New York State Department of Health

New York State
Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Statewide Needs Assessment Update

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I. Introduction

The New York State Department of Health (NYSDOH) was designated by the Governor as the lead entity for the State to accept and administer funds made available through the Affordable Care Act (ACA) in 2010. The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program under the ACA expired in September of 2017 and was reauthorized for five years under the Bipartisan Budget Bill of 2018. This critical program provides funds to states, territories, and tribal entities for implementing voluntary, evidence-based home visiting programs to support at-risk families. The Bipartisan Act of 2018 requires MIECHV awardees to review and update a Statewide Needs Assessment by October 1, 2020. The New York State (NYS) MIECHV statewide needs assessment update was led by the NYS MIECHV program, which sits within the Division of Family Health (DFH) within the NYSDOH and was completed in close coordination with the NYS Title V Maternal and Child Health Services Block Grant (MCHSBG) needs assessment, which also sits within the DFH.

To complete the statewide needs assessment update, the NYSDOH engaged in a thorough and multi-faceted process to gather and analyze data and information required by HRSA[1], as well as collected and reviewed additional data indicators and supporting information from a wide variety of sources. A logic model (see Appendix A) was developed to guide the process. Working closely with home visiting stakeholders in New York State (NYS) has been, and continues to be, an integral component of the State's efforts to address families' needs for home visiting services. The NYSDOH solicited input from a broad range of stakeholders on the home visiting needs of families around the state. These stakeholders included state advisory councils, key federal investments, NYSDOH programs, State agencies, academic partners, and other organizations and workgroups. Community input was also gathered to inform this statewide needs assessment update. The community input included conducting community listening forums (CLF), Title V MCHSBG[2] consumer and provider surveys, and key informant interviews (KII), and reviewing the recently conducted statewide maternal mortality listening forums, 2019 MIECHV community needs assessments, 2019 home visiting focus groups, and the Home Visiting Transportation Survey.

Stakeholder and community input allowed the NYSDOH to strengthen the comprehensive needs assessment process. Stakeholders also identified strengths of the home visiting programs in their communities, identified specific gaps and barriers to services, and provided valuable insight into how home visiting services can be strengthened. These efforts were included throughout the process of conducting the statewide needs assessment. Following its submission to HRSA, the statewide needs assessment update will be presented to the Statewide Home Visiting Workgroup, which includes representation of all relevant stakeholders, at a webinar to be scheduled this Fall.

Another facet of the process included a close review of the results of other statewide needs assessments and community reviews to document home visiting-related needs identified by several service systems. In addition to reviewing the required the New York State Head Start Collaboration Project needs assessment, Title V MCHSBG needs assessment, and the Title II of the Child Abuse and Prevention Treatment Act, the NYS Birth through Five Preschool Development Grant needs assessment, [3]2020 Home Visiting Coordinated Initiative Regional Summit Report, and MIHOPE[4] studies were reviewed. The information gathered through these reviews confirmed the important role that home visiting services play in promoting the health and stability of families in NYS.

[1] HRSA – Human Resources and Services Administration
[2] MCHSBG – Maternal and Child Health Services Block Grant
[3] Report written by Prevent Child Abuse New York, can be found at: https://raisingnewyork.org/home-visitation/
[4] MIHOPE – Mother and Infant Home Visiting Program Evaluation

For the purposes of this needs assessment update, the NYSDOH has identified at-risk counties per HRSA guidance. This needs assessment demonstrates the state's capacity to determine and summarize home visiting-related needs at the county level and is essential to inform the development of an effective updated MIECHV State Plan for home visiting services. State agency partners and other stakeholders will be provided with this updated statewide needs assessment and involved in developing recommendations on addressing gaps in home visiting services.

Description of New York State's Population

New York State is a large, populous and diverse state. The current status and emerging trends in the state provide an understanding of the environment in which the home visiting needs are being identified. What follows is a brief overview of the state's population.

According to population estimates from the 2018 American Community Survey, NYS is the fourth most populous state in the country, housing more than 19 million people (19,542,209). Within the state, approximately 43% of the population, or 8 million people (8,398,748), reside in New York City (NYC).

Population Density

Estimates from the 2018 Census indicate that there are 414.70 people per square mile in NYS. The most densely populated counties include New York County (71,886 persons per square mile), Kings County (37,232 persons per square mile), and Bronx County (34,058 persons per square mile). In addition to counties in NYC (New York, Kings, Bronx, Richmond, and Queens counties), Long Island (Nassau and Suffolk counties), and the Hudson Valley region (Sullivan, Putnam, Rockland, Westchester, Dutchess, Orange, and Ulster counties), other densely populated counties include Erie County, Monroe County, Onondaga County, Schenectady County, and Albany County.

Growth

According to Census estimates, NYS's population as a whole has grown between 2010 and 2018 at a rate of 0.8%. This statistic, however, masks significant variation observed at the county level. While many counties surrounding NYC and the Hudson Valley experienced population gains between 2010 and 2016, the majority of counties in the state (41 of 62 counties) experienced population losses between zero and 4%.

Race and Ethnicity

NYS is home to a highly diverse population. Across all states, NYS ranks second in terms of having the highest percentage of foreign-born people. According to data from the 2017 American Community Survey, 22.7% of NYS's population is foreign born.

Of the state's 19,542,209 residents, approximately 70% of individuals identify as White alone, 19% identify as Hispanic or Latino, 18% identify as Black or African American, 9% identify as Asian alone, 1% identify as American Indian or Alaska Native, and 0.1% identify as Native Hawaiian or Other Pacific Islander. Compared to national estimates, NYS has a higher percentage of non-Hispanic Black, Asian, and Hispanic residents.

Counties in NYC and the Hudson Valley have the highest percentage of Black or African American residents. According to the 2017 American Community Survey, 30 to 40% of residents living in both Kings County and Bronx County identify as Black or African American. Larger population centers including Buffalo (Erie County), Rochester (Monroe County), Syracuse (Onondaga County), and Albany (Albany County) also have higher percentages of Black or African residents compared to the rest of the state.

Similar geographic patterns can be observed for NYS's Hispanic and Latino population. Bronx County ranks highest across the state with approximately 55% of the total county population identifying as Hispanic or Latino.

Immigration

2017 Census estimates indicate that 22.7% of NYS's population (4,490,656) is foreign born. Among this group, 12.6% (2,484,644) are naturalized citizens while 10.1% (2,006,012) are non-citizens. The largest percentage of foreign-born individuals migrated from the Americas (50.3%), Asia (28.8%), and Europe (16.3%). In addition to counties surrounding NYC, Long Island, and the Hudson Valley, counties with larger population centers, including Buffalo, Rochester, and Albany, have higher percentages of foreign-born residents.

Households and Families

According to 5-year estimates from the 2017 American Community Survey, there are 7,302,710 households in NYS, with an average of 2.63 people per household. Of these households, 63.4% (4,633,030) are married couple families, and 36.6% (2,669,680) are non-family households. Approximately 30% (2,194,841) of all households have at least one child under the age of 18.

Median Household Income

Five-year estimates from 2017 American Community Survey reveal that the median household income in NYS is $62,765. Counties with the highest income levels are heavily concentrated in NYC, Long Island, and the Hudson Valley. Nassau County, in particular, ranks highest in the state with a median household income level above $100,000.

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

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

Poverty

According to 2017 estimates from the American Community Survey, 15.1% of NYS's population is living below the federal poverty line. Counties with the highest percentage of families falling below the threshold are concentrated in the NYC region, particularly in Bronx County (26.76%) and Kings County (17.87%).

Age

The median age in NYS is 38.7. Approximately 21% (4,153,497) of the population is under 18 years of age, and roughly 16% (3,161,049) of the population is 65 years or older. The median age has increased over the past decade, rising from 37.7 in 2007 to 38.7 in 2017.

Women of Childbearing Age

Estimates from the 2017 American Community Survey indicate that there are 4,027,930 women of childbearing age (15-44 years) in NYS, representing 39% of the total female population. The percentage of women of childbearing age has steadily decreased over the years.

Educational Attainment of Mothers

Data from the National Vital Statistics System indicate that 25.24% (973,025) of mothers giving birth have graduated from high school or completed their GED. Further, 20.07% (773,944) of all mothers giving birth have a bachelor's degree.

Children

Of NYS's 19,542,209 residents, 5.8% of the population is under the age of 5 and 20.8% of the population is under the age of 18. According to 2017 estimates from the Kids Count Data Center, approximately 20% of all children in the state are living with families below the federal poverty line. Further, 30% of children are living with families where no parent has regular, full-time employment.

Education

According to 2018 data published by the New York State Department of Education, 2,622,879 children are enrolled in K-12 public schools. Approximately 43% (1,133,631) of public-school students are White, 27% (708,319) are Hispanic, and 17% (448,499) are Black or African American.

The high school graduation rate for all public-school students is 80%. However, graduation rates vary significantly by ethnicity. While 89% of White students graduate, only 70% of Black or African American students graduate from high school. Additionally, graduation rates for migrant students is 39%.

In terms of educational attainment of young adults (ages 25 to 34), approximately 37% of the population has a high school diploma or GED[5], 29% of the population has a bachelor's degree, and 16% of the population has a graduate degree. The percentage of individuals with a bachelor's or graduate degree has increased over the past decade while the percentage of individuals with a high school diploma or less has decreased.

Language

According to five-year estimates from the 2017 American Community Survey, approximately 70% of the population over the age of 5 (12,924,635) speaks only English. Of the 5,696,716 residents that speak a language other than English at home, 15.1% speak Spanish, 8.7% speak other Indo-European languages, and 5.1% speak Asian and Pacific Island languages. Approximately 44.3% of the population who speaks a language other than English report that they speak English less than "very well."

Health Insurance

Approximately 7% of the non-elderly population (ages 0-64) in NYS has no health insurance. Estimates from the 2017 American Community Survey reveal that uninsured rates vary significantly by ethnicity. While only 4% of Whites are uninsured, 12% of Hispanics, 11% of American Indians or Alaska Natives, 8% of Asians or Native Hawaiian and Pacific Islanders, and 7% of Blacks have no health insurance coverage.

II. Identifying At-Risk Communities with Concentration of Risk

The process of completing the updated statewide needs assessment began with gathering data on the indicators of risk. NYSDOH collaborated with the Bronfenbrenner Center for Translational Research at Cornell University for the quantitative data. Data were compiled from state and federal population health data sources. A total of 15 indicators of risk were used and analyzed to determine which communities in the State have concentrations of risk.

[5] GED – General Education Development Test

Data Sources Used to Complete the Statewide Data Report

All data used to complete the statewide and county reports are publicly available from NYS or federal sources. NYS used 15 metrics from five domains in an independent method to determine the at-risk communities. County is the geographic unit for each indicator and will be the unit to describe communities with concentrations of risk. The table below provides an overview of definitions and data sources for the included indicators.

Table 1: Definitions and Data Sources

Domain	Indicator	Rate	Burden	Source	Geographic Unit
Adverse Perinatal Outcomes	Preterm Births	# live births before 37 weeks/ # live births	# live births before 37 weeks	NYS Vital Statistics	County
	Low-birth Weight	# live births < 2,500 grams/# live births	# live births < 2,500 grams	NYS Vital Statistics	County
	Infant Mortality	# infant deaths ages 0-1/1,000 live births	# infant deaths ages 0-1	NYS Vital Statistics	County
	Maternal Mortality	# maternal deaths / 100,000 live births	# maternal deaths	NYS Maternal and Child Health Dashboard	County
	Teen Births	# teen births (15-19) / 1,000 females (15-19)	# teen births (15-19)	NYS Vital Statistics	County
Substance Use Disorder	Neonatal Abstinence Syndrome	# newborns with neonatal withdrawal syndrome/1,000 births	# newborns with neonatal withdrawal syndrome	NYS Opioid Data Dashboard	County
Crime	Index Crime	# reported index crimes/100,000 residents	# reported index crimes	NYS Division of Criminal Justice Services	County
	Juvenile Arrests	# arrests (7-15) / 100,000 juveniles (7-15)	# arrests (7-15)	NYS Division of Criminal Justice Services	County
Socioeconomic Status	School Dropouts	# HS student dropouts / # HS students	# HS student dropouts	NYS Education Department Graduation Rates	County
	Poverty	# children (0-17) living below 100% FPL/ # children (0-17)	# children (0-17) living below 100% FPL	Census Bureau Small Area Income and Poverty Estimates	County
	Unemployment	# unemployed and seeking work/ # workforce	# unemployed and seeking work	Bureau of Labor Statistics	County

Domain	Indicator	Rate	Burden	Source	Geographic Unit
Socioeconomic Status (continued)	Disparity Index	Ratio of adverse perinatal outcomes of non-Hispanic Black women to non-Hispanic White women		NYS County Health Indicators by Race/Ethnicity	County
	Limited English Households	# Households where members 14 and older have limited English / # households	# Households where members 14 and older have limited English	Census Bureau American Community Survey	County
Child Maltreatment	CPS[6] Reports	# indicated CPS reports for children (0-17) / 10,00 children (0-17)	# indicated CPS reports for children (0-17)	Office of Children and Family Services (OCFS) Administration for Children's Services (ACS)	County
	Foster Care	# in foster care / 10,000 children	# in foster care	OCFS ACS	County

Statewide Data Report

NYS used an Independent Method to complete a quantitative data analysis to identify at-risk counties with concentrations of risk using 15 metrics categorized within five domains to determine the at-risk counties. Medicaid births often equated as the population eligible for home visiting ranges from 13 to nearly 25,000 from the least to most populous county in NYS. The diverse population and geographic regions within NYS required the inclusion of rate and burden (absolute number of events or cases) for the indicators. This is consistent with the methodology utilized in other public health initiatives. The use of burden was deemed to be an essential element in identifying at-risk counties. The use of both rate and burden recognizes the geographic diversity of NYS and the need to assign limited resources to maximize population impact. In some cases, high rates alone represent a very small number of events or cases due to a small population base. Available funding will not be enough to address all areas of need in NYS, therefore the burden for the indicators of risk in each county has been factored into New York's analysis and identification of at-risk communities.

NYS included several of the potential metrics described in the SIR and included additional indicators to assess the needs of counties in NYS. The additional indicators include teen births, maternal mortality, limited English households, low birth weight births, preterm births, and infant mortality experienced by non-Hispanic Black women compared to non-Hispanic White women. The additional indicators add both breadth and depth to NYS's analysis of the comparative health of counties and the factors that place families at-risk. Even though immigrant families are disproportionately likely to be experiencing some of the risk factors that many home visiting programs target, they are generally underserved by home visiting programs.

[6] CPS - Child Protective Services

While multilingualism and multiculturalism have been proven to be an important strength and asset for children born in families that do not primarily speak English, dual language learners (DLL) in NYS are likely to face several risk factors that make them an important target for home visiting services. For instance:

- 31 percent live below the federal poverty level (compared to 20 percent of children of non-DLLs[7]).
- 22 percent of parents of DLLs have less than a high school diploma (compared to 6 percent of parents of non-DLLs).
- 42 percent of parents of DLLs are limited English proficient (LEP) and 26 percent of DLLs live in linguistically isolated homes, meaning that no one over the age of 14 speaks English very well.

Immigrant families, particularly those with undocumented status, are explicitly excluded from certain federal and state supports due to their status, including supports for preventative health care and SNAP[8] benefits, which can have dire long-term health consequences for these families. Further, fear of engaging with government and healthcare systems can lead to immigrant families avoiding those supports out of fear of deportation or separation from their young children, which can lead to families not seeking out preventative and acute care services that will ultimately negatively affect the health of themselves and their children. Additionally, studies have found that acculturation to the U.S. has been cited as having a negative effect on Latina women's' health, associated with "worse birth and perinatal outcomes (prematurity, low birthweight (LBW), teen pregnancy, neonatal mortality), as well as with undesirable prenatal and postnatal behaviors (smoking and drug use during pregnancy, decreased number of breastfeeding mothers)[9]." As these issues develop over time, they may not show up within current risk indicators for new U.S. residents, but can develop over time to lead to poor health outcomes for Latino families. Immigration status, identified through both home language and country of birth, can be an extremely valuable social indicator of health.

Teen births have been steadily declining in most NYS counties for the past two decades but remain an adverse perinatal outcome and indicator of counties that could benefit from home visiting services. Mothers under 21 years of age continue to be a priority population within the MIECHV program.

Due to NYS's strong commitment to improving birth outcomes for all mothers, measures of racial disparity were included as indicators of risk. The Disparity Index was defined as the ratio of adverse perinatal outcomes for non-Hispanic Black women compared to non-Hispanic White women. The rate and burden of maternal mortality were also included as an indicator of risk. In 2018, Governor Andrew M. Cuomo created the Taskforce on Maternal Mortality and Disparate Racial Outcomes (the Taskforce), part of a multi-pronged effort to reduce maternal mortality and racial disparities. Membership was comprised of appointees from the NYS Senate and Assembly, as well as obstetricians, midwives, hospital representatives, doulas and other stakeholders and members of the community. The Taskforce heard from state and national experts and community stakeholders on the landscape of maternal mortality in the U.S. compared to maternal mortality in NYS, as well as the impact of racism on perinatal health outcomes among Black women. Members of the Taskforce submitted recommendations to the Governor on ways to reduce racial disparities and preventable maternal mortality and morbidity. Recommendations were informed by Taskforce meetings, feedback from statewide community listening sessions led by NYSDOH Commissioner Dr. Howard A. Zucker and other breakout sessions, and their own expertise. The Taskforce is advancing ten recommendations to decrease maternal mortality and morbidity and reduce

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[7] DLLs – Dual Language Learners

[8] SNAP – Supplemental Nutrition Assistance Program

[9] Acculturation and Latino Health in the United States: A Review of the Literature and its Sociopolitical Context, (Annu. Rev. Public Health 2005), 26:367–97, https://www.annualreviews.org/doi/pdf/10.1146/annurev.publhealth.26.021304.144615

racial disparities in New York. In addition, in his 2019 State of the State address, Governor Cuomo committed to immediately implementing the top recommendations of the Taskforce, including launching a Maternal Mortality Review Board, creating an implicit racial bias training and education program for hospitals, investing in community health worker programs, and creating a data warehouse on perinatal outcomes[10].

Finally, most of the data included were available at the county level with one exception, only citywide foster care data was available for New York City. This data was extrapolated consistent with the proportions of children (0-17) in each county in NYC. The most recent year of statewide data for NY is reported below.

Table 2: Statewide Data by Indicator

Domain	Indicator	Rate	Burden
Adverse Perinatal Outcomes	Preterm Births	9.2%	20,421
	Low Birth Weight	8.1%	18,423
	Infant Mortality	4.5 / 1,000 births	1,026
	Maternal Mortality	20.7 / 100,000 births	148
	Teen Births	12.4 / 1,000 females (15-19)	7,453
Substance Use Disorder	Neonatal Abstinence Syndrome	10.1 / 1,000 births	2,202
Crime	Index Crime	1,784 / 100,000 residents	348,598
	Juvenile Arrests	512 / 100,000 juveniles (7-15)	10,472
Socioeconomic Status	High School Dropouts	9.0%	19,072
	Childhood Poverty	19.9%	812,334
	Unemployment	4.7%	393,647
	Disparity Index	1.9	NA
	Limited English Households	4.1%	593,391
Child Maltreatment	CPS Reports	145.3 / 10,000 children (0-17)	58,780
	Foster Care	38.6 / 10,000 children (0-17)	15,599

Methodology to Identify At-Risk Communities

For the purposes of this needs assessment, county is the geographic unit NYS used to define community and make the determination of at-risk communities. There are 62 counties in NYS. Each county is well-defined with its own governance structure and varying service delivery systems based on population size, geographic area and resources.

A two-step z-score methodology was used to identify counties at-risk. The z-score allows for a standard score that indicates how many standard deviations the data are above or below the mean. A z-score with a positive value indicates that it is above the statewide mean; a z-score with a negative value indicates that

[10] New York State Taskforce on Maternal Mortality and Disparate Racial Outcomes Recommendations to the Governor to Reduce Maternal Mortality and Racial Disparities, March 2019

it is below the statewide mean. The domains described in the SIR, socioeconomic status, perinatal outcomes, substance use, crime, and child maltreatment were used as equal indicators of need for families that would benefit from home visiting. Z-scores were calculated for the rates of all 15 indicators and for the burden (number of cases) for all indicators for each county. Step one was to calculate the average z-score by domain for each county, each indicator was treated with equal weight within a domain, this was completed for both rate and burden. The second step was to calculate an average z-score of domains for both rate and burden to provide a composite index for ranking the counties from highest to lowest in overall need, relative to the statewide value.

At-Risk Counties Identified

The application of two-step z-score methodology resulted in the following groupings:

Group 1 – Positive z-score for both rate and burden
Group 2 – Positive z-score for burden but not for rate
Group 3 – All other counties

Table 3: NYS Counties Grouped by Risk

Group 1	**Group 2**	**Group 3**				
Albany	Nassau	Allegany	Dutchess	Livingston	Saratoga	Ulster
Bronx	Orange	Cattaraugus	Essex	Madison	Schenectady	Warren
Broome	Queens	Cayuga	Franklin	Montgomery	Schoharie	Washington
Erie	Richmond	Chautauqua	Fulton	Ontario	Schuyler	Wayne
Kings	Suffolk	Chemung	Genesee	Orleans	Seneca	Wyoming
Monroe	Westchester	Chenango	Greene	Oswego	St. Lawrence	Yates
New York		Clinton	Hamilton	Otsego	Steuben	
Niagara		Columbia	Herkimer	Putnam	Sullivan	
Oneida		Cortland	Jefferson	Rensselaer	Tioga	
Onondaga		Delaware	Lewis	Rockland	Tompkins	

All counties within Groups 1 and 2 will be considered counties at-risk. In this assessment, 16 priority counties were identified (Albany, Bronx, Broome, Erie, Kings, Monroe, Nassau, New York, Niagara, Oneida, Onondaga, Orange, Queens, Richmond, Suffolk, and Westchester). Group 1 counties were identified as high priority with higher rate and burden than the state (Albany, Bronx, Broome, Erie, Kings, Monroe, New York, Niagara, Oneida, Onondaga).

In the 2010 needs assessment, there were 14 priority counties identified: Albany, Bronx, Erie, Kings, Monroe, Nassau, New York, Oneida, Onondaga, Orange, Queens, Richmond, Suffolk, and Westchester. Additional counties identified in the current process include Broome and Niagara.

Data Reports for the Identified At-Risk Counties in the State

The same set of metrics used for the statewide data report was used to produce data reports for each of the counties identified with NYS data for comparison. Data reports for the counties identified above in Group 1 and Group 2 can be found in Appendix D. These profiles include information about each county's population, demographics, and a table of home visiting programs that are current in the county.

The counties identified include all five boroughs of New York City (Bronx, Kings, New York, Queens, and Richmond), the 3 counties in the immediate New York City metropolitan area (Nassau, Suffolk, and Westchester) and the upstate counties with urban centers (Albany/City of Albany, Broome/Binghamton, Erie/Buffalo, Monroe/Rochester, Niagara/Niagara Falls, Oneida/Utica, Onondaga/Syracuse, and

Orange/Newburgh). The counties identified include 16 of the 18 counties with the largest numbers of Medicaid births. New Yorkers are not evenly distributed across the state; there are large metropolitan areas and sparsely populated rural counties. The methodology used to identify at-risk counties was from the perspective of burden, therefore the counties identified align with the known level of risk in the state. This method identified counties with higher concentrations of risk compared to all counties in the state.

III. Quality and Capacity of Existing Home Visiting Programs

Information was collected about existing home visiting programs through a variety of methods and sources. An environmental scan was conducted to collect information on existing home visiting models in NYS including their current level of services and their operating history in NYS. The home visiting models in NYS include Attachment and Biobehavioral Catch-Up Intervention, Building Healthy Children, Early Head Start, Family Connects, Healthy Families New York, Home Instruction for Parents of Preschool Youngsters, Maternal and Infant Community Health Collaboratives, Nurse-Family Partnership, Parents as Teachers, ParentChild+, and SafeCare. Summaries of the information collected on the home visiting programs operating in NYS are provided below.

Current Home Visiting Models in NYS, as of 2020

Attachment and Biobehavioral Catch-Up Intervention (ABC) Power of Two is a non-profit organization that is disseminating the evidence-based Attachment and Biobehavioral Catch-up parent coaching program in New York City. Power of Two partners with caregivers to develop resilience, so that they can better care for their families and promote healthy trajectories for their children and communities. Power of Two delivers ABC in families' homes by a trained parent coach who spends one hour per week with a parent and their baby (ages six months to 48 months) for ten weeks. The coach focuses on the specific behaviors that have been proven to lead to strong attachment and self-regulation. They provide positive, in-the-moment feedback, helping the caregiver develop new patterns of parenting. The coach is not simply telling the caregiver what to do. Instead, they are reinforcing what the caregiver is doing right. Through this process, they guide the parent to adopt behaviors that are highly rewarding and critically helpful to the child. Power of Two, which was founded in 2015, has two offices, in Brownsville, Brooklyn and in the South Bronx, and has served approximately 3,000 caregiver-child dyads.

Building Healthy Children (BHC) offers a collaborative approach that integrates high quality, comprehensive, evidence-based treatment to families at risk for child maltreatment within a primary care setting, with attention to medical and health needs. Since 2007, this approach brings critical expertise in the areas of engagement of hard to reach populations, coordinated health and social/emotional/educational services, parenting education, parent-child trauma and depression therapy, care of victims of domestic violence, and support services under one umbrella to ensure that the complex and multiple service needs of vulnerable families are addressed effectively. Benefits of this home visitation model include those associated with the avoidance of child maltreatment and with improved family health and overall functioning. Services are responsive to the needs of young parents (low-income, pregnant woman under 21 years of age) and drawn upon knowledge of adolescent development to meet the needs of young women who are transitioning into parenthood, as well as the needs of children in their care. Monroe Family Health Center (MFHC) has partnered with the Monroe County Department of Human Services, the United Way of Greater Rochester, University of Rochester Medical Center (URMC) Pediatrics and Social Work, and several pediatric and family medicine practices (N=11) in the Rochester community through the Building Healthy Children (BHC) Program. The BHC intervention was developed as a primary preventive program that combines three evidence-based practices (i.e., Parents As Teachers (PAT), Interpersonal Psychotherapy (IPT), and Child-Parent Psychotherapy (CPP)) with Community Health Worker Outreach Support services (e.g. assistance with transportation to medical appointments, food, housing, support with enrolling in day care), to provide high quality, intensive services aimed at meeting the multiple needs of this low-income teen and infant client base. This program also works at a

community level to improve collaboration and strengthen the infrastructure to maximize the capacity and efficiency of home visitation.

Early Head Start (EHS) began in 1995 as part of the Head Start program to provide services to families with infants and toddlers. EHS serves low-income pregnant women and families with infants and toddlers from birth through age three and is designed to provide high-quality child and family development services that promote healthy prenatal outcomes, enhance the development of infants and toddlers, and promote family functioning. During weekly home visits parents are provided with information about parenting, health, and child development. Families are linked to other community services and resources and provided with social supports specific to their needs. Every homebased group of families also participate in twice-monthly socializations. This is where the families (parents and EHS enrolled children) join together for learning activities and a meal with their home visitor. EHS programs follow standards set by the Head Start Program Performance Standards on quality early childhood development programs, and tailor their approach to the communities they serve. An evaluation of EHS programs has shown EHS to have statistically significant positive impacts on standardized measures of children's cognitive and language development. Services generally fall into one of three program approaches, home-based, center-based, or mixed-approach combining both home and center-based approaches. Currently, the total funded capacity for the Early Head Start programs in NY is 9,905. There are 106 EHS programs serving the state.

Family Connects is a short-term, universal, inexpensive postnatal nurse home visiting program designed to provide brief parenting intervention and to connect families with community resources based on individualized assessments of family needs. The focus is of early intervention (education and support by a Nurse Practitioner) and connection to community agencies, in order to: reduce healthcare costs, decrease rate of mothers and infants potentially preventable emergency room visits, adhere to well-baby care and mother's postpartum care schedules, improve family functioning, strengthen family partnerships and well-being, and improve mental and physical health outcomes of mothers and infants within the first six months of life/after birth. Evidence for the Family Connects model has shown a 44% lower rate of Child Protective Services investigations for suspected child abuse or neglect through the second year of life. Northwell Health Visits/ Family Connects Long Island is an evidence-based, grant-sponsored dissemination that is executed and offered to all families delivering at one hospital site, Katz Women's Hospital at Long Island Jewish Medical Center that serves families that reside in Suffolk, Nassau, Queens, Kings, New York, Bronx, and Richmond counties. .

Healthy Families New York (HFNY) is an evidence-based, community-based home visiting program that targets expectant parents and parents with infants less than 3 months of age considered at high-risk for child abuse and neglect. HFNY is affiliated with Healthy Families America (HFA). The program began in 1995 and currently has 44 sites throughout NYS and is present in 35 counties and the five boroughs of NYC. HFNY is directed by the NYS Office of Children and Family Services (OCFS). Families are screened and assessed for risk factors that are predictive of child abuse and neglect. The program prioritizes services to low income, single parents with a history of child abuse/child welfare services, substance abuse, late/no prenatal care, mental health concerns, and domestic violence. HFNY promotes the use of positive parenting skills that support and encourage children's cognitive and social development, links families to a medical provider, and refers families to additional services based on identified needs. Home visitors provide families with support, education and linkages to community services with the goals of promoting positive parenting skills and parent-child interaction, preventing child abuse and neglect, ensuring optimal prenatal care and child health and development and increasing parents' self-sufficiency. Home visits are conducted during pregnancy weekly or biweekly, depending on trimester, and weekly during the first six months of the child's life. As families progress through the program, the frequency of home visits declines from biweekly, to monthly, to quarterly. Families are offered home visiting services until the child is in school or a Head Start program. HFNY has demonstrated outcomes through a randomized controlled trial at three sites, including sustained decreases

in mothers' reports of serious physical child abuse, sustained increases in positive parenting, and reductions in the rate of low birth weight deliveries and participation in special educations programs. HFNY has also demonstrated lower rates of confirmed child protective services reports for young first-time mothers who enroll prenatally and for mothers with confirmed prior involvement with child protective services. The program serves nearly 6,100 families annually in NYS.

Home Instruction for Parents of Preschool Youngsters (HIPPY) is a national evidence-based program in existence since 1969. There is one HIPPY program in NYS, BronxWorks HIPPY, which has been in operation since 1991. HIPPY Prioritizes its services to low income, single-parent families with a history of child abuse/child welfare services who use tobacco, have children with low student achievement and developmental delays, current depression, history of domestic violence, and unemployment. HIPPY is a home-based program whose purpose is to provide parents with the tools they need to become successful first teachers, enabling them to prepare their children for success in kindergarten and beyond. To participate in HIPPY, families must have a child between 3 and 5 years of age at the time of enrollment and be willing to spend a minimum of 15 to 20 minutes a day, five days a week engaging the child in literacy skills development activities at home. Weekly home visits are conducted by paraprofessional educators for a minimum of 30 minutes per visit. The HIPPY curriculum is administered by parents who are trained by the parent educators over a 30-week period. Research by HIPPY USA and BronxWorks indicated that HIPPY has helped improved children's readiness for elementary school and has been a deciding factor in keeping parents engaged in their children's education through middle school. A special feature of BronxWorks is that it is linked to a host of community services (i.e., local hospitals, community mental health centers, Legal Aid Society or Bronx Legal Services; literacy supports through branches of the NY Public Library, and adult education classes through the NYC Department of Education).

