Maternal and Child Health Services
Title V Block Grant

State Narrative for New York

Application for 2015
Annual Report for 2013

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications will be kept on file in the office of the Title V Director, New York State Department of Health, Division of Family Health, Corning Tower Room 890, Empire State Plaza, Albany NY 12237-0567. In addition, assurances and certifications are reprinted in hardcopy and web-based versions of the block grant application. Hardcopies are available at the above address. The grant application appears on the New York State Department of Health Website at: www.health.state.ny.us.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

New York State is substantially invested in obtaining public input into the state's MCH Program. Because of the diverse methods that contribute to the assessment of needs and capacity, DOH can be confident that the needs assessment and resulting program development reflect the needs of communities in our state. Major avenues for stakeholder input related specifically to the five year needs assessment process for the 2011 Title V Block Grant Application include the following:

•NYSDOH's Prevention Agenda (PA) development process: In April, 2008, former Commissioner Daines launched the PA for the Healthiest State, establishing 10 statewide public health priorities with an emphasis on prevention strategies. The PA was a call to action, asking hospitals, local health departments, and other health care and community partners to collaborate in planning to bring about measurable progress toward mutually-established goals related to two to three of the priorities. Across all the priority areas, the PA focuses on eliminating the profound health disparities that impact racial and ethnic minorities.

/2014/A major avenue for public input for this application year is the Prevention Agenda 2013-17; NYS's health improvement plan for 2013 through 2017, developed by the NYS Public Health and Health Planning Council (PHHPC) at the request of the DOH, in partnership with more than 140 organizations across the state. This plan involves a unique mix of organizations, i.e., sectors, including local health departments, health care providers, health plans, community based organizations, advocacy groups, academia, employers as well as state agencies, schools, and businesses whose activities can influence the health of individuals and communities and address health disparities.

The Ad Hoc Committee coordinated a process to obtain input from stakeholders across NYS from various sectors, including consumers. Committee members conducted sessions with stakeholders to obtain feedback on the 2008-2012 Prevention Agenda and how the process could be improved for the 2013-2017 Prevention Agenda. Input was sought on the proposed priorities

for the next planning cycle and how best to ensure continuing involvement of stakeholders in designing and implementing interventions. The feedback was analyzed and categorized into comments as follows:
•Inputs related to infrastructure (communication/coordination, partners/sectors, data and measures, financial/policy supports, and workforce).
•Outputs (comments related to specific priorities and strategies to consider for each priority area).
•Cross-cutting issues such as disparities, social determinants of health, and other gaps and/or concerns.
This feedback was incorporated into the development of the PA priorities which largely align with the Title V priorities. (Refer to Section IIIA for further details regarding the PA.)//2014//
•A survey of stakeholders related to MCH needs and priorities /2014/In 2011,//2014// NYSDOH's Needs Assessment leadership team developed a survey for key stakeholders to obtain their input related to the needs and priorities for the MCH populations in NYS. The survey included background information related to the MCH Block Grant, as well as specific information regarding current national outcome measures, performance measures and current state priorities. The survey was sent to over 183 MCH stakeholders, stakeholders in NYSDOH and other state agencies, as well as a substantial number of external partners, including perinatal consortia and regional perinatal centers, advocacy organizations, community based agencies servicing the MCH population, professional organizations and consumers. /2014/ As stated previously, for this application year, stakeholder input was gleaned through the PA process which provided a more comprehensive assessment of needs and priorities.//2014//
•Regional forums for youth/young adults with special health care needs and families of children with special health care needs were conducted in February and March 2010 by the CSHCN Program to gather consumer input about the system of care for children and youth/young adults. The forums were facilitated to elicit information about the core Maternal and Child Health Bureau performance measures.
•A survey of families of children with special health care needs and youth representatives was developed to elicit feedback for the Maternal Child Health Block Grant application item 13, "Characteristics Documenting Family Participation in the CSHCN Program". /2014/ A Family Satisfaction Survey was developed in collaboration with representatives of LHDs, NYS Parent to Parent (P2P) and the CSHCN Program. A webinar with LHDs was held to discuss implementation of the survey. Survey implementation began in April 2012. Local CSHCN Program staff invite families participating in local CSHCN Programs to complete the survey online via Survey Monkey. A paper copy is mailed to families without access to the internet. Information gleaned by the survey is used on the State and local level to improve the CSHCN program.//2014//
•Focus groups with adolescents and their families were conducted to inform the DOH about how young people get information about sexual health, where they go for sexual health care services, their experiences in accessing services and their unmet needs. The Adolescent Sexual Health Focus Group study was conducted by the DOH-funded adolescence Center of Excellence at Cornell University (and their partners at University of Rochester School of Medicine, NYS Center for School Safety and NYC Cornell Cooperative Extension). /2014/ During the past year, the ACT COE conducted 35 focus groups consisting of 336 adolescents across NYS to obtain information regarding adolescents' beliefs and practices on family planning and barriers to accessing services. This information will be used to further improve DOH programming for adolescents.//2014//
•MCHBG Advisory Council discussions related to MCH needs and priorities, development of the MCH Block Grant needs assessment and application was an agenda item for a Council meeting. /2014/The MCHBG Advisory Council fully participated in the development of the PA 2013-17 and the chair of the Council also co-chaired the Promoting Healthy Women, Infants and Children workgroup.//2014//
•Incorporation of local level stakeholder input to inform the state level assessment, including structured listening sessions with:
-the MCH committee of the NYS County Health Association which includes 17 county members
-local perinatal networks which represent consortia of health and human service providers who address MCH issues at the local level. These networks also co-chair regional perinatal forums which are also co-chaired by regional perinatal centers. These forums provide a comprehensive

picture of MCH needs, incorporating both the community and hospital perspectives; and,
-the NYC DOH and Mental Health MCH Bureau.

/2014/As stated previously, a wide range of stakeholders, including the groups discussed above, were involved in the development of the PA.//2014//

•The application was posted on the Department's website to obtain further information regarding development and implementation of the needs assessment.

In addition to the specific efforts described above to obtain public input related to assessment of need and development of state priorities, DOH has a significant number of regular mechanisms to obtain public input related to needs assessment, priority identification and resource allocation and program planning, development, implementation and evaluation. This includes obtaining ongoing input from families of CSHCN.

In 2010-11, a major effort to obtain public input regarding MCH needs and services related to the development of the state needs assessment and plan related to creation of the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) authorized under the Patient Protection and Affordable Care Act (ACA) of 2010. This historic legislation marks a significant commitment to promote and improve the health, development and well-being of at-risk children and families through evidence-based home visiting programs. NYS's MIECHV State Plan reflects over a year of intensive assessment and planning work, led by the DOH MCH Program and conducted in collaboration with a core group of state agency partners and many other stakeholders.

Fourteen counties were identified through the Needs Assessment as "at-risk" communities for NYS' MIECHV initiative. As part of the plan development process, a structured on-line survey was distributed to stakeholders in those 14 counties to further identify: community risk factors, strengths and resources; characteristics of target populations; mechanisms for screening identifying and referring families to home visiting programs; and referral resources currently available and needed. In-person and conference call discussions were held with several stakeholder groups during the plan development process. Respondents include local home visiting programs as well as other stakeholder organizations. Through these processes, input was received from other State agencies, more than 100 community-based organizations, local government agencies and home visiting programs. /2014/These high risk areas are being targeted for the Maternal and Infant Health Initiative Request for Applications that was released in 2012 with awards to be made in 2013.//2014//

Parent representatives have meaningful roles on councils and task forces that provide input to DOH policy and programs, including the MCHBG Advisory Council, the Early Intervention Coordinating Council, and the Lead Poisoning Prevention Advisory Council. In addition, DOH has ongoing communication and engagement with parent organizations. DOH staff met with parent support staff of Parent to Parent of NYS, the Family-to-Family Health Care Information and Education Center grantee, to affirm collaboration on family support activities, to obtain input on DOH programming related to CSHCN /2014/and input into the development of the family survey used in the CSHCN program.//2014// As you can see throughout this application, consumers, including parents, play a critical role in the ongoing work of the NYSDOH in improving health outcomes for New Yorkers.

In addition to these efforts to obtain public input, NYSDOH continued a number of regular mechanisms to obtain public input related to MCH programs, including advisory council meetings, providers meetings, meetings with advocates and other activities.

The application will be available to key stakeholders, including the MCHBG Advisory Council , to provide any additional input for consideration prior to submission. The application will also be posted on the Department's website.

II. Needs Assessment

In application year 2015, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The needs assessment process was primarily addressed through the development the Prevention Agenda (PA) 2013-17; NY's State Health Improvement Plan and continues through periodic review of the status of key outcomes measures related to the maternal and child health population. During the PA planning process, DOH conducted a health assessment to describe the health status of the state's population, identify factors that contribute to health status and health challenges, and assets that can be used to improve population health. Various data sources were analyzed including information from birth, death and hospital records, program statistics, U. S. Census and national survey data. Statistics were analyzed at different geographic levels such as state, region and county as well as by socioeconomic factors including race/ethnicity, gender, age, disability status and income. Both historical and current data were reviewed to identify progress made as well as areas for improvement.

DOH in partnership with the Public Health and Health Planning Council (PHHPC) identified five key priority areas to improve the health status of NY's including: Prevent Chronic Disease; Advance a Healthy Environment; Healthy Mothers, Babies and Children; Prevent Substance Abuse, Depression and Other Mental Illness, and Prevent HIV, STIs and Vaccine Preventable Diseases.

The outcomes of the PA continue to guide public health initiatives to improve health outcomes and promote health equity. Title V staff play a key role in the Promoting Healthy Women, Infants and Children (PHWIC) Action Plan that addresses three key life course periods -- maternal and infant health, child health and reproductive/preconception/inter-conception health -- with goals, objectives and indicators for each. The Plan identifies evidence-based and promising practices, programs and policies to achieve these goals and objectives.

