. While most parents indicate that their child is **"flourishing"**, this decreases as children age and there are notable racial/ethnic and economic disparities [11]; stakeholders voiced deep concerns about the impact of toxic stress on early brain development [3]. One in five NYS children live in poverty and 4.5 per 1,000 are in foster care [17]. Nearly 18% of children age 0-18 have had two or more **adverse childhood experiences**, and preliminary data show that about 7 per 100,000 children

are hospitalized annually related to **child maltreatment**, with highest rates among infants, black and low income children [7]. One-third of young children age 0-5 years are at moderate or high **risk for developmental or behavioral problems** based on parents' concerns, 7.4% of children 2-17 are taking **medication for ADHD, emotional or behavioral concerns** and 4.9% of children 6-11 have current **behavioral or conduct problems** [11]. Both parents and providers articulated needs for universal education and enhanced social support to help parents better understand normal child development and strengthen parenting skills [3].

"It's not that families don't want to be healthy –

They have more important things to deal with"

Key NYS successes to build on include:

- **Generous public health insurance programs** and strong systems for enrolling children in insurance, including linkages with Title V programs.
- **Systematic incentives for high quality care**, with 50% of children in Medicaid Managed Care plans enrolled in NCQA-recognized Patient Centered Medical Homes in 2014 and emerging Title V partnership with the state's Health Innovation Plan/Advanced Primary Care initiative.
- **A rich network of pediatric primary health care service providers** in hospitals, community health centers and private practices, including the largest **School-Based Health Center (SBHC) program** in the nation serving over 160,000 children annually.
- **Statewide and targeted public health programs** to increase the availability of healthy food and opportunities for physical activity in schools, neighborhoods and communities.
- **Strong partnerships with child care** to enhance regulatory and quality standards for health promotion, including nutrition, physical activity and social-emotional health.
- **Growing recognition** of the fundamental importance of children's social-emotional development and relationships, including many established partnerships and a growing evidence base for action, coupled with NYS Title V program's strong history of developing innovative asset-based public health programming for children and youth.

"I am seeing a decrease in insurance being a barrier. Navigators are able to go into the community, even into homes – it's been a game changer."

Key challenges and opportunities include: strengthening **collaboration across child-serving programs**, which are more decentralized across DOH and other state agencies than programs serving other MCH populations; supporting **SBHCs to successfully transition Medicaid reimbursement** from fee-for-service to managed care and institutionalizing quality improvement activities; increasing **developmental screening and immunization rates** within well child visits; identifying and expanding **evidence-based strategies**, and **building capacity** among pediatric health care providers, to support families and other caregivers in nurturing children's **social-emotional development**; and, further expanding **partnerships with child care and schools** to promote health across settings, including **child care health quality standards and consultation** and **community schools** initiatives.

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

The proportion of NYS children reported by their parents to have **special health care needs** increased from 17% in 2003 to 20.8% in 2012; prevalence increases with age and is higher for boys [11]. Among NY CYSHCN, 28% report their health conditions **consistently or greatly affect their daily activities** and 17% report **missing 11 or more days of school due to illness**, compared with 6% of children generally [18]. The most **commonly reported chronic conditions among NY CYSHCN** include: asthma (37% of CYSHCN), ADD/ADHD (27%), developmental delay (20.6%), anxiety (15.6%), food allergies (15.3%), behavioral or conduct disorders (14.9%), depression (10.1%) and autism spectrum disorders (9%) [18]. The overall **prevalence of ADD/ ADHD** among all NYS children age 0-17 increased from 5.6% in 2003 to 8.3% in 2011-12 [11].

In 2009-10, while 97% of NY CSHCN had current **health insurance**, only 56.8% had **consistent health insurance adequate to pay for all the services they need**, and 22% had one or more **unmet needs for health care services** [18]. While 92% reported having a **regular source of care**, only 38.4% of NY CYSCHN received care meeting all national criteria for **medical home**, and 16.8% were served by a **system of care** that met all age-relevant core outcomes, with lower percentages for CYSHCN who are non-white, uninsured or lower income [18]. Of those who needed a **referral for specialist care** or services, 25% had difficulty getting it [18]. Of the 79% of CYSHCN needing **care coordination**, nearly half reported that they did not receive help with coordination of care and/or were not satisfied with communication among providers and/or schools [18]. Among all children 0-17, the proportion of **children with mental/behavioral conditions who are receiving treatment** has slowly increased from 58.7% in 2003 to 61% in 2011-12, below the national goal and with disparities for younger, lower income and Black children [11]. For CYSHCN age 12-17, only 39.7% report receiving the services necessary to **transition to adult health care, work and independence**, with even lower rates among Hispanic and uninsured youth [18]. Families and providers noted **lack of care coordination**, difficulty **managing multiple care systems**, access to care for **non-English speaking families**, **availability of specialists** including mental health providers, **out-of-pocket expenses** and the need for **transition services** as key challenges for CYSHCN and their families in NYS [3].

"**It is difficult to arrange for transportation to specialists far away."**

Support for families is a key cross-cutting need identified by stakeholders [3]. In 2009-10, 17.6% of CYSHCN families indicated their child's health needs created **financial problems** for the family, 14.4% spent **11+ hours/week providing or coordinating their child's health care** and 26.7% **cut back or stopped working** due to their child's health condition, while 43.1% reported their child does not receive **family-centered health care** [18]**.** Increasing support for families is a central priority for the state's Early Intervention (IDEA Part C) program, for which the proportion of **families reporting positive family outcomes** decreased from 2008 to 2012.

"I am told I am an important member of my child's

health care team, but I don't feel like I really am"

In addition to those noted for *Domain 3*, **key NYS strengths and successes** to build on include:

- **Generous public health** insurance for children including several expanded Medicaid options for CYSHCN;
- **Comprehensive statewide Early Intervention Program** serving over 65,000 infants and toddlers with developmental delays, with a focus on both child and family outcomes and strong commitments to better addressing children's **social-emotional developmental** needs as well as **family-centered practices and outcomes**;
- Highly effective partnership with Medicaid to develop a new **Health Home benefit to provide enhanced care coordination for CYSHCN** pursuant to ACA **–** Title V has played a central role in all steps of this initiative, with continued collaboration for implementation;
- **Family representation** on state advisory groups for MCHSBG, Early Intervention and Hands & Voices and strong **partnerships with statewide family support organizations** and other child-serving agencies.
- A **high level of family satisfaction** with information and referral services provided to families of CYSHCN by LHD programs, with gap-filling financial supports available for families in some counties.

Key challenges and opportunities include: strengthening ongoing **surveillance and use of data** to prioritize, monitor and evaluate public health activities serving CYSHCN; implementing statewide enhanced **care coordination through Medicaid Health Home** to better support CYSHCN and families; identifying and disseminating effective **strategies for social-emotional development and family support** through Early Intervention and other programs; providing updated guidance and technical assistance to **local health departments**, and building expanded **statewide and regional supports for quality improvement** efforts related to care of CYSHCN, while re-assessing the **viability of the current gap-filling PHCP** reimbursement system in light of ACA and declining county participation; and, secure appointment of a **family representative** to fill a current vacancy on the state's MCHSBG Advisory Council.

Domain 5: Adolescent Health

Families report that 83% of NYS youth age 12-17 years are in **excellent or very good health** [11]. The NY **mortality** rate for youth age 10-19 years steadily decreased from 30.7/100,000 in 2003 to 22.6 in 2012, better than national goals for both younger (10-14) and older (15-19) teens [4]. However, suicide mortality among youth 15-19 increased from 4.5/100,000 in 2003 to 6.0 in 2012, with higher rates outside of NYC and for boys, making suicide the 2nd leading cause of death for teens 10-19 behind accidents [4]. Nearly 24% of NYS youth report **feeling sad or hopeless** for 2+ weeks in the last year and 13.7% say they seriously **considered suicide**, though both declined since 2003 [19]. Over 25% of teens have had two or more **adverse childhood experiences** and 9.6% are taking **medication for ADHD, concentration, emotional or behavioral** concerns [11]. Parent reports indicate that nearly 15% of NYS teens age 10-17 are **obese** and another 15-20% are **overweight**, less than 20% are **physically active** for at least 20 minutes daily [11]; 20% of NYS youth report drinking soda daily, 40% report spending 3+ hours daily on non-school related computer or video games and 27% report 3+ hours daily watching television [19].

"Junk food is cheaper and more convenient than healthy food"

About 97% of NYS teens age 12-17 had **health insurance** in 2012, though 6% had **inconsistent insurance coverage** over the year and only 71% had **coverage adequate for all the services they need** [11]. NYS parents report that 50% of teens receive care meeting all medical home criteria, and 90.7% had a **preventive medical visit** in the past year, with lower utilization among older, Hispanic, publicly-insured and English language learners [11]. However, state quality reporting data from Medicaid and commercial managed care plans indicate that 61-64% of teens had a preventive visit in the past year, and among these ~60-75% received preventive counseling on weight status, sexual activity, depression, tobacco use and substance use (data vary by visit component) [10]. Among teens age 13-17 in 2013, 61.7% of girls and 38.6% of boys had at least one dose of **HPV vaccine**, 89.5% had at least one dose of **Tdap** and 83.3% at least one dose of **meningococcal vaccine** all of these are increasing [12]. About 66% of teens with **mental health problems receive treatment**, higher than for younger children [11].

Because they are in developmental transition, teens are especially sensitive to environmental influences including family, peer, school, neighborhood and social cues, and are susceptible to engaging in risky behavior. NYS teens and adults identified **community resources** and **social relationships** as key factors influencing adolescent health [3]. NYS youth report declining **tobacco use**, from 32.5% of teens in 2000 to 15.2% in 2014 with regional, gender and racial/ethnic gaps narrowing [19]. Since 2003, NYS youth report: less use of **alcoho**l (32.5% 2013 vs 44.2% 2003), and **cocaine** (5.3% vs 6.2%); steady use of **marijuana** (21%) and **methamphetamines** (4.5%); and increased use of **heroin** (3.7% vs 1.8%) [19]. About 38% of teens have **ever had sex**, and 28% are **currently sexually active**, both decreased since 2003 [19]. Among teens who are sexually active, **condom use** at last intercourse decreased (70% in 2003 to 63% in 2013) while use of another **effective method of birth control** at last intercourse increased (20.5% in 2011 to 25.8% in 2013) and **use of any method to prevent pregnancy** declined (90.1% in 2003 to 87.4% in 2013) [19]. The NYS **teen pregnancy rate** declined from 38.2 to 22.6/1,000 girls age 15-17 since 2003, but with persistent racial/ethnic disparities [4]. NYS parents report that 61% of teens age 12-17 are usually or always **engaged in school, participate in extracurricular activities and usually or always feel safe in school**; 88% of teens have at least one adult mentor [11]. NYS parents report that about 22% of girls and 17% of boys age 12-17 **experience bullying**, with higher percentages for younger and white teens, and that 28% of teens have **bullied others** [11]**.** NYS youth report that 19.7% have been bullied at school and 15.3% bullied electronically, and 7.4% indicate they did not go to school because they **felt unsafe at or on their way to/from school**, up from 5.9% in 2003 [19]. 12.1% of youth say they have experienced **physical dating violence** and 11.8% **sexual dating violence** [19].

"Get us involved. The minute I feel like my word matters, I will stay involved…I will think and I will make better choices"

Key successes to build on in NYS include:

- strong and longstanding **networks of youth-serving community and clinical providers** across the state;
- widespread implementation of **evidence-based sexual health education** through community-based

adolescent programs, with strong training and technical support to ensure **fidelity;**

- long history of innovative **asset-based youth development strategies** across programs for both younger and older teens;
- **access to confidential health care services** for teens in a variety of settings including community family planning and school-based clinics; and
- mature and productive **state-academic partnerships** to support development, implementation and evaluation of evidence- and theory-based youth programming.

Key challenges and opportunities include: persistent racial, ethnic and economic **disparities** in health outcomes for youth; identifying effective models and strategies for serving **rural communities**; inconsistent **sexual health education policies** across school districts; and increasing recognition of the need to address **overall wellness**, **health literacy**, **transition to adult health care services** and **social-emotional well-being and relationships** for NYS adolescents.

Domain 6: Cross-Cutting & Life Course

Throughout NY's needs assessment process, several recurring themes emerged that cut across all MCH populations and life course stages: **oral health**; **mental health**; enrollment in **affordable and adequate health insurance;** access to and use of **preventive health care services**; **social support and healthy relationships**; **neighborhood and community environments** that protect health and support healthy behaviors; and the need to **reduce health disparities and promote health equity**. See *Domains 1-5* above for additional domain-specific references to these cross-cutting factors and *II.A* for additional information on NYS health insurance capacity and reforms.

Oral health is a key health issue across the life course. Tooth decay (dental caries) is the most common chronic condition among children, with implications for personal well-being, school attendance and performance, social interactions and nutrition. In 2011, NYS parents reported that 19.4% of children age 0-17 had one or more **oral health problems**, with highest prevalence among children age 6-11, Hispanic and low income children and similar rates for CSHCN [11, 18]. NYS 2009-12 oral health surveillance data show that 45% of 3rd graders experienced **tooth decay**, down from 54% in 2002-04; evidence of **untreated tooth decay** was present for 24% of 3rd graders, down from 33% [20]. Prevalence was higher outside of NYC and for lower income children. State quality reporting data from Medicaid and commercial managed care plans show that about 60% of children had an annual dental visit [10], while parents report that 77% of all NYS children 1-17 had a **preventive dental visit** in the last year, with lower visit rates for children age < 5, Hispanic, low income and uninsured children [11]; CSHCN had higher visit rates [18]. **Tooth decay and periodontal disease among women** impact their personal health and are associated with poorer pregnancy outcomes and increased tooth decay among their children. About 19% of NYS (excluding NYC) pregnant women say they needed to see a dentist for a problem during pregnancy, and less than half of NYS women had any **dental visit during pregnancy**, with lowest rates for younger, Black, low income and unmarried women [2]. Currently, 71% of NYS residents live in areas served by **fluoridated water systems** [21]. Barriers to good oral health and use of dental care noted by NYS stakeholders include: lack of **awareness/health literacy** for oral hygiene practices,

dental insurance and **integration of oral health in primary care**; inconsistent **community water fluoridation**; and, **shortages of dentists** in underserved communities and who accept Medicaid [3].

"Oral health needs to be integrated into well child care"

Across all MCH stakeholder groups, **home, neighborhood and community environments** were noted as key factors influencing cross-cutting health risks and issues including nutrition, physical activity, social supports and relationships, violence, injury prevention, asthma and lead poisoning [3]. Parents report that 79% of children and youth age 0-17 live in **supportive/cohesive neighborhoods** and 80% feel that their child is usually or always **safe in their community or neighborhood**, with disparities for non-white and lower income young people [11]. About 58% of young people live in a **neighborhood that has a park, recreation center, sidewalks and library**; 85% live in neighborhoods with at least three of these resources [11]. In contrast, about 17% of young people live in neighborhoods with two or more **detracting elements (vandalism, rundown housing, litter)**, with notable racial and ethnic disparities [11]. In 2011, USDA identified **food deserts** in more than half of NYS counties, with about 2.5% of low-income NYS residents living > 1 mile (urban) or > 10 miles (rural) from a supermarket or grocery store that provides affordable fruits and vegetables [22]. About 19% of young people age 0-17 live in a **household in which someone smokes**, which is declining [11]. Common **home environmental hazards** identified by the DOH Healthy Neighborhoods Program include: second-hand smoke, lack of carbon monoxide and smoke detectors, lead paint hazards, rodent and insect pests, mold and structural disrepairs [23].

"My kids would be healthier if they could

go out to play instead of watching TV"

Throughout NYS' needs assessment, **racial, ethnic, economic and geographic disparities** are highlighted for virtually all MCH outcomes and factors assessed. Persistent disparities limit the ability to improve the health of the total MCH population. Recognizing that disparities reflect complex and pervasive factors including **social determinants of health**, a deeper understanding of disparities, contributing factors and effective strategies is needed for Title V to impact systems and services to improve the health status of all individuals.

In addition to those noted for *Domains 1-5* above, **key strengths** to build on in NYS include:

- Strong **evidence base for action to improve oral health** through **community water fluoridation**, **school-based programs** and other prevention practices, combined with diverse partnerships and new funding support;
- Infrastructure to conduct **in-home assessments and interventions** for environmental health hazards in targeted neighborhoods through the state's **Healthy Neighborhoods Program**, with significant improvements in tobacco control, fire safety, lead poisoning risks, indoor air quality and asthma triggers on follow-up visits.
- A strong cross-sector commitment to investing in **proven community-based programs to improve physical activity and nutrition and reduce tobacco use**, with particular focus on **policy and**

environmental change strategies.

- **Statewide nutrition programs** that provide resources for healthy food as well as family and community nutrition education in a number of settings.
- An array of strategies to **reduce disparities and promote health equity** across MCH programs and initiatives, with a shared commitment to advancing further evidence-based approaches.

Challenges and opportunities include: **inconsistent access to fluoridated community water supplies** with ongoing challenges from groups opposing fluoridation; **integration of oral health in primary care** while addressing the supply of **dentists serving low income children and pregnant women**; strengthening **linkages between MCH and chronic disease** prevention sectors across the life course; and, identifying and advancing additional partnerships and approaches to **promote health equity and address social determinants of health**.

II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

NY's state government is comprised of executive, legislative and judicial branches. The bicameral Legislature includes a 62 member Senate and 150 member Assembly. The judicial branch, comprised of courts with jurisdictions from village/town to the State Court of Appeals, functions under a Unified Court System to resolve civil, family, and criminal matters and provide legal protection for children, mentally ill persons and others entitled to special protections. The Governor heads the executive branch, including 20 departments; department and agency heads are appointed by the Governor, with the exception of the Commissioner of the State Education Department who is appointed by the State Board of Regents.

Under the direction of Commissioner Howard Zucker, MD, JD, DOH meets its responsibilities through the Offices of: Health Insurance Programs (OHIP), the Long Term Care (OLTC), Quality and Patient Safety (OQPS); Public Health (OPH); Primary Care and Health Systems Management (OPCHSM) and Minority Health and Health Disparities Prevention. OPH and OPCHSM regional office staff conduct health facility surveillance, public health monitoring and oversight of local county health department activities with policy and management direction from DOH central office, and DOH is responsible for five health care facilities. DOH has a workforce of 3,503 filled positions, including 1,659 in state health facilities.

The OPH encompasses all DOH public health programs, including: biomedical research, public health science and quality assurance of clinical and environmental laboratories (Wadsworth Center); disease surveillance and the provision of quality prevention, health care and support services for those impacted by HIV, AIDS, sexually transmitted diseases and related health concerns (AIDS Institute); protection of human health from environmental contaminants through regulation, research and education (Center for Environmental Health); nutrition, chronic disease prevention and management, tobacco control, promotion of maternal and child health and public health surveillance and disease prevention and control activities (Center for Community Health, CCH); support and oversight of local health departments and public health workforce development (Office of Public Health Practice); and, comprehensive emergency preparedness and response activities (Office of Public Health Preparedness). Public health programs serving MCH populations span DOH, but are mainly focused in the four Divisions of CCH:

Chronic Disease Prevention; Nutrition; Epidemiology; and, Family Health (DFH).

The DFH leads the State's public health efforts to improve birth outcomes; promote healthy children, youth and families across the lifespan; and, build healthy communities through community engagement, public-private partnerships, policy analysis and education. The DFH provides the central focus for NYS's Title V MCH programming, and consists of five bureaus: Women, Infants and Adolescent Health; Child Health; Early Intervention; Dental Health; and, Administration. Additional initiatives, including maternal mortality review, clinical quality improvement projects and SSDI are led at the Division level. See Attachment 2 for an organizational chart.

II.B.2.b.ii. Agency Capacity

NY's commitment to ensuring the health and well-being of the MCH population is manifest in an extraordinary array of resources. Supports and services span organizational units within DOH and other state and local agencies and organizations. The federal Title V Program provides not only key funding but serves as a critical guiding framework for MCH work across the agency. As a large and diverse state most "front line" services are carried out by local partners, with funding, policy, planning, training, technical assistance, quality improvement and other supports from DOH/NYS Title V program. Within NYSDOH, the DFH leads and serves as NY's Title V program. As the Title V program, the DFH directly manages in excess of $900 million annually in state and federal funds to support a comprehensive portfolio of MCH programs and services; coordinates with other key MCH-serving public health programs outside the Division, including allocation of Title V funding to support MCH programs and initiatives administered in outside DFH; serves as the liaison with HRSA MCHB and ensures accountability to federal Title V requirements; and, provides leadership throughout DOH and other state agencies to advance additional MCH activities to fulfill the mission of Title V. A full description of MCH programs and resources is beyond the scope and limits of this NA summary; key resources are highlighted below, including programs directly overseen by the Title V program within DFH or supported through the Title V program. Note that resources are organized by primary population health domain, but many are relevant to multiple domains. (See also *II.A.* for health insurance and health care systems capacity).

Domain 1: Women's & Maternal Health

Family Planning Program – community-based outreach and clinical services with 49 agencies in 177 sites serving 340,000 clients annually in accordance with Title X standards; expanded Medicaid (MA) coverage for family planning (FP) services through **Family Planning Extension Program** (FP benefits up to 26 months postpartum for women MA eligible during pregnancy) and **Family Planning Benefit Program** (FP benefits for individuals ≤223% FPL, with presumptive eligibility period). Training, TA and QI support through FP **Center of Excellence**.

Maternal Mortality Review – comprehensive case ascertainment and review, data analysis, reporting and data-driven intervention/ prevention strategies, with support from OPCHSM and expert advisory committee.

Medicaid Prenatal Care – coverage for pregnant women ≤223% of the FPL, including state funds for undocumented women; comprehensive care standards and QI activities developed in collaboration with Title V.

Pathways to Success – federally-funded demonstration project in three communities to mobilize supports for pregnant and parenting teens and young adults to improve health outcomes and parental life course.

Public Health Surveillance Systems – Statewide Perinatal Data System (SPDS) electronic birth certificate and NICU module; PRAMS, BRFSS including new preconception/ family planning module.

Aid to Localities (Article VI) – standards, guidance and state formula funding to 58 local health departments for core public health activities, including **Family Health.**

Domain 2: Perinatal & Infant Health

Evidence-based home visiting– Nurse Family Partnership and Healthy Families New York models supported with state, Medicaid TCM and federal MIECHV funds; additional expansion planned through Pay for Success and Medicaid DSRIP initiatives.

Maternal and Infant Community Health Collaboratives (MICHC) – individual supports via community health workers and partnerships to improve local systems for outreach, risk assessment and follow-up supports for low income women preconception, prenatal and postpartum. Training, TA and implementation support for MICHC and MIECHV through new **Maternal & Infant Health Center of Excellence**.

Perinatal Regionalization – statewide system of birthing hospitals led by Regional Perinatal Centers (Level IV) that coordinate care and transfers for high-risk women and babies, provide consultation and lead quality improvement activities within regional affiliate networks (Levels I-III).

NYS State Perinatal Quality Collaborative (NYSPQC) – Title V-led collaboration with birthing hospitals and NICHQ to improve quality of care, maternal and newborn birth outcomes and QI capacity. Successful projects include: reducing non-indicated elective deliveries, improving assessment for hemorrhage risk and education of women on postpartum hypertension, improving nutrition and reducing central line infections for high-risk newborns.

National Infant Mortality Collaborative Improvement and Innovation Network (CoIIN) –broad partnerships and structured QI projects to promote: use of LARC; integration of preconception and interconception care in primary care; and, safe sleep practices.

Newborn Screening - Newborn Metabolic Screening Program (NBSP) collects, analyzes and reports 275,000 specimens annually for 49 diseases and conditions including all core conditions recommended by the American College of Medical Genetics and the March of Dimes; mandatory screening and for newborn hearing and critical congenital heart defects.

Breastfeeding Supports - Breastfeeding Mothers' Bill of Rights law (2010) requires health care providers and facilities to encourage and support breastfeeding, with array of DOH-led implementation activities including media and education campaigns, compliance and quality improvement work with hospitals; WIC program supports breastfeeding with lactation consultants, peer counselors, and special food package for breastfeeding mothers; home visiting and CHW programs provide additional education and support to clients.

Domain 3: Child Health

Public Health Insurance – NYS has generous public health insurance coverage: infants <223% FPL and children age 1-18 <154% FPL are eligible for **Medicaid**; children <400% FPL can enroll in subsidized insurance through **Child Health Plus** (NYS' CHIP), with no premium < 160 % FPL and sliding scale premium 160-400 % FPL.

School-Based Health Centers (SBHCs) – largest SBHC network in the country, with 50 agencies operating 230 school-based clinics providing primary medical and mental health services to 160,000 children and youth annually; School-based dental clinics in 1,200 sites provide preventive dental care to 60,000 children annually.

Immunization Program – multi-pronged program to educate families and providers, ensure access to vaccines and improve provider immunization practices.

Public Health Nutrition Programs – statewide programs provide access to healthy food for MCH and other populations: **Special Supplemental Nutrition Program for Women, Infants and Children (WIC**), the third largest in the country, offers nutrition education, breastfeeding support, referrals and nutritious foods to 500,000 participants per month through 93 WIC local agencies via a network of 500 service sites; **Child and Adult Care**

Food Program (CACFP) ensures that nutritious meals and snacks are available in eligible child care and after school programs, with 1,400 sponsoring organizations representing 14,000 participating care sites serving 340,000 meals daily; **Hunger Prevention and Nutrition Assistance Program (HPNAP)** funds 47 contractors and their 2,400 emergency food programs to provide nutritious food to those in need throughout NYS. *See Domain 6 for additional related capacity.*

Keeping Kids Alive - coordinates child death review and safety initiatives with other agencies; public outreach and education about SUID and SIDS risk and protective factors; bereavement support for families.

Domain 4: Children with Special Health Care Needs

Early Intervention Program (EIP) - largest **IDEA Part C** program in the nation, statewide service delivery system for 65,000 infants and toddlers (0-3) with disabilities and their families, with no out of pocket expenses for families; central emphasis on **family engagement and support** including current family outcomes systemic improvement project; strong focus on research, policy and outreach/education to improve identification and supports for children with **autism spectrum disorders**.

Children with Special Health Care Needs (CSHCN) Title V Programs – grant funding to LHDs to provide information, referral and other assistance to CSHCN birth to 21 and their families; gap-filling financial assistance through **Physically Handicapped Children's Program (PHCP),** voluntary direct service program operating in 31 counties to pay for medical equipment, co-pays, pharmaceuticals, medically necessary orthodontia and other health-related services for CSHCN meeting local financial and medical eligibility criteria.

Childhood Asthma - **Asthma coalitions** in regions with a high burden of asthma bring healthcare and community systems together to develop, implement, spread and sustain policy and system level changes to improve asthma care and health outcomes; the **NYS Asthma Outcomes Learning Network** builds quality improvement capacity and spreads best practices.

Medicaid (MA) – in NYS all **SSI beneficiaries are categorically eligible for MA**; MA covers all **EIP services for MA enrollees**; Title V staff are extensively engaged in the development and implementation of **Health Home** to provide enhanced care coordination for children with chronic medical and/or behavioral needs, including the transition from current waiver and TCM programs and integration with EIP.

Domain 5: Adolescent Health

Comprehensive Adolescent Pregnancy Prevention Program (CAPP) - statewide primary prevention initiative uses a youth development framework, comprehensive evidence-based sexual health programs and access to reproductive health care services for teens; 50 community-based organizations funded throughout NYS in high-need communities. **Personal Responsibility Education Program (PREP)** federal grant funds support nine additional local projects and enhanced programs working with youth in foster care and youth with emotional and behavioral problems. **ACT for Youth Center of Excellence** provides training, TA and evaluation support to all Title V adolescent health initiatives.

Successfully Transitioning Youth to Adolescence (STYA) – innovative community-based initiative funded through the federal Abstinence Education Grant Program supports mentoring, counseling and adult supervision for pre-teen youth age 9-12 in high-risk communities.

OMH's Suicide Prevention Office (SPO) - established in May 2014 to coordinate a comprehensive approach to suicide prevention in NYS; aligned with **National Action Alliance for Suicide Prevention** guidelines and the **Zero Suicide** approach in health and behavioral care; key collaborations with the **Center for Practice Innovation** to

advance implementation of evidence based practices, the **Suicide Prevention Center of New York** to coordinate and provide -training and the **DOH Injury Prevention program** to develop research opportunities.

Domain 6: Cross-cutting & Life Course

Oral health – several initiatives to promote oral health across the life course, with primary focus on MCH populations. **Community Water Fluoridation (CWF)** focuses on education and training, including: training for water operators and dental/medical and public health professionals; technical assistance to water systems and monitoring fluoride levels in drinking water; resource development to gain and maintain support for fluoridation; and, surveillance, evaluation and research. New state CWF grant program will support construction, installation, repair, rehabilitation, replacement, or upgrades of community water systems. **Fluoride Rinse Programs** provide fluoride to children in schools in non-fluoridated communities. **School-Based Dental Clinics** provide preventive dental care (*see Domain 3*). HRSA-funded **Perinatal and Infant Oral Health Quality Improvement (PIOHQI)** project seeks to integrate oral health in maternal and infant community systems and services.

Physical Activity and Nutrition – NYS public health programs to prevent obesity focus on environmental, policy and systems changes: **Eat Well Play Hard in Child Care Settings (EWPHCCS)** is a nutrition education and obesity prevention intervention in selected child care centers serving low-income children and their families; **Healthy Schools New York (HSNY)** provides technical assistance and resources to 180 school districts to establish healthful eating environments and daily physical activity opportunities, including physical education; the **Healthy Eating and Active Living by Design (HEALD) Program** implements community policy, systems and environmental changes in schools and communities to reduce risks for heart disease and obesity by increasing access to healthful foods and opportunities for physical activity; the **Just Say Yes to Fruits and Vegetables Project (JSY)** uses nutrition education workshops, food demonstrations and environmental strategies to improve access to healthier foods and physical activity.

Sexual Violence Prevention – six **regional centers** to advance evidence-based primary prevention community-level change strategies aimed at youth and young adults age 10-24, including strong focus on healthy relationships; **Sexual Assault Forensic Examiner (SAFE)** standards and training for hospitals; emerging **partnership with SUNY** to prevent sexual violence on college campuses.

Environmental Health –public health programs and infrastructure seek to protect individuals from environmental hazards including built environments; **Lead Poisoning Prevention Program (LPPP)** reduces the occurrence and consequences of childhood lead poisoning through primary prevention, surveillance, care coordination and environmental management; **Healthy Neighborhoods Program** conducts door-to-door neighborhood outreach, assessments, and interventions to address multiple common home hazards including lead paint, indoor air quality, pests and structural injury risks; **Injury Prevention programs** monitor and apply surveillance data to “Injury-Free Kids!" Campaign and focused prevention strategies.

Tobacco Prevention – comprehensive initiatives to prevent initiation, reduce current use, eliminate exposure to secondhand smoke and reduce the social acceptability of tobacco use; **Advancing Tobacco-Free Communities (ATFC)** and **Health Systems for a Tobacco-Free NY** regional contractors use evidence-based and high-level systems interventions to promote policy changes, with a primary focus on tobacco-disparate populations through housing, outdoor initiatives and large or dominant health care organizations; **NYS Smoker's Quitline** and media campaigns are key evidence-based components of smoking cessation efforts.

As noted, New York’s Title V Program, based in the NYSDOH Division of Family Health, supports and collaborates with MCH-serving programs and partners spanning multiple organizational units outside the Division and within other state agencies and organizations to achieve MCH goals. **Systems-building**, **integration and coordination of**

services, **community engagement** and **family support and empowerment** are hallmarks of this work across all domains and focus areas. See *II.A* and *II.B.2.c* for additional information on Title V coordination and collaboration with other state and local agencies, non-governmental partners, health services and systems, including current major national and state health systems reform efforts.

II.B.2.b.iii. MCH Workforce Development and Capacity

A strong and diverse MCH workforce is needed to implement the resources described in *II.B.2.b.ii*. At the community level, most services and programs are implemented by local partners including LHDs, universities and academic medical centers, hospitals and clinics, and community based organizations. Training and technical assistance are provided to support the workforce carrying out Title V activities, and DFH seeks relevant professional development opportunities for state staff.

Reducing health disparities requires that services are accessible and culturally competent. Whenever feasible, funding is targeted to organizations that are embedded within and employ staff reflective of underserved populations. For example, a required component the MICHC initiative is the use of community health workers (CHW) indigenous to the communities served to provide outreach, home visiting and other supports to link underserved populations with health care and other community services. Title V staff have championed the expansion of this CHW model through DSRIP.

At the state level, the DFH leads NYS' MCH efforts, coordinating Title V activities across DOH and directly managing core MCH programs. Due to the size and complexity of NYS, this requires significant program and policy development, program operations/ implementation, data analysis and evaluation and intra- and inter-agency communication and collaboration. There are currently 140 filled Title V-funded positions within DOH central, regional and district offices, with additional non-Title V-funded positions performing MCH activities. Staff cover the full range of MCH populations and essential public health services. Key DFH staff include (see ***Appendix*** for staff biographies):

Rachel de Long, M.D., M.P.H., Director, DFH and NYS Title V Director

Wendy Shaw, M.S., B.S.N., Associate Director, DFH

Marilyn Kacica, M.D., M.P.H., Medical Director, DFH

Christopher Kus, M.D., M.P.H., Associate Medical Director, DFH

Kristine Mesler, M.P.A., B.S.N., Director, Bureau of Women, Infant and Adolescent Health and NYS Title V Adolescent Health Coordinator

Susan Slade, RN, MS, CHES, Director, Bureau of Child Health and NYS Title V CSHCN Director

Brenda Knudson Chouffi, MS.Ed, Co-Director, Bureau of Early Intervention

Donna Noyes, PhD, Co-Director, Bureau of Early Intervention

Rachel Gaul, MBA, Director, Bureau of Administration

The position of DFH Dental Director is currently under recruitment following the retirement of Dr. Jayanth Kumar in May 2015.

Finally, NY's Title V program has cultivated strong partnerships with the SUNY School of Public Health (SPH) to support training the "next generation" of MCH professionals. Title V funds support a vibrant internship program placing SPH students in MCH programs as well as the NYS Preventive Medicine and Dental Public Health Residency Programs. Title V staff regularly mentor and advise SPH students and provide guest lectures in relevant SPH courses, including specific collaboration for this NA described in *II.B.1.* As an outgrowth of this partnership, SPH and DOH recently were awarded a new HRSA MCH Catalyst Program grant to develop an increased focus on

MCH and introduce students to MCH careers.

II.B.2.c. Partnerships, Collaboration, and Coordination

As highlighted throughout this NA, NY's Title V Program has extensive partnerships to meet the needs of NY's MCH population, including coordination and collaboration with other public health programs, state and local agencies, private sector partners, families and consumers. See Attachment 1 **f**or highlights of selected key collaborations.

II.C. State Selected Priorities

No.	Priority Need
1	Reduce maternal mortality and morbidity
2	Reduce infant mortality & morbidity
3	Support and enhance social-emotional development and relationships for children and adolescents
4	Increase supports to address the special health care needs of children and youth
5	Increase the use of preventive health care services across the life course.
6	Promote oral health and reduce tooth decay across the life course
7	Promote home and community environments that support health, safety, physical activity and healthy food choices across the life course.
8	Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population(cross-cutting).

As a result of the Needs Assessment Summary contained in NY's Year 1 (FFY 2016) application, NYS selected eight MCH priorities for 2016-20:

1. Reduce maternal mortality & morbidity
2. Reduce infant mortality & morbidity
3. Support and enhance social-emotional development and relationships for children and adolescents
4. Increase supports to address the special health care needs of children and youth
5. Increase the use of preventive health care services across the life course
6. Promote oral health and reduce tooth decay across the life course

1. Promote supports and opportunities that foster healthy home and community environments.
2. Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH populations.

The process to select priorities for the Year 1 application had several key steps building on the state's Needs Assessment (NA) Summary. This included the development of a NA profile for each MCH domain with: population health status; strengths and needs; state successes, challenges, gaps and disparities; and Title V capacity. A webinar was held with the state's MCHSBG Advisory Council to present highlights of each profile and facilitate discussion of potential priorities within the respective domains. Council members were asked to consider several factors : impact on MCH health and well-being; status and trends in key measures; gaps and disparities; evidence base for action; capacity (including financial resources, infrastructure and workforce) for implementation; momentum and buy-in; and, the need for Title V leadership and attention. Profiles and presentations were refined to incorporate Council member input and feedback. Updated materials were used as the basis for a meeting with the internal DOH Leadership group (see *II.B.1),* at which in-depth discussion was facilitated to generate a list of potential priorities for each MCH domain. Group members then had the opportunity to vote for up to 10 priorities, with at least one vote in each Domain; voters were asked to consider the same criteria as listed above for the Advisory Council.

Information gathered from all of the steps above and throughout the Needs Assessment process was reviewed by

the core MCH management team (Title V Director, Associate Director and Medical Director) to select the final priorities. The list of potential priorities was refined to consolidate similar ideas. Along with the voting results, consideration was given to all the criteria above as well as overall feasibility and alignment with the NYS Prevention Agenda, other major MCH initiatives and health systems reform efforts. In particular, the need for strong leadership from Title V was considered in choosing the final priorities.

The eight selected priorities were presented to leadership staff and Advisory Council members at the Council's meeting in April 2015; participants expressed endorsement for the priorities selected and enthusiasm for working together to advance an action plan to achieve them.

Over the course of the past year (2015-16), these priorities were revisited as part of the process to refine the preliminary Year 1 Action Plan (*see Section II.F.1*). This process was guided by the life course model, including the 2010 Maternal and Child Health Bureau's 2010 *Rethinking MCH: The Life Course Model as an Organizing Framework Concept Paper.* The eight initial priorities were affirmed, with revision to wording of Priority 7 reflected in the list above.

The **Priority Results Table** (***Attachment 3***) compares the eight priorities selected for 2016-20 to the previous 2011-2015 priorities (note that several priorities appear more than once in the table as they apply to more than one domain). The new priorities reflect a comprehensive and systematic approach to improving the health of the MCH population based on our state's needs assessment. As shown, priorities from the previous funding cycle will continue to be addressed in the new cycle, either directly and/or as objectives or strategies encompassed within priorities set for 2016-20 in the context of the life course framework. The only current priority that is not explicitly reflected in the eight priorities for 2016-20, diagnosis and treatment of asthma in women and children, is linked to priorities for primary and preventive health care (priority #5) and healthy home and community environments (priority #7), and also will continue to be addressed directly through other DOH programs. Many priorities have been expanded or refined from the previous 5-year cycle to reflect the key needs and opportunities identified in our state NA.

Overall, there was consensus among the leadership group and Council members about the priority areas selected, and no major priorities that rose to the level of strong consideration in the process needed to be deferred. Details of priorities by population health domain are presented below.

Domain 1: Maternal/Women Health

Priority 1: Reduce maternal mortality and morbidity

NY will continue its focus on maternal mortality as the rate of mortality in NYS is higher than the national rate and has significant racial disparity. This focus will be expanded to include maternal morbidity, including severe ("near miss") morbidity and the more common specific issue of maternal depression and opiod abuse. By examining severe maternal morbidity, we can highlight aspects which need immediate consideration, such as hemorrhage and hypertension, to focus interventions for improvement. Maternal depression and increasing use of opioids were identified as key emerging issues with significant implications for both maternal health outcomes and infants' and childrens' health and social-emotional development (*Domains 2 & 3*). Addressing disparities will also continue specific to maternal mortality and through cross-cutting focus (*Domain 6*).

Also closely linked to this priority, NY will continue and expand work associated with the use of preventive services by women of reproductive age (*Domain 6)*. Previous work has focused primarily on prenatal care along with reducing and eliminating disparities in birth outcomes and unintended pregnancies. There is increasing recognition that further improvements in birth outcomes for both women and infants require focus on women's health before (preconception) and between (interconception) pregnancies, reinforced by NA findings demonstrating high rates of unintended pregnancy and the impact of chronic health conditions on maternal mortality.

While we continue efforts to increase early enrollment in prenatal care and improve the quality and effectiveness of

that care, we will expand our focus on the use and quality of “well woman” preventive services, with particular focus on the integration of pregnancy planning and prevention in primary care for all women and especially for women with known risk factors. This priority aligns with our NYS IM CoIIN as well as major healthcare reform efforts in NYS, thus providing opportunities to leverage and strengthen collaborations with key external partners and internally with the NY State of Health, Medicaid DSRIP, Health Home, and the SHIP/Advanced Primary Care initiative.

Domain 2: Perinatal/Infant Health

Priority 2: Reduce infant mortality and morbidity

NY will continue a priority focus on reducing infant mortality and expand the focus to include morbidity. Within this priority, key focus areas include prevention of unintended pregnancy, preterm birth, perinatal regionalization, home visiting, safe sleep and breastfeeding, which align with the Department’s Prevention Agenda and national IM CoIIN Initiative, which focuses on safe sleep practices and prevention of unintended pregnancy to reduce infant mortality through a combination of clinical quality improvement, family education and support, in partnership with hospitals, health care providers and community-based maternal and infant public health programs. NY will continue to focus on enrollment of infants in affordable health insurance and primary medical care and on reducing disparities in birth outcomes (*Domain 6*).

Domain 3 & 5: Child & Adolescent Health

Priority 3: Support and enhance social-emotional development and relationships for children and adolescents

NY’s shared priority for child and adolescent health reflects consistent stakeholder input concerning the impact of poverty, toxic stress, critical periods of development and social-emotional relationships on lifelong health and well-being. These factors have profound influence on health outcomes across the life course including weight status/ obesity, behavioral health, risk-taking behavior, school success and future birth outcomes and parenting practices. While there has been significant attention to social-emotional development for very young children, our NA highlighted the importance of continuing to support and nurture social-emotional development and healthy relationships throughout development. Moreover, a balanced approach is needed that supports population-based positive development and asset-building strategies with strategies to recognize and support specific behavioral health needs, adverse experiences and trauma. Additional work is needed to build awareness and capacity for measuring and addressing social-emotional wellness, behavioral health and trauma within clinical primary care and population health programs and services.

This priority is closely related to the *Domain 6* priorities to support healthy home and community environments, promote use of preventive health care services and reduce health disparities, and is linked to the *Domain 1* focus on addressing maternal depression. It also aligns with existing partnerships with the state Office of Mental Health and Early Childhood and Early Intervention Advisory Councils. This priority will enable the Title V program to collaborate with other Department programs as well as other state agencies to achieve collective impact.

Domain 4: Children and Adolescents with Special Health Care Needs

Priority 4: Increase supports to address the special health care needs of children and youth.

Supporting the health and well-being of the growing population of children and youth with special health care needs and their families remains a foundational priority for NY’s Title V program. The changing landscape of health care reform provides both opportunities and continued challenges for this vulnerable population. Through our continued planning work in Year 1, the need was identified to conduct a systematic analysis, including system mapping, of the current and emerging service system to identify specific gaps and ensure new resources are fully leveraged; families and providers need to be directly engaged in this activity. Key focus areas previously identified include strengthening

family engagement and support, care management/ care coordination and transition supports for youth and young adults with special health care needs. An additional specific focal point within this priority identified as a result of continued planning work in Year 1 is follow-up of newborn hearing screening results.

This priority closely aligns with NY's current work to implement a tailored Medicaid *Health Home* benefit for CSHCN pursuant to ACA, in which the Title V program has been extensively engaged. *Health Home* is a key strategy to improve care coordination and transition supports for CSHCN that will help meet medical and behavioral needs of CSHCN, improve health and school attendance and lessen the stress on families, all of which were voiced as priorities by our stakeholders. This priority also aligns with a major systems improvement initiative to strengthen family support and family outcomes within the Early Intervention Program, which serves a key population of CSHCN and can be leveraged to identify effective practices to disseminate to additional public health programs. This priority also links to the *Domain 3 & 5* priority on supporting social-emotional well-being and the *Domain 6* life course priorities.

Domain 6: Cross-cutting Life Course

Priority 5: Increase the use of preventive health care services across the life course

Priority 6: Promote oral health and reduce tooth decay across the life course

Priority 7: Promote supports and opportunities that foster healthy home and community environments

Priority 8: Reduce racial, ethnic, economic and geographic disparities and promote health equity for the MCH population.

The introduction of the life course framework for the development of the Year 1 application prompted stakeholders to re-frame many of NY's previous 5-year MCH priorities as needs that cut across all MCH populations and life course stages. Previous priorities related to specific health care services (such as prenatal care) were revised to emphasize age-appropriate preventive health care services across the life course; priorities for oral health at specific stages were similarly expanded to embrace a life course focus. Previous issue-specific priorities related to obesity, tobacco, asthma, substance use and lead poisoning were integrated within the new life course priority to support healthy home and community environments.

Cutting across our entire state NA are persistent and compelling health disparities. These differences in health outcomes are closely linked with social, economic, and environmental disadvantage and driven by the social conditions in which individuals and families live, learn, work and play. These "social determinants of health", beyond health insurance and health care, drive disparities in MCH health outcomes. Given NY's diversity and striking disparities across virtually all MCH outcomes, it was determined that a cross-cutting priority to focus on reducing disparities and promoting health equity was needed.

This cross-cutting, life course perspective was reaffirmed in the continued planning work during Year 1 to refine our priorities and action plan. That process also served to both deepen and refine our approach to addressing life course priorities through the Title V program. For several priorities in this domain, specific focus areas were identified, as reflected in the updated Action Plan for Year 2 (*see Section II.F.1*). Additionally, our continued exploration of priorities #7 and #8 highlighted the critical importance of strengthening and integrating key cross-cutting structural elements of our work related to **collaboration**, **community engagement** and **health equity** across the entire portfolio of Title V programs. Strategies to pursue this capacity-building are also highlighted in the Year 2 Action Plan.

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

- NPM 1 - Percent of women with a past year preventive medical visit
- NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
- NPM 5 - Percent of infants placed to sleep on their backs
- NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
- NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day
- NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
- NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
- NPM 13 - A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Linkage of State Selected Priorities with National Performance and Outcome Measures

National Performance Measures (NPMs) for NY's MCH Action Plan were determined through the needs assessment conducted by NYS that consisted of extensive data analysis and evaluation, stakeholder input and discussion as well as the discussions related to selection of state priorities. The eight NPMs selected for focus are listed in the following table. Additional State Performance Measures (SPMs) have been developed for Year 2 (See Section II.E). Alignment of selected NPMs with NY's priorities and federally-defined MCH population domains is demonstrated below. Note that several NPM selected are associated with more than one priority and/or population domain.

MCH Priorities, National Performance Measures and Federal Population Domains

2016-2020 MCH Priority	National Performance Measure	Population Domain(s)
Reduce maternal mortality and morbidity	NPM 1: Percent of Women with a past year preventive visit	Maternal / Women Health
Reduce infant mortality and morbidity	NPM 3: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU) NPM 5: Percent of infants placed to sleep on their backs	Perinatal / Infant Health
Support and enhance social-emotional development and relationships for children and adolescents	NPM 6: Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool NPM 10: Percent of adolescents age 12 - 17 with a preventive medical visit in the last year NPM 12: Percent of children with and without special health care needs who received services necessary to make transitions to adult health care	Child Health Adolescent Health

Increase supports to address the special health care needs of children and youth	NPM 6: Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool NPM 12: Percent of children with special health care needs who received services necessary to make transitions to adult health care	Children and Adolescents with Special Health Care Needs
Increase use of preventive health care services across the life course:	NPM 1: Percent of Women with a past year preventive visit NPM 6: Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool NPM 10: Percent of adolescents with a preventive services visit in the last year	Cross-cutting Life Course Maternal/Women Health Perinatal/InfantHealth Child Health Adolescent Health
Promote oral health and reduce tooth decay across the life course	NPM 13: Percent of women who had a dental visit during pregnancy NPM 13b: Percent of infants and children, ages 1 to 17 years, who had a preventive dental visit in the last year	Cross-cutting Life Course Maternal/Women Health Child Health Adolescent Health
Promote supports and opportunities that foster healthy home and community environments	NPM 8 - Percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day	Cross-cutting Life Course Child Health Adolescent Health
Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population	Use in stratifying measures	Cross-cutting Life Course All domains

Priority #1 Maternal mortality and morbidity will be followed by **NPM1 percent of women with a past year preventive visit** for all women. The NYS Expanded BRFSS Report 2008-2009 shows the NYS performance on NPM 1 is 78.5% ,which is better than the national average of 73.4% (as reported by the CDC BRFSS 2007-2009). More recent information from the NYS BRFSS Report (2013) has a percentage of 69.4% for women ages 18 – 44 years compared to a US average of 66.7% (the US rate is from the CDC BRFSS 2007-2009). This visit is the basis to beginning preventive healthcare as well as initiating pregnancy planning and prevention of unintended pregnancies.

Priority #2 Infant mortality and morbidity will be followed by multiple National Performance Measures. **NPM3 percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)** will impact both mortality and morbidity. We have seen from NYS data that since 2009, 90% of VLBW infants have been delivered in hospitals with Level III-IV NICUs, with a corresponding decline in mortality rates. If an infant is delivered in a hospital with the correct clinical expertise and equipment, risk should be decreased for poor outcomes. NYS will continue to focus on its system of regionalized perinatal care to evaluate mortality and morbidity to identify areas for intervention and improvement. **NPM5 percent of infants placed to sleep on their backs** has

improved slowly over time with a 2011 NYS rate of 70% while the NYC rate is 64.3% and rest of state rate of 75.6% (PRAMS). NYS will be focusing on this measure specifically as part of the NYS IM CoIIN initiative to effect improvement, using this measure as a proxy for other safe sleep practices. Of note, while not selected for reporting purposes due to MCHB's limit on the number of NPMs per state, NYS also will follow and focus on improving NPM4 percent of infants ever breastfed and exclusively breastfed for 6 months.

Priority #3 Social-emotional development and relationships for children and adolescents will be followed by several NPMs. **NPM6 Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool** captures a critical (but not sufficient) aspect of supporting children's development. Although parent reporting of screening based on this measure has increased over time to 21.3% in 2012, NY lags behind the national average of 30.8%. **NPM10 percent of adolescents with a preventive services visit in the last year** and **NPM12 percent of adolescents who received services necessary to make transitions to adult health care** capture selected elements of supporting adolescent development and relationships. Expanding data collection and analysis related to a broader spectrum of well-being and development for young people is part of this priority, and additional state performance measures and evidence-based strategy measures for this priority will be emphasized given the limits of the available NPMs.

Priority #4 Supports for children and youth with special health care needs will be followed by a series of measures. **NPM6 Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool** reflects the importance of routine developmental screening to identify CSHCN, and as noted above current NYS performance is relatively low on this measure. **NPM12 percent of children with special health care needs who received services necessary to make transitions to adult health care** was reported in 2010 to be 39.7% with a HP2020 target of 45.3%. Performance of this measure needs improvement in NYS and reflects a key area of concern identified by families, youth and other stakeholders in our NA.

Priority #5 Use of preventive and primary health care services across the life course will be followed through a suite of measures reflecting health care service utilization and quality for key life course periods. **NPM1 percent of women with a past year preventive visit** for all women is 78.5% for NYS which is better than the national average of 73.4%. More recent information from the NYS Expanded BRFSS Report 2013 has a percentage of 69.4% for women ages 18 – 44 years compared to a US average of 69.4%. This visit is the basis to beginning preventive healthcare as well as initiating pregnancy planning and prevention of unintended pregnancies. **NPM6 percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool** measures a key recommended component of comprehensive well child care. Although parent reporting of developmental screening based on this measure has increased over time to 21.3% in 2012, NY lags behind the national average of 30.8%. **NPM10 percent of adolescents with a preventive services visit in the last year** has seen a slight increase from 85.3% in 2003 to 91.7% in 2012. When ages are viewed separately, the percentage of adolescents receiving a preventive visit decreases with age; for adolescents' age 12 years, the frequency was 97.7% in 2012 while age 17 years was 89.1%. Moreover, state managed care quality data show more significant discrepancies in delivery of specific preventive services, including risk assessment and counseling on key topics, to adolescents. Since older adolescents are transitioning to adult care and health care consumer roles, and have changing developmental needs related to sexual health and other health behaviors, this is a crucial visit.

Priority #6 Oral health and tooth decay will be followed with **NPM13 A and B. NPM13A percent of women who had a dental visit during pregnancy** has been a focus in NYS for many years and is a focus of the NYS Prevention Agenda. However, with this focus, rates have hovered between 40 – 50% without improvement (PRAMS**). NPM13B percent of infants and children, ages 1 to 17 years, who had a preventive dental visit in the last year** through parent report was 77% in 2012. This measure also needs improvement.

Priority #7 Healthy home and community environments will be followed by NPM8. **NPM8 percent of children**

ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day has remained relatively stable and was 24.6% in 2012. In 2012, children age 12 – 17 (19.6%) and females (19.4%) were less likely to exercise at least 20 minutes daily. In the context of this priority, this measure is understood to be a proxy for a broader array of community and neighborhood supports that promote healthy behaviors.
Priority #8 Racial, ethnic and economic disparities and health equity across in all core MCH outcomes does not align with any specific NPM. Since NYS has diverse populations and noted disparities, all measures will be stratified by racial, ethnic, economic and geographic variables.