Maternal and Infant Community Health Collaboratives (MICHC) is an initiative through the NYSDOH that works to improve maternal and infant health outcomes for high need, low-income, or Medicaid-eligible women and their families while reducing persistent racial, ethnic, and economic disparities in those outcomes. MICHC projects implement collaborative strategies at multiple ecologic levels (individual/family, organizational, and community) to address maternal and infant health behaviors, supports and service systems across three key life course stages: preconception, prenatal/postpartum, and interconception. The core individual-level strategy utilized by MICHC projects is the use of community health workers (CHW) to assist high-risk pregnant and parenting women and their families to effectively access continuous and coordinated health care and other services, including home visiting. On a systems level, MICHC providers work with the community partners to assess resources and prioritize community needs and strengths and implement community-level strategies to address the needs identified. The Department has awarded 23 MICHC projects in 32 high risk communities across the state. In 2019, as a result of recommendations by the Governor's Taskforce on Maternal Mortality and Disparate Racial Outcomes to address maternal mortality, the program received additional Medicaid funds to expand CHW services in key communities across the state to reduce maternal mortality and racial disparities in outcomes. The funding supports approximately 50 additional CHWs, with the capacity to serve an additional 2,400 prenatal and postpartum women and families.

Nurse-Family Partnership (NFP) is a national, evidence-based nurse home visiting program for at-risk first-time mothers, their infants, and families. There are currently six local partners in Upstate New York, located in Monroe, Onondaga, Cayuga, Chautauqua, Chemung, and Erie counties, and five local partners in Downstate New York, located in Kings, Queens, Rockland, Bronx, Westchester, and Nassau counties. The New York City programs are operated across 10 sites through all 5 boroughs with the Targeted Citywide Initiative which serves teens in foster care, women and teens in homeless shelters, and women at the Rikers Island Correctional Facility. Home visits are conducted by trained registered nurses on average of two times per month during pregnancy and until the infant's second birthday. Nurses carry a caseload of no more than 25 families. The program helps families improve maternal and child health, build a secure and nurturing relationship between parent and child, and reach education and employment

goals. With each visit, nurses focus on personal health, environmental health, quality of caregiving for the child, maternal life-course development, social networks, and health and human service utilization. Through randomized controlled trials, NFP programs have consistently demonstrated such positive effects as improved prenatal health, increased intervals between births, fewer subsequent pregnancies, increased maternal employment, improved school readiness, and fewer childhood injuries. Since 2003, over 19,552 families in the State of New York have been served by Nurse-Family Partnership. Currently, NFP's full-time equivalency nurse home visitor capacity is 172, which equates to a client capacity of 4,300 families.

Parents as Teachers (PAT) is an evidence-based home visiting model that provides supports to families with young children, prenatal through Kindergarten, with trained Parent Educators using a research-driven curriculum. Services include the four model components (personal visits, screening, resource networking, and group connections) adapted to fit the local community. Within their local contexts, the four model affiliates in New York implement these services to families in Monroe, Chautauqua, and Broome Counties. Personal visits are individualized for each family and focus on parent-child interaction, child development, development-centered parenting, and the overall family well-being. All children receive developmental screening, monitoring of developmental milestones, and health reviews. Families are connected to other resources in the community to meet their specific needs, and through group connections, families are also able to build social connections. The Parents as Teachers model has been tested by rigorous peer-reviewed studies and shown to produce results. Outcomes for families engaged with PAT model affiliates include prevention of child abuse and neglect, increased parent knowledge of early childhood development, improved parent practices, early detection of developmental delays and health issues, and increased school readiness and success. Affiliates follow the essential requirements of the model, which provide minimum expectations for program design, infrastructure, and service delivery. Parents as Teachers also provides training and ongoing support for affiliates to meet those requirements as well as further quality standards that represent best practices in the field.

ParentChild+ (previously known as Parent-Child Home Program (PCHP)) is a national evidence-based home visiting program that prepares young children for school success by increasing language and literacy skills, enhancing social-emotional development and strengthening the parent-child relationship. ParentChild+ is overseen by a national organization and has been in existence for over 50 years. Local ParentChild+ sites implement a research-validated replication model according to national guidelines and training. The program targets families with two and three-year olds who face multiple obstacles to educational and economic success. The program operates in 26 program partner sites in NYS and prioritizes its services to low-income families challenged by limited parental education levels, literacy and language barriers, lack of transportation, and other barriers. These families include those that have a history of child abuse/child welfare services, domestic violence, and older children with low student achievement, as well as women with late/no prenatal care. The families served include two parent, single parent, teen parent, foster parent, and grandparent families. ParentChild+ Early Learning Specialists, and home visitors are paraprofessionals who receive 16 hours of training prior to beginning home visits, two hours of weekly group training and supervision, and as needed individual supervision throughout the year. Families receive twice-weekly home visits for a minimum of 92 home visits over a two-year period, linking families to early intervention, social and community services, and the next appropriate educational step for the child, such as pre-kindergarten and Head Start. Families are provided books and educational toys that are age appropriate each week by the Early Learning Specialists which are gifts to the families for a total of 46 books.

A randomized controlled trial found that children who completed the full two years of ParentChild+ graduated at an 84% rate from high school, 30% higher than the control group. In NYS, two ParentChild+ programs are supported by the Children and Family Trust Fund, which is administered by the NYS Office

of Children and Family Services as well as by partial funding through Title 1/McKinney Act funds for education of Homeless Children and Young, and through BOCES[11] and local school aid.

SafeCare is an in-home behavioral parenting program that promotes positive parent-child interactions, informed caregiver response to childhood illness and injury and a safe home environment. SafeCare is designed for parents and caregivers of children birth through five who are either at-risk for or have a history of child neglect and/or physical abuse. The program aims to reduce both types of child maltreatment. The SafeCare curriculum is delivered by trained and certified providers. The curriculum includes three modules: (1) The home safety module targets risk factors for environmental neglect and unintentional injury by helping parents/caregivers identify and eliminate common household hazards and teaching them about age-appropriate supervision; (2) The health module targets risk factors for medical neglect by teaching parents/caregivers how to identify and address illness, injury, and health generally; (3) The parent-child/parent-infant interaction module targets risk factors associated with neglect and physical abuse by teaching parents/caregivers how to positively interact with their infant/child, and how to structure activities to engage their children and promote positive behavior. Each module is designed to be delivered in 6 sessions (18 total), but some families may need fewer or more sessions to reach skill mastery. Each session typically lasts 60 minutes and is delivered in the family's home or at another location of the parent's choice.

Capacity of Existing NYS Home Visiting Programs

The home visiting model developers were surveyed in Spring 2020 to determine the capacity of existing home visiting programs in NYS. The table in Appendix I shows a breakdown of program models by county with the funded capacity and number of families served in the last year. Family Connects is a light-touch model with the addition of a monthly check-in call and a six-month discharge home visit for developmental milestone achievement screening and serves one hospital system in four counties in NYS. in Programs that receive NYS DOH funding ("State") or MIECHV funding are labelled in the table. Many of these programs braid multiple funding streams to provide programming. Additional funders not listed include state funding through OCFS, NYC funding through NYCDOHMH, federal funding for EHS, county health department, local, private, and philanthropic funding.

Over 22,000 families benefitted from home visiting in NYS. These families represent 19.0% of Medicaid births (2017) often equated with the population eligible for home visiting services. Although there is a limit to the proportion of families that will accept services, it is evident that the majority of eligible families are not served. Staffing can impact capacity of home visiting programs. In the NYS MIECHV survey, 58% of home visiting programs who responded stated that they are always or most of the time able to fill home visitor positions within 2-3 months of vacancy and 38% of respondents stated that they are not or only some of the time able to fill home visitor positions within 2-3 months of vacancy.

In the 2020 HVCI Regional Summits, home visiting programs expressed that inadequate salaries and staff burnout lead to low retention and high turnover of home visitors. Home visitors require model specific training before they can begin to provide home visits to clients and new home visitors usually have a ramp up period which allows them to see fewer clients than the model requires for experienced home visitors. High turnover of home visitors leaves agencies with a lower capacity to meet the funded capacity expectation. The 2020 HVCI Regional Summits also highlighted the shortage of nurses (which impacts the home visiting programs that used nurses as home visitors), low retention of home visitors, a high cost of training new staff, and a need for self-care among home visitors to prevent burnout. They also indicated that turnover of home visitors leads to low family retention as families do not want to change home visitors.

[11] BOCES – Boards of Cooperative Educational Services

Quality of Existing NYS Home Visiting Programs

In order to identify the quality of existing home visiting programs in NYS, a survey was created by using a selection of the High Quality Indicators from the Standards of Quality (SOQ) for Family Strengthening and Support, developed by the California Network of Family Strengthening Networks and adopted by the National Family Support Network. The five sections of the Standards are: Family Centeredness, Family Strengthening, Embracing Diversity, Community Building, and Evaluation. In the NYS MIECHV survey, each of the five SOQ sections are represented by two questions. The survey allowed the home visiting programs to rate the extent to which they implement the practice on a five-point scale. The survey also assessed the program's need for technical assistance on the topics covered. For a copy of the NYS MIECHV survey, see Appendix E.

The survey was sent out to almost 250 home visiting programs across NYS. At the time of analysis, there were 66 respondents that represented 37 counties. The survey had a 27% response rate, with representation from almost all home visiting models. Several factors negatively impacted the response rate, including its presentation during the COVID-19 pandemic. Programs receiving MIECHV and/or NYS DOH funding were overrepresented in the results. Below is a summary of the results of the survey, based on the five sections of the Standards:

Family Centeredness: Working with families to make improvements and changes
55% have performance measures in place to track this topic
61% have quality improvement activities related to this topic

Family Centeredness: Having dedicated outreach strategies or a plan to gain potential participants
95% address this topic
90% having committed resources to address this topic

Family Strengthening: Having a formal process for obtaining family input
83% address this topic
63% have quality improvement activities related to this topic
54% have performance measures in place to track this topic

Family Strengthening: Facilitating or referring families to support/peer groups to build social connections within the community
87% have addressed this topic for more than three months.
45% have performance measures in place to track this topic
37% have quality improvement activities related to this topic

Embracing Diversity: Staff reflect diversity of families served
89% have addressed this topic for more than three months
8% have plans to address this topic or have addressed the topic for less than three months

Embracing Diversity: System in place to address the culture and diversity of the priority population
86% have been addressing this topic for more than three months

Community Building: Work with families to build health literacy and self-advocacy skills
98% have been addressing this topic for more than three months
59% have performance measures in place to track this topic
41% have quality improvement activities related to this topic

Community Building: Participate in coordinated efforts with other community-based organizations or providers to strengthen families
100% address this topic, with 98% participating in meetings at least quarterly

Use of Data to Support Program Improvement: Data system to track participant and program outcomes
89% have addressed this topic for more than three months

Use of Data to Support Program Improvement: Use data to plan and implement program activities
92% have addressed this topic for more than three months

Additionally, the survey asked home visiting programs to report on what types of funding they receive. The Statewide Home Visiting Workgroup indicated that in order to look at the actual amount spent on home visiting services in NYS, fiscal mapping should be done across all home visiting. Many agencies and organizations contribute a large amount of indirect rate to their home visiting program and home visiting programs often have several funding streams. The NYS MIECHV survey showed that 52% of home visiting programs who responded receive at least some funding from NYS, 38% receive at least some Federal funding (not limited to MIECHV), and 20% receive some private or foundation funding.

Gaps in Home Visiting and Community Resources in NYS

To identify gaps in home visiting services, additional needs of the community, and extent to which home visiting programs are meeting the needs of the community, several methods of community input were conducted, in collaboration with the Title V MCHSBG[12] needs assessment. The community input included conducting community listening forums (CLF), the Title V MCHSBG Public and Provider Surveys, key informant interviews (KII) with healthcare providers, the Home Visiting Transportation Survey, and a review of the 2019 MIECHV community needs assessments. From these qualitative data sources, several themes emerged. Graduate Assistants from the University at Albany's School of Public Health were integral in planning, conducting, and analyzing this qualitative data for community input. Themes identified in these sessions and surveys as gaps in home visiting and community resources are described below.

Awareness and Acceptability of Home Visiting Services: Lack of awareness of community programs was one of the most frequently reported gaps and highlighted in all forms of community input. Families expressed that they rely on word-of-mouth to find out about resources and services within the community, including home visiting programs. Community input from healthcare providers through the KII, pregnant and parenting families through the CLF, home visiting programs through the 2019 Community Needs Assessments, and themes from the 2020 HVCI Regional Summits indicated that there are several common barriers to accessing home visiting programs including lack of knowledge about home visiting programs and hesitancy to accept home visiting programs due to misconceptions and fear of home visiting. Fears expressed included a fear of CPS[13] and a fear of ICE[14]/detainment. Pregnant and parenting families in the 2019 home visiting focus groups expressed that they wish it was known that home visiting was a service that anyone could use and that it's not just for families who are stressed out. Participants in the 2020 HVCI Regional Summits noted that universal home visiting using a light touch model would help to decrease stigma and normalize home visiting.

"Something shouldn't have to be wrong in order for someone to call for the support. It should be for everyone."
(2019 Home Visiting Focus Groups)

"My clients are hesitant when I mention it [home visiting]…once I explain what the program is they are more accepting"
(Key Informant Interview, Monroe County)

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[12] MCHSBG - Maternal and Child Health Services Block Grant
[13] CPS – Child Protective Services
[14] ICE - Immigration and Customs Enforcement

"If it was not for finding myself in a shelter due to a domestic violence situation, I would have not known about resources in my community and I do not feel like that is a good thing."
(Community Listening Forums)

Positive Parenting Education and Support: Multiple forms of community input indicated that families have a desire for more positive parenting education, parent support, mentoring, encouragement, and positive relationships. Community members in the Community Listening Forums expressed interest in father or partner involvement in existing programs and events and adding additional events specific to fatherhood education and support. Several fathers and partners attended the Community Listening Forums and were grateful to be included to express their thoughts/concerns. Participants in the Community Listening Forums emphasized the need for these educational classes, stating that they would "make them better fathers". The 2020 HVCI Regional Summits also identified parent education as an opportunity for home visiting programs. Additionally, the summary of the results from the MIHOPE[15] and MIHOPE-Strong Start studies of evidence-based home visiting stated that positive parenting behavior was among the most common topics that families are discussing with their home visitors.

"Child victimization and domestic violence reporting for the areas served also demonstrate a dire need for evidence-based intervention that supports positive parent-child relationships…"
(Kings County Community Needs Assessment)

"The most frequently discussed topics were child development and positive parenting behavior."
(A Summary of Results from the MIHOPE and MIHOPE-Strong Start Studies of Evidence-Based Home Visiting, 2019)

"It's important for me to know and be educated and guided on what it would be like to care for a baby."
(Community Listening Forum)

Families with Multiple Children: The focus on family support across all stages of childhood and for the whole family was highlighted in community input from pregnant and parenting families, as well as in the NYSB5[16] needs assessment. According to the National Center for Children in Poverty Young Child Risk Calculator, 25% of NYS children under age three living in deep poverty (defined as household income <50% Federal Poverty Level) have a large family (defined as families with 4 or more children in a family) as a risk factor[17]. Families voiced the need for support at the different stages, from pregnancy to postpartum through early childhood and school-aged years. They described the need for more support related to health promotion and healthcare, parenting education, and other areas that home visiting touches on. Additionally, with not all NYS children ages 3-5 years old in childcare or preschool, there is greater need for home visiting programs that provides parent education.

"It's challenging, especially when you have multiple children. It's exhausting, because you might not have the answer, but you have four kids running around, and you have to figure it out."
(2019 Home Visiting Focus Groups)

"NYS ranks fifth in the nation with the largest percentage of childcare deserts."
(NYSB5 Needs Assessment)

Group Connections: Families expressed feelings of isolation including geographic, social, and language-based. A lack of supports was identified as a factor negatively impacting health and wellbeing, including mental health. They called for the need to cultivate a better sense of community, in which community

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[15] MIHOPE – Maternal and Infant Home Visiting Program Evaluation
[16] NYSB5 – New York State Birth to Five
[17] National Center for Children in Poverty. (n.d.). American Community Survey (2014-2018). Retrieved from: http://www.nccp.org/tools/risk/?state=NY&age-level=3&income-level=Extreme&ids%5B%5D=84&ids%5B%5D=76&ids%5B%5D=72&submit=Recalculate

members help or care for each other and children. They described a need for more courtesy, kindness, empathy, and trust among community members. Community Listening Forum participants indicated a need for social support, specifically to feel included and have a sense of belonging in their community. One parent commented that she valued "having a village, not doing it alone." They offered numerous recommendations to address this gap including more support groups, both peer and face-to-face support, opportunities and resources to support mentoring, encouragement, and positive relationships. Facilitated groups can be powerful tools for providing learning experiences, building social connections, engaging families more deeply in a program, building support networks, and giving parents the ability to parent their children around other families. In the 2020 Home Visiting Coordination Initiative Regional Summits, feedback indicated that families want more peer and community connections. In some cases, group offerings help recruit and retain new parents in the program. Some home visiting programs that do not have group connections as a required part of their model have responded to this community need by organizing and providing group connections for clients to meet each other to build a sense of community, but this augmentation is not practiced statewide.

"I don't think people value spaces to vent and talk. That's why I really enjoy the Fatherhood Program." (Community Listening Forum)

"There are a lot of things that we don't know as new mothers and having support can be very important during that period of time." (Community Listening Forum)

"For somebody who doesn't have a community around them, or they are doing it on their own…to have people in the community around to give that advice, I think it would help." (2019 Home Visiting Focus Groups)

Culturally and Linguistically Responsive Services: Community input highlighted the need to have healthcare and service providers match the ethnicity, culture, and language of the community. Families are becoming more diverse and the need for culturally and linguistically responsive programs are critical. According to the Title V MCHSBG[18] Provider Survey, providers indicated that they are taking steps needed to address racism, sexism, homophobia, provider bias, and lack of provider cultural competence by way of cultural competency and cultural humility training, offering translation services, and working close with their communities to address racism among other things. The need to have culturally and racially diverse providers extends across NYS as the rates of dual language learners (DLL), immigrants, and minority populations continue to grow. Results from the NYS MIECHV Survey showed that 88% of respondents have had staff that reflects the diversity of the families they serve for at least three months and 86% indicated that they have a system in place to address the culture and diversity of their priority populations. However, despite a high percentage of home visiting programs indicating that they provide culturally and linguistically responsive services in the NYS MIECHV Survey, community input from the Title V MCHSBG Public survey, Community Listening Forums, Key Informant Interviews, and 2020 HVCI Regional Summits stated that the lack of cultural diversity and linguistically responsive services is an issue in their community.

"I was recommended to a pediatrician and was told that he was good but didn't speak Spanish. I don't speak English, so it would have been challenging to communicate." (Community Listening Forum)

"They [service providers] make us feel like less of a person – that's why we lack services." (Community Listening Forum)

"Healthcare staff does not reflect the patient – they want a doctor that looks like them." (Key Informant Interview, Monroe County)

[18] MCHSBG – Maternal and Child Health Services Block Grant

Short-Term Home Visiting: Community input highlighted that home visiting programs should be offered on a short-term basis. Pregnant and parenting families who participated in the 2019 home visiting focus groups suggested home visiting services be offered for under two years with an option of less time. They noted that during pregnancy and the first year of the child's life are a time when parenting support is most needed and that first time parents are most likely going to need the full length of the program, while parents who are pregnant or parenting their second/third child may need less time with the program. Participants of the 2020 HVCI Regional Summits noted the stigma attached to home visiting and suggested universal home visiting and/or a light-touch model to help decrease stigma and normalize home visiting. Additionally, the MIHOPE[19] study found that while home visiting models end when the child reaches various ages, up to 5 years, families participated in home visiting for an average of eight months in the first year of services.

"[I would want home visiting services] up until one, because usually that first year is really scary." (2019 Home Visiting Focus Group)

"Moms need the most help when babies are first born" (Community Listening Forum)

"Families participated in home visiting for an average of eight months in the first year of services." (A Summary of Results from the MIHOPE[20] and MIHOPE-Strong Start Studies of Evidence-Based Home Visiting, 2019)

Systems Building: NYS needs a stronger, more coordinated early childhood system. This need was identified in the NYS Birth through Five Preschool Development Grant Needs Assessment, the 2020 HVCI Regional Summits, and confirmed by stakeholder and community input. Stakeholder input noted that referrals between programs can be challenging but when community programs are under the same umbrella, it helps to facilitate referrals for services. Community Listening Forum participants highlighted the ease of using a community program that provides a "one stop shop" for connecting parents to resources. The need for a "central referral point' for services for pregnant and parenting people was referred to as a need in communities. Work is in progress to improve home visiting systems at the State level, including the First 1,000 Days on Medicaid Initiative, NYS Coordinated Intake Pilot Project, and the Home Visiting Coordination Initiative. The 2020 HVCI Regional Summits highlighted poor communication between home visiting programs, and a need for a formalized coordinated referral system. Participants also mentioned a need for better interagency relationships, data standards, tracking systems, a one stop shop for families to access services, and a need to break down silos. Home visiting coordination at the local level was highlighted as a gap in the 2010 MIECHV Statewide Needs Assessment and even though work to coordinate efforts at the local level have been addressed, it continues to be a gap. Families would benefit from a stronger network at the local level.

"*I tell people to enroll into whatever program is offered because through that you can be connected to other services that might be available in the community*." (2019 Home Visiting Focus Group)

"*We have a lot of programs in our community! People don't know about them*!" (2019 Home Visiting Focus Group)

"They really should advertise resources at clinics and hospitals!" (Community Listening Forum)

[19] Maternal and Infant Home Visiting Program Evaluation
[20] MIHOPE – Maternal and Infant Home Visiting Program Evaluation

See Appendix B for the Community Listening Forums summary, Appendix F for the Key Informant Interview Summary, Appendix G for the Home Visiting Transportation Survey summary, and Appendix H for the Title V MCHSBG Public and Provider Surveys summary.

Extent Home Visiting Meet the Needs of Families in NYS

Home visiting programs build upon the strengths of families and the community they live in and aim to reduce barriers by connecting families to community services and resources. Community and stakeholder input gathered to inform this statewide needs assessment revealed several ways in which current home visiting services meet the needs of families in NYS. Below are the most commonly mentioned ways in which home visiting meets the needs of families in NYS.

Adaptability: Community input indicated that many community programs are not accessible to all pregnant and parenting families and that there is a need to redefine the home used for home visiting. A parent from the 2019 Home Visiting Focus Groups stated that "the problem is that a lot of these programs are not for working parents. I do need that help, but it's only going to be provided while I'm at work." The 2020 HVCI Regional Summit and Community Listening Forum participants stated that many home visitors often have flexible hours and are able to accommodate their families by working around the family's schedule. Several models have approved virtual home visits as a form of home visiting. As seen during the COVID-19 pandemic, home visiting programs in NYS have shown that they are able to adapt, while maintaining model fidelity, to meet the needs of their clients. NYS home visiting programs reacted quickly and effectively to modify service strategies in order to provide home visiting services to current and new clients. Model developers provided home visiting programs with guidance on how to conduct Ages and Stages Questionnaires (ASQ) and other screenings/assessments virtually. Home visiting during the COVID-19 pandemic in NYS has been shown to help families feel less alone and anxious. It helps to improve families' self-advocacy skills and connect to community services and resources. It builds families' confidence and resilience to handle their current stresses. Having a home visitor during a public health emergency allows families to connect (virtually) with someone that they know and trust. Pregnant families participating in a home visiting program during public health emergencies receive education about the importance of prenatal care and the birthing process as well as correct information about the safety of giving birth in hospitals. Stakeholders from the Statewide Home Visiting Workgroup expressed the importance of home visiting during public health emergencies, such as the COVID-19 pandemic. They highlighted the increased stress that low-income families are feeling during public health emergencies and the quick response that home visiting programs had in order to meet the needs of their clients and community.

Awareness of Community Resources and Services: One of the most frequently reported needs of families in NYS is a better awareness of community resources and services, including local healthcare providers and specialists, mental health and substance use treatment providers, domestic violence shelters, activities or centers for children and families, walkable areas to provide opportunities for exercise, and locations of food/baby item banks. Families in the Community Listening Forums expressed that they rely on word-of-mouth to find out about resources and services within the community. They also indicated that families who have home visitors are able to easily connect to information and referrals to community resources and services. Home visiting programs have shown to address their client's needs through their strong partnerships in the community. Their community partnerships improve their awareness of the ever-changing community programs and services and home visitors can connect clients to the many resources and services within their community. In the NYS MIECHV survey, 98% of the programs indicated they participate in coordinated efforts with other community-based organizations or providers to strengthen families at least quarterly.

Mental Health Treatment and Counseling Services: All forms of community input highlighted the need for improved awareness, availability, and accessibility of mental health treatment and counseling

services, specifically in the prenatal and postpartum periods. Community members specifically mentioned how home visiting programs help with postpartum depression and mental health. Home visitors provide referrals to mental health services in their community and some home visiting models have an approved depression and anxiety intervention as a component of their model. Community input highlighted many barriers to accessing mental health services, including fear of stigma, childcare concerns, and transportation issues. Some home visiting programs in NYS have mental health professionals on staff to accompany home visitors when clients need PMAD[21] services and/or provide support to the home visitors who have clients dealing with perinatal mood and anxiety disorders. A participant in a Community Listening Forum stated that "I wouldn't know what I would have done if I didn't have an NFP[22] nurse while I was going through PPD[23]".

Transportation: Though transportation was the second most commonly cited community issue in the community input, including both rural and urban communities, home visiting has shown to address this community issue by providing home visiting services in the family's home. Families in the community input stated many barriers to transportation including a lack of public transportation options, cost, reliability, long wait times, safety, and accessibility. A survey completed by home visiting programs regarding transportation, see Appendix G Home Visiting Transportation Survey, suggested that barriers to transportation include transportation not being family-friendly, medical transportation is limited, and that transportation is not accessible and hard to navigate. While most home visiting programs do not provide transportation to their clients, some home visiting programs have partnered with other community organizations to address transportation barriers together. In the 2019 MIECHV[24] community needs assessments and the Home Visiting Transportation Survey, home visiting programs shared successes in improving transportation including applying for grant funding to provide transportation to clients, connecting clients to local transportation services (e.g. nonprofit organizations that provide transportation), improving their clients' personal support systems, and using medical transportation services.

"It is more convenient and accessible when the services are offered in the home"
(Community Listening Forum)

"Having someone come directly to my home during postpartum was helpful"
(Community Listening Forum)

"We are also identifying and sharing the locations of the support services nearest to the client's address, especially those in walking distance to their homes or work locations. We continue to seek insight on how to overcome the transportation barrier." (Home Visiting Transportation Survey)

IV. State's Capacity to Provide Substance Use Treatment and Counseling Services

The New York State Office of Addiction Services and Supports (OASAS) plans, develops and regulates the state's system of addiction prevention, treatment and recovery services. OASAS-certified chemical dependence treatment programs serve more than 230,000 people per year in more than 900 programs with an average daily enrollment of 100,000. This includes the direct operation of twelve Addiction Treatment Centers where doctors, nurses, and clinical staff provide inpatient and residential services to approximately 8,000 individuals per year. The table below shows the total number of current[25] chemical

[21] PMAD – Perinatal Mood and Anxiety Disorder
[22] NFP – Nurse-Family Partnership
[23] PPD – Postpartum Depression
[24] MIECHV – Maternal, Infant, and Early Childhood Home Visiting
[25] As of June 29, 2020 from OASAS Provider Directory System

dependence treatment programs and certified capacities for the five major service categories for the initially identified high risk counties and statewide.

Table 4: Substance Use Treatment and Counseling Services Capacity

	Crisis		Outpatient		Opioid Treatment		Inpatient Treatment		Residential	
County	**Progs.**	**Cap.**	**Progs.**	**Cap.**	**Progs.**	**Cap.**	**Progs.**	**Cap.**	**Progs.**	**Cap.**
Albany	2	63	15	N/A	3	750	1	40	13	323
Bronx	5	105	26	N/A	15	10,015	3	86	14	959
Broome	1	30	3	N/A	1	150	2	40	4	107
Erie	2	42	27	N/A	5	1,629	2	53	10	382
Kings	8	128	39	N/A	13	6,850	3	110	7	252
Monroe	3	39	15	N/A	3	750	3	94	15	313
Nassau	1	20	31	N/A	3	675	1	30	3	74
New York	12	327	59	N/A	33	12,732	4	120	18	1,376
Niagara	2	24	8	N/A	1	85	2	75	8	190
Oneida	0	0	5	N/A	2	400	1	68	5	107
Onondaga	3	33	11	N/A	3	1,250	3	122	6	243
Orange	2	32	14	N/A	1	450	3	83	4	84
Queens	4	212	26	N/A	5	1,591	1	60	9	679
Richmond	1	44	13	N/A	2	770	2	54	4	109
Suffolk	6	78	38	N/A	4	1,175	7	291	13	459
Westchester	1	72	26	N/A	5	1,785	4	135	4	58
Statewide	68	1,483	455	N/A	111	42,882	64	2,382	213	7,572

Source: OASAS Provider Directory System, June 23, 2020. Note: OASAS does not certify a capacity for outpatient services. Opioid Treatment capacity is higher than shown due to capacity lifts approved for some programs.

The major addiction treatment service categories include crisis, outpatient, opioid treatment, inpatient, and residential. Most services are planned for and delivered at the county level. Inpatient and certain residential services are considered regional resources and serve residents on a multi-county basis.

Crisis Services provide a variety of treatment options designed to provide immediate care for people who are intoxicated or incapacitated by their use of alcohol or other substances. The primary goal of these services is to manage withdrawals from substances, as well as medical and psychiatric complications during withdrawals. Crisis services include detox services and are also designed to facilitate connections to continued care.

Outpatient Services provide clinical services for people with an addiction to substances and their families who have been impacted by their addiction. Outpatient services may be delivered at different levels of intensity according to the needs of the patient. These services include counseling, education, and connections to community services.

Opioid Treatment Programs (OTPs) are OASAS-certified sites where medication to treat opioid dependency is administered. These medications can include methadone, buprenorphine, and suboxone. In addition to medications, these facilities also offer counseling and educational services. In most cases, patients receiving services at an OTP clinic are provided treatment over a lifetime, similar to management of chronic physical ailments

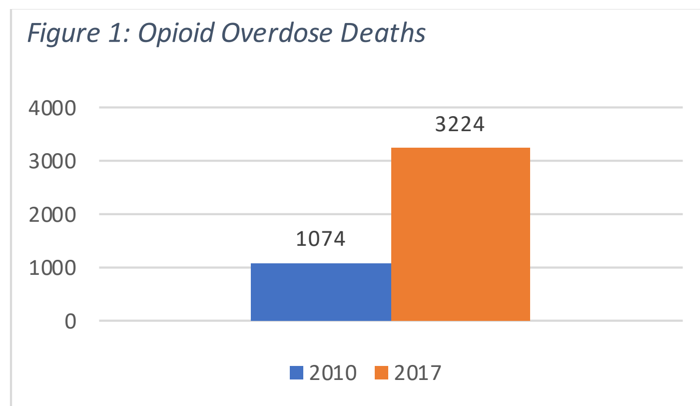
Inpatient Services provide a safe and supportive setting for the evaluation, treatment, and rehabilitation of people with substance use disorders. These facilities offer 24-hour, 7-day a-week care that is supervised at all times by a medical professional. Inpatient services include intensive management of symptoms related to addiction and monitoring of the physical and mental complications resulting from substance use.

Residential Services are designed for people who are in need of support in their recovery and may not be able to participate in treatment without a 24-hour residential setting. Residential services are designed to develop or maintain recovery through a structured, substance-free setting, and can include group support, skills development related to independent living, and other services designed to promote recovery.

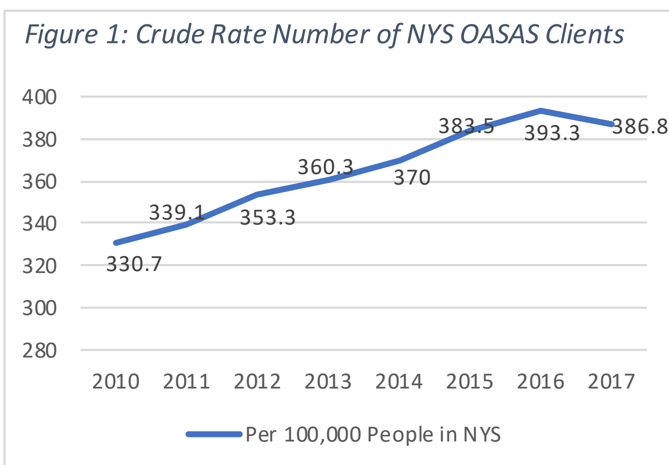
For any of the services above, women who are pregnant and/or nursing children are given priority admission at any OASAS-certified addiction treatment program. Many OASAS Addiction Treatment Centers and certified programs also have specialized programming for the treatment of pregnant women.