Title V staff are working with the Public Health Committee of the PHHPC to continue to promote cross-sector collaboration on PA priorities that are well aligned with Title V priorities, and fully support DOH's work in addressing National and State MCH priorities. A priority of this group is to promote and assure women's health and well-being across the reproductive life course to improve health outcomes and reduce disparities.

Title V staff are also working with the DOH Office of Public Health Practice and Local Health Departments across NYS to redesign their approach to maternal and child health activities, using the PA as a resource to identify priorities within their municipalities and evidence-based and promising practices to improve maternal and infant health outcomes while reducing disparities.

Ongoing assessment and planning related to children with special health care needs (CSHCN) is also a priority of DOH using national, state and local information. The National Survey of Children with Special Health Care Needs (NSCSHCN) indicated that almost sixty-six (65.7%) percent of NY families reported they can easily access community-based services. NY scored slightly higher than the national average of 65.1% on this measure. However, NY continues to strive to improve access to quality services and to obtain input from parents and CSHCN to guide future direction. Refer to NPM 2 for further information.

DOH makes every effort to assess the needs of its population on an ongoing basis to ensure that scarce resources are being well utilized. However, impacting health disparities requires a more comprehensive approach to the public health needs of NY's diverse population. NYS has made

steady progress in several outcomes, but despite improvements, NYS is below Healthy People 2020 objectives for several measures, and health disparities continue to be significant. Addressing racial and ethnic disparities necessitates a more holistic, comprehensive approach that addresses the biological, behavioral, psychological, social and environmental factors that contribute to health outcomes across the lifespan. Moving towards a life-course perspective of MCH services requires a reframing of priorities and outcomes, focusing on families and communities and the factors and conditions that impact health. Approaching public health from the life-course perspective highlights those areas for improvement, and provides a framework to promote healthy behaviors rather than focusing on the identification and treatment of health issues.

The early years of a child's life, including a healthy start from birth, significantly impacts the child's well-being in later years. NYS has made steady progress in reducing infant and neonatal mortality, perinatal HIV transmission, and ensuring the delivery of very low birth weight babies in higher level hospitals. High rates of newborn screening and follow up continue, including significant increases in newborn hearing screening and children identified with autism. Although infant mortality rates have been declining, Black non-Hispanic infant mortality rates are still significantly higher than rates for White non-Hispanics, Asian/Pacific Islander non-Hispanics and Hispanics. Rates of low birth weight remain unchanged. Trends in neonatal mortality mimic those of infant mortality. Among infants born in 2012, 40.6 percent were exclusively fed breast milk in the delivery hospital, an increase from 39.7 percent in 2011. White non-Hispanic women exclusively breastfed at a higher rate than Black non-Hispanics, Asian/Pacific Islander non-Hispanic and Hispanic women, though there was an increase in exclusive breastfeeding in White non-Hispanic women as well as Black non-Hispanics.

NY has also generally made improvements in children's health measures related to lead, immunization, oral health, asthma, obesity and tobacco use have generally improved, though data tends to fluctuate annually for children hospitalized due to asthma. Obesity in children and adolescents remains a significant public health problem. Currently, one third of NY's children are obese or overweight. The percent of children, including CSHCN, who have insurance coverage and a medical home have improved, though some other access and quality measures for primary and specialty care for CSHCN have been relatively unchanged. The percent of children with health insurance in NYS decreased from 6.6% in 2011 to 5.6% in 2012. In addition, implementation of New York's Health Exchange (New York State of Health) in October 2013 has resulted in an additional 960,000 individuals being enrolled into health insurance. Ensuring comprehensive, quality health care for all New Yorkers is a DOH priority. (Refer to Section IIA for further details on health care reform in NYS.)

Health disparities are also evident in NY's adolescents. Although NYS has had significant success in decreasing teen (15-17 years) birth rates, including a decrease in the rate for every race and ethnicity, disparities continue to exist. After years of increasing, Chlamydia morbidity in the 15 through 19 year range declined slightly in 2012 to 36.1 per 1,000, down from 39.2 per 1,000 in 2011, though a slight increase occurred in women 20 through 44 years of age (12.3 per 1,000 in 2011 and 12.5 per 1,000 in 2012). It remains the most commonly reported communicable disease.

The statewide rates of early and adequate prenatal care increased including among Black and Hispanic women while smoking in pregnancy saw a slight improvement, and alcohol use in pregnancy remain relatively unchanged. The percentage of preterm births declined slightly and births delivered by C-section remained consistent.

New York continues to make slow progress in some areas related to racial/ethnic disparities. The racial/ethnic disparity in early prenatal care has been steadily increasing in the past few years. The percentage of infants born to Black and Hispanic women receiving prenatal care in the first trimester rose from 62.4% in 2008 to 66.9% in 2012. The ratio of Black infant low birth weight rate decreased slightly from 1.9 in 2010 to 1.8 in 2012. Promoting a life course approach to

DOH's public health initiatives will move the focus to improving the health of all NY's women resulting in improved birth outcomes.

DOH continues to support key initiatives to improve MCH outcomes. DOH also received federal grants that support MCH initiatives, including home visiting, adolescent health initiatives, newborn hearing screening, autism, oral health, breastfeeding, immunization, obesity, and perinatal quality improvement. Significant investments have been made in developing initiatives to improve quality of MCH services. DOH is committed to continuous efforts to identify needs, maximize resources and better meet the needs of underserved population in order to reach MCH goals and improve health disparities related to NY's population. Through the PA 2013-2017, NY will strive to truly be the Healthiest State in the Nation.

III. State Overview

A. Overview

NYS is notable for the great diversity of its geography and its people. As of ***/2015/2013//2015//***, NY was the 3rd largest state after California and Texas, with a population of ***/2015/19,651,127//2015//***. NY ***/2015/is one of the top five states in the//2015//*** nation in numbers of immigrants from across the world.

Cultural diversity is both a strength and challenge. NYS is geographically diverse, with both rural and urban areas. Population density often determines the number and types of health services in an area. In 2010 there were 411 persons per square mile in NYS, compared to 88 persons per square mile in the US. New Yorkers are more likely to live in urban areas than residents of other states. Population density within NY varies widely. NYC is 104 times more densely populated than the rest of the state. Manhattan has the highest population density at 69,467 persons per square mile, while Hamilton County in the Adirondack Mountain Range has the lowest density, with only 3 people per square mile. Sixty-four percent of NY's population live in the NY Metropolitan area; 43% in NYC alone.

NY has a rich system of health care as well. According to a 2011 Center for Workforce Study, NY had over 59,000 active primary care physicians and is second in the country for the number of dentists in the state. However, physicians are more likely practicing in urban areas and only 10% are representative of minority populations. NY is also home to 51 Federally Qualified Health Centers, 231 hospitals with 130 of those certified to provide perinatal services, and numerous other health care resources as described later in this application.

The changing landscape of NY's population, services and resources, as well as health care on the federal level, coupled with efforts to enhance and streamline health services in NYS has been the impetus for strategic planning processes for the NYSDOH. Under the direction of ***/2015/former//2015//*** Commissioner Nirav Shah ***/2015/(Howard Zucker, MD, MPH began serving as Acting Commissioner on May 5, 2014)//2015//***, NYSDOH leadership redefined the mission and vision of the NYSDOH to protect, improve and promote the health and well-being of all NYS residents through outcome-based, cost effective strategies that:
-Focus on opportunities to reinvent core functions and improve efficiency;
-Increase the effectiveness of statewide health infrastructure;
-Optimize resource acquisition and utilization; and,
-Reinvent the NYSDOH as a model performance-based organization.

DOH responsibilities include:
-Promoting and supervising public health activities throughout the State;
-Ensuring high quality medical care in a sound and cost effective manner for all residents;
-Reducing infectious diseases such as food and waterborne illnesses, hepatitis, HIV, meningitis, sexually transmitted infections, tuberculosis, vaccine preventable diseases and chronic disabling illnesses such as heart disease, cancer, stroke and respiratory diseases; and,
-Directing a variety of emergency preparedness initiatives in response to statewide and local epidemic outbreaks.

In a state as large and diverse as NY, achieving the mission and responsibilities is a daunting task. This task continues to be complicated by New York's economic and fiscal challenges, ***/2015/however NY continues to make progress under Governor Cuomo's leadership through the adoption of State budgets reflecting fiscal discipline.//2015//*** Both financial and human resources continue to be ***/2015/challenges//2015//*** to accomplishing the Department's core mission. Yet, despite these challenges, DOH is committed to ensuring NY meets the needs of its most vulnerable maternal and child health population.

Maximizing resources and cultivating collaborative relationships is essential to achieving DOH's mission. DOH works with the State's health care community to improve the health of all New Yorkers, and ensure appropriate readiness and response to potential public health threats. DOH is also the principal State agency that interacts with the Federal and local governments, health care providers and program participants for the State's Medicaid (MA) program.

Andrew M. Cuomo was elected the 56th Governor of New York State on November 2, 2010. One of the Governor's first significant acts was to obtain passage of a transformational 2011-12 New York State budget. The budget included historic reforms that redesign state government; create efficiencies through consolidation, cap spending increases for education and Medicaid and transform the future budgeting process.