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

- SPM 1 - The percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy
- SPM 2 - The percentage of women aged 15 to 44 years that adopt or continue use of the most effective or moderately effective methods of contraception.
- SPM 3 - The percentage of children and adolescents survey who demonstrate 20 or more developmental assets
- SPM 4 - The percent of families participating in the Early Intervention Program who meet or exceed the state's standard for the New York Impact on Family Scale
- SPM 5 - The percentage of NYS residents served by community water systems that have optimally fluoridated water

Linkage of State Selected Priorities with State Performance and Outcome Measures

State Performance Measures (SPMs) for NY's MCH Action Plan were determined through the needs assessment conducted by NYS that consisted of extensive data analysis and evaluation, stakeholder input and discussion as well as the discussions related to selection of state priorities. The eight National Performance Measures (NPMs) selected for focus are listed in the following table. Additional State Performance Measures (SPMs) were then developed for Year 2 to further identify progress in State priorities where NPMs were insufficient to do so. Section II.F.1 State Action Plan Narrative clearly outlines the linkages of all performance measures contained in NYS's Action Plan. The information below summarizes the significance of the State Performance Measures identified by NY in order to assess improvement in the selected MCH priorities. Alignment of selected SPMs with NY's priorities and federally-defined MCH population domains is contained in the table below.

MCH Priorities, State Performance Measures and Federal Population Domains

2016-2020 MCH Priority	National and State Performance Measure	Population Domain(s)
#1 Reduce maternal mortality and morbidity	NPM 1 - Percent of Women with a past year preventive visit. **SPM 1 – The percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy.** **SPM 2 – The percentage of women age 15-44 years who are enrolled in Medicaid and use the most effective reversible methods of contraception**.	Maternal / Women Health
#2 Reduce infant mortality and morbidity	NPM 3 -Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU) NPM 5 - Percent of infants placed to sleep on their backs	Perinatal / Infant Health
#3 Support and enhance social-	NPM 6 - Percent of children, ages 9 through 71	Child Health/

emotional development and relationships for children and adolescents	months, receiving a developmental screening using a parent-completed screening tool NPM 10 - Percent of adolescents with a preventive services visit in the last year NPM 12 - Percent of children with special health care needs who received services necessary to make transitions to adult health care. **SPM 3 – Percent of children and adolescents surveyed who demonstrate 20 or more developmental assets.**	Adolescent Health
#4 Increase supports to address the special health care needs of children and youth	NPM 6 - Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool NPM 12 -Percent of children with special health care needs who received services necessary to make transitions to adult health care. **SPM 4 – Percent of families participating in the Early Intervention Program who meet or exceed the state's standard for the NY Impact on Family Scale.**	Children and Adolescents with Special Health Care Needs
#5 Increase use of preventive health care services across the life course.	NPM 1 -Percent of women with a past year preventive visit NPM 6 -Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool NPM 10 - Percent of adolescents with a preventive services visit in the last year. **SPM 1 – The percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy.** **SPM 2 – The percentage of women age 15-44 years and enrolled in Medicaid using the most effective reversible methods of contraception.**	Cross-cutting Life Course Maternal/Women Health Perinatal/InfantHealth Child Health/ Adolescent Health
#6 Promote oral health and reduce tooth decay across the life course	NPM 13a - Percent of women who had a dental visit during pregnancy NPM 13b - Percent of infants and children, ages 1 to 17 years, who had a preventive dental visit in the	Cross-cutting Life Course Maternal/Women Health

	last year. **SPM 5 – Percent of NYS residents served by community water systems that have optimally fluoridated water.**	Child Health Adolescent Health
#7 Promote home and community environments that support health, safety, physical activity and healthy food choices	NPM 8 - Percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day	Cross-cutting Life Course Child Health/ Adolescent Health
#8 Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population	Use in stratifying measures	Cross-cutting Life Course All domains

Priority #1 Maternal mortality and morbidity will be followed by NPM1 percent of women with a past year preventive visit for all women as discussed in Section II.D. Progress toward achievement of objectives and outcomes associated with Priority #1 will be tracked through NPM #1: Due to the significant impact primary and preventive health care can have on maternal mortality and morbidity, two new state performance measures (SPM) were identified: **SPM 1: The percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy and SPM 2: Percentage of women age 15-44 years and enrolled in Medicaid using the most effective, reversible methods of contraception.** These SPMs address key elements of preconception health care and will build on collaborations that NY's Title V Program has developed with the DOH Division of Chronic Disease Prevention (DCDP)/Behavioral Risk Factor Surveillance System (BRFSS) (SPM 1), and DOH OHIP and Office of Quality and Patient Safety (OQPS) for NY's Infant Mortality CoIIN initiative and CDC-led 6|18 initiative (SPM 2).

Priority #2 Infant mortality and morbidity will be followed by multiple National Performance Measures including: NPM 3: Percent of Very Low Birth Weight (VLBW) infants born in a hospital with a Level III or higher Neonatal Intensive Care Unit (NICU) and NPM 5: Percent of infants placed to sleep on their backs. While not selected for reporting purposes due to MCHB's limit on the number of NPMs per state, NYS also will follow and focus on improving NPM 4: Percent of infants ever breastfed and exclusively breastfed for 6 months. There have been no additional State Performance Measures developed for this MCH priority.

Priority #3 Social-emotional development and relationships for children and adolescents will be followed by several NPMs. NMP6: Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool captures a critical (but not sufficient) aspect of supporting children's development. NPM10: Percent of adolescents with a preventive services visit in the last year and NPM12: Percent of adolescents who received services necessary to make transitions to adult health care capture selected elements of supporting adolescent development and relationships.

While this is an emerging focus for NY's Title V program, there are many relevant frameworks and an evidence base to support this work. Resources reviewed as part of NY's action plan refinement process during Year 1 include: *From Neurons to Neighborhoods*; the CDC's *Essentials for Childhood* model; The Center for Social Emotional Foundations of Early Learning (CSEFEL); Center for the Study of Social Policy; Preparing Youth to Thrive; the Search Institute's Developmental Assets® framework; and, the collective body of Adverse Childhood Experiences (ACES) foundational research. NY's State Action Plan seeks to focus on a strength-based rather than a deficit model to address this extremely important priority for children and adolescents. Therefore, **SPM 3: Percentage of adolescents surveyed who demonstrate 20 or more developmental assets** has been added to NY's State Action Plan. Title V staff will work with the ACT for Youth Center of Excellence to develop or modify a tool that can be

used by child- and adolescent-serving MCH programs across age groups to support and enhance positive youth development to improve outcomes in this MCH priority.

Priority #4 Supports for children and youth with special health care needs will be followed by a series of measures including NPM6: Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool, NPM12: Percent of children with special health care needs who received services necessary to make transitions to adult health care, and a new **SPM 4: Percent of families participating in the Early Intervention Program who meet or exceed the state's standard for the NY Impact on Family Scale.** Pursuant to a requirement of the U.S. Department of Education, Office of Special Education Programs (OSEP) for the Individuals with Disability Education Act (IDEA) Part C state programs, New York's Early Intervention Program (EIP) developed a State Systemic Improvement Plan (SSIP). OSEP required that the SSIP be focused on a child outcome, family outcome, or on a constellation of outcomes related to the child and family outcome indicators currently reported to OSEP. (Refer to Section II.F.1 State Action Plan Narrative for further detail.) NY is focusing on positive family outcomes for NY's State Identified Measurable Results with a goal to increase the percentage of families exiting the EIP who report that the EIP helped them achieve the level of positive family outcomes defined in conjunction with stakeholders as representing the State standard. Lessons from this initiative will inform NY's efforts in enhancing supports for CSHCN and their families to improve efforts such as developing or improving supports for the transitions families and youth experience as they access the myriad of services and service systems throughout the child/young adult's life.

Priority #5 Use of preventive and primary health care services across the life course will be followed through several measures reflecting health care service utilization and quality for key life course periods including: NPM1: Percent of women with a past year preventive visit; NPM6: Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool measures a key recommended component of comprehensive well child care; and, NPM10: Percent of adolescents with a preventive services visit in the last year. As stated in the State Action Plan Narrative, across the MCH life course, preventive health care services encompass well woman, preconception, prenatal, postpartum, interconception, well baby, well child and well teen care. Given the potential breadth of this priority, in refining NY's Action Plan, Title V staff considered fundamental cross-cutting needs to support use of preventive health care as well as specific populations and areas of clinical practice most in need of improvement, based on analysis of available data and stakeholder input. Important resources for development of this priority include the USPSTF recommendations for preventive care; The AAP *Bright Futures* Guidelines for Health Supervision of Infants, Children and Adolescents; and EPSDT guidelines for state Medicaid programs.

This priority is closely linked to other state priorities in all five other domains, reflecting the key importance of preventive health care services to promoting health across the life course. Therefore, NY has added two State Performance Measures to more fully assess progress in this MCH priority area including: **SPM1: Percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy; and SPM 2: Percentage of women age 15-44 years and enrolled in Medicaid using the most effective, reversible methods of contraception**. The addition of the SPMs will support NY's ability to assess practices related to preconception/interconception care as well as use of Long Acting Reversible Contraception and develop strategies and processes to improve policies and practices.

Priority #6 Oral health and tooth decay will be followed with NPM13: A and B. NPM13A: Percent of women who had a dental visit during pregnancy, and NPM13B: percent of infants and children, ages 1 to 17 years, who had a preventive dental visit in the last year. NY has also included a new **SPM5: Percent of NYS residents served by community water systems that have optimally fluoridated water.**

Community Water Fluoridation (CWF) is an essential public health strategy to prevent dental caries and promote oral health for those individuals who are served by public water systems. As described in the 2015 Annual Report, Title V staff, in collaboration with colleagues from the DOH Center for Environmental Health (CEH) lead several key efforts to support community water fluoridation. These efforts include implementation of legislation and state funding for CWF enacted in 2015, providing $5 million in annual grant funding to support public community water systems for

costs related to the construction, installation, repair, rehabilitation, replacement, or upgrade of drinking water fluoridation facilities. Title V and CEH also support onsite technical assistance to fluoridated public water systems, or those looking to start fluoridation. The addition of this SPM will enable NY's Title V program to more fully understand the success of the Title V program in promoting CWF and the potential to improve oral health of NY's MCH population.

Priority #8 Healthy home and community environments will be followed by: NPM8: Percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day. There have been no additional State Performance Measures developed for this MCH priority.

Priority #9 Racial, ethnic and economic disparities and health equity across all core MCH priorities and outcomes does not align with any specific NPM. Since NYS has diverse populations and noted disparities, all measures will be stratified by racial, ethnic, economic and geographic variables. It is a priority of NY's Title V program to assess all performance measures, wherever possible, by race and ethnicity to more fully understand the needs of the MCH population, develop improved strategies to address those needs and determine the level of success in reducing long-standing racial and other disparities to improve the health and wellness of NY's MCH population.

II.F. Five Year State Action Plan

II.F.1 State Action Plan and Strategies by MCH Population Domain

New York's State Action Plan builds on years of MCH leadership and public health investments. Flowing from the Needs Assessment (NA) (*Section II.B*), State Priorities (*II.C)* and National Performance Measures *(II.D*), NY's plan is driven by data, evidence and input from stakeholders including families. Informed by MCHB's 2010 *Rethinking MCH: The Life Course Model as an Organizing Framework Concept Paper*, NY's plan aims to translate life course concepts into an integrated portfolio of actionable, effective and measurable strategies to improve MCH outcomes and equity.

The Preliminary Action Plan submitted with our Year 1 application identified preliminary objectives, strategies and NPMs for each of NY's eight state priorities. The plan was updated this year to establish quantitative 2020 targets for objectives, refine strategies, and establish state performance measures (SPM) and Evidence-Based/Informed Strategy Measures (ESM). This work was led by cross-programmatic Title V Staff Action Planning Teams, with leadership development support from the National MCH Workforce Development Center. Targets were set based on analysis of data trends and projected impact of strategies. Key considerations for refining strategies included evidence base, feasibility and alignment with stakeholder priorities, with attention to advancing a balanced portfolio of population health surveillance, policy, workforce development, community-based prevention and clinical quality improvement strategies.

State Action Plan Table

Please go to the Appendix to view a full version of the State Action Plan Table.

Women/Maternal Health

Measures

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	73.4	73.8	74.2	74.7	75.1	75.6

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	72.7 %	1.6 %	2,603,754	3,583,912
2013	72.9 %	1.4 %	2,626,463	3,603,633
2012	70.9 %	1.8 %	2,519,090	3,554,528
2011	70.1 %	1.6 %	2,448,481	3,495,201
2010	72.1 %	1.4 %	2,590,596	3,593,486
2009	70.1 %	1.7 %	2,524,914	3,600,765

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 1.1 - Life Course - 13

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2.0	10.0	15.0	20.0	25.0

ESM 1.2 - Life Course - 14

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	10.0	30.0	40.0	50.0	60.0

ESM 1.3 - Life Course - 15

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	40.0	50.0	60.0	70.0	80.0

ESM 1.4 - Life Course - 16

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	40.0	50.0	60.0	70.0	80.0

ESM 1.5 - Life Course - 1

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

ESM 1.6 - Life Course - 2

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

ESM 1.7 - Life Course - 3

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

ESM 1.8 - Maternal Women's Health - 1

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

ESM 1.9 - Maternal Women's Health - 2

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

ESM 1.10 - Maternal Women's Health - 3

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

ESM 1.11 - Maternal Women's Health - 4

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	20.0	30.0	35.0	40.0	50.0

ESM 1.12 - Maternal Women's Health - 5

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	87.0	89.0	90.0	92.0	94.0

ESM 1.13 - Maternal Women's Health - 6

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Women/Maternal Health - Plan for the Application Year

MATERNAL & WOMEN'S HEALTH

State Priority #1: Reduce maternal mortality and morbidity

2020 State Objectives:

- Objective MWH-1: Reduce the maternal mortality rate in NYS by 10% to 16.1 maternal deaths per 100,000 live births in 2020.
- Objective MWH-2: Increase the percentage of women enrolled in Medicaid Managed Care who are screened for maternal depression during prenatal care by 10% to 94.2%, and during postpartum care by 10% to 90.9%.

As highlighted in the NA, maternal mortality and morbidity are critical indictors for maternal and women's health in New York State (NYS). The U.S. is one of only eight countries worldwide with a rise in maternal mortality from 2003 – 2013, and NYS ranks 47th among 50 states in relation to maternal mortality. NY's maternal mortality rate of 18.9 maternal deaths per 100,000 live births remains 1.5 times higher than the Health People 2020 objective of 11.4. Racial disparities in maternal deaths are significant but appear to be improving, with a statewide black to white mortality ratio that peaked in 2006 at 6.3 to 1 and declined to 4.9 to 1 in 2009 and continued to decrease to 3.3 to 1 in 2013. Leading causes of maternal death in NYS, based on the review of the 2006 – 2008 case cohort (n=125)

completed this year, include: hemorrhage (23%); hypertension (23%); embolism (17%); cardiovascular problems (10%); intracerebral hemorrhage (4%) and cardiac arrest/failure (3%). Over half the women who died were obese (30%) or overweight (15%).

Severe Maternal Morbidity (SMM) – defined as life threatening medical complications (e.g., sepsis, embolism, etc.) and/or the need for life saving interventions (e.g., assisted ventilation) during delivery-related hospitalizations is 50 – 100 times more common than maternal mortality. SMM fundamentally affects the lives of mothers, newborns, families and health care provider teams, and 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. Initial analysis of SMM in NY completed in 2015 identified an increase in SMM from 2008 to 2013 – peaking in 2010 at 290 cases per 10,000 deliveries. Leading diagnoses included: severe anemia (10%); hypertensive disorders (8%); pregnancy-related hypertension (6%); hemorrhage (5%); and chronic lung disease (4.4%).

In the January 2015 paper *Putting the "M" Back in the Maternal and Child Health Bureau: Reducing Maternal Mortality and Morbidity,* the federal Maternal and Child Health Bureau described the five main areas that need to be addressed to improve maternal health in the U.S. as improving women's health before, during and beyond pregnancy; improving the quality and safety of maternal health care; improving both clinical and public health systems of maternity care; improving public awareness and education; and, improving surveillance and research. These align closely with the six core elements of a comprehensive maternal health initiative identified in the Association of Maternal & Child Health Programs' 2015 *Health for Every Mother: A Maternal Resource and Planning Guide for States*, which include: strengthen maternal data systems; increase the value of investments in maternal health; enable healthy living; improve access to care; ensure high quality health care for women; and, ensure readiness and response to obstetric emergencies.

In updating and refining our state action plan for this critical priority, NY's Title V program seeks to strategically focus and align our work with both of these national frameworks. This will require internal work to strengthen public health surveillance and data analysis as well as steps to enhance strategic collaboration with both internal and external partners to advance data-driven clinical and community-based prevention strategies. As emphasized in the NA, improving birth outcomes for both mothers and infants requires a life course perspective to support women's health before, during and beyond/between pregnancies. Preconception and inter-conception health care – including prevention of unintended pregnancy through the use of effective contraception; identification and follow-up for medical, behavioral and psycho-social risk factors; and, optimal management of chronic disease – should be an integral component of health care for all women regardless of future pregnancy intentions.

While this updated Action Plan focuses on specific strategies and measures, it is important to recognize that these efforts will build on and be embedded within the extensive body of MCH public health programs and activities already in place through NY's Title V Program, including: Comprehensive Adolescent Pregnancy Prevention Program (CAPP); Family Planning Program; School-Based Health Center (SBHC) Program; Maternal and Infant Community Health Collaborative (MICHC); Maternal, Infant and Early Childhood Home Visiting (MIECHV); Perinatal Regionalization; Maternal Mortality Review; New York State Perinatal Quality Collaborative (NYSPQC); Text4Baby; and, the Growing Up Healthy Hotline (See *Section II.B* and *2015 Annual Report*). Additionally, this work will leverage continued collaboration with our extensive network of partners including the New York State of Health (our state-operated health insurance exchange) and the NYS Office of Health Insurance Programs (OHIP) which administers our state's Medicaid Family Planning Benefit Program (FPBP), Family Planning Extension Program (FPEP) and Medicaid Prenatal Care Programs, respectively.

This priority is closely linked to other state priorities including: Priority #2: Reduce infant mortality and morbidity; Priority #3: Support and enhance social-emotional development and relationships for children and adolescents; and all four Life Course priorities (#5-8).). In particular, strategies to address maternal mortality and morbidity are largely inextricable from those to address infant mortality and morbidity; thus, the strategies described below for Domain 2 should be considered part of the continuum of public health activities to address Priority #1.

Progress toward achievement of objectives and outcomes associated with Priority #1 will be tracked through **NPM #1:** Percent of women with a past year preventive medical visit and two new state performance measures (SPM): **SPM 1**: The percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy
and **SPM 2**: Percentage of women age 15-44 years and enrolled in Medicaid using the most effective, reversible methods of contraception. These SPMs address key elements of preconception health care and leverage important investments and collaborations NY's Title V Program has developed with the DOH Division of Chronic Disease Prevention (DCDP)/Behavioral Risk Factor Surveillance System (BRFSS) **(SPM 1),** and DOH OHIP and Office of Quality and Patient Safety (OQPS) for NY's Infant Mortality CoIIN initiative and CDC-led 6|18 initiative **(SPM 2)**.

Strategy MWH-1: Continue maternal death case ascertainment and review process and issue reports of maternal death review findings and trends.

As described in the 2015 annual report, NY 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, and is supported by a maternal mortality expert committee. Building on the 2015 release of the maternal mortality data report for 2006-08, analysis of 2012-13 is currently being completed, with report release planned for next year. Going forward, Title V plans to continue this review process while aiming to release data reports annually to support prevention and clinical improvement strategies in conjunction with partners. Because lags in data reporting remain a perennial challenge in issuing "real time" data reports, the development of annual reports may require the use of interim data. Through the updates to NY's perinatal regionalization system and standards (see Priority #2) and our emerging collaboration with the *New York State Partnership for Maternal Health* (See Strategy MWH-3), NY's Title V Program will continue to explore opportunities to streamline data analysis processes, and share lessons learned to improve maternity care practices, such as through grand rounds style webinars.

Implementation of this strategy will be tracked by **ESM MWH-1:** maternal mortality report issued at least annually.

Strategy MWH-2: Expand surveillance and reporting activities to include severe maternal morbidity

Studying severe maternal morbidity (SMM) is critical both to preventing maternal morbidity and to strengthening our understanding of maternal death. Because SMM captures the most serious cases of maternal illness, analysis of SMM improves the opportunity to identify factors that are relevant to preventing future cases from progressing to the most serious stages of illness, disability or death. Building on the initial SMM data analysis work described above and in the 2015 annual report, we plan to work toward incorporating SMM case identification and analysis in annual surveillance reports to inform clinical and community prevention activities led by both Title V and our partners. As noted for mortality data, issuing annual reports may require the use of preliminary or "interim" data given lags in data reporting and analysis.

Implementation of this strategy will be tracked by **ESM MWH-2**: severe maternal morbidity surveillance will be initiated and operationalized by the program.

Implementation of this strategy will be tracked by **ESM MWH-2**: severe maternal morbidity report issued at least annually.

Strategy MWH-3: In collaboration with key partners, co-convene the *New York State Partnership for Maternal Health* to advance a comprehensive maternal health agenda that includes policy, community prevention and clinical quality improvement strategies.

Advancing a comprehensive approach to address maternal mortality and morbidity requires the coordinated work of many partners spanning public health, clinical medicine, health systems, health insurance, community-based prevention and policy. In NYS, heightened attention to the problem of maternal mortality – in particular the striking racial and economic disparities – has prompted significant work across several key organizations and settings, including the DOH Title V Program, NYS chapter of American Congress of Obstetricians and Gynecologists (ACOG), state hospital associations including both the Health Care Association of New York State (HANYS) and Greater New York Hospital Association (GNYHA), the New York City Department of Health and Mental Hygiene

(NYCDOHMH) and the New York Academy of Medicine (NYAM). See the 2015 annual report for more detail on key initiatives.

Maternal Mortality was identified as one of the core focus areas in the *Prevention Agenda*, New York State's health improvement plan for 2013-18 developed by the New York State Public Health and Health Planning Council (PHHPC) at the request of NYSDOH and in partnership with more than 140 organizations across the state. Following the release of the *Prevention Agenda,* the Public Health Committee of PHHPC, under the leadership of chairperson Dr. Jo Ivey Boufford, identified maternal mortality as a specific health issue from the *Prevention Agenda* for special attention to "move the needle" in the state. From 2012-2015 the Committee, in partnership with our Title V Program, convened a series of meetings to focus on the problem of maternal mortality. In particular, these meetings focused on clinical practice and policy opportunities to integrate preconception health care, pregnancy planning and prevention of unintended pregnancy in health care for all women of reproductive age, including leveraging key health reform initiatives in the state. The proceedings of this work were published in January 2016 and is posted on the DOH web at

http://www.health.ny.gov/facilities/public_health_and_health_planning_council/docs/prevention_of_maternal_mortality.

As an outgrowth of this dialogue, key organizations noted above (DOH, ACOG, HANYS, GHYHA, NYCDOHMH, NYAM) took steps beginning in November 2015 to convene a formal partnership to strengthen collaboration among partners to improve maternal health and reduce maternal mortality in NYS. Mirroring the federal Maternal Health Initiative described in the 2015 MCHB paper, the ***New York State Partnership for Maternal Health*** seeks to advance a comprehensive and collaborative agenda for improving maternal health across the life course and ensuring the quality and safety of maternity care in NYS. Building on the Public Health Committee discussions and an initial review of shared goals resources and data, the partnership identified pre/interconception health as a starting point for collaboration and a specific initial focus on improving pre/interconception care for women. In the next year, the partnership plans to identify opportunities to promote preconception health planning through development of education and information for health care providers and promote public awareness of the importance of pregnancy planning among women of reproductive age, with an initial focus on women with chronic disease.

Implementation of this strategy will be tracked by **ESM MWH-3**: Number of policy, community prevention or clinical quality improvement strategies implemented in past year as a result of Partnership collaboration.

Strategy MWH-4: Collaborate with Medicaid to institute reimbursement for immediate postpartum insertion of LARC

As highlighted in the NA, over half of pregnancies in NYS are unintended. Pregnancy planning and prevention are greatly influenced by use of effective contraception. Unintended pregnancy is associated with an increased risk of poor birth outcomes. Long-acting reversible contraception (LARC) is safe and highly effective in preventing unintended pregnancies. Unlike other forms of birth control (such as barrier methods, oral contraceptives, and sterilization), LARC requires no user intervention, works over long periods of time, and can be reversed. Contraceptive implants and Intrauterine Devices (IUDs) are highly effective and reversible contraceptive methods with failure rates of less than one percent.

IUDs can be inserted at any time during a woman's menstrual cycle as well as immediately after miscarriage, abortion, or post-delivery. Immediate insertion post-delivery has several benefits for a new mother, including the convenience of not having to schedule and return for a follow-up procedure and it requires no further action for pregnancy prevention. This reduces the risk of pregnancy due to missed follow-up visits or failure to use a method of contraception. Non-hormonal IUDs are especially beneficial for breastfeeding mothers.

Despite the effectiveness of LARC, it is not widely used by most women due to concerns regarding safety, misunderstanding that devices may cause Sexually Transmitted Diseases, and a general lack of knowledge regarding LARC. Additionally, because of the decreasing popularity of IUDs in the past, health care providers may not have had experience placing IUDs during their medical training. In addition, lack of insurance reimbursement and inadequate supplies of readily available IUDs in provider offices may pose challenges for the use of LARC in cost-effective and time-efficient ways.

Building on the extensive work summarized in the 2015 Annual Report, including NY's Infant Mortality CoIIN initiative and CDC-led 6|18 initiative, NY's Title V Program will continue to collaborate with NY's State Medicaid Program to advance policy changes that will support reimbursement for immediate postpartum insertion of LARC as a key policy strategy for prevention of unintended pregnancy and supporting healthy birth spacing.
Implementation of this strategy will be tracked by **ESM MWH-4**: Percentage of managed care organizations that provide reimbursement for postpartum LARC insertion.

Strategy MWH-5: Collaborate with partners to increase screening and follow-up support for maternal depression.
As highlighted in the NA, maternal depression is the most common morbidity among postpartum women, affecting 10-20% of women during or within 12 months of pregnancy. Maternal depression has been elevated as a priority concern across many stakeholder groups and organizations in NYS, creating both significant opportunity for collective impact along with the challenge of coordinating and leveraging multiple interests to achieve that result. The Title V Program is uniquely positioned to provide leadership in facilitating connections between partners and advancing collaborative strategies that span health insurance, health care and community-based settings and partners across the state.
Pregnant women and new mothers have frequent contact with the health care system – including both maternal and pediatric health care providers - but providers may not know how to identify or address depression within their practices, and women may be reluctant to raise questions with their providers because of stigma or lack of knowledge about depression. Screening women for maternal depression can improve outcomes for women and infants. There is good evidence that maternal depression can be accurately identified using brief standardized depression screening instruments, and that treatment improves the prognosis for the woman and her family. Screening can be incorporated in routine prenatal, postpartum and well-baby visits, and must be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. Studies have found that many women prefer to receive follow up care, and are more likely to actually engage in follow-up care, when it is provided within the primary care practice where screening is conducted; several specific models of primary care-based collaborative management have been positively evaluated.

Despite widespread acknowledgement of the prevalence and impact of maternal depression, previous studies suggest that screening for maternal depression is not standard practice, and especially that few providers use standardized validated screening tools – specific studies found that less than half of OB/GYN providers and less than 10% of pediatricians routinely screen their patients (or patients' mothers) for depression using standardized screening tools.

For the past few years, Title V staff have participated in a Prenatal Care workgroup with the OQPS to support implementation of Medicaid Prenatal Care standards and other related collaborative efforts. Part of the focus of this workgroup has been the development and implementation of a focused study on the quality of prenatal care provided through the Medicaid Prenatal Care Program. NYS specific data from the baseline 2013 Medicaid Prenatal Care Study showed that 63% of women were assessed for depression at the initial prenatal visit assessment, and 51.4% at postpartum visits, but among these only 7% of records documented using standardized screening tools. More recent Medicaid quality data reviews suggest that depression assessment practices are improving for both prenatal (85.6%) and postpartum (82.6%) visits, which is promising. There is also a need to improve follow-up for women identified with depression symptoms through screening. Of the 18% of women identified with depression symptoms at the initial prenatal care visit in the Medicaid Prenatal Care Study, 87% were addressed in practice or referred, but only 28% actually received follow-up care; the latter measure of documented follow-up care was slightly better for those identified with depression symptoms at the third trimester visit (42%), but worse for those identified at the postpartum visit (17%).

Following the enactment of state legislation in 2014, the Title V Program has worked closely with the DOH OHIP, NYS Department of Financial Services (DFS) and NYS Office of Mental Health (OMH) to implement provisions of the

law requiring information for health care providers, education of maternity patients in birthing hospitals and health insurance coverage for maternal depression screening *(see 2015 Annual Report*). This coordination has continued this year as Title V staff have facilitated discussions with external stakeholders related to insurance reimbursement for screening conducted by pediatric health care providers, and have ensured that partners remain up to date with changes in national recommendations, including recent updates to United States Preventive Services Task Force (USPSTF) guidelines for maternal depression screening, CMS guidance on Medicaid coverage for screening and monitoring forthcoming updates in the AAP *Bright Futures* guidelines and periodicity schedule.

This year, Title V staff also partnered with the NYS Council on Children and Families (CCF), as the state's current Early Childhood Comprehensive Systems (ECCS) grantee, to develop and submit an application for the new ECCS initiative; if awarded, this funding would support collaborative quality improvement projects in two high need communities to improve maternal depression screening and follow-up as well as developmental screening and follow-up for young children. This project would complement a new initiative led by the NYS OMH to fund the expansion of *Healthy Steps* model in pediatric health care practice settings. Additionally, the state's Early Childhood Advisory Council (ECAC) has identified early identification, prevention and intervention for maternal depression as a current priority, with plans to convene a workgroup to develop and help advance relevant strategies.

Looking ahead, it is clear that concern about maternal depression, and the need for leadership to coordinate efforts to address it will continue to grow as we seek to fully understand needs of both families and providers, identify evidence-based strategies for screening and follow-up, and support practices and policies to improve outcomes for mothers and families. The Title V Program will continue to collaborate with partners including OHIP, OQPS, DFS, OMH and the ECAC to advance this work.

Implementation of this strategy will be tracked by **ESM MWH-5**: Percentage of women enrolled in Medicaid Managed Care who are screened for maternal depression during: a) prenatal and b) postpartum care.

Strategy MWH-6: Participate in intra- and interagency groups developing response to increased opioid use to ensure maternal and child health perspectives and populations are addressed.

Concern about increasing opioid use among MCH population is a key concern raised by many stakeholders in NY, and is one manifestation of a larger national and statewide epidemic of increased opioid use and addiction. It was estimated in 2012 that 2.1 million people in the U. S. were suffering from substance use disorders related to prescription opioid pain relievers and an estimated 467,000 were addicted to heroin. While women were less likely to misuse or abuse prescription pain medicines, results for the 2014 National Survey of Drug Use and Health estimated that 4 million US women had past-year misuse of prescription pain medicine. In NYS both heroin and opioid analgesic-related deaths have increased - in 2013 NYS saw 2,175 drug-related deaths, 40 percent more than in 2009. For the MCH population specifically, the impact of this crisis is visible in the dramatic increase in rates of drug-related discharges for newborns over the last several years. While rates have increased across the state and all racial/ethnic groups, the trend is especially pronounced outside of New York City, where the rate of Neonatal Abstinence Syndrome has doubled since 2008.

In response to this rapidly emerging issue, Title V staff have been engaging with several key partners to assess needs, identify existing resources and participate in the development of additional strategies. Since spring 2015, Title V staff have been participating on an interagency work group, led by the NYS Office of Alcohol and Substance Abuse Services (OASAS), to address work with pregnant and parenting women with opioid use disorders. The work group participated in a day-long technical assistance session provided by the National Center for Substance Abuse and Child Welfare in August of 2015. Title V staff have shared information about Title V's community-based MICHC and MIECHV initiatives as part of this developing work. Building on this work, OASAS is currently applying for an in-depth technical assistance project with National Center for Substance Abuse and Child Welfare, focused on women with substance use disorders and their substance exposed infants in Onondaga County. Title V staff have committed to participate on the oversight committee for this proposed project. Lessons learned will be disseminated to other counties.

Title V staff are engaged in several efforts to contribute to and benefit from work related to surveillance and data for opioid use. Title V staff participate on the Metrics and Data Subcommittee of the Interagency Opioid Overdose Prevention Steering Committee. This subcommittee, convened by the DOH AIDS Institute, aims to share data and provide a platform for interagency communication to address the prevention of opioid overdoses in NY. Title V staff also completed an analysis of state vital statistics and hospital discharge data on neonatal abstinence in NYS for the period 2008 – 2013; results were presented to Regional Perinatal Center (RPC) coordinators to investigate interest in developing a NYS Perinatal Quality Collaborative (NYSPQC) project. Although that specific NYSPQC project was not selected by the group to pursue at this time, data analysis continues and an abstract has recently been developed to submit for consideration at the upcoming Northeast Epidemiology Conference. In addition, DOH has been awarded the Centers for Disease Control and Prevention Prescription Drug Overdose (PDO) Prevention Grant which, as part of its implementation plan, will convene an Epidemiology Surveillance Committee; Dr. Marilyn Kacica, Title V Medical Director, will be a member of that committee to ensure maternal and child health perspectives are included.
In addition, as information about this issue becomes available the Title V program is taking steps to incorporate it within relevant community-based prevention programs. For example, the Maternal and Infant Health Center of Excellence will provide training for home visitors and community health workers on screening and providing referrals for opioid use as part of a larger training on substance abuse for these programs.
In May 2016, Governor Cuomo announced plans to form a new statewide task force to combat heroin and opioid abuse. Comprised of experts in health care, drug policy, advocacy, education, parents and New Yorkers in recovery, the group will build on the state's previous efforts and use members' expertise and experience to develop a comprehensive action plan. Members of the task force will hold public listening sessions across NY to inform their recommendations. Title V staff will identify opportunities to assure the needs of NY's MCH population are included in statewide efforts to address this issue and make recommendations regarding opportunities to intervene.

Implementation of this strategy will be tracked by **ESM MWH-6:** Title V staff participate in intra- and inter-agency groups developing response to opioid use.

Women/Maternal Health - Annual Report

Women's /Maternal Health

Health care coverage is a significant factor in making health care accessible and available to women. In a publication by the Kaiser Foundation in March 2016, *Women's Health Insurance Coverage, "*among the 97.5 million women ages 19 to 64 residing in the U.S., most had some form of coverage in 2014". However, gaps in private sector and publicly-funded programs left almost one in eight women uninsured. One of the Affordable Care Act's (ACA's) primary goals is to expand access to insurance coverage to reduce the number of uninsured. In 2015, NY continued its efforts to enroll all New Yorkers into comprehensive health care coverage. As of January 2016, the NY State of Health (NYSOH), the state's official health plan Marketplace, enrolled more than 2.8 million individuals. Since the Marketplace opened in 2013, the number of uninsured New Yorkers has declined by nearly 850,000.

In the open enrollment period in 2015, males and females each represented roughly half of enrollees across all programs. Females comprised a slightly larger majority of enrollees than males in Medicaid and Qualified Health Plans (QHPs), while more males than females were enrolled in Child Health Plus (CHP). Within QHPs, females outnumber males in the subsidized program, but males are the small majority of enrollees in full pay QHPs.

In-person assistors continued to play an important role in enrolling New Yorkers into coverage. In 2015, there were more than 11,000 certified enrollment experts: 765 navigators, 5,384 Certified Application Counselors, and 5,239 brokers. These assistors have enrolled more than two-thirds (67 %) of Marketplace enrollees. Another 23 % of consumers enrolled through the Marketplace website. The website has experienced very high volumes of website traffic, with nearly 2 million unique visitors during the 2015 open enrollment period. Despite these volumes, the website has operated at or above expectations, with an average system response time of 2.5 seconds for each web

page. Finally, 10 % of consumers enrolled over the phone with the assistance of the Marketplace Customer Service Center.

In addition to enrolling consumers by telephone, the NYSOH Customer Service Center handles a range of questions and inquiries from consumers. During the three month 2015 open enrollment period, the Customer Service Center answered nearly 1.3 million calls, with a peak call volume of over 26,000 calls per day in the final days of the open enrollment period. New Yorkers continue to have a broad choice of health plan options through the marketplace in every county of the state. Statewide, sixteen health insurers offer health plan coverage to individuals and ten health insurers also offer plans to small businesses through the Marketplace. A number of health insurers expanded their Marketplace service area in 2015 as compared to 2014. Six of the sixteen insurers expanded their individual Marketplace offerings to additional counties and 3 insurers expanded their small business offerings.

Recognizing that health insurance coverage is essential in order for women to access primary and preventive health care services, an emphasis of Title V in NYS over the past year continued to be to ensure women were enrolled into health care coverage. In addition to the extensive efforts by the NYSOH to reach all New Yorkers, including those women and families currently uninsured and more challenging to engage into the health care system, all Title V programs and initiatives prioritized engaging all women into health care coverage.

Many Title V contractors, including family planning providers, school based health center sponsors and community-based maternal and infant health collaboratives, among others, are also approved navigators to assist individuals to enroll in health insurance. All contractors are required to identify uninsured women and assist them to enroll in health insurance or refer them to a navigator for enrollment. Programs such as NY's extensive system of family planning programs have made significant inroads in this arena. In 2011 57.3% of family planning clients had health insurance. Preliminary data shows continued increase from 71.1% in 2014 to 75.9% in 2015.

Title V continues to lead efforts to improve the health and wellness of women in NYS with an essential element being women's ability to control their reproductive health. NYS has had a long-standing Medicaid 1115 demonstration project for expanded access to family planning services. In 2013, NYS converted this waiver into a part of its State Medicaid Plan by receiving approval of a State Plan Amendment. The NYS Family Planning Benefit Program (FPBP) provides family planning services to individuals with incomes up to 223% of the Federal Poverty Level. The FPBP now also includes the benefit of Presumptive Eligibility that allows a client to receive immediate access to family planning services, and programs to receive reimbursement for those services, pending final determination of the client's ultimate eligibility for FPBP. The addition of Presumptive Eligibility has substantially increased the utilization of FPBP as demonstrated by the fact that the percent of family planning clients who had FPBP as a source of payment for services increased from 7.1% in 2012 to 8.5% in 2014. The family planning providers report that a total of 26,147 family planning clients in 2014 had FPBP as the source of payment.

Title V staff work closely with staff from the Office of Health Insurance Programs (OHIP) who are responsible for the implementation and oversight of FPBP. Collaborative activities include monthly conference calls with OHIP staff and family planning programs to discuss and solve enrollment issues, the coordination of the training and technical assistance services provided by four regional FPBP coordinators who are supported with grant funding to promote FPBP utilization, and the regular sharing of FPBP enrollment data. These data are actively tracked by Title V staff to identify sub-recipient agencies that are not enrolling clients into FPBP and following up with them to provide training and assistance.

One of the most effective means of birth control is Long Acting Reversible Contraception (LARC). In 2015, all grant-funded family planning programs participated in a structured performance management project designed to improve the percent of unduplicated female clients who leave a family planning clinic with an effective or highly effective contraceptive method (e.g., LARC - IUDs and implants). The percent of female clients served by the programs who left a family planning visit with an effective contraceptive method (e.g., oral contraceptives, Depo-Provera) increased from 61% in 2012 to 73.4% by the end of the first half of 2015. The percent of all female clients who left a visit with a highly effective contraceptive method (LARC) increased from 12.4% in 2013 to 18.3% by the end of the first half of 2015. Title V will continue to focus on this performance measure and provide training and technical assistance to the programs to maintain this momentum.

To further promote and support the use of LARC in NYS, OHIP and the Title V program are participating in CDC's 6|18 Initiative, targeting six common and costly health conditions – tobacco use, high blood pressure, healthcare-associated infections, asthma, unintended pregnancies, and diabetes – and 18 proven specific interventions that formed the starting point of discussions with purchasers, payors, and providers. DOH is specifically focusing on the high-burden health condition of unintended pregnancy. The goal is to improve health and control health care costs by providing these partners with rigorous evidence about high-burden health conditions and associated interventions to inform their decisions to have the greatest health and cost impact. This initiative offers proven interventions that prevent chronic and infectious diseases by increasing their coverage, access, utilization and quality of care. Additionally, it aligns evidence-based preventive practices with emerging value-based payment and delivery models. Title V staff have been working collaboratively with the OHIP to: reimburse providers for the full range of contraceptive services; reimburse providers or health systems for the actual cost of LARC or other contraceptive devices in order to provide the full range of contraceptive methods; reimburse for immediate postpartum LARC by unbundling payment for LARC insertion; and remove administrative and logistical barriers to LARC.

The lessons learned through the family planning contraceptive coverage performance management projects continues to inform NYSDOH's participation on National Infant Mortality Collaborative Improvement and Innovation Network (CoIIN). NY's Title V program is focusing on promoting the use of LARC in the postpartum setting and implementing the use of the One Key Question to document pregnancy intention and provide contraceptive services in non-family planning clinics.
As with all providers funded through DOH, the family planning programs are key partners in NYS' efforts to enroll people into health insurance. Many family planning programs have certified application counselors on staff at their programs to actively screen and enroll clients or have enrollers on site or actively refer clients for enrollment assistance.

Supporting and promoting access to early prenatal care has been a cornerstone of NY's perinatal services for all women, but especially low income women disengaged from the health care system. In June 2015, legislation was passed making pregnancy a qualifying event through the state-run exchange, NYSOH and became effective in January 2016. New York is the first state in the nation where the commencement of pregnancy allows a woman to enroll in a plan through the exchange. The new law allows a pregnant woman to enroll with an effective date of the first day of the month in which her pregnancy is confirmed by a licensed healthcare provider. It is anticipated this policy will have a positive impact on ensuring pregnant women have health care coverage through their pregnancy and beyond.

The percent of infants born to women receiving prenatal care in the first trimester has seen a slight increase from 73.8% in 2012 to 75.1% in 2014. The percentage of infants born to Black and Hispanic women receiving prenatal care in the first trimester remained relatively stable at 66.9% both in 2012 and 67% in 2014. NY's Medicaid Prenatal Care Program provides comprehensive prenatal care to women up to 223% of FPL including undocumented women (using state only funding.) Presumptive Eligibility ensures women can receive care immediately when accessing services, while awaiting full eligibility determination. NY's maternal and infant health programs integrate broad-based systems approaches involving regional and local planning; one-on-one outreach and support; population-based education; public health insurance and clinical practice standards; and extensive surveillance to support public health planning and clinical quality improvement efforts. These efforts include the Maternal and Infant Community Health Collaboratives Initiative (MICHC) comprised of 24 projects in 31 high-risk counties that work to implement evidence-based/best practice strategies across the reproductive life course, including enrollment in health insurance and engagement in preventive health services. Each MICHC also employ community health workers, individuals indigenous to the communities served, to conduct outreach to engage women and families into prenatal care and ongoing primary and preventive health care. As part of the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative, 17 evidenced-based home visiting programs (7 Nurse-Family Partnership and 10 Healthy Families New York) were funded in 9 high-risk counties to support community-based

programs to improve maternal and infant health outcomes for high-need women and families, and to reduce racial, ethnic and economic disparities in those outcomes. Seven of these seventeen projects were newly awarded in July 2015 as a result of NYS being awarded a MIECHV Competitive grant. The MIECHV initiative provided home visiting services to over 3,000 women and their families and showed improvement in the following maternal construct measures:

- Increased percentage of clients screened for alcohol use at intake from 81.8% in 2012 to 92% in 2015.
- Increased percentage of prenatal clients screened for depression at intake from 39.8% in 2012 to 96% in 2015.
- Increased percentage of families screened for needed services annually from 67.7% in 2012 to 98.1% in 2015.
- Increased percentage of mothers and infants insured at 6 months postpartum from 42.8% in 2013 to 73.5% in 2015, and insured at 12 months postpartum from 72.7% in 2013 to 78.6% in 2015.

Promoting healthy behaviors is paramount to improving the health and wellness of women in NYS, including pregnant women. Although the percentage of women who smoke in the last three months of pregnancy has decreased over time, NYS is still below the HP 2020 target of 98.6% of women delivering a live birth abstaining from smoking. In 2013, 6.2% pregnant women smoked in the last 3 months of pregnancy, with NYC (2.3%) being much lower than the rest of NYS (10.69%). NY has been a leader in addressing smoking cessation for all New Yorkers, including pregnant women.

In 2015, the DFH implemented a media campaign in collaboration with the DOH Bureau of Tobacco Control to develop and implement a smoking cessation media campaign targeted to preconception and pregnant women in 24 rural counties with high rates of babies born to women who smoked. The media messaging was designed to motivate women of reproductive age to quit smoking by providing information on the effects of smoking, available resources and supports available to attempt quitting. The campaign included television, YouTube and Facebook messages that were aired by DOH and health systems contractors to promote cessation and use of Medicaid cessation benefits. “Amanda’s Tip”, from the CDC *Tips from Former Smokers* campaign, described a woman’s experience of her baby’s premature birth and health complications due to her smoking while pregnant. Amanda smoked during pregnancy, and in the campaign materials she talks about the weeks her baby spent in the NICU after she was born 2 months early. Title V will continue to review data to ascertain the impact of this campaign in the targeted areas of NYS.

In addition to pregnant women, DOH anti-smoking messages targeted all New Yorkers. Over the past year, DOH supported media campaigns, using television, radio, digital and out of home channels. Campaigns included tobacco-free pharmacies, encouraging tobacco users to talk with their doctor about quitting and Medicaid cessation benefits. The New York State Smokers’ Quitline has received approximately 185,000 incoming calls and generates approximately 12,000 unique outgoing call attempts to tobacco users seeking assistance with quit attempts.

In line with federal guidelines and recommendations, DOH supported the Advancing Tobacco-Free Communities (ATFC) and Health Systems for a Tobacco-Free NY (HS) programs. Regional contractors use evidence-based and high-level systems interventions to promote policy changes that reduce the uptake of tobacco use, increase cessation and eliminate secondhand smoke exposure. The primary focus is on tobacco-disparate populations, i.e., persons with low income, low educational attainment, poor mental health or substance use disorders. ATFC contractors worked on smoke-free multi-unit housing and tobacco-free outdoor initiatives to ensure protection for New York’s families. Twelve housing authorities, covering 4,195 units, adopted smoke-free policies. Additionally, other multi-unit housing policies were adopted, covering 5,909 units. Local municipal tobacco-free outdoor policies were enacted in 35 communities, protecting public parks, playgrounds, beaches and building entryways. Major employers and organizations implemented voluntary smoking bans, covering a total of 130 facility grounds and/or entryways.

Health System (HS) contractors worked to improve the delivery of care for tobacco dependence by targeting high-level administrators who promoted systems improvement. HS contractors focused on Federally Qualified Health

Centers (FQHCs), Community Health Centers (CHCs) and other large or dominant health care organizations that provided care to persons with low socioeconomic status and/or poor mental health. HS contractors identified potential partners and conducted needs assessments. HS contractors also worked with 16 Performing Provider Systems (PPSs) on 24 Delivery System Reform Incentive Payment (DSRIP) tobacco cessation projects that involved health systems improvements. DOH and the statewide HS Center of Excellence developed a stakeholder workgroup of key partners from across the state to identify strategies to effect system change to improve outcomes.

There were also other initiatives that specifically targeted pregnant women. The DFH promoted a NYS customized version of Text4baby, a free text message service with messages delivered each week, timed to the woman's due date or baby's date of birth to provide new and expectant mothers with important health information to promote good health for their babies. Text4baby is available through a broad public-private partnership that includes the U.S. Department of Health and Human Services; the National Healthy Mothers, Healthy Babies Coalition; state and local governments; corporations; professional organizations; and community-based organizations. Women sign up for the service by texting BABY to 511411(BEBE for Spanish) or online at http://text4baby.org. Messages focus on maternal and child health topics, including the prevention of birth defects, immunization, nutrition, seasonal flu, mental health, oral health, zika virus, healthy behaviors, with a specific message addressing smoking cessation, and safe sleep as part of IM CoIIN initiative in NYS. Text4baby also connects women to prenatal and infant care, and other health services and resources. 17,000 NYS women are now enrolled in Text4baby.

Maternal mortality is a tragic event and determining causes for poor birth outcomes and developing strategies to address these issues is of significant importance. Although NYS's maternal mortality rate has dropped over the past few years (23.1 per 100,000 live births in 2010 vs. 18.9 in 2014), it remains above the HP 2020 goal of 11.4 per 100,000 live births that includes maternal deaths occurring within 42 days from termination of pregnancy. Racial disparities in maternal deaths are significant and exceed any disparity noted in infant mortality and low birth weight births. The ratio of Black non-Hispanic to White non-Hispanic maternal deaths in NYS is 3.3 (2013) versus a national ratio of 2.7 (2007).

The Title V program in conjunction with the Office of Primary Care and Health Systems Management (OPCHSM) continued its focus on a comprehensive maternal mortality review process, taking a public health approach to ascertain and review all maternal death cases and analyze data to identify populations at risk and factors contributing to maternal mortality, including the development of recommendations and interventions to reduce maternal risk. DOH has convened an expert review committee to review the results of maternal death reviews and provide recommendations related to improvement opportunities. The processes identifies pregnancy-related death defined as the death of a woman while pregnant or within a year from termination of pregnancy, occurring as result of a pregnancy-related illness (e.g., preeclampsia) or as a result of an underlying illness exacerbated by the physiology of pregnancy (e.g., mitral stenosis.) A pregnancy-related death that occurred within 42 day of the termination of the pregnancy is considered a maternal death. Pregnancy-associated, not related death is defined as the death of a woman while pregnant or within one year of termination of pregnancy from any cause, not as a cause of pregnancy or illness exacerbated by pregnancy (i.e. motor vehicle accident.)

During 2015 DOH completed a review of all maternal deaths for the period 2006-2008 and identified 125 pregnancy-related and 215 pregnancy-associated, not related deaths. The following are key findings from that review:

- The majority of women in the pregnancy-related deaths cohort were in their thirties (30-39), overweight or obese, spoke English as their primary language, were non- Hispanic, delivered in a Level 3 hospital or regional perinatal center, delivered by caesarean section, and had no previous hospitalizations during the index pregnancy.
- Black women were the group with the largest number of pregnancy-related deaths.
- Medicaid was the most common health insurance coverage among women in the pregnancy-related deaths cohort.
- The leading causes of pregnancy-related deaths were hemorrhage (23%), hypertension (23%), embolism

(17%), and cardiovascular problems (10%).

- The leading causes of pregnancy-associated deaths were cancer (25%), external causes (12%), auto accidents (11%), assault (9%), diseases of the circulatory system (8%), and self-harm (6%). The care and services for one third of the women in the pregnancy-related deaths cohort were deemed as not in accordance with national professionally recognized standards. Among these cases, 57% of the deaths were considered preventable.

The DFH is also working with the Public Health Committee of the NYS Public Health and Health Planning Council (PHHPC) to address this significant public health issue. The focus of this work is on the "pre-hospital" antecedents of maternal mortality, including: promotion of women's health and wellness across the reproductive life course; early identification and coordinated management of high-risk pregnancies; and, prevention of unintended pregnancies among women with known serious risk factors. The PHHPC in collaboration with Title V staff have explored opportunities to improve birth outcomes through program and policy improvements. A summary of this collaborative work is posted on the DOH web at http://www.health.ny.gov/facilities/public_health_and_health_planning_council/docs/prevention_of_maternal_mortality.

The Partnership for Maternal Health is an outgrowth of the work with this committee. The Partnership is comprised of various key stakeholders including Title V staff, ACOG, NY's hospital associations, NYCDHMH and others with a common interest of identifying collaborative opportunities to decrease maternal mortality and morbidity. The Partnership coalesced in 2015 and will continue to develop a focus on priorities to improve the health of all NY's women.

DOH has successfully reached the Prevention Agenda 2013-2017: NYS's Health Improvement Plan goal to reduce maternal mortality to less than 21 maternal deaths for every 100,000 live births by 2018, but much more work is left to do. By continuing the comprehensive review of factors leading to maternal deaths through the Maternal Mortality Review Initiative (MMR), Title V aims to continue to improve outcomes for mothers and babies.

NY's Title V program also embarked on collaborative work to increase understanding and develop strategies to address NY's growing public health issue of opioid abuse. In 2015, Title V staff participated in a team organized by NY's Office of Alcoholism and Substance Abuse Services (OASAS) based on guidance from SAMSHA consisting of various state and local agencies and stakeholders to improve outcomes for families that are affected by substance use disorders and involved in the child welfare system by: facilitating cross-system collaboration, developing effective policy, practice and organizational changes, facilitating implementation in pilot sites, and monitoring implementation and initial outcomes and facilitating changes and adaptations as needed. Title V is providing a MCH focus to ensure the needs of the MCH population are addressed and Title V supports and services are integrated in any planned programs and initiatives. Title V is also participating on a workgroup to identify and support women with substance use disorders and their substance exposed infants as well as other focused projects to address this public health issue in the MCH population.