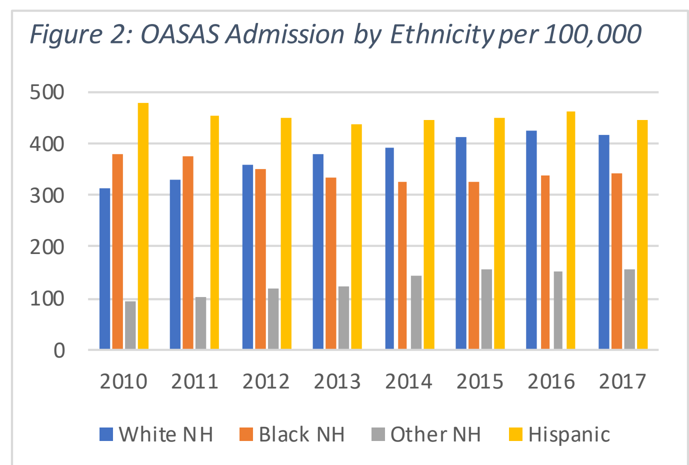
Substance Use Disorder Trends in NYS

Over the last ten years, NYS has had a steady increase in substance use disorder (SUD). Since our last needs assessment update in 2010, there has been a 200% increase in overall opioid overdose deaths throughout the state. The graph below shows the number of opioid overdose deaths in 2010 as compared to 2017.

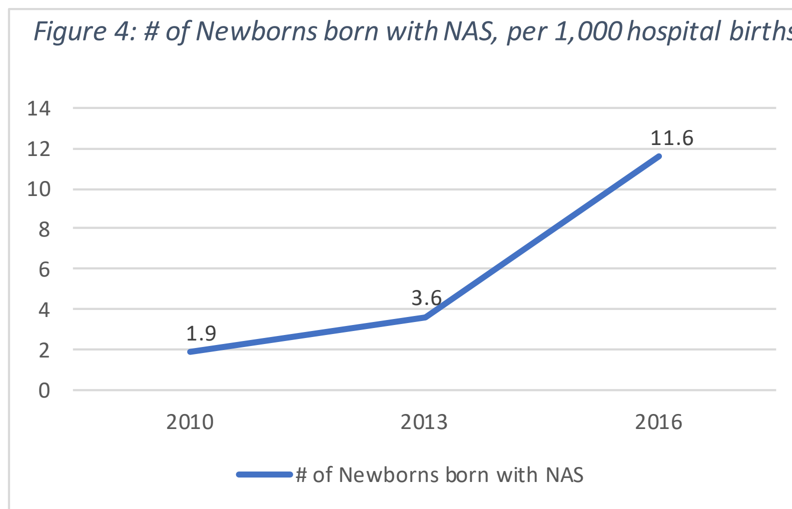


In addition, from 2010 to 2017 there was a 17% increase in unique OASAS admissions in NYS. There has been a steady increase in admissions to opioid use treatment programs. The chart depicts the rate of admissions from 2010 to 2017 per 100,000 population in NYS. The chart depicting the rate of admissions by race and ethnicity shows that Hispanics have had the highest rate of admissions for several years, followed closely by White participants.





The current rate for NAS is 10.1 in NYS where the NYS MCH[26] 2020 goal is a rate of 5.2. Data from recent years show that the numbers are slowly increasing across the state. The chart below shows the steady increase of the number of newborns with NAS per 1,000 births, showing 2010, 2013, and 2016.



Furthermore, averages from the 2017 and 2018 National Survey on Drug Use and Health (NSDUH) indicate that 1.2 million New York residents over the age of 12 have a substance use disorder. Opioids and alcohol carry the greatest SUD-related public health risks in New York Opioid use disorder (OUD) is a major public health crisis in NYS. The most serious consequence of the crisis has been the sharp rise in fatal overdoses due to opioids. Total drug overdose deaths have increased rapidly from 2,761 in 2015 to 3,719 in 2018, driven mostly by increases in opioid-related overdose deaths. In 2018, 81% of all fatal drug overdoses were opioid-related.

In NYS, excessive alcohol use causes over 4,000 deaths annually resulting in an average of 28 years of potential life lost per death. Averages from the 2017 and 2018 NSDUH indicate that 5% of New York residents, or slightly under 1 million people, have an alcohol use disorder.

Gaps in Substance Use Services and Barriers to Receipt

In order to provide a better reflection of substance use disorder treatment and counseling services in NYS, community input was gathered from public through Community Listening Forums and from healthcare providers through key-informant interviews. The Title V Provider Survey results and the 2019 MIECHV community needs assessments were also reviewed.

The healthcare providers reported that they direct their patients to social workers, primary care providers, various organizations, hotline numbers, and police programs who help connect individuals to treatment. Some providers indicated that they refer to treatment and counseling services in a neighboring county. Around 50% of the healthcare providers interviewed, commented on the ability of the mother and baby to stay together during the mother's treatment. Two counties referenced substance use treatment programs that allow the children to accompany the mother during treatment. The other counties stated that the mother-baby dyad has to travel far to attend treatment together or that there was not a program for the mother-baby dyad to go together.

Common barriers to accessing substance use treatment and counseling services described by the KII[27] healthcare providers included:

[26] MCH – Maternal and Child Health
[27] KII – Key Informant Interview

- Transportation
- Stigma
- Reasons relating to leaving their child(ren): childcare, fear of CPS[28], difficulty leaving family
- Psychological/emotional reasons
- Wait lists; although pregnant women get treated as priority

Additionally, substance use was reported as a major concern in over half of the Community Listening Forums. Participants commented that community violence or exposure to drug users or paraphernalia in parks and around town make it hard to take their family outside. In some of the Community Listening Forums, participants said they felt unsafe in their community because of visible drug dealers and open drug use on the streets. In these counties, participants agreed that there was a need for better awareness of substance use treatment and counseling services in their communities, but that due to the stigma associated with drug use, people are afraid to seek services.

In response to the Title V MCHSBG[29] Provider Survey question regarding what their community needed in order to improve people's health, providers indicated a need for more substance use treatment and counseling services, and highlighted the importance of substance use services for pregnant people. Emphasis was also placed on the need for substance use prevention. Thirty percent of providers stated that they work closely with substance use treatment and counseling services that exist in their communities to address the health needs of substance users.

Input from current MIECHV[30] funded programs through their 2019 community needs assessments echoed the community input, stating that substance use disorder is common in their communities and the major barriers to seeking treatment are client resistance and stigma/fear.

Current Activities and Opportunities for Collaboration to Strengthen the System of Care

An environmental scan of current collaboration efforts addressing substance use treatment and counseling services in NYS highlights the current activities and opportunities for collaboration to strengthen the system of care. While not comprehensive, below is a list of current collaboration efforts in NYS that address the rise in substance use disorders.

Division of Family Health (DFH)[31] collaborations:

- Pregnancy classes for people with substance use disorder: Some NYSDOH-funded Maternal and Infant Community Health Collaborative (MICHC) programs collaborate with substance use treatment and counseling service programs to provide pregnancy classes for pregnant people.

- Trainings: NYS MIECHV and the MICHC program collaborate with state and local agencies to present (virtual and in-person) to provide trainings on many topics, including substance use disorder in pregnancy, to the MIECHV and MICHC home visiting programs.

- New York State Department of Health Annual and Quarterly Opioid Reports: NYS MIECHV and the MICHC program distribute the NYSDOH annual opioid report and the County Opioid Quarterly Reports to the MIECHV and MICHC home visiting programs.

- Fetal Alcohol Spectrum Disorder (FASD) Workgroup: NYS MIECHV staff participate on the FASD workgroup that aims to increase awareness and advance the effective prevention and treatment of FASD in NYS through collaboration and coordination. In addition, each

[28] CPS – Child Protective Services
[29] MCHSBG – Maternal and Child Health Services Block Grant
[30] MIECHV – Maternal, Infant, and Early Childhood Home Visiting
[31] Division of Family Health (DFH) - NYS MIECHV is seated within the DFH at the NYSDOH

participating organization is empowered to examine its own policies, practices, regulations and laws, to determine how it can positively impact the goals of eliminating alcohol use during pregnancy and improving the lives of New Yorkers affected by prenatal alcohol exposure.

- NYS Opioid Use Disorder (OUD) in Pregnancy and Neonatal Abstinence Syndrome (NAS) Project: In response to this growing issue, the New York State Perinatal Quality Collaborative (NYSPQC) has joined together with the American College of Obstetricians and Gynecologists (ACOG) District II, Healthcare Association of New York State (HANYS) and Greater New York Hospital Association (GNYHA), with support from the National Institute for Children's Health Quality (NICHQ), to work with NYS birthing hospitals through a quality improvement learning collaborative, the NYS OUD in Pregnancy & NAS Project. These lead organizations convened a clinical advisory workgroup to guide the work of the project. The workgroup, which meets bi-monthly, includes specialists in maternal-fetal medicine, obstetrics, pediatrics/neonatology, anesthesiology and chemical dependence; and staff from the NYS Office of Addiction Services and Supports (OASAS). OASAS is specifically assisting with identifying and communicating linkages to services and education. The project has engaged pilot site birthing hospitals from diverse geographic areas and representing all levels of perinatal designations. The project plans to expand from a pilot to all interested NYS birthing hospitals in Fall 2020. Linkages to care has shown to be a struggle for many hospitals. There is an opportunity for collaboration with NYS MIECHV to address the gaps in services and barriers to receipt of substance use disorder treatment and counseling services. Additionally, many of the project's webinars are open to all NYS providers. Expanding the reach of the webinar announcement to all home visiting programs in NYS would improve state and local collaboration on this topic. Additionally, NYS MIECHV will provide NYSPQC-developed resources to home visiting programs, once available.

Other activities and collaborations that address substance use disorder in NYS:

- New York State Office of Addiction Services (OASAS) and Supports and the New York State Education Department (NYSED) have partnered to provide resources for educators and administrators, school nurses and counselors, as well as students and families, to address drug/alcohol and e-cig use in school settings. Alcohol and drug use early in life can cause irreversible brain damage and sometimes lead to addiction later in life. Adolescence is a critical time for brain development. OASAS provides a number of resources for the prevention and treatment of school-age children, including conversation aids, youth-centered programs such as clubhouses, and added support services for family and community.

- New Hope, New Life: In 2019 OASAS launched "New Hope, New Life", an educational resource center with a video series that helps New Yorkers understand the nature of alcohol and drug addiction and where to find help.

- State Opioid Response: OASAS is using funding from State Opioid Response to pilot a Maternal Wrap Around Project looking to provide care management services to pregnant and postpartum women with a SUD either in need of treatment or who are currently in treatment.

- Project Promise: This is a three-year SAMHSA grant looking to provide enhanced outpatient care for pregnant and postpartum women and their families. The targeted communities for this initiative are Westchester, Queens, and Onondaga.

- Heroin and Opioid Taskforce: OASAS, in collaboration with other state agencies, responded to the heroin and opioid epidemic by implementing innovative programming aimed at increasing access for communities across the state. Recognizing that there is no one size fits all approach to

combatting addiction, multi-faceted and evidence-based solutions have been designed to expand access to services while targeting regions and populations that are unserved or underserved. A few examples include establishing a center for treatment innovation, instituting open access centers that are available to the population 24 hours a day, 7 days a week, increasing access to MAT at FQHC, and expanding insurance access.

V. State's Capacity to Provide Perinatal Mood and Anxiety Disorder Treatment and Counseling Services

Perinatal mood and anxiety disorders (PMAD), primarily depression, affects 10-20% of women during pregnancy or within 12 months after giving birth[32]. While more than half of low-income mothers have shown to experience some level of depressive symptoms[33], MIECHV home visiting programs often have clients struggling with PMADs. Home visitors see the impacts it has, not only on the parent, but also on the infant and the whole family. While some NYS MIECHV home visiting programs have mechanisms built in to address PMAD disorders including tailored curriculum and referral metrics, it is important to understand the need and demand met for PMAD treatment and services throughout NYS. Presently, statistics on PMAD treatment are not maintained in NYS.

The New York State Office of Mental Health is leading the Moving on Maternal Depression (MOMD) learning collaborative, with the Schuyler Center for Analysis and Advocacy serving as project coordinator, and the Center for Law and Social Policy providing technical assistance. The MOMD project aims to advance structural changes to health systems to prioritize policies proven to strengthen perinatal mental health, particularly interventions that prevent, and if that is not possible, detect and treat, PMADs. The four goals of the MOMD project are to:

1. Integrate key metrics for implementing continuous improvement activities on perinatal depression across State agencies and through health care providers and community-based organizations.

2. Use innovative mechanisms to meaningfully engage in policy-making processes by collaborating with women who have experienced perinatal depression, with an emphasis on the inclusion of communities that have been historically marginalized.

3. Share and align information on perinatal depression and other PMADs across State agencies and with partnerships at the community level that are working in the areas of maternal and child health, early childhood development, and family economic security with an emphasis on strategic alliances to advance health equity.

4. Better understand the capacity of each region in the state for screening and treating those with perinatal depression and other PMADs, and develop a plan that focuses on workforce capacity for screening and treatment options. The plan will address the needs of geographic areas and populations that have been historically underserved. The MOMD project presents a great opportunity to improve and track the perinatal health of expecting and new mothers to better enable NYS mothers, babies, and families to thrive.

To address the first goal of integrating key metrics for implementing improvement activities on perinatal depression across the State, the MOMD project has created a data sub-workgroup to focus on collecting

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[32] New York State Department of Health. (n.d.). Maternal Depression. Retrieved from: https://www.health.ny.gov/community/pregnancy/health_care/perinatal/perinatal_depression.htm

[33] Schmit, S., Golden, O., Beardslee, W. (March 2014). Maternal Depression: Why it Matters for Anti-Poverty Agenda for Parents and Children. CLASP. Retrieved from https://www.clasp.org/sites/default/files/public/resources-and-publications/publication-1/Maternal-Depression-and-Poverty-Brief-1.pdf

data metrics from a range of stakeholders that touch on PMADs[34]. This data sub-workgroup has been working with a variety of organizations to get a sense of how organizations and agencies within NYS are collecting data related to PMADs in order to establish and collect consistent data as a state. The information currently being collected includes population being served, data sources being used, data currently collected, whether the organization is accounting for race and ethnicity, and the barriers to collecting data.

Information on treatment and services available by county were collected through collaborations with the Postpartum Resource Center of NY (PRCNY) and the NYS Office of Mental Health (NYS OMH). A comprehensive list of mental health services specifically for parents dealing with PMAD in NYS does not exist. It is unclear how many mental health programs allow children to accompany the parent, but key informants (providers) refer to a program that allow children to accompany the parent, if available.

- PRCNY provides a resource directory for PMAD resources, including providers, support groups, and support services throughout NYS.
- NYS OMH provides a resource directory on their website of mental health programs (e.g., outpatient, inpatient, residential, etc.) throughout NYS that are licensed, funded, or operated by OMH. The link to the directory can be found here: https://my.omh.ny.gov/bi/pd/saw.dll?PortalPages. This list does not specify whether programs specialize in PMADs or whether they allow children to accompany the parent.

The Postpartum Resource Center of New York (PRCNY) is a non-profit organization that connects NYS families to perinatal mental health services. The PRCNY works to strengthen perinatal mental wellness, build community partnerships, train providers, and offer education, screening and treatment services. In an interview with Co-founder and Executive Director Sonia Murdock, Ms. Murdock explained that women are generally able to access treatment, but much depends on the county they are in and the insurance they have. However, as with most services for young families in at-risk counties, barriers persist to accessing treatment. These barriers include lack of patient-centered care, language and cultural barriers, transportation issues, lack of childcare options, financial restraints, and the overall stigma against perinatal mood and anxiety disorders. Ms. Murdock indicated ways to address the barriers and close the gap to women accessing quality perinatal mental health care. These included enhancing the continuum of care from screening to hospital admission, addressing mental health care across the life course, establishing quality federally qualified health center (FQHC) support groups for parents, and enhancing inpatient and intensive outpatient programs.

Gaps in Services and Barriers to Receipt

In order to provide a better reflection of PMAD treatment and services throughout NYS, community input from the public as well as healthcare providers throughout the State was collected. While lists of mental health services provided throughout the State appear long and comprehensive, community input on the perceived awareness and availability of PMAD treatment and services indicate otherwise.

All forms of community input (CLF[35], KII[36], Title V Provider and Public surveys, and 2019 MIECHV[37] community needs assessments), highlighted the need for improved awareness, availability, and accessibility of mental health services, specifically in the prenatal and postpartum periods. Home visitors were noted as improving client's awareness of mental health services in the community. However, community and stakeholder input noted that while some home visiting clients may get connected to

[34] PMADs – Perinatal Mood and Anxiety Disorders
[35] CLF – Community Listening Forum
[36] KII – Key Informant Interview
[37] MIECHV – Maternal, Infant, and Early Childhood Home Visiting

mental health services, others will not close the loop on their referral due to cultural reasons, fear of stigma, lack of transportation, and lack of childcare. The 2019 MIECHV community needs assessments indicated that some home visiting programs have a mental health professional on staff to treat clients during home visiting sessions. This allows for a mental health professional to see the client in their home, which removes the barriers of stigma, childcare, and transportation. However, the incorporation of a mental health professional within home visiting programs in NYS is not common.

During the Home Visiting Listening Forums[38], a portion of the Community Listening Forums that were conducted specifically with home visiting clients or families who are eligible for home visiting services (pregnant or parenting families), seven gaps in services to addressing PMADs[39] arose. The gaps in services are listed in order of frequency – with the first being mentioned the most.

Gaps in PMAD treatment and services in the community:

1. Need for better awareness of mental health services
2. Need for better awareness, resources, coping supports for the postpartum period and postpartum depression and anxiety
3. Need for more mental health treatment providers
4. Afraid to seek services due to stigma
5. Do not feel heard by providers about treatment preferences
6. Long wait list
7. Providers should increase screening and provide more education on postpartum depression

"If we had more mental health programs/options that would help our community to not be so depressed."

"I feel bad that I wouldn't know where to guide a friend or myself if I needed help with depression or anxiety"

"The social worker in my OB/GYN office is how I got connected to resources but only because I said I was depressed."

During the Key Informant Interviews (KII), mental health was named one of the biggest issues for young families. Healthcare providers in Key Informant Interviews were able to provide information about PMAD treatment and services, however the most common places the healthcare providers indicated they would refer to is the obstetrician/gynecologist or to general mental health resources. Healthcare providers also noted that there are resources, screenings, and/or educational materials for PMAD provided at hospitals that pregnant people can access. Some healthcare providers talked about the ways in which they monitor or identify women at risk for perinatal mood and anxiety disorders. The healthcare providers reported screenings at hospitals, healthcare centers and offices, and in community programs. However, most healthcare providers stating that they are not aware of whether women are able to access the services once referred.

Among all counties where healthcare providers were interviewed, several themes arose in reference to their barriers to accessing PMAD treatment and services. The barriers to accessing maternal mental health services include:

- Stigma
- Lack of education including families not being able to recognize the signs and symptoms of maternal mental health disorders

[38] Home Visiting Listening Forums – a portion of the Community Listening Forums that were conducted specifically with home visiting clients or families who are eligible for home visiting services.
[39] PMADs – Perinatal Mood and Anxiety Disorders

- CPS[40]/taking child(ren) away
- Lack of services
- Transportation

"Motherhood is tough. Many moms think it's supposed to be hard and try their best to push through and ignore symptoms until they are stuck. We need awareness of the actual signs of depression, not the baby blues." (Key Informant Interview)

The 2019 MIECHV community needs assessments echoed the community input mentioned above. The home visiting programs highlighted the barriers to accessing perinatal mood and anxiety disorder services including a lack of: mental health programs, perinatal-specific mental health providers, openings in programs, and transportation.

Current Activities and Opportunities for Collaboration

Stakeholder feedback and community input indicated that there is a lack of awareness of currently available mental health services available for pregnant and parenting families. Work on this issue is being done at the state level, with community input and input from people with lived experiences. Part of improving awareness and availability of PMAD treatment and services in NYS is improving the state's ability to collect data in a uniform way. The work of the MOMD project to improve data collection will allow NYS to determine need and demand met of PMAD treatment and services.

VI. Stakeholder Feedback and Coordination with other Statewide Needs Assessments

To obtain stakeholder feedback in the development of this document, a multitude of virtual meetings were held to discuss the MIECHV statewide needs assessment update and allow for stakeholder input. The meetings consisted of an explanation of the requirements and process of conducting the statewide needs assessment as well as the gaps in services and ways in which home visiting services are meeting the needs of the community. Home visiting stakeholders who participated in these virtual meetings included Maternal and Child Health Services Block Grant Advisory Council, NYS Early Childhood Advisory Council (NYS ECAC), the NYS Healthy Start programs, state agency partners including NYS OMH[41], NYS OASAS[42], NYS OCFS[43], NYS CCF[44] and other NYS home visiting partners including the Statewide Home Visiting Workgroup, Docs for Tots, Moving On Maternal Depression (MOMD) Initiative, New York Immigration Coalition, Prevent Child Abuse New York, and all home visiting models that have programs in NYS. Additionally, stakeholder input was received from NYS MIECHV[45] and MICHC[46] programs through surveys to gather additional information about transportation barriers and strategies they use to address these barriers. Input was solicited from all home visiting programs in NYS in order to assess the five Standards of Quality (SOQ) for Family Strengthening and Support and gauge interest in technical assistance related to these five standards.

The needs assessment reviews of the Title V Maternal and Child Health Services Block Grant, Head Start, Preschool Development Grant, and CAPTA[47] helped determine overlap with home visiting and to pull out

[40] CPS – Child Protective Services
[41] OMH – Office of Mental Health
[42] OASAS - Office of Addiction Services and Supports
[43] OCFS – Office of Children and Family Services
[44] CCF – Council on Children and Families
[45] MIECHV – Maternal, Infant, and Early Childhood Home Visiting
[46] MICHC – Maternal and Infant Community Health Collaboratives Initiative
[47] CAPTA – Child Abuse Prevention and Treatment Act

gaps and needs related to home visiting in NYS. Summaries of the review of the individual needs assessments are below.

Title V Maternal and Child Health Services Block Grant Needs Assessment

Title V Maternal and Child Health Services Block Grant (MCHSBG) and the NYS MIECHV grant are both located within the Division of Family Health (DFH) at the NYSDOH. The two needs assessments were worked on collaboratively and had parallel processes. Staff working on the two needs assessments met weekly to review workplans, conduct data collection, plan for the collection of community and stakeholder input, and discuss preliminary findings from data collection and community and stakeholder input. The Community Listening Forums were conducted and analyzed collaboratively. Additionally, results from the Title V Public and Provider Surveys were reviewed to enhance community input on gaps in home visiting and extent to which home visiting meets the needs of the community.

Information on the Title V MCHSBG and MIECHV statewide needs assessments was incorporated in meetings with stakeholder groups on an ongoing basis, with input from partners routinely shared and integrated in the program's assessment of key issues and recommendations. The two needs assessment teams convened a special meeting in June 2019 with representatives of community-based programs and their community member partners, which directly informed the content and process for the community listening forums. The State's Title V Advisory Council provided key input and feedback throughout both NA processes, with meetings convened in September 2019 and February and June 2020.

The Title V needs assessment addresses a broad range of issues and received input from many stakeholders representing a variety of perspectives. Through the Title V Public Survey and the statewide Community Listening Forums, over 1,000 NYS women and adolescents voiced many needs and challenges, as well as current strengths and recommendations for improvement. (See Appendix H for a summary of the Title V MCHSBG Public and Provider Surveys.) Specific to perinatal health, participants emphasized the need for better supports and services related to family planning, pregnancy, birth, and postpartum care, especially resources and coping supports for Perinatal Mood and Anxiety Disorders. Families want more continuous support in the postpartum period beyond a single medical visit and called for increased and more extended access to doulas, midwives, home visiting, and breastfeeding support services, along with longer paid leave for both parents. They also called for more programs specifically for fathers, peer support groups for parents and families, and supports for co-parenting, conflict resolution, and healthy partner relationships.

The Title V MCHSBG needs assessment had ten key cross-cutting themes emerge.

Theme One: Lack of awareness of resources and services in the community
Theme Two: Transportation barriers
Theme Three: Availability and accessibility of services and amenities in the community
Theme Four: Poverty and issues of the working poor
Theme Five: Supports for parents and families
Theme Six: Social support and social cohesion
Theme Seven: Health care access and quality
Theme Eight: Community and environmental safety
Theme Nine: Housing
Theme Ten: Healthy eating

Through collaboration with the Title V MCHSBG[48] and a broad network of community-based partner organizations, Community Listening Forums were hosted across the state with families and community members to facilitate open discussion about individual, family, and community health and services. A

[48] MCHSBG – Maternal and Child Health Services Block Grant

total of 37 sessions were held in 18 NYS counties and in the Akwesasne Territory of the St. Regis Mohawk Tribe, with over 700 individual community members participating. Individual forums focused on specific populations including: expectant parents and parents of young children (n=10 forums and 230 parent participants); other adult men and women (n=15 forums and 292 participants, primarily parents and grandparents); adolescents (n=9 forums and 154 teen and young adult participants); and families of CYSHCN[49] (n=3 forums and 37 family participants). Forums were conducted and notes of the discussions were recorded by community partners. Participants were racially diverse: 32% identified as Black or African American, 28% as White, 19% as Asian or other race(s), and 3% as American Indian. Approximately 25% of participants identified as Hispanic, and participants reported primary languages of English, Spanish, Chinese, and Haitian/Creole. NYSDOH staff reviewed and analyzed all forum documentation for emergent themes using qualitative analysis methods.

Additionally, the Community Listening Forums included ten forums that were conducted to hear from expectant parents and parents of young children who are either currently enrolled in, or potentially eligible for, home visiting programs. Two hundred and thirty individuals, including 203 women and 25 men, participated in these tailored Community Listening Forums. Their comments encompassed all ten cross-cutting themes described above, with issues specific to perinatal and infant periods. Many families expressed the need to raise awareness about available community resources and services, in particular for Perinatal Mood and Anxiety Disorders, and to increase the availability and scope of services to support families in the postpartum period, including postpartum doulas, home visitors, Community Health Workers, and breastfeeding support. Transportation barriers described across groups were especially challenging for parents with young children, and homelessness is a special challenge for families seeking family-friendly shelters. Parents also described a desire for more parenting education classes and resources, on a range of specific topics that include infant care, infant development, childproofing and safety, behavior and discipline, and bonding. They called for more classes and programs specifically for fathers, including single fathers, more parenting support groups, and more community activities and programs to help new parents get out of the house. Returning to work after birth is a special challenge for lower income families, and the need for longer paid parental leave and sick leave for both mothers and fathers was emphasized. Childcare was also a topic of frequent concern, with parents describing challenges to find affordable, reliable, safe, and trusted childcare providers – both to work and to be able to participate in community programs and services – especially for parents working second and third shifts and variable schedules.

For a full summary of the Community Listening Forums conducted collaboratively with the Title V MCHSBG needs assessment, including quotes from participants, see Appendix B.

Title II of the Child Abuse and Prevention Treatment Act (CAPTA)

The NYS DOH has a strong partnership with NYS OCFS, who provides the project coordination necessary for NYS to use CAPTA funds. Both NYS DOH, through MIECHV, and CAPTA provide some funding for Healthy Families New York (HFNY) home visiting programs. Because of this intersect of funding sources on the HFNY home visiting programs, collaboration between NYSDOH and NYSOCFS, CAPTA is integrated into the work of home visiting in NYS.

The federal Child Abuse Prevention and Treatment Act (CAPTA) (42 USC 5101, et seq.) supports a number of activities designed to develop and strengthen child abuse and neglect prevention programs in NYS. CAPTA funds continue to support the federal Children's Justice Act programs and the federal Community-Based Child Abuse Prevention (CBCAP) program. In addition, funds supported scientific research; training and technical assistance, public awareness, and data collection and analysis to support development of best practices and to better serve children and families of NYS.

[49] CYSHCN – Children and Youth with Special Health Care Needs

The Comprehensive Addiction and Recovery Act of 2016 (CARA) has been included in CAPTA, and as a result all infants that have been born drug exposed are required to have a plan of safe care, to support families caring for the infant that was born drug exposed. As a result of this requirement, plans are required to be counted and monitored. OCFS[50], OASAS[51], and NYSDOH[52] have been collaborating to develop and implement a consistent Plan of Safe Care that can be used not only by CPS[53], but also the treatment provider agencies, prenatal providers, home visitors, and hospital staff that come in contact with the parents who deliver infants drug exposed.

NYS's expansive early childhood infrastructure and investment programs and services reflect a commitment to supporting young children and families. There are cross-sector collaborations that exists, such as the First 1,000 Days on Medicaid Initiative led by the NYSDOH and the Home Visiting Coordination Initiative led by Prevent Child Abuse New York.

OCFS will also monitor case documentation on the development and implementation of the plans of safe care through the review of child protective services cases using the Ongoing Monitoring Assessment (OMA) process. During this past year, OCFS, OASAS and DOH have been meeting to develop and implement a consistent Plan of Safe Care that can be used not only by CPS, but also by the treatment provider agencies and hospital staff. The Plan of Safe Care template has been finalized, and OCFS is working on making additional system changes that will allow for the collection of the required data elements.

OCFS, OASAS, and DOH participate in a standing monthly meeting for the Core Team of the New York State In-Depth Technical Assistance for Pregnant and Parenting Women with Substance Use Disorders and their Substance Exposed Infants (IDTA SEI). This collaborative effort is the result of an OASAS application for an 18-24-month period of in-depth technical assistance (IDTA) from the National Center on Substance Abuse and Child Welfare on behalf of Onondaga County in NYS. The focus of this IDTA is on pregnant and parenting women with substance use disorders and their substance exposed infants.

This population of mothers and babies is particularly vulnerable, and in great need of services. Onondaga County was chosen to participate in this IDTA because they reflect a location that is, with the exception of racial composition, representative NYS. Moreover, Onondaga County has an increasing number of pregnant women admitted to substance use disorder treatment, and an increasing number of babies born substance exposed, with Neonatal Abstinence Syndrome.

Finally, Onondaga already has the basis of a collaboration to bring in additional stakeholders for a more comprehensive cross-systems team. Stakeholders in Washington and Warren counties have also begun to work on increasing screening and referring to treatment when indicated. DOH and OCFS are also part of this state team for this project. This team will work together on the following goals: increase universal screening of pregnant women, as well as infants; increase access to treatment for women and infants, including outreach to women in marginalized populations; and develop a scope of practice for the use of peer services with this target population of women.

During the remainder of this project, the plan is to explore expansion to other counties across the state as addiction to heroin and other opioids continues to be at crisis level for many counties of NYS.

NYS Birth through Five Preschool Development Grant Needs Assessment

The NYS Council on Children and Families (CCF) is the grant recipient of the NYS Birth through Five Preschool Development Grant in NYS. The NYS Birth through Five Preschool Development Grant needs

[50] OCFS – Office of Children and Family Services
[51] OASAS – Office of Addition Services and Support
[52] NYSDOH – New York State Department of Health
[53] CPS – Child Protective Services

assessment was reviewed to inform the statewide needs assessment update. The themes highlighted in the NYS Birth through Five Preschool Development Grant needs assessment are consistent with the themes found in the MIECHV and Title V MCHSBG needs assessments. Major themes and gaps in services drawn from the NYS Birth through Five Preschool Development needs assessment are below:

Barriers to System Building

NYS's expansive early childhood infrastructure and investment in programs and services reflect a commitment to supporting young children and families. There are a variety of prevention based programs available, yet NYS's current system, with multiple oversight agencies and differences in governing laws, regulations, and policies, varying funding streams and eligibility requirements, and varying workforce qualifications and compensation scales, translate into inequitable accessibility and quality of early childhood service opportunities, especially for NYS's most vulnerable, and inefficiencies in the provision of services. There are a number of rural counties in the State that receive no funding to provide necessary services to families.