The Governor's Budget continues to reshape the health environment in New York through significant reforms of the Medicaid Program. The budget process brought together health care providers, labor, government and other Medicaid stakeholders to form the Governor's Medicaid Redesign Team (MRT). Tasked with identifying ways to provide critical health care services at lower costs and control unsustainable growth, the MRT recommended a series of proposals to fundamentally restructure New York's extensive Medicaid program. The 2011, 2012 and 2013 budget implemented many of the MRT recommendations resulting in significant cost savings. The Governor's budget builds on the success of this past year, including major expansion of patient-centered medical homes, better control of home health care services, and care management for individuals with complex and continuing health needs. ***/2015/The 2014-2015 Budget continues to support historic Medicaid reforms that are achieving better health care outcomes at a more sustainable cost including more effective models of care, sustains the State's health benefit exchange, encourages regional collaborations among providers and communities, and makes investments in health care infrastructure and health information technology to transform the health care delivery system.//2015//***

The MA reform efforts focused on achieving greater efficiency without creating barriers to enrollment or reducing benefits for those eligible for MA services These reforms fully support the mission of NY's Title V program in ensuring comprehensive primary and preventive health and support services to the maternal and child health population, including children with special health care needs. /2014/In August, 2013, the Governor submitted a Federal Waiver to invest $10 billion in MRT savings to transform NY's health care system. The Medicaid 1115 Waiver amendment ***/2015/was designed//2015//*** to fully implement the MRT plans, facilitate innovation, and lower health care costs over the long term through improvements in access, quality, and the provision and utilization of appropriate health care services. Key strategies outlined in the waiver amendment document included:

-Major investments to expand access to high quality primary care;
-***/2015/Global spending cap that has fundamentally changed how the program is managed and has brought transparency to the program;//2015//***
-Grants to establish Health Homes to improve the quality of care for NY's highest need/cost patients;
-Expanding resources available to transform and protect safety net providers;
-Positioning health care providers and consumers for long term integration into managed care;
-Innovations in public health strategies that will generate significant long-term Medicaid savings ***/2015/including addressing social determinants of health;//2015//***
-Training and support to ensure NY has the workforce it needs as national health care reform is implemented;
-Thorough evaluation of both new and ongoing MRT initiatives to ensure appropriate investment of State funding and to enhance health care outcomes; and,
-Strategies that will reduce hospital readmissions and help protect patients from adverse health outcomes during their hospital stay.

/2015/In April 2014, the Governor announced that NY reached an agreement with the Centers for Medicare & Medicaid Services (CMS) on a federal waiver that allows the state

to reinvest $8 billion in federal savings generated by the MRT to transform the state's health care system and preserve vital health services in NYS. The Delivery System Reform Incentive Payment (DSRIP) program is one component of NY's proposed Medicaid Waiver Amendment submitted to CMS, and is designed to stabilize the state's health care safety-net system, re-align the state's delivery system as well as reduce avoidable hospitalizations and emergency department use by 25% over the next 5 years. To accomplish this goal, the state's DSRIP program will encompass a variety of projects that will engage a wide array of providers.

The projects funded through DSRIP will assist safety-net institutions in their effort to both right-size inpatient capacities as well as transform their care delivery models to provide a more precise mix of services necessary in the communities in which they serve. Additionally, the DSRIP program will incentivize collaboration across previously siloed providers to reduce system fragmentation. By working together through the DSRIP program, health care providers can deliver more appropriate, coordinated care to their communities. Increased support for programs for maternal and child health (including high risk pregnancies) to reduce avoidable hospital use through use of programs such as Nurse-Family Partnership and community health workers are being considered as part of this effort.
In April 2013, the DOH was awarded a State Innovation Models (SIM) grant by the Centers for Medicare and Medicaid Innovation (CMMI) to develop a State Healthcare Innovation Plan (Plan). The intent and goal of the Plan is to identify and stimulate the spread of promising innovations in health care delivery and finance that result in optimal health outcomes for all New Yorkers. Multi-payer support of these initiatives is key to long-term success as is the input and recommendations of key stakeholders throughout the State. The Plan will pave the way for the state to support innovations in health care delivery, to implement strategies to spread those innovations more broadly throughout New York and will serve as the basis for an application for funding from CMMI that is expected to provide as much $60M in support of proposed initiatives.
The 2014-2015 Budget continues the implementation of MRT recommendations. A cost neutral package of new MRT initiatives is proposed to make critical investments in health care delivery, which include: supporting the integration of physical health and behavior health services; making increased payments to essential community providers; leveraging health homes to establish better linkages and improve care coordination for the mentally ill and criminal justice populations and facilitating the transition of foster care children into managed care.//2015//

The state's overall goal is to expand enrollment in the Medicaid Managed Care Program (MMCP) by requiring many of the high need populations which were previously exempted or excluded to enroll in a managed care plan. The MMCP provides an organized system of care, an accountable entity and the ability to coordinate and manage care. As part of this effort, the expedited enrollment of pregnant women into managed care will promote better management of health and psychosocial risks leading to improved birth outcomes. Additional groups previously "carved out" of MC will be transitioned into MC in 2013 including children enrolled in the Bridges to Health foster care waiver program, non-institutionalized foster care children living in the community, individuals receiving services through a MA Home and Community-based Services Waiver (HCBSW) and those individuals with characteristics and needs similar to those receiving services through a MA HCBSW, individuals receiving services through a MA Model Waiver (Care at Home) Program, individuals with characteristics and needs similar to those receiving services through a MA Model Waiver (Care at Home) Program, among others. Title V staff is part of a DOH workgroup on MA payment for services for medically fragile children (MFC). This workgroup, co-chaired with the Office for People with Developmental Disabilities, is charged with making recommendations on MA payment rates to providers of critical services to MFC and models of care coordination to transition the pediatric nursing home population and benefit into MA MC. Beginning in July 2012, three workgroup meetings were held with stakeholders to facilitate input into recommendations. In January, 2013, the final report was sent to the Governor.

The Title V Program is also working with OHIP to plan for the transition of other MCH services into MC such as School Based Health Center services, which will be transitioned into MC in 2015. ***/2015/In 2014, several meetings have been held with representatives of the Title V Program, OHIP, and representatives of School Based Health Centers and manage care plans to develop a viable model to "carve in "school based health center services into managed care plans.//2015//***

Work continues on several additional proposals of the MRT pertaining to the MCH population, including expanding current statewide patient-centered medical homes and reducing inappropriate use of services such as non-medically indicated C-section delivery and reforming malpractice and patient safety. Significant progress has been made regarding MA changes related to family planning, including moving the Family Planning Benefit Program, an income expansion of MA eligibility approved through a MA waiver, to NYS's MA State Plan effective November 1, 2012 (March 1, 2013 in New York City). Title V staff partnered with OHIP to develop and implement these changes. As a result, FPBP will now include a period of presumptive eligibility that will ensure immediate access to family planning services while waiting for final eligibility determination, and eligible women (including undocumented immigrants) will be automatically enrolled into FPEP.; Title V and OHIP staff developed a series of webinars to inform providers regarding the changes in FPBP and to promote outreach to underserved populations.

DFH staff continue to work with OHIP on additional MRT proposals to enhance services to the MCH population, including: development of a children's health home to provide enhanced care coordination for children with chronic physical and behavioral health needs; reimbursement to Local Health Departments (LHD)s for environmental and nursing follow-up services provided to children with lead poisoning; reimbursement for interpretation services for patients with limited English proficiency and communication services for people who are deaf and hard of hearing; expansion of Medicaid to include pre-diabetes counseling, lead poisoning prevention and asthma home visits; home blood pressure monitors for patients with uncontrolled hypertension; Medicaid enhancements to promote maternal and child health, including interconceptional health, breastfeeding support and efficient use of HIT to improve care delivery; denial of Medicaid payment for elective c-section prior to 39 weeks gestation without medical indication; Medicaid coverage of intensive behavioral therapy for treatment of obesity and water fluoridation; and, statewide expansion of Nurse Family Partnership.

During 2012, progress was been made in several MRT proposals related to the MCH population. Staff from the Division of Family Health, as well as staff from other public health offices, are participating in the implementation committees of relevant MRT proposals.
-Over the past year, Title V staff, in collaboration with the AIDS Institute and the Office of Health Insurance Programs and an interagency team, continued discussions regarding creation of a "Health Homes for Children with Chronic Conditions". Areas of focus included pediatric health home condition eligibility, recommendations for services and provider standards for children's health homes, among other priority areas. Discussion occurred with State Office of Mental Health staff to discuss preliminary recommendations for children's health homes to assure a separate behavioral health initiative for children aligns with DOH's preliminary recommendations.
-Effective October 1, 2012, Medicaid fee-for-service began reimbursing outpatient departments, hospital emergency rooms, diagnostic and treatment centers, federally qualified health centers and office-based practitioners to provide medical language interpreter services for Medicaid members with limited English proficiency (LEP) and communication services for people who are deaf and hard of hearing. Medicaid Managed Care and Family Health Plus plans began reimbursing providers for these services effective December 1, 2012.
-Progress has also been made on the MRT initiative to demonstrate the effective and efficient use of health information technology (HIT) among hospitals, health care systems and community-based organizations to improve coordination and delivery of care. Poor perinatal outcomes are major cost drivers for health care institutions and the Medicaid program. Birth outcomes for women and babies can be greatly improved when high risk pregnant and postpartum women receive early and comprehensive screening to identify special needs and risk factors, along with

timely social and medical interventions to address those risks. The development of a comprehensive system of risk identification, assessment and referral through linkage of a web-based referral and case management system with the Regional Health Information Organizations (RHIOs) system has been underway in several regions of NYS. The systems are being designed to capture perinatal risk information for access by health and human services organizations, Medicaid managed care plans, health care providers and hospitals systems, and to facilitate referrals to needed services. Proposals ***/2015/have been received//2015//*** from organizations that have developed collaborative partnerships consisting of community-based organizations, health and human services providers and the RHIOs to use HIT to improve perinatal outcomes. Partnerships identified are those that can rapidly implement or expand pilot projects during 2013 and 2014. ***/2015/Title V staff are in the process with developing contracts with the selected agencies.//2015//*** These projects will improve care delivery and promote maternal health among high risk, Medicaid-eligible pregnant and postpartum women through improved care coordination and referrals, and will provide critical information to the MRT and the DOH on effective and replicable HIT models that can result in significant cost savings to NYS through improved health outcomes.
-Effective April 1, 2013, qualified practitioners who are International Board Certified Lactation Consultants credentialed by the International Board of Lactation Consultant Examiners may be reimbursed by Medicaid for prenatal and postpartum lactation counseling services. Despite the need for the budget to reduce a significant deficit, with some exceptions, maternal and child health programs were relatively successful in maintaining funding levels. The Governor has also supported specific health related efforts such as expanding fresh food access into urban areas. In the 2014 State of the State address, the Governor, once again, has indicated that he fully supports passage of reproductive rights legislation in the State to protect the fundamental right of reproductive freedom and a woman's right to make private health care decisions.