Maternal depression has a significant impact on mothers as well as the social-emotional stability of their children and is the most common maternal morbidity. For the past few years, Title V staff have participated in a Prenatal Care workgroup with the OQPS to promote information sharing and collaboration. Title V staff provided input into the development and implementation of a study on the quality of prenatal care provided through the Medicaid Prenatal Care Program. Selected medical records from provider agencies are reviewed to determine compliance with comprehensive care requirements such as required education, laboratory testing and screening such as screening for maternal depression. NYS specific data from the 2013 Medicaid Prenatal Care Study showed that 63% of women were assessed for depression at the initial prenatal visit assessment, and 51.4% at postpartum visits, but among these only 7% of records documented using standardized screening tools. More recent Medicaid quality data reviews suggest that depression assessment practices are improving for both prenatal (85.6%) and postpartum (82.6%) visits. Of the 18% of women identified with depression symptoms at the initial prenatal care visit in the Medicaid Prenatal Care Study, 87% were addressed in practice or referred, but only 28% actually received follow-up care; the latter measure of documented follow-up care was slightly better for those identified with depression

symptoms at the third trimester visit (42%), but worse for those identified at the postpartum visit (17%).
NY however is making progress is addressing this maternal health issue. In 2014 NYS passed a law requiring hospitals to educate patients about maternal depression, and maternal depression screening and referral. The DFH in collaboration with the OPCHSM notified all obstetrical hospitals of this requirement and has updated resources on the DOH web site. In addition, the DFH initiated discussions with the Office of Mental Health and other key stakeholders to discuss strategies to improve maternal depression screening and enhance resources for those women experiencing depression. In addition, legislation was passed mandating that to the extent depression screening is already a covered benefit, insurers must pay regardless of which health care provider performs the screening. OHIP released guidance on how pediatric providers can bill a mother's insurance if they screen her. Over the past year, Title V has engaged in discussions with OHIP, AAP and other key stakeholders to operationalize the intent of this legislation.
Finally, DOH's Growing Up Healthy Hotline (GUHH), available 24/7, provides information and referral in English and Spanish and in other languages via the AT&T language line. The Growing Up Healthy Hotline (GUHH) is available 24/7, provides information and referral in English and Spanish and in other languages via the AT&T language line, and is used in media campaigns to promote early and continuous access to prenatal care and other services. In 2015 GUHH responded to 23,646 calls including 678 calls requesting referral and information related to pregnancy testing, prenatal care or perinatal depression, and 2,684 calls related to health insurance.

Perinatal/Infant Health

Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	91	91	92	93	94	94.5

FAD not available for this measure.

ESM 3.1 - Perinatal Infant Health - 2

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	0.0	50.0	100.0	100.0	100.0

ESM 3.2 - Perinatal Infant Health - 5

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	75.0	80.0	85.0	90.0	95.0

NPM 5 - Percent of infants placed to sleep on their backs

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	77	77	77.8	78.9	80	80.5

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	68.9 %	2.0 %	73,310	106,442
2012	63.8 %	1.6 %	69,466	108,861
2011	70.0 %	1.2 %	152,776	218,387
2010	67.6 %	1.2 %	148,645	219,832
2008	73.4 %	1.7 %	83,268	113,422
2007	62.3 %	1.3 %	145,176	232,956

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% and should be interpreted with caution

ESM 5.1 - Perinatal Infant Health - 1

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

ESM 5.2 - Perinatal Infant Health - 3

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	15.0	15.0	30.0	30.0	40.0

ESM 5.3 - Perinatal Infant Health - 4

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	65.0	85.0	85.0	90.0	90.0

ESM 5.4 - Perinatal Infant Health - 6

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

Perinatal/Infant Health - Plan for the Application Year

State Priority #2: Reduce infant mortality and morbidity

2020 State Objectives:

- Objective PIH-1: Decrease the infant mortality rate by 18%, to 4.0 per 1,000 live births
- Objective PIH-2: Decrease the preterm birth rate by 12%, to 9.5% of live births
- Objective PIH-3: Increase the percent of very low birthweight (VLBW) infants born in a hospital with a Level III or higher Neonatal Intensive Care Unit (NICU) by 0.4%, to 91% of eligible infants.
- Objective PIH-4: Decrease the SUID rate by 20%, to 0.3 per 1,000 live births

Infant Mortality – the death of a baby - is an outcome that is devastating for individual families and a critically important population indicator of maternal and child health and the overall health of a society. Reducing infant mortality is a longstanding, fundamental priority for NY's Title V Program, with renewed focus resulting from redesign of our community-based maternal and infant health initiatives, development of the state's *Prevention Agenda,* and most recently through the work of our state's Infant Mortality CoIIN initiative.

New York's infant mortality rate is better than the HP2020 Goal and US rate, and has been improving over the last decade, driven primarily by reductions in New York City, where about half the births in the state occur. However there are persistent and marked racial, ethnic and economic disparities in infant mortality rates across the state. Leading causes of infant death in NYS include disorders related to short gestation and low birth weight, congenital malformations, cardiovascular disorders originating in the perinatal period and sleep-related sudden unexpected infant death (SUID).

In refining NY's State Action Plan priority to reduce infant mortality and morbidity, Title V staff reviewed the 2012 recommendations from the federal Department of Health and Human Services Secretary's Advisory Council on Infant Mortality (SACIM) as well as South Carolina's Conceptual Model for Reducing Infant Mortality and the results of recently-completed Perinatal Periods of Risk (PPOR) analysis for NYS. PPOR is a comprehensive approach for analyzing feto-infant mortality to facilitate the development of focused prevention strategies. In Phase 1 of the assessment, feto-infant mortality was analyzed by birthweight and age at death to identify populations with excess mortality. The results of Phase 1 analysis completed for 2009-2013 showed a statewide feto-infant mortality rate of 7.3 deaths per 1,000 live births and fetal deaths. The maternal health/prematurity category had the highest feto-infant mortality rate of 3.4 (n=3,997) followed by the maternal care category with fetal mortality rate of 2.0 (n=2,334) per 1,000 live births and fetal deaths.

Using these frameworks, priority areas for intervention for the leading causes of infant mortality in NYS include access to systems of care, evidenced-based practices, and health across the lifespan. Current NYS public health programs and services were assessed through this lens to identify areas where new or enhanced strategies are needed to ensure a comprehensive, systematic approach. The translation of this work to the Title V Action Plan was aligned closely with NYS's Infant Mortality CoIIN project (see 2015 annual report).

As noted for Domain 1, while this updated Action Plan focuses on specific strategies and measures to reduce infant mortality and morbidity, it is important to recognize that these efforts will build on and be embedded within the

extensive body of MCH public health programs and activities already in place through NY's Title V Program, including: Maternal and Infant Community Health Collaborative (MICHC); Maternal, Infant and Early Childhood Home Visiting (MIECHV); New York State Perinatal Quality Collaborative (NYSPQC); Perinatal Regionalization; Text4Baby; and, the Growing up Healthy Hotline (See *Section II.B.2.bi.ii* and *2015 Annual Report*).
This priority is closely linked to other state priorities including in particular Priority #1: Reduce maternal mortality and morbidity and all four Life Course priorities (#5-8). As noted for Priority #1 above, strategies to address infant mortality are largely inextricable from those to address maternal mortality and morbidity; thus, the strategies and performance measures described above for Domain 1 should be considered part of the continuum of public health activities to address Priority #2.
Progress toward achievement of objectives and outcomes associated with Priority #2 will be tracked through **NPM 3:** Percent of Very Low Birth Weight (VLBW) infants born in a hospital with a Level III or higher Neonatal Intensive Care Unit (NICU) and **NPM 5**: Percent of infants placed to sleep on their backs. **NPM 5** is viewed as a proxy for both sleep positioning and other safe sleep practices that are the focus of prevention strategies. While not selected for reporting purposes due to MCHB's limit on the number of NPMs per state, NYS also will follow and focus on improving **NPM 4:** Percent of infants ever breastfed and exclusively breastfed for 6 months.

Strategy PIH-1: Develop and implement an expanded plan for analysis and reporting of infant mortality and selected morbidity data, and issue initial data report.
As noted above, inclusion of strategies to enhance public health surveillance and data analysis activities in each population health domain are a cross-cutting priority for NY's Action Plan, as an essential public health function to inform ongoing program and policy development, implementation and evaluation. While infant mortality data from NY's Statewide Perinatal Data System (SPDS), including birth certificate and Neonatal Intensive Care Unit (NICU) module data, are reviewed annually by Title V staff as part of our core work, more focused analyses have not been conducted. As noted above, in 2016 a PPOR analysis for NYS was completed, and an infant mortality report is currently being developed as part of our Infant Mortality CoIIN initiative. As part of our action plan, Title V staff will review available sources of data and relevant methods to develop an updated plan for analysis and reporting of infant health data. We anticipate that application of the Perinatal Periods of Risk (PPOR) model will be included in this work, as an approach to analyzing vital statistics data that provides actionable findings for both state and local MCH work. Specific emerging issues including neonatal abstinence syndrome, will also be incorporated to inform new work in this area *(see Strategy MWH-6 above*).
Implementation of this strategy will be tracked by **ESM PIH-1**: Initial data report published.

Strategy PIH-2: Update NYS perinatal regionalization standards and designations and implement updated performance measures for Regional Perinatal Centers and affiliate birthing hospitals.
As noted elsewhere in this application, NYS has been a leader and national model for the development and oversight of a regionalized system of perinatal care. NYS's system includes a hierarchy of four levels of perinatal care, led by Regional Perinatal Centers (RPCs) capable of providing all the services and expertise required by the most acutely sick or at-risk pregnant women and newborns. RPCs provide or coordinate maternal-fetal and newborn transfers of high-risk patients from their affiliate hospitals, and are responsible for support, education, consultation, and improvements in the quality of care in the affiliate hospitals within their regions.

The last comprehensive review of NY's regionalized system was in the early 2000s. Although NY continues to exceed the HP 2020 goals for delivery of very low birthweight (VLBW) infants in Level 3 or 4 perinatal hospitals, standards of perinatal care have evolved and the landscape of the perinatal hospital system, as well as health care coverage and systems, has changed as well. It is imperative for NY to ensure all perinatal hospitals are functioning in accordance with current standards of care for both maternal and infant outcomes. Building on the progress described in the 2015 Annual Report, the Title V program will continue to lead efforts to update standards for perinatal regionalization in NYS, re-designate all birthing hospitals in the state, and engage RPCs and their affiliates in quality assurance and improvement activities to implement the updated standards, monitor and improve

performance and outcomes. This work will be jointly led by the DOH OPCHSM, which is responsible for regulatory oversight of hospitals, and will be accomplished in close partnership with the new contractor to be selected through the Request for Proposals issued in 2015 and with other key partners including birthing hospitals, hospital associations and professional medical organizations.

Implementation of this strategy will be tracked by **ESM PIH-2**: Percentage of birthing hospitals re-designated with updated standards.

Strategy PIH 3: Continue to convene and lead structured statewide clinical quality improvement initiatives in birthing hospitals through the NYS Perinatal Quality Collaborative (NYSPQC).

As described in the NA (*Section II.B.2.b.ii*) and 2015 Annual Report, NY's Title V Program leads the New York State Perinatal Quality Collaborative (NYSPQC), a robust initiative comprising multiple longitudinal, structured projects to improve the quality of care and maternal and infant health outcomes in birthing hospitals. Building on the previously-completed projects to reduce early elective deliveries and clinical practices related to assessment and education for maternal hemorrhage and hypertension, there are several NYSPQC projects currently underway related to infant mortality reduction.

As part of the IM-CoIIN, NYS has a focus on improving infant safe sleep practices to reduce infant mortality. The central goals of the NYSPQC Hospital Safe Sleep Project include: educating health care professionals so they understand, actively endorse and model safe sleep practices and providing infant caregivers with education and opportunities so they have the knowledge, skills and self-efficacy to practice safe sleep for every sleep. The project evaluates key performance measures including: percent of medical records with documentation of safe sleep education; percent of infants, sleeping or awake and unattended in crib, positioned supine, in safe clothing, with head of crib flat and crib free of objects; percent of caregivers who reported they received information on how to put their baby to sleep safely and indicating they understand safe sleep practices (indicating infant should be alone, on back, in crib, without items in the crib). Recruitment began in August 2015 with both Regional Perinatal Centers (RPCs) and affiliate hospitals participating in startup activities simultaneously. Project kick-off activities occurred in September 2015. The project engages 77 hospitals and is anticipated to continue through September 2016, however, pending direction by the national IM-CoIIN Project, it may be extended an additional year through September 2017.

A second current NYSPQC project focuses on proper administration of Antenatal Corticosteroids (ACT) that can help to reduce neonatal morbidity and mortality as a result of preterm birth. The NYSPQC chose ACT as a new project area in spring 2015. At that time the NYSPQC was offered the opportunity to partner with the March of Dimes Big 5 State Prematurity Collaborative on this topic. The Big 5 State Prematurity Collaborative is comprised of perinatal leaders from five states with the highest birth rates in the country, and includes California, Florida, Illinois, New York and Texas. Participating NYS RPCs have the opportunity to collaborate with hospitals from the other Big 5 states regarding ACT. This collaboration allows us to align goals and resources to bring more attention and energy to this effort. The project addresses several objectives, including the understanding and timing of ACT administration, and standardizing the assessment of imminent delivery. RPCs were recruited to participate in Phase 1 of the project, and 16 RPCs have been recruited and are actively participating in the project. Measures for the project are still under development. Tentative measures include: the percent of births at 23 0/7 – 33 6/7 weeks gestation receiving steroids; the percent of births at 23 0/7 – 33 6/7 weeks gestation receiving steroids between 24 hours and 7 days prior to delivery; and the percent of births at 23 0/7 – 33 6/7 weeks gestation receiving steroids between 24 hours and 14 days prior to delivery. Startup of the project began in February 2016 and Activities with March of Dimes are expected to continue through December 2016. Once the project is well established and best practices are identified, the NYSPQC plans to expand the initiative to all interested birthing facilities. Expansion to affiliate facilities is expected in late 2016 / early 2017, and the expanded project will tentatively run for one year through at least early 2018.

A third NYSPQC focus is our Nutrition Improvement Project, which aims to reduce the percentage of newborns <31

weeks gestational age who are discharged from a Neonatal Intensive Care Unit (NICU) below the tenth percentile on the Fenton growth scales. Outcome, process, and balancing measures are calculated for infants born prior to 31 weeks in gestation and admitted within 48 hours of birth to a NICU and discharged alive. Key measures being evaluated include: the percentage who were below the 10th percentile for discharge weight on the Fenton Growth Scale; the difference in Z-scores for birth and discharge weights; the percentage who were below the 10th percentile for head circumference on the Fenton Growth Scale; the difference in Z-scores for birth and discharge head circumferences; the Postmenstrual age at discharge (days); and the median initial length of stay (days). All 18 RPCs have been participating since 2010. In March 2016, 18 Level III NICU hospitals agreed to participate in the expanded project, such that 36 NICUs are currently participating in the project. The project is expected to continue through December 2017.

Finally, data gathered through the Maternal Mortality Review Initiative is used by the NYSPQC to identify areas where QI activities can improve outcomes. For example, the NYSPQC Obstetrical Improvement Project expanded its focus in early 2014 to include the early recognition and management of maternal hemorrhage and hypertension, the two leading causes of maternal death in NYS. Completed in September 2015, this initiative assisted the 70 participating birthing hospitals by rapidly advancing improvement in identifying and managing maternal hemorrhage by increasing the percent of facilities aware of blood utilization in their facility and by increasing the percent of maternity patients ≥20 weeks completed gestation with a documented risk assessment for maternal hemorrhage completed on admission for the birth hospitalization. Additionally, the project sought to assist the participating birthing hospitals by rapidly advancing improvement in identifying and managing hypertensive disorders in pregnancy. This was accomplished by increasing the percent of facilities aware of the percent of maternity patients who have given birth ≥ 20 weeks completed gestation with prolonged post-delivery length of stay (LOS) in the hospital resulting from pre-eclampsia, eclampsia, severe hypertension, and related complications and increasing the percent of postpartum maternity patients ≥ 20 weeks completed gestation receiving education on the signs and symptoms of post-partum pre-eclampsia prior to hospital discharge.

Through the work on SMM, MMR and assessment of other sources of data, the NYSDOH will continue to expand and improve areas of NYSPQC collaborative work. Undertaking future projects will be done after review of available data and with guidance from expert faculty. Potential projects that may be explored include: unplanned extubation in NICU infants and management of the obese obstetric patient. There is no specific time frame for the start of new projects at this time, given the focus on existing priority projects.

Implementation of this strategy will be tracked by **ESM PIH-3:** Percentage of eligible birthing hospitals participating in a current QI activity.

Strategy PIH 4: Work with local home visiting grantees to increase capacity of established programs through improvements in outreach, enrollment and retention of eligible families.

As the designated lead agency for New York's Maternal, Infant and Early Childhood Home Visiting (MIECHV) initiative, our Title V Program plays a key leadership role in overseeing the implementation of both federal and state funds for evidence-based home visiting programs, specifically local Nurse Family Partnership projects, and coordinating closely with partner agencies that implement other home visiting programs, including the Healthy Families New York Program led by the NYS Office of Children and Family Services. Within the DOH Division of Family Health/Title V Program, our Bureau of Women, Infant and Adolescent Health (BWIAH) leads this work. In addition to funding local home visiting programs, BWIAH established a Maternal and Infant Health Center of Excellence (MIH COE) to provide training, technical assistance and evaluation support for both home visiting and other community-based maternal and infant health initiatives. See our 2015 Annual Report for more background on our work in this area.

As a key focal point for strengthening and increasing the impact of home visiting on MCH outcomes that aligns closely with federal MIECHV priorities, BWIAH is collaborating with the MIH COE to provide training, technical

assistance and evaluation for home visiting agencies on strategies to improve recruitment and retention of families in home visiting services to increase program capacity (serve more families). In the first phase, the COE is identifying best practices in client retention through a literature review and surveying the local home visiting programs. Programs will be offered a menu of strategies to employ and will select one or two initially to try. The COE will provide training and technical assistance on implementation and will evaluate results of programs' efforts on retention and provide further guidance, as needed. As retention and, in a later phase, recruitment improve, programs will be able to maintain a higher level of program capacity.

Implementation of this strategy will be tracked by **ESM PIH-4**: Capacity rates of local home visiting grantee projects, to be aligned with new federal MIEHCV performance measure *(currently pending from HRSA MCHB).*

Strategy PIH 4: Provide training and technical assistance to local MIECHV and MICHC grantees to enhance competencies of home visitors and community health workers related to pre- and interconception health, smoking cessation, substance abuse, safe sleep and breastfeeding promotion

Ensuring supports are available in the community to improve maternal and infant health outcomes and to reduce racial, ethnic and economic disparities in those outcomes is a priority of NY's Title V program. As described elsewhere in this application, in addition to MIECHV, the Title V BWIAH supports a Maternal and Infant Health Community Health Collaborative (MICHC) initiative. MICHC grantees are community-based organizations that strive to improve maternal and infant health outcomes for Medicaid-eligible high-need low-income women and their families while reducing persistent racial, ethnic and economic disparities in those outcomes. MICHC projects use a combination of individual/family strategies, implemented primarily through the engagement of community health workers, and organizational/community level strategies to improve environmental factors and systems. The Title V program will continue to oversee the local implementation of both MICHC and MIECHV projects as a central component of our Action Plan for both maternal and infant health. See the NA and 2015 Annual Report for additional information on these initiatives.

Both MICHC and MIECHV are designed around defined sets of performance standards. Four performance standards define the goals of the MICHCs including: high-need women and infants are enrolled in health insurance; high-need women and infants are engaged in health care and other supportive services appropriate to their needs; the medical, behavioral, and psychological risk factors of high-need women and infants are identified and addressed through timely and coordinated counseling, management, referral, and follow-up; and, within the community there are supports and opportunities in place that help high-need women engage in and maintain healthy behaviors and reduce or eliminate risky behaviors. Five performance standards have been established for MIECHV programs including: recruitment, and training home visitors consistent with model-specific requirements; identifying high need families and screening for eligibility and enrollment in home visiting services; providing home visiting services with fidelity to the evidence based program selected; achieving measurable improvements across key benchmark areas (maternal and newborn health; improvements in family economic self-sufficiency; improvement in children's health and development; and, strengthen family functioning and life course); and, coordination and integrating with other maternal, infant and early childhood service systems.

As noted under Strategy PIH-3 above, the Title V program established a Maternal and Infant Health Center of Excellence (MIH- COE) to support MICHC and MIECHV grantees in achieving these standards through the provision of guidance, training and technical support to grantees on numerous program elements including performance measure development, data collection and reporting systems, and quality improvement methodology. The MIH COE serves as a clearinghouse and resource for current research and is available to grantees for technical assistance. The MIH COE currently is developing a web site which will provide grantees with access to technical information, publications and other pertinent resources for the most current, research-based best practices in maternal and infant health and community-based interventions. In addition, the website will post a minimum of six original reports or publications annually. Annual training for MIH contractors includes statewide in person trainings and webinars. Training topics are based on feedback from grantees and in collaboration with the DOH. An annual meeting

addresses pertinent training needs for MIH grantees. An introductory training is provided for new staff, which includes all of the above topics as well as other core competencies. Training logs, performance measures, quarterly reports, CQI and data analysis will all serve to evaluate progress and success in meeting training needs, competencies and desired outcomes with the target population.

Both MICHC and MIECHV are part of NY's core Title V infrastructure for reaching, engaging and supporting MCH populations, in particular high-need women, infants and families. Based on the NA and continued strategic planning process, several key topics/practices have been identified as persistent or emerging priorities to be further strengthened through MICHC and MIECHV. These include: pre- and interconception health including birth spacing and prevention of unintended pregnancy, well woman care, chronic disease management and other elements of pre-/interconception health; smoking cessation; substance abuse, including dramatic increase in opiate use; safe sleep practices; and initiation and continuation of breastfeeding. With support from MIH COE as described, information and skills-development on these topics will be incorporated within training and other QI strategies for local MIECHV home visitors and MICHC community health workers to strengthen their competency and skill to work directly with families in these areas.
Implementation of this strategy will be tracked by **ESM PIH-5**: Number of home visiting and community health worker staff trained in the identified competencies.

Strategy PIH-6: Lead collaborative strategies to reduce sleep-related infant deaths
As described in our Annual Report and other relevant Action Plan strategies, NY's Title V Program has been leading the state's work under the HRSA-led national Infant Mortality Collaborative Improvement and Innovation Network (CoIIN). A major focus of this work in NYS has been to promote safe sleep practices. SUID is among the leading causes of infant mortality in the state, and a focus of increasing concern for many stakeholders including partners working in the child welfare system. Our state CoIIN Team for Safe Sleep includes partners from the NYS Office of Children and Family Services and the Division of Nutrition's (DON) Women, Infant and Children's (WIC) clinics. Several key projects have been developed as a result of these partnerships, and will continue as described in the coming year.
As part of our Infant Mortality CoIIN, a structured clinical quality improvement project to influence safe sleep practices within birthing hospitals is being implemented through our Title V NYSPQC infrastructure (see *Strategy PIH-3* above). In addition, a second core CoIIN safe sleep project is a structured statewide quality improvement initiative to promote safe sleep practices in community based organizations. Through this project, NY's Title V Program has engaged Local Health Departments and partnering community-based organizations (all of which are Title V MICHC grantees, see *Strategy PIH-5* above) in three communities (Orange, Onondaga and Suffolk Counties) to develop and implement safe sleep practices in local settings. Local agency staff provide safe sleep education to caregivers, 98% of whom are mothers. Surveys are administered 30-60 days later to assess the effectiveness of safe sleep education on caregivers' safe sleep practices in the home setting. Through collaborative sharing and learning, participating organizations are trying to improve the uptake of safe sleep practices by infant caregivers, primarily mothers. This project began in September 2015, and is expected to continue through September 2016, with consideration being given to extending this collaboration an additional year pending further direction from HRSA/ national CoIIN leaders.

A third core project through our CoIIN initiative has focused on collaboration with other state agencies (OCFS and OASAS) to jointly develop and deliver safe sleep messages to individuals served through our respective agencies. This collaboration includes co-branded messaging and dissemination strategies that effectively reach their respective populations. OCFS, working with several Child Fatality Review Teams and volunteer hospitals, is implementing a new project to provide safe sleep kits to up to 400 new mothers in the hospital along with the standard safe sleep education. Those mothers will be asked for permission to contact them a month after discharge to assess their understanding and compliance with safe sleep recommendations. Understanding that many SUID deaths are caused by suffocation by co-sleeping parents who have been drinking or taking drugs, DOH is reaching

out to OASAS to develop a new campaign targeting their clients about the severe risks they take by combining alcohol and drugs with parenting.

Finally, as an outgrowth of this work Title V will strengthen collaboration with NY's WIC Program to disseminate safe sleep messages to mothers. Safe Sleep posters are being printed in English and Spanish that will be posted in all of the 400 WIC clinics. These, along with supplies of the Safe Sleep brochure, will reinforce the safe sleep message that the new mothers receive during the birth of their infants.
Implementation of this strategy will be tracked by **ESM PIH-6**: Number of collaborative strategies implemented to reduce sleep-related infant death.

Perinatal/Infant Health - Annual Report

Perinatal/Infants Health

Improving the health of NY's mothers and infants is paramount. Overall, infant and neonatal mortality rates are declining in NYS. State rates for infant mortality and morbidity outcome measures are better than the HP 2020 targets. NYS's infant mortality rate was 4.5 per 1,000 live births in 2014, down slightly from 4.9 per 1,000 births in 2013. The number of infant deaths was 1,068 in 2014: 291 fewer than in 2008. From 2008 to 2014, the infant mortality rate declined 11.3% for non-Hispanic whites to 3.70 per 1,000 live births; 28.1% for non-Hispanic blacks to 8.5 per 1,000 live births; and 20.1% for Hispanics to 3.5 per 1,000 live births. Asian and Pacific Islanders had the lowest rate in 2014 at 2.2 per 1,000 live births; however, this represented a 6.9% increase since 2002 for this group. From 2008 to 2014, the neonatal mortality rate declined by 16.2% to 3.1 per 1,000 live births, while the post-neonatal mortality rate declined 22.2% to 1.4 per 1,000 live births.
Despite improvements, disparities still exist. The ratio of Black infant low birth weight rate to White infant low birth weight rate in 2014 was 1.6, though a slight improvement from 1.8 in 2012 and 1.9 in 2010. In 2012, the mortality rate for early term infants (37-38 weeks gestation) was more than twice the rate of full term infants (39-40 weeks gestation): 2.61 and 1.21 per 1,000 live births, respectively. The three leading causes of infant death in 2012 were prematurity, congenital malformation and cardiovascular disorders originating in the perinatal period.
Ensuring access to comprehensive prenatal care is imperative to improve birth outcomes. As stated previously, the DFH collaborates with OHIP to ensure quality prenatal care services are available to NY's MA population. Services are available to women up to 223% of the FPL and to undocumented women using State only funding. Supports are also provided to women on an ongoing basis to promote healthy behaviors and foster infant development. The DFH is home to the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. NY's MIECHV initiative works to improve the health and well-being of at-risk families through implementation of evidence-based home visiting programs proven to positively impact maternal and child health including Nurse Family Partnership (NFP) and Healthy Families New York (HFNY). As part of the federal MIECHV initiative, 17 evidenced-based home visiting programs (7 Nurse-Family Partnership and 10 Healthy Families New York) were funded in 9 high-risk counties to support community-based programs to improve maternal and infant health outcomes for high-need women and families, and to reduce racial, ethnic and economic disparities in those outcomes. Seven of these seventeen projects were newly awarded in July 2015 as a result of NYS being awarded a MIECHV Competitive grant. The MIECHV initiative provided home visiting services to over 3,000 women and their families. The MIECHV grantees showed improvement in the following infant construct measures:

- Increased percentage of clients enrolled prenatally who initiated breastfeeding from 78.5% in 2012 to 86% in 2015.
- Increased percentage of infants who received four or more well-child visits by age 12 months from 78.8% in 2014 to 86.8% in 2015.
- Increased percentage of infants who received an Ages and Stages Questionnaire assessment at 4 months from 70.1% in 2014 to 78.7% in 2015.

Recognizing the need to promote systems change on the local level to improve MCH outcomes for the long term, Title V continued to work with Maternal and Infant Community Health Collaboratives (MICHC), community organizations funded to improve maternal and infant health outcomes for high-need MA-eligible women and their families. MICHC projects work with other community partners to assess community needs and strengths and to foster the development and coordination of services within larger community systems. Projects develop systems that: find and engage high-need women and their families in health insurance and needed services; promote timely identification of their risks and ensure coordinated follow-up to address them; and, facilitate healthy behaviors across the lifespan. Twenty-three MICHC projects were funded in 32 counties to engage high-risk women and their families in health insurance, health care and other needed community services. Specific training on the NY State of Health via webinar was provided as projects accessed local resources to assist families with insurance enrollment. Projects encourage breastfeeding and connect women to community support resources.

NYS also has Healthy Start (HS) grantees in Queens, Brooklyn, Staten Island, Harlem, Bronx, Syracuse and Rochester. All 7 of these communities are served by the MICHC programs, and 5 of the 7 HS grantees are also MICHC grantees. Staff are working with the HRSA Regional HS Project Officer to coordinate communication, collaboration and coordination between the HS and MICHC programs. MICHC projects are required to coordinate outreach, intake and referral processes with other community maternal and infant health programs including HS.

To assist the DOH with local systems building efforts, Maternal and Infant Health Center of Excellence (MIHCOE) contracts were awarded in July, 2015 to support efforts to promote a standard of excellence among statewide funded programs through the Maternal and Infant Health Initiative which includes both MICHC and MIECHV programs. The University of Rochester was awarded funding to provide training, technical assistance and evaluation to the DOH and MICHC grantees. The SUNY-Center for Human Services Research was awarded funding for the development, maintenance and management of a data management information system for collecting/analyzing client and program-level data from MIHI grantees. Over the past year, efforts have focused on development of performance measures to assess improvement of these initiatives on the local level.

Title V continues to be involved in NYS efforts to redesign the MA system. This includes participation in DSRIP discussions as well as serving on working groups such as groups to develop value-based systems of payment in the MCH arena. Through Medicaid Redesign, Health Information Technology (HIT) projects were developed in 4 high need areas of NYS to demonstrate the effective use of HIT to coordinate perinatal services, reduce costs by streamlining fragmented and redundant systems, increase patient access to medical records, and improve quality of care. The 4 projects, located in Monroe, Onondaga, Westchester and Kings counties, completed the development of HIT systems designed to identify the psycho-social risk factors of high-risk pregnant women and make referrals to needed services. There remains significant work to be done on addressing systems and issues with regards to centrally assessing need and ensuring appropriate referrals are made while maintaining confidentiality as required by federal and state law.

Over the past year, Title V continued to lead efforts to improve the health and well-being of young mothers, fathers and their newborns. Through the Pathways to Success initiative, DOH continued to provide support for high-schools and community colleges to create and sustain supportive systems that help expectant and parenting teens and young adults succeed through health, education, self-sufficiency and strong families. DOH contracts with three school districts and three community colleges in Erie and Monroe Counties and the Bronx, all 3 of which are also served by MICHC and MIECHV projects. Contractors focused on building collaborations with other DOH programs to strengthen support networks and referral systems for expectant and parenting teens/young adults in these communities. Clients enrolled in the projects receive healthcare referrals for prenatal, interconception and post-partum care, social referrals to WIC and DSS and educational supports to ensure academic success. Over the past year, the program served a total of 902 students (156 high school and 746 community college) of which 123 were pregnant/expectant and 779 were parenting. Additionally, 162 children received health and supportive services.

DOH remains poised to address any public health issue impacting the MCH population. Zika virus is newly emerging as a worldwide threat to public health, and is spreading widely in the Western Hemisphere, primarily by the bite of an infected *Aedes aegypti* mosquito, although sexual transmission has also been documented. Although

Aedes aegypti mosquitoes are not present in NYS, a related species named *Aedes albopictus* is active in the downstate region, and may be able to effectively transmit the virus. At present, no local mosquito-borne Zika Virus Disease cases have been reported in the United States, but there have been travel-associatedcases identified, including cases in NYS.

Title V staff have participated in various DOH activities to address potential issues with this virus. DOH initiated and continues to conduct surveillance to collect information on all positive cases and exposed pregnant women. Plans are underway to conduct enhanced and active surveillance during the mosquito season. DOH has held several webinars with physicians and nurse practitioners to inform them about Zika virus disease and how to obtain testing in NYS. DOH also developed educational materials for the public on Zika virus disease, how it is transmitted, how to prevent mosquito bites and breeding, and travel precautions. Plans are also underway to improve communication regarding the role of community-based organizations to ensure outreach and education of women who may be at risk for contracting the Zika virus.

Ensuring pregnant and postpartum women and newborns are delivered at, and receive care from, a perinatal hospital with the appropriate level of expertise to provide care is paramount to a system of regionalized care. NY has also been a long-standing leader in the field of perinatal regionalization. In 2014, 92.3% of VLBW infants were delivered at facilities for high risk deliveries and neonates, well above the HP 2020 target of 82.5%. NYS's system of regionalized perinatal services includes a hierarchy of four levels of perinatal care provided by the hospitals within a region and led by a Regional Perinatal Center (RPCs). The regional systems are led by RPCs capable of providing all the services and expertise required by the most acutely sick or at-risk pregnant women and newborns. RPCs provide or coordinate maternal-fetal and newborn transfers of high-risk patients from their affiliate hospitals, and are responsible for support, education, consultation, and improvements in the quality of care in the affiliate hospitals within their regions. Due to the changing landscape of the health care system, DOH released a Request for Proposals in 2015 to assist the DOH to update standards for perinatal levels of care, assist with the process to redesignate all obstetrical hospitals in NYS and enhance and improve metrics to assess maternal and neonatal outcomes, align the system with the evolving health care landscape and identify opportunities for quality improvement. This will be a major focus for Title V over the next few years to continue to ensure NY leads the Nation in perinatal regionalization.

Building on the rich system of perinatal care in NY, the NYS Perinatal Quality Collaborative (NYSPQ) an initiative of NY's RPCs, DOH and National Initiative for Children's Healthcare Quality (NICHQ), is working to improve maternal and newborn birth outcomes and increase patient safety by applying evidence-based system change interventions, and to establish capacity within RPCs for ongoing QI activities. Over the past year, NYSPQC completed a multi-year initiative to reduce the number of scheduled deliveries performed without a medical indication between 36 0/7 and 38 6/7 weeks gestation. Of the 126 NYS birthing facilities, 97 (77%) participated in the NYSPQC Obstetrical Improvement Project since its expansion in 2012 to its completion in December of 2014. As a result, there were significant decreases in the percentage of scheduled deliveries occurring without a medical indication among the participating hospitals. At the conclusion of the initiative, participants reported a 94% reduction in scheduled deliveries without a medical indication, including an 89% decrease in scheduled inductions without a medical indication, and a 96% decrease in scheduled C-sections without a medical indication, including a 93% reduction in primary C-sections without a medical indication. Participants also reported a 67% increase in the percent of women informed about the maternal and fetal risks and benefits of scheduled delivery between 36 0/7 and 38 6/7 weeks documented in the medical record. Overall, NYS's primary cesarean delivery rate has been declining since 2010. Declines in the primary cesarean rates in recent years may be due in part to multipronged efforts such as NYSPQC, and other perinatal initiatives. NY's primary cesarean rate was 21.1 in 2010, 19.9 in 2013 and declined slightly to 19.2 in 2014. . As a culmination of project activities, the NYSPQC developed the *NYSPQC/NYSPFP Obstetrical Improvement Project Toolkit: Reducing Early Elective Deliveries c*ontaining information from Learning Sessions and Coaching Calls, and tools developed by participating facilities and distributed the toolkit to all NYS birthing

facilities.
Over the past year, as part of the IM-CoIIN, NYS has a focus on improving infant safe sleep practices to reduce infant mortality. The central goals of the NYSPQC Hospital Safe Sleep Project include: educating health care professionals so they understand, actively endorse and model safe sleep practices and providing infant caregivers with education and opportunities so they have the knowledge, skills and self-efficacy to practice safe sleep for every sleep. The project evaluates key performance measures including: percent of medical records with documentation of safe sleep education; percent of infants, sleeping or awake and unattended in crib, positioned supine, in safe clothing, with head of crib flat and crib free of objects; percent of caregivers who reported they received information on how to put their baby to sleep safely and indicating they understand safe sleep practices (indicating infant should be alone, on back, in crib, without items in the crib). Recruitment began in August 2015 with both RPCs and affiliate hospitals participating in startup activities simultaneously. Project kick-off activities occurred in September 2015. The project engaged 77 hospitals and is anticipated to continue through September 2016.
In addition, NYSPQC began an initiative to focus on proper administration of Antenatal Corticosteroids (ACT) to help reduce neonatal morbidity and mortality as a result of preterm birth. NYSPQC is partnering with the March of Dimes Big 5 State Prematurity Collaborative on this topic. The Big 5 State Prematurity Collaborative is comprised of perinatal leaders from five states with the highest birth rates in the country, and includes California, Florida, Illinois, New York and Texas. Participating NYS RPCs have the opportunity to collaborate with hospitals from the other Big 5 states regarding ACT. This collaboration allows Title V to align goals and resources to bring more attention and energy to this effort. The project will address several objectives, including the understanding and timing of ACT administration, and standardizing the assessment of imminent delivery. RPCs will be recruited to participate in Phase 1 of the project, and 16 RPCs have been recruited and are actively participating in the project. Measures for the project are still under development. Tentative measures include: the percent of births at 23 0/7 – 33 6/7 weeks gestation receiving steroids; the percent of births at 23 0/7 – 33 6/7 weeks gestation receiving steroids between 24 hours and 7 days prior to delivery; and the percent of births at 23 0/7 – 33 6/7 weeks gestation receiving steroids between 24 hours and 14 days prior to delivery. The project is targeted to begin in 2016.
NYSPQC also focused on a Nutrition Improvement Project, which aims to reduce the percentage of newborns <31 weeks gestational age who are discharged from a Neonatal Intensive Care Unit (NICU) below the tenth percentile on the Fenton growth scales. Outcome, process, and balancing measures are calculated for infants born prior to 31 weeks in gestation and admitted within 48 hours of birth to a NICU and discharged alive. Key measures being evaluated include: the percentage who were below the 10^{th} percentile for discharge weight on the Fenton Growth Scale; the difference in Z-scores for birth and discharge weights; the percentage who were below the 10^{th} percentile for head circumference on the Fenton Growth Scale; the difference in Z-scores for birth and discharge head circumferences; the Postmenstrual age at discharge (days); and the median initial length of stay (days). All 18 RPCs have been participating since 2010. .
Finally, data gathered through the Maternal Mortality Review Initiative is used by the NYSPQC to identify areas where QI activities can improve outcomes. NYSPQC expanded its focus in early 2014 to include the early recognition and management of maternal hemorrhage and hypertension, the two leading causes of maternal death in NYS. Completed in September 2015, this initiative assisted the 70 participating birthing hospitals by rapidly advancing improvement in identifying and managing maternal hemorrhage by increasing the percent of facilities aware of blood utilization in their facility and by increasing the percent of maternity patients ≥20 weeks completed gestation with a documented risk assessment for maternal hemorrhage completed on admission for the birth hospitalization. Additionally, the project sought to assist the participating birthing hospitals by rapidly advancing improvement in identifying and managing hypertensive disorders in pregnancy by increasing the percent of facilities aware of the percent of maternity patients who have given birth ≥ 20 weeks completed gestation with prolonged post-delivery length of stay (LOS) in the hospital resulting from pre-eclampsia, eclampsia, severe hypertension, and related complications and increasing the percent of postpartum maternity patients ≥ 20 weeks completed gestation receiving education on the signs and symptoms of post-partum pre-eclampsia prior to hospital discharge.
The NYSPQC Project Team is also currently assisting the DOH Office of Quality Care and Patient Safety (OQPS)

with the DSRIP Project Early Elective Delivery metric, which aims to reduce the percentage of scheduled deliveries without a medical indication between 36 0/7 to 38 6/7 weeks gestation. The DSRIP Project utilizes the NYSPQC data system on the NYSDOH Health Commerce System. The NYSPQC Project Team provides data on a monthly basis to the OQPS staff and provides technical assistance with data entry to the 21 participating hospitals regarding use of the NYSPQC data collection system. The DSRIP Project is expected to continue through June 2019 and supports and enhances the value of NYSPQC in improving MCH outcomes.

Developing a comprehensive, coordinated, seamless system of supports and services for CSHCN and their families is imperative to promote health, wellness and self-sufficiency. NY is fortunate to have extensive supports and services for CSHCN. This includes NY's Newborn Screening Program (NBSP) that performs blood testing and processes the data from over 270,000 specimens annually for 49 diseases and conditions, including all core conditions recommended by the American College of Medical Genetics and the March of Dimes. This is extremely important as early identification of medical issues in newborns is critical to ameliorating long-term health impact. Follow-up is provided through condition-specific Specialty Care Centers located throughout NYS. In 2015, 2,521 newborns were determined to be presumptively positive for a disease or condition and 392 were confirmed.

All birthing facilities are also required to have in place a newborn hearing screening program to conduct hearing screenings on all babies born in NYS and for critical congenital heart defects of the newborn. If the result of a screening test is abnormal, a referral is made to an appropriate specialized care center. The NY Early Hearing Detection Intervention Information System (NYEHDI-IS), an online information system, was successfully launched statewide. The system integrates information from the NY's two vital records systems, which were modified in 2011 to capture inpatient hearing screening, and allows for the manual entry of additional hearing screening and follow-up that occurs after the birth certificate is registered. The system is integrated with the state's immunization information system. The data generated from this system will assist NY to ensure newborns with positive screenings will be connected with appropriate follow-up, supports and services.

In 2014, DOH was awarded a three-year quality improvement (QI) grant from HRSA to reduce loss to follow-up for newborn hearing screening and follow-up. The purpose of the collaborative is to work with hospitals to improve reporting of hearing screening into the statewide information system, and to identify root causes for loss to follow-up and solutions to reduce it by 5% each year over the three-year grant. The individual level data collected by NYEHDI-IS is critical to the QI initiative and will be used to monitor the birthing facilities' performance during the QI initiative. Over the past year, a statewide QI team of stakeholders, including parents and a young adult who is deaf, was identified to provide guidance and expertise to the initiative.

A total of 16 hospitals, which have almost 60,000 births annually and represented about 70% of the missing hearing screening results, participated in the kick-off Learning Session in April, 2015. The hospital teams included pediatricians, nurses, hearing screening managers, and medical records personnel. Each team identified root causes for newborns not being screened or the results of the screening not being reported. The teams then implemented small changes and participated in monthly coaching webinars to discuss successes and challenges and to review data, which was provided to them from the DOH's online data system in the form of run charts. These ongoing reviews allowed them to quickly identify whether the changes that were implemented had a positive impact on the hearing screening performance. The 16 hospitals began with a baseline of 80.6% of newborns having a documented hearing screening but achieved a rate of over 98% from July 1 to September 30, 2015. Statewide the impact of the QI initiative has resulted in an improvement from 84.4% of newborns having a documented hearing screening in calendar year 2014 to 90.4% in 2015.

Title V staff have been involved in discussions and plans related to DSRIP since the inception of the initiative. All DSRIP plans include at least one project focusing on increasing the use of evidence-informed policies and evidence-based programs pertaining to the healthy development of children, youth, and adults. The project must be based on the Community Needs Assessment and consistent with their project plan. These Domain 4 projects are based on the NYS Prevention Agenda, and, as such, the DSRIP providers are encouraged to work in collaboration with the

community and other providers to address these statewide public health priorities including: Prevention of Chronic Diseases; Promoting a Healthy and Safe Environment; Promoting Healthy Women, Infants and Children; Promoting Mental Health and Prevent Substance Abuse; Prevention of HIV/STDs; and, Vaccine-Preventable Disease and Healthcare-Associated Infections. The focus of Healthy Women, Infants and Children is the prevention of prematurity. Several projects are focused on increasing support for MCH through expansion of home visiting (Nurse Family Partnership) or the use of Community Health Workers for community outreach and engage women into prenatal care. Others are focusing on evidence-based models of care such as Centering Pregnancy, enhanced services and the use of Health Information Technology (HIT) for communication to improve prenatal care. Over the past year Title V staff reviewed quarterly reports for the 4 DSRIP projects implementing strategies to increase support for MCH, and the 3 DSRIP projects implementing strategies to reduce premature birth and provided feedback regarding community partners that could be included to enhance project activities. The 3 DSRIP projects using Community Health Workers (CHWs) participated in the DOH's established trainings for CHWs and CHW supervisors. Staff also participated in the DSRIP Workforce Workgroup which is developing recommendations for defining the role of care coordination, including identifying titles, education-level and skill-set needed.

Scientific evidence supports the concept that breastmilk is the healthiest food for almost all infants and has extensive benefits for the health of the mother as well. Title V in NYS considers promotion and support for exclusive breastfeeding a public health priority. Increasingly, maintaining breastfeeding as the norm is seen as an important preventative health measure. NY's WIC program supports initiatives to promote breastfeeding. WIC agencies implemented 34 Performance Improvement Projects (PIPs) targeting early enrollment in prenatal care and 45 PIPs to improve breastfeeding outcomes through evidence-based strategies and/or piloting new culturally-specific actions. In 2014, 82.4% of WIC enrolled infants were ever breastfeed and 39.9% were breastfed for at least 6 months.

From September 2014 - January 2015, 401 prenatal women in 12 WIC agencies were enrolled in the *You Can Do It/ WIC Can Help* initiative designed to increase exclusive breastfeeding. Of those enrolled, 28% were exclusively breastfeeding at 7 days and 25.9% were exclusively breastfeeding at 30 days. In a similar group of prenatal women enrolled in the same 12 clinics preceding the initiative 19.0% and 12.2% had been exclusively breastfeeding at 7 and 30 days, respectively. Breastfeeding Grand Rounds 2015, *Breastfeeding in the Workplace – Success Takes a Team* featured Cathy Carothers, Every Mother, Inc. and Dr. Ruth Lawrence, University of Rochester. The webcast was viewed by more than 3,000 individuals from 42 States, Mexico, Denmark and Canada.

NY Child and Adult Care Food Program (CACFP) collaborated with the Office of Children and Family Services (OCFS) to provide training for child care providers on breastfeeding and infant nutrition. To date, the web-based training on breastfeeding has been viewed by home providers on 154 occasions and by centers, 43 times. Viewing of the infant meal pattern training has reached 146 providers.

Twelve hospitals continued to participate in the Breastfeeding Quality Improvement in Hospitals (BQIH) Learning Collaborative. The Breastfeeding Friendly (BFF) Practice Designation was spread across the state through the BFF Erie County initiative and the Obesity Prevention in Pediatric Health Care Settings Learning Collaborative. Twenty-six primary care practices across NYS were designated as BFF. Two manuscripts on the BFF Erie County Initiative were published in the *Journal of Human Lactation*.

These concerted efforts have had a positive impact on breastfeeding rates in NYS, namely the percent of mothers who breastfeed their infants at six months of age. In 2015 the rate of mothers breastfeeding their infants at 6 months of age was 60.6%, an increase from 55.8% in 2014 and 47.7 % in 2011. For the first time, NYS has exceeded the HP 2020 rate of 60.5 %.

Maternal depression is a serious and common problem that can impact both the mother's and child's well-being. It encompasses a wide range of mood disorders that can affect women during pregnancy or after the birth of a child. Approximately 10 to 20 % of women experience some form of depression during pregnancy or in the postpartum period. Maternal depression significantly impacts the health and well-being of women, infants and families – yet often goes unrecognized or untreated. Pregnant women and new mothers have frequent contact with the health care

system – including both maternal and pediatric health care providers however providers may not know how to identify or address depression within their practices. In addition, women may be reluctant to raise questions with their providers because of stigma or lack of knowledge about depression. Recognizing the significance of this public health issue, legislation was passed and became effective in 2015 requiring the addition of information related to maternal depression in information provided to pregnant women at birthing hospitals through NYS as well as education on maternal depression as part of maternity care. In addition, legislation was passed requiring reimbursement for development screening as addressed in the previous domain. Maternal depression will continue to be a priority for Title V in NYS.

Finally, DOH is participating in the national Infant Mortality Collaborative Improvement and Innovation Network (IM CoIIN), with quality improvement strategies to promote safe sleep practices, promote healthy birth spacing and reduce unintended pregnancy. Although sleep-related infant death rates in Black, non-Hispanics and Hispanics have been decreasing, rates are 2.5 times higher in Black, non-Hispanics than White, non-Hispanics. Safe Sleep public awareness materials were produced and widely disseminated in 2015 to all perinatal hospitals and other key stakeholders and a webinar on Safe Sleep was developed and implemented to the same target audience. Over the past year, work continued in collaboration with key stakeholders on quality improvement projects to: promote safe sleep; promote postpartum visit completion; promote birth spacing; reduce unintended pregnancy through promotion and use of Long Acting Reversible Contraception (LARC); and integration of preconception/interconception messages into the delivery of primary care services. Participant sites include NYS birthing hospitals, three Federally Qualified Health Centers (FQHCs) and six MICHCs.

DOH continues to support public health initiatives to increase access to prenatal care; support community-based programs that target high-risk areas to identify and address gaps in needed services; and assessment and referral of high-risk women to appropriate level of services. DFH supports the 4 DSRIP projects specific to perinatal health that are implementing various strategies designed to improve perinatal health outcomes, including support of community health workers to identify high-risk pregnant women and connect them to needed services; Nurse-Family Partnership home visiting; and use of Health Information Technology systems to assess risk and refer women to needed services.

Child Health

Measures

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	33.2	35.6	38	40.4	42.8	44

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	21.3 %	2.4 %	237,057	1,115,288
2007	11.7 %	2.2 %	134,616	1,152,859

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 6.1 - Child Health - 1

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

ESM 6.2 - Child Health - 2

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	0.0	1.0	1.0	1.0	1.0

ESM 6.3 - Child Health - 3

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

ESM 6.4 - Child Health - 4

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

ESM 6.5 - Child Health - 5

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

ESM 6.6 - Life Course - 4

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Child Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	27.1	27.5	27.8	28.1	28.5	29

Data Source: National Survey of Children's Health (NSCH) - CHILD

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	30.0 %	2.4 %	414,344	1,379,538
2007	33.7 %	2.8 %	470,174	1,393,525
2003	24.6 %	2.1 %	354,091	1,438,198

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 8.1 - Life Course - 10

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

ESM 8.2 - Life Course - 11

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

ESM 8.3 - Life Course - 12

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Child Health - Plan for the Application Year

CHILD HEALTH

State Priority #3: Support and enhance children's social-emotional development and relationships *(as part of shared priority for children and adolescents)*

2020 State Objectives:

- Objective CH-1: Increase the percentage of children surveyed who demonstrate 20 or more developmental

assets by 10% from baseline (to be established in Years 2-3)

- Objective CH-2: Increase the percentage of children age 10-71 months whose parents report receiving developmental screening using a parent-completed screening tool by 10% to 31.3%

Positive social-emotional development and relationships are the building blocks of healthy development that help young people grow up healthy, caring and responsible. In the NA process, both professional and family stakeholders strongly emphasized the central importance of overall child well-being, social-emotional development, along with concerns about the impact of trauma, toxic stress and intergenerational adverse childhood experiences on children's development and well-being. As noted by the CDC, childhood experiences, both positive and negative, have a tremendous impact on future violence victimization and perpetration, and lifelong health and opportunity, making them an important public health issue. Trauma experiences can have profound impact on children's social-emotional well-being. When children are injured, see others harmed by violence, suffer sexual abuse, lose loved ones or witness other tragic events, it can increase their risk of experiencing social, emotional or behavioral health problems. These "Adverse Childhood Experiences" (ACES) have been linked to risky health behaviors, chronic health conditions, academic and work achievement and early death. As the number of ACEs increases, so does the risk for these outcomes. From a life course perspective, the impact of ACES is intergenerational, as individuals bring all their own previous experience to their adult roles including parenting.

In a 2003 article in the American Journal of Public Health, Kichbusch described social-emotional well-being as part of the "third revolution of public health", following paradigm shifts in the areas of communicable disease and chronic disease prevention. Just as thinking in the larger public health field has evolved to incorporate a focus on behavioral health and social-emotional development, NY's 2015-20 Title V Plan reflects this as a new key MCH priority for children and adolescents. Building on the inclusion of mental health as a priority in NY's *Prevention Agenda,* by adopting this new priority specifically in our Title V strategic plan, we further highlight the fundamental importance of social-emotional health to overall health and life long well-being of children and families across the life course.

At the same time, we recognize the need to identify an optimal role and effective strategies where MCH public health programs can play a leadership role to contribute to larger cross-systems efforts to support children's social-emotional health and well-being. In establishing this new priority for our Title V plan and program, well-being is viewed as a holistic concept that integrates mental, physical, and social domain. Within this framework, emotional regulation is recognized as central to healthy mental, cognitive, social and moral functioning. Children's social-emotional development is based on relationships. Promoting healthy social-emotional development early and throughout childhood and adolescence supports a wide spectrum of positive learning and health outcomes across the life course, with benefits to health, family, work, and economic status. These supportive, nurturing relationships are needed for all children and families to thrive. Children and families that face adverse experiences may need additional help to recognize and support their needs, informed by a structure and practices that are attentive and responsive to those experiences (trauma informed care); those who experience highly complex trauma or have serious and persistent emotional or mental health issues need more intensive supports and interventions.

While some of these supports are beyond the scope of MCH public health programs, all programs and service providers that work with families and children should have basic knowledge and tools to support positive social-emotional development and connect families and children in need with other available resources. In refining our Title V Action Plan this year, we identified the need for a balanced approach that includes both population-based strategies to understand and support social-emotional wellness and healthy relationships for all children and youth, as well as strategies to help MCH practitioners recognize and provide support to children and youth who have adverse or traumatic experiences. While this is an emerging focus for NY's Title V program, there are many relevant frameworks and an evidence base to support this work. Resources reviewed as part of our action plan refinement process during Year 1 include: *From Neurons to Neighborhoods*; the CDC's *Essentials for Childhood* model; The Center for Social Emotional Foundations of Early Learning (CSEFEL); Center for the Study of Social Policy; Preparing Youth to Thrive; the Search Institute's Developmental Assets® framework; and, the collective body of

Adverse Childhood Experiences (ACES) foundational research.