There are cross-sector collaborations that exist, such as the First 1,000 Days on Medicaid Initiative led by the NYSDOH[54] and the Home Visiting Coordination Initiative lead by Prevent Child Abuse New York; however, more coordination is needed among these collaborations.

Vulnerable and Underserved Populations in NYS

A substantial proportion of children in NYS are considered to be a member of a vulnerable population, including:

1. Young children of minority/ethnic groups
2. Young children living in low-income households
3. Young children experiencing homelessness
4. Young children receiving Early Intervention or Preschool Special Education Services
5. Young children living in multi-language households
6. Young immigrant, migrant, or refugee children
7. Young children living in rural areas

Gaps in Knowledge of Programs and Supports Available

Data from New York State Birth through Five Preschool Development Grant Needs Assessment focus groups and surveys reveal that parents tend to find information about programs from friends and family, rather than from more centralized resources. For example, in focus group discussions, parents repeatedly said they found the programs and services their children participate in mostly through word-of-mouth. Parents participating in the focus groups and surveys also expressed interest in finding out about programs and services using online tools. While there are a number of state agency websites developed expressly for parents to locate resources, it is apparent that they need to be better publicized. Focus group data suggest that there are gaps in knowledge about available social and health care services. Administrators spoke about the need for more support services and resources for families, such as mental health programs, employee assistance programs, and early intervention services. Compounding this stated lack of services, many parents in the focus groups shared that they were not aware of available services, while others indicated that they are aware but choose not to apply because of perceived stigma associated with public benefit receipt.

Access to Quality Programs

[54] NYSDOH – New York State Department of Health

There are significant challenges for families, which disproportionately impact children from vulnerable populations, to access high quality care and education. Challenges include location and transportation. Many programs are inaccessible to families living outside of higher socio-economic status communities and in rural areas where there is limited ability to travel. Additionally, families face unreliable or no transportation, which is a barrier for families when accessing services.

The Birth through Five Preschool Development Grant supports the NYS Coordination Initiative, led by Prevent Child Abuse New York (PCANY), to conduct regional summits to assist communities in coordinating their home visiting programs and connect them to other early childhood service providers. PCANY conducted 25 regional summits in ten regions across the state and brought together home visiting programs/providers funded by the NYSDOH, the NYS OCFS[55] as well as county funded and privately funded programs. These cross-program regional summits provided an opportunity to systematize home visiting at the state and local levels, assess each communities' continuum of services available for families with children birth through five, develop coordinated understanding of service eligibility and identify service gaps, discuss shared trainings, referrals and community partnerships. Regular communication was kept with PCANY about the status of the regional summits and to discuss themes that emerged. These themes align with the Community Listening Forums and Key Informant Interviews NYSDOH did for this MIECHV statewide home visiting needs assessment update and the Title V MCHSBG[56] needs assessments.

New York State Home Visiting Coordination Initiative (HVCI) 2020 Regional Summit Final Report

The NYS Home Visiting Coordination Initiative (HVCI) was launched in 2018 by Prevent Child Abuse New York (PCANY). The goals of the NYS HVCI include:

- promote partnership among home visiting programs in NYS
- share resources
- increase the number of families receiving home visiting services
- refer families to supportive services
- ensure the provision of high quality and comprehensive services that are most responsive to families

In 2019, through funding from the Preschool Development Grant, Prevent Child Abuse New York conducted 25 Regional Summits throughout NYS to obtain input from home visiting programs, healthcare and community providers, and parents. Participants discussed the strengths, weaknesses opportunities, and threats to supporting families through home visiting in their region. They highlighted three recommendations for the State to consider: institute a workforce development plan, implement coordinated intake and a referral data system to support collaboration, and create a statewide public education campaign.

Over the course of the Summits, more than 200 parents who are currently participating in or who had previously participated in home visiting shared their experiences and insights. Statewide themes emerged. Themes included: focus on trust, redefine home, redefine dosage, address gender issues, be aware of community resources, address implicit bias, and be intentionally strengths-based.

Since the HVCI Regional Summits were held with home visiting programs and community providers, they provided additional context for the needs of the community that was used to inform this MIECHV statewide needs assessment update. The HVCI 2020 Regional Summit Report and the NYS DOH

[55] OCFS – Office of Children and Family Services
[56] MCHSBG – Maternal and Child Health Services Block Grant

Community Listening Forums provided complementary feedback on the gaps in home visiting services and strengths of home visiting in NYS.

New York State Head Start Collaboration Project Needs Assessment 2020

The New York State Council on Children and Families (CCF) administers the New York State Head Start Collaboration Project with support from the federal Office of Head Start and the New York State Head Start Association. The Head Start Collaboration project conducted a needs assessment survey of the Head Start and Early Head Start programs through NYS in 2020. For the purposes of completing this MIECHV statewide needs assessment update, the 2020 Head Start needs assessment was reviewed. The following key findings, listed by national priority area, are highlighted due their potential collaboration to home visiting services.

Health Care: Within the context of healthcare, Head Start programs appear to have the most difficulty working with mental health services. They indicated areas for improvement including maternal depression screening, developmental screening for all, and Adverse Childhood Experiences (ACEs) education for staff and others in the community.

Early Childhood Systems Development & Education: Head Start indicated that leadership and administration opportunities for shared professional development would help them better address the difficulty of engaging in activities related to early childhood systems.

Services for Children with Disabilities: Approximately 20% of children enrolled in Head Start receive special education or early intervention services. Head Start indicated the need to establish relationships with university/community college programs, establish relationships with State Lead Agency for Part B/619 (preschool special education), and to be able to increase therapist availability including bilingual and specialized therapists.

Services for Children Experiencing Homelessness: 5% of the children enrolled in Head Start were homeless at some point during 2018. Head Start indicated that a specific area of improvement would be to develop and implement family outreach and support efforts including transition planning according to the McKinney-Vento Homeless Assistance Act, which requires schools to designate a staff person to serve as a liaison to help students in temporary housing and their families.

Welfare/Child Welfare: About half of families enrolled in Head Start receive other needs-based programs (51% received WIC[57], 47% received SNAP[58]), which highlights the importance of being able to support families in this area. Head Start indicated the need to establish relationships with economic and community development councils, establish relationships with state child welfare agencies, and to work together with TANF[59], Employment and Training, and related support services to recruit families.

Community Services: Head Start found that relationships with the providers of military families were rated as the least well-established of all community services. While NYS does not serve many military families, they remain a priority population. Head Start indicated establishing relationships/partnerships with providers of services to military families as a specific area for improvement that will be addressed through their strategic plan.

The key findings highlighted above show potential for collaboration with home visiting in NYS. Additionally, the Head Start needs assessment emphasizes the need for improved coordination and communication between Head Start and home visiting programs in NYS.

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[57] WIC – Special Supplemental Nutrition Program for Women, Infants, and Children
[58] SNAP – Supplemental Nutrition Assistance Program
[59] TANF – Temporary Assistance for Needy Families

VII. Conclusion

A statewide quantitative data analysis at the county level was completed to determine communities with concentrations of risk. An independent method of analysis was developed to address the diverse population and geographic regions within the state. A main component of the analysis was the inclusion of burden for the included 15 indicators. Indicators were standardized within each HRSA provided domain and then averaged across domains for composite measures of rate and burden. These composite measures were used to rank all counties in the state. This is consistent with the methodology utilized in other NYS public health initiatives.

The recommended measures from the SIR were used, as well as indicators to measure teen births, maternal mortality, limited English Households, and the burden of adverse perinatal outcomes including, low birth weight births, preterm births, and infant mortality experienced by non-Hispanic Black women compared to non-Hispanic White women. NYS champions health equity for families and women across the life course. These additional indicators prioritize equity for families in NYS.

NYS completed a statewide data report as well as data reports for all 16 priority counties with average NYS data for comparison. The reports include the 15 indicators categorized by HRSA domain. The selected counties align with the areas with the greatest population of Medicaid births, most diverse populations, and urban areas. The selected 16 counties include 14 of the counties selected in the original 2010 needs assessment. This updated list of at-risk counties will be identified in the Updated State Plan for home visiting services.

While there is an obvious need for more home visiting services to serve more families in need in the counties with concentrations of risk, the need to build effective state and local coordination of home visiting services cannot be ignored. The existing home visiting program models currently in operation in NYS can effectively address certain specific needs of families, but no one model can adequately address all of the issues that impact families' health, well-being, and stability. As noted by community input and home visiting stakeholders who contributed to this statewide needs assessment, and as reiterated in the NYSB5[60] and Head Start Collaboration Project needs assessments, families lack access to a wide scope of essential supports (e.g. housing, food, transportation, health care, mental health services, employment assistance, child care, substance use treatment, etc.). When asked to identify the strengths of home visiting programs in their communities, stakeholders stated that collaboration among service providers in a community was essential in order to address families' multiple needs. As noted by one stakeholder, "With all of the challenges facing families, right now in particular, it is very beneficial that relationships among the models and programs already exist here in New York". This is the most concise summation of the strategy and challenge that NYS must address in constructing an effective home visiting system.

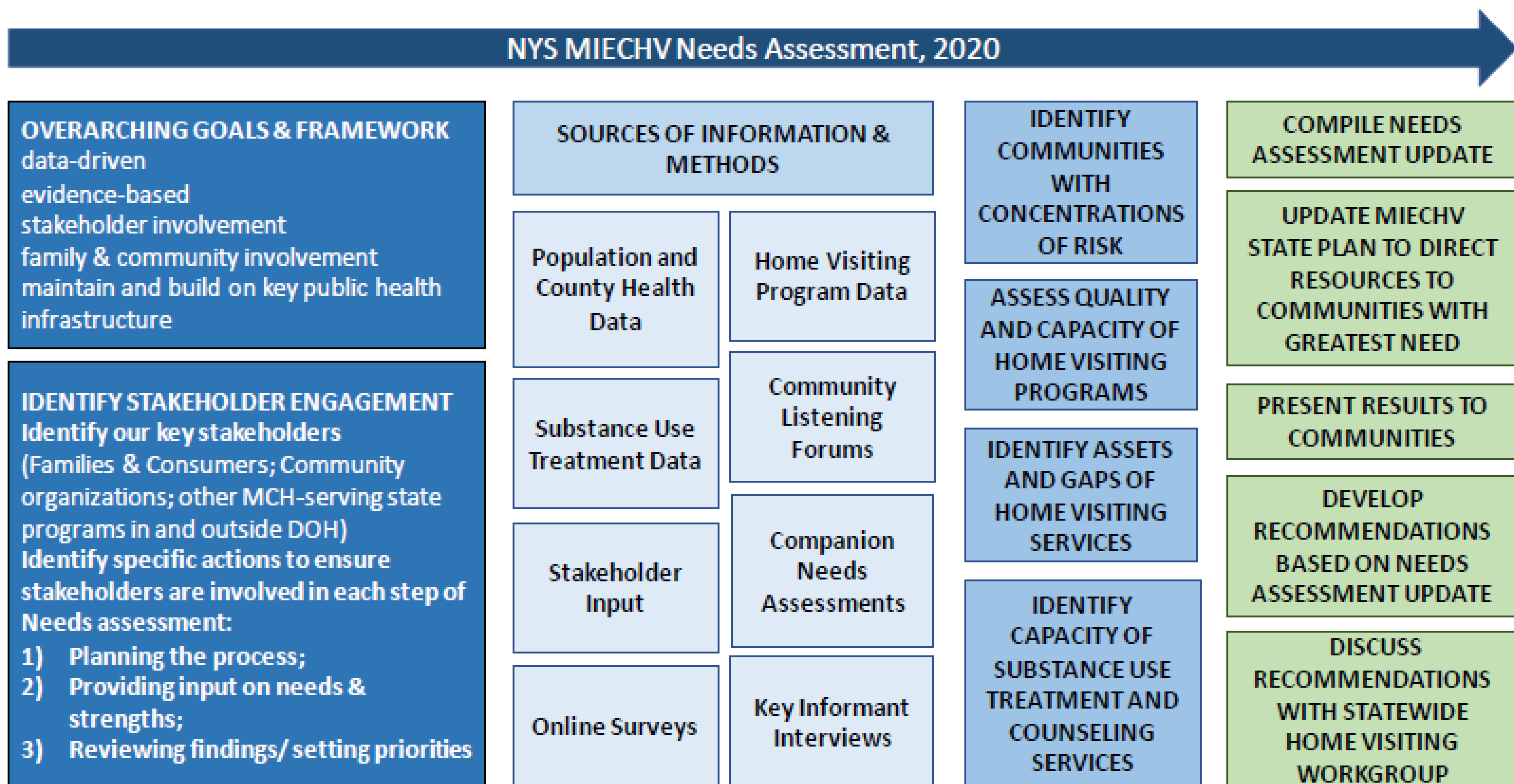
The next steps New York State will undertake to address the identified gaps in home visiting and develop an Updated MIECHV[61] State Plan for home visiting services include:

- Developing a dissemination plan and materials to share and review results of this analysis with stakeholders including the Statewide Home Visiting Workgroup, home visiting models, NYS OCFS (including those who oversee CAPTA), NYS OASAS, NYS OMH, NYS CCF, and other interested stakeholders. This plan includes:
    - Sharing the NYS MIECHV Needs Assessment Update with stakeholders
    - Creating and sharing an Executive Summary
    - Presenting the results of the needs assessment update with stakeholders on a webinar

[60] NYSB5 – New York State Birth to Five Preschool Development Grant
[61] MIECHV – Maternal, Infant, and Early Childhood Home Visiting

- Consult with the Statewide Home Visiting Workgroup members regarding recommendations based on the gaps in home visiting services identified in this statewide needs assessment update.
- Prepare an updated NYS MIECHV State Plan, in consultation with the Statewide Home Visiting Workgroup.

Appendix A, NYS MIECHV Statewide Needs Assessment Logic Model



Appendix B, Community Listening Forums Summary

In collaboration with the NYS MCHSBG Title V Program and a broad network of community-based partner organizations, forums were hosted across the state with families and community members to facilitate open discussion about individual, family, and community health and services. In 2019, NYS DOH convened a special meeting with representatives of community-based programs and their community member partners, which directly informed the content and process for the community listening forums. Discussion guides were developed for the community programs to use in the community listening forums to maintain consistency with questions and format.

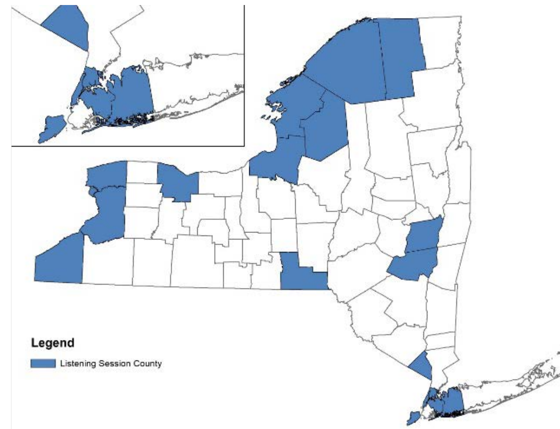
A total of 37 community listening forums were held in 18 NYS counties and in the Akwesasne Territory of the St. Regis Mohawk Tribe, with over 700 individual community members participating. Individual forums focused on specific populations including: expectant parents and parents of young children (done in partnership with the MIECHV Program, n=10 forums and 230 parent participants); other adult men and women (n=15 forums and 292 participants, primarily parents and grandparents); adolescents (n=9 forums and 154 teen and young adult participants); and families of Children and Youth with Special Healthcare Needs (CYSHCN) (n=3 forums and 37 family participants. Forums were conducted and notes of the discussions were recorded by community partners. Participants were racially diverse: 32% identified as Black or African American, 28% as White, 19% as Asian or other race(s), and 3% as American Indian. Approximately 25% of participants identified as Hispanic, and participants reported primary languages of English, Spanish, Chinese, and Haitian/Creole. NYS MCHSBG and MIECHV staff reviewed and analyzed all forum documentation for emergent themes using qualitative analysis methods.

Ten Themes from the Community Listening Forums

During the community listening forums 10 themes arose. It is important to note that these themes emerged organically from open-ended group discussions in community members' own voices and were not prompted by topic-specific questions.

1. Lack of awareness of resources and services in the community
2. Transportation barriers
3. Availability and accessibility of services and amenities in the community
4. Poverty and issues of the working poor
5. Supports for parents and families
6. Social support and social cohesion
7. Health care access and quality
8. Community and environmental safety
9. Housing
10. Healthy eating

The map of NYS, shown below, displays the counties that held the 37 community listening forums.



Theme One: Lack of awareness of resources and services in the community. This was the most frequently reported need, raised in three-quarters of the community forums. Participants noted that they rely on "word of mouth" to know about services in their communities or that you must encounter a problem (e.g., have a preterm infant or enter a domestic violence shelter) to enter the system and be connected to needed services. They offered numerous recommendations including enhanced community outreach using existing outlets (such as churches and supermarkets) and new groups; printed and virtual materials and resources; and increased referrals, coordination, and navigation support from service providers. Specific services frequently mentioned by participants for which increased awareness is needed include mental health, substance use, and family planning services.

"Just tonight, everyone is talking about different programs that a lot of us didn't know about. Education, knowing more about what's out there and the people who are providing these services, getting the info out there"

"If it was not for finding myself in a shelter due to a domestic violence situation, I would have not known about resources in my community and I do not feel like that is a good thing"

Theme Two: Transportation barriers. This was the second most commonly cited issue, voiced by participants in two-thirds of community forums. Participants cited lack of public transportation options, cost, reliability, long wait times, and accessibility as key barriers. They described the impact of transportation barriers on keeping and arriving on time for appointments, reliably getting to jobs, running errands, and participating in community activities. They voiced recommendations for low/no cost transportation to non-medical services (such as WIC and DSS), more short-notice and "emergency" transportation options, more informational resources to help community members know what's available, and more "family-friendly" transportation that is accessible to strollers, wheelchairs, and families with multiple children. Families also described concerns about pedestrian safety – especially for children – and called for improvements to make communities (both streets and sidewalks) more walkable.

"I had to walk through town with my groceries in a cart and walk the cart back. It was embarrassing"

"We have the […] county bus that goes around, but there's not a lot of them. There are big gaps in the day when you either have to… go early and spend your whole day waiting for your appointment. So you waste a lot of your day, that you [could] have worked or done something else"

Theme Three: Availability and accessibility of services and amenities in the community. Within this common theme, participants identified many different specific resources needed in their communities. Most notably, each of the following were identified by two-thirds of the community forums as needs:

- Sources for affordable and fresh/healthy food
- Local health care providers and specialists
- Mental health and substance abuse treatment providers
- Activities or centers for children and families (including activities for preschool age, teenagers, differently abled)
- Fitness centers or walkable areas to provide opportunities for exercise

Respondents cited barriers to using community services including: the cost of programs; distance/ travel time; inconvenient locations and hours; challenges with eligibility, available "slots" or long waiting lists; and fears of seeking services due to stigma about undocumented status or mental health issues. They also described bad experiences and bad "reputations" with some programs and staff as factors that discouraged use of available services. These challenges were exacerbated by transportation issues (see theme above), forcing residents to travel outside the community for services or go without.

"We need more healthy food in the hood all hoods have crappy food."

"They know that we are immigrants and don't help us."

"If we had more mental health programs/options that would help our community to not be so depressed"

"A lot of people are afraid to get services, if they use drugs, they think their baby will get taken away"

Theme Four: Poverty and issues of the working poor. In one-third of the community forums, participants described challenges specific to earning too much to qualify for benefits but not enough to get by – voicing a sentiment that "the system holds you down" with no opportunity to save and get ahead. Individuals described challenges qualifying for and obtaining services, citing the burdensome nature of documentation and application processes, inconsistent information, and experiences of feeling judged and disrespected by social service systems and staff. Some noted that benefits they did receive were insufficient to meet their family's needs. They also described being "suddenly dropped" from services if their income increases or if two adults are working, with gaps in coverage. They suggested providing access to copiers and fax machines to assist people with applications, and instituting processes to "wean off" of benefits when eligibility changes.

Within this theme, respondents also described the desire for financial stability and opportunities to grow financially for their family and children. They cited the need for more stable, quality job opportunities, with livable wages and benefits. Participants asked for more assistance to find jobs, develop career skills, continue education, and obtain free or affordable higher education. Both youth and adults called for more education in schools on financial literacy skills related to budgeting, taxes, and credit. The high cost of basic needs – including food, health insurance and health care, housing, child care, clothing, diapers, and others – was frequently noted as a barrier to saving and getting ahead financially, and organizations that assist with meeting those basic needs were often discussed as an important asset.

"If you are in poverty, you are more likely to spend more money because there is this whole thing of like you pay for something to get it immediately rather than saving up to get something that lasts, so you end up buying something that will break really quick. So you end up spending more money. So really, being poor is expensive"

"If you are making a 'livable wage' you can't qualify for certain services. The system is made for us to fail. If you do improve, you lose services, you fall back."

Theme Five: Supports for parents and families. The focus on family support across all stages was highlighted in the community listening forums. Families voiced the need for additional supports at different stages, from pregnancy and postpartum through early childhood and school-age years. They described needs for more support related to health promotion and health care; parenting education –

including relationship support - for both mothers and fathers; benefits such as paid family leave and sick leave; affordable high-quality childcare; and, safe positive after school activities for children and youth. Families expressed the need for more support during the postpartum period, indicating that they do not receive support until the postpartum medical visit at six weeks and stated that c-section births need additional support. Families specified the need for more doulas, midwives, perinatal home visiting, and community health workers.

"Father support is very important- taking to appts, being engaged, being there for birth, delivery, after. Helping with medications, rest, take slack off mom, cook dinner"

"I had a c-section and was alone at home. I did not have help."

"We struggle financially if the dad stays home after the birth. He either goes to work to help pay the bills and pampers or stays home and not have things we need."

Theme Six: Social support and social cohesion. Beyond the needs for tangible parent supports described in theme five, participants across all demographic groups frequently described feelings of isolation - geographic, social, and language-based. Participants identified family and friend support as an important asset, while lack of those supports was identified as a factor negatively impacting health and wellbeing, including mental health. They offered numerous recommendations in this area, including:

- more support groups, both peer and face-to-face support
- opportunities and resources to support mentoring, encouragement, and positive relationships, both for children/teens and adults
- more community events for socializing and to connect with each other
- more opportunities for community engagement, empowerment, and organization

More fundamentally, participants called for the need to cultivate a better sense of community, in which community members help or care for each other and children. They described the need for more courtesy, kindness, empathy, and trust among community members – this was raised in more than half the forums across all populations and demographic groups.

"I feel isolated because not everyone is experiencing what I am experiencing"

"Back in the old days, neighbors watched out for others' children"

"If they had these types of sessions in the community to talk about success stories there might be more success."

"It's good when someone can guide you. More people you can talk to, more mentors and role models to give feedback on behavior for personal growth."

Theme Seven: Health care access and quality. Participants across many local forums (approximately one-third of sessions) described that they do not "feel heard" by their health care providers. They described feeling that their concerns and treatment preferences are not taken seriously, and that providers do not care about them or understand what they are going through, resulting in people avoiding seeking care and services because they feel judged or anticipate being treated poorly. Participants expressed a desire for providers to show more compassion and respect, and to have more providers who are like themselves – from their own community and who speak their language. In addition, participants describe numerous barriers to care including long wait times for appointments, inconvenient hours (paired with inability to take time off from work), long travel times/distance, lack of providers accepting Medicaid or uninsured patients, high insurance costs and co-pays (especially for prescriptions), inadequate insurance coverage, high provider turnover/lack of continuity, and insufficient numbers of providers in some communities. They voiced recommendations for bias and cultural competence training for providers and

staff, help to improve their own advocacy skills and health literacy, extended service hours, and more assistance with insurance and care navigation.

"Must have hope that you trust your provider and make sure someone is not trying to hurt you."

"I tried out a new doctor and it was taking a while for me to get in. I was called in and the doctor came in and she asked her questions. Then she started talking to me for half an hour to an hour about my classes, my life and my friends. And I had never had an experience like that before. She showed me that I can trust her and I was really comfortable receiving care."

Theme Eight: Community and environmental safety. Concerns about community violence and safety were another common theme. In many forums, participants reported feeling unsafe in their communities, specifically describing concerns that include guns, gangs, and public drug use, with special concern for children's safety in schools and neighborhoods. Parents and teens described a sense of isolation related to crime and safety concerns. Participants called for better community policing and adult supervision, more community centers and after-school programs, safer parks and playground equipment, and more greenspace where families can go safely. Additionally, many groups raised concerns about visible trash in streets and public spaces and air, water, and noise pollution that negatively impact their communities.

"I have to cover my kids' eyes as they walk through the park"

"I see syringes in the stairs, in the elevators, this is a big need in my building"

"We live in front of a school so there's always a police car pulled there but people will sell drugs right in front of him and he doesn't do anything."

Theme Nine: Housing. More than half the community groups discussed the need for affordable housing. The high cost of rent and utilities, the prohibitive expense of security deposits, long waits and cumbersome processes for housing subsidies, a lack of safe quality housing appropriate for families, and lack of accountability from landlords were frequently cited as barriers. Homelessness and the need for more shelters for families were also mentioned frequently.

"Affordable housing is not affordable for people trying to get out of the project."

"Kids are sleeping on top of each other because there's no room in the houses. It's crazy"

"I don't feel there's a system in place to make sure landlords treat you like human beings"

Theme Ten: Healthy eating. The majority of groups described a need for sources for affordable fresh and healthy foods in their communities. Participants indicated that healthy foods are too expensive, while unhealthy foods are more affordable and have more coupons, and some stores and pantries provide food that is rotten or expired. Community members recommended removing advertising for unhealthy and fast foods, more farmer's markets (emphasizing food rather than crafts), more food pantries with healthy options, more affordable healthy food in schools, community gardens, and education for students and community members on healthy food choices, cooking, and budgeting.

"There is never enough to go around. We go to soup kitchen, pantries but there needs to be more."

"We need more healthy food in the hood all hoods have crappy food" (expectant/parenting CLF participant)

Home Visiting Listening Forums

Of the 37 community listening forums, 10 were tailored to home visiting. The participants in these home visiting listening forums were expectant parents and parents of young children. This allowed us to gather community input specifically from individuals that are currently enrolled in home visiting or who are eligible for home visiting programs. These home visiting listening forums included 230 individuals, including 203 women and 25 men, participated and focused on services available in their community, ability to access services, and other services that could be helpful. The ten themes listed above were consistent with the home visiting listening forums. The home visiting listening forums also highlighted on the need for improved awareness of services including programs and resources available for families and increased supports for parents including maternal mental health services and supports, affordable childcare options, activities for children, prenatal and postpartum preparation and postpartum supports, perinatal home visitors, support groups for all family members, and parenting classes specifically offered for fathers.

Perinatal Mood and Anxiety Disorders

During the community listening forums, community members discussed the need for improved awareness of services, resources, and supports available for families including perinatal mood and anxiety disorders (PMAD). Community members also discussed the need for certain services in their communities, including mental health. During the home visiting specific community listening forums (home visiting listening forums), seven needs/barriers and five strengths in the community to addressing maternal mental health. These home visiting listening forums were held with current home visiting clients or families who were eligible for home visiting services (pregnant or parenting families). The strengths and needs/barriers are listed in order of frequency – with the first being mentioned during the most home visiting listening forums and the last being mentioned during three of the seven home visiting listening forums. Only strengths and needs/barriers that were mentioned in at least three of the seven home visiting listening forums are included. Strengths and needs/barriers mentioned at 1-2 listening forums were not included.

Needs/barriers in the community to addressing PMAD:

1. Need for better awareness of mental health services (6/7)
2. Need for better awareness, resources, coping supports for the postpartum period and postpartum depression and anxiety (6/7)
3. Need for more mental health treatment providers (5/7)
4. Afraid to seek services due to stigma (3/7)
5. Do not feel heard by providers about treatment preferences (3/7)
6. Long wait list (3/7)
7. Providers should increase screening and provide more education on postpartum depression (3/7)

"If we had more mental health programs/options that would help our community to not be so depressed"

Strengths in the community for addressing PMADs:

1. Mental health services (4/7)
2. Counseling services/therapists are helpful (3/7)
3. Home visiting programs help with postpartum depression and mental health (3/7)
4. Mental Health Hotline (3/7)
5. Social workers provide information and referrals to mental health services (3/7)

"I feel bad that I wouldn't know where to guide a friend or myself if I needed help with depression or anxiety" and "The social worker in my OB/GYN office is how I got connected to resources but only because I said I was depressed."

Appendix C, Key Informant Interview Summary

Method:

Key informant interviews were conducted across New York State (NYS) to obtain a professional perspective on services and gaps or barriers to maternal and infant health. A total of twenty-six key informant interviews were completed over the phone across ten counties: Bronx, Cayuga, Chautauqua, Monroe, Nassau, Oneida, Orange, Richmond, Sullivan, and Westchester. The counties were chosen to allow for a diverse representation of NYS regarding geographic location and population size. Interviewees were selected according to their position in maternal and infant health as well as their likelihood to serve pregnant women and families with young children eligible for Maternal, Infant, and Early Childhood Home Visiting. The interviewees were staff, including social workers, referral specialists and doctors, from federally qualified health centers, hospitals, maternal and child community organizations, WICs, Planned Parenthoods, early childcare centers, and County Departments of Health.

The responses from the key informant interviews were compiled and analyzed by staff at the NYS Department of Health. The responses to the interviews in a county were compiled into one large response for that county. Open-ended questions and yes/no/I don't know questions were analyzed differently due to the vast array of responses for open-ended questions compared to the sample size. For open-ended questions, if three or more counties had the same response, then the response was considered a common response of NYS. If multiple responses had an overarching theme with at least three responses under that theme, the theme was considered the common response and the three responses under that theme were described. For yes/no/I don't know questions, individual responses were analyzed between and within counties. Each response was counted and totaled to find the most common response. If interviewees provided explanation for their answers to these questions, they were described. Responses were going to be analyzed for differences between New York City or New York City and Long Island compared to the rest of the state, but there were not enough key informant interviews done for New York City to make comparisons.

Four main topics were included in the survey: overall family needs, home visiting, substance use, and perinatal mood disorders. Issues, gaps, and barriers were asked for all main topics and in addition, available services were asked for home visiting, substance use and perinatal mood disorders. Below are the main themes that emerged according to each question that was asked.

General:

Participants were asked what the biggest issues are in the county for young families. The following were the most common responses regardless of whether the county was urban or rural:

- Transportation
- Childcare
- Housing
- Substance Use
- Mental Health

At least one interviewee in all ten counties said transportation was one of the biggest issues and for many of the counties more than one interviewee in that county said transportation was one of the biggest issues. Childcare was also frequently discussed in the interviews as an issue when either returning to work or attending appointments. Overall, childcare was described as expensive and not affordable. Some interviewees also stressed that there was a shortage of childcare available. Housing was another one of the biggest issues brought forth. Housing was described as not affordable, old, and unsafe, for reasons such as lead. Both substance use and mental health are top issues which are outlined further in the key informant interviews.

"This area is deceiving, overall we have good outcomes but that's not true for minorities."

"Medical providers need to know about optimal levels of care regardless of if the person is rich or poor."

"People believe they will get treated poorly because they have Medicaid."

"Do we put food on the table or get OB check?"

Similar gaps in support services for young families were found throughout the counties. The most common answers were issues relating to services as a whole. Similar gaps are:

- Lack of awareness of services
- Lack of access to services
- Lack of services/resources
- Transportation
- Housing

When counties talked about the lack of access to services, they said that programs such as shelters, financial support, and early intervention were all full and maxed out. They also commented on how programs target specific populations therefore excluding people who could really use the service. In addition, the lack of access to basic care items, providers, and places were also mentioned. When counties described what services and resources were lacking, the counties all named different areas. The lack of services and resources is very county specific instead of NYS wide.