Under the direction of the ***/2015/Acting//2015//*** Commissioner, Dr. ***/2015/Howard Zucker,//2015//*** who is appointed by the Governor, DOH meets its responsibilities through the Office of Health Insurance Programs (OHIP), the Office of Long Term Care (OLTC), the centers located in the Office of Public Health (OPH) and the Office of Health Systems Management (OHSM). In 2007, DOH established OHIP which consolidated operations of the State's public health insurance programs under the direction of the State MA Director. OHIP is responsible for developing and implementing strategies to improve access to health insurance coverage for the uninsured and providing for an integrated approach to oversight and administration of the MA program to strengthen coordination within the DOH and among State agencies. The establishment of OHIP marked the adoption of a new mission for MA, namely to expand coverage and access; to buy value with NY's health care dollars; and, to advance system wide reform. OHIP is responsible for MA, Family Health Plus, Child Health Plus, Elderly Pharmaceutical Insurance Coverage, and the AIDS Drug Assistance Program. The OLTC oversees the integration of planning and program development for services related to long term care. The OPH and the OHSM are responsible for providing policy and management direction to the DOH's system of regional offices. The Office of Minority Health now reports directly to the Commissioner to ensure high level involvement to the issue of health disparities. DOH staff located in regional offices conduct health facility surveillance, monitor public health, provide technical assistance and monitor DOH contracted providers, provide direct services and oversee county health department activities. In addition, DOH also contracts with organizations, such as the Island Peer Review Organization (IPRO), to conduct monitoring and surveillance activities for programs such as the Early Intervention Program, Family Planning Program and School Based Health Centers and School Based Health Center Dental programs. The DOH is also responsible for five health care facilities that are engaged in patient care: the Helen Hayes Hospital in West Haverstraw, which offers specialty rehabilitation services, and four nursing homes for the care of veterans and their dependents in Oxford, NYC, Batavia and Montrose.

The OPH was established in 2007 to strengthen coordination among the DOH's public health programs and to ensure public health input into all the DOH's programs. OPH is made up of the Department's four principal public health centers:

-AIDS Institute;
-Center for Community Health;
-Center for Environmental Health; and,
-Wadsworth Center.

In addition, the Office of Public Health Practice (formerly the Office of Local Health Services in the Center for Community Health), the Health Emergency Preparedness Program, the Office of Public Health Informatics and Project Management and the CDC Senior Management Official in NY report to OPH. The purposes of the OPH are to:
-continue and increase coordination and integration across the department's public health centers and programs;
-assure that public health is fully represented at the departmental level including full incorporation of public health principles into the redesign of the health care system and health insurance programs;
-keep New York active as an innovator in the emerging areas on the cutting edge of public health practice such as maternal and child health; chronic disease prevention; nutrition; environmental health; laboratory science; prevention and control of infectious diseases such as HIV, hepatitis C and others; genomics and informatics;
-coordinate public health activities with the Centers for Disease Control and Prevention, other federal agencies, other state health departments, and local health departments in New York;
-convene partners in the community, academia and the health care system to further public health goals; and,
-rebuild and strengthen the state and local public health infrastructure.

The Center for Community Health (CCH) works with communities to promote good public health for all New Yorkers. A priority of the CCH is to address the root causes of diseases, not just the diseases themselves, in order to make a longer term impact. Aiming programs at the problems of obesity, lack of exercise, poor diet and smoking, helps reduce illness and death from a variety of diseases including heart disease, cancer, diabetes mellitus and stroke--the nation's leading killers. Promoting healthy behavior across the lifespan, and preconception health to better ensure women are healthy before pregnancy to improve birth outcomes are also significant priorities.

The majority of deaths in NYS are not caused by inadequate access to health care (10%) but by behavioral (50%), environmental (20%), and genetic (20%) factors that can be addressed by public health actions. According to a report on Public Health in America produced by the U.S. Department of Health and Human Services in 1994, public health provides ten essential services:
-Monitor health status to identify community health problems;
-Diagnose and investigate health problems and health hazards in the community;
-Inform, educate, and empower people about health issues;
-Mobilize community partnerships to identify and solve health problems;
-Develop policies and plans that support individual and community health efforts;
-Enforce laws and regulations that protect health and ensure safety;
-Link people to needed personal health services and assure the provision of health care when otherwise unavailable;
-Assure a competent public health and personal health care workforce;
-Evaluate effectiveness, accessibility, and quality of personal and population-based health services; and,
-Research for new insights and innovative solutions to health problems.

CCH's responsibilities are broad and far-reaching, touching every aspect of public health in NYS. CCH identifies and assists local agencies with disease outbreaks, makes nutritious foods available to pregnant women, infants and children and tracks cancer incidence across the state. The center conducts public health surveillance to help identify and respond to emerging health threats; to plan, implement and monitor public health programs that respond to these threats; and to show New Yorkers how to minimize health risks. CCH staff helps local health agencies and

community organizations fight the root causes of poor birth outcomes, killer diseases such cancer, heart disease and diabetes, , and work to prevent people from starting to use tobacco and they help those already hooked to quit. Through surveillance, education, prevention and treatment they fight tuberculosis, adolescent pregnancy, sexually transmitted diseases, injuries, abuse, hunger, diseases carried by animals and insects, osteoporosis, dementias and the other public health threats known and still to be discovered. CCH staff work closely with the staff of other centers - Center for Environmental Health, Wadsworth Center, AIDS Institute - that make up the NYSDOH's OPH. The OPH umbrella helps strengthen coordination among public health programs and ensures public health input into all the department's programs.
CCH consists of four Divisions, including:
-The Division of Family Health (DFH) that promotes the health of families by assessing needs, promoting healthy behaviors and providing services to support families.
-The Division of Chronic Disease Prevention (DCDP) that addresses specific risk factors associated with the leading causes of death, disability and chronic disease among New Yorkers.
-The Division of Nutrition (DON) that manages programs designed to improve the nutritional status of the residents of NYS. Improving the diet of the public is a key factor in improving public health among those most at risk for serious illness.
-The Division of Epidemiology whose mission is to use sound scientific practices and principles to protect the health of all New Yorkers through disease surveillance, expert technical assistance, collaborations with local health departments and health care professionals, and by sharing expertise, epidemiologic information, and knowledge the division confronts a variety of new and emerging communicable diseases found in the state.

CCH also includes an Internet Development and Communications unit, which facilitates development of web-based materials, an Office of Information Technology and Project Management, and a Resource Management Unit. This arrangement of services within the Center helps to ensure proper oversight and assistance of all program functions within the Center.

NY's Title V program is located in the DFH in the CCH. Recognizing the importance of maximizing limited resources and re-envisioning strategies, supports and services in light of health care coverage under the ACA, while continuing to focus on improving health outcomes for the MCH population and eliminating health disparities, the DFH embarked on a Strategic Planning process in 2012. This process includes key management staff as well as every staff person within the DFH. The mission of the DFH was defined as "leads the State's public health efforts to improve birth outcomes, promote healthy children, youth and families throughout the lifespan, and build healthy communities through community engagement, public-private partnerships, policy analysis, education, and advocacy." The central challenge of this effort is to "transform the DFH to improve targeted health outcomes". The five "tracks of work" on the DFH 3-year Strategic Map include:
-Maximize effectiveness of public health investments;
-Facilitate health systems improvements;
-Promote DFH priorities, initiatives and accomplishments;
-Foster and maintain an empowered DFH workforce; and,
-Strengthen organizational effectiveness and infrastructure.
DFH staff participate in workgroups focusing on selected priorities in each of these "tracks of work". A priority of the DFH is to promote performance-based, evidence-based practice with a clear understanding of DFH priorities and outcomes.
DFH's primary focus is to improve the health of women, children and adolescents. Its programs touch new mothers, adolescents including those considering sexual activity, children, including those with disabilities and special health care needs, rape victims and children with lack of access to dental services. Programs promote healthy behaviors while also assuring access to quality health care. DFH provides access to primary medical and dental care and preventive health services for migrant farm workers and Native Americans living in reservation communities. DFH consists of the:
-Bureau of Maternal and Child Health;
-Bureau of Early Intervention;

-Bureau of Dental Health;
-Office of the Medical Director.

DFH works very closely with the other Divisions within CCH as well as with the major organizational segments of DOH whose work complements that of DFH, in particular the Office of Health Systems Management (OHSM) and the Office of Health Insurance Programs (OHIP). DON, which includes the WIC program and various other nutrition and fitness programs, works closely with the DFH and OHIP in implementing both prenatal programs and children's programs to ensure that the nutritional needs of at risk pregnant and nursing women as well as infants and children are being met. DCDP works closely with the DFH on programs such as the family planning program, which collects extensive annual data on Chlamydia testing for reproductive age women in NYS, with the cancer screening program in referral of women for screening and treatment for breast and cervical cancer. The DFH, DON and DCDP are also collaborating on a major effort to promote exclusive breastfeeding in NYS. Ongoing communication and collaboration are essential to ensure messaging is consistent in areas such as preconception and interconceptional health, screening for intimate partner violence and substance use and abuse, among other topics of importance to Title V.