Population health data on social-emotional and mental health needs of children are not as readily available as other MCH health outcomes. While many mental health conditions develop during late adolescence, younger children may be diagnosed as well; common conditions include anxiety disorders, attention-deficit / hyperactivity disorder, eating disorders and mood disorders. Based on data from the most recent National Survey of Children's Health (NSCH), most parents report that their child is "flourishing", but this decreases as children age and there are notable disparities. Parents report that one-third of young children age 0-5 years are at moderate or high risk for developmental or behavioral problems, 4.9% of children age 6-11 years have current behavioral or conduct problems and nearly 18% of children age 0-18 years have had two or more adverse childhood experiences. (NSCH). (See Adolescent Health domain for data on older youth.)

The New York State Early Intervention Program (NYSEIP) collects and reports social-emotional development among a sample of children who have received early intervention services. Social-emotional development is quantified using the Early Childhood Outcome (ECO) Center developed Child Outcome Summary (COS) process. Of those children who entered or exited below age expectation in social-emotional development relative to their same-age peers, 58.2% made substantial progress in their social-emotional development by the time they turned three years of age or exited the NYSEIP. As noted by the National Center for Children in Poverty, children and youth from low-income households are at an increased risk for social emotional and behavioral health problems, associated with factors such as parental stress, inadequate child care and family or community violence. Studies show that children with mental health disorders who are receiving appropriate treatment are more successful in schools, home and communities, but many children and youth who require mental health treatment do not receive it; NSCH data for NYS show that 35.6% of children who need mental health services did not receive them.

MCH work to promote social-emotional well-being of children must be done in collaboration with partners across systems, including families. New York's ECAC will be a key partner to develop and implement strategies related to supporting children's social-emotional development. Formed in 2009, the ECAC is comprised of experts in education, health care, child welfare and mental health. Members represent state agencies, advocacy groups, foundations, higher education, unions and other key organizations concerned with the wellbeing of young children and their families. Several Title V staff serve on the Council and/or its workgroups. Through the ECAC, significant work has been done to build a common understanding of the importance of social-emotional development among early childhood practitioners across many sectors, create educational messages and materials for parents and professionals on practices to nurture development and developmental screening and develop and integrate quality standards and measures related to social-emotional development for child care programs.
A specific project currently underway is a Joint Task Force on Social-Emotional Development, convened by the ECAC and the NYS Early Intervention Coordinating Council (EICC) to develop guidance for the systems serving infants and toddlers and their families - including early care and education programs, Early Intervention, health and mental health care services - to assist them in partnering with families to support healthy social-emotional development of infants and toddlers. Title V staff will continue to be engaged in and help lead this work, with additional attention to how Title V can help advance relevant strategies related to developmental screening of young children (See Domain 6, Priority #5) and supports for maternal depression (See Domain 1). In addition, we will build on this work to expand our focus to older children and youth, including continued collaboration with the state's Community Schools initiative and MCH programs serving older children and teens (See Domain 5).
As an emerging priority area that spans multiple organizational units and programs within our Title V Program, we plan to establish a cross-programmatic team to help develop and guide strategies for this priority and domain. Building on the planning work accomplished over the past year, this team will include staff from all areas of the Division who can cultivate expertise and connections, both within NYSDOH and external partners, to advance the strategies described below.
While this updated Action Plan focuses on specific strategies and measures, it is important to recognize that these

efforts will build on and be embedded within the extensive body of child- and family-serving MCH public health programs and activities already in place through NY's Title V Program, including: Children with Special Health Care Needs Local Health Department Programs, Early Intervention, Maternal and Infant Community Health Collaboratives (MICHC); Maternal, Infant and Early Childhood Home Visiting (MIECHV); School-Based Health Centers (SBHCs);Text4Baby; and, the Growing up Healthy Hotline (See *Section II.B* and *2015 Annual Report*).
This priority is closely linked to other state priorities including in particular strategies related to addressing maternal depression (Priority #1), supporting new families to promote children's health and early parenting skills (Priority #2), implementation of Health Home for children (Priority #4), improving developmental screening as part of preventive health care services for children (Priority #5) and all life course priorities.
Progress toward achievement of objectives and outcomes for children associated with Priority #3 will be tracked through **NPM 6:** Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool and a new **SPM 3**: The percentage of children and adolescents surveyed who demonstrate 20 or more developmental assets (pending successful implementation of Strategy CH-1).

Strategy CH-1: Develop and implement a plan for analysis and reporting of available data on children's social-emotional well-being and adverse childhood experiences (ACES).

As a fundamental starting point for public health work, population and program data are needed to help drive and evaluate work in this emerging area. As part of our Year 1 work, Title V staff reviewed available data sources for social-emotional health of children. As highlighted in the NA (*Section II.B*) population health data on social-emotional wellness, development and adverse experiences for different life course periods can be found in national and state surveys including the National Survey of Children's Health (NSCH), Youth Risk Behavior Survey (YRBS) and Behavioral Risk Factor Surveillance System (BRFSS). Program-specific data on social-emotional needs and outcomes for children served in the state's Early Intervention Program and to be served in the expanded Medicaid Health Home for children can provide additional information for children with more intensive needs, while forthcoming updates to the NSCH hold promise for further expanding the breadth of population-based health data in this domain. As a foundation of our work, we will continue and expand this review of available data and develop a plan for analyzing and reporting available data to inform dialogue both within Title V programs and with external partners. This essential public health and MCH function will be a positive contribution to ongoing work in this field.

Implementation of this strategy will be tracked by **ESM CH-1:** Initial data report is issued.

Strategy CH-2: Identify, pilot test and implement validated tool for measuring positive developmental social-emotional assets among children and adolescents that can be used across MCH child-serving programs.

While various data sources include measures of relevance to social-emotional wellness of children (see *Strategy CH-1* above), we currently lack a specific framework and measures to meaningfully assess and track positive social-emotional development within public health programs. This presents an important challenge to subsequent strategies aiming to integrate effective strategies for promoting social-emotional health within existing programs and services. As described above, there are several promising frameworks with the potential to be operationalized for this purpose.

To advance this strategy, Title V staff will work with our existing Centers of Excellence to develop or modify a tool that can be used by child- and adolescent-serving MCH programs across age groups. In seeking an "actionable" framework for defining and measuring social-emotional development and relationships across the entire period of childhood and adolescence, the Search Institute model was tentatively identified as an especially relevant resource and framework for our Title V Program. The Search Institute has a 50-year legacy of linking research and practice to address critical issues in education and youth development, and has been utilized as a cornerstone of NY Title V Program's positive youth development strategies (within our core adolescent health programs) for decades. The Search Institute's 40 Developmental Assets® framework identifies building blocks of healthy development,

organized into “assets”. This framework can be used to measure and increase the external supports and internal strengths that young people need to grow up successfully.

The Developmental assets are 40 research-based, positive qualities that influence young people’s development, helping them become caring, responsible, and productive adults, organized into eight categories: Support, Empowerment, Boundaries & Expectations, Constructive Use of Time (External Assets); Commitment to Learning; Positive Values; Social Competencies, Positive Identity (Internal Assets). All 40 assets have been described across five developmental age groups: Infants and Toddlers (age 0-3 years); Early Childhood (3-5); Childhood (5-9); Middle Childhood (8-12) and Adolescence (12-18). While the categories and developmental assets of social–emotional needs apply to all age subsets, as children grow and mature these developmental assets are attained in different ways. For example, *Developmental Asset #25: Reading for Pleasure (Commitment to Learning)* is measured for infants and toddlers as *Parents read to infants in enjoyable ways every day,* while for adolescents the same asset is measured as *Young person reads for pleasure three or more hours/week.* This framework provides a promising approach to measuring positive development.

Stakeholders, including families, youth and providers will be engaged in the process of selecting and implementing a measurement tool for Title V child- and adolescent-serving programs. We anticipate that a candidate measurement tool initially will be piloted through a small number of established MCH/Title V programs to evaluate its feasibility and effectiveness. Depending on the success of this initial pilot, we will explore adoption and integration of the tool across all child- and youth-serving MCH/Title V programs to support additional strategies below.

Implementation of this strategy will be tracked by **ESM CH-2:** Number of child-serving MCH programs implementing the asset profile tool

Strategy CH-3: Provide training for Title V staff and external partners, including local child-serving grantees, to increase: 1) awareness, knowledge, and skills to support children’s social emotional development and 2) trauma-informed care practices.

Workforce development is another fundamental public health approach that is needed to advance and sustain our MCH work. As an emerging priority for our Title V program and many local MCH grantees, training is needed to introduce key concepts and framework, expand knowledge base and begin to develop new skills. As with the broader approach to this priority, training will focus on both population-based knowledge and skills to support and reinforce children’s positive social emotional development, as well as more focused knowledge and skills to recognize and connect children and families who have had adverse experiences using trauma-informed care practices.

Advancing this strategy will require significant collaboration with other partners and leveraging existing infrastructure and resources. Potential key resources for this work include an existing CSEFEL initiative convened by the NYS CCF in which Title V staff are participating; ECCS workgroups; NYSDOH-funded Centers of Excellence for Maternal and Infant Health and Adolescent Health; and Medicaid Health Home. Details for this strategy will be developed as initial work commences and progresses, to be further updated in our Action Plan submission for Year 3.

Implementation of this strategy will be tracked by **ESM CH-3:** Number of DOH MCH staff and external partners trained about a) social-emotional wellness and b) trauma-informed care practices

Strategy CH-4: Identify, support and integrate evidence-based/-informed strategies to promote children’s social-emotional wellness and positive developmental assets through established Title V programs, including:

- **Maternal and Infant Community Health Collaboratives (MICHC)**
- **Home Visiting**
- **Infant/Child Mortality initiative**
- **Early Intervention**

- **Successfully Transitioning Youth to Adolescence (STYA)**
- **School-Based Health Centers**

Building on the work described in *Strategies CH-1 to CH-3* above, a critical element of our approach to addressing this new priority will be the identification and integration of effective strategies to support children's social-emotional development and healthy relationships across existing Title V Programs. Building on existing program infrastructure leverages the significant investments and experience already in place at both state and community levels, while additional attention to ensuring strategies are evidence-based or evidence-informed will increase the impact of this collective work.

In refining our Action Plan for Year 2, it was highlighted that many current Title V programs already include a strong focus on social-emotional and behavioral health, which will be built upon to address this new priority. Evidence-based home visiting programs including Nurse Family Partnership (NFP) and Healthy Families New York (HFNY), as well as the DOH-developed Community Health Worker component of the MICHC collaborative, include dedicated strategies to support and assist families in developing and practicing positive parenting skills that enhance early bonding and nurture children's development. All of these programs also include activities to promote developmental screening of infants and young children with referral to local EI programs, pediatric providers and other local resources as needed. The state's Early Intervention Program (NY's IDEA Part C Program) provides comprehensive developmental evaluations for children age birth to three with potential concerns about development and, for children found eligible, provides ongoing developmental services in accordance with an Individualized Family Services Plan (IFSP).

Title V Programs serving school-age children also include core strategies that address positive development and behavioral health. School-Based Health Centers (SBHC) are required to provide behavioral health screening for all patients (elementary, middle and high school age) as part of ongoing primary care, and most provide additional mental health services on-site within SBHC clinics; mental health services are provided by referral in sites that do not have in-clinic resources. Our innovative Successfully Transitioning Youth to Adolescence (STYA) program, funded through the federal Abstinence Education Grant Program, supports 17 community based organizations across the state to implement strategies to build protective factors for young people ages 9-12 living in high risk communities, including youth in foster care, youth with physical disabilities, and homeless and disconnected youth, to promote a transition to a healthy, productive, connected adolescence. Mentors provides youth with support and information on a wide range of topics framed in a youth development philosophy, focusing on the needs of youth and building on and nurturing the youth's individuals strengths and needs. They provide adult-supervised activities to stimulate cognitive, social, physical and emotional growth. Group discussions occur to share information regarding topics of interest to pre-teen youth. Caring adults are available for more in-depth support and discussions. These programs also provide parent education to parents, guardians and adult caregivers to create a more nurturing environment for these youth. Title V staff will continue to work with these providers to promote social emotional development of NY's pre-teen population.

These existing Title V programs are critical assets that can be effectively leveraged to further support social-emotional development and relationships for children and their families through the integration of additional evidence-based/-informed practices and strategies (See *Domain 5* for companion information on Title V adolescent-serving programs).

Implementation of this strategy will be tracked by **ESM CH-4:** Number of child-serving MCH programs identified with an evidence-based social-emotional component.

Strategy CH-5: Continue to provide subject matter and technical support to NY's Medicaid Health Home Program to implement enhanced care coordination for eligible children with serious emotional disturbance and complex trauma.

As described in our 2015 Annual Report, our Title V Program has been extensively involved in supporting the development of Medicaid Health Home (HH) services for children, including innovative leadership by NYS to

incorporate complex trauma as a qualifying condition for HH eligibility. Please refer to *Domain 4, Strategy CSHCN-3* below for more detail on this work.
Title V staff from both the Bureau of Child Health and the Bureau of Early Intervention have been deeply involved in this work from the outset, including articulation of standards for child-serving HH, review of applications and planning for implementation. Our staff will remain engaged to support implementation.

Implementation of this strategy will be tracked by **ESM CH-5:** number of children with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home

Child Health - Annual Report

Child Health

The majority of NYS children are insured which increases their likelihood of accessing primary and preventive health care. NY provides insurance to nearly 2.2 million children. MA covers over 1.9 million children and nearly 300,000 children are covered by Child Health Plus (CHPlus). The NYSOH, a web-based eligibility and health insurance enrollment Marketplace opened 10/1/13 for enrollments effective 1/1/2014. The ACA made several changes to waiting periods in place under the Children's Health Insurance Program. Waiting periods can be no longer than 90 days in duration. In addition, NY added three new exceptions to its waiting period including children with special health care needs (CSHCN), children who lost coverage as a result of a divorce; for pregnancy and when the cost of family coverage is more than 9.5% of the household income. Exceptions are determined based on the applicant's responses to questions on the on-line application. In 2014 only 3.3% of NY's children were uninsured as compared to 4% in 2013 and 7.9 percent in 2010, demonstrating NY's commitment and success with enrolling children into health insurance. As stated in Section IIA State Overview, NYS has devoted significant efforts to increasing awareness of, and enrolling individuals into health insurance.
Recognizing that health care coverage doesn't always equate with receipt of quality health care services, NY is committed to ensuring all children have access to health care coverage and health care services. In 2013, 82 percent of Medicaid enrolled children ages three to six years had a well- child and preventive health visit as compared to 83 percent in 2012 and 79 percent in 2010. A priority of DOH is to improve children's access to primary and preventive health care. Ensuring care is delivered where children are located for much of their day increases the likelihood children will receive essential health care services. The DFH oversees the largest School-Based Health Center Program (SBHC) in the country designed to improve access to comprehensive health care for children and adolescents in schools in high-need areas of NYS. SBHCs provide preventive, acute, chronic disease management and mental health services through more than 680,000 health care visits to approximately 160,000 students annually. SBHCs are required to perform activities that ensure each child receives comprehensive, primary and preventive care in accordance with the American Academy of Pediatrics Bright Futures guidelines. SBHCs have required standard work plans with performance management activities to ensure program standards are being met. A number of the SBHC Program standards directly relate to improvements in NYS and national performance measures for children including:

- Each enrolled student receives a Body Mass Index (BMI) by the SBHC or by their primary provider and results must be documented in their medical record.
- Each enrolled student must have a documented comprehensive physical exam (CPE) performed by the SBHC or primary provider and results must be documented in the medical record.
- Each student's health insurance status must be assessed and documented at enrollment and at each visit encounter.

Over the past year, Title V in collaboration with OHIP has worked with SBHC staff and key stakeholders to plan for the integration of SBHC and SBHC-Dental (SBHC-D) Services into the Medicaid Managed Care (MMC) benefit package, resulting in reimbursement for SBHC services to Medicaid enrollees transitioning from current fee for service "carve out" to Medicaid Managed Care Plans (MMCPs). Starting in 2014, Title V in collaboration with OHIP

initiated ongoing meetings with SBHC and MMCP representatives to discuss the transition to MMC. The goal of this transition is to maintain access to these critical SBHC and SBHC-D services while integrating the services into the larger health care delivery system. It is anticipated that the integration of SBHC and SBHC-D services within the existing managed care framework and coordination of services with the child's primary care provider will improve quality and promote an efficient, effective delivery system. A policy paper was developed by this group to guide policy development, clarify questions, processes and procedures with the ultimate goal of maintaining the continuity of care and the wellness of the child to facilitate learning and improved school attendance through this transition. This SBHC managed care transition was to occur on July 1, 2016 but legislation was recently passed delaying implementation until July 1, 2017. Title V will continue to co-lead efforts with OHIP, SBHCs and key stakeholders to ensure quality, comprehensive services are provided through NY's SCHCs and SBHC-D programs through MMC.
New York's Early Childhood Advisory Council (ECAC) will be a key partner to develop and implement strategies related to supporting children's social-emotional development. Formed in 2009, the ECAC is comprised of experts in education, health care, child welfare and mental health. Members represent state agencies, advocacy groups, foundations, higher education, unions and other key organizations concerned with the wellbeing of young children and their families. The goal of the ECCS Project is to strengthen health promotion practices in early childhood education programs serving infants and toddlers.The Title V director serves on the Council and its Steering Committee, and several other key Title V staff members (from the Bureaus of Child Health, Early Intervention and Women, Infant and Adolescent Health) serve on the Council and/or its workgroups. Through the ECAC, significant work has been done to build a common understanding of the importance of social-emotional development among early childhood practitioners across many sectors, create educational messages and materials for parents and professionals on practices to nurture development and developmental screening and develop and integrate quality standards and measures related to social-emotional development for child care programs.
A specific project currently underway is the convening by the ECAC and Early Intervention Coordinating Council (EICC) of a Joint Task Force on Social-Emotional Development. This Task Force has been charged with developing guidance for the systems that provide care for infants and toddlers and their families - including early childhood education programs, Early Intervention and health and mental health care services - to assist them in partnering with families to support healthy social-emotional development of infants and toddlers. Over the past year, this task force has developed a policy document to better articulate the unique roles as well as interrelationships between these sectors, including recommendations for identification, screening and treatment supports for children experiencing social-emotional developmental delays through the Early Intervention Program. As members and co-conveners of this Task Force, NY's Title V program will help inform the completion and implementation of these guidance documents.
In order to improve the health and development of children, it is imperative to support the health and well-being of parents, including those experiencing depression. Maternal depression is a serious and common problem that can impact both the mother's and child's well-being. Pregnant women and new mothers have frequent contact with the health care system – including both maternal and pediatric health care providers. Women in the postpartum period may be more likely seek care. To facilitate screening for maternal depression, legislation was enacted in 2015 that requires that, to the extent health care plans already cover depression screening, they should not limit pediatricians from providing the screening as long as other plan requirements are met. Title V initiated and coordinated discussions with clinicians and stakeholders as well as OHIP regarding operationalizing this legislation, namely related to documentation and reimbursement for these services.
An essential component of promoting and supporting childhood health and wellness is ensuring access to childhood immunizations. DOH also oversees a strong childhood immunization program that works to prevent the occurrence and transmission of vaccine-preventable diseases by ensuring the delivery of vaccines to children and adults. The program assures that: all children have access to vaccines irrespective of financial status; adequate vaccine supplies are available for all primary health care providers; and that health care providers are aware of immunization standards of practice. During the past year, under the Assessment, Feedback, Incentives and eXchange (AFIX) quality improvement strategy used by DOH to raise immunization coverage levels and improve standards of

practice, local health department (LHD) staff visited health care providers to assess immunization rates for compliance with the Advisory Committee on Immunization Practices (ACIP) vaccine recommendations. Provider immunization rates are assessed for the 4:3:1:3:3:1:4 series for all patients 19-35 months of age and for ACIP-recommended adolescent vaccines at 13 years of age. DOH Bureau of Immunization (BI) staff worked with LHD staff to assess and improve pediatric immunization rates by providing technical assistance and subject-matter experts via materials available on the DOH public website and at statewide webinars. In 2014, 74.6% of 19 to 35 month old NYS children received the full schedule of age appropriate immunizations against Measles, Mumps, Rubella (MMR), Polio, Diphtheria, Tetanus, Pertussis (DTaP), Haemophilus Influenzae (Hib), and Hepatitis B. NYS has met and exceeded Healthy People 2020 targets for 19 to 35 month old vaccination with MMR, Polio, and Hepatitis B; progress continues towards 2020 targets for DTaP and Hib vaccine coverage.

In July 2015, NYS updated school immunization requirements to ensure that children receive complete MMR, Polio and DTaP vaccine series by kindergarten entry. DOH worked with the State Education Department and other partners to provide technical assistance to public and private schools, day care programs and pre-kindergarten programs to implement the new requirements. It is anticipated that that this new requirement will improve kindergarten MMR, Polio and DTaP vaccination uptake.

Childhood obesity has both immediate and long-term health and social impacts. Children who are obese are more likely to experience obesity as adults. Obesity prevention is a priority of NYS to better ensure health across the lifespan. The Special Supplemental Nutrition Program for Women, Infants and Children (WIC), the third largest WIC program in the country, offers nutrition education, breastfeeding support, referrals and a variety of nutritious foods to approximately 500,000 participants per month, through 93 WIC local agencies via a network of 500 service sites and approximately 1,500 local agency staff influence lifetime nutrition and health behaviors. The Child and Adult Care Food Program (CACFP) ensures that nutritious and safely prepared meals and snacks are available to children age 18 and under and to functionally impaired adults and senior citizens participating in eligible day care programs. More than 1,400 sponsoring organizations representing 14,000 licensed or registered center-based or family day care sites are participating statewide serving approximately 340,000 meals to children and adults each day. Over the past year, NY WIC added more fresh produce, whole wheat grains, yogurt, and bananas as a substitute for baby food to the WIC food package; and added $4 to the Cash Value Voucher for fruits/vegetables for children, prenatal and fully breastfeeding women. In FFY 2015, 75.9% of children ate vegetables, 84% ate fruit, and 59.5% ate whole grains daily.

In 2014, 13.6% of children 2-5 years old in WIC were obese, a decrease from 14.1% in 2013 (BMI $\geq 95^{th}$ percentile of the CDC reference) and 29.7% were overweight or obese, down from 30.3% in 2013 (BMI $> 85^{th}$ percentile of the CDC growth reference). Of all infants and children less than five years of age, 11.3% were obese, a decrease from 12.0% in 2013 ($\geq 95^{th}$ percentile of the CDC reference for children 2-5 years; $\geq 97.7^{th}$ percentile of the 2006 WHO growth chart for children less than 2 years).

Recognizing the need to provide healthy meals in child care setting since a large majority of NY's children are in child care during much of the day, NY's Child and Adult Care Food Program (CACFP) collaborated with the Office of Children and Family Services (OCFS) to train child care providers on enhanced nutrition requirements. Web-based training on the child meal pattern has been viewed by 213 child care providers; training on healthy beverages has been viewed 748 times. In addition, Farm to Preschool brings fresh produce directly to 22 child care centers. Data shows a significant improvement in consumption of 2 or more fruits and vegetables per day in centers outside NYC, a slight increase in consumption of 2 or more fruits per day, and a significant improvement in consumption of 2 or more vegetables per day within the NYC area.

Comprehensive efforts are underway to increase children's access to physical activity and healthy foods. In 2015, twenty-two state-funded community projects and eighteen school-based projects trained 175 school district staff to promote and support health behaviors. School district wellness policies were assessed and found comprehensiveness scores increased from 58 to 83, and strength scores increased from 24 to 55 (out of 100). School districts adopted policies addressing nutrition (135), physical activity (129), and physical education (39),

reaching 483,390 students (grades K-12) and 2,922 staff. Community projects focusing on children and staff included use of environmental assessment tools for child care (127 sites) and after-school (121 sites) reaching 21,083 persons.

In addition to efforts to decrease obesity through breastfeeding and nutrition programs, DOH established additional programs to increase physical activity and improve nutrition among residents of NYS, with a focus on the prevention of childhood obesity. Program goals are achieved through policy, systems and environmental interventions in early child care, school, health care and community settings. Eat Well Play Hard in Child Care Settings (EWPHCCS) is a nutrition education and obesity prevention intervention in selected child care centers serving low-income children and their families. The EWPHCCS obesity prevention intervention reached over 16,000 children, their families and child care staff; 219 child care centers and 125 family DCH participated. A Farm to Preschool project was implemented in 25 child care centers where 2,500 parents purchased locally grown produce totaling $66,925. An evaluation of EWPH in Day Care Homes (DCH) showed providers purchased/served healthier foods, improved mealtime environments, and increased adult-led indoor active play.

Healthy Schools New York (HSNY) provides technical assistance and resources to 180 school districts to establish healthful eating environments and daily physical activity opportunities, including physical education. The Healthy Eating and Active Living by Design (HEALD) Program implement community policy, systems and environmental changes in schools and communities to reduce risks for heart disease and obesity by increasing access to healthful foods and opportunities for physical activity. The Just Say Yes to Fruits and Vegetables Project (JSY) uses nutrition education workshops, food demonstrations and environmental strategies to improve access to healthier foods and physical activity.

NY has long-standing established efforts to address childhood asthma as evidenced by the slight decrease in the rate of hospitalization for asthma per 100,000 children and adolescents ages 0-17 years. In 2013 25.9 per 100,000 children were hospitalized for asthma as compared to 27.1 per 100,000 in 2010. For children less than 5 years of age, in 2013 47.7 per 10,000 children were hospitalized for asthma as compared to 51.8 in 2012 and 56.3 in 2010. Regional Asthma Coalitions (RACs) in high-burden areas planned, tested, and implemented population-based, system change interventions to improve care processes and decrease asthma-related hospitalizations, emergency department (ED) visits, and school/work days lost. RACs continued to implement 25 health system quality improvement projects through the Asthma Outcomes Learning Network (AOLN).

Asthma prevention initiatives are also a component of DSRIP projects including home-based asthma management, medication adherence, and clinical guideline implementation. DSRIP aims to decrease avoidable hospital and ED use by 25 percent within 5 yrs. The population of focus is children for whom asthma is a major driver of avoidable hospital use. Thirteen Performing Provider Systems, entities that are responsible for performing a DSRIP project, which include both major public general hospitals and safety net providers, collaborating together, with a designated lead provider for the group, chose asthma project work.

DOH also updated the *NYS Asthma Surveillance Summary Report* and current NY regional, county and zip code level asthma surveillance data was made available to the Regional Advisory Councils (RACs) and other partners via this report, the DOH public website, and other reports and data summary documents. Focused technical assistance was provided to the RACs to assist in their utilization of this data. In addition, more than 5,700 hard copies of the "Clinical Guideline for the Diagnosis, Evaluation and Management of Adults and Children with Asthma", a NYS consensus asthma guideline decision support tool for health care providers, were distributed at no cost to health care providers, educators, health plans and community-based partners in NY.

Lead is the leading recognized environmental poison for children in NYS. Exposure to lead is associated with a range of serious health effects on children, including detrimental effects on cognitive and behavioral development with serious personal and social consequences that may persist throughout their lifetime. Lead poisoning is a completely preventable condition. Reflecting decades of work at a federal, state, and local level, average blood lead levels among children have declined steadily in NYS and nationwide. Yet in some communities, especially those suffering from poverty and other social disadvantage, lead poisoning remains a significant problem. Moreover, growing knowledge about the toxicity of lead demonstrates that even levels of lead once thought to be safe can have

serious detrimental effects on young children.
NY's Childhood Lead Poisoning Prevention Program (LPPP) supports lead poisoning prevention surveillance, case coordination, and primary prevention. LHDs receive grant funds to target neighborhoods and housing most at risk for containing lead hazards. Through a CDC grant, DOH has been able to support and enhance lead poisoning prevention surveillance, case coordination, and primary prevention including the addition of infrastructure support within DOH to continue to build and enhance lead poisoning prevention initiatives.
Revisions to state regulations, effective 2009, authorized private physician office laboratories (POLs) and limited services registrant laboratories to conduct blood lead testing using point-of-care (POC) testing devices. More than 600 devices have been purchased in NYS as of the end of 2015, and 54 new laboratories were contacted and trained on how to report the results. Over the past year, LPPP program staff continued to work with both physician office laboratories (POLs) and limited service laboratories (LSLs) that conduct blood lead testing using point-of-care blood lead testing devices. The LPPP program staff trained POLs and LSLs on how to accurately report the blood lead test results to DOH. The use of point-of-care testing has decreased one of the barriers in performing the required lead testing at ages 1- and 2-years-old by physicians. In 2013, 53 percent of NY's children were tested for lead two or more times by age three years.
Over the past year, LPPP program staff also continued to work with both physician office laboratories (POLs) and limited service laboratories (LSLs) that conduct blood lead testing using point-of-care blood lead testing devices. The LPPP program staff trained POLs and LSLs on how to accurately report the blood lead test results to DOH. The use of point-of-care testing has decreased one of the barriers in performing the required lead testing at one and two years of age by providers.
In order to enhance surveillance related to lead poisoning in NYS, reporting mechanisms for POLs were streamlined in 2009 when Public Health Law (PHL) was amended to authorize linkage of the DOH childhood blood lead registry (LeadWeb) and the NYS Immunization Information System (NYSIIS). In 2010, the linkage was completed and a NYSIIS lead module was implemented to allow POLs to enter lead test results. Additional improvements to enhance the NYSIIS lead module included allowing providers the ability to view a child's lead testing history in NYSIIS; the addition of "Responsible person" area to be utilized in pertinent care coordination reminders; and Health Care provider educational "One Pager" training sheets to reinforce compliance with reporting lead test results into NYSIIS in accordance with PHL and regulations. In 2015, an additional report was created in NYSIIS for providers and health plans. The "Limited History Report" allowed a user to generate a report of children associated with their practice that had a lead test within the last month or less along with the details of the test result. Prior to the creation of this report, a user would have to generate multiple reports that included more data than was needed. In addition, business rules were created for an enhancement to the Aggregate Clinical Performance Report to allow LHD LPPP staff to generate their own county blood lead testing rates using a variety of criteria. The streamlining of these reports has increased access to information to simplify access to lead testing information and facilitate identification and treatment of lead poisoned children. Over the past year, DOH also began the process of reviewing the overall quality and performance of the LeadWeb system and consider the future direction planned for the statewide system.
To support LHDs in identifying health care providers with low lead testing rates, DOH have initiated the development of instructions for LHDs on the use of the NYSIIS Clinical Performance Reports in order to target their educational efforts to the providers with the three lowest testing rates. Title V also continued to fund LHDs to support the statewide delivery of a comprehensive LPPP, and 3 Regional Lead Resource Centers (RLRCs) in 5 teaching hospitals throughout NYS to provide expert clinical support, education and outreach to LHDs and health care providers to improve lead testing and other preventive practices.
DOH continues data analysis activities to enhance the ability to identify and treat lead poisoned children, including, working with the National Workgroup for Lead Content for the Environmental Public Health Tracking (EPHT) Indicators. This partnership has included the addition of a new indicator for BLLs under 10 µg/dl and to geocode addresses greater or equal to 10 µg/dL for the years 2010 -2012; along with geographic analysis of BLLs from 5 to less than 10 µg/dL by zip code. Lead program staff also began the process of developing clinical and care

coordination recommendations for children and pregnant women with BLLs of 5 µg/dL or greater to be consistent with the CDC recommendations released in 2012.

The rate of deaths of children aged 14 years and younger in NYS caused by motor vehicle crashes has had a slight downward trend over the past few years. In 2010, there were 1.3 deaths per 100,000 children as compared to 1.1 per 100,000 in 2013 and 0.9 in 2014. Over the past year, the DOH-led Injury Community Planning Group (ICPG) focused on enhancing injury infrastructure in NY, including childhood and motor vehicle safety and the continued development of the NY Injury Action Plan. The Child Injury Prevention Policy Subgroup of the ICPG focused specifically on startegies to decrease childhood injuries. A major goal of this policy subgroup is to educate decision makers and public health professionals about safety benefits for children ages 12 and under to ride properly restrained in the back seat of a motor vehicle. NY law requires children to be properly restrained but does not require children to be in the back seat. Over the past year, the DOH Bureau of Occupational Health and Injury Prevention (BOHIP) worked with the National Highway Traffic Safety Administration to conduct a Walking Safety Assessment in Rockland County. Convening partners to complete the Assessment is an activity outlined in the national plan, "*Safer People, Safer Streets: Summary of US Department of Transportation Action Plan to Increase Walking and Biking and Reduce Pedestrian and Bicycle Fatalities*." The team documented observations during a visit to areas with an overrepresentation of pedestrian crashes. A study was then conducted to identify pedestrian safety needs and develop recommendations for improving safety with an emphasis on better roadway engineering, and increased education and enforcement.. The "*Under 13? Back seat and buckle up!*" campaign video PSA was shown in movie theaters and physicians' offices in five high risk counties. Educational materials were also distributed in physicians' offices and posted on the DOH website.

DOH also collaborates with the NY Child Passenger Safety Advising Board to continue to develop outreach messages to increase the number of children riding properly restrained in a motor vehicle and the NY Safe Routes to School Network, the NYS Association of Traffic Safety Boards, SAFE KIDS Worldwide and the NY Bicycle Coalition to promote helmet use at a variety of traffic safety and bicycling promotion events. The BOHIP works with these agencies to incorporate helmet distribution, helmet fitting and bicycle safety education at a variety of annual events. Event opportunities to incorporate bicycle helmet safety include, but are not limited to Safe Kids Week, child passenger safety check up events, or "Bike to School Day" events. Community-based home visiting and other maternal and infant health initiatives will continue to emphasize injury prevention and motor vehicle safety.

Finally, DOH spearheaded the Keeping Kids Alive Initiative. In collaboration with other state agencies, the program is working to develop a more comprehensive statewide child death review and prevention initiative. By partnering with these agencies the program helps coordinate child safety initiatives aimed at reducing the risk for future deaths. The program also provides public outreach and education about risk factors associated with sudden unexplained infant deaths (SUID). Although sleep-related SUID rates in Black, non-Hispanics and Hispanics have been decreasing, rates are 2.5 times higher in Black, non-Hispanics than White, non-Hispanics.

The SAFE Sleep Work Group of the Infant Mortality CoIIN is aimed at reducing infant deaths and relative racial disparities by 10% through a learning network of public and private partners.

Adolescent Health

Measures

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Adolescent Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	27.1	27.5	27.8	28.1	28.5	29

Data Source: Youth Risk Behavior Surveillance System (YRBSS) - ADOLESCENT

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	25.7 %	1.7 %	189,405	736,224
2011	25.1 %	1.2 %	190,505	759,973
2009	23.1 %	1.1 %	180,512	781,932
2007	20.6 %	0.8 %	159,428	775,787

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.6 %	2.1 %	289,706	1,477,307
2007	22.1 %	2.1 %	341,421	1,542,976
2003	18.9 %	1.8 %	293,965	1,557,570

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 8.1 - Life Course - 10

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

ESM 8.2 - Life Course - 11

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

ESM 8.3 - Life Course - 12

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	94.9	95.6	96.2	96.9	97.6	98

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	90.7 %	1.6 %	1,346,186	1,483,708
2007	94.3 %	1.0 %	1,460,432	1,549,163
2003	84.8 %	1.6 %	1,338,406	1,578,173

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 10.2 - Adolescent Health - 1

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

ESM 10.1 - Life Course - 5

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

Adolescent Health - Plan for the Application Year

ADOLESCENT HEALTH

State Priority #3: Support and enhance adolescents' social-emotional development and relationships (*as part of shared priority for children and adolescents)*

2020 State Objectives:

- Objective AH-1: Increase the percentage of adolescents surveyed who demonstrate 20 or more developmental assets by 10% from baseline *(to be established in Years 2-3)*
- Objective AH-2: Reduce the percentage of adolescents who feel sad or hopeless for two weeks or longer in the past year by 10%, to 21.6%.
- Objective AH-3: Increase the percentage of adolescents age 12-17 with a preventive medical visit in the past year by 6.5% to 97.7%.

NY's leading priority for adolescent health (State Priority #3) is a shared priority with child health, driven by the same needs and frameworks described more extensively under the Child Health Domain of this narrative (please refer to that section for additional detail). While much research, policy action and stakeholder attention has focused on the critical importance of early brain development and social-emotional development, in particular from children age birth to three, the NA highlighted the importance of continuing to support social-emotional development and healthy relationships throughout childhood and adolescence. Equally compelling emerging research on adolescent brain development highlights the continued neural development that occurs through the teen years, and should inform public health programs and prevention strategies for reducing risk-taking behavior, supporting the development of healthy behaviors and promoting a positive transition to adulthood and lifelong health that recognizes the changing developmental tasks, personal identities (including emerging sexual identities) and relationships adolescents experience as they grow and develop.

NY's Title V Program has a long history of developing public health programs for adolescents based on concepts of positive youth development and strength-based, rather than deficit-based, approaches. This work has gained national recognition and served as a model for other states. We currently support a diverse portfolio of state- and federal-funded public health initiatives that serve adolescents and young adults including the Comprehensive Adolescent Pregnancy Prevention Program (CAPP), Family Planning Program, Pathways to Success, Personal Responsibility Education Program (PREP), School Based Health Center (SBHC) Program and a Sexual Violence Prevention initiative. This body of work is supported by a longstanding partnership with the ACT for Youth Center of

Excellence based at Cornell University's Center for Translational Research. Please refer to the NA and 2015 Annual Report for additional detail on these current programs.

Population health data on adolescents' social-emotional development and relationships are not as readily available as other MCH health outcomes. Important sources of information on behaviors and relationships include the Youth Risk Behavior Survey (YRBS), National Survey of Children's Health (NSCH) – noting that NSCH responses come from parents rather than directly from youth. Data on health care service utilization are found in NSCH as well as New York State managed care quality assurance reports (QARR) for both public and commercial insurance plans. Vital Statistics data provide important information on teen pregnancy and birth rates, while data collected through our large public health adolescent-serving programs, including SBHC, Family Planning and CAPP are a good resource for identifying and tracking health needs and service delivery/utilization. Data from Medicaid Health Home on adolescent enrollment and services will be an important new source of information for youth with more significant medical and behavioral health needs, including complex trauma and serious mental illness. Key data points are highlighted in the NA (see *IIB, Domain 5*). While families report that most teens are healthy and mortality for teens has declined, suicide mortality is increasing. Many risk-taking behaviors have declined, including sexual activity, tobacco use, alcohol and other substance use (with the exception of heroin, which is increasing). However, many teens and parents report relatively high rates of concerning social relationship measures, including bullying (both victimization and perpetration) and peer/dating violence (both physical and sexual). Social-emotional health has important connections to obesity and physical activity status, which remain concerns for this population. For the most vulnerable youth, extreme experiences such as homelessness, gang violence and sex trafficking challenge their healthy development. See *Domain 6, Priority #6* below for additional relevant data on adolescents' use of preventive health care services.

Mirroring the plan for this shared priority discussed in the Child Health domain (*See Domain 3*), the plan for supporting social-emotional development and relationships for adolescents seeks to balance population-based strategies to understand and support social-emotional wellness and healthy relationships for all adolescents with strategies to help MCH/Adolescent practitioners recognize and provide support to children and youth who have adverse or traumatic experiences. While some of these supports are beyond the scope of public health programs, all programs and service providers that work with adolescents and their families should have basic knowledge and tools to support positive social-emotional development and to connect youth and families in need with other available resources. Title V works to promote social-emotional well-being of adolescents must be done in collaboration with partners across systems, including youth and families.

As noted in Domain 3, as an emerging priority area that spans multiple organizational units and programs within our Title V Program, we plan to establish a cross-programmatic team to help develop and guide strategies for this priority, to include shared leadership from our Adolescent Health Unit within the Bureau of Women, Infants and Adolescent Health (BWIAH). Building on the planning work accomplished over the past year, this team will include staff from all areas of the Division who can cultivate expertise and connections, both within NYSDOH and external partners, to advance the strategies described below.

While this updated Action Plan focuses on specific strategies and measures, it is important to recognize that these efforts will build on and be embedded within the extensive body of adolescent-serving MCH public health programs and activities already in place through NY's Title V Program, including: CAPP, Family Planning, Pathways to Success, PREP, SBHCs and Sexual Violence Prevention, with key support from our ACT for Youth Center of Excellence (See *Section II.B* and *2015 Annual Report*).

This priority is closely linked to other state priorities including in particular strategies related to promoting preconception health (Priority #1), implementation of Medicaid Health Homes for children and youth (Priority #4), improving preventive health care services for adolescents (Priority #5) and all life course priorities.

Progress toward achievement of objectives and outcomes for children associated with Priority #3 will be tracked through **NPM 10:** Percent of adolescents age 12-17 years with a preventive medical visit in the past year; **NPM 12:**

Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care; and new **SPM 3:** Percentage of adolescents surveyed who demonstrate 20 or more developmental assets (See Strategy AH-2 below). While not selected for reporting purposes due to MCHB's limit on the number of NPMs per state, NYS also will follow and focus on improving **NPM 9:** Percent of adolescents age 12 to 17 years who are bullied.

Strategy AH-1: Develop and implement a plan for analysis and reporting of available data on adolescent's social-emotional well-being and adverse childhood experiences (ACES), including Youth Risk Behavior Survey (YRBS) and forthcoming revised National Survey of Children's Health (NSCH) data.

This strategy closely mirrors companion *Strategy CH-1* in Domain 3; please refer to that section for additional supporting information. As a foundational starting point for public health work, population and program data are needed to help drive and evaluate work in this emerging area. As part of our Year 1 work, Title V staff reviewed available data sources for social-emotional health of adolescents. We will continue and expand this review of available data and develop a plan for analyzing and reporting available data to augment more source-specific data reports already available (e.g., YRBS) to inform dialogue both within Title V programs and with external partners. This essential public health and MCH function will be a positive contribution to ongoing work in this field.

Implementation of this strategy will be tracked by **ESM AH-1:** Initial data report is issued.

Strategy AH-2: Identify, pilot test and implement validated tool for measuring positive developmental social-emotional assets among children and adolescents that can be used across MCH child-serving programs.

This strategy closely mirrors companion *Strategy CH-2* in Domain 3; please refer to that section for additional supporting information.

While various data sources include measures of relevance to social-emotional wellness of adolescents (see *Strategy AH-1* above), we currently lack a specific framework and measures to meaningfully assess and track positive social-emotional development within public health programs serving adolescents. Title V staff will work with our existing Center of Excellence to develop or modify a tool that can be used by child- and adolescent-serving MCH programs across age groups; the Search Institute 40 Developmental Assets® model tentatively has been identified as a strong candidate for this work, and has been utilized as a cornerstone of NY Title V Program's positive youth development strategies (within our core adolescent health programs) for decades. This model includes specific developmental assets for Adolescence (age 12-18). Stakeholders, including families, youth and providers will be engaged in the process of selecting and implementing a measurement tool for Title V adolescent-serving programs. We anticipate that a candidate measurement tool initially will be piloted through a small number of established MCH/Title V programs, including at least one adolescent-serving program, to evaluate its feasibility and effectiveness. Depending on the success of this initial pilot, we will explore adoption and integration of the tool across all child- and youth-serving MCH/Title V programs to support additional strategies below.

Implementation of this strategy will be tracked by **ESM AH-2:** Number of adolescent-serving MCH programs implementing the asset profile tool

Strategy AH-3: Provide training for Title V staff and external partners, including local adolescent-serving grantees, to increase: 1) awareness, knowledge, and skills to support adolescents' social emotional development and relationships and 2) trauma-informed care practices.

This strategy closely mirrors companion *Strategy CH-3* in Domain 3; please refer to that section for additional supporting information.
Workforce development is another foundational public health approach needed to advance our MCH work for this emerging priority. Training for both Title V state staff and local grantees and practitioners is needed to introduce key

concepts and frameworks, expand knowledge base and begin to develop new skills. As with the broader approach to this priority, training will focus on both population-based knowledge and skills to support and reinforce adolescents' positive social emotional development, as well as more focused knowledge and skills to recognize and connect children and families with adverse experiences using trauma-informed care practices.
Advancing this strategy will require significant collaboration with other partners and leveraging existing infrastructure and resources. Key resources for this work include the NYSDOH-funded Centers of Excellence for Adolescent Health and Family Planning, respectively; the NYS Alliance for School-Based Health Care; and the Statewide Center for Sexual Violence Prevention Training and Technical Assistance. Details for this strategy will be developed as initial work commences and progresses, to be further updated in our Action Plan submission for Year 3.
Implementation of this strategy will be tracked by **ESM AH-3:** Number of adolescent-serving DOH MCH staff and external partners trained about a) social-emotional wellness and b) trauma-informed care practices

Strategy AH-4: Identify, support and integrate evidence-based/-informed strategies to promote adolescents' social-emotional wellness and positive developmental assets through established Title V programs, including:

- **Comprehensive Adolescent Pregnancy Prevention (CAPP)**
- **Family Planning**
- **Pathways to Success**
- **Personal Responsibility Education Program (PREP)**
- **School-Based Health Centers**
- **Sexual Violence Prevention Program**

This strategy closely mirrors companion *Strategy CH-4* in Domain 3; please refer to that section for additional supporting information.

Building on the work described in *Strategies AH-1 to AH-3* above, a critical element of our approach to addressing this new priority will be the identification and integration of effective strategies to supporting adolescents' social-emotional development and healthy relationships across existing youth-serving Title V Programs. Building on existing program infrastructure leverages the significant investments and experience already in place at both state and community levels, while additional attention to ensuring strategies are evidence-based or evidence-informed will increase the impact of this collective work.
In refining our Action Plan for Year 2, it was highlighted that many current Title V programs already include a strong focus on social-emotional and behavioral health, which will be built upon to address this new priority. The CAPP program is built on a positive youth development framework, using a multi-pronged model that includes evidence-based programs to support sexual health education; innovative approaches to make reproductive health care welcoming and accessible to youth; and, multidimensional educational, vocational, economic and recreational activities to introduce youth to new situations, ideas and people that challenge them to learn and build skills, build on strengths and assets and shape their ideas and aspirations for the future. PREP grantees, who focus specifically on serving high-risk youth populations to reduce adolescent pregnancy, incorporate an array of activities to support development of adult skills such as financial literacy, educational and career success, healthy life skills, healthy relationships, adolescent development, and parent-child communication. School-Based Health Centers (SBHC) are required to provide behavioral health screening for all patients (elementary, middle and high school age) as part of ongoing primary care, and most provide additional mental health services on-site within SBHC clinics, with referral to mental health services by sites that do not have in-clinic resources.
These existing Title V programs are critical assets that can be effectively leveraged to further support social-emotional development and relationships for adolescents and their families through the integration of additional evidence-based/-informed practices and strategies (See *Domain 3* for companion information on Title V child-serving programs).
Implementation of this strategy will be tracked by **ESM AH-4:** Number of adolescent-serving MCH programs

identified with an evidence-based social-emotional component.

Strategy AH-5: Continue to provide subject matter and technical support to NY's Medicaid Health Home Program to implement enhanced care coordination for eligible children with serious emotional disturbance/serious and persistent mental illness and complex trauma.

This strategy closely mirrors companion *Strategy CH-5* in Domain 3; please refer to that section for additional supporting information.

As described the Title V Program has been extensively involved in supporting the development of Medicaid Health Home (HH) services for children and youth, including innovative leadership by NYS to incorporate complex trauma as a qualifying condition for HH eligibility. Please refer to *Domain 4, Strategy CSHCN-3* below for more detail on this work. While some youth are already being served by HH, the launch of a wider network of HH providers specifically designated to serve children and youth will greatly expand the availability of intensive care management services for young people struggling to manage serious mental health conditions or complex trauma.

Title V staff from have been deeply involved in this work from the outset, including articulation of standards for child-serving HH, review of applications and planning for implementation. Our staff will remain engaged to support implementation and incorporate information learned from the program in our larger public health work.

Implementation of this strategy will be tracked by **ESM AH-5:** number of adolescents with documented serious emotional disturbance and/or complex trauma who are a) enrolled in Medicaid Health Home and b) transitioned to adult-serving Health Homes.

Adolescent Health - Annual Report

Adolescent Health

Teen pregnancy prevention is one of CDC's top "winnable battles" in public health, and of paramount importance to health and quality of life for youth. Teen pregnancy and childbearing bring substantial social and economic costs through immediate and long-term impacts on teen parents and their children. Title V in NYS has been a leader in advocating for, and implementing several evidence-based startegies and approaches to not only have a positive impact on preventing teen pregnancies, sexually transmitted infections, and sexual risk behavior but in promoting the ability for teens to make healthy choices in their lives. Advances in this public health priority have resulted in significant improvements in the health and wellness of NY's teens.

Adolescent pregnancy rates in NYS are at an all-time low. NY's teen pregnancy rate has declined significantly over the past few years. In 2014 the teen pregnancy rate was 33.2 pregnancies per 1,000 15-19 year olds as compared to 36.8 in 2013 and 50.2 in 2010. Although the white teen pregnancy rate of 12.4 per 1000 females age 15-17 was much lower than the rate of 40.3 for black females and 37.7 for Hispanic females of the same age, these rates continue to decline. The birth rate for teens aged 15-17 declined to a new low of 8.2 births per 1,000 in 2013 from 9.5 in 2012 and 11.2 in 2010. This represents 528 fewer births for teens 15-17 in 2013 than 2012. For adolescents 15 through 17 years of age, the rate has dropped from 11.2 per 1,000 in 2010 to at 8.2 per 1,000 in 2013.

DOH's Comprehensive Adolescent Pregnancy Prevention Program (CAPP) is a statewide primary pregnancy prevention initiative which utilizes a youth development framework, including comprehensive sexual health evidence-based programs and access to reproductive health care services, to promote health, reduce the risk of initial and repeat pregnancies, STDs and HIV among NYS adolescents, and reduce racial, ethnic, and geographic disparities that are related to adolescent sexual health outcomes. Funding supports 50 community-based organizations throughout NYS in high-need communities. Through federal funding from HHS Administration on Children and Families HHS Administration on Children and Families, the Personal Responsibility Education Program (PREP) supports eight programs that are part of the statewide adolescent primary prevention initiatives as well as a program working with youth in foster care and youth with emotional and behavioral problems to:

- Provide comprehensive, age appropriate, evidence-based, and medically accurate sexuality education to

promote healthy sexual behaviors including abstinence, delay the onset of sexual activity and reduce the practice of risky sexual behaviors among youth.

- Ensure access to comprehensive reproductive healthcare and family planning services for adolescents.
- Expand opportunities and provide support and alternatives to sexual activity for adolescents, including pregnant and parenting teens, in order to promote an optimal transition through adolescent developmental milestones into a healthy young adulthood.
- Advance a comprehensive and sustainable local community effort to improve the community environment for adolescents through the development of a coordinated community plan.

Over the past year, CAPP and PREP provided evidence-based program (EBPs) to over 25,000 adolescents. One additional organization funded through PREP was chosen to participate in the Federal Impact Evaluation Study to evaluate their adolescent pregnancy prevention program as an EBP.

DOH further supports adolescent health initiatives through the New York Promoting and Advancing Teen Health (NYPATH) initiative at the Columbia University Mailman School of Public Health. NYPATH provides professional educational opportunities and develops resources for healthcare providers throughout the state to increase the delivery and utilization of accessible, high quality, "adolescent friendly" sexual, reproductive and other preventive healthcare services for adolescents. NYPATH provided training on adolescent sexual health to 576 NY health care providers.

The Successfully Transitioning Youth to Adolescence (STYA) is supported through the federal Abstinence Education Grant Program and supports 17 community-based organizations that provide mentoring, counseling and adult supervision programs designed to delay the initiation of sexual behavior among youth, ages 9-12, residing in high-risk communities.

The ACT for Youth Center of Excellence (ACT COE) through Cornell University and their partner agencies (University of Rochester and the NYS Center for School Safety) provided training and technical assistance to the adolescent pregnancy prevention initiatives, including CAPP, PREP and STYA projects. In addition, the ACT COE conducted program evaluation, including data collection and analysis, and ensured the fidelity of implementation of EBPs with fidelity. Over the past year:

- Implemented 31 in-person regional training events and held 23 webinars.
- Responded to 1,221 requests for technical assistance from CAPP and PREP contractors.
- Maintained a web site (www.actforyouth.net) which provides online narrated presentations, evaluation tools, videos, training manuals and other resources and is continuously being expanded.
- Developed an online implementation training course that has been used by 335 new CAPP and PREP educators and coordinators; 214 completed the course in 2015.
- Developed and distributed 5 newsletters, *CAPP and PREP News,* with the most recent one discussing the benefits of developing master lists of adaptations.
- Published six fact sheets: *Research Facts and Findings* & *Practice Matters*; the most recent one focused on pregnancy risk among LGBTQ youth. All publications are disseminated electronically and archived on the web site.

  The COE maintains a data management system to assess the quality of EBP implementation and conducted an evaluation for the local project and for the overall CAPP and PREP initiative. Qualitative and quantitative evaluation findings are used in performance management and enhancement of EBP implementation.