"People think we are still in NYC and that it is easy to get here and there. We have the Long Island train or buses. The train is too expensive for my clients. Busses are hard to manage and there might be a lot of transfers."

"There's a lack of awareness of services, then once they come to my office I get bombarded with questions and need for help. How can we reach them and get them the right information?"

When key informant interviewees were asked if people can access services that reflect their culture, the overall response from the counties was uncertainty but they did name a few services that incorporated culture in some way. Within most counties, there were both responses of yes and no for whether the county does provide services that reflect different cultures. When interviewees explained exactly what cultural services they knew of, most commonly they were referring to languages spoken and the race/ethnicity of providers. It was common to hear from interviewees that certain organizations or community health workers offered services in at least one other language. It was also common to hear that providers did not reflect different cultures.

"There is not enough diversity in mental health."

Home Visiting:

Every interviewee, except for one, knew of local home visiting programs. Most of the counties knew of at least a few different home visiting programs in their area. Nurse-Family Partnership was the most commonly named program followed by Healthy Families and Catholic Charities and then Early Head Start. Many counties also named home visiting programs that were specific to their county. Every interviewee except for one said they refer to home visiting programs, but most interviewees did not track referrals. Overall most interviewees said that people are accessing home visiting programs. Some did respond that they did not know if people are accessing home visiting programs but only one person responded no, they weren't accessing them. A few people who said people were accessing home visiting programs also commented that there is hesitancy or programs are not filled to capacity.

The most common barriers to accessing home visiting programs included:

- Pregnant women, families, or someone they lived with not wanting people in their homes
- They do not want someone watching over them
- Fear that CPS would remove their child from them
- Lack of knowledge

Substance Use Disorder:

When interviewees were asked about resources for substance use disorder treatment, responses were a mixture of specific programs available in their area and where they would direct someone to learn of the resources. They also mentioned support groups someone can attend. Many of the specific programs were not in their county, but a neighboring county. Places they would direct someone to include social workers, primary care providers, organizations, hotline numbers, and police programs who help them connect to treatment. In half of the counties, interviewees commented on the ability of the mother and baby to stay together during the mother's treatment. A couple of counties named programs where the baby can join the mother during treatment and other counties said that the mothers would have to travel far or that there was nowhere for the mother and baby to go together.

Most interviewees said either people do access substance use disorder treatment, or they did not know if people access substance use disorder treatment. Answers among interviewees in the same county greatly varied as well. Common barriers to accessing these treatment programs described by interviewees were:

- Transportation
- Stigma
- Reasons relating to leaving children
- Psychological/emotional reasons

Many reasons relating to leaving the child during treatment arose; including childcare, CPS taking the child away, the difficulty of leaving families, and not being able to bring the child with them. In addition, many barriers are related to psychological and emotional reasons. These barriers include the difficulty of addiction, fear, resistance, and motivation. Many interviewees commented on the long waitlists but many also followed with the fact that pregnant women get to skip the line.

Perinatal Mood and Anxiety Disorder:

For resources available for perinatal mood and anxiety disorder treatment, counties gave names of specific programs they knew about and/or places who would know what resources are available. Many interviewees named local hospitals. Some of these responses were referring to the time when the mother is in the hospital for the birth. The most common places interviewees said they would refer to is the obstetrician/gynecologist. Interviewees within and across counties varied greatly in their responses to whether people access the treatment. Most interviewees said they do not know whether people access the treatment.

Among counties, there were many similar barriers to accessing perinatal mood and anxiety disorder treatment. The following barriers start with the most common:

- Stigma
- Lack of education
- CPS/taking child away
- Lack of services
- Transportation

Some participants explained the lack of education further. Among the pregnant women and families, it was noted that they did not have the ability to recognize the signs and symptoms of perinatal mood and anxiety disorder.

"Motherhood is tough. Many moms think it's supposed to be hard and try their best to push through and ignore symptoms until they are stuck. We need awareness of the actual signs of depression, not the baby blues."

For the medical providers, some are hesitant to prescribe because they are unsure of the effects to the fetus.

Conclusion:

Common gaps, barriers, and issues were found between topics discussed in the key informant interviews. For every topic except for home visiting, transportation was always one of the most common barriers reported by interviewees. Two of the common issues among counties, substance use and mental health, were two of the focus areas of the key informant interviews. Housing was both one of the biggest issues and one of the most common gaps in social services in the counties. For topics discussing specific services, such as home visiting programs, substance use disorder treatment, and perinatal mood disorder treatment, interviewees shared that people are fearful that CPS will take away their children. For substance use disorder treatment and perinatal mood and anxiety disorder treatment, stigma was one of the most common barriers to accessing the treatment. Interviewees also reported there was a lack of services, both social services and perinatal mood disorder treatment services.

Appendix D, At-Risk County Data Reports

Data Report for At-Risk Community: Albany

Demographics

The Census Bureau estimated that Albany County's population was approximately 307,117 inhabiting a land area of 522.7 square miles. The ethnic composition of the county in the American Community Survey estimates was 5.8% Hispanic or Latino, 12.5% Black or African American, 75.6% White, 6.5% Asian, 0.2% American Indian and Alaska Native, In Albany, the median household income was $64,535 and 11.2% were living below the federal poverty level, compared to NYS which has 13.6%. Albany County has about 10.4% who were foreign born and 13% spoke a language other than English in the home. The percent of children under 5 is 5.1%.

	Albany Data		**NYS Data**	
Indicator	**Rate**	**Burden (No)**	**Rate**	**Burden (No)**
Medicaid Births	36.1%	1,146	50.8%	116,084
Premature Births	9.9%	314	9.2%	329
Low Birth Weight	8.4%	268	8.1%	297
Infant Mortality	5 / 1,000 births	16	4.5 / 1,000 births	17
Maternal Mortality	31.7 / 100,000 births	3	20.9 / 100,000 births	2.4
Teen Births	9.1 / 1,000 females	107	12.4 / 1,000 females	120
Neonatal Abstinence Syndrome	11.9 / 1,000 births	35	10.1 / 1,000 births	42
Index Crime	2,745 / 100,000 residents	8,361	1,784 / 100,000 residents	5,623
Juvenile Arrests	938 / 100,000 juveniles (7-15)	268	512 / 100,000 juveniles (7-15)	169
High school dropouts	10%	308	9.0%	308
Childhood Poverty	13.2%	7,443	19.9%	13,102
Unemployment	3.7%	5,844	4.7%	6,349
Disparity Index	1.9	NA	1.9	NA
Limited English Households	2.6%	3,235	4.1%	9,571
CPS Reports	149 / 10,000 children (0-17)	910	145.3 / 10,000 children (0-17)	948
Foster Care	36 / 10,000 children (0-17)	220	38.6 / 10,000 children (0-17)	252

Home Visiting Programs

Home Visiting Model	**Agency**
Healthy Families New York	Healthy Families of Albany County
Maternal and Infant Community Health Collaborative	WILLOW

Data Report for At-Risk County: Bronx

Demographics

The Bronx is the northmost of the five boroughs of New York City. The Bronx is the only borough located primarily on the mainland. In 2017, the Census Bureau estimated that the borough's population was approximately 1,471,160, inhabiting a land area of 42 square miles. The makes the Bronx the fourth-most-populated of the five boroughs, the fourth largest in land area, and the third highest in density of population. The ethnic composition of the borough in the 2017 American Community Survey estimates was 56.2% Hispanic and Latino, 35.2% Black or African American, 22.3% White, 3.9% Asian, 3.3% Multiracial, and 0.1% Other (including Pacific Islanders and Native Americans, Alaskans, or Hawaiians). In the Bronx, the median household income in 2017 was $35,467 and 27.4% were living below the federal poverty level, compared to NYS which has 13.6%. The percent of children under 5 is 126,111 or 7.2%

	Bronx Data		**NYS Data**	
Indicator	**Rate**	**Burden**	**Rate**	**Burden**
Medicaid Births	78.8%	15,962	50.8%	116,084
Premature Births	10.1%	2,035	9.2%	329
Low Birth Weight	9.8%	1,994	8.1%	297
Infant Mortality	5.3 / 1,000 births	107	4.5 / 1,000 births	17
Maternal Mortality	36.2 / 100,000 births	23	20.9 / 100,000 births	2.4
Teen Births	21.0 / 1,000 females	1,019	12.4 / 1,000 females	120
Neonatal Abstinence Syndrome	8.4 / 1,000 births	170	10.1 / 1,000 births	42
Index Crime	2,431 / 100,000 residents	35,355	1,784/ 100,000 residents	5,623
Juvenile Arrests	586 / 100,000 juveniles (7-15)	1,035	512 / 100,000 juveniles (7-15)	169
High school dropouts	18%	2,646	9.0%	308
Childhood Poverty	39.3%	14,0279	19.9%	13,102
Unemployment	5.7%	34,319	4.7%	6,349
Disparity Index	1.4	N/A	1.9	NA
Limited English Households	18.0%	89,994	4.1%	9,571
CPS Reports	173.3 / 10,000 children (0-17)	6,156	145.3 / 10,000 children (0-17)	948
Foster Care	48.8 / 10,000 children (0-17)	1,734	38.6 / 10,000 children (0-17)	252

Home Visiting Programs

Home Visiting Model	**Agency**
Attachment & Biobehavioral Catch-Up (ABC)	Power of Two
Early Head Start	South Bronx Early Head Start
Early Head Start	Fort George Community Enrichment Center Early Head Start
Early Head Start	Leake and Watts Early Head Start
Early Head Start	Children's Aid Society Early Head Start

Nurse-Family Partnership	Nurse-Family Partnership: Targeted Citywide Initiative-NYC Department of Health and Mental Hygiene
Nurse-Family Partnership	Nurse-Family Partnership: Visiting Nurse Service of New York
Nurse-Family Partnership	Nurse-Family Partnership: Montefiore Home Care
Healthy Families New York	Catholic Guardian Services/Healthy Families Parkchester
Healthy Families New York	South Bronx Healthy Families/Bronx Lebanon Hospital
Healthy Families New York	Healthy Families Morris Heights
Early Head Start	Sheltering Arms Children and Family Services Early Head Start
Maternal and Infant Community Health Collaborative	Urban Health Plan
Home Instruction for Parents of Preschool Youngsters	Bronx Works Home Instruction for Parents of Preschool Youngsters
Parent Child Plus	MASA Inc
Parent Child Plus	Rising Ground
SafeCare	The New York Foundling

Data Report for At-Risk County: Broome

Demographics

According to 2017 Census estimates, Broome County has a population of 191,659. Approximately one in five residents are under the age of 18 and about 5.1% are under the age of 5. The ethnic makeup of the county was 87.2% White, 7.4% Black or African American, 4.3% was Hispanic or Latino, 0.6% Native American, 5.3% Asian, 2.0% from other races, and 2.1% from two or more races. Broome County has about 9.0% who were foreign born and 11.7% spoke a language other than English in the home. The percentage of children under 5 is 5.3% and the median household income of Broome county is $ 47,758.

	Broome Data		NYS Data	
Indicator	**Rate**	**Burden**	**Rate**	**Burden**
Medicaid Births	56.8%	1,123	50.8%	116,084
Premature Births	11.3%	224	9.2%	329
Low Birth Weight	8.6%	170	8.1%	297
Infant Mortality	5.1 / 1,000 births	10	4.5 / 1,000 births	17
Maternal Mortality	16.3 / 100,000 births	1	20.9 / 100,000 births	2.4
Teen Births	13.5 / 1,000 females	97	12.4 / 1,000 females	120
Neonatal Abstinence Syndrome	29.8 / 1,000 births	46	10.1 / 1,000 births	42
Index Crime	2,717 / 100,000 residents	5,137	1,784 / 100,000 residents	5,623
Juvenile Arrests	1,196 / 100,000 juveniles (7-15)	224	512 / 100,000 juveniles (7-15)	169
High school dropouts	9%	207	9.0%	308
Childhood Poverty	21.2%	7,789	19.9%	13,102
Unemployment	4.9%	4,115	4.7%	6,349
Disparity Index	1.9	N/A	1.9	N/A
Limited English Households	1.7%	1,338	4.1%	9,571
CPS Reports	397.4 / 10,000 children (0-17)	1,608	145.3 / 10,000 children (0-17)	948
Foster Care	66.5 / 10,000 children (0-17)	269	38.6 / 10,000 children (0-17)	252

Home Visiting Programs

Home Visiting Model	**Agency**
Parents As Teachers	Binghamton City School District PACT Program Parents as Teachers
Parents As Teachers	Parents and Children Together (PACT)/Lourdes Hospital Parents as Teachers
Healthy Families New York	Healthy Families Broome
Maternal and Infant Community Health Collaborative	Mothers and Babies Perinatal Network

Data Report for At-Risk County: Erie

Demographics

Erie County is in the western part of New York State. According to the 2017 estimates, the population was 919,719. The urban center is Buffalo – the third poorest city in the country. The ethnic makeup of the county was 75.2% White, 14.0% Black or African American, 5.7% was Hispanic or Latino, 1.1% Native American, 4.3% Asian, 3.0% from other races, and 2.1% from two or more races. Erie County has 5.5% of its population under 5 years of age, 7.8% were foreign born, and 11.1% spoke a language other than English in the home. The median household income in Erie county was $56, 369.

	Erie Data		NYS Data	
Indicator	**Rate**	**Burden**	**Rate**	**Burden**
Medicaid Births	38.7%	3,808	50.8%	116,084
Premature Births	9.9%	976	9.2%	329
Low Birth Weight	9.1%	893	8.1%	297
Infant Mortality	4.8 / 1,000 births	47	4.5 / 1,000 births	17
Maternal Mortality	29.9 / 100,000 births	9	20.9 / 100,000 births	2.4
Teen Births	14.9 / 1,000 females	431	12.4 / 1,000 females	120
Neonatal Abstinence Syndrome	26.8 / 1,000 births	261	10.1 / 1,000 births	42
Index Crime	2,519 / 100,000 residents	22,901	1,784 / 100,000 residents	5,623
Juvenile Arrests	642 / 100,000 juveniles (7-15)	606	512 / 100,000 juveniles (7-15)	169
High school dropouts	9.0%	858	9.0%	308
Childhood Poverty	21.4%	39,964	19.9%	13,102
Unemployment	4.4%	19,574	4.7%	6,349
Disparity Index	2.1	N/A	1.9	N/A
Limited English Households	2.3%	8,822	4.1%	9,571
CPS Reports	215.2 / 10,000 children (0-17)	4,172	145.3 / 10,000 children (0-17)	948
Foster Care	39.7 / 10,000 children (0-17)	770	38.6 / 10,000 children (0-17)	252

Home Visiting Programs

Home Visiting Model	Agency
Healthy Families New York	Buffalo Home Visiting Program/Buffalo Prenatal-Perinatal Network
Early Head Start	Erie Early Head Start
Nurse-Family Partnership	Nurse-Family Partnership: Catholic Health System
Maternal and Infant Community Health Collaborative	Buffalo Prenatal-Perinatal Network
Parent Child Plus	King Urban Life Center

Data Report for At-Risk County: Kings

Demographics

Kings County is better known as Brooklyn, one of the five boroughs of New York City, with an estimated population of 2,582,830 in 2017. The racial composition of Kings County is 34.1% are Black or African American, 36.4% are White persons of non-Hispanic/Latino origin, 0.9% are Native American Indian and/or Alaska Native persons, 0.1% are Native Hawaiian and Other Pacific Islander, 12.7% are Asian, and 19.1% are of Latino or Hispanic origin. Approximately 36.5% were foreign born and 45.4% spoke a language other than English at home. The median income was $56,015. In Kings county, 7.2% are under 5 years old.

	Kings Data		NYS Data	
Indicator	**Rate**	**Burden**	**Rate**	**Burden**
Medicaid Births	63.6%	24,855	50.8%	116,084
Premature Births	8.5%	3,309	9.2%	329
Low Birth Weight	7.7%	2,996	8.1%	297
Infant Mortality	3.9 / 1,000 births	151	4.5 / 1,000 births	17
Maternal Mortality	20.1 / 100,000 births	25	20.9 / 100,000 births	2.4
Teen Births	13.1 / 1,000 females	926	12.4 / 1,000 females	120
Neonatal Abstinence Syndrome	3.4 / 1,000 births	133	10.1 / 1,000 births	42
Index Crime	1,913 / 100,000 residents	50,106	1,784 / 100,000 residents	5,623
Juvenile Arrests	475 / 100,000 juveniles (7-15)	1,330	512 / 100,000 juveniles (7-15)	169
High school dropouts	13%	2,715	9.0%	308
Childhood Poverty	26.7%	159,509	19.9%	13,102
Unemployment	4.2%	51,220	4.7%	6,349
Disparity Index	2.5	N/A	1.9	N/A
Limited English Households	15.1%	143,386	4.1%	9,571
CPS Reports	108.4 / 10,000 children (0-17)	6,386	145.3 / 10,000 children (0-17)	948
Foster Care	48.8 / 10,000 children (0-17)	2,874	38.6 / 10,000 children (0-17)	252

Home Visiting Programs

Home Visiting Model	**Agency**
Early Head Start	Yeshiva Kehilath Yahov Early Head Start
Early Head Start	Beth Rivkah Early Head Start Program
Early Head Start	Yeled V' Yalada Early Head Start Program
Family Connects	Northwell Health
Nurse-Family Partnership	Nurse-Family Partnership: Targeted Citywide Initiative- NYC Department of Health and Mental Hygiene
Nurse-Family Partnership	Nurse-Family Partnership: SCO Family Services
Healthy Families New York	Healthy Families Sunset Park
Healthy Families New York	CAMBA's Healthy Families Program
Healthy Families New York	Bushwick Bright Start Healthy Families/Public Health Solutions
Healthy Families New York	Healthy Families Brookdale

Healthy Families New York	Healthy Families Successful Start/Bedford-Stuyvesant Family Medical Health Center
Attachment and Biobehavioral Catch-Up (ABC)	Power of Two
SafeCare	Safe Care Family Services
Maternal and Infant Community Health Collaborative	CAMBA, Inc.
Maternal and Infant Community Health Collaborative	Wyckoff Heights Medical Center
Parent Child Plus	Family Health Centers at NYU Langone
Parent Child Plus	SCO Family of Services Brooklyn – University Settlement

Data Report for At-Risk County: Monroe

Demographics

Monroe County is in the Finger Lakes region, with an estimated population of 742,474 in 2017. The ethnic makeup of Monroe is 16.2% are Black or African American, 70.3% are White persons of non-Hispanic/Latino origin, 0.4% are Native American Indian and/or Alaska Native persons, 0.1% are Native Hawaiian and Other Pacific Islander, 3.7% are Asian, and 9.0% are of Latino or Hispanic origin. Approximately 8.6% were foreign born and 13.6% spoke a language other than English at home. The median income was $57,479. In Monroe county, 5.5% are under 5 years old.

	Monroe Data		NYS Data	
Indicator	**Rate**	**Burden**	**Rate**	**Burden**
Medicaid Births	48.4%	3,814	50.8%	116,084
Premature Births	9.8%	770	9.2%	329
Low Birth Weight	9.3%	731	8.1%	297
Infant Mortality	8.4 / 1,000 births	66	4.5 / 1,000 births	17
Maternal Mortality	20.1 / 100,000 births	5	20.9 / 100,000 births	2.4
Teen Births	13.8 / 1,000 females	344	12.4 / 1,000 females	120
Neonatal Abstinence Syndrome	9.1 / 1,000 births	72	10.1 / 1,000 births	42
Index Crime	2,298 / 100,000 residents	16,874	1,784 / 100,000 residents	5,623
Juvenile Arrests	649 / 100,000 juveniles (7-15)	514	512 / 100,000 juveniles (7-15)	169
High school dropouts	10%	891	9.0%	308
Poverty	22.2%	34,237	19.9%	13,102
Unemployment	4.3%	15,459	4.7%	6,349
Disparity Index	1.9	N/A	1.9	N/A
Limited English Households	3.3%	9,939	4.1%	9,571
CPS Reports	154.1 / 10,000 children (0-17)	2,544	145.3 / 10,000 children (0-17)	948
Foster Care	25.4 / 10,000 children (0-17)	419	38.6 / 10,000 children (0-17)	252

Home Visiting Programs

Home Visiting Model	Agency
Parents As Teachers	Mt. Hope Family Center Parents as Teachers
Parents As Teachers	YWCA of Rochester and Monroe County Parents as Teachers
Parents As Teachers	Parents as Teachers Program Family Resource Center of Rochester
Parents As Teachers	Rochester Society for the Prevention of Cruelty to Children/TAPSS Parents as Teachers
Parents As Teachers	University of Rochester Medical Center/Strong Memorial Hospital Parents as Teachers
Nurse-Family Partnership	Nurse-Family Partnership: Monroe County Health Department
Early Head Start	Action For A Better Community Inc, Home Based Program
Maternal and Infant Community Health Collaborative	Healthy Baby Network; formerly The Perinatal Network of Monroe County
Healthy Families New York	Society for the Prevention of Cruelty to Children (SPCCC)
Building Healthy Children	Mt. Hope Family Center

Data Report for At-Risk County: Nassau

Demographics

Nassau County is in located within Long Island with an estimated population of 1,358,343 in 2017. The ethnic makeup of Nassau is 13% are Black or African American, 59.3% are White persons of non-Hispanic/Latino origin, 0.5% are Native American Indian and/or Alaska Native persons, 0.1% are Native Hawaiian and Other Pacific Islander, 10.5% are Asian, and 17.2% are of Latino or Hispanic origin. Approximately 22.2% were foreign born and 28.3% spoke a language other than English at home. The median income was $111,240. In Nassau county, 5.5% are under 5 years old.

	Nassau Data		NYS Data	
Indicator	**Rate**	**Burden**	**Rate**	**Burden**
Medicaid Births	32.6%	4,631	50.8%	116,084
Premature Births	9.2%	1,304	9.2%	329
Low Birth Weight	7.8%	1,108	8.1%	297
Infant Mortality	3.0 / 1,000 births	42	4.5 / 1,000 births	17
Maternal Mortality	28.3 / 100,000 births	12	20.9 / 100,000 births	2.4
Teen Births	5.9 / 1,000 females	256	12.4 / 1,000 females	120
Neonatal Abstinence Syndrome	4.2 / 1,000 births	55	10.1 / 1,000 births	42
Index Crime	991 / 100,000 residents	13,363	1,784 / 100,000 residents	5,623
Juvenile Arrests	286 / 100,000 juveniles (7-15)	435	512 / 100,000 juveniles (7-15)	169
High school dropouts	3.0%	522	9.0%	308
Childhood Poverty	7.7%	22,360	19.9%	13,102
Unemployment	3.5%	25,027	4.7%	6,349
Disparity Index	2.2	N/A	1.9	N/A
Limited English Households	5.6%	24,828	4.1%	9,571
CPS Reports	56.6 / 10,000 children (0-17)	1,708	145.3 / 10,000 children (0-17)	948
Foster Care	5.2 / 10,000 children (0-17)	158	38.6 / 10,000 children (0-17)	252

Home Visiting Programs

Home Visiting Model	Agency
Nurse-Family Partnership	Nurse-Family Partnership: The Visiting Nurses Service of New York
Maternal and Infant Community Health Collaborative	Economic Opportunities Commission of Nassau Co.
Family Connects	Northwell Health
Parent Child Plus	Nassau BOCES
Parent Child Plus	Roslyn Middle School – PPS Office

Data Report for At-Risk County: New York

Demographics

New York County has an estimated population of 1,628,701 in 2017. The ethnic makeup of New York County is 17.9% are Black or African American, 47% are White persons of non-Hispanic/Latino origin, 1.2% are Native American Indian and/or Alaska Native persons, 0.2% are Native Hawaiian and Other Pacific Islander, 12.8% are Asian, and 25.9% are of Latino or Hispanic origin. Approximately 29% were foreign born and 39.7% spoke a language other than English at home. The median income was $82,459. In New York County, 4.7% are under 5 years old.

	New York Data		NYS Data	
Indicator	**Rate**	**Burden**	**Rate**	**Burden**
Medicaid Births	32.3%	5,534	50.8%	116,084
Premature Births	8.4%	1,445	9.2%	329
Low Birth Weight	8.3%	1,419	8.1%	297
Infant Mortality	3.2 / 1,000 births	55	4.5 / 1,000 births	17
Maternal Mortality	18.3 / 100,000 births	10	20.9 / 100,000 births	2.4
Teen Births	8.7 / 1,000 females	326	12.4 / 1,000 females	120
Neonatal Abstinence Syndrome	3.4 / 1,000 births	58	10.1 / 1,000 births	42
Index Crime	3,028 / 100,000 residents	49,830	1,784 / 100,000 residents	5,623
Juvenile Arrests	662 / 100,000 juveniles (7-15)	715	512 / 100,000 juveniles (7-15)	169
High school dropouts	12%	1,963	9.0%	308
Poverty	23.4%	55,056	19.9%	13,102
Unemployment	3.7%	33,750	4.7%	6,349
Disparity Index	2.4	N/A	1.9	N/A
Limited English Households	9.4%	71,571	4.1%	9,571
CPS Reports	108.6 / 10,000 children (0-17)	2,529	145.3 / 10,000 children (0-17)	948
Foster Care	48.8 / 10,000 children (0-17)	1,137	38.6 / 10,000 children (0-17)	252

Home Visiting Programs

Home Visiting Model	**Agency**
Early Head Start	Childrens Aid Society Early Head Start
Early Head Start	The Mama Tingo Early Head Start
Early Head Start	New Square Community Improvement Inc
Early Head Start	Grandsreet Settlement EHS
Early Head Start	GRADS early head start program
Early Head Start	Columbia University Early Head Start
Nurse-Family Partnership	Nurse-Family Partnership: Targeted Citywide Initiative-NYC Department of Health and Mental Hygiene
Nurse-Family Partnership	Nurse-Family Partnership: Harlem Hospital Center
Healthy Families New York	Healthy Families Washington Heights
Healthy Families New York	Healthy Families Central Harlem
Healthy Families New York	University Settlement's Healthy Families Program

Maternal and Infant Community Health Collaborative	Northern Manhattan Perinatal Partnership
Attachment Biobehavioral Catch Up	Power of Two
Parent Child Plus	Broadway Housing Communities

Data Report for At-Risk County: Niagara

Demographics

Niagara County, New York has an estimated population of 211,328 in 2017. The ethnic makeup of Niagara is 7.5% are Black or African American, 85.5% are White persons of non-Hispanic/Latino origin, 1.3% are Native American Indian and/or Alaska Native persons, 4.2% are Asian, and 2.9% are of Latino or Hispanic origin. Approximately 4.3% were foreign born and 4.1% spoke a language other than English at home. The median income was $54,085. In Niagara county, 5.2% are under 5 years old.

	Niagara Data		NYS Data	
Indicator	**Rate**	**Burden**	**Rate**	**Burden**
Medicaid Births	43.1%	912	50.8%	116,084
Premature Births	9.3%	196	9.2%	329
Low Birth Weight	9.0%	190	8.1%	297
Infant Mortality	4.3 / 1,000 births	9	4.5 / 1,000 births	17
Maternal Mortality	61.4 / 100,000 births	4	20.9 / 100,000 births	2.4
Teen Births	18.4 / 1,000 females	116	12.4 / 1,000 females	120
Neonatal Abstinence Syndrome	47.9 / 1,000 births	100	10.1 / 1,000 births	42
Index Crime	2,061 / 100,000 residents	4,261	1,784 / 100,000 residents	5,623
Juvenile Arrests	781 / 100,000 juveniles (7-15)	168	512 / 100,000 juveniles (7-15)	169
High school dropouts	9.0%	222	9.0%	308
Childhood Poverty	17.6%	7,340	19.9%	13,102
Unemployment	5.2%	5,197	4.7%	6,349
Disparity Index	3.1	N/A	1.9	N/A
Limited English Households	1.0%	879	4.1%	9,571
CPS Reports	234.4 / 10,000 children (0-17)	1,082	145.3 / 10,000 children (0-17)	948
Foster Care	36 / 10,000 children (0-17)	166	38.6 / 10,000 children (0-17)	252

Home Visiting Programs

Home Visiting Model	Agency
Healthy Families New York	Health Families Niagara
Maternal and Infant Community Health Collaborative	Economic Opportunity Commission of Niagara
Nurse-Family Partnership	Catholic Health System

Data Report for At-Risk County: Oneida

Demographics

Oneida County is in located within the central New York region with an estimated population of 229,577 in 2017. The ethnic makeup of Oneida is 7.1% are Black or African American, 81.6% are White persons of non-Hispanic/Latino origin, 0.3% are Native American Indian and/or Alaska Native persons, 0.1% are Native Hawaiian and Other Pacific Islander, 4.2% are Asian, and 6.1% are of Latino or Hispanic origin. Approximately 7.6% were foreign born and 12.1% spoke a language other than English at home. The median income was $53,844. In Oneida county, 5.6% are under 5 years old.

	Oneida Data		NYS Data	
Indicator	**Rate**	**Burden**	**Rate**	**Burden**
Medicaid Births	55.6%	1,427	50.8%	116,084
Premature Births	8.9%	228	9.2%	329
Low Birth Weight	7.7%	197	8.1%	297
Infant Mortality	5.5 / 1,000 births	14	4.5 / 1,000 births	17
Maternal Mortality	26.1 / 100,000 births	2	20.9 / 100,000 births	2.4
Teen Births	20.2 / 1,000 females	144	12.4 / 1,000 females	120
Neonatal Abstinence Syndrome	24.3 / 1,000 births	61	10.1 / 1,000 births	42
Index Crime	2,050 / 100,000 residents	4,645	1,784 / 100,000 residents	5,623
Juvenile Arrests	1,796 / 100,000 juveniles (7-15)	448	512 / 100,000 juveniles (7-15)	169
High school dropouts	9%	233	9.0%	308
Childhood Poverty	24.9%	12,068	19.9%	13,102
Unemployment	4.4%	4,498	4.7%	6,349
Disparity Index	1.9	N/A	1.9	N/A
Limited English Households	3.0%	2,709	4.1%	9,571
CPS Reports	242.5 / 10,000 children (0-17)	1,224	145.3 / 10,000 children (0-17)	948
Foster Care	38.4 / 10,000 children (0-17)	194	38.6 / 10,000 children (0-17)	252

Home Visiting Programs

Home Visiting Model	Agency
Healthy Families New York	Health Families Oneida County
Early Head Start	Oneida & Herkimer Early Head Start
Maternal and Infant Community Health Collaborative	Mohawk Valley Perinatal Network

Data Report for At-Risk County: Onondaga

Demographics

Onondaga County is in located within the Central New York region with an estimated population of 461,809 in 2017. The ethnic makeup of Onondaga is 11.9% are Black or African American, 76.6% are White persons of non-Hispanic/Latino origin, 0.9% are Native American Indian and/or Alaska Native persons, 0.1% are Native Hawaiian and Other Pacific Islander, 3.9% are Asian, and 5.1% are of Latino or Hispanic origin. Approximately 7.9% were foreign born and 10.8% spoke a language other than English at home. The median income was $59,225. In Onondaga County, 5.7% are under 5 years old.