OHSM oversees all hospitals and licensed clinics as well as related services in NYS. These facilities, licensed under Article 28 of the Public Health Law to provide health care services, are frequently targeted by the Division's programs in RFPs as eligible awardees for contracts. Since the licensing and monitoring process carried out on an ongoing basis ensures that facilities obtain approval for provision of specific services, these facilities have a demonstrable range of services and quality of care level appropriate for many of the services and programs provided by the DFH. Further, the BMCH, in particular, within DFH, collaborates closely with OHSM in designation of hospitals for level of perinatal care, and in fact drafted the revisions of hospital regulations on which these designations are based, as well as certifying hospitals as Sexual Assault Centers of Excellence (SAFE Centers). BMCH and DFH are consulted by OHSM whenever hospital or clinic closures are threatened, to ensure that sufficient service providers are available to meet the obstetric and perinatal needs within the region.

There has been a long and very close partnership between the MA programs and the maternal and child health programs in NYS. The DFH worked closely with OHIP over the past couple years on major initiatives of significance to the MCH population including the transition of the Prenatal Care Assistance Program to the MA Prenatal Care Program, revising prenatal care program policies and standards to conform with current standards of professional practice, streamlining enrollment of pregnant women from Fee for Service MA into Managed Care, improving the coordination of home visiting services, including the development of a Risk Summary form to better ensure providers are working with Managed Care Plans to address identification and referral of pregnant women at risk for poor birth outcomes, development and implementation of the new Ambulatory Patient Group reimbursement to ensure providers were adequately reimbursed for comprehensive services, and efforts such as submission of the 1115 MA Waiver to ensure NY can continue to provide comprehensive reproductive health services to eligible populations of the state. DFH is working closely with OHIP on an ongoing basis to ensure that guidelines for high quality care are in place, in addition to helping inform providers of changes, streamline application processes, and generally provide a systems level approach to implementation. The DFH and Office of Quality and Patient Safety (OOQPS) are currently collaborating on a focused prenatal care study to establish priority areas for improvement. The core mission of the OOQPS is to improve the health, quality of care and patient safety of NYS residents, consistent with the NYSDOH Strategic Plan and MRT recommendations.

A further characteristic of the state's Title V program is maintenance of local level contacts through the network of regional offices around the state. These offices all have family health directors, who regularly communicate with the Title V Director via meetings or telephone contacts, as required, of local level issues that might potentially influence services or health care status of Title V populations in any area of NYS

Title V's position within the OPH promotes collaborative efforts with programs and services aimed at the maternal and child health population and promotes maximizing resources to improve health outcomes.

Title V priorities align with DOH's overall priorities. Dr. ***/2015/Zucker,//2015//*** the DOH ***/2015/Acting//2015//*** Commissioner continues to stress the importance of restoring NY to national prominence in health care delivery and the need to reshape NY's health care system to serve New Yorkers more efficiently and cost effectively. Dr. /2015Zucker//***2015// continues to support the need to maintain core public health programs in critical areas such as tobacco control, obesity prevention, and HIV AIDS prevention and services. As with the previous budget, there are several themes that run through all of the Department's budget proposals including:***
-preserving services that support the DOH's core mission of protecting and improving the public's health;
-achieving reforms that increase efficiency while maintaining quality;
-accountability and transparency;
-elimination of duplication of services;
-consolidation, streamlining and simplification;
-flexibility to target resources where they are needed most; and,
-use of innovation to reduce the State's greatest public health threats while at the same time helping to reduce the deficit.

Major priority areas of DOH closely align with the priorities of NY's Title V program including:
-Obesity Prevention - Overweight and obesity are now challenging smoking for the top public health threat in NYS. Currently, about 60 percent of adults and 35 percent of children and adolescents in NYS are obese or overweight. The increase in overweight and obesity is dramatically increasing NY's risk for many chronic and debilitating conditions -- including heart disease, diabetes, hypertension, and some cancers. NY's approach to obesity as well as other chronic diseases uses the social-ecological model focusing on activities at all levels of influence (society, community, organizational, interpersonal and individual) in order to facilitate healthy choices and limit promoters of poor health. The obesity prevention agenda includes the promotion of exclusive breastfeeding, initiatives to increase exercise among children, decrease television viewing, and improve nutrition, including a calorie posting requirement, a ban on the use of trans fats in certain restaurants and food service establishments, and a ban on the sale of high-fat, high-sugar junk foods in schools.
-Tobacco prevention and control - Tobacco use continues to be NY's number one cause of preventable disease and death. Health care costs related to treating smoking-caused diseases total approximately $8 billion annually for NY alone, including $3 billion annually in Medicaid costs. Between 2000 and 2009, the adult smoking rate in NYS declined from 21.6 percent to 17.9 percent, resulting in 500,000 fewer smokers in only one year. Between 2000 and 2010, the high school smoking rate in NYS dropped from 27.1 percent to only 12.6 percent.
-Lead poisoning -- NY has made a commitment to end childhood lead poisoning in NYS. Childhood lead poisoning has decreased by 17 percent in upstate NY since 2005. The Childhood Lead Poisoning Primary Prevention Program is a priority of DOH to keep NY's children safe from this public health threat.
-HIV/AIDS and Sexually Transmitted Diseases -- DOH remains committed to addressing the AIDS/HIV epidemic and addressing sexually transmitted diseases.
-Targeting primary and preventive public health strategies that will decrease obesity rates, increase healthy eating and physical exercise, prevent childhood lead poisoning, expand access to cervical cancer vaccines, prenatal and postpartum home visiting, high-quality mammograms and public health education.
-Early Intervention Program (EIP) -- DOH continues to work on reforms to the program

including a variety of administrative actions that would require preferred assessment tools, modified speech eligibility standards, and revised reimbursement rates. /2013/Significant reforms were enacted as part of the 2012-13 State Budget to improve coordination of care and reduce the local burden of the early intervention system for localities. These reforms, which /2015/became//2015// effective in 2013, include a new requirement for service coordinators to notify regional OPWD, with parent consent, when children referred to the EIP might also be eligible for that system; elimination of local contracts with EIP providers, to be replaced by direct State-level provider agreements; the establishment of a State fiscal agent to manage provider billing and claiming to third party payors; and, expansion of the role of service coordinators to include timely implementation of children's Individual Family Services Plans and management of the transition process.
-Ensuring there are health care professionals available to meet the primary and preventive health care needs in NY's underserved areas of the state;
-Ensuring that the Graduate Medical Education (GME) system provides the state with the value desired for the funds invested;
-No longer using MA to cross-subsidize commercial insurers, nor supporting deep discounts for hospital services their members use.
-Paying fair reimbursements that reflect the true costs of providing high-quality care through a work force whose needs are met fairly, redirecting MA dollars to those facilities that serve the bulk of the MA patients.
-Purchasing health care in the appropriate setting, using the highest standards at the best price, and starting with the patients that have multiple medical needs. With better coordination of care, patients with medically-complicated conditions will get better care, their conditions will be better managed, and the cost of their total care will be reduced.
-Expanding the managed long-term care programs which have been successful in coordinating and managing long-term care needs.
-Driving the implementation of health information technology, which is essential to improving health care quality, reducing bureaucratic barriers and saving health care dollars.
-Increasing efforts to root out MA fraud, which wastes precious resources and reduces our ability to care for those in need.

Refer to Section IIIB Agency Capacity for a more comprehensive description of NY's MCH activities.

The Governor's proposed Budget for ***/2015/2014//2015//*** continues the historic health care reforms achieved over the last four years. DOH's efforts focus on achieving greater efficiency without creating barriers to enrollment for those eligible for MA services. In NY, MA is the largest single payer of health care, so through MA reform, DOH will have an opportunity to leverage changes in the health care system. These reforms fully support the mission of NY's Title V program in ensuring comprehensive primary and preventive health and support services to the maternal and child health population, including children with special health care needs.

To better serve patients in the right setting at the right price, NY has invested more than $600 million in outpatient care in the last three years. The investments include investments in hospital programs, including outpatient clinics, ambulatory surgery, and emergency room; physicians' fees; primary care; freestanding programs; and, mental hygiene enhancements. The ***/2015/2014-15//2015//*** Budget continues these investments including supports for implementing Health Homes for complex high-cost recipients, investments in affordable housing, and the continued move to care management for all Medicaid recipients, which is expected to be completed in 2015-16.

Another critical component of NY's historic health care reform of the last four years has been the updating of the decade-old hospital reimbursement system and addressing the issue of potentially preventable hospital readmissions. Potentially preventable readmissions occur because the patient is discharged too soon or too sick or because of a lack of follow-up care in the community following the discharge. The 2010-11 Budget began reducing funding for

preventable admissions and in 2012 began to reinvest a portion of the savings in rewarding hospitals that reduce readmissions and in post discharge linkages. The budget also funded an additional 100 slots for Doctors Across NY -- 50 for physician loan repayment and 50 for physician practice support -- to improve access in medically underserved areas of the state.

DOH continues its efforts to make it easier for eligible individuals to access public health insurance programs. Since 2008, DOH has permitted self-attestation of income and residency at renewal for non-SSI related MA beneficiaries and Family Health Plus members. The 2010-11 budget permitted MA enrollees receiving community-based long-term care to attest to their income and residency at renewal. DOH is in the process of implementing a federal option called Express Lane eligibility that will allow children no longer eligible for Child Health Plus to transfer to MA.

Plans are also underway for the implementation of the Statewide Enrollment Center that will consolidate the MA, Family Health Plus and Child Health Plus toll-free numbers to provide one-stop shopping for persons already enrolled in public health insurance and for those seeking information about applying, and it will augment the local social services districts by processing telephone and mail-in renewals.