In 2014, DFH implemented a performance management approach to many initiatives, including CAPP, to monitor participant dosage at Evidence-Based Programs (EBP) 100% of youth participants in EBPs complete 75% or more of the EBP sessions. The ACT COE monitored performance and reported to DOH quarterly. Tools were developed

by ACT COE to assist programs to improve attendance and meet performance measure, including an on-line implementation course for new educators and an attendance toolkit. Since the adoption of this measure, there has been a 4% increase in participant dosage.

Title V's Pathways to Success initiative, supported with federal Pregnancy Assistance Funds through the Office of Adolescent Health, aims to create and sustain supportive communities that assist expectant and parenting adolescents and young adults travel pathways to success through health, education, self-sufficiency and strong families. Over the past year, Title V staff have worked collaboratively in three target communities in the Bronx, Erie and Monroe Counties through public school districts, community colleges and one academic research institution, namely Hostos Community College, Monroe Community College, Erie Community College, Fund for Public Health NY, Buffalo Public Schools, Rochester City School District, and Cornell University (ACT for Youth Center of Excellence). Emphasis has been on the development of strong collaborative relationships among various organizations in the community to promote a systems-based approach to support and services for these adolescents. Programs served 291 high school and 356 community college students, totaling 766. 60 were expectant and 455 were parenting students (remainder had unknown status). 647 Female, 119 Male, and 32 children of students were served by our programming.

As stated previously, the DFH oversees the largest School-Based Health Center Program (SBHC) in the country that improves access to comprehensive health care for children and adolescents in high-need areas. SBHCs provide preventive, acute, chronic disease management and mental health services through more than 680,000 health care visits to approximately 160,000 students annually. Over the past year, Title V in collaboration with OHIP has worked with SBHC staff and key stakeholders to plan for the incorporation of SBHC and SBHC-Dental (SBHC-D) Services into the Medicaid Managed Care (MMC) benefit package, resulting in reimbursement for SBHC services to Medicaid enrollees transitioning from current fee for service "carve out" to Medicaid Managed Care Plans (MMCPs). Starting in 2014, Title V in collaboration with OHIP initiated ongoing meetings with SBHC and MMCP representatives to discuss the transition to MMC. The goal of this transition is to maintain access to these critical SBHC and SBHC-D services while integrating the services into the larger health care delivery system. It is anticipated that the integration of SBHC and SBHC-D services within the existing managed care framework and coordination of services with the child's primary care provider will improve quality and promote an efficient, effective delivery system.

A policy paper was developed by this group to guide policy development, and clarify questions on processes and procedures with the ultimate goal of maintaining the continuity of care and the wellness of the child to facilitate learning and improved school attendance through this transition. One of the priority areas discussed during this timeframe was the need to ensure protection of confidentiality for minors accessing family planning and reproductive health services. MMCPs are required through federal and NYS statute and regulations to prevent unauthorized disclosure of their enrollee's protected health information. MMCPs, however, are required to provide enrollees with written notice of all adverse Actions (in general terms, where the plan denies a service authorization request, approves a services authorization request for less than what was requested, or denies payment for a claim) in the normal course of business between health care providers and MMCP. In the case of minors, Notice of Actions, and other routine payment notices such as: explanation of benefits (EOB); authorization notices; and provider invoices, may inadvertently release protected information to a parent or guardian, even if addressed to the enrollee. Concern over such disclosure is a known barrier for adolescents to seek necessary and timely health care services, particularly for family planning, HIV testing, sexually transmitted disease treatment, mental health services and substance use disorder treatment. This potential for disclosure rests primarily with notices that may be received after an enrollee has received the health care service. In order to prevent this from occurring, as a result of discussions through this group, the DOH is making administrative changes to this process and developing guidance to MMCPs and the field supporting targeted suppression of these claim denial notices to protect the confidentiality rights of adolescents and foster access to family planning, HIV testing, sexually transmitted disease treatment, mental health services, substance use disorder treatment, and health care services related to pregnancy and childbirth. This policy will apply to all health care service confidentiality rights provided to minors by federal or NYS

law or regulation.

This SBHC managed care transition was to occur on July 1, 2016 but legislation was recently passed delaying implementation until July 1, 2017. Title V will continue to co-lead efforts with OHIP, SBHCs and key stakeholders to ensure quality, comprehensive services are provided through NY's SCHCs and SBHC-D programs through MMC.

NY's comprehensive family planning and reproductive health program consists of a state-wide network of 49 agencies in 168 sites, that provide women, men, and adolescents, especially low income individuals and those without health insurance, confidential contraceptive services, preconception planning and counseling, pregnancy testing and counseling, HIV testing and counseling, STD testing and treatment, screening for breast and cervical cancer, health education, and referral to primary and prenatal care and other preventative services. Family planning programs served 50,462 clients between the ages of 13-19 in 2015, which represents 16.5% of all clients served. In addition, DFH led a performance improvement initiative with the family planning providers to increase the use of Long Acting Reversible Contraception (LARC). As a result, the percent of teens ages 15-17 and 18-19 who left a family planning visit with an effective contraceptive method increased 3.8 % and 3% respectively from 2014 to June 2015; and increased 3.2% and 3.5% respectively for a highly effective method. As stated previously, NY is also participating in CDC's 6|18 Initiative and HRSA's Infant Mortality COIIN, targeting reducing unintended pregnancy through the promotion of LARC.

Obesity is a cross-cutting health issue that impacts all populations across the lifespan, including adolescents. There has been a slight improvement in this issue in NYS related to adolescents the past few years. In 2010, 25.7 % of high school students were overweight or obese as compared to 24.4 in 2013 which remains above the HP 2020 target of 16.1 %. The Healthy Schools New York (HSNY) initiative (discussed previously in the Child Health domain) also targets adolescents and provides technical assistance and resources to 180 school districts to establish healthful eating environments and daily physical activity opportunities, including physical education. The Healthy Eating and Active Living by Design (HEALD) Program implements community policy, systems and environmental changes in schools and communities to reduce risks for heart disease and obesity by increasing access to healthful foods and opportunities for physical activity. The Just Say Yes to Fruits and Vegetables Project (JSY) uses nutrition education workshops, food demonstrations and environmental strategies to improve access to healthier foods and physical activity.

DOH has and continues to lead very successful youth smoking cessation initiatives. DOH uses two different data sources to determine the percentage of adolescents in grades 9 through 12 who report tobacco use in the past month. The DOH conducts the Youth Risk Behavior Surveillance Survey (YRBS) in collaboration with the NYS Education Department (NYSED), on odd numbered years, and the Youth Tobacco Survey (YTS) on even numbered years. The YTS was conducted in 2014 and the YRBS was conducted in 2015. An analysis of 2014 YTS data found historically low smoking rates among high school youth (7.3%) and middle school youth (1.2%) in NYS. These results were published in a January 2015 StatShot: *Trends in Smoking Prevalence among NYS Youth*, available on the DOH website and disseminated to tobacco control partners via email. Among high school students, smoking prevalence dropped significantly between 2000 (27.1%) and 2014 (7.3%) representing a 73.1% decrease. The percentage of students who have ever tried a cigarette, even just one or two puffs, dropped 64% among high school students and 83% among middle school students since the year 2000. These data were presented at various program meetings. The rate of high school students smoking declined from 11.9% in 2012 to 7.3% in 2014, a 39% decrease.

Due to DOH-funded Advancing Tobacco-Free Community (ATFC) contractor and Reality Check (RC) youth activities, two new local policies were passed designed to decrease youth exposure to tobacco marketing in the retail environment (referred to as Point of Sale; POS). The City of Newburgh passed a policy that requires all tobacco retailers to obtain a city tobacco license in order to sell tobacco products; no new licenses will be issued to tobacco retailers within 1,000 feet of schools; the number of licenses will be capped at the full registered number for year one, to be reduced in future years. Ulster County passed a policy that requires all tobacco retailers to obtain a county license, including ENDS (e.g., e-cigarettes) retailers, and no new licenses will be issued to tobacco retailers

within 1000 feet of schools.
DOH also ran a $7.7 million statewide health communication campaign featuring ads that tell the story of a man who died at age 30 from lung cancer and similar ads. Ads were placed on TV, digital, transit (e.g. bus shelters), billboards and in malls. Additionally, DOH-funded contractors garnered 724 POS and 425 tobacco-free outdoor (TFO) earned media hits. TFO policies were enacted at public places that youth frequent, including parks, beaches and playgrounds. Multiple employers who serve youth, including churches, a Boys & Girls Club, a YMCA, an aquarium, a ski area, and a museum, adopted smoke-free grounds policies. A total of 130 employer policies and 35 municipal policies were adopted. DOH-funded contractors obtained 26 policies from local media outlets to limit youth exposure to tobacco marketing and imagery.
The Retail Advertising Tobacco Study (RATS) was conducted in 2014 and 2015. RATS describes and monitors the amount, type and placement of pro-tobacco advertising and promotions in the retail environment. RATS data are used to support and evaluate local initiatives associated with reducing retail advertising of tobacco products.
The Regional Asthma Coalitions (RACs) began 25 asthma control projects in high burden counties across the state to address asthma in children and adolescents. Projects, in collaboration with local partners, used an evidence-based systems changes approach to improving asthma care and asthma health outcomes. RACs provided evidence-based training to clinical providers and allied care professionals to support translation of national asthma guidelines into practice. DSRIP projects included home-based asthma management, medication adherence, and clinical guideline implementation. 13 Performing Provider Systems chose asthma project work. Health care providers received a decision support tool and *Asthma in the Primary Care Setting* course at no cost. DOH and State Education Department (SED) began development of a comprehensive asthma management guidance for schools, including tools and resources for implementing a team approach to care for students with asthma.
22 community and 18 school-based DOH-funded projects trained 175 school district (SD) staff on promoting health and wellness policies within schools. SD wellness policies were assessed and found comprehensiveness scores increased from 58 to 83, and strength scores increased from 24 to 55 (out of 100). SDs adopted policies addressing nutrition, physical activity, and physical education, reaching 483,390 students (grades K-12) and 2,922 staff. Community projects reached adolescents through increased physical opportunities and access to healthy foods.
The social-emotional wellness of NY's children and adolescent is a major priority of Title V. Many mental health problems emerge in late childhood and early adolescence. Recent studies have identified mental health problems, in particular depression, as the largest cause of the burden of disease among young people. Poor mental health can impact health and development of adolescents and is associated with several health and social outcomes such as higher alcohol, tobacco and illicit substances use, adolescent pregnancy, school drop-out rates and delinquent behaviors.

OMH's Suicide Prevention Office (SPO) was established in May 2014 to oversee all aspects of a comprehensive and coordinated approach to suicide prevention in NYS. SPO is aligned with the guidelines offered by the National Action Alliance for Suicide Prevention, and committed to advancing the Zero Suicide approach in health and behavioral care. SPO works in concert with key stakeholders, including the Center for Practice Innovation (CPI). Under the direction of Dr. Barbara Stanley, CPI adds its core competency in implementation of evidence-based practices to the statewide efforts, particularly in the area of clinical training. In addition, SPO relies on the operational support of the Suicide Prevention Center of New York (SPCNY) which has been instrumental in coordinating and providing gatekeeper training throughout NYS.

OMH also received the 3 year National Strategy for Suicide Prevention (NSSP) grant from SAMHSA. The goals of the project are to promote suicide prevention as a core component of health care services; and to promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behavior.
In 2015, NYS was one of six states to participate in the Zero Suicide Breakthrough Series, a 10-month project

sponsored by the National Council for Behavioral Health in partnership with the Suicide Prevention Resource Center. The aim of the project was to collect quantitative and qualitative data from states and partnering organizations on the implementation of Zero Suicide to identify key barriers, and to develop strategies to address those barriers and improve the suicide safe care provided. In addition, the New York Academy for Suicide Safer Care (NYASSC) was established to broadly disseminate the Zero Suicide Model to organizations willing to voluntarily raise their standard of suicide care. NYASSC worked with outpatient organizations through participation in Learning Collaborative webinars. In 2015 12 organizations participated, providing information and training to 24 individuals. SP-TIE, a suicide prevention project through OMH, released three web-based training modules, AIM (Assessment-Intervene-Monitor) on managing suicidal individuals. To date, over 4,000 clinicians have received training which is available on the OMH website free of charge. Other OMH training and technical assistance initiatives include:

- Collaborative Assessment and Management of Suicidality (CAMS) - 305 clinicians from across the State were trained in CAMS.
- Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP) 252 clinicians from across the state were trained in CBT-SP.
- Lifelines Trilogy of Trainings and Creating Suicide Safety in Schools Workshop, all national best practice workshops, were provided to 292 school-based professionals in 11 full day training sessions.
- QPR, SafeTALK and ASIST are gatekeeper trainings provided to persons in all kinds of helping professions. These trainings teach simple techniques to recognize, engage, listen to and refer persons who may be in suicidal distress. 103 trainers provided a total of 308 gatekeeper trainings that potentially reached a total of 10,254 individuals.
- Caring and Competent Communities provided biannual regional networking meetings attended by representatives of the 41 existing suicide prevention coalitions in New York State.

The NYSDOH Bureau of Occupational Health and Injury Prevention (BOHIP) and the NYS Office of Mental Health (OMH) worked collaboratively to develop research opportunities to enhance efforts to address suicide in the population. Under the leadership of OMH, NY continued a major Suicide Prevention (SP) Initiative. OMH provided Prevention, Intervention and Postvention Curriculum to schools throughout NYS. OMH added Nassau and Suffolk Counties to its Garret Lee Smith "Caring and Competent Suicide Prevention Counties." OMH added a major behavioral health provider, Federation Education Guidance Services, to its Zero Suicide Collaborative; this agency serves over 40,000 children and families in NYC and Long Island. OMH worked with the NY Army National Guard (NYANG) family readiness groups to improve family awareness of suicide prevention, intervention and postvention supports. OMH provided *Creating Suicide Safety in Schools* workshops and its *Lifelines* program. All SBHCs continue to address the mental health needs of enrolled students, either directly or by referral.
BOHIP worked with the National Highway Traffic Safety Administration to conduct a Walking Safety Assessment in Rockland County. Convening partners to complete the Assessment is an activity outlined in the national plan, "*Safer People, Safer Streets: Summary of US Department of Transportation Action Plan to Increase Walking and Biking and Reduce Pedestrian and Bicycle Fatalities*." The team documented observations during a visit to areas with an overrepresentation of pedestrian crashes. A study was then conducted to identify pedestrian safety needs and develop recommendations for improving safety with an emphasis on better roadway engineering, and increased education and enforcement. DOH staff produced pedestrian safety public service announcements (PSA) that focus on avoiding distractions when walking and driving. The PSAs will be featured as part of a statewide educational strategy to reduce pedestrian injuries. The "*Under 13? Back seat and buckle up!*" campaign video PSA was shown in movie theaters and physicians' offices in five high risk counties. Educational materials were also distributed in physicians' offices and posted on the DOH website. BOHIP worked with the Governor's Traffic Safety Committee and the NY Department of Motor Vehicles to develop the Graduated Driver Licensing (GDL) Guide for Law Enforcement. The Guide aims to educate officers about GDL restrictions and increase enforcement of restrictions in order to reduce motor vehicle crashes among young drivers.

Adolescents are also particularly vulnerable to sexual violence and bullying. DOH is currently funding six Regional Centers for Sexual Violence Prevention (Regional Centers) who are conducting sexual violence primary prevention community-level and individual-level change strategies to youth and young adults aged 10-24 years old and influential adults in the community who work closely with them. Three out of the six Regional Centers are conducting activities with adolescents and young adults on healthy relationships and/or decreasing bullying. One Regional Center is providing educational programs for parents, teachers and influential adults on building and modeling healthy, respectful relationships and challenging rigid gender roles. Another Regional Center has initiated “Working Group on Girls’” which is a community-wide effort to prevent interpersonal violence and empower girls to seek healthy, supportive relationships. This center is also working with LGBTQ youth providing a Healthy Relationship Skills curriculum. Another is developing a healthy relationship, social norms project to be implemented with middle and high school youth using PhotoVoice Participatory Photography for Social Change as a tool for communication, self-expression, advocacy, and social change. The Regional Centers developed and distributed a toolkit which provides an overview of existing programs and resources designed for youth that utilize the bystander intervention approach. Reducing teen suicide and promoting mental health were selected as priority areas of focus in the 2013-17 NYS DOH Prevention Agenda.

Children with Special Health Care Needs

Measures

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	41.9	42.4	42.6	42.9	43.3	43.8

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	39.7 %	3.4 %	100,326	252,737
2005_2006	38.4 %	2.9 %	87,662	228,271

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 12.1 - Children with Special Health Care Needs - 1

Annual Objectives					
2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

ESM 12.2 - Children with Special Health Care Needs - 2

Annual Objectives					
2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

ESM 12.3 - Children with Special Health Care Needs - 3

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

ESM 12.4 - Children with Special Health Care Needs - 4

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	0.0	25.0	50.0	90.0	0.0

ESM 12.5 - Children with Special Health Care Needs - 5

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

ESM 12.6 - Children with Special Health Care Needs - 6

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.5	2.0	2.5	3.0

ESM 12.7 - Children with Special Health Care Needs - 7

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	45.0	60.0	70.0	75.0	78.0

ESM 12.9 - Adolescent Health - 2

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	0.0	1.0	1.0	1.0	1.0

ESM 12.8 - Adolescent Health - 3

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

ESM 12.10 - Adolescent Health - 4

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

ESM 12.11 - Adolescent Health - 5

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

Children with Special Health Care Needs - Plan for the Application Year

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

State Priority #4: Increase supports to address the special health care needs of children and youth

2020 State Objectives:

- Objective CSHCN-1: Increase the percentage of adolescents with special health care needs who receive services necessary to make transitions to adult services by 10% to 44%.
- Objective CSHCN-2: Increase the percentage of families participating in the Early Intervention Program who meet the state's standard for the NY Impact on Family Scale (≥ 576) by 0.5% to 66.5% in 2018.
- Objective CSHCN-3: Increase the percentage of CSHCN who need and receive care coordination services that meet their needs by 10% to 44%.
- Objective CSHCN-4: Increase the percentage of infants who receive a follow-up hearing screening after failing initial hearing screening by 45% to 50%

A comprehensive, coordinated, seamless system of supports and services for Children with Special Health Care Needs (CSHCN) and their families is imperative to child health, wellness and self-sufficiency. NYS has extensive services and supports for CSHCN and their families across the life course. Beginning at birth, NY's Newborn Screening Program (NBSP) performs blood testing for over 275,000 specimens annually for 49 diseases and conditions, including all core conditions recommended by the American College of Medical Genetics and the March of Dimes. Follow-up is provided through specialty centers located throughout NYS. Birthing facilities in NYS are required to conduct hearing screening on all babies born in NYS and to report the results of screening to the New York Early Hearing Detection and Intervention Program. In 2014, 90% of newborns received hearing screening prior to discharge. Follow up of positive screens and referrals for early services are key to optimal language development for hearing impaired infants. For all infants and toddlers with developmental disabilities or delays, NY's Early

Intervention Program, the largest in the nation, provides services to more than 65,000 infants and toddlers and their families statewide. NY's Local Health Department (LHD)-based CSHCN Program, funded by Title V and currently offered in 50 localities, provides information and referral services to over 1200 families of CSHCN birth to 21 years. The Physically Handicapped Children's Program (PHCP), a voluntary gap-filling program that currently operates in 31 counties of the state, provides reimbursement for specialty medical and orthodontic care for uninsured or underinsured CSHCN financed through a combination of state and local funds.

In light of the vast array of NYS services, creating a more seamless system of care and support for CSHCN and their families is one of NY's challenges. While individual needs vary, as a group CSHCN require both pediatric primary and preventive health services as well as access to and coordination of specialized services. These services include pediatric specialty and subspecialty care, early intervention, special education and related habilitative and rehabilitative services. In addition, CSHCN need the same life course information, i.e. life skills and reproductive health, that other children need to grow into healthy, well-adjusted adults. The families of CSHCN need access to an array of family support services, including individual and group support and respite care. Moreover, in the context of the Affordable Care Act and continued expansion of health insurance coverage for children, our Title V Program sees an opportunity to focus on strengthening service coordination, at both the family and systems level.
Over the last year, a MCH team of Title V professionals, including staff from the Bureau of Early Intervention (BEI) and Child Health (BCH), met regularly to review data, literature and program outcomes to further inform the assessment about the system of care supported by the Department's public health programs and provided by other state agencies, health care providers and community based organizations. The team identified that, while individual programs contribute in various ways to the provision of comprehensive, coordinated, family centered and culturally sensitive services, NYS families face uncertainty about gaining the information they need to access the vast array of available programs and services. Children "aging out" of programs and either losing services or making transitions to new services is a particular challenge. With this information, the Title V team consulted with HRSA-funded Catalyst Center at the Boston University School of Public to further develop ideas about how to gain additional systems information, which in turn can be used to develop Title V actions and information for future coordinated program planning and implementation.
Based on this work including the consultation with the Catalyst Center, conducting a comprehensive system mapping initiative has been identified as an important next step. Systems Mapping is designed to strengthen understanding of how services are arranged, offered to and accessed by families. Related priorities that emerged included understanding how satisfied families of CSHCN are during service provision and how to better support CSHCN and their families during times of transition.
In addition to assessment, informing and developing policy for children is a major role that the Title V program undertakes in NYS. Title V staff are working with Office of Health Insurance Program (OHIP) staff to transition School Based Health Centers from Medicaid fee-for-service reimbursement to managed care programs. Title V staff continue to collaborate with OHIP on planning of Health Homes for children that is expected to begin implementation in October 2016. Title V staff will continue to develop policies, programs, and initiatives which ensure CSHCN and their families receive the needed supports and services, and gaps in service coverage are addressed.

Providing the skills and supports families need to navigate the service system, and helping families and CSHCN become self-advocates are important roles of Title V. The Family Initiatives Coordination Services Project in the BEI coordinates the development and implementation of a variety of family initiatives which train parents involved in the EIP to become advocates for special needs children at local, state and national levels. This initiative will continue to build tomorrow's family leaders. The CSHCN Program will continue to work with Parent to Parent of NYS to obtain input regarding the needs of CSHCN and how to improve the system. Family involvement will continue to be an important aspect of building a more coordinated system for CSHCN and their families, and with our partners we will explore opportunities to strengthen this component of our work.

While this updated Action Plan focuses on specific strategies and measures, it is important to recognize that these

efforts will build on and be embedded within the extensive body of child- and family-serving MCH public health programs and activities already in place through NY's Title V Program, including: Early Hearing Detection and Intervention (EHDI) Program; Early Intervention (IDEA Part C) Program; Local Health Department-based Children with Special Health Care Needs and Physically Handicapped Children's Programs; Maternal and Infant Community Health Collaboratives (MICHC); Maternal, Infant and Early Childhood Home Visiting (MIECHV); School-Based Health Centers and School-Based Dental Clinics (See *Section II.B.2.bi.ii* and *2015 Annual Report*).
This priority is closely linked to other state priorities including in particular strategies related to supporting children's social-emotional development (Priority #3), improving developmental screening as part of preventive health care services for children (Priority #5) and all life course priorities.
Progress toward achievement of objectives and outcomes for children associated with Priority #3 will be tracked through **NPM 6:** Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool and **NPM 12**: Percent of children with special health care needs who received services necessary to make transitions to adult health care.
Strategy CSHCN-1: **Develop and implement a plan for analysis and reporting of CSCHN data for NYS, including forthcoming data from revised National Survey of Children's Health, and issue initial data report.**

As noted throughout this plan, population and program data are needed to help drive and evaluate work across all areas of our MCH work, including CSHCN. As part of our Year 1 work, Title V staff reviewed available data for CSHCN population including data from the most recent National Survey of Children's Health (NSCH), National Survey of Children with Special Health Care Needs (NSCSHCN) and data reported by our Title V Local Health Department-based CSHCN and Early Intervention programs. As a foundation of our work, we will continue and expand this review of available data and develop a plan for analyzing and reporting available data to inform dialogue and continued program planning, both within our Title V CSHCN programs and with external partners. While this essential public health and MCH function has always been an element of our work, through this strategy we aim to expand and formalize this process to include a data analysis plan and regular summary reports. Forthcoming revisions to the National Survey of Children's Health will be an essential component of this strategy.

Implementation of this strategy will be tracked by **ESM CH-1:** Initial data report is issued.

Strategy CSHCN-2: Engage parents, families and providers in a system mapping exercise to identify the gaps and barriers in the system of public health programs and services for CSHCN and their families

New York State is estimated to be home to over 750,000 CSHCN. Several state agencies, including the Department of Health, Office of Children and Family Services, Office of Mental Health and Office of Persons with Developmental Disabilities, funds a multitude of programs and services to provide assistance to CSHCN and their families. This year, as described above, our Title V Action Planning Team reviewed the current state systems in place for this widely diverse and substantial population of CSHCN. As a result of this work, we have identified the need to more systematically assess and articulate how agencies and programs relate to each other and to the CSHCN and families served. While certain systems and programs are in place for CSHCN, they may not be easy to understand or navigate for families, and may not be optimally coordinated with one another.

With the assistance of the National MCH Workforce Development Center and the HRSA-funded Catalyst Center, the Title V program plans to conduct a system mapping initiative in the upcoming year. This initiative will include engaging a variety of members representing the numerous stakeholders involved with CSHCN including parents, advocacy groups, health care systems and community-based providers, academia, county officials, and state agency staff. The goal of the initiative is to construct a comprehensive systems map which will identify whether connections/relationships exists between programs and services and identify specific issues, gaps and barriers in the system of public health programs and services for CSHCN and their families. We anticipate that this systems mapping will be shaped by facilitated group processes, key informant interviews and data collection to capture what the system looks like and how it functions. The Title V Program will share information gained with partners to support

more integrated, comprehensive, family centered and consistent system of care for the families of CSHCN. In accomplishing this, the Title V Program hopes to increase understanding, communication, and access to services that can improve the lives of families of CSHCN. Resources to support this new activity will be sought from within available Title V funding.

Implementation of this strategy will be tracked by **ESM CSHCN-2**: Number of partners engaged in system mapping

Strategy CSHCN-3: Provide subject matter and technical support to NYS Medicaid Program to implement enhanced care coordination and transition support services for CSHCN through Children's Health Homes.

An extremely important role that NY's Title V program has, and will continue to play in the future is ensuring the needs of CSHCN are addressed in the emerging Medicaid Health Home for Children. As stated previously, to enhance services for CSHCN and their families, DOH (including the Office of Health Insurance Programs, the Center for Community Health, Division of Family Health and the AIDS Institute) and State Agency partners (the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services, and the Office of Children and Family Services) have been working collaboratively to develop Health Home (HH) for Children. The HH will provide care management to children with Medicaid who have complex physical and/or behavioral health conditions under the NYS HH model as tailored to serve the unique needs of children.

Health Homes will expand the availability of care management from the limited population of children currently served by "waivers" (e.g., Bridges to Health, Care at Home) and targeted case management programs (approximately 12,000 children) to potentially 150,000-200,000 children across the Medicaid population that have unique needs and may qualify and be appropriate for HH. Health Homes provide an opportunity to establish critical linkages and help break down silos of care by linking systems and programs (education, child welfare, Early Intervention) to comprehensive care planning.

NY's Title V program has been intimately involved with the development of eligibility criteria and determination, care management model and service delivery system to ensure NY's HH best meets the needs of CSHCN. To achieve the goal of ensuring eligibility condition-based criteria captures high need children's populations, including Medically Fragile Children with complex health issues, children in foster care, children with Serious Emotional Disturbance, children enrolled in "Waiver" programs and other case management programs, NYS has proposed and the Centers for Medicare and Medicaid Services (CMS) has accepted a modification to HH eligibility criteria that includes complex trauma. Complex trauma is defined as "exposure to a single severely distressing event, or multiple or chronic or prolonged traumatic events as a child or adolescent, which is often invasive and interpersonal in nature." This innovative approach further strengthens the significant opportunity offered by HH to help support CSHCN and their families.
In addition, Title V staff have worked closely with OHIP to ensure the successful integration of HH care management with service coordination provided through the Early Intervention Program (EIP), in accordance with federal and state laws and regulations for that program. We will continue to work with OHIP and key stakeholders to ensure children ages birth to three with developmental delay or disability who are served in the EIP and who are eligible for Health Home have a smooth transition in that system. Much work is to be done to ensure Health Home care managers can provide the supports and services required by the federal Individuals with Disabilities Education Act Part C and state law and regulations. Similarly, systems must be designed to ensure that those children in Health Home are referred to the EIP when potentially eligible for those services.

The Title V program will work with OHIP and others to guide the development of policies and procedures, as well as training that will be necessary to ensure that all CSHCN and their families receive the highest quality supports and services from agencies approved to serve as Health Homes. Title V staff have provided feedback on the Children's and Adolescent's Needs and Strengths (CANS) tool that will be used by the Health Homes upon enrollment to

determine individual level care management acuity upon which payment will be based.

Title V staff has been collaborating on the webinars that will be presented to providers beginning June 2016 in order to prepare for the fall Children's HH implementation. There has been modifications to the HH eligibility criteria for children to include Social Emotional Disturbance(SED) and defining what this is for NYS HH and complex trauma (CMA/SAMHSA definition) as a single qualifying condition for HH eligibility.

Title V staff has been part of the interagency team that reviewed all Children's Health Homes (CHH) applications. Currently there are 13 approved CHH (that also serve Adults in Health Homes) and 3 that are only CHH approved. Children will begin enrolling into Health Homes as of October 2016.

In September 2016, Medicaid Analytical Performance Portal (MAPP), the Health Home tracking system, will be going live for children. This portal tracks children's referrals, consents, and billing based on the CANS-NY algorithm. There is connectivity between MAPP and the Uniform Assessment System (UAS) which houses all the individual CANS performed statewide. Title V staff has been providing feedback on materials included for this process. Title V will continue to provide input and feedback on policies, procedures, and systems components to better serve our children in HH.

Implementation of this strategy will be tracked by **ESM CSHCN-3:** Number of CSHCN enrolled in Health Homes designated to serve children.

Strategy CSHCN-4: Provide grant funding and technical assistance to support successful transition to adult services for young adults with Sickle Cell Disease (SCD), and evaluate projects to identify best practices for enhancing transition support to other key CSHCN populations.

As highlighted in the NA, transition of CSHCN to adult services continues to be a challenge in NYS. Local CSHCN Programs will continue to provide adolescents with information about transitions to adult services, while Health Home (see Strategy CSHCN-3) is poised to significantly strengthen transition supports for eligible adolescents enrolled in Medicaid.

A specific group of CSHCN for whom transition supports are a concern and for which our Title V Program has an opportunity to pursue strategic action are those with Sickle Cell Disease. New York State has been screening newborns for sickle cell disease (SCD) since 1975. According to the National Institutes of Health, with the advances in the diagnosis and care of SCD, the average lifespan of a person with SCD living in a high-income country such as the US has increased from 14 years in 1973 to 40-60 years. As a result, each year hundreds of adolescents and young adults (AYA)/SCD must turn their attention to acquiring the skills and knowledge they need to become healthy and productive adults. Research shows that AYA/SCD have a higher morbidity and mortality than their younger and older cohorts during the five years following transition. This includes higher hospitalization rates, more acute care visits and increased use of emergency departments. In addition, many individuals with SCD need care management services to help them address medical and support needs as they interact with the health care delivery system. AYA/SCD are a vulnerable group as they begin to assume more responsibility for their own health care. Currently there are four NYS grant-funded transition projects in the Bronx, Brooklyn and Manhattan. These grantees integrate Transition Navigators into their medical teams to prepare AYA/SCD and their families to successfully transition to self-responsibility of health needs and transfer to adult-care physicians. As we near the end of the current grant funding cycle, a new Request for Applications will be issued during 2016-2017 to fund SCD Transition demonstration projects that will use proven transition strategies to improve quality of life/health outcomes for AYA/SCD during transition and continuing through adulthood; promote successful transfer of AYA/SCD to adult health care providers; promote engagement of Medicaid-eligible AYA/SCD who need intensive care management with Health Homes; and model and share with other medical professionals a transition program for AYA that includes collaboration with Health Home care managers for Medicaid-enrolled AYA/SCD.

Experience gleaned through this initiative will help inform future planning regarding CSHCN as discussed below.

Implementation of this strategy will be tracked by **ESM CSHCN-4:** Percent of Adolescents/ Young Adults with SCD age 12-21 years in the funded projects who have a transition readiness assessment completed and documented.

Strategy CSHCN-5: In collaboration with University Centers of Excellence for Developmental Disabilities (UCEDDs) and other stakeholders implement NY's State Systemic Improvement Plan (SSIP) to:

- **create a repository of evidence-based practices for family centered services;**
- **convene statewide Learning Collaboratives to improve family outcomes for children served in the state's Early Intervention Program; and,**
- **evaluate projects to identify resources and best practices that can be extended to other CSHCN populations.**

Pursuant to a requirement of the U.S. Department of Education, Office of Special Education Programs (OSEP) for the Individuals with Disability Education Act (IDEA) Part C state programs, New York's Early Intervention Program (EIP) developed a State Systemic Improvement Plan (SSIP). OSEP required that the SSIP be focused on a child outcome, family outcome, or on a constellation of outcomes related to the child and family outcome indicators currently reported to OSEP. Extensive data analyses and synthesis were required to prepare the SSIP including more than a decade of child and family outcomes data collected on families of children in the EIP. Based on this work, and with support of NY stakeholders including the NY's EICC, a decision was made to focus on positive family outcomes for NY's State Identified Measurable Results. The goal will be to increase the percentage of families exiting the EIP who report that the EIP helped them achieve the level of positive family outcomes defined in conjunction with stakeholders as representing the State standard. A state-level advisory council, including state agency, provider and family membership, will guide the project.

To improve the level of positive family outcomes, the DFH will be conducting a Learning Collaborative, using the Institute for Healthcare Improvement (IHI) Breakthrough Series Model.

The DFH will be working with the UCEDDs, local counties, providers and families for approximately 12 months to improve family-centered practices. The goals of the initiative will be to ensure providers use family-centered practices in delivering early intervention services, and that families are engaged as partners and meaningfully involved in promoting their children's development. Lessons learned from this initiative will inform other programs and initiatives to better meet the needs of families of CSHCN.

In the next few months, teams from each county will be paired with members of the UCEDD. They will be asked to review their current local data regarding Early Intervention services and create their own AIM statement, which will be a time-specific, population specific, and measurable goal to improve family-centered services in their county. The teams will implement Plan-Do-Study-Act cycles, from the IHI series, which will help quickly test these changes in their work environment, then if successful, test on a larger scale. Using provided documents, the teams will monitor their progress, make changes as needed, and fully implement the change when it's been determined the change has worked. There will be Learning Sessions throughout the 12 month period where teams can share their experiences, successes, and failures. They will be able to learn from experts and colleagues and gather new information on subject matter and process improvement.

Implementation of this strategy will be tracked by **ESM CSHCN-5**: Number of best practice strategies for improving family outcomes that are documented through review and learning collaboratives.

Strategy CSHCN-6: Use EI family survey data to inform the CSHCN Program of the needs of families transitioning from EI to CSHCN Program in order to better coordinate services.

Families of children who are transitioning from the EIP to the State Education Department (SED) Preschool Program may experience stress as their child moves from one system to another. Families lose the assistance of the EI Case Manager once the transition is complete in the SED Preschool Program. Some families of CSHCN

enrolled in the SED Preschool Program may need brief or ongoing care coordination assistance. There are several options available depending upon the child and family's need, ranging from assistance/support available from the CSHCN Program to the more intensive care coordination to be provided by Health Homes for eligible Medicaid enrollees.

There are over 65,000 children currently in the Early Intervention Program, of which over 12,000 are referred annually to the SED Preschool Program. Current data shows only 66 children ages 1-5 years are referred from the EIP back to the Local Health Department (LHD)-based CSHCN programs, despite the vast majority of local EIPs being housed in LHDs.

Currently there is no "warm handoff" between the EI and CSHCN Programs at the time of EI transition for children who do not qualify for Health Homes. The Title V Program plans to examine the data from the EI survey to determine the needs of the families that are exiting the EI Program. The information gathered can then be shared with the CSHCN Program to address the needs of the families in that community and identify any patterns that are negatively effecting the transition period. Once the information is gathered and the patterns are identified, the Title V Program will review the areas of insufficiency and create strategies to address identified needs related to the transition process. An initial strategy may include a webinar with a small working group of local EI and CSHCN Programs to understand their processes and identify strategies for improvement. Once strategies are identified, these can be shared statewide. The number of local programs making improvements in referrals back and forth will be monitored. The Title V Program will also stress to local programs the importance of documenting referrals from both programs. The warm transition will improve the fluidity of transition between programs and create a more supportive environment for families.

Implementation of this strategy will be tracked by **ESM CSHCN-6:** Percent of children transitioning from EIP to Special Education services who have documented referral to LHD-based CSHCN Program.

Strategy CSHCN-7: Provide technical assistance and facilitate a structured quality improvement project to engage health care providers, hospital staff, parent representatives, audiologists to improve reporting of initial hearing screening and follow up results into the New York Early Hearing Detection and Intervention Information System (NYEHDI-IS).

As described in the 2015 Annual Report, birthing facilities in NYS are required to conduct hearing screening on all babies born in NYS and to report the results of screening through the New York Early Hearing Detection and Intervention Information System (NYEHDI-IS). If the result of a screening test is abnormal, a referral is made to an appropriate specialized care center, and information on subsequent screening tests and follow-up care is also recorded in NYEHDI-IS. As a result of outreach to hospitals including dissemination of hospital-specific data reports and the structured quality improvement initiative described in the Annual Report, documentation of initial hearing screening has improved dramatically (see below).

Building on this initial success we have expanded our focus to improving reporting of appropriate follow-up services for infants with abnormal initial screening results, with continued support from our HRSA Universal Newborn Hearing Screening grant. Improving loss to follow-up is important to ensure that infants identified with potential hearing loss receive timely assessments and services as needed to promote their growth and development, including referral to our Early Intervention (IDEA Part C) Program. In addition to offering ongoing technical assistance to hospitals, audiologists and other health care providers, we are implementing a structured quality improvement project to improve reporting of follow-up, identify root causes of missing information, share best practices among teams and reduce loss to follow-up for potentially affected infants. A statewide team of stakeholders, including parents and a young adult who is deaf, provide guidance and expertise to the initiative.

Achievements accomplished in the first year of this initiative include improvement of reporting of initial hearing screening results, from a baseline of 85% of all birthing hospitals in NYS in 2013 to 90% in 2014, and identifying

gaps in follow-up reporting by birthing facilities, audiologists, pediatricians and other hearing screening professionals. The focus for years 2 and 3 will be reducing loss to follow-up by engaging audiologists and other hearing screening professionals to educate them on New York State Newborn Hearing Screening Public Health Law and the NYEHDI-IS and provide access and training. With over 140 known pediatric audiologists in New York State and 126 birthing facilities, efforts to engage these professionals include virtual educational webinars and NYEHDI-IS trainings, on-site education sessions and collaboration with New York State Chapter Champions of the American Academy of Pediatrics and New York State Regional Perinatal Centers (RPCs). Lastly, the amount of time will be tracked between referral of infants with confirmed hearing loss to Early Intervention Services and the date of EI service initiation to assess barriers or delays in that process for this population.

Implementation of this strategy will be tracked by **ESM CSHCN-7:** Percentage of infants with initial abnormal hearing screening results for whom follow-up is documented in NYEHDI-IS.

Children with Special Health Care Needs - Annual Report

Children with Special Health Care Needs

Families with children with special health care needs (CSHCN) require health and supportive services from a complex web of public and private programs in the health care, social service, and education systems in NYS. Caring for CSHCN can be a challenge for families, particularly with respect to meeting the complex and varied medical needs of these children. Consistent access to comprehensive health care services is essential to ensuring positive health outcomes for CSHCN.

CSHCN are less likely than well children to have a medical home. Approximately 38.4% of NYS CSHCN have a medical home in 2009-2010 compared to the 43% of CSHCN in the US. NYS has a long-standing history of striving to improve health and supportive services for CSHCN and their families. Since 2010, NYS has made incentivized payments to MA medical providers who offer a higher level of coordinated primary care as recognized by the National Committee for Quality Assurance's Patient Centered Medical Home (PCMH). Payments are made either through increased capitation of MA Managed Care (MMC) plans or fee-for-service PCMH "add-ons" for qualifying visits.

To enhance services for CSHCN and their families, DOH (including the Office of Health Insurance Programs, the Center for Community Health, Division of Family Health and the AIDS Institute) and State Agency partners (the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services, and the Office of Children and Family Services) have been working collaboratively to develop Health Home (HH) for Children. The HH will provide care management to children with Medicaid who have complex physical and/or behavioral health conditions under the NYS HH model as tailored to serve the unique needs of children.

The HH model was implemented in NYS in 2012 with 33 HH serving every county in NYS. NYS initially implemented the HH program by prioritizing the enrollment of adults. This approached allowed NYS to establish the HH infrastructure and subsequently tailor that infrastructure to recognize the differences between children and adults by: tailoring the eligibility criteria for HH; and, expanding the networks of existing HH and potentially new HH serving children to ensure HH and their provider networks accommodate the special needs of children. These needs include care managers with expertise in serving children, networks of providers that meet special needs of children with chronic and complex conditions (pediatricians, children's specialty providers), linkages to systems and programs that care for an interface with children (education, child welfare, juvenile justice); and, tailoring the delivery of the six core HH services to the needs of children and their families.

The Title V program has been intimately involved with the development of eligibility criteria and determination, care management model and service delivery system to ensure NY's HH best meets the needs of CSHCN. To achieve the goal of ensuring eligibility, condition-based criteria captures high needs children's populations, including Medically Fragile Children with complex health issues, children in foster care, children with Serious Emotional

Disturbance, children enrolled in "Waiver" programs and other case management programs, NYS has submitted a State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) that seeks to modify HH eligibility criteria to include trauma as defined as "exposure to a single severely distressing event, or multiple or chronic or prolonged traumatic events as a child or adolescent, which is often invasive and interpersonal in nature. Trauma includes complex trauma exposure which involves the simultaneous or sequential occurrence of child maltreatment, including psychological maltreatment, neglect, and exposure to violence and physical and sexual abuse. A child or adolescent who has experienced trauma would be defined to be at risk for another chronic condition if they have one or more functional limitations that interferes with their ability to function in family, school, or community activities, or they have been placed outside the home. Functional limitations are defined as "difficulties that substantially interfere with or limit the child in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills, or for a child who experienced trauma due to child maltreatment, a functional limitation is defined as a serious disruption in family relationships necessary for normal childhood growth and development."

Health Homes will expand the availability of care management from the limited population of children served by "waivers" (e.g., Bridges to Health) and targeted case management programs (approximately 12,000 children) to potentially 150,000-200,000 children across the Medicaid population that have unique needs and may qualify. Title V staff regularly participated in discussion to flesh out the components of Children's HH. These components include:

- Development of Comprehensive Care Management to identify and address medical, mental health, chemical dependency and social service needs.
- Care Coordination and Health Promotion for engaging and retaining Health Home enrollees in care; coordinating and arranging for the provision of services; supporting adherence to treatment recommendations; and monitoring and evaluating a patient's needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services where appropriate.
- Comprehensive Transitional Care comprised of a system with hospitals and residential/rehabilitation facilities in their network to provide the Health Home with prompt notification of an individual's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.
- Patient and Family Support driven by an individualized care plan that reflects patient and family or caregiver preferences, education and support for self-management, self-help recovery, and other resources as appropriate.
- Referral to Community Supports to identify and refer to available community-based resources and actively manage appropriate referrals, access, engagement, follow-up and coordination of services; and,
- Use of Health Information Technology (HIT) to link services and access data through the regional health information organization/qualified entities to conduct these processes as feasible, to comply with the initial standards and final standards as required.

  In addition, during this time period, DOH along with its State partners collaborated with experts in the field in the development of a comprehensive version of the CANS for NYS, hereafter known as the CANS-NY. The CANS-NY serves as a guide in decision making for Health Homes Serving Children regarding acuity, as well as to guide service planning specifically for children and adolescents under the age of 21 with behavioral needs, medical needs, mental retardation/developmental disabilities, and juvenile justice involvement. Training and certification in the CANS-NY will be required to complete the CANS-NY in order to bill for care management as a Health Home Serving Children.

Title V staff also engaged in much discussion regarding a proposed approach for having the Health Home Care Manager serve as the Ongoing Service Coordinator for children enrolled in both Health Homes and the Early Intervention Program. Staff qualifications for care managers that serve children with an acuity level of "high" as determined by the CANS-NY will be required to have specific qualifications. For children enrolled in the Early Intervention Program and receiving Health Home services through a provider approved under the Early Intervention Program, the minimum qualifications for EIP service coordinators set forth in NYS regulation will apply.

HH provide an opportunity to establish critical linkages and help break down silos of care of by linking systems and programs (education, child welfare, Early Intervention) to comprehensive care planning. The enrollment of children in HH will begin October 2016. Title V will continue to be involved in the implementation of Children HH and ongoing training and education of care management staff.

The first few years of a child's life are a particularly sensitive period in the process of development, laying a foundation in childhood and beyond for cognitive functioning; behavioral, social, and self-regulatory capacities; and physical health. However, many children face stressors in their early years that can impact their healthy growth and development. Early childhood intervention programs are designed to mitigate the factors that place children at risk of poor outcomes. Such programs provide supports for the parents, the children, or the family as a whole.

NY's Title V director and Co-director of the BEI actively participate in NY's Early Childhood Advisory Council (ECAC). The ECAC was formed in 2009 to provide counsel to the Governor on issues related to young children and their families. The mission of the ECAC is to provide strategic direction and advice to NYS on early childhood issues. By monitoring and guiding the implementation of a range of strategies, the ECAC supports NY in building a comprehensive and sustainable early childhood system that will ensure success for all young children. Members represent state agencies, advocacy groups, foundations, higher education, unions and other key organizations concerned with the wellbeing of young children and their families, as appointed by the Governor. Over the past year, a major focus of this group has been on developing supportive systems to foster children's social-emotional development, including the establishment of a joint task force with the Early Intervention Coordination Council (EICC). The Early Intervention Coordinating Council (EICC) is a 27-member advisory council established in Section 2553 of the Public Health Law. The EICC assists the New York State Department of Health with the administration of the Early Intervention Program and makes recommendations to the Department regarding appropriate services for infants and toddlers with disabilities and their families.

The DFH is home to the largest Early Intervention Program (EIP) in the nation. EIP is a statewide service delivery system for infants and toddlers (birth to three years) with disabilities and their families. Its mission is to identify and evaluate those children whose healthy development is compromised and provide appropriate interventions to improve child and family development. The EIP currently provides services to more than 65,000 infants and toddlers and their families statewide. Through grant funding, the DFH has undertaken efforts to improve awareness and identification of autism to ensure children are identified and receive services as early as possible. Starting in 2014, NYS law required insurers to cover services for individuals with autism spectrum disorders (ASD), including Applied Behavior Analysis (ABA). Regulations were then adopted that established standards for EIP providers of ABA services. The Bureau of Early Intervention (BEI) completed a multiyear project funded by a MCH R-40 research program, to evaluate the impact of early intervention services on children with an autism spectrum disorder (ASD) and their families and submitted a final report to HRSA in June 2015.

Over the past year, NY's EIP developed the State Systemic Improvement Plan (SSIP) which is a comprehensive, multi-year plan for improving results for infants and toddlers with special needs. The SSIP is part of the federal required State Performance Plan (SPP) and Annual Performance Report (APR) required by the Office of Special Education Programs (OSEP) Results Driven Accountability (RDA) system. NY's plan is focused on improving and enhancing the "family-centeredness" of EI services and will be utilizing the Institute for Healthcare Improvement (IHI) quality improvement (QI) framework to effect changes in practices at the local level to increase the quality and family-centeredness of services and, as a result, improve family outcomes. The EIP also enhanced the NYS Family Survey that captures families' feedback about outcomes for the family and child and the quality of EI services. The survey was finalized and will be distributed to families exiting the EIP to obtain input to improve the delivery of EI services in NYS.

Plans were also developed to update the Autism Clinical Practice Guidelines (CPG), which were originally published in 1999. Experts in the field have completed literature reviews and updated the evidence, and a panel of experts recruited from across NYS, including parents, will update the recommendations using the evidence were recruited

from across NYS.

NY recognizes the need to provide supports and services for CSHCN that span ages and systems. NY's CSHCN Program provides funding to LHDs to provide services to CSHCN birth to 21 and their families. The local CSHCN Programs assist families in accessing necessary health care and related services; promote "medical homes" for the provision of high-quality health care services that meet the needs of children and families and develop partnerships with families of children with special health care needs that involve them in program planning and policy development. Local CSHCN programs obtain family input to inform plans to improve services. In 2015, LHDs assessed family satisfaction with services. Families were asked, "How easy is it to get information and help from staff" 91% stated always easy, 7.8% stated sometimes easy. DFH staff have regular contact with CSHCN programs to share information and promote improvement activities. During the past year, CSHCN programs also provided adolescents with information about Healthy Transitions and a health summary document. Information regarding transition resources were made available on DOH's website.
Ensuring access to needed health and supportive services is important in the health and development of CSHCN. In NYS, all SSI beneficiaries are categorically eligible for Medicaid. For CSHCN in the EIP with SSI, the local EIP reimburses for those services not covered by MA.
To supplement these services, the Physically Handicapped Children's Program (PHCP), operating in 31 counties in NYS, provides reimbursement for specialty health care for severe chronic illness or physically handicapping conditions in children. Medical equipment, office visits, hospitalizations, pharmaceuticals, and other health-related services can be reimbursed for children meeting county financial and medical eligibility criteria. In 2015, 321 received treatment services. Service categories were orthodontia, medications, hearing aids & medical equipment/supplies. An important aspect of this program, the Dental Rehabilitation Program (DRP) provides children with physically-handicapping malocclusions access to appropriate orthodontic services. The DRP provides both diagnostic/evaluative and treatment services and is open to children under the age of 21 in counties participating in PHCP. NY's 22 Genetic Centers served 16,746 children & 17,998 pregnant women, providing an array of services including diagnosis, laboratory testing, counseling and referral to specialty treatment centers.
Title V is a strong advocate to ensure all children and their families receive the supports and services necessary to live healthy, productive lives. For example, promoting changes in law and policy is paramount. Effective April 2014, NYS public health law was amended to add coverage for outpatient blood clotting factor concentrates and other necessary treatments/services for persons with hemophilia under the CHPlus program. The work in partnership with OHIP in Children's HH is another example of the significant role Title V can play in driving and promoting policy to support MCH in general and CSHCN in particular. Title V staff will continue to promote and support evidence-based policy and practice to enhance the health and well-being of CSHCN and their families.

Involving parents in policy and program planning and implementation is imperative to ensure the needs of CSHCN and their families are met. OHIP will lead public input sessions to obtain input from parents and other key stakeholders related to aspect of Children's Health Home. All Title V contractors that provide services to the MCH population are required to obtain regular input regarding services provided to ensure they met the need of the target population.

Title V staff fully support engaging parents of CSHCN when children are first entering the system to help parents build advocacy and leadership skills to influence the systems of services for years to come. The EIP Family Initiatives Coordination Services Project coordinates the development and implementation of a variety of family initiatives which train parents involved in the EIP to become advocates for special needs children at local, state and national levels. The Early Intervention Partners in Policymaking training for parents, which is nationally renowned, provides information, training, resources and skill-building activities designed to increase advocacy and leadership skills. In 2015, 61 parents attended the Partners Training sessions.

Activities that are carried out through this program which provides leadership training to parents who have children

eligible for the EIP, include the following:

- Assisting in orienting and preparing family members of the EICC
- Participate in ad hoc early intervention activities in support of families
- Sponsor the attendance of family leaders at relevant national conferences
- Develop family-friendly materials that complement Department issued EIP policy guidance
- Plan and deliver the Early Intervention Partners training for parents. This nationally renowned leadership training project helps parents of various diverse backgrounds to learn more about opportunities for parent involvement with the EIP. The training sessions provide information, resources and skill-building activities designed to increase advocacy and leadership skills. Training consists of three consecutive weekend sessions for parents that are offered twice per year in different locations throughout New York State. It is expected that parents will attend all three sessions. The first session is provided as an interactive webinar where information is provided to parents and they are given opportunities to participate in "chat" activities to develop work products. The second and third session is in-person training which consists of training provided by parents who are members of the EICC, and include group activities, some informal lecture, small groups working with parent's Early Intervention officials, interaction with a Department policy maker and other speakers who provide leadership and advocacy training.

Parents are also members of the EI Coordinating Council as well as the MCHSBG Advisory Council. Parents play key roles in initiatives such as EI's process to update clinical practice guidelines, ensuring the family voice and perspective is heard. In 2015, Michele Juda, Executive Director of Parent to Parent of NYS, was appointed as a member of the NYS MCHSBG Advisory Council. This will bring a stronger "parent voice" to this group and assist Title V in NYS to build a more supportive network of services for NY's families and influence systems development, programs and policies to reflect the needs of CSHCN and their families.