	Onondaga Data		NYS Data	
Indicator	**Rate**	**Burden**	**Rate**	**Burden**
Medicaid Births	50.2%	2,540	50.8%	116,084
Premature Births	8.7%	439	9.2%	329
Low Birth Weight	7.9%	402	8.1%	297
Infant Mortality	4.9 / 1,000 births	25	4.5 / 1,000 births	17
Maternal Mortality	25.3 / 100,000 births	4	20.9 / 100,000 births	2.4
Teen Births	13.5 / 1,000 females	227	12.4 / 1,000 females	120
Neonatal Abstinence Syndrome	35.2 / 1,000 births	184	10.1 / 1,000 births	42
Index Crime	2,178 / 100,000 residents	9,942	1,784 / 100,000 residents	5,623
Juvenile Arrests	912 / 100,000 juveniles (7-15)	456	512 / 100,000 juveniles (7-15)	169
High school dropouts	10%	521	9.0%	308
Childhood Poverty	19.9%	19,541	19.9%	13,102
Unemployment	4.0%	8,826	4.7%	6,349
Disparity Index	2.0	N/A	1.9	N/A
Limited English Households	2.4%	4,392	4.1%	9,571
CPS Reports	176.4 / 10,000 children (0-17)	1,854	145.3 / 10,000 children (0-17)	948
Foster Care	37.2 / 10,000 children (0-17)	391	38.6 / 10,000 children (0-17)	252

Home Visiting Programs

Home Visiting Model	**Agency**
Nurse-Family Partnership	Nurse-Family Partnership: Onondaga County Health Department
Early Head Start	PEACE Early Head Start
Maternal and Infant Community Health Collaborative	Onondaga County Health Department
Parent Child Plus	Catholic Charities Onondaga

Data Report for At-Risk County: Orange

Demographics

Orange County is made up of 812.1 square miles. Orange county has an estimated population of 382,226 in 2017. The ethnic makeup of Orange is 11.2% Black or African American, 64% are White persons of non-Hispanic/Latino origin, 0.3% are Native American Indian and/or Alaska Native persons, 0.1% are Native Hawaiian and Other Pacific Islander, 2.5% are Asian, and 20.6% are of Latino or Hispanic origin. Approximately 11.7% were foreign born and 24.2% spoke a language other than English at home. The median income was $76,716. In Orange County, 6.5% are under 5 years old.

	Orange Data		NYS Data	
Indicator	**Rate**	**Burden**	**Rate**	**Burden**
Medicaid Births	54.3%	2,761	50.8%	116,084
Premature Births	8.2%	416	9.2%	329
Low Birth Weight	6.2%	315	8.1%	297
Infant Mortality	2.9 / 1,000 births	15	4.5 / 1,000 births	17
Maternal Mortality	0 / 100,000 births	0	20.9 / 100,000 births	2.4
Teen Births	14.9 / 1,000 females	201	12.4 / 1,000 females	120
Neonatal Abstinence Syndrome	17.7 / 1,000 births	81	10.1 / 1,000 births	42
Index Crime	1,575 / 100,000 residents	5,928	1,784 / 100,000 residents	5,623
Juvenile Arrests	449 / 100,000 juveniles (7-15)	224	512 / 100,000 juveniles (7-15)	169
High school dropouts	6%	301	9.0%	308
Childhood Poverty	16.5%	15,885	19.9%	13,102
Unemployment	3.9%	7,155	4.7%	6,349
Disparity Index	3.0	N/A	1.9	N/A
Limited English Households	3.3%	4,214	4.1%	9,571
CPS Reports	74.3 / 10,000 children (0-17)	756	145.3 / 10,000 children (0-17)	948
Foster Care	33.8 / 10,000 children (0-17)	344	38.6 / 10,000 children (0-17)	252

Home Visiting Programs

Home Visiting Model	Agency
Early Head Start	Kiryas Joel MLDC Early Head Start
Early Head Start	Agri Business Child Development Early Head Start
Healthy Families New York	Middletown Healthy Families
Healthy Families New York	Newburgh Healthy Families
Maternal and Infant Community Health Collaborative	Orange County Health Department

Data Report for At-Risk County: Queens

Demographics

Queens County is in located within NYC with an estimated population of 2,278,906 in 2017. The ethnic makeup of Queens is 18.4% are Black or African American, 37.2% are White persons of non-Hispanic/Latino origin, 0.4% are Native American Indian and/or Alaska Native persons, 0.0% are Native Hawaiian and Other Pacific Islander, 25.8% are Asian, and 28.1% are of Latino or Hispanic origin. Approximately 47.3% were foreign born and 56.4% spoke a language other than English at home. The median income was $69,320. In Queens County, 6.2% are under 5 years old.

	Queens Data		NYS Data	
Indicator	**Rate**	**Burden**	**Rate**	**Burden**
Medicaid Births	60.8%	17,567	50.8%	116,084
Premature Births	8.8%	2,542	9.2%	329
Low Birth Weight	8.6%	2,478	8.1%	297
Infant Mortality	4.1 / 1,000 births	118	4.5 / 1,000 births	17
Maternal Mortality	22 / 100,000 births	20	20.9 / 100,000 births	2.4
Teen Births	11.6 / 1,000 females	684	12.4 / 1,000 females	120
Neonatal Abstinence Syndrome	2.3 / 1,000 births	66	10.1 / 1,000 births	42
Index Crime	1,421 / 100,000 residents	33,135	1,784 / 100,000 residents	5,623
Juvenile Arrests	363 / 100,000 juveniles (7-15)	808	512 / 100,000 juveniles (7-15)	169
High school dropouts	11.0%	2,178	9.0%	308
Childhood Poverty	16.3%	75,941	19.9%	13,102
Unemployment	3.6%	41,766	4.7%	6,349
Disparity Index	1.8	N/A	1.9	N/A
Limited English Households	19.1%	148,949	4.1%	9,571
CPS Reports	89.6 / 10,000 children (0-17)	4,106	145.3 / 10,000 children (0-17)	948
Foster Care	48.8 / 10,000 children (0-17)	2,236	38.6 / 10,000 children (0-17)	252

Home Visiting Programs

Home Visiting Model	**Agency**
Nurse-Family Partnership	Nurse-Family Partnership: Targeted Citywide Initiative-NYC Department of Health and Mental Hygiene
Nurse-Family Partnership	Nurse-Family Partnership: Public Health Solutions
Early Head Start	Early Head Start Child Center of Corona
Early Head Start	CDI Head Start and Early Head Start
Healthy Families New York	Healthy Families Jamaica
Maternal and Infant Community Health Collaborative	Public Health Solutions
Attachment Biobehavioral Catch Up	Power of Two
Family Connects	Northwell Health
Parent Child Plus	Child Center of NY

Data Report for At-Risk County: Richmond

Demographics

Richmond County is in located within NYC with an estimated population of 476,179 in 2017.
The ethnic makeup of Richmond is 11.7% are Black or African American, 60.3% are White persons of non-Hispanic/Latino origin, 0.6% are Native American Indian and/or Alaska Native persons, 0.1% are Native Hawaiian and Other Pacific Islander, 10.2% are Asian, and 18.7% are of Latino or Hispanic origin. Approximately 23% were foreign born and 31.9% spoke a language other than English at home. The median income was $79,267. In Richmond County, 5.8% are under 5 years old.

	Richmond Data		NYS Data	
Indicator	**Rate**	**Burden**	**Rate**	**Burden**
Medicaid Births	43.7%	2,339	50.8%	116,084
Premature Births	9.2%	495	9.2%	329
Low Birth Weight	8.6%	458	8.1%	297
Infant Mortality	7.3 / 1,000 births	39	4.5 / 1,000 births	17
Maternal Mortality	12.6 / 100,000 births	2	20.9 / 100,000 births	2.4
Teen Births	8.8 / 1,000 females	125	12.4 / 1,000 females	120
Neonatal Abstinence Syndrome	8.5 / 1,000 births	45	10.1 / 1,000 births	42
Index Crime	1,210 / 100,000 residents	5,738	1,784 / 100,000 residents	5,623
Juvenile Arrests	394 / 100,000 juveniles (7-15)	211	512 / 100,000 juveniles (7-15)	169
High school dropouts	9.0%	430	9.0%	308
Childhood Poverty	16.8%	17,390	19.9%	13,102
Unemployment	4.1%	9,112	4.7%	6,349
Disparity Index	2.2	N/A	1.9	N/A
Limited English Households	6.3%	10,529	4.1%	9,571
CPS Reports	105.7 / 10,000 children (0-17)	1,098	145.3 / 10,000 children (0-17)	948
Foster Care	48.8 / 10,000 children (0-17)	504	38.6 / 10,000 children (0-17)	252

Home Visiting Programs

Home Visiting Model	**Agency**
Nurse-Family Partnership	Nurse-Family Partnership: Richmond Home Needs Services, Inc.
Nurse-Family Partnership	Nurse-Family Partnership: Targeted Citywide Initiative- NYC Department of Health and Mental Hygiene
Healthy Families New York	Healthy Families Staten Island
Maternal and Infant Community Health Collaborative	Community Health Center of Richmond
Attachment Biobehavioral Catch Up	Power of Two
Early Head Start	Staten Island Mental Health Society, Inc

Data Report for At-Risk County: Suffolk

Demographics

Suffolk County is in located within Long Island with an estimated population of 1,481,093 in 2017. The ethnic makeup of Suffolk is 8.7% are Black or African American, 67.2% are White persons of non-Hispanic/Latino origin, 0.6% are Native American Indian and/or Alaska Native persons, 0.1% are Native Hawaiian and Other Pacific Islander, 4.2% are Asian, and 19.8% are of Latino or Hispanic origin. Approximately 15.5% were foreign born and 22.7% spoke a language other than English at home. The median income was $96,675. In Suffolk County, 5.4% are under 5 years old.

	Suffolk Data		NYS Data	
Indicator	**Rate**	**Burden**	**Rate**	**Burden**
Medicaid Births	40.3%	6,175	50.8%	116,084
Premature Births	9.9%	1,515	9.2%	329
Low Birth Weight	7.8%	1,200	8.1%	297
Infant Mortality	4.6 / 1,000 births	70	4.5 / 1,000 births	17
Maternal Mortality	14.9 / 100,000 births	7	20.9 / 100,000 births	2.4
Teen Births	10.0 / 1,000 females	480	12.4 / 1,000 females	120
Neonatal Abstinence Syndrome	12.4 / 1,000 births	185	10.1 / 1,000 births	42
Index Crime	1,293 / 100,000 residents	18,945	1,784 / 100,000 residents	5,623
Juvenile Arrests	134 / 100,000 juveniles (7-15)	222	512 / 100,000 juveniles (7-15)	169
High school dropouts	5.0%	971	9.0%	308
Childhood Poverty	8.9%	27,920	19.9%	13,102
Unemployment	3.9%	29,952	4.7%	6,349
Disparity Index	1.8	N/A	1.9	N/A
Limited English Households	3.5%	17,056	4.1%	9,571
CPS Reports	85.4 / 10,000 children (0-17)	3,074	145.3 / 10,000 children (0-17)	948
Foster Care	13.1 / 10,000 children (0-17)	473	38.6 / 10,000 children (0-17)	252

Home Visiting Programs

Home Visiting Model	**Agency**
Early Head Start	L.I Child & Family Development Services Inc, Early Head Start
Healthy Families New York	Healthy Families Suffolk
Maternal and Infant Community Health Collaborative	Suffolk County Health Department
Family Connects	Northwell Health
Parent Child Plus	Middle Country Public Library

Data Report for At-Risk County: Westchester

Demographics

	Westchester Data		NYS Data	
Indicator	**Rate**	**Burden**	**Rate**	**Burden**
Medicaid Births	33.3%	3,472	50.8%	116,084
Premature Births	8.9%	924	9.2%	329
Low Birth Weight	7.9%	820	8.1%	297
Infant Mortality	3.5 / 1,000 births	36	4.5 / 1,000 births	17
Maternal Mortality	15.7 / 100,000 births	5	20.9 / 100,000 births	2.4
Teen Births	6.9 / 1,000 females	223	12.4 / 1,000 females	120
Neonatal Abstinence Syndrome	5.7 / 1,000 births	49	10.1 / 1,000 births	42
Index Crime	1,019 / 100,000 residents	9,849	1,784 / 100,000 residents	5,623
Juvenile Arrests	290 / 100,000 juveniles (7-15)	324	512 / 100,000 juveniles (7-15)	169
High school dropouts	4.0%	489	9.0%	308
Childhood Poverty	10.6%	22,655	19.9%	13,102
Unemployment	3.9%	18,828	4.7%	6,349
Disparity Index	2.3	N/A	1.9	N/A
Limited English Households	7.7%	26,575	4.1%	9,571
CPS Reports	61.5 / 10,000 children (0-17)	1,381	145.3 / 10,000 children (0-17)	948
Foster Care	19.7 / 10,000 children (0-17)	443	38.6 / 10,000 children (0-17)	252

Home Visiting Programs

Home Visiting Model	**Agency**
Healthy Families New York	Westchester County Healthy Families
Maternal and Infant Community Health Collaborative	Lower Hudson Valley Perinatal Network
Parent Child Plus	Westchester Jewish Community Services
SafeCare	SafeCare Family Services
Nurse-Family Partnership	Montefiore NFP
Early Head Start	Cattaraugus & Wyoming Early Head Start

Appendix E, NYS MIECHV Survey

NYS MIECHV Survey

Introduction

The NYS Department of Health (NYS DOH) is collecting information for the statewide Maternal, Infant, and Early Childhood Home Visiting (MIECHV) needs assessment, due October 1, 2020. This needs assessment is a critical resource for identifying and understanding how to meet the diverse needs of the families in our communities and the capacity for meeting those needs. Results of the previous Needs Assessment increased interest in understanding home visiting programs and how their processes support community infrastructure. This is important to align supports and services with the needs of our communities.

As part of this Needs Assessment, we are collecting information on existing programs or initiatives for early childhood home visiting in NYS. We are requesting your assistance in completing the following survey on your program's implementation of practices related to the following elements: family centeredness, family strengthening, embracing diversity, community building, and use of data to support program improvement. The results of this survey will help identify strengths and needs in the early childhood services across the state.

Your responses to this survey will be kept confidential and will only be reported in aggregate. The results of this survey will allow us to work with our partners and other stakeholders to identify and prioritize resources and supports and to strengthen the provision of services provided by home visiting programs across the state.

Thank you for your assistance with this project and for your commitment to serving the children and families of New York State.

* 1. Program Name and Model

2. What type of funding do you receive (check all that apply)

- [ ] MIECHV
- [ ] Federal (other than MIECHV)
- [ ] State
- [ ] Other (please specify)
- [ ] County
- [ ] Private/Foundation
- [ ] Don't know

* 3. Program County

* 4. Contact Person Name, Number, Email

5. Contact Position/Title

6. Is your program able to fill home visitor positions within 2-3 months of vacancy?
   - No
   - Yes, always
   - Yes, some of the time
   - Don't know
   - Yes, most of the time

7. Does your program work with families to make improvements and changes to the program?
   - No, with no plans to address
   - Yes, and we've been doing this for more than three months
   - No, with plans to address
   - Don't know
   - Yes, but we've been doing this for less than three months

8. In regards to working with families to make improvements and changes to the program (check all that apply):
   - There are performance measures in place to track how we are doing
   - There are quality improvement activities related to this topic
   - We are interested in technical assistance
   - N/A or None of the above

   Other (please specify)

9. Does your program have a formal process to obtain family input (e.g client satisfaction surveys, focus groups)?
   - No, with no plans to address
   - Yes, and we've been doing this for more than three months
   - No, with plans to address
   - Don't know
   - Yes, but we've been doing this for less than three months

10. In regards to obtaining family input (e.g client satisfaction surveys, focus groups) (check all that apply):
   - There are performance measures in place to track how we are doing
   - There are quality improvement activities related to this topic
   - We are interested in technical assistance
   - None of the above
   - Other (please specify)

11. Does your program have dedicated outreach strategies or a plan to gain potential participants?

- ◯ No, with no plans to address
- ◯ No, with plans to address
- ◯ Yes, but we've been doing this for less than three months
- ◯ Yes, and we've been doing this for more than three months
- ◯ N/A or don't know

12. Does your program have committed resources for outreach activities to gain potential participants?

- ◯ No, with no plans to address
- ◯ No, with plans to address
- ◯ Yes, but we've been doing this for less than three months
- ◯ Yes, and we've been doing this for more than three months
- ◯ N/A or don't know

13. In regards to outreach strategies to gain potential participants (check all that apply):

- ☐ There are performance measures in place to track how we are doing
- ☐ There are quality improvement activities related to this topic
- ☐ We are interested in technical assistance
- ☐ Other (please specify)
- ☐ Not applicable
- ☐ None of the above

14. Does your program facilitate or refer families to support/peer groups to build social connections within the community?

- ◯ No, with no plans to address
- ◯ No, with plans to address
- ◯ Yes, but we've been doing this for less than three months
- ◯ Yes, and we've been doing this for more than three months
- ◯ N/A or don't know

15. In regards to facilitating or referring families to support/peer groups to build social connections within the community (check all that apply):

- ☐ There are performance measures in place to track how we are doing
- ☐ There are quality improvement activities related to this topic
- ☐ We are interested in technical assistance
- ☐ Other (please specify)
- ☐ Not applicable
- ☐ None of the above

16. Does your program have a system in place to address the culture and diversity of the priority population?

- ◯ No, with no plans to address
- ◯ No, with plans to address
- ◯ Yes, but we've been doing this for less than three months
- ◯ Yes, and we've been doing this for more than three months
- ◯ N/A or don't know

17. Do your program staff reflect the diversity of families served?
    - No, with no plans to address
    - No, with plans to address
    - Yes, but we've been doing this for less than three months
    - Yes, and we've been doing this for more than three months
    - N/A or don't know

18. Is this an area you are interested in technical assistance/improvement activities to strengthen?
    - Yes
    - No

19. Does your program work with families to build health literacy and self-advocacy skills?
    - No, with no plans to address
    - No, with plans to address
    - Yes, but we've been doing this for less than three months
    - Yes, and we've been doing this for more than three months
    - N/A or don't know

20. In regards to working with families to build health literacy and self-advocacy skills (check all that apply):
    - There are performance measures in place to track how we are doing
    - There are quality improvement activities related to this topic
    - We are interested in technical assistance
    - None of the above
    - Other (please specify)

21. Does your program participate in coordinated efforts with other community-based organizations or providers to strengthen families?
    - No, with no plans to address
    - No, with no plans to address
    - Yes, program participates in meetings with other organizations/providers annually
    - Yes, program participates in meetings with other organizations/providers quarterly
    - Yes, program participates in meetings with other organizations/providers every other month
    - Yes, program participates in meetings with other organizations/providers monthly
    - Yes, program participates in meetings with other organizations/providers continuously

22. Is this an area you are interested in technical assistance/improvement activities to strengthen?
    - Yes
    - No

23. Does your program have a data system to track participant and program outcomes?
    - No, with no plans to address
    - No, with plans to address
    - Yes, but we've been doing this for less than three months
    - Yes, and we've been doing this for more than three months
    - N/A or don't know

24. Does your program use data to plan and implement program activities?

- ◯ No, with no plans to address
- ◯ No, with plans to address
- ◯ Yes, but we've been doing this for less than three months
- ◯ Yes, and we've been doing this for more than three months
- ◯ N/A or don't know

25. Program funded capacity (for the whole program/all funded sources)

[ ]

26. Current program enrollment as of 01/01/2020 (for the whole program/all funded sources)

[ ]

27. Do you maintain a waiting list?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Other (please specify)

[ ]

Appendix G, Home Visiting Transportation Survey Summary

The Home Visiting Transportation Survey was distributed to 42 home visiting programs, including Healthy Families New York (HFNY), Nurse-Family Partnership (NFP), and Maternal and Infant Community Health Collaboratives (MICHC) in NYS. With 38 of the 43 home visiting programs who received the survey, the response rate was around 90%.

The purpose of the transportation survey was to dig deeper into the theme of transportation that emerged from the key informant interviews and community listening forums and collect information on transportation successes and barriers. In nearly every key informant interview, transportation was mentioned as an issue for young families. Information was collected from the home visiting programs who relayed information from personal experience or experience from visiting with families. The survey consisted of the following eight questions:

1. What county does your program serve?
2. What is the name of your program?
3. We learned through key informant interviews that transportation is an issue for young families. Is transportation an issue in your county? If no, skip to #8. If yes, keep going to the next question.
4. How has transportation impacted young families in your county?
5. What specific transportation barriers are in your county?
6. Are you aware of any transportation services that are offered for families in your county?
7. What transportation services do you currently recommend to your clients?
8. How have you overcome transportation barriers in your community?

Out of all survey respondents, one answered "no" to question 3 and therefore skipped the rest of the questions in the survey. All other (37) respondents indicated that transportation was an issue for young families in their county and completed the rest of the survey. Survey results were analyzed by the county represented in each response rather than by individual response to ensure multiple responses per county were not overrepresented.

The survey represented the 5 boroughs of NYC and 24 other NYS counties. While nearly all counties indicated that transportation was an issue, both barriers to and successes in improving transportation in their counties were reported. Successes included providing clients with the means to take public transportation with bus passes, cab payments, or MetroCards as well as working with clients to improve their connections to community members who may be willing to drive them to appointments. Barriers included transportation being hard to access, afford, and use with children, the process and paperwork for using medical transportation is burdensome, dental and mental health visits are not included in medical transportation, and transportation inaccessible for women and families living in rural areas. Additional detail about the successes and barriers mentioned in the transportation survey, with quotations from the survey response, is listed below:

Successes in Improving Transportation in New York State:

1. **Grants/funding can help.** Monroe county was awarded a transportation grant (RGRTA/FLPPS Innovation Grant) that allows them to extend transportation help to young families via cab or bus passes to get to doctor appointments, WIC appointments, pharmacies, mental health appointments, dentist appointments, and other healthcare appointments. Phase II began in March 2020 with implementing UberHealth and monthly bus passes.

"We provide a two-way MetroCard for families that struggle financially and/or accompany them to their appointment based on the family needs.", Public Health Solutions

2. **Connections to local services improve access to transportation**. Home visiting programs connect clients to community services, volunteer services, and social services that have access to transportation including bus passes and MetroCards.

"We are asking clients in advance if they have upcoming appointment so we can assist in scheduling medical transportation far enough in advance. We are asking the clients to identify those individuals in their support circle that can assist them with getting to their needed community support services... We are also identifying and sharing the locations of the support services nearest to the client's address, especially those in walking distance to their homes or work locations. We continue to seek insight on how to overcome the transportation barrier.", Lower Hudson Valley Perinatal Network

3. **Personal support systems improve access to transportation**. Home visiting programs work with clients to help them build personal support systems to build connections to other families who are willing to drive them to appointments and other trips including groceries, WIC appointments, etc.

"Volunteer Transportation has been helpful, but I think that identifying personal support systems has been most beneficial.", North County Prenatal/Perinatal Council

4. **Medical transportation helps families access medical appointments.** Medical transportation such as Medicab can be reliable in connecting families to their medical appointments.

Barriers to Transportation in New York State:

1. **Public transportation is not family friendly.** Families find it difficult to get to a bus stop or metro station, especially for those with small children who need a stroller/car seat. Transportation is not being "child-friendly" and families have difficulty accessing childcare.

"Certain bus lines have infrequent service resulting in long waits or extreme overcrowding, making traveling with young children extremely difficult. Bus drivers frequently yell at mothers with strollers on the bus that they cannot come on bus with strollers. Many train stations do not have elevators, which presents a barrier to parents with strollers. Elevators at stations are frequently broken/out of service", CAMBA Inc., Kings County

2. **Medical transportation is limited and burdensome**. Medical transportation does not do enough in their county. While medical appointments are covered, appointments at the dentist and or mental health services are not included in coverage. Additionally, if a family qualifies for medical transportation, the paperwork and process to apply as a pregnant mother or young family can be a huge burden.

"One family was eligible for transportation to clinic appointments as arranged by the clinic social worker and covered by Medicaid. However, the logistics/process were nearly unmanageable for this pregnant woman and due to transportation issues, she missed multiple prenatal appointments for a high-risk pregnancy.", VNSNY, Nassau County

3. **Transportation is not accessible**. Transportation can have a high cost and the limited bus schedule can be unreliable and inconsistent which can cause women and families to miss a whole day of work or miss a medical appointment. Transportation is also inaccessible for young mothers who live in rural areas. While home visiting programs travel to the home, the rural families' other needs are not met due to lack of transportation.

"The bus system is poor; you have to change buses to get across the city. The bus doesn't go to the hospital where most births occur. Parents rely on cabs and Uber, both expensive. Cabs often double up fares and don't require car seats.", Healthy Schenectady Families

4. **Public transportation can be difficult to navigate.** The bus and metro system can be difficult for those with mental health issues to navigate or feel safe taking into town.

"Certain bus lines have infrequent service resulting in long waits or extreme overcrowding, making traveling with young children extremely difficult. Bus drivers frequently yell at mothers with strollers on the bus that they cannot come on bus with strollers. Many train stations do not have elevators, which presents a barrier to parents with strollers. Elevators at stations are frequently broken/out of service", CAMBA Inc., Kings County

Appendix H, Title V MCHSBG[62] Public and Provider Surveys summary

Web-based surveys designed specifically for the public and service providers, respectively, that were posted on the DOH website and social media and distributed widely in coordination with a broad network of over 20 organizational partner groups. Through a mix of closed- and open-ended questions, providers were asked about: what's working and what can be strengthened in their communities; social determinants, root causes, disparities, and health outcomes; community partnerships; population engagement strategies; and, to rate a range of potential MCH priorities. Family/Consumer respondents were asked about: factors that affect health in their communities; available and needed services; and barriers to and satisfaction with existing services.

Over 770 providers and over 320 individual families/consumers responded, representing all regions of the state. While the provider respondents reflected the diverse array of MCH-serving organizations in NYS, family/consumer respondents were less diverse, with 80% of respondents identifying as female, 70% as White, and over 60% with private health insurance, suggesting the survey did not reach or engage a sufficiently diverse demographic. Thus, additional sub-analysis limited to respondents with Medicaid or no insurance coverage (n=45) was conducted.

Survey methodology

As mentioned above, two surveys were created: one for service providers and one for the general public (consumers and families), in English. The survey links were posted to the NYSDOH website and promoted on the NYSDOH social media platforms via the SurveyMonkey weblink. The survey was distributed to over 20 maternal and child health provider or stakeholder groups where providers were asked to share the survey with the colleagues and the general public (clients, patients, community members).

Title V Provider Survey Results

Provider responses indicated that the groups they are currently engaging with include low-income, Black/African American, and uninsured while wanted to expand their reach to refugees, new immigrants, and undocumented residents.

Responses from providers also indicated that availability of community services, social support, and availability of health care were social determinants of health impacting their programs that they are working to address in their communities. Some strengths of their communities include:

- Community programs that engage families (walking programs, group activities, farmers markets)
- Early Childhood programs (Nurse-Family Partnership, Healthy Families, WIC)
- Programs that take care of "immediate needs" (food pantries, home visiting, affordable clothing "closets", Planned Parenthood)

Public Survey Results

As mentioned previously, the public survey did not reach the intended MCH populations associated with our programs. The most common responses from the public centered around access and included:

- Access to mental health programs
- Access to healthy food
- Access to public transportation in their communities

[62] MCHSBG – Maternal and Child Health Services Block Grant

For respondents who receive Medicaid insurance, access to mental health care and the cost of insurance were the top responses when asked about their most important health issues. Respondents who receive Medicaid insurance reported wanting to see more behavioral services for their children and more community activities at local parks and libraries.

Appendix I, Chart of Home Visiting Programs by County

Area Served	Program Model	Funders	Funded Enrollment	# Families Served Last Fiscal Year
Albany	HFNY		230	288
	MICHC	State	120	226
Allegany	EHS		36	54
	HFNY		155	60
Bronx	ABC		330	421
	EHS		72	92
	HFNY		412	444
	HIPPY		50	47
	MICHC	State	160	288
	NFP	State/MIECHV	925	1,282
	PCHP		101	101
	SafeCare		125	78
Broome	HFNY		108	137
	MICHC	State	96	1,003
	PAT		117	73
Cattaraugus	EHS		50	50
	HFNY		155	100
Cayuga	EHS		44	55
	HFNY		100	65
	NFP	State	50	21
	SafeCare		150	105
Chautauqua	EHS		40	40
	MICHC	State	160	158
	NFP	State/MIECHV	75	152
	PAT		23	30
Chemung	HFNY		120	138
	MICHC	State	7	12
	NFP	State	63	57
Chenango	EHS		88	122
	MICHC	State	7	74
Clinton	EHS		48	48
	HFNY		80	85
Columbia	EHS		134	134
	HFNY		45	38
Cortland	EHS		14	24
	HFNY		80	28
	MICHC	State	2	24
Delaware	HFNY		60	75
	MICHC	State	5	48
Dutchess	EHS		143	0
	HFNY	MIECHV	214	190
	MICHC	State	120	383

Area Served	Program Model	Funders	Funded Enrollment	# Families Served Last Fiscal Year
Erie	EHS		34	74
	HFNY	MIECHV	420	506
	MICHC	State	160	217
	NFP	State/MIECHV	125	92
	PCHP		138	138
Essex	EHS		65	72
Franklin	HFNY		44	26
Herkimer	EHS		12	0
	HFNY		87	125
	MICHC	State	120	143
Jefferson	HFNY		80	79
	MICHC	State	40	91
Kings	ABC		330	547
	EHS		26	304
	Family Connects		Light-Touch Model	1
	HFNY	MIECHV	789	686
	MICHC	State	220	550
	NFP	State/MIECHV	400	721
	PCHP		76	76
	SafeCare		150	221
Lewis	EHS		20	20
	MICHC	State	20	46
Livingston	MICHC	State	60	80
Madison	EHS		58	57
	HFNY		160	184
Monroe	EHS		48	72
	HFNY	MIECHV	65	38
	MICHC	State	120	210
	NFP	State/MIECHV	250	319
	PAT		155	171
Nassau	Family Connects		Light-Touch Model	69
	MICHC	State	140	122
	NFP	State/MIECHV	85	124
	PCHP		98	98
New York	ABC		330	261
	EHS		40	706
	HFNY		280	196
	MICHC	State	120	118
	NFP	NYC	200	414
	PCHP		35	35
Niagara	HFNY		140	163
	MICHC	State	80	280
	NFP		0	6
Oneida	EHS		12	36
	HFNY		122	152
	MICHC	State	120	143

Area Served	Program Model	Funders	Funded Enrollment	# Families Served Last Fiscal Year
Onondaga	EHS		75	111
	MICHC	State	160	209
	NFP	State/MIECHV	150	158
	PCHP		82	82
Ontario	HFNY		50	62
Orange	EHS		12	12
	HFNY		205	261
	MICHC	State	160	112
Orleans	EHS		16	6
	HFNY		140	26
Oswego	HFNY		60	27
	MICHC	State	120	160
Otsego	EHS		79	87
	HFNY		65	77
Queens	ABC		330	89
	EHS		12	129
	Family Connects		Light-Touch Model	103
	HFNY	MIECHV	182	217
	MICHC	State	120	291
	NFP	State/MIECHV	400	745
	PCHP		85	85
Rensselaer	EHS		16	16
	HFNY		210	160
Richmond	ABC		330	0
	HFNY		112	113
	MICHC	State	120	145
	NFP		400	115
Rockland	EHS		42	73
	HFNY		100	??
	MICHC	State	120	99
	PAT		46	0
	PCHP		50	50
Saratoga	EHS		108	116
Schenectady	EHS		48	46
	HFNY	MIECHV	220	228
Schoharie	EHS		29	29
Schuyler	EHS		10	10
Seneca	EHS		44	0
	HFNY		100	35
St. Lawrence	MICHC	State	40	91
Steuben	EHS		110	50
	HFNY		202	240
Suffolk	EHS		42	112
	Family Connects		Light-Touch Model	8
	HFNY		114	133
	MICHC	State	260	346
	PCHP		163	163
Sullivan	HFNY		100	111
	MICHC	State	40	73

Area Served	Program Model	Funders	Funded Enrollment	# Families Served Last Fiscal Year
Tioga	HFNY		87	121
	MICHC		7	72
Tompkins	EHS		62	39
	SafeCare		35	35
Ulster	HFNY		160	195
	MICHC	State	40	74
Warren	EHS		24	42
Washington	EHS		67	78
Wayne	EHS		68	90
	HFNY		80	48
Westchester	EHS		20	50
	HFNY		80	81
	MICHC	State	120	99
	NFP		50	59
	PCHP		126	126
	SafeCare		30	9
Yates	EHS		110	47
	HFNY		20	23