/2015/In 2014, the exchange, NY State of Health, was fully implemented and serves as a centralized market place to shop for, compare and enroll in health plans, in accordance with the ACA. The health plans offered through NY State of Health are on average 53% less expensive than individual coverage purchased in 2013 for comparable coverage. As of March 24, 2014, over 1 million New Yorkers have completed applications and more than 700,000 have enrolled in coverage. NYS has been successful in enrolling individuals in private plans, as well as in enrolling the younger population. Federal funding for the initial operations of the NY Health Benefit Exchange will end January 1, 2015, and the Executive Budge provides $54.3 million in 2014-15 growing to $148 million in State funding, between the DOH and the State's Department of Financial Service budgets, to sustain its continued operation.

The Governor included the ACA's Basic Health Program (BHP) in his budget proposal released in late January. If approved by the NY legislature, the BHP could be providing health insurance for people with incomes between 133% and 200% of poverty by 2016.//2015//

The Affordable Care Act (ACA) at the federal level may significantly impact NY's public health programs and maternal and child health services, and support NY's efforts in this arena. Although DOH awaits specific guidance around some of these areas, the federal Patient Protection and ACA will assist DOH to achieve improved maternal and child health outcomes if DOH has the ability to obtain funding and support. DOH has already been awarded a small Community Transformation Grant from the Centers for Disease Control and Prevention (CDC) through the Communities Putting Prevention to Work (CPPW) initiative. The Title V staff is collaborating with the DCOD to implement this grant that will help support DOH's initiative to increase exclusive breastfeeding rates in NYS. DOH's Personal Responsibility Education Program funding supports additional programs in the Comprehensive Adolescent Pregnancy Prevention program to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections, including HIV/AIDS; and adult preparation subjects (financial literacy, parent child communication, career planning, etc). This funding will augments adolescent health services in the state. The OHIP has also obtained state plan approval to provide MA funding support to two Nurse Family Partnership programs in Monroe County and NYC as targeted case management programs. DOH was awarded Abstinence Education funds to support innovative activities focusing on adult mentorship and supervision of children 9 through age 12 years. Awards for this funding have been made based on a Request for Applications that was released in 2012.

DOH also received funding through the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Programs, a new section in Title V that provides funding to States to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation model(s) that will support NY's evolving work on home visiting. Title V staff developed and submitted a comprehensive needs assessment on home visiting in NY in collaboration with the several State agencies and a state plan for use of the funds. ***/2015/In addition to the 6 MIECHV projects (2 NFPs and 4 HFNYs) in 3 of the 14 primary target communities (Bronx, Erie and Monroe), a competitive Request for Applications resulted in the expansion or establishment of evidence-based HV programs by awarding Maternal Infant and Early Childhood Home Visiting funds to 3 NFP and 1 HFNY projects.//2015//***

The new federal law also contains measures that will enhance NY's already rich public health insurance system. The following are major highlights of those provisions impacting NYS.
-MA Expansion. Creates a new mandatory MA eligibility category for most adults and children with income at or below 133 percent of the Federal Poverty Level (FPL) beginning January 1, 2014. States are required to adopt a "modified adjusted gross income" (MAGI) test to further streamline eligibility determinations. The OHIP will be working with CMS to define the MAGI to ensure greater access for NY's uninsured or underinsured population. Eligibility for most non-disabled adults under age 65 will be based on this MAGI.
-NYS is already in compliance with the requirement that there be no resource test for most populations, including pregnant women, most families, children and single adults. That provision is required by the HCRA starting in 2014.
-State Health Insurance Exchange. In April 2012, Governor Cuomo signed an Executive Order to establish a statewide Health Exchange that will reduce the cost of coverage for individuals, small businesses, and local governments, and will be instrumental in establishing the first-ever comparative marketplace to bring down the cost of health/2014/The 2013-14 NY Health Benefit ***/2015/was//2015//*** implemented ***/2015/in October 2013.//2015//***
-States are required to maintain income eligibility levels for CHIP through September 30, 2019. Low income children will continue to be covered in NY up to 400% of the FPL either through Child Health Plus, MA or the Exchange.

There are also provisions that will bolster NY's health care system, especially for underserved areas of the state, including:
-Community Health Centers. Creates a Community Health Center (CHC) Fund that provides mandatory funding for the CHC program, the National Health Service Corps and construction and renovation of community health centers. DOH is ensuring that CHCs are positioned to apply for grant funding to serve NY's populations whenever feasible.
-Increasing Primary Care and Public Health Workforce. Includes numerous provisions intended to increase the primary care and public health workforce by including amended and expanded health workforce programs authorized under Title VII (health professions) and Title VIII (nursing) of the Public Health Service Act. A variety of incentives are included to support education and training of pediatric specialists, oral health providers, and nurses. Title V staff are working with the OHSM staff to identify workforce shortages and support community partners to address these shortages where possible.

Recognizing the complexity of Health Care Reform, the Governor created the Governor's Health Care Reform Cabinet to manage the implementation of federal health care reform in NYS. The Cabinet will advises and makes recommendations to the Governor on all aspects of federal health care reform and strategic planning to guide the implementation of the Patient Protection and AAC and the Health Care and Education Reconciliation Act. State agencies serving in the Cabinet include: DOH, the Department of Financial Services, the Division of the Budget, the Department of Civil Service, the Department of Taxation and Finance, the Department of Labor, the Office for Technology, the Office of Temporary and Disability Assistance, the Office of Mental Health, the Office for People with Developmental Disabilities, the Office of Alcoholism and Substance Abuse Services, the Office for the Aging, the Office of the Medicaid Inspector General, and the Office of Children and Family Services. The Deputy Secretary for Human Services,

Technology and Operations, Deputy Secretary for Intergovernmental Affairs and Counsel to the Governor also serves in the Cabinet. In addition, the Governor has named an external advisory group to assist and advise the Cabinet on reform provisions and ensure stakeholder and public engagement. The advisory group includes organizations representing health care providers, consumers, businesses, organized labor, local governments, and health plans and health insurers, as well as health policy experts. In this way, NY can be better assured that changes and improvements will be made to improve the health outcomes of all New Yorkers.

NY has proceeded to implement the health reform law provision related to the establishment of a temporary statewide insurance pool for high risk individuals. Coverage through this program is available until January 2014 when more health insurance coverage options become available through a Health Insurance Exchange. In NYS, the preexisting condition pool is called the NY Bridge Plan which covers a broad range of services, including primary and specialty care, inpatient and outpatient hospital care and prescription drugs, as well as assistance from professional nurses and caseworkers to help members manage chronic conditions and maintain health. Eligibility is not based on income. Coverage for preexisting conditions begins right away, with no waiting period. In 2011, the Governor signed a law amending Insurance and Public Health Law relating to prescription drug coverage, pre-existing conditions and preventive health care, increased the age of dependent children for coverage, prohibited lifetime and annual coverage limits, among others, that ensured NYS will be in compliance with the ACA.

A series of public forums were held on the establishment of health insurance exchanges in NYS. A wide array of stakeholders participated in the meetings including health care consumers, administrators, doctors, hospitals and other health care providers, insurers, producers, businesses, unions, academics and the general public. Stakeholders provided input related to key design options related to exchanges. NYS received conditional certification from HHS to operate a state-based Exchange in 2012. Extensive outreach has begun to engage Health Plans in the Exchange. Selection of Plans will occur in July 2013. DOH issued a RFA to solicit applications ***/2015/and awarded contracts//2015//*** for the Exchange In Person Assistor/Navigator Program to provide health insurance application assistance. It is designed to reduce barriers in accessing insurance by providing in person assistance in community based locations frequented by target populations, at times that are convenient to potential enrollees. Title V staff disseminated this RFA to all MCH partners. The Navigator Program and Customer Service center will be initiated in September 2013. Initial applications through the Exchange will be taken in October 2013 with coverage starting in January 2014.

NY is also committed to ensuring all New Yorker's are insured and do not lose their insurance due to unnecessarily high premiums. To that end the former Governor signed legislation requiring health insurers and HMOs to make an application to the State Department of Financial Services to implement premium increases. DOH would have the opportunity to review the rate applications, as well as the underlying calculations, to ensure that the rates are justified and not excessive, and may approve, modify or disapprove the rate application. The law applies to all rate increases taking effect on or after October 1, 2010.

Through health care reform and investing in primary and preventive care, and strengthening NY's public insurance programs, as previously discussed, NY is striving to increase availability and accessibility of health care for historically underserved populations. In April, 2008, former Commissioner Daines launched the Prevention Agenda (PA) for the Healthiest State, establishing 10 statewide public health priorities with an emphasis on prevention strategies. The PA was a call to action, asking hospitals, LHDs and other health care and community partners to collaborate in planning to bring about measurable progress toward mutually-established goals related to two to three of the priorities. Across all the priority areas, the PA focuses on eliminating the profound health disparities that impact racial and ethnic minorities. The public health priorities include:
-Access to Quality Health Care
-Tobacco Use
-Healthy Mothers, Healthy Babies, Healthy Children

-Healthy Environment
-Physical Activity & Nutrition
-Community Preparedness
-Unintentional Injury
-Mental Health & Substance Abuse
-Chronic Disease
-Infectious Disease

LHDs recorded their efforts in Community Health Assessments (CHA) and Municipal Public Health Service Plans (MPHSP), which were submitted to DOH in July of 2009 as part of requirements for receipt of state funding through Article 6 of the NY Public Health Law. Hospitals submitted their Community Service Plans (CSP) in mid-September, 2009. With input from community members and stakeholders, two or three Prevention Agenda priorities were selected for community action and a plan was developed. By coordinating their needs assessment and program planning activities, all participants are better able to meet the needs of their communities while avoiding duplicative efforts and achieving economies of scale. The goal is for LHDs and hospitals to develop shared visions of what must be addressed. DOH provided technical assistance on accessing county-specific data, using evidence-based prevention approaches, and monitoring their impacts. Community-based efforts were complemented by local and statewide policy initiatives to help achieve the prevention goals. Although Title V's major focus is Healthy Mothers, Healthy Babies, Healthy Children, all of the areas of focus impact health outcomes of the maternal and child health population. Over the past year, DOH assessed progress on the 2008-2012 PA toward the Healthiest State, in order to identify new health priorities and develop a plan for multi-sector action on priority health issues