Cross-Cutting/Life Course

Measures

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	57.2	59.0	61.1	63.0	65.0	66.0

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	57.1 %	2.1 %	60,818	106,528
2012	48.2 %	1.6 %	53,882	111,710
2011	44.3 %	2.0 %	48,346	109,244
2010	44.1 %	2.0 %	48,670	110,432
2008	41.8 %	1.9 %	44,213	105,698

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% and should be interpreted with caution

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	77.8	78.5	79.3	80.0	80.7	81.2

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	77.1 %	1.3 %	3,075,807	3,991,985
2007	80.8 %	1.3 %	3,350,192	4,148,736

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 13.1 - Life Course - 6

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	20.0	25.0	30.0	35.0	40.0

ESM 13.2 - Life Course - 7a

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	40.0	41.0	44.0	47.0	50.0

ESM 13.3 - Life Course - 7b

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

ESM 13.4 - Life Course - 7c

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

ESM 13.5 - Life Course - 8

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	10.0	10.0	20.0	25.0	30.0

ESM 13.6 - Life Course - 9

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

Cross-Cutting/Life Course - Plan for the Application Year

As highlighted in our Year 1 NA and 2015 Annual Report, the introduction of a Life Course Domain to this cycle of Title V funding inspired significant thinking and learning about how to apply the Life Course framework to NY's MCH public health work. During the initial NA (leading up to Year 1 application), several recurring themes emerged that cut across MCH population domains/ life course stages: oral health; mental health; enrollment in adequate and affordable health insurance; access to, use of, and quality of preventive health care services; social support, development and healthy relationships; neighborhood and community environments; and the fundamental impact of social determinants of health on health outcomes and disparities. These emerging themes were captured in the state priorities established for our Year 1 Action Plan, in particular the four priorities designated under this Domain.

Building on this initial work, our process to refine the Action Plan for Years 2-5 embraced the Life Course concept. Cross-programmatic Title V staff teams working on each priority area were challenged to use the Life Course Model as a guiding framework, and to identify tangible approaches for translating life course concepts into an integrated portfolio of actionable, effective and measurable strategies to improve MCH outcomes and equity. All staff were asked to apply MCHB's 2010 *Rethinking MCH: The Life Course Model as an Organizing Framework Concept Paper* as a guiding resource in meeting this challenge. While this approach is reflected throughout all six domains of this action plan, it is most explicitly implemented through the LC priorities below.

State Priority #5: Increase use of primary and preventive health care services across the life course

2020 State Objectives:

- Objective LC-1: Increase the percentage of women with a past year preventive medical visit by 10% to 79.4%.
- Objective LC-2: Increase the percentage of children 10-71 months whose parents report that they received a developmental screening using a parent-completed screening tool by 10%. to 31.3%
- Objective LC-3: Increase the percentage of adolescents who received a preventive health care visit in the last year by 6.5% to 97.7%.

Use of preventive health care services is a key element of health promotion across the life course. Preventive visits offer opportunities to deliver health education, anticipatory guidance and counseling; monitor growth and development; screen for risk factors, special needs and undetected health conditions; and administer protective interventions such as immunizations and contraception. The enactment of the ACA creates significant opportunity for increasing the number of individuals receiving preventive health care services through expanding eligibility for affordable insurance to more people and instituting requirements for full coverage of specific evidence-based

preventive services without cost sharing.
Across the MCH life course, preventive health care services encompass well woman, preconception, prenatal, postpartum, interconception, well baby, well child and well teen care. The periodicity and content of care varies by developmental stage and, in some cases, patient-specific needs or risk factors. It encompasses care provided in many settings by different health care providers. Given the potential breadth of this priority, in refining our Action Plan, Title V staff considered fundamental cross-cutting needs to support use of preventive health care (e.g., access to health insurance) as well as specific populations and areas of clinical practice most in need of improvement, based on analysis of available data and stakeholder input. Important resources for development of this priority include the USPSTF recommendations for preventive care; The AAP *Bright Futures* Guidelines for Health Supervision of Infants, Children and Adolescents; and EPSDT guidelines for state Medicaid programs.
This priority is closely linked to other state priorities in all five other domains, reflecting the key importance of preventive health care services to promoting health across the life course. Progress toward achievement of objectives and outcomes for Priority #5 will be tracked through **NPM 1:** Percent of women with a past year preventive medical visit; **NPM 6:** Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool; **NPM 10:** Percent of adolescents age 12-17 with a preventive medical visit in the past year; **SPM 1:** Percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy; and **SPM 2**: Percentage of women age 15-44 years and enrolled in Medicaid using the most effective, reversible methods of contraception.

Strategy LC-1: Integrate performance standards, measures and improvement strategies related to health insurance enrollment across all Title V/ MCH programs.

Enrollment in affordable health insurance is essential, but not sufficient, to ensure access to health care and promotion of overall health. The landscape of health insurance has changed dramatically over the last several years and continues to evolve. NYS historically has established eligibility for public health insurance (including Medicaid and Child Health Plus, NYS' S-CHIP program) that make no-cost or low-cost insurance available to large numbers of individuals and families, including low-income pregnant women, children and (for family planning services) men and women of reproductive age; eligibility for Medicaid and subsidized private insurance has been further expanded in accordance with the national ACA and launch of NY's health insurance exchange, the NY State Of Health.
Title V staff play a significant role in engaging with colleagues in the DOH OHIP, which administers the state's Medicaid and CHPlus programs, the NY State of Health, and the NYS DFS, which regulates commercial plans, to ensure the needs of the MCH population are recognized and addressed. (See Annual Report for further details.)
While linking individuals served to health insurance is a long-standing expectation of NY's Title V program, as MCH programs are updated over the next several years, the DFH will integrate more formal performance standards and measures related to health insurance assessment and enrollment across all Title V programs, and ensure that providers have up to date information about health insurance resources for the populations they serve.

Implementation of this strategy will be tracked by **ESM LC-1: #** of Title V programs with health insurance elements incorporated in program requirements.

Strategy LC-2: Continue to support preconception/ reproductive health module within state's Behavioral Risk Factor Surveillance System (BRFSS), and produce focused reports of results to inform Title V program and partner strategies.

As noted in previous priorities, inclusion of strategies to enhance public health surveillance and data analysis activities in each area of work is key to ensuring this essential public health function informs ongoing program and policy development, implementation and evaluation. Information on use of preventive services by MCH populations is currently available from several sources including Pregnancy Risk Assessment Monitoring System (PRAMS) and Vital Statistics (for prenatal care), the National Survey of Children's Health (for infants, children and youth), National Survey of Children with Special Health Care Needs (for CSHCN), Behavioral Risk Factor Surveillance System (for

adult men and women) and state Quality Assurance Reports (QARR) for both public and commercial managed care plans (all ages). Additional data on services delivered through specific programs, such as School-Based Health Centers (SBHC) and Family Planning are also informative.

In reviewing data on preventive service utilization, an important gap identified in NYS was our capacity to assess the use of preconception health care services, including specific content of visits related to pregnancy planning and prevention, beyond general measures of preventive health care utilization. Because preconception health care is such a critical focus of our work and that of our partners, we took steps to augment the state's current BRFSS tool with a supplemental Preconception Health/Family Planning Module. Preliminary analysis of the initial dataset has been completed to inform strategies in Domain 1 (See *Strategy MWH-3*), and Title V staff are in the process of drafting a manuscript to submit for peer-reviewed publication to highlight the unique information gleaned from this module. Implemented for the first time in the 2013-2014 expanded county-level survey, the module was also included in the 2014 and 2016 state survey and is planned to be included every other year to support tracking. This project also provided an excellent opportunity to strengthen collaboration with the DOH DCDP, which manages the state's BRFSS program.

Implementation of this strategy will be tracked by **ESM LC-2**: # of analytic reports developed and shared

Strategy LC-3: Incorporate performance measures and strategies to reinforce use of well-woman care including pregnancy planning and prevention across core Title V programs serving women of reproductive age, including:

- **Family Planning Program**
- **Maternal & Infant Community Heath Collaboratives**
- **Maternal, Infant & Early Childhood Home Visiting**
- **Perinatal Regionalization**
- **School-Based Health Centers**

The most recent available BRFSS data indicate that 69.4% of women age 18-44 in NYS had a preventive medical visit in the past year. Lack of preventive "well woman" visits represent a missed opportunity for addressing multiple aspects of health promotion, including assessment of current and future pregnancy intentions, steps to optimize health prior to pregnancy for those women desiring pregnancy, and assurance of consistent use of highly effective contraception for women not desiring pregnancy. Given that more than half of pregnancies in NYS are unintended, and the potential impact of preconception and prenatal health on pregnancy outcomes for both mothers and infants, more effort is needed to engage women in preventive health care and ensure that preventive visits for all women of reproductive age routinely incorporate preconception care.

NY's Title V Program is well positioned to reinforce messages and strategies to strengthen utilization of well woman care through our network of existing local and regional grantees, including both clinical and community prevention providers. These programs have extensive interaction with adolescent and adult women as well as service providers, and have programmatic goals consistent with increasing preventive care service utilization. Building on existing program infrastructure leverages the significant investments and experience already in place at both state and community levels, while incorporating specific performance standards, measures and strategies, will improve consistency and enhance the impact of this collective work.

Implementation of this strategy will be tracked by **ESM LC-3**: # of relevant Title V programs that demonstrate incorporation of strategies to reinforce well-woman and preconception health care services.

Strategy LC 4: Collaborate with partners to improve developmental screening in NYS.

Developmental screening is an important element of preventive care to promote children's healthy development. Screening provides an opportunity to reinforce the continuum of normal development and responsive parenting,

identify and monitor potential concerns about children's development, and initiate more comprehensive evaluation and intervention services, as needed, for children found to have developmental delays. AAP *Bright Futures* guidelines recommend routine developmental screening for all children at ages 9, 18 and 30 months. Data from the NSCH for NYS show that only 21.3% of parents surveyed indicated that their child (age 10-71 months) had been screened for developmental delays using a parent-reported standardized screening tool at a health care visit within the last year; this is significantly below the national average of 30.8%, although it has improved since the previous survey. While there are notable limitations to this particular measure, the findings are consistent with other reviews conducted by OQPS in NYS as part of focused quality improvement projects and a quality measure pilot study conducted for the State's managed care programs.

Barriers to routine developmental screening in well-child visits that have been identified by stakeholders and in the literature include time, reimbursement, training needs (both for screening and billing), stigma around disabilities, cultural and communication challenges with diverse families, and perceived lack of community services and systems to facilitate coordinated referrals and follow up. From a public health systems perspective, the lack of data to identify needs and drive improvement is also a challenge to improvement efforts. Several improvement models and interventions have been demonstrated to significantly improve screening practices within pediatric practice settings.

There are notable connections between efforts to address maternal depression screening and follow-up (see Strategy MWH-5) and developmental screening. The significant interest in developmental screening across many stakeholders and organizations in NYS creates both significant opportunity for collective impact as well as the challenge of coordinating and leveraging multiple partners and interests. The Title V Program is positioned to provide leadership in facilitating connections between partners and advancing collaborative strategies that span health insurance, health care and community-based settings and partners across the state. As noted in Strategy MWH-5, this year Title V staff partnered with the NYS CCF to develop and submit an application for the new Early Childhood Comprehensive Systems (ECCS) initiative; if awarded, this funding would support collaborative quality improvement projects in two high need communities to improve developmental screening and follow-up for young children as well as maternal depression screening and follow-up. Additionally, the state's ECAC has identified promotion of developmental screening as a current priority, with plans to convene a workgroup to develop and help advance relevant strategies. The Title V Program will continue to collaborate with partners including OQPS, OHIP, DFS, OMH and the ECAC to advance this work.
Implementation of this strategy will be tracked by **ESM LC-4**: Number of strategies implemented to improve developmental screening

Strategy LC-5: Convene focus groups and review literature to identify contributing factors and effective strategies for improving preventive health care service delivery to adolescents, with a focus on reducing disparities.

As discussed in Domain 5, adolescence is a critical developmental period marked by numerous transitions and emergence of new roles, relationships and behaviors, providing important opportunities to support adolescents' needs through preventive health visits. Preventive care during adolescence is also an important element of the continuum of preconception care (for both girls and boys) as well as preparing adolescents to become effective adult health care consumers. NSCH data indicate that overall 91.7% of youth age 12-17 years in NYS had a preventive health care visit in the past year, which has increased modestly over time. Preventive visit utilization declines over the adolescent period, from 97.7% of 12 year olds to 89.1% of 17 year olds, and there are racial-ethnic disparities in utilization rates.

While these data (aligned with HRSA's NPM 10) suggest fairly high preventive service utilization, quality reporting data from NYS managed care plans are less promising, showing that only 65% of adolescents (age 12-21 years) enrolled in Medicaid, and 61% of adolescents in commercial HMO plans, had a comprehensive well visit in the past year. Moreover, quality data on specific components of preventive care show many missed opportunities for

assessment and counseling on key health issues including physical activity and nutrition, sexual activity, depression, tobacco, alcohol and other substance use, with only 61-77% of teens with visits receiving these services (rates vary by specific service and are lower for all services for teens in commercial vs. Medicaid plans). Rates of HPV vaccination for teens are even lower with only 28% of teens enrolled in Medicaid and 61% enrolled in commercial plans being vaccinated in 2014.

Adolescents may not feel comfortable discussing sensitive health issues, including sexual activity, drug use, violence and other behavioral/ interpersonal needs with providers, especially if they do not feel welcome and respected, or if they have concerns about confidentiality. School-Based Health Centers and Family Planning Clinics funded through NYSDOH Title V Program are important settings for providing preventive care, including reproductive health care and other confidential services to teens.

Improving utilization of preventive services by teens, especially those from disadvantaged groups with lower utilization rates, requires input from young people to better understand the challenges and barriers they face in seeking and engaging in care. In collaboration with our ACT for Youth Center of Excellence, we plan to conduct focus groups with young people, combined with review of the evidence base, to identify additional approaches to improving use of preventive health services and successful transition to adult health care consumer roles. Information gleaned from this work will be disseminated and integrated across our youth-serving programs including CAPP, Family Planning and SBHC programs.

Implementation of this strategy will be tracked by **ESM LC-5**: The number of focus groups conducted.

State Priority #6: Promote oral health and reduce tooth decay across the life course

2020 State Objectives:

- Objective LC-4: Increase the percentage of NYS residents served by community water systems that have optimally fluoridated water by 10% to 78.5%.
- Objective LC-5: Reduce the prevalence of dental caries among NYS children by 10% to 40.5%.
- Objective LC-6: Increase the percentage of children and adolescents age 1-17 who had a preventive dental visit in the past year by 5% to 80.9%
- Objective LC-7: Increase the percentage of pregnant women who had a dental visit during pregnancy by 10% to 54.6%

As highlighted in the NA and 2015 Annual Report, promoting oral health across the life span is an important priority for our Title V Program. Among children, tooth decay is the most common chronic disease, five times more common than asthma, and 20 times more common than diabetes. Disparities in oral health in NYS mirror national data. Although most oral diseases are preventable, not all individuals in NYS benefit fully from evidence-based preventive measures. While community water fluoridation (CWF) has been found to be highly effective in controlling tooth decay, only about 72 percent of the population on public water supplies receives fluoridated water in NYS. Dental sealants, a protective coating applied on the chewing surfaces of teeth to prevent tooth decay, are present in approximately 40 percent of third-grade children in NYS. Poor oral health, including tooth decay, tooth loss and periodontal (gum) disease, has implications for personal well-being, school and work attendance and performance, social interactions, nutrition and may be associated with adverse birth outcomes. Continued Title V leadership is needed to advance an integrated set of effective strategies to protect oral health as a key component of overall health and well-being across the life course.

This priority is closely linked to other state priorities including preterm birth (Priority #2), social-emotional development (Priority #3), preventive health care service use (Priority# 6) and other life course priorities. Progress toward achievement of objectives and outcomes for Priority #6 will be tracked through **NPM 13:** Percent of a) women who had a dental visit during pregnancy and b) children age 1-17 who had a preventive dental visit in the past year; and **SPM 5:** Percentage of NYS residents served by community water systems that are optimally fluoridated.

Strategy LC-6: Provide financial and technical support for maintenance and expansion of community water fluoridation.

Water fluoridation is the adjustment of the natural fluoride concentration in water supplies to a level that results in optimum oral health benefits. More than 70 years of scientific research and implementation provides the evidence that clearly justifies support for CWF, an intervention listed as one of the top ten public health achievements of the 20th century. As described in the 2015 Annual Report, Title V staff, in collaboration with colleagues from the DOH Center for Environmental Health (CEH) lead several key efforts to support community water fluoridation. These efforts include implementation of legislation and state funding for CWF enacted in 2015, providing $5 million in annual grant funding to support public community water systems for costs related to the construction, installation, repair, rehabilitation, replacement, or upgrade of drinking water fluoridation facilities. The first procurement of these funds was recently completed with awards to be announced shortly. The second procurement was recently released.

Title V and CEH also support onsite technical assistance to fluoridated public water systems, or those looking to start fluoridation. This initiative provides training for water operators to ensure safe and effective implementation of community water fluoridation, in an effort to ensure that New Yorkers have consistent access to optimally fluoridated water. This work is conducted by the NY Rural Water Association (NYRWA) under a contract with DOH. The work conducted by NYRWA will help identify water systems in need of equipment replacement/repair and will help promote the new funding available to communities for fluoridation.

Title V staff will also work with fluoridation advocates and key stakeholders to promote an understanding of the health benefits and costs savings that result from community water fluoridation. The Fluoride Mouth Rinse (Supplemental Fluoride) Program, which provides fluoride to children in schools, also will be continued as a safe and effective method of reducing dental decay for children living in communities without public water systems, including many rural communities. Finally, staff will undertake a focused quality improvement project to improve reporting of water fluoridation information to the state, as an important tool for informing these policy and programmatic activities.

Implementation of this strategy will be tracked by **ESM LC-6**: Number of public water systems that receive financial and/or technical support from NYSDOH to maintain or initiate community water fluoridation.

Strategy LC-7: Increase the delivery of evidence-based preventive dental services across key settings:

- **school-based clinics**
- **primary care practices**
- **public health nutrition programs**

A strength of NY's oral health promotion work with demonstrated evidence-base for preventing tooth decay among children. NY's challenge is to partner effectively with providers across a variety of settings to ensure that these evidence-based services are offered and delivered to as many children as possible, including those who may not access dental care in traditional settings. Evidence-based clinical preventive practices include sealants and fluoride varnish. Proper oral hygiene habits, including tooth-brushing when done correctly using fluoride toothpaste, flossing and avoidance of certain hygiene behaviors (e.g., putting infants or toddlers to bed with a bottle or putting baby's pacifier in mom's mouth before giving it to baby) are also effective for preventing tooth decay.

Over the next year, Title V staff will expand efforts to collaborate with both internal and external partners to increase the number of children receiving one or more of these preventive dental services, with a particular focus on school-based dental (SBD) clinics (for sealants), pediatric primary care practices (for fluoride varnish) and public health nutrition programs (for promotion/ reinforcement of tooth brushing and other family hygiene practices). This approach leverages existing investments in SBD clinics and other federal oral health workforce development grant funding. It also provides an opportunity to explore new partnerships with the DOH DON, which oversees several key public health nutrition programs that have potential to reach key MCH populations. Building on initial discussions with these colleagues in Year 1, a specific initial project will be defined and initiated in Year 2.

Implementation of this strategy will be tracked by **ESM LC-7**: a) Percentage of 2nd and 3rd graders served by SBD Programs who receive sealants; b) # Medicaid claims submitted by primary care providers for application of fluoride varnish for children aged 0-5 enrolled in Medicaid that receive fluoride varnish applications from their primary care providers; c) specific plan adopted in collaboration with DOH DON to promote integration of oral health strategies in at least one public health nutrition program.

Strategy LC-8: Integrate oral health messages and strategies within existing community-based maternal and infant health programs.

As noted in our 2015 Annual Report, NY's Title V program has been a national leader in developing guidelines for oral health care during pregnancy. Building on this work, Title V's Prenatal Infant Oral Health Quality Initiative (PIOHQI) aims to improve perinatal and infant oral health services by integrating oral health messages and services within the MICHC model. Title V supports a pilot project in Rochester, with a focus on promoting systems changes in the community to integrate oral hygiene practices and information about services within MICHC services, and linking families with dental services. The community level approach incorporates best practices related to oral health promotion across all levels of the MICHC model, including: outreach, education and social support provided to high-risk women and their families by community health workers (family level strategies); professional outreach, education and technical assistance to prenatal care providers to promote integration of oral health screening and referrals in accordance with Medicaid prenatal care guidelines (organizational-level strategies); and, facilitating the creation of effective referral networks and linkages between prenatal care providers, dental providers and health plans (community-level strategies). Successful strategies gleaned from this initiative will be disseminated to other MICHC, and potentially other home visiting projects.

Implementation of this strategy will be tracked by **ESM LC-8:** Percentage of pregnant women served by Title V community health workers that have a documented screening or referral for dental services.

Strategy LC-9: Strengthen internal capacity, dental public health core competencies and workforce development for oral health surveillance and evidence-based interventions through continued support for the NYS Dental Public Health Residency.

In an effort to build capacity for the dental public health workforce, the DOH has an accredited dental public health residency program to train residents to develop public health competencies that can be applied in dental public health settings. The residency curriculum focuses on eight core competencies recognized by the American Association of Public Health Dentistry: demonstrate the ability to incorporate ethical reasoning and actions that promote culturally competent oral health care to individuals and populations; critique, synthesize and apply information from scientific and lay sources to improve the public's oral health; describe social and health care systems and determinants of health and their impact on the oral health of the individual and population; assess risk for oral diseases and select appropriate, evidence-based preventive interventions and strategies to promote health and control oral diseases at the individual and population level; demonstrate the ability to access and describe the use of population-based health data for health promotion, patient care, and quality improvement; demonstrate the ability to communicate and collaborate with relevant stakeholders to advocate for policies that impact oral and general health for individuals or populations; develop a capacity for lifelong learning and professional growth in order to provide leadership that utilizes principles of dental public health; and, demonstrate the ability to participate in inter-professional care across the lifespan of people from diverse communities and cultures.

Residents are also integrally involved in the analysis of the 3rd grade oral health screening data. Their involvement often fosters interests in data projects that often lead to building and enhancing the evidence base to inform prevention efforts in oral health activities. The residency program curriculum also includes monitoring programs for effectiveness, developing elements of interventions that assist in promoting and preventing dental diseases.

Implementation of this strategy will be tracked by **ESM LC-9:** Number of dental public health residents with

completed residency projects utilizing data systems.

State Priority #7: Promote supports and opportunities that foster healthy home and community environments

2020 Objectives:

- Objective LC-8: Increase the percentage of children and adolescents who are physically active at least 60 minutes daily by 10%, from 25.7% in 2013 to 28.5% in 2020.
- Objective LC-9: Increase the percentage of children and adolescents who live in supportive/ cohesive neighborhoods by 6%, from 79.2% in 2011/12 to 84% in 2020.
- Objective LC-10: Increase the percentage of children and adolescents who are usually or always safe in their community or neighborhood by 5%, from 79.9% in 2011/12 to 84% in 2020.

As highlighted in the NA, both families and providers identified the critical role that home and community environments play in health outcomes and health behaviors. Factors including access to healthy affordable food and places to engage safely in physical activity have significant impact on families' health and well-being. These perceptions are consistent with broader and longstanding public health approaches aimed at supporting "healthy communities", including strong commitments to community-driven change, policy and environmental change strategies (vs. individual-level strategies), and a focus on addressing social determinants of health rather than treating disease. They are also consistent with a current emphasis on place based initiatives (PBI) - multidisciplinary team based approaches to achieving significant and holistic changes in a physical location by improving health equity and access to healthy lifestyle choices, health care and social services and other essentials such as quality housing. PBIs are built upon and driven by tenets of collaborative team based efforts, effective use of data, community involvement in the process of decision making, and sustaining the desired outcomes beyond the funded period. While these are not new concepts, prior to this funding cycle the Title V Program did not have an explicit priority focused on engaging in, and helping to lead, PBIs aimed at supporting overall health of communities as a means to improve a broad spectrum of MCH outcomes and reduce disparities across the life course. As an emerging focus for our program, the strategies for this priority represent an initial set of activities to engage with other public health colleagues and build capacity, both among Title V staff and our partners, for collaboration to advance health-promoting change in community environments.

As a cross-cutting priority, it is closely linked with all other state priorities. Progress toward achievement of objectives and outcomes for Priority #7 will be tracked through **NPM 8:** Percent of children age 6-11 and adolescents age 12-17 who are physically active at least 60 minutes per day. This measure was selected for this strategy as a proxy for a broader array of community environmental changes that facilitate healthy behaviors.

Strategy LC-10: Continue and increase Title V staff leadership and participation in the DOH Place-Based Initiative (PBI) work group to:

- **Adopt a shared definition and set of indicators to measure healthy communities**
- **Review place-based initiatives to identify best practices for community environmental change**
- **Develop a toolkit of data and evidence-based/-informed practices for community change**
- **Incorporate requirements for healthy community practices within relevant MCH funding procurements**

In the 2013 State of the State, Governor Cuomo introduced the Community, Opportunity, Reinvestment (CORe) Initiative which aimed to improve the well-being of NY's most distressed communities. CORe is a neighborhood-based community change model – the first in the nation to be introduced at the state level - to address disparities in employment, public safety, education, health and housing. Based on the work of CORe, the DOH Commissioner commissioned a workgroup in September 2015 to review all of the PBIs sponsored by the DOH over the last ten years to 1) determine promising practices and strategies for current and future place-based efforts; 2) identify

duplicative efforts and opportunities for synergy; and 3) develop collaborative efforts to address health inequities. The PBI Workgroup meets quarterly and is comprised of staff from the DFH, DCDP, and DON, the CEH, DOH OMH, the AIDS Institute, and the Office of Public Health Practice. Title V staff from both the maternal and infant health and child health programs participate in the PBI workgroup to ensure that MCH initiatives, priorities and perspectives are addressed.

The deliverables of the PBI Workgroup will be shared with executive DOH leadership and have the potential to be implemented DOH-wide. Title V staff will actively contribute throughout the discussion and development process to ensure MCH priorities and perspectives are reflected in the final workgroup recommendations and products.

- Adopt a shared definition and set of indicators to measure healthy communities – The initial task of the PBI Workgroup was to define PBI and identify all DOH PBI over the last ten years. The Workgroup is working to define what a healthy NY would look like and has identified the importance and need for a comprehensive set of indicators to determine the health of a community.
- Review place-based initiatives to identify best practices for community environmental change - The Workgroup is now reviewing the data, qualitative and quantitative, from these initiatives to determine characteristics, outcomes (intended and unintended), and facilitators and barriers of success/sustainability, etc. The goal of this review is to identify best practices from previous or current DOH grantees that can be promoted or used as a model for replication across the state.
- Develop a toolkit of data and evidence-based/-informed practices for community change – The Workgroup is discussing ways to present PBI data at the state and local level. This includes information both health/safety/neighborhood and program-level data. The concept is to have a universal source of data for these indicators communities across the state.
- Incorporate requirements for healthy community practices within relevant MCH funding procurements – A priority of the Workgroup is to identify/develop model program designs that all future DOH PBIs should include. This would then be reflected in all MCH funding opportunities released by DOH.

  Implementation of this strategy will be tracked by **ESM LC-10: a**) # PBI workgroup meetings held and attended by Title V staff; **b**) # of resources developed and disseminated based on PBI workgroup

Strategy LC-11: Enhance collaboration with key partners to advance changes in community environments that promote maternal and child health:

- **increase demand for and access to healthy, affordable foods and opportunities for daily physical activity in high-need communities through the Creating Healthy Schools and Communities program *(with DOH DCDP)***
- **strengthen linkages between Title V programs and the Healthy Neighborhoods Program (*with DOH CEH)***
- **support the Regional Centers for Sexual Violence Prevention to implement primary prevention environmental change strategies at the community and individual levels *(with NYSDOH Bureau of Injury Prevention)***
- **incorporate selected health-related quality indicators in new quality improvement initiative for regulated child care programs *(with OCFS)***
- **incorporate health promotion information and linkages within Community Schools initiative (*with State Education Department and CCF)***

As described in more detail in Strategy LC-12 below, collaboration is a hallmark of our planned work to address this priority. Collaboration is essential because of the cross-cutting nature of community environments and the recognition that responsibility for current programs and services is distributed across organizational units and other agencies.

The five initiatives listed for this strategy offer specific opportunities to contribute Title V leadership, subject matter expertise and other assets to advancing positive environmental changes in community settings, with the potential to

impact health outcomes of significance to MCH. Collectively, these strategies also will help strengthen strategic partnerships with other programs, bureaus and agencies that have shared interest in improving health and life outcomes for women, children and families.
Implementation of this strategy will be tracked by **ESM LC-11**: # of community environmental changes demonstrated as a result of enhanced collaborations.

Strategy LC-12: Establish or adopt an evidence-informed framework for structuring, measuring and improving collaboration at state and community levels, and provide support to strengthen both internal and external partner capacity to implement the framework across MCH programs.

Several factors play a key role in desired health outcomes which results in many DOH programs collaborating internally and with external stakeholders of varying interests. While collaboration is often a key component of Title V programs, it is often loosely structured or undefined. Title V will elicit the assistance of the DFH Centers of Excellence and the SUNY School of Public Health to define meaningful collaboration and then operationalize and implement the definition. Outcomes will be assessed to determine the level of meaningful collaboration and its impact on various projects. Building internal capacity for meaningful collaboration will help Title V staff be more equipped to guide grantees through the process, resulting in improved health outcomes.

Implementation of this strategy will be tracked by **ESM LC-12: a)** Evidence-informed framework to structure and measure collaborative efforts is established or identified; **b)** # of internal partners trained; **c)** # of external partners trained

State Priority #8: Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population

2020 State Objectives:

- Objective LC-11: Increase the percentage of Title V staff that improve their knowledge of health equity concepts by 20% from baseline *(baseline to be established in conjunction with Strategy LC-14).*
- Objective LC-12: Increase the percentage of DFH procurements that demonstrate application of health equity strategies listed by 20% from baseline *(to be established in Year 2-3).*
- Objective LC-13: Reduce disparities for all selected national and state performance measures by 5% from baseline (*targets vary by measure)*.

As highlighted in NY's Year 1 NA and throughout the application, addressing racial, ethnic, economic and geographic disparities and promoting health equity for the entire MCH population are overarching priorities for NY's Title V plan. While concern about disparities has been a fundamental priority for NY's Title V Program for many years, this marks the first time it has been explicitly adopted as a focal point for a body of strategic work

The Title V staff team that focused on refining NY's Action Plan for this priority explored frameworks and recommendations, with an emphasis on identifying practical steps we can take to enhance our understanding, skills and practices over time. Core policy recommendations identified by this team, based on the work of Drs. Rowley and Hogan from the University of North Carolina-Gillings School of Public Health and Michael McAfee of PolicyLink include: using data to explicitly measure disparities and identify examples of successful strategies that improved equity; recognizing and addressing racism as a target for interventions; investing in long-term, over-arching strategies such as positive youth development, anti-poverty initiatives and life course approaches; and adopting frameworks to create structural changes in the environment to promote equity, including multi-sector involvement and community engagement as key tools. Specific frameworks explored by the team include the Collective Impact Framework, the Community Action Model and the Community Readiness Model, with attention to the common elements across these models for facilitating and supporting community-driven solutions.

Like Priority #7 above, as a new dedicated focus for NY's Title V program, the strategies outlined for this priority

represent an initial set of activities to learn and build capacity, both within Title V staff and our partners, to advance incremental but meaningful changes toward achieving health equity for the MCH population.

Strategy LC-13: Develop and implement a data analysis plan to assess distribution of DFH/Title V resources and services through a health equity lens

This strategy is consistent with the recommendations noted above and with the cross-cutting focus on use of data as a foundational tool for advancing MCH work. While measurement of disparities (e.g., disparity ratios) has been a common element of our data analysis activities, Title V aims to enhance the visibility and application of these data to inform planning and decision-making across our programs. A review of best practice methods for data analysis, including consultation with partners in other program areas engaged in similar work, will be conducted to identify overall approaches to this strategy. The Title V Program will use these data to inform quality improvement efforts and to make informed decisions regarding resources.

Implementation of this strategy will be tracked by **ESM LC-13:** # of Title V programs for which health equity analyses completed

Strategy LC-14: Build internal capacity within the Division of Family Health (DFH)/ Title V Program to advance health equity through all Title V programs, including:

- **creation of a cross-program DFH Equity Action Team**
- **completion of an organizational assessment of equity practices**
- **facilitate staff training and professional development through Equity Learning Labs**

Building on the work started over the past year through the MCH Leaders of Tomorrow, this strategy provides an opportunity to continue that commitment to professional development while working to promote substantial improvements in health equity across the DFH. Unlike other professional development, when dealing with health equity in particular, it is imperative to address not only lack of knowledge, but the more difficult issues of staff values and understanding of the evolution of inequalities currently manifesting in persistently high rates of health disparities. By engaging employees in an ongoing approach to understand the systemic underpinnings of inequities, as well as practical strategies to address those inequities, NY aims to create a work force capable of enhanced support of the implementation of community-driven initiatives to improve health equity.

Activities will include identifying DFH staff to serve on an Equity Action Team tasked with planning for the implementation of employee training programs. The team will collaborate with staff from the DOH Office of Minority Health (DOH OMH) and state and national experts to develop and implement health equity strategies. This will be followed by a multidimensional organizational assessment of health equity accomplished using the Brooks Equity Typology, a tool developed for use within the larger framework of the R4P methodology developed by Drs. Rowley and Hogan, which served as the basis for the development of the strategies included in the Action Plan. Following that assessment, the information gathered will serve as the foundation for the development Equity Learning Labs (ELLs) offered to all DFH staff. Based on information gathered through the organizational assessment, ELLs will provide ongoing training and professional development education designed to address the particular issues of health disparities identified. An emphasis will be on building staff knowledge and understanding of issues related to health disparity as well as the self-efficacy necessary to implement strategies aimed at promoting health equity in programs throughout DFH.

Implementation of this strategy will be tracked by **ESM LC-14**: a) # of Equity Action Team meetings held; b) # of DFH staff who have completed one or more Equity Learning Labs

Strategy LC-15: Integrate an equity framework into the development of all DFH/Title V procurements through community listening forums conducted as part of the concept development process.

Implementation of this strategy will be tracked by **ESM LC-15:** Percentage of DFH procurements that complete community listening forums as part of concept development process

Understanding the social, political, and environmental factors that contribute to challenges that drive health disparities is a complex and ongoing task. By providing opportunities for that input in the earliest stages of program development, it will support an improved approach and scope of services to better meet the needs of the MCH population. Title V aims to ensure the provision of opportunities during the initial development phase of grant-funded procurements to solicit direct community feedback on planned programs prior to implementation to better ensure that all funding opportunities released by DFH are not only sensitive to the various issues of disparities they are aimed at addressing, but also that they are directly focused on issues/problems identified by the populations affected.

Strategy LC-16: Incorporate evidence-based/-informed community engagement and collective impact strategies in all relevant DFH/Title V programs.

The development of this strategy was influenced not only by a desire to address the conditions leading to the perpetuation of health inequities, but to recognize the growing literature supporting the need for community engagement in any social change program. Based on years of research, Barnes and Schmidt report that, "data-driven solutions will be feasible and sustainable only if leaders create and implement those solutions with the active participation of the people in the communities they target."(Barnes & Schmidt, 2016). Although earlier efforts to implement evidence-based interventions across NYS have been successful in achieving positive changes to population-level health, high rates of health disparities persist. This clearly shows that while evidence-based interventions can affect positive change, they alone are insufficient to address the larger issues contributing to health inequities. Therefore, NY's strategy combines the strength of data-driven, evidence-based programs with authentic community engagement opportunities in all DFH programs. Title V staff identified several evidenced-informed approaches to community engagement that will become essential components of all DFH programs.

Barnes, M., Schmitz, P. (2016, Spring). Community Engagement Matters (Now More Than Ever). *Stanford Social Innovation Review, Vol. 14 (2).*

Implementation of this strategy will be tracked by **ESM LC-16:** Percentage of DFH procurements that demonstrate inclusion of evidence-based/-informed community engagement and collective impact strategies.

Cross-Cutting/Life Course - Annual Report

Life Course/Crosscutting

A Life course theory is a conceptual framework that helps explain health and disease patterns, including health disparities, across populations and over the lifespan. This approach focuses on the broad social, economic and community/environmental factors as underlying causes of inequalities in health for a wide range of diseases and conditions across population groups. Rather than a disease-focus approach to health, it is population focused, and firmly rooted in social determinants and social equity models of health. This necessitates a more community-based approach that takes into consideration the social, economic and environmental factors influencing health behaviors and outcomes. This aligns directly with the scope of public health that focuses on improving and protecting the health of the population, eliminating health disparities and promoting health equity across population groups, and building healthy communities to improve health outcomes.

A critical aspect of health promotion is to ensure health insurance coverage as a vehicle to increase access to health care services. The landscape of health insurance has changed dramatically in recent years and continues to evolve. As stated throughout this application and report, Title V staff play a significant role in advocating to ensure the needs of the MCH population are well addressed. Title V staff will continue to serve as an important connection between the MCH population and the providers who serve them and OHIP staff establishing policy and overseeing the implementation of the NY State of Health to ensure comprehensive, quality health care services are available and

accessible to NY's MCH population.
As discussed in Section IIA of this application, NYS has aggressively pursued implementation of the ACA through the NYSOH. Promoting access to quality health care throughout the life span is imperative to promote the health and well-being of a population. Other areas of focus for this domain including oral health, obesity, mental health and disparities are included in the prior domains.
Title V focused on several cross-cutting priority areas over the past year. Oral health is an integral aspect of primary and preventive health care. The SBHC- Dental Program (SBHC-D) ensures those students with limited or no access to care have access to preventive dental care through SBHC dental sites. Through fifty-six Article 28 facilities, the program provides dental services with mobile vans, portable equipment or in a fixed facility within the school in more than 1,200 schools that provide services to over 60,000 students. The primary objective the SBHC-D program is to increase the prevalence of dental sealants in second and third grade children. NY's Oral Health Collaborative Systems grant through HRSA supports school-based primary and preventive care services. Access to oral health services has improved the past few years. In 2011 41.8 % of Medicaid children and adolescents ages two to twenty-one years had at least one dental visit within the past year while 43.6 % had a visit in 2013.
Fluoridation is recognized as a significant public health success in preventing dental caries. Currently 71.7% of NY's population on public water systems receive optimally fluoridated water. When NYC is excluded, this drops to 47%. Legislation was passed in 2015 in NY that established a $5 million grant program to support community water systems through funding costs related to the construction, installation, repair, rehabilitation, replacement, or upgrade of drinking water fluoridation facilities. It also required notice of DOH as well as public notice for communities considering discontinuation of community water fluoridation. Over the past year, the Title V program released competitive Request for Applications to providing funding to communities seeking to newly fluoridate public water systems or seeking to replace outdated equipment to continue fluoridation. Title V also provides funds to provide Fluoride Mouth Rinse (Supplemental Fluoride) Programs in schools that serve children without public water systems. This provides a safe and effective method of reducing dental decay through the provision of fluoride to children living in non-fluoridated communities.
The DFH recognizes the importance of oral health services as a vital component of primary and preventive health care. Access to oral health care for pregnant women at times presents challenges due to a lack of understanding by dentists and a lack of availability of dentist that accept Medicaid. NY was a leader in the development of the *Oral Health Care During Pregnancy and Early Childhood Guidelines* and has widely disseminated these guidelines. The Medicaid prenatal care standards requires all prenatal care providers to conduct an assessment of the woman's oral health care needs at the first prenatal care visit including but not be limited to interviewing the patient regarding current oral health problems, previous dental problems, and the availability of a dental provider. The guidelines recommend that pregnant women identified as having a current oral health problem or not having a dental visit in the past six months be referred to a dentist as soon as possible, preferably before 20 weeks gestation.
Fostering healthy communities was a focus of the DOH Center for Environmental Health (CEH) over the past year. CEH awarded 13 Healthy Neighborhood Program (HNP) grants to LHDs through a competitive RFA process. The new programs were designed to develop a comprehensive and holistic approach to addressing a broad range of housing hazards associated with lead poisoning, asthma, and injury prevention within their targeted communities. Residents of the dwellings were interviewed to determine their individual needs and a room-by-room visual inspection was conducted to identify peeling paint, carbon monoxide hazards, asthma triggers and fire hazards. In 2014 a total of 13,987 dwelling units were approached by HNPs statewide and 6,373 (46%) households had a home assessment initiated; 2,555 (40%) of the dwellings visited had a minority respondent; 2,855 (45%) dwellings visited did not have a functional smoke alarm on floors with living space; 1,704 (27%) households had children younger than six years old. In 2015, DOH was able to award six additional LHDs Healthy Neighborhood awards.
In addition, the Childhood Lead Poisoning Primary Prevention Program (CLPPPP) continued to fund 15 LHDs to focus on targeting neighborhoods and housing most at risk for containing lead hazards. From October 2007 to March 2015, Primary Prevention Program Grantees have visited and inspected the interior of 31,615 housing units; inspected 10,678 units with confirmed or potential interior lead-based paint hazards; (Potential interior lead hazards

are those identified through visual assessment alone. Confirmed interior lead hazards are hazards identified through sampling or testing, such as XRF measurement, paint chip sampling, etc.); and made at least 7,759 units lead-safe through remediation of interior lead-based paint and lead-based paint dust hazards.

Title V continued to oversee and implement the NYS Perinatal and Infant Oral Health Collaborative Initiative grant through CDC aimed at improving the oral health of pregnant women and infants in NYS through integration of oral health services into MICHC programs. Overall goals of the project include increasing the percent of women: who visit a dentist during pregnancy; who receive an assessment for oral health problems and appropriate referral by a prenatal care provider; and are engaged in healthy behavior (i.e., appropriate feeding habits and infant oral hygiene practices). The Healthy Baby Network (HBN) in Rochester, NY was selected via a competitive application process in 2014 to serve as a MICHC pilot site, and developed and piloted community and individual level intervention strategies: public health detailing focused on prenatal care providers and consumers to increase capacity to provide oral health services to the target population; and care coordination aimed at improving access to dental care for perinatal clients being served through the MICHC program. All lessons learned from this initiative, as well as tools and resources developed by the contractor, will be shared with the remaining MICHC projects throughout NYS to increase the reach and impact of this most important initiative.

Racial and ethnic disparities cross all ages and populations. In all domains, significant attention needs to be given to the public health priority to promote health equity. All Title V programs in NYS are focused to improve the health and wellness of all New York's regarding of race or ethnicity. Funds, programs and initiatives are targeted to the highest need areas of the state. This is a major focus and will be a priority in NY's Title V State Action Plan in order to improve in future years.

One of those disparate populations is Native Americans in NYS. The American Indian Health Program (AIHP) provides primary and preventive health care to NY's Native American population living on reservations using state appropriated funds. Pursuant to Public Health Law § 201(1)(s), DOH is required to "administer to the medical and health needs of the ambulant sick and needy Indians on reservations." Services include primary medical care, dental care, eye care, pharmacy needs, specialty care and preventive health services for approximately 25,000 Native Americans living within reservation communities. These services are provided to eligible members in one state recognized and eight federally recognized nations. Eligibility for all services is determined by the tribal councils of each nation. NYS maintains a government-to-government relationship with the nations for whom the program provides these healthcare services. Therefore, Title V does not have access to specific data regarding this high need population. It is estimated that the AIHP served 10,917 individuals in 2015. Title V staff conducts on-site visits, and is in regular telephone and email contact with clinic staff, grant administrators and nation leadership to hear their concerns and work to resolve issues as they arise.

While linking individuals served to health insurance is a long-standing expectation of NY's Title V program, as MCH programs are updated over the next several years, the DFH will integrate more formal performance standards and measures related to health insurance assessment and enrollment across all Title V programs. Title V staff also will continue to engage in major state health systems reform initiatives to identify and pursue options to leverage those key policy initiatives to reinforce and improve health care service access and quality for the MCH population.

Other Programmatic Activities

No content was entered for Other Programmatic Activities in the State Action Plan Narrative section.

II.F.2 MCH Workforce Development and Capacity

A strong and diverse MCH workforce is needed to meet the needs of NY's MCH population. As stated previously, at the community level, most services and programs are implemented by local partners including 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, Centers of Excellence (COEs) have

been established that provide information and education to major Title V provider groups including COEs for adolescent health, family planning, reproductive health, oral health and perinatal health. This allows the Title V 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 COE is also facilitating performance improvement efforts within the network of family planning providers. The perinatal COE is developing common metrics for community-based perinatal providers to enable standard and ongoing assessment of program outcomes related to the MCH population. This not only provides opportunities for current practice improvement efforts, but serves 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 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 advocates for staff to attend national conferences whenever possible to continue to build expertise in the MCH arena and make connections on the federal level as well as develop partnership across state to continue to improve NY's approach to improving the health and wellness of the MCH population.

As previously discussed, NY's Title V 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 NYSPQC, training and information provided to and through professional organizations such as the identification of children with ASD, developmental screening, the identification and treatment of hypertension during pregnancy, screening and referral of children for oral health services and a range of other topics. The development of the NYS Partnership for Maternal Health will further support efforts to promote public awareness and clinical quality improvement efforts to improve maternal and infant mortality and morbidity.

Title V staff within DOH are the core of the Title V program and responsible to ensure the scope and mission of Title V is carried out in NYS. To ensure a strong focus on the needs of the Title V program staff, a unique aspect of the process to develop the Title V application this year was a partnership with the HRSA-funded National MCH Workforce Development Center at the University of North Carolina that served as an invaluable resource to identify information, tools and resources to gain a better understanding of MCH needs and priorities as well as potential strategies to address these needs and priorities. The Center also worked with Title V to develop and enhance skills in Title V staff to build NY's "MCH Leaders of Tomorrow" to support and promote MCH leaders of the future in NYS and plan for the succession of key Title V staff who will be retiring within the next few years. Title V staff participated as members of cross-functional teams to refine NY's State Action Plan. Each team had an experienced mentor for internal guidance and received technical assistance from the Center to identify leadership and work styles and develop a personal plan to improve and enhance skills during this year long process. Title V will continue to foster this growth to further develop NY's MCH leaders of tomorrow including encouraging staff to access the Association of Maternal and Child Health Programs' (AMCHP) educational opportunities to network and grow in the field of MCH. A similar process will be undertaken to move into implementation of NY's State Action Plan to ensure continued staff development while ensuring comprehensive planning and implementation of NY's State Action Plan.
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In an effort to build capacity for the dental public health workforce, the DOH has an accredited dental public health residency program to train residents to develop public health competencies and skills that can be applied in dental public health settings. The residency curriculum focuses on eight core competencies recognized by the American Association of Public Health Dentistry. They include : demonstrate the ability to incorporate ethical reasoning and actions that promote culturally competent oral health care to individuals and populations: critique, synthesize and apply information from scientific and lay sources to improve the public's oral health; describe social and health care systems and determinants of health and their impact on the oral health of the individual and population; assess risk for oral diseases and select appropriate, evidence-based preventive interventions and strategies to promote health and control oral diseases at the individual and population level; demonstrate the ability to access and describe the

use of population-based health data for health promotion, patient care, and quality improvement; 6.)Demonstrate the ability to communicate and collaborate with relevant stakeholders to advocate for policies that impact oral and general health for individuals or populations; develop a capacity for lifelong learning and professional growth in order to provide leadership that utilizes principles of dental public health; and; demonstrate the ability to participate in inter-professional care across the lifespan of people from diverse communities and cultures. The Title V program hosts up to two dental residents annually.

Residents are also integrally involved in the analysis of the 3rd grade screening data. Their involvement often fosters interests in data projects that lead to additional projects that often lead to building and enhancing the evidence base to inform and improve prevention efforts in early childhood caries prevention, oral health and nutrition education and other oral health promotion activities. The residency program curriculum also includes monitoring programs for effectiveness, developing elements of interventions that assist in promoting and preventing dental diseases

Promoting MCH providers outside of DOH is also essential to ensure the needs of the MCH population are met. Through a Memorandum of Understanding with the State University of New York at Albany School of Public Health (SPH), Title V supports graduate-level students working towards their Masters in Public Health to work within the Title V program for a semester to gain real-life, practical experience in the field of MCH. For example, this includes a graduate assistant in the DOH Office of Public Health Practice to assist with analyzing and generating data for the needs assessment of NY's Title V application and report, and state and local level data for the MCH priority area of focus for the Prevention Agenda dashboard, several health topics that are included in the NYS Community Health Indicator Reports (http://www.health.ny.gov/statistics/chac/indicators/) such as: Maternal and Infant Health Indicators, Family Planning/Natality Indicators; and Child and Adolescent Health Indicators, as well as and other data related to maternal and child health. These data are used by state DOH programs and external partners, the local health departments, hospitals and community organizations in assessing community health needs, targeting interventions among high-burden populations, and monitoring progress related to key maternal and child health priority areas and indicators.

As an outgrowth of this partnership, the SPH and DOH were awarded a HRSA MCH Catalyst Program grant to develop an increased focus on MCH and introduce students to MCH careers. Rachel deLong, M.D., M.P.H., the former Title V director, is continuing her work as co-director of the Catalyst Center at the SPH. The Catalyst Center also supports SPH internships with local community-based MCH partners to provide an opportunity for community organizations to request funding to support a student intern through the MCH Public Health Catalyst Program that provides a resources for smaller organizations who may not otherwise have the funds to support a student intern, while providing these students with invaluable, real-life MCH experience.

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

II.F.3. Family Consumer Partnership

As stated previously, at the community level, most services and programs are implemented by local partners including LHDs, universities and academic medical centers, hospitals and clinics, and community based organizations. When procuring services, efforts are made to locate services within communities served provided by individuals from the community or reflect the diversity of the community. Contractors are required to obtain consumer input from the MCH population served whether it is membership on a board to guide services, workgroups to provide input regarding education materials or outreach strategies, or direct input from families served. In a state the size of NY, obtaining input through provider organizations or other organizations representative of the population is the most practical, meaningful way to obtain input from the broad population that is MCH in NY. As stated in the state plan, a focus in the Early Intervention Program this coming year will be on assessment of family outcomes that will assist

NY's Title V program to enhance the understanding of family input and disseminate this learning to other programs and services.

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 will continue. Parents are also members of the EI 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 NYS has been designated as a member of NY's MCHSBG Advisory Council and NY's family representation to AMCHP.

Title V also provides staff support to Hands & Voices of NY, a family support organization that provides support for families with children who are deaf or hard of hearing, regardless of communication modes the family selects. Hands & Voices is affiliated with and receives technical support from the National Hands and Voices, which is the leading parent support group in the country for these children. It is a parent driven non-profit organization providing families with the resources, networks, and information they need to improve communication access and educational outcomes for their children. Hands & Voices of New York has been an official non-profit 501(c)(3) organization for 3 years and currently has about 40 paid members. While the organization is based in the Capital District, there are satellites in Rochester, Buffalo, Utica, and Columbia Counties as well as Long Island. There are efforts underway to link more closely with Parent to Parent of NY in the coming year.

The Title V program will further build supports and services as well as stronger connections with parents through the systems mapping efforts for CSHCN as contained in the State Action Plan and promote strategies to support ongoing communication with parents of CSHCN throughout NYS. The Title V program will seek to develop standardized processes and measures to ensure all MCH providers obtain and use meaningful consumer input to improve the MCH system of services in NYS. This will be especially important in NY's upcoming plans to promote health equity across all NYS' families as well.

II.F.4. Health Reform

As stated throughout this report, Title V staff have been directly involved in NY's implementation of the Affordable Care Act. This includes input into the basic health plan, outreach and awareness and in keeping abreast of developments and the impact on the MCH population. Title V staff have facilitated information sharing with providers and consumers throughout NYS and requires all MCH programs to assess individuals for insurance status and facilitate enrollment into the Exchange. Work on this, Health Homes, DSRIP including SHIP/APC and others will remain a key part of the work of NY's Title V program to ensure the MCH population has ongoing access to comprehensive health care coverage and that Title V continues to build and maintain a leadership role in this arena.

II.F.5. Emerging Issues

All issues have been succinctly addressed in previous sections of this application, including the State Plan section. Title V staff in NY will continue to monitor the status of health insurance coverage for the MCH population, access to Health Home for Children, implementation of DSRIP, SHIP, including APC and other health care reform initiatives to advocate for supports and services for the MCH population. An enhanced focus will be placed on understanding and developing strategies to promote health equity, addressing the opioid epidemic particularly focused on the MCH population, increasing an understand of the social-emotional needs of children and adolescents and developing a strength-based approach to supporting positive youth development. A major effort will be undertaken to update standards for perinatal regionalization as well as ensuring the structure of the perinatal regionalized system will be developed to align with the evolving health care system. Throughout the next year, Title V staff will also continue to

implement the strategies identified in the State Action Plan through evidence-based or evidence-informed practice to potentially update policy, program and other supports as new evidence emerges. Finally, Title V recognizes the need to strengthen internal and external partnerships, including formal and informal community leaders, in order to address some of the most challenging MCH issues faced across the Nation.

II.F.6. Public Input

As stated in the Needs Assessment Summary Update section of this application, internal and external input was obtained during the refinement of NY's State Action Plan. Discussions were held with the MCHSBG Advisory Council and other partners and stakeholders to guide the development of measurable objectives and evidence-based strategies in the State Action Plan. Input was obtained from key stakeholders and through Parent to Parent of NYS. On an ongoing basis, Title V staff engage in discussions with contractors, programs and other groups regarding MCH issues, challenges and successes. In addition, the State Plan will also be posted on the DOH public web site and information regarding the plan widely disseminated to provide an opportunity for further input and development of partnerships to foster the goals as outlined in NY's Title V State Plan.