MIEChV Needs Assessment Data Summary
NEW YORK

Data Summary Contents

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Table 7. At-Risk Counties

Domain	Indicator	Indicator Definition	Rate Definition	Burden Definition	Alignment with statute definition of at-risk communities	Year	Source	Source Link
Socioeconomic Status (SES)	Poverty	Population (0-17) living below 100% FPL	# children (0-17) living below 100% FPL/ # children (0-17)	# children (0-17) living below 100% FPL	Poverty	2017	Census Small Area Income and Poverty Estimates	https://www.census.gov/data/datasets/2017/demo/saipe/2017-state-and-county.html
	Unemployment	Civilian labor force unemployed	# unemployed and seeking work/ # workforce	# unemployed and seeking work	Unemployment	2017	Bureau of Labor Statistics	https://www.bls.gov/lau/#cntyaa
	Limited English Spreaking Households	Households with limited English	# Households where members 14 and older have limited English / # households	# Households where members 14 and older have limited English	Language spoken at home and country of birth	2014-2018	Census Bureau American Community Survey 5 Year Estimates	www.census.gov
	Disparity Index	Additional Burden of adverse birth outcomes experienced by non-Hispanic black mothers compared to non-Hispanic while mothers	Ratio of adverse perinatal outcomes of non-Hispanic black women to non-Hispanic white women	non applicable	Racial disparities	2014-2016	New York State County Health Indicators by Race and Ethnicity	https://www.health.ny.gov/statistics/community/minority/county/index.htm
	HS Dropout	Students that dropout of high school within 6 years of starting high school	# HS student dropouts / # HS students	# HS student dropouts	High school dropouts	2017/2018 graduation rates	NYSED Graduation Rates	https://data.nysed.gov/downloads.php
Adverse Perinatal Outcomes	Preterm Birth	Live births <37 weeks completed gestation	# live births before 37 weeks/ # live births	# live births before 37 weeks	Preterm Birth	2017	NYS Vital Statistics Table 11c	https://www.health.ny.gov/statistics/vital_statistics/2017/table11c.htm
	Low Birth Weight	Live births <2,500 grams	# live births < 2,500 grams/# live births	# live births < 2,500 grams	Low birth weight births	2017	NYS Vital Statistics Table 11a	https://www.health.ny.gov/statistics/vital_statistics/2017/table11a.htm
	Infant Mortality	Infant Deaths <1 year	# infant deaths ages 0-1/1,000 live births	# infant deaths ages 0-1	Infant Mortality	2017	NYS Vital Statistics Table 45	https://www.health.ny.gov/statistics/vital_statistics/2017/table45.htm
	Maternal Mortality	Maternal Deaths within 42 days of a pregnancy (defined as death records with causes of death ICD-10: A34, O00-O95,O98-O99)	# maternal deaths / 100,000 live births	# maternal deaths	Maternal Mortality	2014-2016	New York State Community Health Indicator Reports	https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/chir_dashboard/chir_dashboard&p=it&ind_id=Ib33
	Teen Pregnancy	Births to teens (15-19)	# teen births (15-19) / 1,000 females (15-19)	# teen births (15-19)	Births to teens	2017	NYS Vital Statistics Table 7 NYS Vital Statistics Table 1a	https://www.health.ny.gov/statistics/vital_statistics/2017/table01a.htm
Substance Use Disorder	Neonatal Abstinance Syndrome	Newborns with neonatal withdrawal syndrome and/or affected by maternal use of drugs of addiction	# newborns with neonatal withdrawal syndrome/1,000 births	# newborns with neonatal withdrawal syndrome	Newborns with neonatal withdrawal syndrome and/or affected by maternal use of drugs of addiction	2016	NYS Opioid Data Dashboard NYS SPARCS	https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/opioid_dashboard/op_dashboard&p=it&ind_id=op34
Crime	Index Crime	# reported crimes/100,000, number of reported crimes	# reported index crimes/100,000 residents	# reported index crimes	Index Crime	2017	NYS DCJS	https://www.criminaljustice.ny.gov/crimnet/ojsa/countycrimestats.htm
	Juvenile Arrests	# crime arrests ages 0-17/100,000 juveniles aged 0-17	# arrests (7-15) / 100,000 juveniles (7-15)	# arrests (7-15)		2014-2018	NYS DCJS	https://www.criminaljustice.ny.gov/crimnet/ojsa/juvenilearrests/index.htm
Child Maltreatment	CPS Reports	Indicated CPS reports for chilren aged 0-17	# indicated CPS reports for children (0-17) / 10,00 children (0-17)	# indicated CPS reports for children (0-17)	Child maltreatment	2018	NYS: OCFS data NYC: ACS Data	NYS: OCFS data NYC: ACS data: https://www1.nyc.gov/assets/acs/pdf/data-analysis/2018/AbuseNeglectReport2015To2018.pdf
	Foster Care	Children in foster care	# in foster care / 10,000 children	# in foster care		2018	NYS: OCFS data NYC: ACS Data	NYC data extrapolated from NYC foster care numbers https://www1.nyc.gov/assets/acs/pdf/data-analysis/2018/ReportOnYouthInFC2018.pdf

Domain	Indicator	Indicator Definition	Year	Missing (n)	Missing %	Mean of Counties	SD	Median	Q1	Q3	Interquartile Range	Min	Max	State Estimate	Other Notes
Socioeconomic Status (SES)	Poverty	% population (0-17) living below 100% FPL	2017		0	19.3%	0.06	19.2%	15.7%	23.4%	7.7%	5.9%	39.3%	19.9%	%
	Unemployment	% of the civilian labor force	2018		0	4.5%	0.01	4.4%	3.9%	4.9%	1.0%	3.3%	6.8%	4.7%	%
	Limited English Spreaking Households	% households			0	2.5%	0.04	1.1%	0.5%	2.6%	2.1%	0.1%	19.1%	4.1%	%
	Disparity Index	Ratio of excess perinatal outcomes for non-Hispanic black mothers	2014-2016	28	45%	1.90	0.59	1.95	1.77	2.30	0.53	0.60	3.16	1.90	Available only in diverse counties (34)
	HS Dropout	% of students that dropout within 6 years	2017/2018 grad rates		0	8.7%	0.03	9.0%	6.0%	10.0%	4.0%	3.0%	19.0%	9.0%	%
Adverse Perinatal Outcomes	Preterm Birth	% live births <37 weeks	2017		0	8.3%	0.01	8.5%	7.4%	9.3%	1.9%	4.5%	11.3%	9.2%	%
	Low Birth Weight	% live births <2500 g	2017		0	7.1%	0.02	7.3%	6.4%	8.1%	1.7%	3.3%	11.1%	8.1%	%
	Infant Mortality	infant death rate	2017		0	4.9	2.47	4.9	3.2	6.2	3.1	0.0	11.7	4.5	per 1,000 Live births
	Maternal Mortality	deaths/100,000 live births	2013-2015	0	0	20.9	32.90	0.0	0.0	25.6	25.6	0.0	198.4	20.9	per 100,000 births
	Teen Pregnancy	teen birth rate/1,000 female teen	2017		0	14.5	6.6	13.5	9.4	18.6	9.2	2.9	35.5	12.4	per 1,000 female teens
Substance Use Disorder	Neonatal Abstinance Syndrome	crude rate	2016	9	14.5%	19.5	12.9	15.6	11.1	27.6	16.5	0.0	48.1	10.1	9 counties suppressed data per 1,000 newborns discharged
Crime	Index Crime	# reported crimes/100,000	2018		0	1503.3	574.4	1441.4	1053.7	1793.8	740.1	340.5	3028.2	1784.2	per 100,000
	County Juvenile Justice Profiles	# arrest/criminal activity per 100,000 juveniles (ages 7-15)	2017		0	685.0	399.8	642.6	403.6	877.1	473.5	59.1	1886.1	512.2	per 100,000 (7-15)
Child Maltreatment	CPS Reports	Indicated CPS reports per 10,000 children aged 0-17	2018		0	217.5	99.9	211.4	150.6	260.9	110.2	32.4	515.2	145.3	per 10,000 (0-17)
	Foster Care	Number in Foster care per 10,000 children aged 0-17	2018		0	41.5	25.2	39.7	25.2	50.9	25.7	5.2	171.0	38.6	per 10,000 (0-17)

Domain	Indicator	Indicator Definition	Year	Missing (n)	Missing %	Mean of Counties	SD	Median	Q1	Q3	Interquartile Range	Min	Max	State Total	Other Notes
Socioeconomic Status (SES)	Poverty	number of children (0-17) living below 100% FPL	2017	0		13,102	28,392	3,149	1,775	7,530	5,754	96	159,509	812,334	
	Unemployment	number of the civilian labor force unemployed	2018	0		6,349	10,773	1,822	1,084	5,224	4,140	157	51,220	393,647	
	Limited English Spreaking Households	number of households	2014-2018	0		9,571	29,052	326	123	2,711	2,588	2	148,949	593,391	
	HS Dropout	number of students that dropout within 6 years	2017/2018 graduation rates	0		308	587	86	42	225	183	1	2,715	19,072	
Adverse Perinatal Outcomes	Preterm Birth	number of live births <37 weeks	2017	0		329	630	63	36	236	200	2	3,309	20,421	
	Low Birth Weight	number of live births <2500 g	2017	0		297	586	59	31	201	170	1	2,996	18,423	
	Infant Mortality	number of infant deaths	2017	0		17	29	5	2	14	12	-	151	1,026	
	Maternal Mortality	number of maternal deaths	2013-2015	0		2	5	0	0	2	2	0	24	147	
	Teen Pregnancy	number of teen births	2017	0		120	201	39	23	111	88	1	1,019	7,453	
Substance Use Disorder	Neonatal Abstinance Syndrome	number of discharges	2016	9	14.5%	42	53	17	11	50	39	-	261	2,202	9 counties suppressed (<10)
Crime	Index Crime	number of reported crimes	2018	0		5,623	10,804	1,217	604	4,620	4,016	46	50,106	348,598	
	County Juvenile Justice Profiles	number arrest/criminal activity juveniles (ages 7-15)	2017	0		169	256	70	26	179	153	1	1,330	10,472	
Child Maltreatment	CPS Reports	Number of indicated CPS reports for chilren aged 0-18	2018	0		948	1,307	415	245	997	751	17	6,386	58,780	
	Foster Care	number of children in foster care	2018	0		252	507	70	39	203	164	2	2,874	15,599	

County Year	Poverty 2017	Unemployment 2018	Limited English Household 2014-2018	Racial Disparity Index 2014-2016	HS Dropout 2017/2018	Preterm Birth 2017	Low Birth Weight 2017	Infant Mortality 2017	Maternal Mortality 2013-2015	Teen Pregnancy 2017	Neonatal Abstinance Syndrome 2016	Index Crime 2018	Arrest/Criminal Activity 2017	CPS Reports	Foster Care
Albany County	13.2%	3.7%	2.6%	1.99	10%	9.9%	8.4%	5.0	31.7	9.1	11.9	2745.0	938.4	149.0	36.0
Allegany County	25.0%	5.6%	0.6%		5%	9.5%	8.2%	6.2	0.0	12.9		999.3	760.8	218.1	44.8
Bronx County	39.3%	5.7%	18.0%	1.43	18%	10.1%	9.8%	5.3	36.2	21.0	8.4	2431.3	586.0	173.3	48.8
Broome County	21.2%	4.9%	1.7%	1.90	9%	11.3%	8.6%	5.1	16.3	13.5	29.8	2717.0	1196.3	397.4	66.5
Cattaraugus County	23.4%	5.3%	0.9%		10%	7.1%	6.9%	4.9	0.0	18.4	18.8	1475.1	966.1	260.1	26.6
Cayuga County	19.7%	4.5%	0.8%	2.10	11%	6.3%	6.9%	7.7	0.0	16.3	11.5	1629.9	757.2	207.3	42.6
Chautauqua County	27.5%	5.0%	1.6%	1.96	9%	9.0%	6.2%	5.9	23.5	19.6	44.2	2107.2	1193.4	315.0	37.9
Chemung County	23.7%	4.7%	0.3%	1.55	19%	9.4%	7.1%	11.1	0.0	23.1	18.4	1722.5	1260.5	400.0	47.9
Chenango County	18.2%	4.7%	0.4%		8%	6.7%	4.7%	8.2	0.0	25.5	42.8	1516.5	870.9	355.2	60.4
Clinton County	17.3%	4.4%	0.5%		9%	5.3%	4.9%	7.0	0.0	9.8	10.9	1461.4	620.4	191.0	50.9
Columbia County	16.2%	3.3%	1.5%	2.01	10%	9.7%	6.5%	3.9	0.0	10.9	27.4	1505.0	547.7	160.0	32.0
Cortland County	20.1%	5.1%	0.2%		9%	8.5%	7.1%	4.2	0.0	8.0	19.7	1660.0	1625.8	412.1	56.5
Delaware County	30.0%	4.8%	0.9%		7%	6.4%	5.6%	2.8	0.0	12.1	48.1	1355.8	647.6	327.2	40.5
Dutchess County	12.9%	3.7%	2.5%	1.92	8%	9.9%	8.1%	3.9	25.4	7.0	11.4	1255.7	201.8	127.2	30.9
Erie County	21.4%	4.4%	2.3%	2.17	9%	9.9%	9.1%	4.8	29.9	14.9	26.8	2519.2	642.5	215.2	39.7
Essex County	16.8%	4.9%	0.4%		8%	7.4%	9.2%	0.0	0.0	17.1		824.4	440.7	223.0	85.4
Franklin County	26.7%	5.2%	0.5%		7%	5.5%	4.1%	2.3	0.0	23.7	14.6	1034.2	486.8	422.4	171.0
Fulton County	25.3%	5.1%	0.4%		15%	8.4%	6.7%	1.9	0.0	21.0	29.7	1797.2	675.2	240.8	20.7
Genesee County	14.5%	4.2%	0.6%		6%	5.8%	6.7%	1.8	0.0	18.2	27.7	1671.5	244.8	261.0	49.1
Greene County	19.5%	4.5%	1.3%		8%	9.3%	7.8%	0.0	0.0	7.4	21.3	1307.4	660.2	204.2	55.8
Hamilton County	15.8%	6.8%	0.2%		4%	7.4%	3.7%	0.0	0.0	10.8	0	1057.0	895.5	223.4	26.3
Herkimer County	21.2%	4.9%	0.6%		9%	9.4%	7.3%	5.1	51.6	15.6	15.8	1058.1	562.2	182.5	59.2
Jefferson County	21.0%	5.6%	0.8%	1.84	7%	7.7%	6.5%	6.5	15.7	35.5	11.2	1792.7	647.7	258.3	40.0
Kings County	26.7%	4.2%	15.1%	2.58	13%	8.5%	7.7%	3.9	20.1	13.1	3.4	1913.8	475.2	108.4	48.8
Lewis County	20.2%	5.5%	0.3%		6%	6.9%	7.2%	9.0	100.1	25.3		796.7	358.0	182.2	18.5
Livingston County	14.6%	4.3%	0.5%		4%	7.2%	5.8%	4.0	0.0	6.1	13.6	1014.4	406.5	175.6	29.1
Madison County	14.4%	4.8%	0.3%		6%	9.1%	7.4%	6.0	0.0	11.0	25.2	1356.5	1094.4	252.5	21.4
Monroe County	22.2%	4.3%	3.3%	1.95	10%	9.8%	9.3%	8.4	20.1	13.8	9.1	2298.8	649.3	154.1	25.4
Montgomery County	28.7%	5.1%	2.7%	0.90	14%	8.8%	6.7%	3.3	0.0	28.1	43.8	1485.8	389.2	303.1	42.6
Nassau County	7.7%	3.5%	5.6%	2.28	3%	9.2%	7.8%	3.0	28.3	5.9	4.2	991.5	286.8	56.6	5.2
New York County	23.4%	3.7%	9.4%	2.47	12%	8.4%	8.3%	3.2	18.3	8.7	3.4	3028.2	662.9	108.6	48.8
Niagara County	17.6%	5.2%	1.0%	3.14	9%	9.3%	9.0%	4.3	61.4	18.4	47.9	2061.9	781.0	234.4	36.0
Oneida County	24.9%	4.4%	3.0%	1.94	9%	8.9%	7.7%	5.5	26.1	20.2	24.3	2050.6	1796.9	242.5	38.4
Onondaga County	19.9%	4.0%	2.4%	2.08	10%	8.7%	7.9%	4.9	25.3	13.5	35.2	2178.5	912.0	176.4	37.2
Ontario County	13.1%	3.9%	1.1%	1.29	6%	8.1%	6.7%	3.1	0.0	9.4	13.9	1349.9	1129.0	192.7	24.5
Orange County	16.5%	3.9%	3.3%	3.02	6%	8.2%	6.2%	2.9	0.0	14.9	17.7	1575.3	449.7	74.3	33.8
Orleans County	23.7%	4.9%	1.6%	1.95	6%	8.5%	7.3%	4.9	0.0	19.1	18.6	1491.4	1583.0	260.2	34.5
Oswego County	23.2%	5.5%	0.5%		10%	8.8%	8.1%	11.2	26.3	20.5	35.3	1754.6	754.2	411.0	56.1
Otsego County	19.6%	4.3%	0.7%		7%	10.7%	7.4%	6.2	62.3	5.6	36.6	1225.5	357.1	222.8	27.7
Putnam County	5.9%	3.7%	3.2%	1.06	3%	8.0%	6.6%	2.5	0.0	2.9	12.1	515.3	233.0	65.4	8.9
Queens County	16.3%	3.6%	19.1%	1.81	11%	8.8%	8.6%	4.1	22.0	11.6	2.3	1421.3	363.2	89.6	48.8
Rensselaer County	15.4%	3.9%	1.4%	1.67	8%	10.6%	9.3%	6.4	0.0	8.3	13.8	1972.8	511.4	272.8	21.8
Richmond County	16.8%	4.1%	6.3%	2.20	9%	9.2%	8.6%	7.3	12.6	8.8	8.5	1210.7	394.7	105.7	48.8
Rockland County	21.8%	3.7%	8.1%	2.68	6%	7.0%	6.1%	3.1	0.0	13.5	2.4	937.7	144.2	32.4	6.8
Saratoga County	28.8%	3.5%	1.3%	0.60	5%	8.4%	7.0%	3.7	0.0	7.5	6.3	1148.6	466.6	155.3	91.6
Schenectady County	7.9%	4.0%	0.8%	2.73	12%	8.9%	8.5%	5.8	19.1	17.4	9.6	3018.7	835.0	125.6	9.3
Schoharie County	18.8%	4.8%	1.9%		8%	4.5%	3.3%	4.1	0.0	11.7		1043.8	475.2	265.1	59.7
Schuyler County	19.1%	5.1%	0.4%		9%	7.4%	7.4%	6.2	198.4	31.4		340.5	59.1	260.8	85.4
Seneca County	23.0%	3.9%	0.4%		13%	5.3%	3.5%	5.9	0.0	14.2		1357.2	657.3	515.2	66.6

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St. Lawrence County	19.2%	5.6%	1.1%		9%	9.3%	6.5%	11.7	0.0	9.9	46.6	1303.3	165.4	346.9	53.2
Steuben County	19.1%	4.9%	0.6%		9%	8.5%	6.4%	6.0	31.0	19.0	13	1105.2	663.6	241.8	45.4
Suffolk County	8.9%	3.9%	3.5%	1.87	5%	9.9%	7.8%	4.6	14.9	10.0	12.4	1293.4	134.6	85.4	13.1
Sullivan County	24.8%	4.1%	3.3%	1.84	10%	7.7%	7.3%	2.5	0.0	16.5	28.4	1623.4	849.5	229.4	67.1
Tioga County	15.8%	4.4%	0.4%		10%	8.1%	7.2%	2.3	66.5	20.9		834.5	642.7	196.1	24.6
Tompkins County	15.0%	3.6%	2.6%	0.97	6%	7.3%	6.4%	6.5	79.4	4.3		1835.9	459.8	129.8	41.7
Ulster County	17.4%	3.9%	1.9%	2.02	9%	8.7%	7.4%	3.4	21.4	10.1	22.9	1285.6	526.3	139.7	50.9
Warren County	15.4%	4.6%	0.8%		9%	11.1%	11.1%	3.7	0.0	16.3	12.5	1507.2	354.6	190.5	14.9
Washington County	17.6%	4.1%	0.1%		12%	7.2%	5.9%	7.6	0.0	17.6	27.3	707.3	1329.8	255.3	30.3
Wayne County	16.3%	4.2%	0.8%	3.16	8%	8.0%	7.5%	8.4	0.0	18.3	11.5	1657.9	1084.0	207.6	10.5
Westchester County	10.6%	3.9%	7.7%	2.37	4%	8.9%	7.9%	3.5	15.7	6.9	5.7	1019.5	290.5	61.5	19.7
Wyoming County	15.0%	4.6%	0.3%		4%	6.3%	5.5%	2.9	87.3	9.3	15.6	842.8	429.6	151.2	39.6
Yates County	24.4%	3.8%	1.6%		13%	7.5%	4.1%	6.3	0.0	10.1		1002.9	1886.1	280.6	17.0
Statewide	**19.90%**	**4.70%**	**4.1%**	**1.90**	**9.00%**	**9.2%**	**8.1%**	**4.5**	**20.9**	**12.4**	**10.1**	**1784.2**	**512.2**	**145.3**	**38.6**
Standard Deviation	**5.9%**	**0.7%**	**3.9%**	**0.59**	**3.2%**	**1.5%**	**1.5%**	**2.47**	**32.90**	**6.65**	**12.87**	**574.43**	**399.77**	**99.92**	**25.24**

County Year	Poverty 2017	Unemployment 2018	Limited English Household 2014-2018	HS Dropout 2017/2018	Preterm Birth 2017	Low Birth Weight 2017	Infant Mortality 2017	Maternal Mortality 2013-2015	Teen Pregnancy 2017	Neonatal Abstinance Syndrome 2016	Index Crime 2018	Arrest/Criminal Activity 2017	CPS Reports	Foster Care
Albany County	7,443	5,844	3,235	308	314	268	16	3	107	35	8,361	268	910	220
Allegany County	2,328	1,096	115	27	46	40	3	0	27		457	37	229	47
Bronx County	140,279	34,319	89,994	2,646	2,035	1,994	107	23	1,019	170	35,355	1,035	6,156	1,734
Broome County	7,789	4,115	1,338	207	224	170	10	1	97	46	5,137	224	1,608	269
Cattaraugus County	3,943	1,820	297	108	58	56	4	0	47	13	1,087	86	498	51
Cayuga County	2,932	1,610	251	84	49	54	6	0	38	8	1,236	60	341	70
Chautauqua County	7,077	2,766	840	141	122	84	8	1	91	50	2,652	158	939	113
Chemung County	4,273	1,649	100	156	84	64	10	0	63	16	1,438	117	794	95
Chenango County	1,755	1,047	87	53	33	23	4	0	37	21	707	44	382	65
Clinton County	2,452	1,597	144	78	38	35	5	0	28	8	1,159	45	300	80
Columbia County	1,658	1,043	368	56	49	33	2	0	16	12	890	30	200	40
Cortland County	1,792	1,165	40	49	41	34	2	0	19	9	775	77	423	58
Delaware County	2,236	928	167	31	23	20	1	0	18	13	583	26	291	36
Dutchess County	7,103	5,305	2,716	303	258	211	10	2	75	27	3,638	59	815	198
Erie County	39,964	19,574	8,822	858	976	893	47	9	431	261	22,901	606	4,172	770
Essex County	1,007	834	55	23	21	26	-	0	16		293	14	162	62
Franklin County	2,577	1,014	94	38	24	18	1	0	32	6	518	25	447	181
Fulton County	2,682	1,166	89	100	45	36	1	0	32	14	944	38	291	25
Genesee County	1,679	1,245	133	42	32	37	1	0	32	16	944	15	340	64
Greene County	1,479	935	216	42	36	30	-	0	8	8	606	26	194	53
Hamilton County	96	157	2	1	2	1	-	0	1	-	46	3	17	2
Herkimer County	2,705	1,374	154	71	55	43	3	1	30	9	643	38	259	84
Jefferson County	5,640	2,510	355	89	155	131	13	1	109	21	2,003	82	845	131
Kings County	159,509	51,220	143,386	2,715	3,309	2,996	151	25	926	133	50,106	1,330	6,386	2,874
Lewis County	1,199	647	31	20	23	24	3	1	21		207	11	128	13
Livingston County	1,627	1,333	125	23	36	29	2	0	17	7	633	24	223	37
Madison County	1,934	1,564	74	52	61	50	4	0	35	15	940	78	377	32
Monroe County	34,237	15,459	9,939	891	770	731	66	5	344	72	16,874	514	2,544	419
Montgomery County	3,162	1,155	525	83	54	41	2	0	41	23	716	22	363	51
Nassau County	22,360	25,027	24,828	522	1,304	1,108	42	12	256	55	13,363	435	1,708	158
New York County	55,056	33,750	71,571	1,963	1,445	1,419	55	10	326	58	49,830	715	2,529	1,137
Niagara County	7,340	5,197	879	222	196	190	9	4	116	100	4,261	168	1,082	166
Oneida County	12,068	4,498	2,709	233	228	197	14	2	144	61	4,645	448	1,224	194
Onondaga County	19,541	8,826	4,392	521	439	402	25	4	227	184	9,942	456	1,854	391
Ontario County	2,890	2,172	469	83	79	65	3	0	33	13	1,459	132	441	56
Orange County	15,885	7,155	4,214	301	416	315	15	0	201	81	5,928	224	756	344
Orleans County	1,880	870	254	29	35	30	2	0	23	7	596	65	234	31
Oswego County	5,680	2,892	212	162	110	101	14	1	90	46	2,031	97	1,150	157
Otsego County	1,852	1,225	173	38	52	36	3	1	16	17	719	17	249	31
Putnam County	1,164	1,886	1,109	36	64	53	2	0	9	9	502	25	147	20
Queens County	75,941	41,766	148,949	2,178	2,542	2,478	118	20	684	66	33,135	808	4,106	2,236
Rensselaer County	4,777	3,166	917	117	166	146	10	0	40	22	3,093	81	950	76
Richmond County	17,390	9,112	10,529	430	495	458	39	2	125	45	5,738	211	1,098	507
Rockland County	19,770	5,775	8,057	211	383	333	17	0	156	11	3,048	66	299	63
Saratoga County	6,236	4,187	529	148	181	150	8	0	52	13	2,607	112	390	230
Schenectady County	3,667	3,063	734	204	153	147	10	1	83	17	4,611	140	661	49

County Year	Poverty 2017	Unemployment 2018	Limited English Household 2014-2018	HS Dropout 2017/2018	Preterm Birth 2017	Low Birth Weight 2017	Infant Mortality 2017	Maternal Mortality 2013-2015	Teen Pregnancy 2017	Neonatal Abstinance Syndrome 2016	Index Crime 2018	Arrest/Criminal Activity 2017	CPS Reports	Foster Care
Schoharie County	6,178	712	993	27	11	8	1	0	14		320	14	968	218
Schuyler County	1,035	423	53	13	12	12	1	1	16		60	1	171	56
Seneca County	777	622	31	41	18	12	2	0	13		458	23	178	23
St. Lawrence County	1,276	2,448	145	103	95	67	12	0	45	46	1,398	19	261	40
Steuben County	3,901	2,106	258	102	85	64	6	1	54	12	1,040	71	549	103
Suffolk County	27,920	29,952	17,056	971	1,515	1,200	70	7	480	185	18,945	222	3,074	473
Sullivan County	3,858	1,472	929	78	61	58	2	0	36	23	1,198	68	407	119
Tioga County	1,594	999	82	59	35	31	1	1	30		395	35	223	28
Tompkins County	2,240	1,829	1,013	51	56	49	5	2	26		1,896	35	218	70
Ulster County	5,457	3,452	1,299	172	128	108	5	1	56	32	2,258	88	494	180
Warren County	1,782	1,473	234	65	60	60	2	0	27	7	952	22	256	20
Washington County	2,030	1,165	30	80	38	31	4	0	27	14	426	81	346	41
Wayne County	3,136	1,823	280	87	76	71	8	0	49	10	1,468	109	435	22
Westchester County	22,655	18,828	26,575	489	924	820	36	5	223	49	9,849	324	1,381	443
Wyoming County	1,130	838	55	13	22	19	1	1	10	6	333	17	126	33
Yates County	1,311	447	141	28	24	13	2	0	9		245	51	182	11
Statewide	**13102.2**	**6349.1**	**9570.8**	**307.6**	**329.4**	**297.1**	**16.5**	**2.4**	**120.2**	**41.5**	**5622.5**	**168.9**	**948.1**	**251.6**
Standard Deviation	**28392.3**	**10772.6**	**29051.6**	**586.5**	**630.1**	**585.9**	**29.4**	**5.2**	**200.5**	**53.2**	**10804.0**	**256.1**	**1306.9**	**507.0**