The Prevention Agenda (PA) 2013-17 was developed by the NYS Public Health and Health Planning Council (PHHPC) in collaboration with DOH, and in partnership with more than 140 organizations across the state. This plan involves a unique mix of organizations, including LHDs, health care providers, health plans, community based organizations, advocacy groups, academia, employers as well as state agencies, schools, and businesses who can influence the health of individuals and communities and address health disparities. This unprecedented collaboration informs a five-year plan designed to demonstrate how communities across the state can work together to improve the health of all New Yorkers. The PA will serve as a guide to LHDs as they work with their community to develop mandated Community Health Assessments and hospitals as they develop mandated Community Service Plans and Community Health Needs Assessments required by the ACA over the coming year. The PA vision is NY as the Healthiest State in the Nation. The plan features five priority areas including:
-Prevent chronic diseases
-Promote healthy and safe environments
-Promote healthy women, infants and children
-Promote mental health and prevent substance abuse
-Prevent HIV, sexually transmitted diseases, vaccine-preventable diseases and healthcare-associated infections.

The Prevention Agenda establishes goals for priority areas and defines indicators to measure progress toward achieving these goals, including reductions in health disparities among racial, ethnic, and socioeconomic groups and persons with disabilities, and identifies interventions shown to be effective to reach each goal. These interventions are displayed by stakeholder groups so each can identify evidence based or promising practices they can adapt to address specific health issues in their communities. They are also displayed by the five tiers of the Health Impact Pyramid that, much like the Title V MCH pyramid, is a framework based on the potential impact of interventions. At the base are efforts to address socio-economic determinants of health (Tier 1). In ascending order are interventions directed at the environment to make individuals' decisions healthy (Tier 2), clinical interventions that confer long-term protection against illness (Tier 3), ongoing direct clinical care (Tier 4), and health education (Tier 5). Interventions at lower levels of the pyramid reach broader society by changing the environments in which people live

through policy changes. Sustaining interventions at each of the levels can achieve maximum public health benefit and address health disparities and social determinants of health.

The Prevention Agenda has five overarching goals:
-Improve health status in five priority areas and reduce disparities including among persons with disabilities.
-Advance a 'Health in all Policies' approach to address broad social determinants of health.
-Create and strengthen public -private and multi-stakeholder partnerships to achieve public health improvement at state and local levels.
-Increase investment in public health to improve health, control health care costs and increase economic productivity.
-Strengthen governmental and nongovernmental public health agencies and resources at state and local levels.
Building on the success of the PA, DOH submitted for accreditation to the Public Health Accreditation Board, the national accrediting organization for state, local, tribal and territorial health departments. Public health department accreditation is a new process to measure health department performance against nationally defined standards, and recognize those health departments that meet the standards.
The Agenda seeks to be a catalyst for action and a blueprint for improving health outcomes, reducing health disparities, and enhances NY's efforts to achieve the mission of Title V.
/2015/In March, 2014, the Commissioner announced the launch of NYS's inaugural Health Innovation Challenge in collaboration with the NYS Health Foundation. The event comes a year after Governor Cuomo announced Open.NY.gov, a comprehensive state data transparency website that provides user-friendly, one-stop access to data from NYS agencies, localities, and the federal government. In March 2013, the State DOH launched Health Data NY, health.data.ny.gov, its open health data site. The site allows health care providers, researchers, legislators, advocates, academics, and the general public to analyze and download valuable health data in a variety of formats.
The Health Innovation Challenge will build on the open government initiatives and provide a way for innovators to put the health data to good use, and invites teams of coders and developers to create a technological solution that addresses the lack of accessible and useful information about the quality, cost and efficiency of health care services.//2015//
As demonstrated in the Needs Assessment Summary portion of NY's application, health disparities continue to exist in NYS, and addressing those factors leading to ethnic and racial disparities in health outcomes remains a DOH priority. Health disparities in NY often occur along the lines of race, ethnicity, nativity, language ability, socioeconomic status, and geography, among other factors. The geographic distribution of NYS also complicates issues related to disparities as there is a great variation between rural and urban areas, providing a sharp contrast among residents and their access to health care services. Small community-based providers in underserved areas of the state often do not have the level of expertise and infrastructure to support comprehensible public health programs.

All efforts discussed previously are devoted to improving health outcomes for all New Yorkers, including ethnically and culturally diverse individuals. The major focus of DOH's efforts include partnerships at the state, local and community level. A 2010 report developed for the DOH's Minority Health Council contained several strategies regarding eliminating disparities. The Title V program in NYS is working to operationalize these concepts to decrease the divide that exists among diverse groups in NYS. The report contained recommendations and promising strategies that NY could implement to potentially reduce disparities including:
-Leverage and expand core system and mission functions to assure an integrative approach for addressing health disparities
-Improve data collection, data systems, and mechanisms for monitoring and reporting disparities.
-Develop, implement and evaluate disparities interventions.
-Ensure leadership and stakeholder support for coordination of effort and institutionalize disparities-reduction work.

The report recognized NY's commitment to addressing disparities, but went on to state that stronger partnerships with local health departments to develop strategies to address disparities may impact the health disparity issue. To that end, the former and current Commissioner made the PA (discussed previously) a priority of state and local leaders. In April, 2010, LHD's and DOH experts in specific topic areas (teen pregnancy prevention, prenatal care, obesity prevention) met to discuss local strategies to improve health outcomes and address disparities in selected health outcomes. These discussions focused on local public and private agencies that could partner to address specific issues, and evidence-based interventions and promising practices to address health issues, including health disparities.During 2012, Title V staff developed a series of webinars for LHDs to discuss their role in promoting MCH and MCH-related outcomes in the PA. Title V staff will continue to promote partnerships to improve the health outcomes of NY's diverse community.

DOH has access to a wealth of data and information to identify issues related to maternal and child health outcomes and disparities. Although resources have always been targeted at high risk populations of the state, a more concerted effort is being made to ensure resources are going to the highest need areas. For example, although NY's outcomes in many areas are improving, in areas such as adolescent pregnancy, disparities continue to exist due to increasing numbers of immigrant and hard to reach adolescents. Extensive data analyses have been completed to target the highest need areas and provide better utilization of resources. DOH also provided statewide training to current and potential providers on evidence based programming and community coordination of resources, and outreached to providers in the hardest to reach areas to ensure there will be a pool of agencies positioned to apply for funds to address the need in the highest need areas of the state. In addition, all requests for applications now specifically identify high risk groups as a priority including specific minority populations, youth in foster care or those otherwise not engaged in the service system.

The Title V program also continues to prioritize resources and activities to address health disparities.

Targeted efforts at disparate populations include the adolescent and perinatal programs, where resources will be targeted to the highest need areas of NYS, and collaborative efforts with the NYS Office of Temporary Disability Assistance (OTDA), Bureau of Refugee and Immigration Affairs and DOH's Refugee Health Program to address emerging state and national concerns about lead poisoning among refugee populations. DOH and OTDA jointly conducted an assessment of educational needs for LHDs and refugee resettlement agencies, resulting in a collaboration to translate basic low literacy lead educational materials for refugees and to develop a new video for local agencies. DOH worked with the Office of Children and Family Services to develop and disseminate materials on lead poisoning prevention for all child care providers throughout NYS.

All providers funded by DOH are required to assess community need and develop outreach strategies to engage hard to reach populations into their services. Providers submit quarterly reports and, if data are available, Title V staff review to determine if high risk populations are being reached, and work with providers to address issues when necessary. Through programs such as the Immigrant Women's Health Program, DOH funds Family Planning Advocates of NYS to work with family planning agencies, to enable them to develop strategies for providing more culturally and linguistically competent, reproductive health services, thereby increasing their reach into the targeted population. Included in the updated standards for MA Prenatal Care providers is the provision that they shall provide, or arrange for, the provision of health and childbirth education based on an assessment of the pregnant woman's individual needs. Prenatal care providers are required to focus on the pregnant woman's ability to comprehend the information and use materials appropriate to the educational, cultural and language needs of the patient as well as her gestational history.

DOH is also requiring funded providers to use, whenever possible, evidence-based or promising

practices that have been tested or evaluated to produce desired outcomes on the target population. For example, in the comprehensive adolescent health request for applications released in 2010, only evidence-based practices were entertained for funding. NY also has a comprehensive system of perinatal regionalization, led by Regional Perinatal Centers (RPCs). This better ensures women at high risk for poor birth outcomes are referred to a hospital that has the capability to care for the women and her infant.

Title V staff communicate regularly with DOH regional staff as well as community providers. This allows issues such a lack of obstetrical coverage in certain areas of the state or issues with health outbreaks or medical coverage to come to the forefront.

DOH strives to better coordinate the state's data system and information technology to streamline and coordinate the flow of information. Through NY's Office of Health Technology Transformation, NY's health IT plan is being advanced in the public's interest and with clinical priorities and quality and population health improvement goals leading the way. The plan includes key organizational, clinical and technical infrastructure as well as cross cutting consumer, financial and regulatory strategies to better coordinate data flow and information sharing. Within the DFH, staff are working on the development of the Child Health Information Integration Project (CHI^2) that aims to develop an integrated data system that will improve quality of care (via timely accurate data), reduce medical errors, collect individual data for activities such as Newborn Hearing Screening, provide seamless flow of information between jurisdictions, link events of public health significance in a child's life (e.g. immunizations) and enable bi-directional data sharing.