II.F.7. Technical Assistance

NY's Title V program would welcome the opportunity to have periodic teleconferences with HRSA and other large states that may be experiencing similar challenges, discussing similar policy issues and developing and evaluating programs and initiatives to support Title V outcomes. Focused discussions on the impact of MCH in the climate of health care reform, and the role Title V can play to better influence those changes in a positive manner would be invaluable. Issues such as 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 examples of areas that may be of benefit to discuss in a forum with large states. Finally, discussions on strategies States have implemented pursuant to their State Action Plans in general, including strategies Title V in other states have taken to address disparities and improve health equity in particular would be extremely helpful as NY's moves forward in addressing this high priority MCH issue.

III. Budget Narrative

	2013		2014	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$40,033,023	$36,320,452	$37,919,712	$37,919,712
Unobligated Balance	$0	$0	$0	$0
State Funds	$62,208,171	$62,208,171	$62,208,171	$78,841,785
Local Funds	$271,491,225	$322,617,868	$271,646,100	$224,894,104
Other Funds	$0	$0	$0	$0
Program Funds	$314,762,086	$234,990,131	$236,737,888	$292,856,562
SubTotal	$688,494,505	$656,136,622	$608,511,871	$634,512,163
Other Federal Funds	$57,643,011	$49,857,001	$62,905,602	
Total	$746,137,516	$705,993,623	$671,417,473	$634,512,163

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$38,909,810	$38,909,810	$38,909,810	
Unobligated Balance	$0	$0	$0	
State Funds	$29,200,000	$58,908,173	$29,226,355	
Local Funds	$22,198,393	$317,759,172	$25,254,603	
Other Funds	$0	$0	$0	
Program Funds	$12,794,604	$274,679,941	$34,368,556	
SubTotal	$103,102,807	$690,257,096	$127,759,324	
Other Federal Funds	$54,870,832	$41,545,988	$72,809,819	
Total	$157,973,639	$731,803,084	$200,569,143	

	2017	
	Budgeted	**Expended**
Federal Allocation	$38,909,810	
Unobligated Balance	$0	
State Funds	$12,147,081	
Local Funds	$102,765,310	
Other Funds	$0	
Program Funds	$34,368,556	
SubTotal	$188,190,757	
Other Federal Funds	$57,096,314	
Total	$245,287,071	

III.A. Expenditures

The State Allocation Plan is described in Section 504, Use of Allotment of Funds, and Section 505, Application for Block Grant Funds. As in previous years, the federal allocation is committed to program services, program support, and program administration. Support in each area remains consistent, including administration at 4.4%. Some differences in state and local contributions are evident as the State continues to maximize its public health funding, utilize state-based resources to match a large variety of public health grant programs, and recognize the growing effect of affordable health insurance. As the payer of last resort, direct care expenses remain less 0.1%. The State continues to provide equivalent or increased levels of service across the other service categories. Of note is the increase in local support for the partnership. Updated local public health policies and reformulated expenditure categories have resulted in additional support for MCH programs.
Expenditures for FY17 are expected to utilize the full allocation of $38,909,810.

III.B. Budget

The Federal/State Partnership

The State has budgeted federal support in the required categories at 30.1% ($11.7M) for children and adolescents and 30.7% ($11.9M) for children with special health care needs, maintaining consistent support and exceeding the 30% - 30% threshold. The State continues significant support for the MCH Federal/State Partnership. As expenditures for direct care services stabilize, program support in enabling services has grown to $74M, while services and systems funding reaches $106M.

The State demonstrates its continued obligation of funds above the mandatory FY1989 maintenance of effort level of $58,268,752. A State contribution of $29M represent a significant state-level investment in a variety of

programs supporting Title V objectives including school health programs, programs delivering perinatal and post-natal services, and Indian and migrant health programs. Local support has expanded based on the newly developed expenditure categories. Over $100M in local support includes expenditures for child health (76%), provision of prenatal/postpartum Care (9%), reproductive care (4%), and community health assessment (11%).

Program income is more than $34M in FY17. It includes contributions from patient collections, private insurance, and local maternal and child health-related revenue. It results in a total State Match of over $166M for FY 17.

Consistent with past program plans, the State will use its Federal MCH funds for the following programs:

The Adolescent Health Initiative, including Centers for Excellence and Youth Risk Behavior Surveillance; American Indian Health Program Community Health Workers; Asthma Coalitions; Children with Special Health Care Needs Program, including the Physically Handicapped Children's Program Diagnostic and Evaluation Program; Community-Based Adolescent Pregnancy Prevention; Family Planning; The Genetics Program and Newborn Metabolic Screening; SUNY School of Public Health MCH Graduate Assistantship Program; Health Communications; Lead Poisoning Prevention; Migrant and Seasonal Farmworker Health; Parent and Consumer Focus Groups; Public Health Information/Community Assessment infrastructure; Preventive Dentistry Initiatives; the Dental Residency Program; Dental Supplemental Fluoride Program, School-Based Health Centers; and STD Screening and Education.

Other federal funds supporting Title V

The State administers an inventory of federally-funded initiatives and activities in support of its Title V program. The Centers for Disease Control and Prevention, Health Resources and Services Administration, Office of Adolescent Health, and Department of Education all provide funds in support of a diverse variety of programs such as early hearing detection, oral disease prevention, rape crisis, perinatal oral health, teen abstinence, community programs for expectant teens, and early intervention.

In FY17, funding for these programs is over $57M with an additional $18M available in Medicaid matching funds. Most of the programs are state-wide and many contain components with subawards to community-based organizations and outstanding educational institutions.

Financial Accountability

The methodology used to identify State expenditures for MCH-related programs has remained consistent with prior years:

• Appropriate cost centers representing specific areas of activity related to MCH are identified.
• Data for the appropriate fiscal periods are obtained from the Statewide Financial System administered by the Office of the State Comptroller.
• Data for selected cost centers are extracted on a quarterly basis.
• Data is compiled from relevant cost centers to reflect expenditures made during the federal grant award period.
• All expenditure data represent payments made on a cash (vs. accrual) basis.
• Transactions associated with specific grants are identified and tracked through appropriation, segregation, encumbrance & reporting processes to permit proper and complete recording of the utilization of available funds.
• Identifying codes are assigned to record these transactions by object of expense within each cost center.

The Department of Health and the Office of the State Comptroller maintain budget documentation for Block Grant

funding and expenditures consistent with Section 505(a) and Section 506(a) (1) for the purpose of maintaining an audit trail. Reporting requirements and procedures for each particular grant are instituted to comply with conditions specified within each notice of grant award.

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IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Title V State Agreement (003).pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Attachment MCH Collaborations 5-28-16.pdf

Supporting Document #02 - Attach IIB2 Staff Quals FINAL.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: New York

	FY17 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	$ 11,717,104	(30.1%)
B. Children with Special Health Care Needs	$ 11,935,885	(30.7%)
C. Title V Administrative Costs	$ 1,727,394	(4.4%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 12,147,081	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 102,765,310	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 34,368,556	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 149,280,947	
A. Your State's FY 1989 Maintenance of Effort Amount $ 58,268,752		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 188,190,757	
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)	$ 57,096,314	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 245,287,071	

OTHER FEDERAL FUNDS	FY17 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 3,022,144
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 1,647,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 9,234,796
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 9,762,000
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 26,106,078
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 156,338
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 310,600
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 4,317,691
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	$ 1,333,436
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State-Based Perinatal Quality Collaboratives (PQCs) Cooperative Agreement	$ 200,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	$ 656,231
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 250,000

	FY15 Application Budgeted		FY15 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 38,909,810		$ 38,909,810	
A. Preventive and Primary Care for Children	$ 12,291,609	(31.6%)	$ 13,438,850	(34.5%)
B. Children with Special Health Care Needs	$ 11,949,203	(30.7%)	$ 12,042,699	(31%)
C. Title V Administrative Costs	$ 3,210,059	(8.2%)	$ 3,046,453	(7.8%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0		$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 29,200,000		$ 58,908,173	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 22,198,393		$ 317,759,172	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 12,794,604		$ 274,679,941	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 64,192,997		$ 651,347,286	
A. Your State's FY 1989 Maintenance of Effort Amount $ 58,268,752				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 103,102,807		$ 690,257,096	
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)	$ 54,870,832		$ 41,545,988	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 157,973,639		$ 731,803,084	

OTHER FEDERAL FUNDS	FY15 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 91,045
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 2,634,308
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State-Based Perinatal Quality Collaboratives (PQCs) Cooperative Agreement	$ 200,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 266,938
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 23,178,502
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 5,604,010
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 9,571,185

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: Under expenditures in School Health programs and redistribution of funds to other service categories in the Indian Health program resulted in lower state spending	
2.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: Local expenditures for the Early Intervention Program were included	
3.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: Program income for the Early Intervention was included in the program income expenditures totals	

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	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	$ 5,923,674	$ 5,526,547
2. Infants < 1 year	$ 761,692	$ 831,477
3. Children 1-22 years	$ 11,842,793	$ 12,607,373
4. CSHCN	$ 12,352,932	$ 12,042,699
5. All Others	$ 6,301,325	$ 7,799,086
Federal Total of Individuals Served	$ 37,182,416	$ 38,807,182

IB. Non Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	$ 19,915,272	$ 30,435,778
2. Infants < 1 year	$ 10,411,409	$ 31,831,626
3. Children 1-22 years	$ 102,057,326	$ 50,711,091
4. CSHCN	$ 31,773,374	$ 399,834,753
5. All Others	$ 20,445,429	$ 28,709,935
Non Federal Total of Individuals Served	$ 184,602,810	$ 541,523,183
Federal State MCH Block Grant Partnership Total	$ 221,785,226	$ 580,330,365

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2017**
	Column Name:	**Application Budgeted**
	Field Note: Does not include children less than 1 year	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: Does not include infants less than 1 year	

Data Alerts:

1.	CSHCN, Application Budgeted does not equal Form 2, Line 1B, Children with Special Health Care Needs, Application Budgeted. Please add a field level note to explain.

Form 3b
Budget and Expenditure Details by Types of Services

State: New York

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	$ 39,549	$ 2,523
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 8,562	$ 412
B. Preventive and Primary Care Services for Children	$ 15,167	$ 817
C. Services for CSHCN	$ 15,820	$ 1,294
2. Enabling Services	$ 26,180,775	$ 17,923,926
3. Public Health Services and Systems	$ 12,689,486	$ 20,983,361
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		
Physician/Office Services		$ 2,523
Hospital Charges (Includes Inpatient and Outpatient Services)		
Dental Care (Does Not Include Orthodontic Services)		
Durable Medical Equipment and Supplies		
Laboratory Services		
Direct Services Line 4 Expended Total		$ 2,523
Federal Total	$ 38,909,810	$ 38,909,810

IIB. Non-Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	$ 10,596,828	$ 314,646,963
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 1,962,123	$ 39,570,195
B. Preventive and Primary Care Services for Children	$ 6,198,669	$ 36,136,309
C. Services for CSHCN	$ 2,436,036	$ 238,940,459
2. Enabling Services	$ 73,972,304	$ 90,070,548
3. Public Health Services and Systems	$ 106,926,933	$ 49,896,438
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		$ 38,230,473
Physician/Office Services		$ 2,554
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 14,336,429
Dental Care (Does Not Include Orthodontic Services)		
Durable Medical Equipment and Supplies		$ 2,389,405
Laboratory Services		
Other		
Other		$ 259,688,102
Direct Services Line 4 Expended Total		$ 314,646,963
Non-Federal Total	$ 191,496,065	$ 454,613,949

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4

Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: New York

Total Births by Occurrence: 237,377

1. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Core RUSP Conditions	237,377 (100.0%)	2,188	351	351 (100.0%)

Program Name(s)				
Propionic acidemia	Methylmalonic acidemia (methylmalonyl-CoA mutase)	Methylmalonic acidemia (cobalamin disorders)	Isovaleric acidemia	3-Methylcrotonyl-CoA carboxylase deficiency
3-Hydroxy-3-methyglutaric aciduria	Glutaric acidemia type I	Medium-chain acyl-CoA dehydrogenase deficiency	Very long-chain acyl-CoA dehydrogenase deficiency	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency
Maple syrup urine disease	Homocystinuria	Classic phenylketonuria	Tyrosinemia, type I	Primary congenital hypothyroidism
Congenital adrenal hyperplasia	S,S disease (Sickle cell anemia)	S,C disease	Biotinidase deficiency	Cystic fibrosis
Severe combined immunodeficiences	Classic galactosemia			

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Newborn Screening - Newborn Screening Program (NBSP) collects, analyzes and reports on approximately 270,000 specimens annually for 47 diseases and conditions including all core conditions recommended by the American College of Medical Genetics and the March of Dimes. The Department also tracks mandatory screening and for newborn hearing and critical congenital heart defects.

Developing a comprehensive, coordinated, seamless system of supports and services for CSHCN and their families is imperative to promote health, wellness and self-sufficiency. NY is fortunate to have extensive supports and services for CSHCN in NYS. This includes NY's NBSP that performs blood testing and processes the data from over 270,000 specimens annually for 47 diseases and conditions, including all core conditions recommended by the American College of Medical Genetics and the March of Dimes. Follow-up is provided through condition-specific Specialty Care Centers located throughout NYS.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

None

Data Alerts: None

Form 5a
Unduplicated Count of Individuals Served under Title V

State: New York

Reporting Year 2015

		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	0	45.8	0.0	51.4	1.7	1.1
2. Infants < 1 Year of Age	0	44.8	1.0	51.4	1.7	1.1
3. Children 1 to 22 Years of Age	0	30.8	6.9	54.4	7.9	0.0
4. Children with Special Health Care Needs	301	37.2	6.9	52.8	3.1	0.0
5. Others	0	21.4	0.0	61.9	16.7	0.0
Total	301					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2015**

Field Note:
This figure is reflective of the only Title V direct services provided in NYS. It includes the Physically Handicapped Children's Program (PHCP) Diagnosis and Evaluation as well as Treatment services.

Form 5b
Total Recipient Count of Individuals Served by Title V

State: New York

Reporting Year 2015

Types Of Individuals Served	Total Served
1. Pregnant Women	94,984
2. Infants < 1 Year of Age	25,079
3. Children 1 to 22 Years of Age	612,400
4. Children with Special Health Care Needs	635,350
5. Others	198,773
Total	1,566,586

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2015**

Field Note:
Due to the change in definition of "direct health care services" and "enabling services" , this figure is not within 10% of total births by occurrence in Form 4.

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

State: New York

Reporting Year 2015

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	238,000	144,089	39,673	495	25,769	0	0	27,974
Title V Served	0	0	0	0	0	0	0	0
Eligible for Title XIX	0	0	0	0	0	0	0	0
2. Total Infants in State	239,804	158,026	56,536	3,681	21,561	0	0	0
Title V Served	0	0	0	0	0	0	0	0
Eligible for Title XIX	0	0	0	0	0	0	0	0

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	182,311	55,206	483	238,000
Title V Served	0	0	0	0
Eligible for Title XIX	0	0	0	0

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
2. Total Infants in State	176,154	63,650	0	239,804
Title V Served	0	0	0	0
Eligible for Title XIX	0	0	0	0

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	2017 Application Year	2015 Reporting Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 522-5006	(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) 474-6061	(518) 474-6061
5. Number of Calls Received on the State MCH "Hotline"		24,063

B. Other Appropriate Methods	2017 Application Year	2015 Reporting 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	Lauren J. Tobias
Title	Director, Division of Family Health
Address 1	Coring Tower Room 890
Address 2	Empire State Plaza
City/State/Zip	Albany / NY / 12237
Telephone	(518) 474-6968
Extension	
Email	lauren.tobias@health.ny.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Susan Slade
Title	Director, Bureau of Child Health
Address 1	Coring Tower Room 878
Address 2	Empire State Plaza
City/State/Zip	Albany / NY / 12237
Telephone	(518) 474-1961
Extension	
Email	susan.slade@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 2017

No.	Priority Need
1.	Reduce maternal mortality and morbidity
2.	Reduce infant mortality & morbidity
3.	Support and enhance social-emotional development and relationships for children and adolescents
4.	Increase supports to address the special health care needs of children and youth
5.	Increase the use of preventive health care services across the life course.
6.	Promote oral health and reduce tooth decay across the life course
7.	Promote home and community environments that support health, safety, physical activity and healthy food choices across the life course.
8.	Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population(cross-cutting).

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Reduce maternal mortality and morbidity	New	
2.	Reduce infant mortality & morbidity	New	
3.	Support and enhance social-emotional development and relationships for children and adolescents	New	
4.	Increase supports to address the special health care needs of children and youth	New	
5.	Increase the use of preventive health care services across the life course.	New	
6.	Promote oral health and reduce tooth decay across the life course	New	
7.	Promote home and community environments that support health, safety, physical activity and healthy food choices across the life course.	New	
8.	Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population(cross-cutting).	New	

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 5

Field Note:

Including:
Preconception/ Interconception (“well woman”, including family planning)
Prenatal & Postpartum
Infants (“well baby”)
Children (“well child”)
Adolescents (“well teen”, including family planning)

Form 10a
National Outcome Measures (NOMs)

State: New York

Form Notes for Form 10a 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
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%, 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: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	239.5	3.3 %	5,401	225,498
2012	235.4	3.2 %	5,441	231,131
2011	214.1	3.1 %	4,831	225,668
2010	217.8	3.1 %	4,935	226,617
2009	196.2	3.0 %	4,510	229,831
2008	173.9	2.8 %	4,047	232,716

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
2010_2014	20.9	1.3 %	251	1,202,356
2009_2013	20.6	1.3 %	250	1,211,693
2008_2012	22.2	1.4 %	272	1,225,096
2007_2011	21.2	1.3 %	262	1,237,631
2006_2010	20.5	1.3 %	256	1,246,423
2005_2009	19.9	1.3 %	248	1,248,399

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 3 - Notes:

None

Data Alerts: None

NOM 4.1 - 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
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%, or >10% missing data and should be interpreted with caution

NOM 4.1 - Notes:

None

Data Alerts: None

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	1.4 %	0.0 %	3,298	238,423
2013	1.4 %	0.0 %	3,210	236,671
2012	1.5 %	0.0 %	3,494	240,654
2011	1.5 %	0.0 %	3,533	241,031
2010	1.5 %	0.0 %	3,682	244,116
2009	1.5 %	0.0 %	3,767	247,850

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.2 - Notes:

None

Data Alerts: None

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.5 %	0.1 %	15,424	238,423
2013	6.6 %	0.1 %	15,637	236,671
2012	6.5 %	0.1 %	15,580	240,654
2011	6.7 %	0.1 %	16,024	241,031
2010	6.7 %	0.1 %	16,367	244,116
2009	6.7 %	0.1 %	16,574	247,850

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.3 - Notes:

None

Data Alerts: None

NOM 5.1 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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%, or >10% missing data and should be interpreted with caution

NOM 5.1 - Notes:

None

Data Alerts: None

NOM 5.2 - Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	2.6 %	0.0 %	6,250	238,475
2013	2.6 %	0.0 %	6,213	236,558
2012	2.7 %	0.0 %	6,589	240,504
2011	2.7 %	0.0 %	6,601	240,932
2010	2.9 %	0.0 %	7,036	244,016
2009	2.9 %	0.0 %	7,052	247,770

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.2 - Notes:

None

Data Alerts: None

NOM 5.3 - Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.2 %	0.1 %	14,864	238,475
2013	6.3 %	0.1 %	14,839	236,558
2012	6.4 %	0.1 %	15,295	240,504
2011	6.4 %	0.1 %	15,516	240,932
2010	6.5 %	0.1 %	15,868	244,016
2009	6.7 %	0.1 %	16,475	247,770

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.3 - 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
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%, 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
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:

Indicator results were based on a shorter time period than required for reporting

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
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
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
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
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
2013	184.0	8.8 %	436	236,980
2012	188.5	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 - Sleep-related 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
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 - The percent of infants born with fetal alcohol exposure 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
2013	7.6 %	1.1 %	8,200	107,743
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 has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.5	0.2 %	1,233	225,501
2012	4.2	0.1 %	974	231,133
2011	4.3	0.1 %	975	225,668
2010	3.3	0.1 %	751	226,617
2009	3.1	0.1 %	705	229,831
2008	2.6	0.1 %	611	232,716

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)

FAD Not Available for this measure.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.

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 12 months

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.4 %	1.3 %	773,251	3,983,245

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% 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
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	15.9	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
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
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
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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	20.8 %	1.3 %	886,553	4,266,861
2007	18.5 %	1.3 %	817,664	4,420,982
2003	17.0 %	1.0 %	765,132	4,503,196

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% 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) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	16.8 %	1.6 %	100,137	597,820

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children 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
2011_2012	1.9 %	0.4 %	67,419	3,574,950
2007	0.7 %	0.2 %	27,641	3,741,722

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children 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
2011_2012	7.2 %	0.9 %	255,081	3,552,777
2007	7.0 %	1.0 %	261,777	3,737,898

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children 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
2011_2012	65.2 %	5.1 %	263,625	404,570
2007	61.4 %	6.6 %	144,514	235,493
2003	57.7 %	5.6 %	178,600	309,782

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children 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
2011_2012	83.2 %	1.3 %	3,547,871	4,266,077
2007	83.4 %	1.3 %	3,684,697	4,420,982
2003	83.2 %	1.1 %	3,742,722	4,498,836

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	32.4 %	2.2 %	595,108	1,835,215
2007	32.9 %	2.2 %	629,579	1,914,847
2003	30.9 %	1.9 %	611,888	1,978,692

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	31.3 %	0.1 %	59,424	190,138

Legends:

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	24.4 %	0.9 %	173,389	711,539
2011	25.8 %	1.0 %	200,200	777,042
2009	26.1 %	1.2 %	166,963	639,137
2007	26.9 %	0.9 %	200,383	745,792
2005	27.1 %	1.1 %	207,294	765,158

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 that is inestimable or >20% and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	70.7 %	2.7 %	239,796	338,984
2013	72.2 %	2.6 %	246,514	341,428
2012	63.7 %	2.3 %	218,450	343,098
2011	61.3 %	2.7 %	213,239	347,888
2010	49.0 %	2.8 %	172,031	351,332
2009	47.8 %	2.7 %	175,404	367,087

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 95% confidence interval half-width/estimate > 0.6

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) - Female

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	58.8 %	3.8 %	346,257	588,802
2013	61.7 %	3.2 %	364,115	589,991
2012	56.0 %	3.6 %	333,275	595,307
2011	46.6 %	3.0 %	282,584	605,855
2010	56.2 %	3.4 %	345,502	614,347
2009	48.8 %	3.8 %	310,829	636,755

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Male

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	49.8 %	3.5 %	306,506	615,513
2013	38.6 %	3.1 %	238,089	616,868
2012	17.9 %	2.6 %	111,455	621,393
2011	6.4 %	1.4 %	40,463	632,743

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 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)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 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)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: New York

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	73.4	73.8	74.2	74.7	75.1	75.6

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	72.7 %	1.6 %	2,603,754	3,583,912
2013	72.9 %	1.4 %	2,626,463	3,603,633
2012	70.9 %	1.8 %	2,519,090	3,554,528
2011	70.1 %	1.6 %	2,448,481	3,495,201
2010	72.1 %	1.4 %	2,590,596	3,593,486
2009	70.1 %	1.7 %	2,524,914	3,600,765

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	91.0	91.0	92.0	93.0	94.0	94.5

FAD not available for this measure.

Field Level Notes for Form 10a NPMs:

None

NPM 5 - Percent of infants placed to sleep on their backs

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	77.0	77.0	77.8	78.9	80.0	80.5

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	68.9 %	2.0 %	73,310	106,442
2012	63.8 %	1.6 %	69,466	108,861
2011	70.0 %	1.2 %	152,776	218,387
2010	67.6 %	1.2 %	148,645	219,832
2008	73.4 %	1.7 %	83,268	113,422
2007	62.3 %	1.3 %	145,176	232,956

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% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	33.2	35.6	38.0	40.4	42.8	44.0

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	21.3 %	2.4 %	237,057	1,115,288
2007	11.7 %	2.2 %	134,616	1,152,859

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Child Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	27.1	27.5	27.8	28.1	28.5	29.0

Data Source: National Survey of Children's Health (NSCH) - CHILD

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	30.0 %	2.4 %	414,344	1,379,538
2007	33.7 %	2.8 %	470,174	1,393,525
2003	24.6 %	2.1 %	354,091	1,438,198

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Child Health) (Adolescent Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	27.1	27.5	27.8	28.1	28.5	29.0

Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.6 %	2.1 %	289,706	1,477,307
2007	22.1 %	2.1 %	341,421	1,542,976
2003	18.9 %	1.8 %	293,965	1,557,570

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	94.9	95.6	96.2	96.9	97.6	98.0

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	90.7 %	1.6 %	1,346,186	1,483,708
2007	94.3 %	1.0 %	1,460,432	1,549,163
2003	84.8 %	1.6 %	1,338,406	1,578,173

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	41.9	42.4	42.6	42.9	43.3	43.8

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	39.7 %	3.4 %	100,326	252,737
2005_2006	38.4 %	2.9 %	87,662	228,271

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 13 - A) Percent of women who had a dental visit during pregnancy

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	57.2	59.0	61.1	63.0	65.0	66.0

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	57.1 %	2.1 %	60,818	106,528
2012	48.2 %	1.6 %	53,882	111,710
2011	44.3 %	2.0 %	48,346	109,244
2010	44.1 %	2.0 %	48,670	110,432
2008	41.8 %	1.9 %	44,213	105,698

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% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 13 - B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	77.8	78.5	79.3	80.0	80.7	81.2

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	77.1 %	1.3 %	3,075,807	3,991,985
2007	80.8 %	1.3 %	3,350,192	4,148,736

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

Form 10a
State Performance Measures (SPMs)

State: New York

SPM 1 - The percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	45.0	48.0	51.0	53.0	56.0

Field Level Notes for Form 10a SPMs:

None

SPM 2 - The percentage of women aged 15 to 44 years that adopt or continue use of the most effective or moderately effective methods of contraception.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	8.0	10.0	12.0	14.0	16.0

Field Level Notes for Form 10a SPMs:

None

SPM 3 - The percentage of children and adolescents survey who demonstrate 20 or more developmental assets

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	50.0	50.0	52.0	55.0

Field Level Notes for Form 10a SPMs:

None

SPM 4 - The percent of families participating in the Early Intervention Program who meet or exceed the state's standard for the New York Impact on Family Scale

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	65.0	65.5	66.0	66.5	67.0

Field Level Notes for Form 10a SPMs:

None

SPM 5 - The percentage of NYS residents served by community water systems that have optimally fluoridated water

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	72.0	73.0	75.0	77.0	78.5

Field Level Notes for Form 10a SPMs:

None

Form 10a
Evidence-Based or-Informed Strategy Measures (ESMs)

State: New York

ESM 1.1 - Life Course - 13

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2.0	10.0	15.0	20.0	25.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.2 - Life Course - 14

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	10.0	30.0	40.0	50.0	60.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.3 - Life Course - 15

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	40.0	50.0	60.0	70.0	80.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.4 - Life Course - 16

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	40.0	50.0	60.0	70.0	80.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.5 - Life Course - 1

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 1.6 - Life Course - 2

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 1.7 - Life Course - 3

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.8 - Maternal Women's Health - 1

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 1.9 - Maternal Women's Health - 2

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 1.10 - Maternal Women's Health - 3

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.11 - Maternal Women's Health - 4

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	20.0	30.0	35.0	40.0	50.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.12 - Maternal Women's Health - 5

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	87.0	89.0	90.0	92.0	94.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.13 - Maternal Women's Health - 6

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 3.1 - Perinatal Infant Health - 2

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	0.0	50.0	100.0	100.0	100.0

Field Level Notes for Form 10a ESMs:

None

ESM 3.2 - Perinatal Infant Health - 5

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	75.0	80.0	85.0	90.0	95.0

Field Level Notes for Form 10a ESMs:

None

ESM 5.1 - Perinatal Infant Health - 1

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 5.2 - Perinatal Infant Health - 3

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	15.0	15.0	30.0	30.0	40.0

Field Level Notes for Form 10a ESMs:

None

ESM 5.3 - Perinatal Infant Health - 4

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	65.0	85.0	85.0	90.0	90.0

Field Level Notes for Form 10a ESMs:

None

ESM 5.4 - Perinatal Infant Health - 6

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.1 - Child Health - 1

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 6.2 - Child Health - 2

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	0.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.3 - Child Health - 3

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.4 - Child Health - 4

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.5 - Child Health - 5

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.6 - Life Course - 4

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.1 - Life Course - 10

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.2 - Life Course - 11

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.3 - Life Course - 12

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 10.2 - Adolescent Health - 1

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 10.1 - Life Course - 5

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.1 - Children with Special Health Care Needs - 1

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 12.2 - Children with Special Health Care Needs - 2

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.3 - Children with Special Health Care Needs - 3

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.4 - Children with Special Health Care Needs - 4

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	0.0	25.0	50.0	90.0	0.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Field Note: Grants will begin 1/1/18 and end 12/31/20	
2.	**Field Name:**	**2021**
	Field Note: Grants will begin 1/1/18 and end 12/31/20	

ESM 12.5 - Children with Special Health Care Needs - 5

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.6 - Children with Special Health Care Needs - 6

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.5	2.0	2.5	3.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.7 - Children with Special Health Care Needs - 7

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	45.0	60.0	70.0	75.0	78.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.9 - Adolescent Health - 2

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	0.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.8 - Adolescent Health - 3

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.10 - Adolescent Health - 4

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.11 - Adolescent Health - 5

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.1 - Life Course - 6

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	20.0	25.0	30.0	35.0	40.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.2 - Life Course - 7a

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	40.0	41.0	44.0	47.0	50.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.3 - Life Course - 7b

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.4 - Life Course - 7c

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 13.5 - Life Course - 8

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	10.0	10.0	20.0	25.0	30.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.6 - Life Course - 9

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

Form 10b
State Performance Measure (SPM) Detail Sheets

State: New York

SPM 1 - The percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy
Population Domain(s) – Women/Maternal Health

Goal:	Increase from baseline the percent of women aged 18 to 44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy.
Definition:	**Numerator:** Female BRFSS respondents 18 – 44 years old who are reproductively capable and who report ever talking with their health care provider about ways to prepare for a healthy pregnancy **Denominator:** All female BRFSS respondents 18-44 years old who are reproductively capable **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	N/A
Data Sources and Data Issues:	NYS BRFSS survey data In some survey years, number of respondents meeting criteria for this measure may be small.
Significance:	Incorporating preconception health care in routine health care for all women of reproductive age is critical to several NYS Title V priorities and strategies.

SPM 2 - The percentage of women aged 15 to 44 years that adopt or continue use of the most effective or moderately effective methods of contraception.
Population Domain(s) – Women/Maternal Health

<table>
<tr><td>Goal:</td><td>Increase from baseline the percent of women aged 15 to 44 years that adopt or continue use of the most effective or moderately effective methods of contraception</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Continuously enrolled female Medicaid recipients, 15-44 years of age, at risk for unintended pregnancy, initiating or continuing use of most or moderately effective contraception in the assessment period (year).</td></tr>
<tr><td>Denominator:</td><td>Continuously enrolled female Medicaid recipients, 15-44 years of age at risk for unintended pregnancy</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>FP – 16: Increase the percentage of women aged 15 to 44 years that adopt or continue use of the most effective or moderately effective methods of contraception. HP2020 uses the National Survey of Family Health to measure.</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>NYS proposes to use Medicaid claims data to measure. NYSDOH OQPS is creating a CMS Developmental Measure of most and moderately effective contraception use in females 15-44 years of age.

Baseline to be established and targets for improvement to be determined as part of implementation</td></tr>
<tr><td>Significance:</td><td>Unplanned and closely spaced pregnancies have less healthy maternal and infant outcomes. Increased rate of use of most/moderately effective contraception will help improve birth spacing and pregnancy planning. This is a shared priority for Title V and Medicaid in NYS.</td></tr>
</table>

SPM 3 - The percentage of children and adolescents survey who demonstrate 20 or more developmental assets
Population Domain(s) – Child Health

Goal:	Increase the percentage of children surveyed who demonstrate 20 or more developmental assets by 10% from baseline
Definition:	**Numerator:** Number of children and adolescents surveyed who demonstrate 20+ developmental assets **Denominator:** Number of children and adolescents surveyed **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	N/A
Data Sources and Data Issues:	Developmental assessment tool to be adopted/ established (tentative consideration for Search Institute tool)
Significance:	Positive social-emotional development and the presence of assets has been associated with positive health and wellbeing outcomes. Measurement of positive developmental assets among young people served by Title V Programs will provide a strong basis for informed youth development activities and interventions.

SPM 4 - The percent of families participating in the Early Intervention Program who meet or exceed the state's standard for the New York Impact on Family Scale
Population Domain(s) – Children with Special Health Care Needs

Goal:	Increase the percent of families participating in the Early Intervention Program who meet or exceed the state's standard for the New York Impact on Family Scale
Definition:	**Numerator:** Number of respondent families participating in Early Intervention who meet the State's standard (person mean >=576) on the New York Impact on Family Scale **Denominator:** Number of respondent families **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	N/A
Data Sources and Data Issues:	Data will be collected using the New York Family Survey, which includes the NYS Impact on Family Scale and is conducted annually with a representative sample of families whose children exited the Part C Early Intervention Program in the year.
Significance:	Positive impact on families, including families of CSHCN, is central to the mission of our Title V Program. This measure is associated with New York's State Systemic Improvement Plan approved by the U.S. Department of Education, Office of Special Education Programs and thus aligns Title V and Early Intervention goals. New York is one of five states focusing on improved family outcomes as part of results-driven accountability for Part C early intervention program for infants and toddlers with disabilities and their families.

SPM 5 - The percentage of NYS residents served by community water systems that have optimally fluoridated water
Population Domain(s) – Cross-Cutting/Life Course

Goal:	Increase the percentage of NYS residents served by community water systems that have optimally fluoridated water
Definition:	**Numerator:** Number of residents served by community water systems with optimal fluoride levels **Denominator:** Number of NYS residents served by community water systems **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	OH13- Increase the proportion of the US population served by community water systems with optimally fluoridated water
Data Sources and Data Issues:	CDC Water Fluoridated Reporting System
Significance:	Community water fluoridation reduces the prevalence and severity of tooth decay

Form 10b
State Outcome Measure (SOM) Detail Sheets

State: New York

No State Outcome Measures were created by the State.

Form 10c
Evidence-Based or –Informed Strategy Measure (ESM) Detail Sheets

State: New York

ESM 1.1 - Life Course - 13
NPM 1 – Percent of women with a past year preventive medical visit

Goal:	Develop and implement a data analysis plan to assess distribution of DFH/Title V resources and services through a health equity lens
Definition:	**Numerator:** Number of Title V programs with health equity analyses completed **Denominator:** N/A **Unit Type:** Count **Unit Number:** 25
Data Sources and Data Issues:	Title V Program records
Significance:	The Title V Program aims to enhance the visibility and application of these data to inform planning and decision-making across our programs. A review of best practice methods for data analysis, including consultation with partners in other program areas engaged in similar work, will be conducted to identify overall approaches to this strategy. Potential applications of resulting data include critical assessments of how distribution of MCH investments align with distribution of need as a factor in developing funding methodologies and review of characteristics of service recipients in relation to characteristics of communities to ensure services are provided equitably or prioritized to those most in need. (Please note: Health disparities will be analyzed for all NYS selected NPMs due to limitations of the system we are unable to reflect this on the form)

ESM 1.2 - Life Course - 14

NPM 1 – Percent of women with a past year preventive medical visit

Goal:	Build internal capacity within the Division of Family Health (DFH)/ Title V Program to advance health equity through all Title V programs
Definition:	**Numerator:** A) Number of Equity Action Team meetings held; B) Number of DFH staff who completed Equity Learning Labs **Denominator:** N/A **Unit Type:** Count **Unit Number:** 60
Data Sources and Data Issues:	Title V Program records DFH Personnel training records
Significance:	The Title V Program aims to create a highly trained workforce capable of better supporting the MCH Title V funded programs through staff engagement in understanding the systemic inequities both internally and externally. This will enable DFH staff to apply a health equity approach in each aspect of their work ultimately leading to improved overall health disparities in New York State. (Please note: Health disparities will be analyzed for all NYS selected NPMs, due to limitations of the system we are unable to reflect this on the form)

ESM 1.3 - Life Course - 15

NPM 1 – Percent of women with a past year preventive medical visit

Goal:	Integrate an equity framework into the development of all DFH/Title V procurements through community listening forums conducted as part of the concept development process.
Definition:	**Numerator:** Number of DFH procurements that include community listening forums as part of concept development process **Denominator:** Number of procurements released by DFH **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Title V Program records
Significance:	Understanding the myriad of social, political, and environmental factors that contribute to issues and factors that drive health disparities is a complex and ongoing task. By providing opportunities for that input in the earliest stages of program development, we will allow for the opportunity to refine the approach and scope of programs to better meet the needs of our priority populations while engaging and empowering affected populations.(Please note: Health disparities will be analyzed for all NYS selected NPMs, due to limitations of the system we are unable to reflect this on the form)

ESM 1.4 - Life Course - 16

NPM 1 – Percent of women with a past year preventive medical visit

Goal:	Incorporate evidence-based/-informed community engagement and collective impact strategies in all relevant DFH/Title V programs.
Definition:	**Numerator:** Number of DFH procurements that include evidence-based/-informed community engagement and collective impact strategies. **Denominator:** Number of procurements released by DFH **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Title V Program records
Significance:	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. This strategy aims to combine the strength of data-driven, evidence based programs and interventions with authentic community engagement opportunities in all DFH programs.(Please note: Health disparities will be analyzed for all NYS selected NPMs, due to limitations of the system we are unable to reflect this on the form)

ESM 1.5 - Life Course - 1

NPM 1 – Percent of women with a past year preventive medical visit

Goal:	Integrate performance standards, measures and improvement strategies related to health insurance enrollment across all Title V/ MCH programs.
Definition:	**Numerator:** Title V programs incorporate health insurance elements in program requirements **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Performance standards, measures and improvement strategies related to health insurance enrollment can be integrated across all Title V/ MCH programs.

ESM 1.6 - Life Course - 2

NPM 1 – Percent of women with a past year preventive medical visit

Goal:	Continue to support preconception/ reproductive health module within state's Behavioral Risk Factor Surveillance System (BRFSS), and produce focused reports of results to inform Title V program and partner strategies.
Definition:	**Numerator:** Analytic reports developed and shared **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	NYS Title V Program records
Significance:	The preconception/ reproductive health module within state's Behavioral Risk Factor Surveillance System (BRFSS) can help produce focused reports of results to inform Title V program and partner strategies.

ESM 1.7 - Life Course - 3

NPM 1 – Percent of women with a past year preventive medical visit

Goal:	Incorporate performance measures and strategies to reinforce use of well-woman care including pregnancy planning and prevention across core Title V programs serving women of reproductive age.
Definition:	**Numerator:** The number of relevant Title V programs that demonstrate incorporation of strategies to reinforce well-woman and preconception health care services **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Incorporation of performance measures and strategies can reinforce use of well-woman care including pregnancy planning and prevention across core Title V programs serving women of reproductive age.

ESM 1.8 - Maternal Women's Health - 1

NPM 1 – Percent of women with a past year preventive medical visit

Goal:	Continue maternal death case ascertainment and review process and issue reports of maternal death review findings and trends.
Definition:	**Numerator:** Maternal mortality report issued **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Mortality reports are needed to understand the causes of and contributing factors to maternal deaths to better focus prevention strategies.

ESM 1.9 - Maternal Women's Health - 2

NPM 1 – Percent of women with a past year preventive medical visit

Goal:	Expand surveillance and reporting activities to include severe maternal morbidity
Definition:	**Numerator:** Maternal morbidity surveillance initiated **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Studying severe maternal morbidity (SMM) is critical both to preventing maternal morbidity and to strengthening our understanding of maternal death. Incorporating SMM case identification and analysis in surveillance activities will inform clinical and community prevention activities led by both Title V and our partners.

ESM 1.10 - Maternal Women's Health - 3

NPM 1 – Percent of women with a past year preventive medical visit

Goal:	In collaboration with key partners, co-convene the New York State Partnership for Maternal Health to advance a comprehensive maternal health agenda that includes policy, community prevention and clinical quality improvement strategies.
Definition:	**Numerator:** Number of strategies implemented with the Partnership **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	Reports of Partnership activities, meeting minutes.
Significance:	Collaborative strategies in multiple settings must be implemented to improve the health of women of childbearing age.

ESM 1.11 - Maternal Women's Health - 4

NPM 1 – Percent of women with a past year preventive medical visit

Goal:	Collaborate with Medicaid to institute reimbursement for immediate postpartum insertion of LARC
Definition:	**Numerator:** Medicaid managed care organizations providing reimbursement for postpartum LARC insertion **Denominator:** The total number of Medicaid managed care organizations **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Medicaid Managed Care Program
Significance:	Managed care organizations need to cover postpartum LARC insertion to increase the number of women receiving this service which would decrease the number of unintended pregnancies.

ESM 1.12 - Maternal Women's Health - 5

NPM 1 – Percent of women with a past year preventive medical visit

Goal:	Collaborate with partners to increase screening and follow-up support for maternal depression.
Definition:	**Numerator:** Number of pregnant and postpartum women enrolled in Medicaid Managed Care who are screened for depression during a) prenatal and b) postpartum care. **Denominator:** The number of pregnant and postpartum women enrolled in Medicaid who are receiving prenatal and postpartum care **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Medicaid Prenatal Care Quality Improvement Project data (annual survey of a sample of Medicaid Managed Care prenatal care practices and a sample of their Medicaid prenatal patient population).
Significance:	Increases in screening for perinatal depression will result in increased referral and treatment rates for depression. Nearly 50% of pregnant women are enrolled in Medicaid in NYS.

ESM 1.13 - Maternal Women's Health - 6

NPM 1 – Percent of women with a past year preventive medical visit

Goal:	Participate in intra- and interagency groups developing response to increased opioid use to ensure maternal and child health perspectives and populations are addressed.
Definition:	**Numerator:** Number of Title V staff that participate in intra-and inter-agency groups developing response to opioid use **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	NYS Title V Program records (inter- and intra-agency workgroup minutes and reports)
Significance:	Title V staff need to participate in opioid workgroups to ensure pregnant and parenting women's needs are addressed in responses developed.

ESM 3.1 - Perinatal Infant Health - 2

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

Goal:	Update NYS perinatal regionalization standards and designations and implement updated performance measures for Regional Perinatal Centers and affiliate birthing hospitals.
Definition:	**Numerator:** Number Birthing Facilities Re-designated **Denominator:** Total Number Birthing Facilities in the state **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	NYS Title V Program records - current list of birthing facilities and updated list as birthing hospitals are re-designated.
Significance:	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. The last comprehensive review of NY's regionalized system was in the early 2000s.

ESM 3.2 - Perinatal Infant Health - 5

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

Goal:	Provide training & technical assistance to MIECHV & MICHC grantees to enhance competencies of home visitors & community health workers related to pre & interconception health smoking cessation substance abuse safe sleep & breastfeeding promotion.
Definition:	**Numerator:** Number of MIECHV-funded home visiting and MICHC community health worker staff trained in the identified competencies **Denominator:** Number of MIECHV home visitors and MICHC CHWs **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	MICHC and MIECHV program data
Significance:	Both MICHC and MIECHV are part of NY's core Title V infrastructure for reaching, engaging and supporting MCH populations, in particular high-need women, infants and families. These topics will be incorporated within training and other QI strategies for local MIECHV home visitors and MICHC community health workers to strengthen their competency and skill to work directly with families in these areas.

ESM 5.1 - Perinatal Infant Health - 1
NPM 5 – Percent of infants placed to sleep on their backs

Goal:	Develop and implement an expanded plan for analysis and reporting of infant mortality and selected morbidity data, and issue initial data report.
Definition:	**Numerator:** Initial infant mortality report issued. **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Public health surveillance and data analysis in each population health domain are an essential public health function to inform ongoing program and policy development, implementation and evaluation. As part of our action plan, Title V staff will review available sources of data and relevant methods to develop an updated plan for analysis and reporting of infant health data.

ESM 5.2 - Perinatal Infant Health - 3
NPM 5 – Percent of infants placed to sleep on their backs

Goal:	Continue to convene and lead structured statewide clinical quality improvement initiatives in birthing hospitals through the NYS Perinatal Quality Collaborative (NYSPQC).
Definition:	**Numerator:** Number of Birthing Facilities Participating in a Specific QI Project **Denominator:** Number of Birthing Facilities Eligible to Participate **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	NYS Title V Program records - list of birthing facilities participating in relevant projects
Significance:	The more facilities that are actively engaged in QI activities, the more rapidly improvements can be disseminated resulting in improvement of maternal and child health outcomes.

ESM 5.3 - Perinatal Infant Health - 4
NPM 5 – Percent of infants placed to sleep on their backs

<table>
<tr><td>Goal:</td><td>Work with local home visiting grantees to increase capacity of established programs through improvements in outreach, enrollment and retention of eligible families.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of clients enrolled in MIECHV-funded home visiting programs</td></tr>
<tr><td>Denominator:</td><td>Total number of clients that can be enrolled in MIECHV-funded home visiting programs based on funding</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Nurse-Family Partnership Efforts to Outcomes database and Healthy Families New York database

Note: data definition will be adjusted as needed to be aligned with new national MIEHCV performance measure, currently pending from HRSA MCHB</td></tr>
<tr><td>Significance:</td><td>When percent capacity is increased, more families are served and therefore benefit from enrollment in MIECHV-funded evidence-based home visiting programs.</td></tr>
</table>

ESM 5.4 - Perinatal Infant Health - 6
NPM 5 – Percent of infants placed to sleep on their backs

Goal:	Lead collaborative strategies to reduce sleep-related infant death
Definition:	**Numerator:** Number of strategies implemented **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	NYS Title V Program data
Significance:	Strengthening collaborations with internal and external partners ensures that safe sleep messages are as widely spread as possible.

ESM 6.1 - Child Health - 1

NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Goal:	Develop and implement a plan for analysis and reporting of available data on children's social-emotional well-being and adverse childhood experiences (ACES).
Definition:	**Numerator:** A data plan is developed and implemented **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	NYS Title V Program records
Significance:	As a fundamental starting point for public health work, population and program data are needed to help drive and evaluate work in this emerging area, both within Title V programs and with external partners.

ESM 6.2 - Child Health - 2

NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Goal:	Identify, pilot test and implement validated tool for measuring positive developmental social-emotional assets among children and adolescents that can be used across MCH child-serving programs.
Definition:	**Numerator:** Number of child-serving programs implementing an asset profile tool **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Research has demonstrated that children with more developmental assets are more likely to engage in positive behaviors and less likely to engage in negative behaviors; the NYS MCH programs will implement a validated tool to assess the children being served to identify and prioritize efforts to improve children's social emotional development.

ESM 6.3 - Child Health - 3

NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Goal:	Provide training for Title V staff and external partners, including local child-serving grantees, to increase: 1) awareness, knowledge, and skills to support children's social emotional development; and 2) trauma-informed care practices.
Definition:	**Numerator:** Number of DOH MCH staff and external partners trained on social-emotional wellness; and, Number of DOH MCH staff and external partners trained on trauma-informed care **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Providing DOH MCH staff and external partners training on social-emotional wellness and trauma-informed practices will increase capacity for supporting social-emotional development and wellbeing of children.

ESM 6.4 - Child Health - 4

NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Goal:	Identify, support and integrate evidence-based/-informed strategies to promote children's social-emotional wellness and positive developmental assets through established Title V programs.
Definition:	**Numerator:** Number of child-serving programs with evidence-based SE component **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Programs implementing evidence-based social-emotional components help strengthen developmental assets, self-awareness, relationship skills, decision-making skills, as well as attitudes about self, others, and education, which has been demonstrated to be positively associated with positive health outcomes.

ESM 6.5 - Child Health - 5

NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Goal:	Continue to provide subject matter and technical support to NY's Medicaid Health Home Program to implement enhanced care coordination for eligible children with serious emotional disturbance and complex trauma.
Definition:	**Numerator:** Number of children with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	NYS Medicaid Health Home Data
Significance:	Children enrolled in a Medicaid Health Home are more likely to access key health care services and receive coordinated care across multiple systems, which may lead to better health outcomes and reduction of unnecessary emergency room visits and hospital stays.

ESM 6.6 - Life Course - 4

NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Goal:	Collaborate with partners to improve developmental screening in NYS.
Definition:	**Numerator:** Number of strategies implemented to improve developmental screening **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	Title V Program Records
Significance:	The significant interest in developmental screening across many stakeholders and organizations in NYS creates both opportunity for collective impact as well as the challenge of coordinating and leveraging multiple partners and interests. The Title V Program is positioned to provide leadership in facilitating connections between partners and advancing collaborative strategies that span health insurance, health care and community-based settings and partners across the state.

ESM 8.1 - Life Course - 10

NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Goal:	Continue and increase Title V staff leadership and participation in the DOH Place-Based Initiative (PBI) work group.
Definition:	**Numerator:** A) Number of PBI workgroup meetings and B) Number of resources developed **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	Title V Program data
Significance:	Public health approaches aimed at supporting healthy communities are the focus of a new place based initiatives (PBI) multidisciplinary team within NYSDOH. Title V staff can play a significant role in this process

ESM 8.2 - Life Course - 11

NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Goal:	Enhance collaboration with key partners to advance changes in community environments that promote maternal and child health
Definition:	**Numerator:** Number of community changes demonstrated as a result of Title V collaborations **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	Title V Program data
Significance:	Enhanced collaboration with key partners will promote maternal and child health as part of larger community environmental change initiatives.

ESM 8.3 - Life Course - 12

NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Goal:	Establish or adopt an evidence-informed framework for structuring, measuring and improving collaboration at state and community levels, and provide support to strengthen both internal and external partner capacity to implement the framework across MC
Definition:	**Numerator:** Evidence-informed framework to structure and measure collaborative efforts is established/ identified; Internal and external partners trained in evidence-informed framework to structure & measure collaborative efforts. **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Title V Program data
Significance:	Measurement of collaborative effort will inform ongoing strategies

ESM 10.2 - Adolescent Health - 1

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

Goal:	Develop and implement a plan for analysis and reporting of available data on adolescent's social-emotional well-being and adverse childhood experiences (ACES), including Youth Risk Behavior Survey (YRBS) and forthcoming revised National Survey of Chi
Definition:	**Numerator:** A data plan is developed and implemented **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	NYS Title V Program records
Significance:	As a fundamental starting point for public health work, population and program data are needed to help drive and evaluate work in this emerging area, both within Title V programs and with external partners.

ESM 10.1 - Life Course - 5
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Goal:	With ACT For Youth Center of Excellence, convene focus groups & review literature to identify contributing factors & effective strategies for improving preventive health care service delivery to adolescents, with a focus on reducing disparities.
Definition:	**Numerator:** The number of focus groups conducted **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	NYS Title V Program records
Significance:	These focus groups can identify contributing factors and effective strategies for improving preventive health care service delivery to adolescents.

ESM 12.1 - Children with Special Health Care Needs - 1
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Goal:	Develop and implement a plan for analysis and reporting of CSCHN data for NYS, including forthcoming data from revised National Survey of Children's Health, and issue initial data report
Definition:	**Numerator:** A data plan is developed and implemented **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Title V Record of report issued
Significance:	Understanding of CSHCN health status, issues and service needs in NYS is essential for program planning

ESM 12.2 - Children with Special Health Care Needs - 2
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Goal:	Engage parents, families and providers in a system mapping exercise to identify the gaps and barriers in the system of public health programs and services for CSHCN and their families
Definition:	**Numerator:** Number of partners engaged in the systems mapping process **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	Title V Program records
Significance:	A comprehensive, family center integrated system of care is necessary to support CSHCN and their families. Creation of the systems map will inform Title V Programs of the access to availability of services for CSHCN and their families and will facilitate planning to improve supports and services. The number of partners participating in systems mapping will be recorded in units.

ESM 12.3 - Children with Special Health Care Needs - 3
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Goal:	Provide subject matter and technical support to NYS Medicaid Program to implement enhanced care coordination and transition support services for CSHCN through Children's Health Homes.
Definition:	**Numerator:** Actual number of Medicaid children 0-18 enrolled in Health Homes **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	NYS Office of Health Insurance Programs Health Home data.
Significance:	Enhanced care coordination provided within Health Homes aims to improve quality outcomes and the experience of care for CSHCN and their families by connecting and partnering with multiple systems involved in the child's care (Early Intervention, foster care, juvenile justice and the educational system).

ESM 12.4 - Children with Special Health Care Needs - 4
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Goal:	Provide grant funding and technical assistance to support successful transition to adult services for young adults with Sickle Cell Disease (SCD), and evaluate projects to identify best practices for enhancing transition support to other key CSHCN po
Definition:	**Numerator:** Number of AYA/SCD ages 12-21 that have an annual readiness assessment documented in their medical records. **Denominator:** Number of AYA/SCD registered in the practice **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Data Source: Sickle Cell Clinic patient registry of AYA/SCD ages 12-21 Data Issues: AYA/SCD may be sporadic attendees at a specific clinic. The database will need to be continually updated to track those 12 year-olds entering transition and those 18 – 21 year-olds transitioning out.
Significance:	Assessment of readiness of AYA/SCD can identify gaps in knowledge about their disease, daily care, response to crises and ability to communicate with hospital and emergency personnel who may be unfamiliar with the presentation of SCD.