County Year	Poverty 2017	Unemployment 2018	Limited English Household 2014-2018	Dispartiy Index 2014-2016	HS Dropout 2017/2018	Preterm Birth 2017	Low Birth Weight 2017	Infant Mortality 2017	Maternal Mortality 2013-2015	Teen Pregnancy 2017	Neonatal Abstinance Syndrome 2016	Index Crime 2018	Arrest/Criminal Activity 2017	CPS Reports	Foster Care
Albany County	-1.14	-1.45	-0.39	0.15	0.31	0.48	0.20	0.20	0.33	-0.50	0.14	1.67	1.07	0.04	-0.10
Allegany County	0.87	1.30	-0.89	0.00	-1.24	0.21	0.07	0.69	-0.64	0.07	-0.78	-1.37	0.62	0.73	0.24
Bronx County	3.31	1.45	3.57	-0.80	2.80	0.62	1.11	0.32	0.46	1.29	-0.13	1.13	0.18	0.28	0.40
Broome County	0.22	0.29	-0.62	-0.01	0.00	1.45	0.33	0.24	-0.14	0.16	1.53	1.62	1.71	2.52	1.10
Cattaraugus County	0.60	0.87	-0.81	0.00	0.31	-1.45	-0.78	0.16	-0.64	0.90	0.68	-0.54	1.14	1.15	-0.47
Cayuga County	-0.03	-0.29	-0.85	0.34	0.62	-2.00	-0.78	1.29	-0.64	0.58	0.11	-0.27	0.61	0.62	0.16
Chautauqua County	1.30	0.43	-0.64	0.09	0.00	-0.14	-1.24	0.57	0.08	1.08	2.65	0.56	1.70	1.70	-0.03
Chemung County	0.65	0.00	-0.98	-0.59	3.11	0.14	-0.65	2.67	-0.64	1.61	0.64	-0.11	1.87	2.55	0.37
Chenango County	-0.29	0.00	-0.95	0.00	-0.31	-1.72	-2.22	1.50	-0.64	1.97	2.54	-0.47	0.90	2.10	0.87
Clinton County	-0.44	-0.43	-0.94	0.00	0.00	-2.69	-2.09	1.01	-0.64	-0.39	0.06	-0.56	0.27	0.46	0.49
Columbia County	-0.63	-2.03	-0.68	0.19	0.31	0.34	-1.05	-0.24	-0.64	-0.23	1.34	-0.49	0.09	0.15	-0.26
Cortland County	0.03	0.58	-1.00	0.00	0.00	-0.48	-0.65	-0.12	-0.64	-0.66	0.75	-0.22	2.79	2.67	0.71
Delaware County	1.72	0.14	-0.83	0.00	-0.62	-1.93	-1.63	-0.69	-0.64	-0.05	2.95	-0.75	0.34	1.82	0.07
Dutchess County	-1.20	-1.45	-0.40	0.04	-0.31	0.48	0.00	-0.24	0.14	-0.82	0.10	-0.92	-0.78	-0.18	-0.31
Erie County	0.26	-0.43	-0.47	0.45	0.00	0.48	0.65	0.12	0.27	0.37	1.30	1.28	0.33	0.70	0.04
Essex County	-0.53	0.29	-0.96	0.00	-0.31	-1.24	0.72	-1.82	-0.64	0.70	-0.78	-1.67	-0.18	0.78	1.85
Franklin County	1.16	0.72	-0.93	0.00	-0.62	-2.55	-2.61	-0.89	-0.64	1.70	0.35	-1.31	-0.06	2.77	5.25
Fulton County	0.92	0.58	-0.95	0.00	1.87	-0.55	-0.91	-1.05	-0.64	1.29	1.52	0.02	0.41	0.96	-0.71
Genesee County	-0.92	-0.72	-0.91	0.00	-0.93	-2.34	-0.91	-1.09	-0.64	0.87	1.37	-0.20	-0.67	1.16	0.42
Greene County	-0.07	-0.29	-0.73	0.00	-0.31	0.07	-0.20	-1.82	-0.64	-0.76	0.87	-0.83	0.37	0.59	0.68
Hamilton County	-0.70	3.04	-1.01	0.00	-1.55	-1.24	-2.87	-1.82	-0.64	-0.24	-0.78	-1.27	0.96	0.78	-0.49
Herkimer County	0.22	0.29	-0.89	0.00	0.00	0.14	-0.52	0.24	0.93	0.48	0.44	-1.26	0.13	0.37	0.82
Jefferson County	0.19	1.30	-0.84	-0.10	-0.62	-1.03	-1.05	0.81	-0.16	3.47	0.09	0.01	0.34	1.13	0.06
Kings County	1.16	-0.72	2.82	1.15	1.24	-0.48	-0.26	-0.24	-0.02	0.10	-0.52	0.23	-0.09	-0.37	0.40
Lewis County	0.05	1.16	-0.98	0.00	-0.93	-1.58	-0.59	1.82	2.41	1.94	-0.78	-1.72	-0.39	0.37	-0.80
Livingston County	-0.90	-0.58	-0.92	0.00	-1.55	-1.38	-1.50	-0.20	-0.64	-0.95	0.27	-1.34	-0.26	0.30	-0.38
Madison County	-0.94	0.14	-0.98	0.00	-0.93	-0.07	-0.46	0.61	-0.64	-0.21	1.17	-0.74	1.46	1.07	-0.68
Monroe County	0.39	-0.58	-0.20	0.08	0.31	0.41	0.78	1.58	-0.03	0.21	-0.08	0.90	0.34	0.09	-0.52
Montgomery County	1.50	0.58	-0.37	-1.68	1.55	-0.28	-0.91	-0.49	-0.64	2.36	2.62	-0.52	-0.31	1.58	0.16
Nassau County	-2.08	-1.74	0.38	0.64	-1.87	0.00	-0.20	-0.61	0.22	-0.98	-0.46	-1.38	-0.56	-0.89	-1.32
New York County	0.60	-1.45	1.37	0.96	0.93	-0.55	0.13	-0.53	-0.08	-0.56	-0.52	2.17	0.38	-0.37	0.40
Niagara County	-0.39	0.72	-0.80	2.09	0.00	0.07	0.59	-0.08	1.23	0.90	2.94	0.48	0.67	0.89	-0.10
Oneida County	0.85	-0.43	-0.28	0.07	0.00	-0.21	-0.26	0.40	0.16	1.17	1.10	0.46	3.21	0.97	-0.01
Onondaga County	0.00	-1.01	-0.45	0.31	0.31	-0.34	-0.13	0.16	0.14	0.16	1.95	0.69	1.00	0.31	-0.06
Ontario County	-1.16	-1.16	-0.78	-1.03	-0.93	-0.76	-0.91	-0.57	-0.64	-0.45	0.30	-0.76	1.54	0.47	-0.56
Orange County	-0.58	-1.16	-0.20	1.90	-0.93	-0.69	-1.24	-0.65	-0.64	0.37	0.59	-0.36	-0.16	-0.71	-0.19
Orleans County	0.65	0.29	-0.65	0.09	-0.93	-0.48	-0.52	0.16	-0.64	1.00	0.66	-0.51	2.68	1.15	-0.16
Oswego County	0.56	1.16	-0.94	0.00	0.31	-0.28	0.00	2.71	0.17	1.22	1.96	-0.05	0.61	2.66	0.69
Otsego County	-0.05	-0.58	-0.86	0.00	-0.62	1.03	-0.46	0.69	1.26	-1.03	2.06	-0.97	-0.39	0.78	-0.43
Putnam County	-2.39	-1.45	-0.24	-1.41	-1.87	-0.83	-0.98	-0.81	-0.64	-1.43	0.16	-2.21	-0.70	-0.80	-1.18
Queens County	-0.61	-1.59	3.86	-0.16	0.62	-0.28	0.33	-0.16	0.03	-0.12	-0.61	-0.63	-0.37	-0.56	0.40
Rensselaer County	-0.77	-1.16	-0.69	-0.38	-0.31	0.96	0.78	0.77	-0.64	-0.62	0.29	0.33	0.00	1.28	-0.66
Richmond County	-0.53	-0.87	0.57	0.51	0.00	0.00	0.33	1.13	-0.25	-0.54	-0.12	-1.00	-0.29	-0.40	0.40
Rockland County	0.32	-1.45	1.02	1.32	-0.93	-1.51	-1.31	-0.57	-0.64	0.16	-0.60	-1.47	-0.92	-1.13	-1.26
Saratoga County	1.52	-1.74	-0.73	-2.20	-1.24	-0.55	-0.72	-0.32	-0.64	-0.74	-0.30	-1.11	-0.11	0.10	2.10
Schenectady County	-2.05	-1.01	-0.85	1.40	0.93	-0.21	0.26	0.53	-0.06	0.75	-0.04	2.15	0.81	-0.20	-1.16

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Schoharie County	-0.19	0.14	-0.57	0.00	-0.31	-3.24	-3.14	-0.16	-0.64	-0.11	-0.78	-1.29	-0.09	1.20	0.84
Schuyler County	-0.14	0.58	-0.95	0.00	0.00	-1.24	-0.46	0.69	5.40	2.85	-0.78	-2.51	-1.13	1.16	1.86
Seneca County	0.53	-1.16	-0.94	0.00	1.24	-2.69	-3.00	0.57	-0.64	0.27	-0.78	-0.74	0.36	3.70	1.11
St. Lawrence County	-0.12	1.30	-0.78	0.00	0.00	0.07	-1.05	2.91	-0.64	-0.38	2.84	-0.84	-0.87	2.02	0.58
Steuben County	-0.14	0.29	-0.89	0.00	0.00	-0.48	-1.11	0.61	0.31	0.99	0.23	-1.18	0.38	0.97	0.27
Suffolk County	-1.88	-1.16	-0.16	-0.04	-1.24	0.48	-0.20	0.04	-0.18	-0.36	0.18	-0.85	-0.94	-0.60	-1.01
Sullivan County	0.84	-0.87	-0.20	-0.10	0.31	-1.03	-0.52	-0.81	-0.64	0.61	1.42	-0.28	0.84	0.84	1.13
Tioga County	-0.70	-0.43	-0.95	0.00	0.31	-0.76	-0.59	-0.89	1.39	1.28	-0.78	-1.65	0.33	0.51	-0.55
Tompkins County	-0.84	-1.59	-0.39	-1.57	-0.93	-1.31	-1.11	0.81	1.78	-1.22	-0.78	0.09	-0.13	-0.15	0.12
Ulster County	-0.43	-1.16	-0.57	0.20	0.00	-0.34	-0.46	-0.45	0.01	-0.35	0.99	-0.87	0.04	-0.06	0.49
Warren County	-0.77	-0.14	-0.84	0.00	0.00	1.31	1.96	-0.32	-0.64	0.58	0.19	-0.48	-0.39	0.45	-0.94
Washington County	-0.39	-0.87	-1.02	0.00	0.93	-1.38	-1.44	1.25	-0.64	0.78	1.34	-1.87	2.05	1.10	-0.33
Wayne County	-0.61	-0.72	-0.86	2.14	-0.31	-0.83	-0.39	1.58	-0.64	0.88	0.11	-0.22	1.43	0.62	-1.11
Westchester County	-1.59	-1.16	0.91	0.80	-1.55	-0.21	-0.13	-0.40	-0.16	-0.83	-0.34	-1.33	-0.55	-0.84	-0.75
Wyoming County	-0.84	-0.14	-0.96	0.00	-1.55	-2.00	-1.70	-0.65	2.02	-0.47	0.43	-1.64	-0.21	0.06	0.04
Yates County	0.77	-1.30	-0.65	0.00	1.24	-1.17	-2.61	0.73	-0.64	-0.35	-0.78	-1.36	3.44	1.35	-0.86

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Albany County	-0.20	-0.05	-0.22	0.00	-0.02	-0.05	-0.02	0.12	-0.07	-0.12	0.25	0.39	-0.03	-0.06
Allegany County	-0.38	-0.49	-0.33	-0.48	-0.45	-0.44	-0.46	-0.46	-0.46	-0.78	-0.48	-0.52	-0.55	-0.40
Bronx County	4.48	2.60	2.77	3.99	2.71	2.90	3.08	3.94	4.48	2.42	2.75	3.38	3.98	2.92
Broome County	-0.19	-0.21	-0.28	-0.17	-0.17	-0.22	-0.22	-0.27	-0.12	0.08	-0.04	0.22	0.50	0.03
Cattaraugus County	-0.32	-0.42	-0.32	-0.34	-0.43	-0.41	-0.43	-0.46	-0.37	-0.54	-0.42	-0.32	-0.34	-0.40
Cayuga County	-0.36	-0.44	-0.32	-0.38	-0.44	-0.42	-0.36	-0.46	-0.41	-0.63	-0.41	-0.43	-0.46	-0.36
Chautauqua County	-0.21	-0.33	-0.30	-0.28	-0.33	-0.36	-0.29	-0.27	-0.15	0.16	-0.27	-0.04	-0.01	-0.27
Chemung County	-0.31	-0.44	-0.33	-0.26	-0.39	-0.40	-0.22	-0.46	-0.29	-0.48	-0.39	-0.20	-0.12	-0.31
Chenango County	-0.40	-0.49	-0.33	-0.43	-0.47	-0.47	-0.43	-0.46	-0.41	-0.39	-0.45	-0.49	-0.43	-0.37
Clinton County	-0.38	-0.44	-0.32	-0.39	-0.46	-0.45	-0.39	-0.46	-0.46	-0.63	-0.41	-0.48	-0.50	-0.34
Columbia County	-0.40	-0.49	-0.32	-0.43	-0.44	-0.45	-0.50	-0.46	-0.52	-0.56	-0.44	-0.54	-0.57	-0.42
Cortland County	-0.40	-0.48	-0.33	-0.44	-0.46	-0.45	-0.50	-0.46	-0.50	-0.61	-0.45	-0.36	-0.40	-0.38
Delaware County	-0.38	-0.50	-0.32	-0.47	-0.49	-0.47	-0.53	-0.46	-0.51	-0.54	-0.47	-0.56	-0.50	-0.43
Dutchess County	-0.21	-0.10	-0.24	-0.01	-0.11	-0.15	-0.22	-0.07	-0.23	-0.27	-0.18	-0.43	-0.10	-0.11
Erie County	0.95	1.23	-0.03	0.94	1.03	1.02	1.04	1.26	1.55	4.13	1.60	1.71	2.47	1.02
Essex County	-0.43	-0.51	-0.33	-0.49	-0.49	-0.46	-0.56	-0.46	-0.52	-0.78	-0.49	-0.60	-0.60	-0.37
Franklin County	-0.37	-0.50	-0.33	-0.46	-0.48	-0.48	-0.53	-0.46	-0.44	-0.67	-0.47	-0.56	-0.38	-0.14
Fulton County	-0.37	-0.48	-0.33	-0.35	-0.45	-0.45	-0.53	-0.46	-0.44	-0.52	-0.43	-0.51	-0.50	-0.45
Genesee County	-0.40	-0.47	-0.32	-0.45	-0.47	-0.44	-0.53	-0.46	-0.44	-0.48	-0.43	-0.60	-0.47	-0.37
Greene County	-0.41	-0.50	-0.32	-0.45	-0.47	-0.46	-0.56	-0.46	-0.56	-0.63	-0.46	-0.56	-0.58	-0.39
Hamilton County	-0.46	-0.57	-0.33	-0.52	-0.52	-0.51	-0.56	-0.46	-0.59	-0.78	-0.52	-0.65	-0.71	-0.49
Herkimer County	-0.37	-0.46	-0.32	-0.40	-0.44	-0.43	-0.46	-0.27	-0.45	-0.61	-0.46	-0.51	-0.53	-0.33
Jefferson County	-0.26	-0.36	-0.32	-0.37	-0.28	-0.28	-0.12	-0.27	-0.06	-0.39	-0.34	-0.34	-0.08	-0.24
Kings County	5.16	4.17	4.61	4.10	4.73	4.61	4.58	4.33	4.02	1.72	4.12	4.53	4.16	5.17
Lewis County	-0.42	-0.53	-0.33	-0.49	-0.49	-0.47	-0.46	-0.27	-0.49	-0.78	-0.50	-0.62	-0.63	-0.47
Livingston County	-0.40	-0.47	-0.33	-0.49	-0.47	-0.46	-0.50	-0.46	-0.51	-0.65	-0.46	-0.57	-0.55	-0.42
Madison County	-0.39	-0.44	-0.33	-0.44	-0.43	-0.42	-0.43	-0.46	-0.42	-0.50	-0.43	-0.35	-0.44	-0.43
Monroe County	0.74	0.85	0.01	0.99	0.70	0.74	1.68	0.50	1.12	0.57	1.04	1.35	1.22	0.33
Montgomery County	-0.35	-0.48	-0.31	-0.38	-0.44	-0.44	-0.50	-0.46	-0.40	-0.35	-0.45	-0.57	-0.45	-0.40
Nassau County	0.33	1.73	0.53	0.37	1.55	1.38	0.87	1.84	0.68	0.25	0.72	1.04	0.58	-0.18
New York County	1.48	2.54	2.13	2.82	1.77	1.91	1.31	1.46	1.03	0.31	4.09	2.13	1.21	1.75
Niagara County	-0.20	-0.11	-0.30	-0.15	-0.21	-0.18	-0.26	0.31	-0.02	1.10	-0.13	0.00	0.10	-0.17
Oneida County	-0.04	-0.17	-0.24	-0.13	-0.16	-0.17	-0.09	-0.07	0.12	0.37	-0.09	1.09	0.21	-0.11
Onondaga County	0.23	0.23	-0.18	0.36	0.17	0.18	0.29	0.31	0.53	2.68	0.40	1.12	0.69	0.27
Ontario County	-0.36	-0.39	-0.31	-0.38	-0.40	-0.40	-0.46	-0.46	-0.43	-0.54	-0.39	-0.14	-0.39	-0.39
Orange County	0.10	0.07	-0.18	-0.01	0.14	0.03	-0.05	-0.46	0.40	0.74	0.03	0.22	-0.15	0.18
Orleans County	-0.40	-0.51	-0.32	-0.48	-0.47	-0.46	-0.50	-0.46	-0.48	-0.65	-0.47	-0.41	-0.55	-0.44
Oswego County	-0.26	-0.32	-0.32	-0.25	-0.35	-0.33	-0.09	-0.27	-0.15	0.08	-0.33	-0.28	0.15	-0.19
Otsego County	-0.40	-0.48	-0.32	-0.46	-0.44	-0.45	-0.46	-0.27	-0.52	-0.46	-0.45	-0.59	-0.53	-0.44
Putnam County	-0.42	-0.41	-0.29	-0.46	-0.42	-0.42	-0.50	-0.46	-0.55	-0.61	-0.47	-0.56	-0.61	-0.46
Queens County	2.21	3.29	4.80	3.19	3.51	3.72	3.46	3.37	2.81	0.46	2.55	2.50	2.42	3.91
Rensselaer County	-0.29	-0.30	-0.30	-0.32	-0.26	-0.26	-0.22	-0.46	-0.40	-0.37	-0.23	-0.34	0.00	-0.35
Richmond County	0.15	0.26	0.03	0.21	0.26	0.27	0.76	-0.07	0.02	0.06	0.01	0.16	0.11	0.50
Rockland County	0.23	-0.05	-0.05	-0.16	0.09	0.06	0.02	-0.46	0.18	-0.57	-0.24	-0.40	-0.50	-0.37
Saratoga County	-0.24	-0.20	-0.31	-0.27	-0.24	-0.25	-0.29	-0.46	-0.34	-0.54	-0.28	-0.22	-0.43	-0.04

County Year	Poverty 2017	Unemployment 2018	Limited English Household 2014-2018	HS Dropout 2017/2018	Preterm Birth 2017	Low Birth Weight 2017	Infant Mortality 2017	Maternal Mortality 2013-2015	Teen Pregnancy 2017	Neonatal Abstinance Syndrome 2016	Index Crime 2018	Arrest/Criminal Activity 2017	CPS Reports	Foster Care
Schenectady County	-0.33	-0.31	-0.30	-0.18	-0.28	-0.26	-0.22	-0.27	-0.19	-0.46	-0.09	-0.11	-0.22	-0.40
Schoharie County	-0.24	-0.52	-0.30	-0.48	-0.51	-0.49	-0.53	-0.46	-0.53	-0.78	-0.49	-0.60	0.02	-0.07
Schuyler County	-0.43	-0.55	-0.33	-0.50	-0.50	-0.49	-0.53	-0.27	-0.52	-0.78	-0.51	-0.66	-0.59	-0.39
Seneca County	-0.43	-0.53	-0.33	-0.45	-0.49	-0.49	-0.50	-0.46	-0.53	-0.78	-0.48	-0.57	-0.59	-0.45
St. Lawrence County	-0.42	-0.36	-0.32	-0.35	-0.37	-0.39	-0.15	-0.46	-0.38	0.08	-0.39	-0.59	-0.53	-0.42
Steuben County	-0.32	-0.39	-0.32	-0.35	-0.39	-0.40	-0.36	-0.27	-0.33	-0.56	-0.42	-0.38	-0.31	-0.29
Suffolk County	0.52	2.19	0.26	1.13	1.88	1.54	1.82	0.88	1.79	2.70	1.23	0.21	1.63	0.44
Sullivan County	-0.33	-0.45	-0.30	-0.39	-0.43	-0.41	-0.50	-0.46	-0.42	-0.35	-0.41	-0.39	-0.41	-0.26
Tioga County	-0.41	-0.50	-0.33	-0.42	-0.47	-0.45	-0.53	-0.27	-0.45	-0.78	-0.48	-0.52	-0.55	-0.44
Tompkins County	-0.38	-0.42	-0.29	-0.44	-0.43	-0.42	-0.39	-0.07	-0.47	-0.78	-0.34	-0.52	-0.56	-0.36
Ulster County	-0.27	-0.27	-0.28	-0.23	-0.32	-0.32	-0.39	-0.27	-0.32	-0.18	-0.31	-0.32	-0.35	-0.14
Warren County	-0.40	-0.45	-0.32	-0.41	-0.43	-0.40	-0.50	-0.46	-0.46	-0.65	-0.43	-0.57	-0.53	-0.46
Washington County	-0.39	-0.48	-0.33	-0.39	-0.46	-0.45	-0.43	-0.46	-0.46	-0.52	-0.48	-0.34	-0.46	-0.42
Wayne County	-0.35	-0.42	-0.32	-0.38	-0.40	-0.39	-0.29	-0.46	-0.36	-0.59	-0.38	-0.23	-0.39	-0.45
Westchester County	0.34	1.16	0.59	0.31	0.94	0.89	0.66	0.50	0.51	0.14	0.39	0.61	0.33	0.38
Wyoming County	-0.42	-0.51	-0.33	-0.50	-0.49	-0.47	-0.53	-0.27	-0.55	-0.67	-0.49	-0.59	-0.63	-0.43
Yates County	-0.42	-0.55	-0.32	-0.48	-0.48	-0.49	-0.50	-0.46	-0.55	-0.78	-0.50	-0.46	-0.59	-0.47

County Year	Socioeconomic Status z-score	Adverse Perinatal Outcomes z-score	Substance Use Disorder z-score	Crime z-score	Child Maltreatment z-score	Rate z-score AVG
Albany County	-0.505	0.142	0.140	1.369	-0.033	0.223
Allegany County	0.008	0.079	-0.785	-0.372	0.487	-0.117
Bronx County	2.067	0.762	-0.132	0.656	0.342	0.739
Broome County	-0.022	0.407	1.531	1.668	1.813	1.079
Cattaraugus County	0.193	-0.361	0.676	0.299	0.337	0.229
Cayuga County	-0.042	-0.308	0.109	0.172	0.389	0.064
Chautauqua County	0.237	0.069	2.650	1.133	0.835	0.985
Chemung County	0.438	0.625	0.645	0.882	1.458	0.810
Chenango County	-0.309	-0.223	2.541	0.216	1.483	0.742
Clinton County	-0.363	-0.959	0.062	-0.146	0.473	-0.186
Columbia County	-0.568	-0.361	1.344	-0.199	-0.057	0.032
Cortland County	-0.076	-0.511	0.746	1.285	1.690	0.627
Delaware County	0.084	-0.986	2.953	-0.204	0.948	0.559
Dutchess County	-0.664	-0.088	0.101	-0.848	-0.243	-0.348
Erie County	-0.040	0.380	1.298	0.803	0.372	0.563
Essex County	-0.302	-0.455	-0.785	-0.925	1.315	-0.230
Franklin County	0.067	-0.998	0.350	-0.685	4.010	0.549
Fulton County	0.483	-0.372	1.523	0.215	0.123	0.394
Genesee County	-0.698	-0.823	1.368	-0.433	0.788	0.040
Greene County	-0.280	-0.668	0.870	-0.230	0.635	0.066
Hamilton County	-0.044	-1.363	-0.785	-0.154	0.147	-0.440
Herkimer County	-0.076	0.254	0.443	-0.569	0.594	0.129
Jefferson County	-0.015	0.409	0.085	0.177	0.594	0.250
Kings County	1.130	-0.182	-0.521	0.067	0.018	0.102
Lewis County	-0.140	0.799	-0.785	-1.052	-0.213	-0.278
Livingston County	-0.792	-0.934	0.272	-0.802	-0.036	-0.458
Madison County	-0.541	-0.154	1.173	0.356	0.196	0.206
Monroe County	0.001	0.591	-0.078	0.619	-0.218	0.183
Montgomery County	0.317	0.010	2.619	-0.414	0.869	0.680
Nassau County	-0.933	-0.312	-0.458	-0.972	-1.104	-0.756
New York County	0.482	-0.317	-0.521	1.271	0.019	0.187
Niagara County	0.325	0.542	2.937	0.578	0.394	0.955
Oneida County	0.043	0.253	1.103	1.839	0.483	0.744
Onondaga County	-0.168	-0.003	1.950	0.843	0.128	0.550
Ontario County	-1.013	-0.666	0.295	0.393	-0.043	-0.206
Orange County	-0.195	-0.568	0.591	-0.260	-0.450	-0.176
Orleans County	-0.112	-0.095	0.660	1.084	0.493	0.406
Oswego County	0.220	0.763	1.958	0.277	1.677	0.979
Otsego County	-0.424	0.299	2.059	-0.680	0.173	0.285
Putnam County	-1.471	-0.936	0.155	-1.454	-0.988	-0.939
Queens County	0.422	-0.040	-0.606	-0.502	-0.076	-0.160
Rensselaer County	-0.662	0.252	0.287	0.163	0.305	0.069
Richmond County	-0.064	0.132	-0.124	-0.646	0.004	-0.139
Rockland County	0.056	-0.772	-0.598	-1.197	-1.194	-0.741
Saratoga County	-0.878	-0.594	-0.295	-0.610	1.099	-0.256
Schenectady County	-0.317	0.255	-0.039	1.478	-0.679	0.140
Schoharie County	-0.186	-1.455	-0.785	-0.691	1.017	-0.420
Schuyler County	-0.100	1.448	-0.785	-1.823	1.506	0.049
Seneca County	-0.066	-1.098	-0.785	-0.190	2.405	0.053
St. Lawrence County	0.081	0.184	2.836	-0.852	1.298	0.709
Steuben County	-0.147	0.062	0.225	-0.402	0.617	0.071

County Year	Socioeconomic Status z-score	Adverse Perinatal Outcomes z-score	Substance Use Disorder z-score	Crime z-score	Child Maltreatment z-score	Rate z-score AVG
Suffolk County	-0.896	-0.044	0.179	-0.900	-0.804	-0.493
Sullivan County	-0.004	-0.477	1.422	0.282	0.985	0.442
Tioga County	-0.354	0.085	-0.785	-0.663	-0.023	-0.348
Tompkins County	-1.065	-0.211	-0.785	-0.021	-0.016	-0.419
Ulster County	-0.391	-0.316	0.995	-0.416	0.215	0.017
Warren County	-0.350	0.578	0.186	-0.438	-0.243	-0.053
Washington County	-0.270	-0.283	1.336	0.085	0.385	0.251
Wayne County	-0.074	0.122	0.109	0.605	-0.245	0.103
Westchester County	-0.518	-0.346	-0.342	-0.943	-0.793	-0.588
Wyoming County	-0.700	-0.559	0.427	-0.923	0.049	-0.341
Yates County	0.011	-0.808	-0.785	1.038	0.249	-0.059

County Year	Socioeconomic Status z-score	Adverse Perinatal Outcomes z-score	Substance Use Disorder z-score	Crime z-score	Child Maltreatment z-score	Cases z-score AVG
Albany County	-0.116	-0.008	-0.123	0.320	-0.046	0.005
Allegany County	-0.418	-0.454	-0.782	-0.497	-0.477	-0.525
Bronx County	3.458	3.422	2.417	3.067	3.454	3.163
Broome County	-0.212	-0.198	0.084	0.085	0.270	0.006
Cattaraugus County	-0.351	-0.418	-0.537	-0.372	-0.370	-0.410
Cayuga County	-0.375	-0.417	-0.631	-0.416	-0.411	-0.450
Chautauqua County	-0.282	-0.279	0.159	-0.159	-0.140	-0.140
Chemung County	-0.333	-0.350	-0.481	-0.295	-0.213	-0.334
Chenango County	-0.413	-0.447	-0.387	-0.471	-0.401	-0.424
Clinton County	-0.383	-0.444	-0.631	-0.448	-0.417	-0.465
Columbia County	-0.410	-0.474	-0.556	-0.490	-0.495	-0.485
Cortland County	-0.412	-0.473	-0.612	-0.404	-0.392	-0.459
Delaware County	-0.420	-0.491	-0.537	-0.512	-0.464	-0.485
Dutchess County	-0.138	-0.157	-0.274	-0.306	-0.104	-0.196
Erie County	0.772	1.179	4.129	1.653	1.745	1.895
Essex County	-0.438	-0.498	-0.782	-0.549	-0.488	-0.551
Franklin County	-0.413	-0.477	-0.669	-0.517	-0.261	-0.468
Fulton County	-0.382	-0.465	-0.518	-0.472	-0.475	-0.462
Genesee County	-0.413	-0.468	-0.481	-0.517	-0.418	-0.459
Greene County	-0.422	-0.500	-0.631	-0.511	-0.484	-0.510
Hamilton County	-0.471	-0.528	-0.782	-0.582	-0.602	-0.593
Herkimer County	-0.389	-0.409	-0.612	-0.486	-0.429	-0.465
Jefferson County	-0.327	-0.200	-0.387	-0.337	-0.158	-0.282
Kings County	4.508	4.452	1.721	4.326	4.667	3.935
Lewis County	-0.442	-0.435	-0.782	-0.559	-0.549	-0.553
Livingston County	-0.420	-0.478	-0.650	-0.514	-0.489	-0.510
Madison County	-0.400	-0.431	-0.499	-0.394	-0.435	-0.432
Monroe County	0.649	0.948	0.573	1.194	0.776	0.828
Montgomery County	-0.382	-0.444	-0.349	-0.514	-0.422	-0.422
Nassau County	0.738	1.263	0.253	0.878	0.198	0.666
New York County	2.244	1.496	0.310	3.112	1.478	1.728
Niagara County	-0.189	-0.073	1.100	-0.065	-0.033	0.148
Oneida County	-0.143	-0.075	0.366	0.500	0.049	0.139
Onondaga County	0.161	0.296	2.680	0.760	0.484	0.876
Ontario County	-0.361	-0.429	-0.537	-0.265	-0.387	-0.396
Orange County	-0.006	0.012	0.742	0.122	0.018	0.178
Orleans County	-0.425	-0.472	-0.650	-0.435	-0.491	-0.495
Oswego County	-0.288	-0.237	0.084	-0.307	-0.016	-0.153
Otsego County	-0.414	-0.426	-0.462	-0.524	-0.485	-0.462
Putnam County	-0.397	-0.469	-0.612	-0.518	-0.535	-0.506
Queens County	3.372	3.374	0.460	2.521	3.165	2.578
Rensselaer County	-0.303	-0.319	-0.368	-0.289	-0.172	-0.290
Richmond County	0.162	0.250	0.065	0.088	0.309	0.175
Rockland County	-0.009	-0.023	-0.575	-0.320	-0.434	-0.272
Saratoga County	-0.256	-0.315	-0.537	-0.251	-0.235	-0.319
Schenectady County	-0.280	-0.242	-0.462	-0.103	-0.310	-0.279
Schoharie County	-0.385	-0.503	-0.782	-0.548	-0.026	-0.449
Schuyler County	-0.451	-0.461	-0.782	-0.585	-0.490	-0.554
Seneca County	-0.437	-0.494	-0.782	-0.524	-0.520	-0.551
St. Lawrence County	-0.363	-0.350	0.084	-0.488	-0.472	-0.318
Steuben County	-0.347	-0.348	-0.556	-0.403	-0.299	-0.391

County Year	Socioeconomic Status z-score	Adverse Perinatal Outcomes z-score	Substance Use Disorder z-score	Crime z-score	Child Maltreatment z-score	Cases z-score AVG
Suffolk County	1.025	1.584	2.699	0.720	1.032	1.412
Sullivan County	-0.367	-0.441	-0.349	-0.402	-0.338	-0.379
Tioga County	-0.413	-0.433	-0.782	-0.503	-0.498	-0.526
Tompkins County	-0.384	-0.359	-0.782	-0.434	-0.458	-0.483
Ulster County	-0.264	-0.324	-0.180	-0.314	-0.244	-0.265
Warren County	-0.397	-0.450	-0.650	-0.503	-0.493	-0.499
Washington County	-0.397	-0.453	-0.518	-0.412	-0.438	-0.444
Wayne County	-0.367	-0.378	-0.594	-0.309	-0.423	-0.414
Westchester County	0.597	0.702	0.140	0.498	0.354	0.459
Wyoming County	-0.441	-0.461	-0.669	-0.541	-0.530	-0.528
Yates County	-0.441	-0.495	-0.782	-0.479	-0.530	-0.545

County	HRSA estimate of need	Medicaid Births 2017 (Alternate Estimate of Need)	Rate Domain z-score AVG	Cases Domain z-score AVG	Concentration of Risk	HV Programs	MIECHV Eligible Model	MIECHV Funding	Families Served
Albany	786	1,146	0.223	0.005	x	x	x		514
Bronx	25,977	15,962	0.739	3.163	x	x	x	x	2,753
Broome	1,638	1,123	1.079	0.006	x	x	x		1,213
Erie	6,316	3,808	0.563	1.895	x	x	x	x	1,027
Kings	21,848	24,855	0.102	3.935	x	x	x	x	3,106
Monroe	6,240	3,814	0.183	0.828	x	x	x	x	810
Nassau	2,396	4,631	-0.756	0.666	x	x	x	x	413
New York	5,917	5,534	0.187	1.728	x	x	x		1,730
Niagara	2,019	912	0.955	0.148	x	x	x		449
Oneida	2,547	1,427	0.744	0.139	x	x	x		331
Onondaga	2,032	2,540	0.550	0.876	x	x	x	x	560
Orange	2,346	2,761	-0.176	0.178	x	x	x		385
Queens	8,539	17,567	-0.160	2.578	x	x	x	x	1,659
Richmond	3,716	2,339	-0.139	0.175	x	x	x		373
Suffolk	3,117	6,175	-0.493	1.412	x	x	x		762
Westchester	2,825	3,472	-0.588	0.459	x	x	x		424