ESM 12.5 - Children with Special Health Care Needs - 5
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Goal:	Collaborate with University Centers for Excellence in Developmental Disabilities Education, Research, & Service (UCEDD) and other stakeholders implement NY's IDEA Part C State Systemic Improvement Plan (SSIP).
Definition:	**Numerator:** Number of best practice strategies for improving family outcomes documented through evidence-based review and learning collaboratives. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	Data sources will for this measure will be a catalogue of evidence-based family-centered services prepared by Department contractors; and, process measures to be collected by learning collaboratives convened to improve family-centered service delivery.
Significance:	This measure is associated with New York's State Systemic Improvement Plan approved by the U.S. Department of Education, Office of Special Education Programs. New York is one of five states focusing on improved family outcomes as part of results-driven accountability for Part C early intervention program for infants and toddlers with disabilities and their families.

ESM 12.6 - Children with Special Health Care Needs - 6
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Goal:	Use EI family survey data to inform CSHCN Program, of the needs of families transitioning from EI to CSHCN Program in order to better coordinate services.
Definition:	**Numerator:** Number of children in the Part C EIP transitioning to Preschool Special Education with a referral to local CSHCN Program. **Denominator:** Number of children in the EIP transitioned to Preschool Special Education **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	NYS DOH Children with Special Health Care Needs Program data, and NYS DOH Early Intervention Program data.
Significance:	A warm handoff between programs within a local Health Department will assist families as they transition from Part C EIP to Preschool Special Education.

ESM 12.7 - Children with Special Health Care Needs - 7
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Goal:	Provide technical assistance and facilitate a structured quality improvement project to engage health care providers, parent representatives, & audiologists to improve reporting of initial hearing screening and follow up results into the NYEHDI-IS.
Definition:	**Numerator:** Number of infants who receive a follow-up hearing screening, diagnostic evaluation or referral to Early Intervention that is documented in NYEHDI-IS **Denominator:** Number of infants who receive an abnormal newborn hearing screening. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	NYEHDI System Data
Significance:	Infants with abnormal hearing screening will have follow-up.

ESM 12.9 - Adolescent Health - 2

NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Goal:	Identify, pilot test and implement a framework and validated tool for measuring developmental social-emotional assets among children and adolescents that can be used across MCH programs.
Definition:	**Numerator:** Number of adolescent-serving programs implementing an asset profile tool **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Research has demonstrated that adolescents with more developmental assets are more likely to engage in positive behaviors and less likely to engage in negative behaviors; the NYS MCH programs will implement a validated tool to assess the adolescents being served to identify and prioritize efforts to improve adolescent's social emotional development.

ESM 12.8 - Adolescent Health - 3

NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Goal:	Provide training for Title V staff and external partners, including local adolescent-serving grantees, to increase awareness, knowledge, and skills to support: 1) adolescents' social emotional development and 2) trauma-informed care practices.
Definition:	**Numerator:** A) Number of DOH MCH staff and external partners trained on social-emotional wellness; B) Number of DOH MCH staff and external partners trained on trauma-informed care **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Providing DOH MCH staff and external partners training on social-emotional wellness and trauma-informed practices will increase capacity for supporting social-emotional development and wellbeing of adolescents.

ESM 12.10 - Adolescent Health - 4

NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Goal:	Identify, support and integrate evidence-based/-informed strategies to promote adolescents' social-emotional wellness and positive developmental assets through established Title V programs
Definition:	**Numerator:** Number of child-serving programs with evidence-based SE component **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Programs implementing evidence-based social-emotional components help strengthen developmental assets, self-awareness, relationship skills, decision-making skills, as well as attitudes about self, others, and education, which has been demonstrated to be positively associated with positive health outcomes.

ESM 12.11 - Adolescent Health - 5

NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

<table>
<tr><td>Goal:</td><td>Continue to provide subject matter and technical support to NY’s Medicaid Health Home Program to implement enhanced care coordination and transition supports for eligible youth and young adults with serious emotional disturbance and complex trauma.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home; Number with documented serious emotional disturbance and/or complex trauma who are transitioned to adult-serving Health Homes.</td></tr>
<tr><td>Denominator:</td><td>N/A</td></tr>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>1</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>NYS Medicaid Health Home Data</td></tr>
<tr><td>Significance:</td><td>Adolescents enrolled in a Medicaid Health Home and successfully transitioned to adult-serving Health Homes are more likely to access key health care services and receive coordinated care across multiple systems, which may lead to better health outcomes and reduction of unnecessary emergency room visits and hospital stays.</td></tr>
</table>

ESM 13.1 - Life Course - 6

NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Goal:	Provide financial and technical support for maintenance and expansion of community water fluoridation.
Definition:	**Numerator:** Number of public water systems that receive financial and/or technical support from NYSDOH **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	NYS Title V Program records
Significance:	CWF improves oral health by reducing the prevalence and severity of tooth decay. DOH provides financial and other technical assistance directly and via contractor to support local water systems.

ESM 13.2 - Life Course - 7a

NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

<table>
<tr><td>Goal:</td><td>Increase the delivery of evidence-based preventive dental services across key settings:
• school-based clinics
• primary care practices
• public health nutrition programs.</td></tr>
<tr><td>Definition:</td><td><table>
<tr><td>Numerator:</td><td>Number of 2nd and 3rd grade children who received sealants in School-Based Health Center – Dental (SBHC-D)</td></tr>
<tr><td>Denominator:</td><td>Number of children in 2nd and 3rd grade who are enrolled in SBHC-D programs</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>SEALS/ CDC Data</td></tr>
<tr><td>Significance:</td><td>Evidence based programs such as school-based or linked dental sealant programs have the potential to reduce the burden of oral diseases.</td></tr>
</table>

ESM 13.3 - Life Course - 7b

NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

<table>
<tr><td>Goal:</td><td>Increase the delivery of evidence-based preventive dental services across key settings:
• school-based clinics
• primary care practices
• public health nutrition programs</td></tr>
<tr><td>Definition:</td><td><table>
<tr><td>Numerator:</td><td>Number of Medicaid claims for fluoride varnish for children ages 0-5</td></tr>
<tr><td>Denominator:</td><td>N/A</td></tr>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>1</td></tr>
</table></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>CMS Medicaid Claims Data</td></tr>
<tr><td>Significance:</td><td>Dental caries, or tooth decay, is the most common chronic disease among children, dental care being the greatest unmet service need. If untreated, dental caries is often painful and can disrupt learning, school performance and daily activities. In extreme cases, dental caries is fatal. Dental care accounts for almost 15 percent of all health care expenditures among school-aged children. Insurance coverage is uneven and out-of-pocket expense is significant.</td></tr>
</table>

ESM 13.4 - Life Course - 7c

NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Goal:	Increase the delivery of evidence-based preventive dental services across key settings: • school-based clinics • primary care practices • public health nutrition programs
Definition:	**Numerator:** Collaborative plan is adopted **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Partnering with providers across a variety of settings can enhance the delivery of evidence-based services to underserved children, including those who may not access dental care in traditional settings. Public health nutrition programs are a promising setting for promotion/ reinforcement of tooth brushing and other family oral hygiene practices.

ESM 13.5 - Life Course - 8

NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

<table>
<tr><td>Goal:</td><td>Integrate oral health messages and strategies within existing community-based maternal and infant health programs.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of pregnant women served by the Title V community health workers that have a documented screening or referral for dental services</td></tr>
<tr><td>Denominator:</td><td>Number of pregnant women served by Title V community health workers</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Reports from MICHC grant (Bureau of Women, Infant and Adolescent Health)</td></tr>
<tr><td>Significance:</td><td>Our current pilot project promotes community-level systems changes to integrate oral hygiene practices and information about services within MICHC and link families with dental services. Successful strategies gleaned from this initiative will be disseminated to other MICHC, and potentially other home visiting projects.</td></tr>
</table>

ESM 13.6 - Life Course - 9

NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Goal:	Strengthen Title V internal capacity, dental public health core competencies and workforce development for oral health surveillance and evidence-based interventions through continued support for NYS Dental Public Health Residency.
Definition:	**Numerator:** Number of dental public health residents w/ completed dental residency projects utilizing data systems in past year **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	NYS Title V Program and Preventive Dental Residents Program Records
Significance:	Enhancement and expansion of the current system will provide an increase in the number of public health dentists with the capacity to perform data analysis and oral health surveillance. Residents build public health competencies to help them address data needed to identify problems, set priorities, establish quality improvement measures and assess progress toward goals and objectives.

Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: New York

Form Notes for Form 10d NPMs and SPMs

None

NPM 01 - The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

	2011	2012	2013	2014	2015
Annual Objective	100.0	88.5	89.4	99.0	99.0
Annual Indicator	86.8	98.8	97.9	96.4	96.4
Numerator	3,300	2,988	2,906	2,791	2,791
Denominator	3,800	3,024	2,967	2,894	2,894
Data Source	Newborn Screening	Newborn Screening	Newborn Screening	Newborn Screening	Newborn Screening
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Please note: 103 infants were lost to follow up. All cases were closed	
2.	**Field Name:**	**2013**
	Field Note: As shown in the table, the numerator is the number of closed cases with documentation of an evaluation, diagnostic testing and a diagnosis as appropriate. The denominator is the number of screen positive newborns for the year. The program follows all screen positive newborns to ensure they receive appropriate follow-up.	
3.	**Field Name:**	**2012**

Field Note:
As shown in the above table, the numerator is the number of closed cases of screen positive newborns with documentation of an evaluation, diagnostic testing and a diagnosis as appropriate. The denominator is the number of screen positive newborns for the year. The program follows all screen positive newborns to ensure they receive appropriate follow-up.

The remaining open 2011 cases represent complicated patients with ongoing diagnostic evaluations. The Newborn Screening (NBS) Program has obtained confirmation that the patients are in care, but a definitive diagnosis is not available. The annual indicator improved significantly from 2010 to 2011 because routine meetings to review open cases were initiated. The number of lost-to-follow-up cases, where documentation of an ongoing evaluation, diagnostic testing and a diagnosis could not be obtained, remained consistent between 2010 (365 cases) and 2011 (381 cases).

2012 data is pending because the standard diagnostic evaluation for some of the disorders takes up to 6 months; therefore, the annual indicator would not be reliable if reported at this time. 2011 data are used as a proxy for 2012. 2012 data will be available in late 2013.

4. **Field Name:** **2011**

Field Note:
As shown in the above table, the numerator is the number of closed cases with documentation of an evaluation, diagnostic testing and a diagnosis as appropriate. The denominator is the number of screen positive newborns for the year. The program follows all screen positive newborns to ensure they receive appropriate follow-up.

The annual indicator is lower for 2010 than 2009 because in some cases, a definitive diagnosis is pending, but confirmation of an ongoing evaluation has been obtained by the Program. Lost-to-follow-up cases, where documentation of an evaluation, diagnostic testing and a diagnosis could not be obtained, remained consistent between 2009 (317 cases) and 2010 (365 cases). Therefore, it is anticipated that the annual indicator for 2010 will increase once the pending cases are resolved.

2011 data is pending because the standard diagnostic evaluation for some of the disorders takes up to 6 months; therefore, the annual indicator would not be a reliable if reported at this time. 2010 data are used as a proxy for 2011. 2011 data will be available in late 2012.

Data Alerts: None

NPM 02 - The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

	2011	2012	2013	2014	2015
Annual Objective	59.6	65.7	66.3	67.0	64.4
Annual Indicator	64.4	64.4	64.4	64.4	64.4
Numerator					
Denominator					
Data Source	CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

5. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

NPM 03 - The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	45.7	39.2	39.6	39.9	40.3
Annual Indicator	38.4	38.4	38.4	38.4	38.4
Numerator					
Denominator					
Data Source	CSHCN survey	CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

NPM 04 - The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	62.7	57.9	58.5	59.1	59.6
Annual Indicator	56.8	56.8	56.8	56.8	56.8
Numerator					
Denominator					
Data Source	CSHCN survey	CSHCN survey	CSHCN Survey	CSHCN Survey	CSHCN Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
2.	**Field Name:**	**2014**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
3.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. Due to the data generated by the new survey, previously established performance objectives prior to 2011 are not realistic and targets for upcoming years were decreased. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

NPM 05 - Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	91.5	66.9	67.6	68.2	68.9
Annual Indicator	65.6	65.6	65.6	65.6	65.6
Numerator					
Denominator					
Data Source	CSHCN survey	CSHCN survey	CSHCN Survey	CSHCN Survey	CSHCN Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. Due to the data generated by the new survey, previously established performance objectives prior to 2011 are not realistic and targets for upcoming years were decreased. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

NPM 06 - The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

	2011	2012	2013	2014	2015
Annual Objective	38.8	40.5	40.9	41.3	41.7
Annual Indicator	39.7	39.7	39.7	39.7	39.7
Numerator					
Denominator					
Data Source	CSHCN survey	CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

CDC current schedule for the next data collection of these data are in 2014.

2. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

CDC current schedule for the next data collection of these data are in 2014.

3. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

CDC current schedule for the next data collection of these data are in 2014.

4. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator the 2009-10 survey. Therefore, the 2005-06 and 2009-10 surveys can be compared. Due to NY's success in achieving this performance measure, the annual performance objective has been increased over previously established targets. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. 2011 data is being used as a proxy for 2012.

5.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

NPM 07 - Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

	2011	2012	2013	2014	2015
Annual Objective	72.9	73.6	74.4	75.1	76.2
Annual Indicator	74.2	72.9	76.2	73.4	73.4
Numerator					
Denominator					
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

   Field Note:
   2014 data are being used as a proxy for 2015 data

2. **Field Name:** **2012**

   Field Note:
   Data is from the National Immunization Survey, 2001, conducted by the CDC. Although NYS as a whole has improved statewide, NYC is 75.9 and Rest of State at 72.6, and is below the national average of 78.7. However, these results may be impacted, in part, due to changes in the survey methodology. Decreasing prevalence of families with land lines (the NIS is a telephone survey) and a small sample size contribute to the variability of the results. 2011 data are used as a proxy for 2012 data.

3. **Field Name:** **2011**

   Field Note:
   The National Immunization Survey rates have decreased, in part, due to changes in the survey methodology. Decreasing prevalence of families with land lines (the National Immunization Survey is a telephone survey) and a small sample size contribute to the variability of the results. 2010 data are used as a proxy for 2011 data. It is estimated that final 2011 immunization data will be available from CDC in late 2012 or early 2013. NYS exceeds the HP 2020 baseline of 68% for the proportion of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and PCV vaccines but is below the target of 80%.

Data Alerts: None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	12.0	11.0	10.0	9.4	9.3
Annual Indicator	10.1	9.5	8.2	7.2	7.2
Numerator	3,811	3,500	2,972	2,571	
Denominator	376,774	369,426	360,940	357,564	
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**

Field Note:
2014 data are being used as a proxy for 2015 data

Data Alerts: None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	40.9	42.7	43.5	44.4	45.3
Annual Indicator	41.9	42.6	42.6	42.6	42.6
Numerator		2,881	2,881	2,881	2,881
Denominator		6,758	6,758	6,758	6,758
Data Source	NYS 3rd Grade Dental Survey	NYS 3rd Grade Surviellance Survey	NYS 3rd Grade Or Health Surveillance Project	NYS 3rd Grade Or Health Surveillance Project	NYS 3rd Grade Or Health Surveillance Project
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

   Field Note:
   2013 data are being used as a proxy for 2014 data

2. **Field Name:** **2013**

   Field Note:
   The NY 3rd Grade Oral Health Surveillance Project (OHSP) is ongoing in both Upstate and NYC schools. Analysis of the data on 6,750 open mouth examinations as part of the second cycle has been completed. A report for the 2009-2012 cycle is being compiled. 2012 data is being used as a proxy for 2013 data.

3. **Field Name:** **2012**

   Field Note:
   The NY 3rd Grade oral health surveillance project is currently underway in NYC schools. The Upstate NY component of the surveillance project, which had originally been completed in early 2011, is continuing, with additional schools being surveyed. Data for 2011 and 2012 are provisional as a result of continuation of the 3rd Grade Oral Health Surveillance Project. Data for 2010 are used as a proxy for 2011 since an updated analysis of the data is not available. Data show that the prevalence of sealants in Upstate school children has increased. However, it falls short of the national performance measure. Due to NY's success in achieving this performance measure in ROS, annual performance objectives were increased over previously established targets by approximately 2% per year. These increases are consistent with the NYS Prevention Agenda, which sets as a target a 10% increase in sealant utilization over a five-year period.

4.	**Field Name:**	**2011**

Field Note:
The NY 3rd Grade oral health surveillance project is currently underway in New York City (NYC) schools. The upstate NY component of the surveillance project was completed in 2011.
*Weighted to reflect the population distribution

Data show that the prevalence of sealants in Upstate school children has increased. However, it falls short of the national performance measure.

Data Alerts: None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	1.0	1.3	0.8	1.0	0.9
Annual Indicator	0.8	1.2	1.1	0.9	0.9
Numerator	29	43	40	30	
Denominator	3,515,032	3,508,643	3,502,059	3,498,359	
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: 2014 data are being used as a proxy for 2015 data	
2.	**Field Name:**	**2012**
	Field Note: The number of motor vehicle deaths is based on the definition used by the DOH Bureau of Biometrics and Health Statistics and includes pedestrians and cyclists. The definition changed in 2004; prior to that time, pedestrians and cyclists were not included.	
3.	**Field Name:**	**2011**
	Field Note: The number of motor vehicle deaths is based on the definition used by the DOH Bureau of Biometrics and Health Statistics and includes pedestrians and cyclists. The definition changed in 2004; prior to that time, pedestrians and cyclists were not included.	

Data Alerts: None

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	47.9	48.3	53.9	54.0	54.2
Annual Indicator	47.7	53.7	52.6	55.8	60.6
Numerator					
Denominator					
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: 2015 data represents the 2012 birth cohort. NIS data collection system results are based on dual sampling land line and cellular phone	
2.	**Field Name:**	**2014**
	Field Note: 2014 data represents the 2011 birth cohort. NIS data collection system results are based on dual sampling land line and cellular phone	
3.	**Field Name:**	**2013**
	Field Note: Data Source: National Immunization Survey 2013 data represents the 2010 birth cohort.	
4.	**Field Name:**	**2012**
	Field Note: 2012 data represents the 2009 birth cohort.	
5.	**Field Name:**	**2011**
	Field Note: 2011 data represents the 2008 birth cohort.	

Data Alerts: None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	99.5	84.1	84.1	88.7	95.3
Numerator	229,377	201,126	201,126	210,851	198,921
Denominator	230,608	239,224	239,224	237,775	208,795
Data Source	Newborn Screening	Newborn Hearing Screening	Newborn Hearing Screening Program	Newborn Hearing Screening Program	Newborn Hearing Screening Program
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2013**
	Field Note: 2012 data are being used as a proxy for 2013 data.	
2.	**Field Name:**	**2012**
	Field Note: Due to the lag in data collection and reporting, 2011 data are used as a proxy for 2012 data. These data are incomplete. Ten hospitals have not submitted their quarterly aggregate data. Therefore, approximately 8,000 to 10,000 births are missing hearing screening data and therefore, 2010 data cannot be compared with 2011 data. Hospitals are no longer required under NY public health law to submit aggregate reports. New York Early Hearing Detection and Intervention (NYEHDI) is transitioning to the collection of individual level hearing screening data.	
3.	**Field Name:**	**2011**
	Field Note: 2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.	

Data Alerts: None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	7.4	7.4	6.5	6.4	6.3
Annual Indicator	6.6	5.6	4.0	3.3	3.3
Numerator	284,000	240,000	171,000	138,000	
Denominator	4,291,000	4,267,000	4,231,000	4,217,000	
Data Source	Current Population Survey	Current Population Survey	US Census American Community Survey	US Census American Community Survey	US Census American Community Survey
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: 2014 data are being used as a proxy for 2015 data	
2.	**Field Name:**	**2013**
	Field Note: Data source has changed to US Census American Community Survey	

Data Alerts: None

NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

	2011	2012	2013	2014	2015
Annual Objective	31.5	31.2	30.3	29.4	29.2
Annual Indicator	31.2	30.4	30.3	29.7	29.7
Numerator	72,042	58,819	67,097	62,265	
Denominator	230,903	193,464	221,688	209,767	
Data Source	PedNSS	PedNSS	PedNSS	PedNSS	PedNSS
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

   Field Note:
   2014 data are being used as a proxy for 2015 data

Data Alerts: None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	8.1	7.1	6.9	6.0	5.8
Annual Indicator	6.2	6.2	6.4	6.4	6.4
Numerator					
Denominator					
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: 2013 PRAMS provisional estimates as of July 1, 2016	
2.	**Field Name:**	**2014**
	Field Note: 2012 data are being used as a proxy for 2014 data.	
3.	**Field Name:**	**2013**
	Field Note: 2012 data are being used as a proxy for 2013 data.	
4.	**Field Name:**	**2012**
	Field Note: 2011 data is being used as a proxy for 2012.	
5.	**Field Name:**	**2011**
	Field Note: Numerator and denominator data are not available (survey data). Previous data reported for 2006-2007 were for NYS (Excluding NYC). CDC has recently provided statewide statistics for this indicator. The comparble NYS percentages for 2006 and 2007 are 8.5% and 9.1%, respectively.	

Data Alerts: None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	4.2	4.5	5.9	5.8	5.7
Annual Indicator	6.1	6.0	4.2	5.1	5.1
Numerator	81	78	54	64	
Denominator	1,324,252	1,307,947	1,279,772	1,262,862	
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: 2014 data are being used as a proxy for 2015 data	

Data Alerts: None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	91.0	91.3	91.7	92.0	92.4
Annual Indicator	90.7	88.6	89.5	92.3	92.3
Numerator	3,131	3,104	2,861	2,970	
Denominator	3,453	3,505	3,197	3,219	
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

   Field Note:
   2014 data are being used as a proxy for 2015 data

Data Alerts: None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	74.0	74.8	75.5	76.2	77.0
Annual Indicator	72.9	73.8	74.7	75.1	75.1
Numerator	167,091	171,806	171,098	172,848	
Denominator	229,052	232,710	229,141	230,180	
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: 2014 data are being used as a proxy for 2015 data	
2.	**Field Name:**	**2014**
	Field Note: VS PNC Methodology Change: calculation of trimester has been revised to incorporate the clinical gestation date for records with unknown PNC start date. As the result – 2,000 records were added to the calculation of the indicators.	
3.	**Field Name:**	**2013**
	Field Note: Methodology Change: calculation of trimester has been revised to incorporate the clinical gestation date for records with unknown PNC start date. As the result – 2,000 records were added to the calculation of the indicators.	
4.	**Field Name:**	**2011**
	Field Note: The denominator is the total number of births for which prenatal care initiation is known and excludes births where trimester of entry into prenatal care is unknown.	

Data Alerts: None

Form 10d
State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: New York

SPM 1 - The percentage of infants born to Black and Hispanic women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	64.9	65.6	66.2	66.9	66.9
Annual Indicator	65.2	66.7	66.9	67.0	67.0
Numerator	58,996	60,402	59,127	59,113	59,113
Denominator	90,516	90,533	88,435	88,170	88,170
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

Field Note:
2014 data are being used as a proxy for 2015 data

Data Alerts: None

SPM 2 - The percentage of Medicaid enrolled children between the ages of 3 and 6 years who had a well-child and preventive health visit in the past year

	2011	2012	2013	2014	2015
Annual Objective	79.5	79.9	80.4	80.9	81.4
Annual Indicator	80.0	83.0	82.0	83.0	84.0
Numerator					
Denominator					
Data Source	NYS Quality Assurance Reporting Requirements	NYS Quality Assurance Reporting Requirements	NYS Quality Assurance Reporting Requirements	eQARR Child Preventive Care-Statewide-Medicaid Managed Care	eQARR Child Preventive Care-Statewide-Medicaid Managed Care
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2013**

   Field Note:
   These data represent children in this age group who are enrolled in the Medicaid Managed Care (MMC) which includes 88% of all children enrolled in Medicaid. Information on children enrolled in Medicaid fee-for-service is not included. Numerator and denominator data are not available (survey data).

2. **Field Name:** **2012**

   Field Note:
   These data represent children in this age group who are enrolled in the Medicaid Managed Care (MMC) which includes 88% of all children enrolled in Medicaid. Information on children enrolled in Medicaid fee-for-service is not included. Numerator and denominator data are not available (survey data).

3. **Field Name:** **2011**

   Field Note:
   These data represent children in this age group who are enrolled in the Managed Care type of Medicaid coverage which includes 87% of all children. Information on children enrolled in Medicaid fee-for-service is not included.

   Numerator and denominator data are not available (survey data).

Data Alerts: None

SPM 3 - The ratio of the Black infant low birth weight rate to the White infant low birth weight rate

	2011	2012	2013	2014	2015
Annual Objective	1.9	1.9	1.8	1.8	1.6
Annual Indicator	1.8	1.8	1.6	1.8	1.8
Numerator	13	12	13	12	
Denominator	7	7	8	7	
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

   Field Note:
   2014 data are being used as a proxy for 2015 data

Data Alerts: None

SPM 4 - The percentage of high school students who were overweight or obese

	2011	2012	2013	2014	2015
Annual Objective	26.3	26.1	25.8	25.5	25.3
Annual Indicator	25.7	25.7	24.4	24.4	27.0
Numerator					
Denominator					
Data Source	YRBS	YRBS	YRBS	YRBSS	YRBSS
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: The YRBS is conducted biannually, 2015 data as of June 9, 2016	
2.	**Field Name:**	**2014**
	Field Note: 2013 estimate. The YRBS is conducted biannually	

Data Alerts: None

SPM 5 - The ratio of the Hispanic teen (ages 15-17) pregnancy rate to the non-Hispanic White teen (ages 15-17) pregnancy rate

	2011	2012	2013	2014	2015
Annual Objective	5.2	4.5	4.5	4.4	4.4
Annual Indicator	4.5	4.4	4.4	4.7	4.7
Numerator	42			3	
Denominator	9			1	
Data Source	Vital Statistics	Vital Statistics	Vital Statistics	Vital Records	Vital Records
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

None

Data Alerts: None

SPM 6 - Percent of High School Students Who Smoked Cigarettes in the Last Month

	2011	2012	2013	2014	2015
Annual Objective	12.5	12.3	12.2	12.1	12.0
Annual Indicator	12.5	11.9	11.9	7.3	7.3
Numerator					
Denominator					
Data Source	YRBS	NYS Youth Tobacco Survey	NYS Youth Tobacco Survey	NYS Youth Tobacco Survey	NYS Youth Tobacco Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: 2014 estimate. NYS Youth Tobacco Survey is collected biannually.	
2.	**Field Name:**	**2013**
	Field Note: 2012 estimate. NYS Youth Tobacco Survey is collected bi-annually.	
3.	**Field Name:**	**2012**
	Field Note: The YRBS and YTS are conducted biannually in alternating years. The numerator for each year and both surveys is the number of high school students who reportedly smoked on one or more days in the past 30 days. The denominator for each year and both surveys is the total number of students in grades 9 through 12.	

Data Alerts: None

SPM 7 - The percentage of Medicaid enrolled children and adolescents between the ages of 2-21 years who had at least one dental visit within the last year

	2011	2012	2013	2014	2015
Annual Objective	41.4	41.8	42.2	42.6	43.1
Annual Indicator	41.8	44.2	45.4	43.6	48.1
Numerator	835,106	814,503	873,813	956,873	1,013,625
Denominator	1,996,387	1,841,199	1,924,213	2,197,024	2,108,741
Data Source	Bur of MA Statistics	Bureau of MA Statistics	Bureau of Mediciad Statistics & Program Analysis	Bureau of Mediciad Statistics & Program Analysis	Bureau of Medical Statistics and Program Analysis
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2012**

   Field Note:
   This indicator is based on data for all Medicaid recipients, including managed care and family health plus paid claims as of June 2012

2. **Field Name:** **2011**

   Field Note:
   This indicator is based on information from both Managed Care and Fee-for- Sevice Medicaid Programs.

Data Alerts: None

SPM 8 - Percentage of children who were tested for lead two or more times before the age of three.

	2011	2012	2013	2014	2015
Annual Objective	51.0	51.5	52.0	52.5	53.0
Annual Indicator	55.0	57.6	55.1	56.3	56.3
Numerator	137,431	142,143	133,862	135,012	
Denominator	249,655	246,592	242,914	239,736	
Data Source	NYS Lead Program	NYS Lead Program	NYS Lead Program	NYS Lead Program	NYS Lead Program
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: 2014 data is being used as a proxy for 2015	
2.	**Field Name:**	**2014**
	Field Note: 2011 Birth Cohort preliminary data as of 6/20/2016. Latter dated 2014 estimates may differ from these results.	
3.	**Field Name:**	**2013**
	Field Note: NYS Lead Program 2010 Birth Cohort	

Data Alerts: None

SPM 9 - Hospitalization Rate for Asthma in Children Ages 0 to 17 years.

	2011	2012	2013	2014	2015
Annual Objective	31.0	26.5	26.4	26.3	26.2
Annual Indicator	26.5	26.8	25.9	27.6	27.6
Numerator	11,341	11,406	10,986	11,660	
Denominator	4,286,008	4,263,154	4,239,976	4,228,906	
Data Source	SPARCS	SPARCS	SPARCS	SPARCS as of Feb. 2016	SPARCS as of Feb. 2016
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: 2014 data are being used as a proxy for 2015 data	
2.	**Field Name:**	**2014**
	Field Note: 2013 data are being used as a proxy for 2014 data.	

Data Alerts: None

SPM 10 - The percentage of infants who were exclusively fed breast milk between birth and hospital discharge

	2011	2012	2013	2014	2015
Annual Objective	43.1	43.6	44.0	44.4	44.8
Annual Indicator	39.8	40.6	41.9	43.1	43.1
Numerator	86,126	87,554	88,663	91,919	
Denominator	216,625	215,852	211,699	213,358	
Data Source	Statewide Perinatal Data System	Statewide Perinatal Data System	Statewide Perinatal Data System	Vital Records	Vital Records
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

   Field Note:
   2014 data are being used as a proxy for 2015 data

2. **Field Name:** **2012**

   Field Note:
   The denominator includes all live born infants, excluding infants who were admitted to the NICU or transferred in or out of the hospital. The method the infant is fed is recorded on the Certificate of Live Birth and is defined as the period between birth and discharge from the hospital, up until 5 days of age (when NYS law requires report of live births). Infants are classified as being fed exclusively breast milk if they were fed only breast milk, and no other liquids or solids except for drops or syrups consisting of vitamins, minerals or medications.

   It should be noted that the percentage of infants exclusively fed breast milk in the delivery hospital appears to have decreased from 43.5% in 2010 to 39.8% in 2011. Efforts were made to improve and standardize the reporting for the infant feeding variables, including exclusively fed breast milk. Guidance from the National Center for Health Statistics, that newborn infant feeding data should be reported for the entire period spent in the delivery hospital (i.e., between birth and discharge), was shared with hospitals. Some hospitals had been reporting infant feeding based only on the last 24 hours or the last day of hospitalization. This change in reporting resulted in a reduction in the percentage of infants reported as being exclusively fed breast milk.

3. **Field Name:** **2011**

Field Note:
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

Data Alerts: None

Form 11
Other State Data

State: New York

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the current application/annual report.

State Action Plan Table

State: New York

Please click the link below to download a PDF of the full version of the State Action Plan Table.
State Action Plan Table

State Action Plan Table

State: New York

Domain: Maternal & Women's Health (MWH)			
State Priority #1: Reduce maternal mortality & morbidity			
2020 State Objectives: · Objective MWH-1: Reduce the maternal mortality rate in NYS by 10%, to 16.1 maternal deaths per 100,000 live births in 2020. · Objective MWH-2: Increase the percentage of women enrolled in Medicaid Managed Care who are screened for maternal depression during prenatal care by 10% to 94.2%, and during postpartum care by 10% to 90.9%.			
Strategies	**National Outcome Measures**	**Performance Measures**	**Evidence-Based Strategy Measures**
Strategy MWH-1: Continue maternal death case ascertainment and review process and issue reports of maternal death review findings and trends. Strategy MWH-2: Expand surveillance and reporting activities to include severe maternal morbidity. Strategy MWH-3: In collaboration with key partners, co-convene the *New York State Partnership for Maternal Health* to advance	NOM 2: Percent of delivery or postpartum hospitalizations with an indication of severe maternal morbidity. NOM 3: Maternal mortality rate per 100,000 live births. NOM 7: Percent of non-medically indicated deliveries at 37, 38 weeks gestation among singleton deliveries without pre-existing conditions. NOM 11: The rate of infants born with neonatal abstinence	NPM 1: Percent of women with a past year preventive medical visit SPM 1: The percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy SPM 2: The percentage of women age 15-44 years and enrolled in Medicaid using the most effective, reversible methods of contraception	ESM MWH-1: maternal mortality report issued at least annually. ESM MWH-2: Severe maternal morbidity surveillance initiated and operationalized by program ESM MWH-3: Number of policy, community prevention or clinical quality improvement strategies implemented in past year as a result of the Partnership collaboration. ESM MWH-4: Percentage of managed care organizations that

a comprehensive maternal health agenda that includes policy, community prevention and clinical quality improvement strategies. Strategy MWH-4: Collaborate with Medicaid to institute reimbursement for immediate postpartum insertion of LARC Strategy MWH-5: Collaborate with partners to increase screening and follow-up support for maternal depression. Strategy MWH-6: Participate in intra- and interagency groups developing response to increased opioid use to ensure maternal and child health perspectives and populations are addressed.	syndrome per 10,000 delivery hospitalizations.		provide reimbursement for postpartum LARC insertion. ESM MWH-5: Percentage of women enrolled in Medicaid Managed Care who are screened for maternal depression during: a) prenatal care b) postpartum care ESM MWH-6: Title V staff participate in intra-and inter-agency groups developing response to opioid use	

Domain: Perinatal and Infant Health (PIH)
State Priority# 2: Reduce infant mortality and morbidity
2020 State Objectives:

· Objective PIH-1: Decrease the infant mortality rate by 18%, to 4.0 per 1,000 live births

· Objective PIH-2: Decrease the preterm birth rate by 12%, to 9.5% of live births

· Objective PIH-3: Increase the percent of very low birthweight (VLBW) infants born in a hospital with a Level III or higher Neonatal Intensive Care Unit (NICU) by 0.4%, to 91% of eligible infants.

· Objective PIH-4: Decrease the SUID rate by 20%, to 0.3 per 1,000 live births

Strategies	**National Outcome Measures**	**Performance Measures**	**Evidence-Based Strategy Measures Core Title V Program Infrastructure**
Strategy PIH-1: Develop and implement an expanded plan for analysis and reporting of infant mortality and selected morbidity data, and issue initial data report. Strategy PIH-2: Update NYS perinatal regionalization standards and designations and implement updated performance measures for Regional Perinatal Centers and affiliate birthing hospitals. Strategy PIH-3: Continue to convene and lead structured statewide clinical quality improvement initiatives in birthing hospitals through the NYS Perinatal Quality Collaborative (NYSPQC).	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 1,000 live births. NOM 9.5: Sudden Unexpected	NPM 3: Percent of VLBW infants born in a hospital with a Level III + NICU NPM 5: Percent of infants placed to sleep on their backs.	ESM PIH-1: Initial infant mortality and morbidity data report published ESM PIH-2: Percentage of birthing hospitals re-designated with updated standards. ESM PIH-3: Percentage of eligible birthing hospitals participating in a current QI activity ESM PIH-4:Capacity rates of local home visiting grantee projects *(to be aligned with new MIEHCV performance measure, currently pending from HRSA MCHB)* ESM PIH-5: Number of home visiting and community health worker staff trained in the identified competencies ESM PIH-6: Number of collaborative

Strategy PIH-4: Work with local home visiting grantees to increase capacity of established programs through improvements in outreach, enrollment and retention of eligible families. Strategy PIH-5: Provide training and technical assistance to local MIECHV and MICHC grantees to enhance competencies of home visitors and community health workers related to pre- and interconception health, smoking cessation, substance abuse, safe sleep and breastfeeding promotion Strategy PIH-6: Lead collaborative strategies to reduce sleep-related infant death	Infant Deaths (SUID) mortality rate per 1,000 live births. NOM 11: The rate of infants born with neonatal abstinence syndrome per 10,000 delivery hospitalizations.		strategies implemented to reduce sleep-related infant death

Domain: Child Health (CH)
State Priority #3: Support and enhance children's social-emotional development and relationships (*as part of shared priority for children and adolescents)*
2020 State Objectives: · Objective CH-1: Increase the percentage of children surveyed who demonstrate 20 or more developmental assets by 10% from baseline (to be established in Years 2-3) · Objective CH-2 *(Same as LC-2*): Increase the percentage of children 10-71 months who whose parents report they have had a developmental screening using a parent-completed screening tool by 10% to 31.3%.

Strategies	National Outcome Measures	Performance Measures	Evidence-Based Strategy Measures
Strategy CH-1: Develop and implement a plan for analysis and reporting of available data on children's social-emotional well-being and adverse childhood experiences (ACES. Strategy CH-2: Identify, pilot test and implement validated tool for measuring positive developmental social-emotional assets among children and adolescents that can be used across MCH child-serving programs. Strategy CH-3: Provide training for Title V staff and external partners, including local child-serving grantees, to increase: 1) awareness, knowledge, and skills to support children's social emotional development; and 2) trauma-informed care practices. Strategy CH-4: Identify, support and integrate evidence-based/-informed strategies to promote children's social-emotional wellness and positive developmental assets through established Title V programs, including: · Maternal and Infant Community	NOM 19: Percent of children in excellent or very good health.	NPM 6: Percent of children 10-71 months receiving developmental screening using a parent-completed screening tool. SPM 3: The percentage of children and adolescents surveyed who demonstrate 20 or more developmental assets	ESM CH-1: Initial data report is issued ESM CH-2: Number of child-serving MCH programs implementing the asset profile tool ESM CH-3: Number of DOH MCH staff and external partners trained on: a) social-emotional wellness and b) trauma-informed care practices ESM CH-4: Number of child-serving MCH programs identified with an evidence-based social-emotional component ESM CH-5: Number of children with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home

Health Collaboratives (MICHC) · Home Visiting · Infant/Child Mortality initiative · Early Intervention, · Successfully Transitioning Youth to Adolescence (STYA) and · School-Based Health Centers. Strategy CH-5: Continue to provide subject matter and technical support to NY's Medicaid Health Home Program to implement enhanced care coordination for eligible children with serious emotional disturbance and complex trauma.			

Domain: Children with Special Health Care Needs (CSHCN)
State Priority #4: Increase supports to address the special health care needs of children and youth
2020 State Objectives: · Objective CSHCN-1: Increase the percentage of adolescents with special health care needs who receive services necessary to make to transitions to adult services by 10% to 44%. · Objective CSHCN-2: Increase the percentage of families participating in the Early Intervention Program who meet the state's standard for the NY Impact on Family Scale (≥ 576) by .50% to 66.5% (in 2018). · Objective CSHCN-3: Increase the percentage of CSHCN who need and receive care coordination services that meet their needs by 10% to 44%.

· Objective CSHCN-4: Increase the percentage of infants who receive a follow-up hearing screenings after failing initial hearing screening by 45% to 50%

Strategies	National Outcome Measures	Performance Measures	Evidence-Based Strategy Measures
Strategy CSHCN-1: Develop and implement a plan for analysis and reporting of CSCHN data for NYS, including forthcoming data from revised National Survey of Children's Health, and issue initial data report. Strategy CSHCN-2: Engage parents, families and providers in a system mapping exercise to identify the gaps and barriers in the system of public health programs and services for CSHCN and their families Strategy CSHCN-3: Provide subject matter and technical support to NYS Medicaid Program to implement enhanced care coordination and transition support services for CSHCN through Children's Health Homes. Strategy CSHCN-4: Provide grant	NOM 17.2: Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system. NOM 18: Percent of children with a mental/behavioral condition who receive treatment. NOM 19: Percent of children in excellent or very good health.	NPM 6: Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool NPM 12: Percent of adolescents with and without special health care needs who receive services necessary to make transitions to adult health care SPM 4: The percent of families participating in the Early Intervention Program who meet or exceed the state's standard for the NY Impact on Family Scale	ESM CSHCN-1: Initial data report published ESM CSHCN-2: Number of partners engaged in system mapping ESM CSHCN-3: Number of CSHCN enrolled in Health Homes designated to serve children ESM CSHCN-4: Percent of Adolescents/ Young Adults with SCD age 12-21 years in the funded projects who have a transition readiness assessment completed and documented ESM CSHCN-5: Number of best practice strategies for improving family outcomes that are documented through review and learning collaboratives. ESM CSHCN-6: Percent of children transitioning from EIP to Special

funding and technical assistance to support successful transition to adult services for young adults with Sickle Cell Disease (SCD), and evaluate projects to identify best practices for enhancing transition support to other key CSHCN populations. Strategy CSHCN-5: In collaboration University Centers for Excellence in **Developmental Disabilities** Education, Research, & Service (UCEDD) and other stakeholders implement NY's IDEA Part C State Systemic Improvement Plan (SSIP) to: · create a repository of evidence-based practices for family centered services; · convene statewide learning collaboratives to improve family outcomes for children served in the state's Early Intervention Program; and, · evaluate projects to identify resources and best practices that can be extended to other CSHCN populations. Strategy CSHCN-6: Use EI family			Education services who have a documented referral to LHD-based CSHCN Program ESM CSHCN-7: Percentage of infants with initial abnormal hearing screening results for whom follow-up is documented in NYEHDI-IS. .

survey data to inform CSHCN Program, of the needs of families transitioning from EI to CSHCN Program in order to better coordinate services. Strategy CSHCN-7: Provide technical assistance and facilitate a structured quality improvement project to engage health care providers, hospital staff, parent representatives, audiologists to improve reporting of initial hearing screening and follow up results into the New YorkEarly Hearing Detection and Intervention Information System (NYEHDI-IS).			

Domain: Adolescent Health (AH)
State Priority #3: Support and enhance adolescents' social-emotional development and relationships (*as part of shared priority for children and adolescents)*
2020 State Objectives: · Objective AH-1: Increase the percentage of adolescents surveyed who demonstrate 20 or more developmental assets by 10% from baseline *(to be established in Years 2-3)* · Objective AH-2: Reduce the percentage of adolescents who feel sad or hopeless for two weeks or longer in the past year by 10%, to 21.6%. · Objective AH-3 *(Same as LC-3):* Increase the percentage of adolescents who received a preventive health care visit in the last year by

6.5% to 97.7%.

Strategies	National Outcome Measures	Performance Measures	Evidence-Based Strategy Measures
Strategy AH-1: Develop and implement a plan for analysis and reporting of available data on adolescent's social-emotional well-being and adverse childhood experiences (ACES), including Youth Risk Behavior Survey (YRBS) and forthcoming revised National Survey of Children's Health data. Strategy AH-2: Identify, pilot test and implement a framework and validated tool for measuring developmental social-emotional assets among children and adolescents that can be used across MCH programs. Strategy AH-3: Provide training for Title V staff and external partners, including local adolescent-serving grantees, to increase awareness, knowledge, and skills to support: 1) adolescents' social emotional development and 2) trauma-informed care practices.	NOM 16.3: Rate of suicide deaths among youth aged 15 through 19 per 100,000. NOM 18: Percent of children with a mental/behavioral condition who receive treatment.	NPM 10: Percent of adolescents age 12-17 with a preventive medical visit in the past year NPM 12: Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care SPM 3: The percentage of children and adolescents surveyed who demonstrate 20 or more developmental assets	ESM AH-1: Initial data report is issued ESM AH-2: Number of adolescent-serving MCH programs implementing the asset profile tool ESM AH-3: Number of DOH MCH staff and external partners trained on: a) social-emotional wellness b) trauma-informed care practices ESM AH-4: Number of adolescent-serving MCH programs identified with an evidence-based social-emotional component ESM AH-5: number of adolescents with documented serious emotional disturbance and/or complex trauma who are: a) enrolled in Medicaid Health Home;

Strategy AH-4: Identify, support and integrate evidence-based/-informed strategies to promote adolescents' social-emotional wellness and positive developmental assets through established Title V programs, including: · Comprehensive Adolescent Pregnancy Prevention (CAPP) · Family Planning · Pathways to Success · Personal Responsibility Education Program (PREP) · School-Based Health Centers and · Sexual Violence Prevention. Strategy AH-5: Continue to provide subject matter and technical support to NY's Medicaid Health Home Program to implement enhanced care coordination and transition supports for eligible youth and young adults with serious emotional disturbance and complex trauma.			b) transitioned to adult-serving Health Homes

Domain: Cross Cutting & Life Course (LC)
State Priority #5: Increase use of primary and preventive health care services across the life course
2020 State Objectives:

Objective LC-1: Increase the percentage of women 18-44 years old with a past year preventive medical visit by 10% to 79.4%.
Objective LC-2 (*same as CH-2)*: Increase the percentage of children 10-71 months who whose parents report they have had a developmental screening using a parent-completed screening tool by 10% to 31.3%.
Objective LC-3 *(same as AH-3):* Increase the percentage of adolescents who received a preventive health care visit in the last year by 6.5% to 97.7%.

Strategies	**National Outcome Measures**	**Performance Measures**	**Evidence-Based Strategy Measures**
Strategy LC-1: Integrate performance standards, measures and improvement strategies related to health insurance enrollment across all Title V/ MCH programs. Strategy LC-2: Continue to support preconception/ reproductive health module within state's Behavioral Risk Factor Surveillance System (BRFSS), and produce focused reports of results to inform Title V program and partner strategies. Strategy LC-3: Incorporate performance measures and strategies to reinforce use of well-woman care including pregnancy planning and prevention across core Title V programs serving women of reproductive age, including: · Family Planning Program	NOM 1: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. NOM 13: Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) NOM 17.3: Percent of children diagnosed with autism spectrum disorder.	NPM 1: Percent of women with a past year preventive medical visit NPM 6: Percent of children 10-71 months receiving developmental screening using a parent-completed screening tool. NPM 10: Percent of adolescents age 12-17 with a preventive medical visit in the past year SPM 1**:** Percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy SPM 2: The percentage of women age 15-44 years and enrolled in Medicaid using the most effective, reversible methods of contraception	ESM LC-1: The number of Title V programs with health insurance elements incorporated in program requirements ESM LC-2: The number of analytic reports developed and shared ESM LC-3: The number of relevant Title V programs that demonstrate incorporation of strategies to reinforce well-woman and preconception health care services ESM LC-4: Number of strategies implemented to improve developmental screening ESM LC-5: The number of focus groups conducted

· Maternal & Infant Community Heath Collaboratives · Maternal, Infant & Early Childhood Home Visiting · Perinatal Regionalization · School-Based Health Centers Strategy LC-4: **Collaborate with partners to improve developmental screening in NYS.** Strategy LC-5: In conjunction with ACT For Youth Center of Excellence, Convene focus groups and review literature to identify contributing factors and effective strategies for improving preventive health care service delivery to adolescents, with a focus on reducing disparities.			
State Priority #6: Promote oral health and reduce tooth decay across the life course			
2020 State Objectives: · Objective LC-4: Increase the percentage of NYS residents served by community water systems that have optimally fluoridated water by 10% to 78.5% · Objective LC-5: Reduce the prevalence of dental caries among NYS children by 10% to 40.5%. · Objective LC-6: Increase the percentage of children and adolescents age 1-17 years who had a preventive dental visit in the past year by 5% to 80.9%			

· Objective LC-7: Increase the percentage of pregnant women who had a dental visit during pregnancy by 10% to 54.6%.			
Strategies	**National Outcome Measures**	**Performance Measures**	**Evidence-Based Strategy Measures**
Strategy LC-6: Provide financial and technical support for maintenance and expansion of community water fluoridation. Strategy LC-7: Increase the delivery of evidence-based preventive dental services across key settings: · school-based clinics · primary care practices · public health nutrition programs. Strategy LC-8: Integrate oral health messages and strategies within existing community-based maternal and infant health programs. Strategy LC-9: Strengthen Title V internal capacity, dental public health core competencies and workforce development for oral health surveillance and evidence-based interventions through continued support for NYS Dental Public Health Residency.	NOM 14: Percent of children ages 1-6 who have decayed teeth or cavities in the past 12 months. NOM 19: Percent of children in excellent or very good health.	NPM 13: Percent of a) women who had a dental visit during pregnancy and b) children age 1-17 who had a preventive dental visit in the past year SPM 5: Percentage of NYS residents served by community water systems that have optimally fluoridated water.	ESM LC-6: Number of public water systems that receive financial and/or technical support from NYSDOH to maintain or initiate community water fluoridation ESM LC-7: a) Percentage of 2nd and 3rd graders served by School-Based Dental Programs who receive sealants; b) # Medicaid claims submitted by primary care providers for application of fluoride varnish for children aged 0-5 enrolled in Medicaid that receive fluoride varnish applications from their primary care providers; c) Plan adopted in collaboration with NYSDOH Division of Nutrition to promote integration of oral health strategies in at least one public health nutrition program. ESM LC-8: Percentage of pregnant women served by Title V community health workers that have a documented screening or referral for dental services

			ESM LC-9: Number of dental public health residents with completed residency projects utilizing data systems in the past year.
State Priority #7: Promote supports and opportunities that foster healthy home and community environments.			
2020 State Objectives: · Objective LC-8: Increase the percentage of children and adolescents who are physically active at least 60 minutes daily by 10%, from 25.7% in 2013 to 28.5%. · Objective LC-9: Increase the percentage of children and adolescents who live in supportive/ cohesive neighborhoods by 6%, from 79.2% in 2011/12 to 84%. · Objective LC-10: Increase the percentage of children and adolescents who are usually or always safe in their community or neighborhood by 5%, from 79.9% in 2011/12 to 84%.			
Strategies	**National Outcome Measures**	**Performance Measures**	**Evidence-Based Strategy Measures**
Strategy LC-10: Continue and increase Title V staff leadership and participation in the DOH Place-Based Initiative (PBI) work group to: · Adopt a shared definition and set of indicators to measure healthy communities; · Review place-based initiatives to identify best practices for community environmental change; · Develop a toolkit of data and evidence-based/-informed practices for community	NOM 15: Rate of death in children aged 1 through 9 per 100,000. NOM 16.1: Rate of deaths in adolescents age 10-19 per 100,000. NOM 19: Percent of children in excellent or very good health. NOM 20: Percent of children and adolescents who are	NPM 8: Percent of children age 6-11 and adolescents age 12-17 who are physically active at least 60 minutes per day	ESM LC-10: a) # PBI workgroup meetings held and attended by Title V staff; b) # of resources are developed and disseminated based on PBI workgroup ESM LC-11: # of community environmental changes demonstrated as a result of enhanced collaborations. ESM LC-12: a) Evidence-informed framework to structure and measure collaborative efforts is established or identified;

change; · Incorporate requirements for healthy community practices within relevant MCH funding procurements. Strategy LC-11: Enhance collaboration with key partners to advance changes in community environments that promote maternal and child health: · increase demand for and access to healthy, affordable foods and opportunities for daily physical activity in high-need communities through the Creating Healthy Schools and Communities program *(with NYSDOH Division of Chronic Disease Prevention)* · strengthen linkages between Title V programs and the Healthy Neighborhoods Program (*with NYSDOH Center for Environmental Health)* · support the Regional Centers for Sexual Violence Prevention to implement primary prevention environmental change strategies at the community and individual levels *(with NYSDOH*	overweight or obese (BMI at or above the 85th percentile.)		b) # of internal partners trained; c) # of external partners trained. .

Bureau of Injury Prevention) · incorporate selected health-related quality indicators in new quality improvement initiative for regulated child care programs *(with Office of Children & Family Services)* · incorporate health promotion information and linkages within Community Schools initiative (*with State Education Department and Council on Children and Families)*; Strategy LC-12: Establish or adopt an evidence-informed framework for structuring, measuring and improving collaboration at state and community levels, and provide support to strengthen both internal and external partner capacity to implement the framework across MCH programs.			
State Priority #8: Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population			
2020 State Objectives: · Objective LC-11: Increase the percentage of Title V staff that improve their knowledge of health equity concepts by 20% from baseline (*baseline to be established in conjunction with Strategy LC-15*). · Objective LC-12: Increase the percentage of DFH procurements that demonstrate application of health equity strategies listed by 20% from baseline *(to be established in Year 2-3).* · Objective LC-13: Reduce disparities for all selected national and state performance measures by 5% from baseline (*targets vary by*			

measure).

Strategies	National Outcome Measures	Performance Measures	Evidence-Based Strategy Measures
Strategy LC-13: Develop and implement a data analysis plan to assess distribution of DFH/Title V resources and services through a health equity lens Strategy LC-14: Build internal capacity within the Division of Family Health (DFH)/ Title V Program to advance health equity through all Title V programs, including: · creation of a cross-program DFH Equity Action Team; · completion of an organizational assessment of equity practices, and · facilitation of staff training and professional development through Equity Learning Labs. Strategy LC-15: Integrate an equity framework into the development of all DFH/Title V procurements through community listening forums conducted as part of the concept development process.	Disparity ratios for key outcome measures above	Disparity ratios for all NYS-selected performance measures above	ESM LC-13: # of Title V programs for which health equity analyses completed ESM LC-14: a) # of Equity Action Team meetings held; b) # of DFH staff who have completed one or more Equity Learning Labs ESM LC-15: Percentage of DFH procurements that complete community listening forums as part of concept development process ESM LC-16: Percentage of DFH procurements that demonstrate inclusion of evidence-based/-informed community engagement and collective impact strategies

Strategy LC-16: Incorporate evidence-based/-informed community engagement and collective impact strategies in all relevant DFH/Title V programs.			