Although there is much left to be done, NYSDOH is committed to continue its work to ensure all NY's citizens receive high quality, comprehensive primary and preventive care to improve health outcomes.

B. Agency Capacity

The NYSDOH, as the Title V agency, plays a major role in assuring access to quality, comprehensive, community-based, family centered care for all NY's women, children and families. Title V provides the foundation for NY's commitment to develop and support core public health functions such as resource development, capacity and systems building, population-based functions such as public information and education, knowledge development, outreach and referral to services, technical assistance to local health departments and communities to address core public health needs, and training and resources to support a cadre of professionals necessary to meet the needs of NY's maternal and child health population. NY's strong commitment to ensuring the health and well-being of the MCH population is manifest in an extraordinary array of resources made available to meet their needs. This section provides an overview of these resources, which extend from the legal framework that authorizes the DOH's work, to the extensive programming conducted on behalf of NY's most vulnerable populations.

1)NYS Statutes Relevant to Title V Program Authority and Impact Upon the Title V
NY's Public Health Law (PHL) provides a strong legal foundation for DOH's efforts to promote and protect the health of mothers, infants and children. Some of the more salient aspects of the law relating to the MCH population are outlined below.

The functions, powers and duties of DOH and the powers and duties of the Commissioner of Health and other DOH officers and employees are detailed in PHL Article 2, the Department of Health. The same article also details the mission of the Office of Minority Health***/2015/and Health Disparities Prevention (OMH-HDP)///2015***//, which is discussed below in the section devoted to cultural competency. Some important powers granted by the legislature to DOH and the Commissioner include: supervision and funding of local health activities; the ability to receive and expend funds for public health purposes; reporting and control of disease; control and supervision

of abatement of nuisances affecting public health; and, to serve as the single state agency for the federal Title XIX (Medicaid) program. Article 2 also provides that DOH shall also exercise all functions that, "…hereafter may be conferred and imposed on it by law."

Law governing the organization and operation of NY's local public health infrastructure, which includes the health departments of 57 counties and the City of NY, is contained in PHL Article 3, Local Health Organization. A major component of the Title V program capacity, these local health departments are supported by millions of state local assistance dollars, which the Department administers under the provisions of PHL Article VI, State Aid to Cities and Counties.

A key determinant of DOH's capacity to serve mothers, infants and children is PHL Article 7, FEDERAL GRANTS-IN-AID, which specifically authorizes DOH to, "…administer the provisions of the federal social security act or any other act of congress which relate to maternal and child health services, the care of children with physical disabilities and other public health work and to co-operate with the duly constituted federal authorities charged with the administration thereof." This provision not only empowers DOH to obtain and distribute Title V funds, but also those from Title X of the PHS Act, WIC nutrition and other federal resources essential to our efforts to improve the health of the MCH population.

DOH's ability to control lead poisoning is conferred by PHL SS1370-1376-a, which defines the State lead poisoning program, specifies lead screening and reporting requirements, and prohibits the manufacture, sale and use of specific products containing lead. The law also details abatement requirements where lead hazards exist, identifies enforcement agencies, and provides remedies for failure to act to abate lead hazards.

The comprehensive tobacco control capacities of DOH are specified in PHL Article 13-E, regulation of smoking in certain public areas, which enables the Department to reduce environmental exposure to tobacco smoke by prohibiting smoking in most ***/2015/indoor//2015//*** public places; PHL Article 13-F, regulation of tobacco products and herbal cigarettes; distribution to minors, which defines the State tobacco use prevention and control program, prohibits free distribution of promotional tobacco and herbal cigarette products, and which prohibits sale of such items to minors.

PHL Article 21, Control of Acute Communicable Diseases, details the role of local health officials in control efforts, and specifies reporting requirements and patient commitment procedures. This Article also provides control requirements for specific diseases, including HIV, rabies, typhoid fever, poliomyelitis and Hepatitis C. PHL Article 23, Control of Sexually Transmissible Diseases, outlines the roles of state and local health officials in the identification, care and treatment of persons with a sexually transmissible disease specified by the Commissioner, and provides for the injunction and abatement of houses of prostitution.
Direct reference to the duties of the Commissioner of Health regarding the health needs for mothers, infant and children is made in PHL Article 25, Maternal and Child Health.

Succeeding sections in PHL Article 25 authorize the Commissioner to, among other important activities, screen newborns for inherited metabolic diseases ***/2015/and critical congenital heart disease//2015//*** (SS2500-a), HIV (SS2500-f) and hearing problems (SS2500-g). NY's Child Health Insurance Plan is detailed in PHL SS2510-2511. The Commissioner's extensive powers to affect prenatal care are enumerated in PHL SS2522-2528, 364-i and 365-k of Social Service Law. An important asset to Departmental efforts to monitor, evaluate and improve patient care and outcomes is provided by PHL SS2500-h, which authorizes development and maintenance of a statewide perinatal data system and sharing of information among perinatal centers.

DOH's Early Intervention (EI) Program, for children who may experience a disability because of medical, biological or environmental factors which may produce developmental delay, is authorized by PHL SSSS2540-2559-b, while programming to provide medical services for the treatment and rehabilitation of children with physical disabilities is authorized by PHL SS2580-

2584.

Nutrition programming conducted on behalf of children in day care settings is authorized by PHL SS2585-2589, while PHL SS2595-2599 establishes the nutrition outreach and public education program to promote utilization of nutrition throughout the state. The makeup and operation of NY's Obesity Prevention Program is detailed in PHLSS2599-a-2599-d.

The ability of NYS to regulate hospitals, including ambulatory health facilities, is conferred by PHL Article 28, Hospitals, and is a prime determinant of DOH's capacity to promote and protect the health of mothers and children. Among the specific provisions of relating to hospitals is the NYS Health Care Reform Act (HCRA), which is codified as PHL SS2807-j-2807-t. A major component of NYS Health Care financing laws, HCRA governs hospital reimbursement methodologies and targets funding for a multitude of health care initiatives. The law also requires that certain third-party payers and providers of health care services participate in the funding of these initiatives through the submission of authorized surcharges and assessments.

Similarly, DOH has been given broad powers to regulate home health care agencies and health maintenance organizations through PHL Article 36 and PHL Article 44, respectively. With increased interest in, and funding allocated to, maternal/newborn home visiting programs, the importance of DOH's home health agency regulation has grown considerably. Now that the majority of MA-eligible mothers and children are enrolled in MA managed care plans, DOH relies on its delegated powers to ensure the quality of care rendered to them.

The broad authority and reach provided through these and other state laws empowers the DOH to plan, implement and oversee a variety of programs focused on improving the health and wellness of the MCH population.

2)Capacity to Provide Preventive and Primary Care Services for Pregnant Women, Mothers, Infants and CSHCNs

NYSDOH oversees a broad array of programs designed to address the needs of pregnant women, mothers, infants and CSHCNs. Descriptions of the major Title V-related efforts are provided below.

Family Planning Program provides accessible reproductive health services in ***/2015/49 agencies in 178//2015 sites. Programs provide low-income, uninsured women with contraceptive education, counseling and methods to reduce unintended pregnancies and to improve birth spacing and outcomes. The program serves /2015/approximately//2015 350,000 women and men per year. The Family Planning Extension Program (FPEP), added in 1998 as an 1115 waiver demonstration project, provides up to 26 months of additional access to family planning services for women who were pregnant while on MA, and subsequently lost coverage. The Family Planning Benefit Program (FPBP) began in October 2002 as an 1115 waiver demonstration project and provides MA coverage for family planning services to individuals with incomes at or below 200 percent of the federal poverty level. As allowed under the Affordable Care Act, both FPBP and FPEP have been added to NYS's Medicaid State Plan effective November 1, 2012 (March 1, 2013 in New York City). As a result, FPBP will now includes a period of presumptive eligibility that ensures immediate access to family planning services while waiting for final eligibility determination, and eligible women (including undocumented immigrants) will be automatically enrolled into FPEP. /2015/Preliminary data indicate that the change has resulted in a significant increase in the number of people whose family planning (FP) services are covered through FPBP.//2015//***

Comprehensive Adolescent Pregnancy Prevention (CAPP) Initiative, launched in January 2011, integrates NY's adolescent health programs, and includes a significant focus on reducing racial and ethnic disparities. Through the CAPP initiative, DOH awarded more than $17.5 million in

state grants to 50 community-based organizations that focus on the prevention of pregnancies, STDs and HIV among male and female adolescents age 10 to 21 years. Projects implement evidence-based sexuality education; ensure access to reproductive healthcare services; expand educational, social, vocational and economic opportunities; and engage adults to advance sustainable local community efforts to improve environments for young people. ***/2015/NY Promoting and Advancing Teen Health (NYPATH) provided training opportunities on adolescent sexual health for health care providers in the state that included development of a new web site designed for medical practitioners who provide healthcare services to adolescents and want evidence-based information and resources about adolescent sexual and reproductive health, and other primary health care issues.//2015//***

Personal Responsibility Education Program (PREP) initiative, supported through new federal funding ($3.4 million), focuses on implementation of evidence-based sexual health education and preparation of youth for successful transition to adulthood to reduce adolescent pregnancy, making it closely aligned with the DOH CAPP initiative described above. A state plan describing NYS's plans for use of this funding was approved in April, 2011 by the federal Administration on Children and Families (ACF). The majority of NYS' PREP funds were used to make eight additional CAPP awards to organizations that were "approved but not funded" through the 2011 CAP RFA. Funds were also used to support ***/2015/a pregnancy prevention project targeting youth in foster care as well as youth with emotional and behavioral needs. The project was//2015//*** developed in consultation with OCFS and will be evaluated for effectiveness by ACF's evaluator, Mathematica, for potential inclusion on the list of effective programs for this specific population. Six of the PREP sub-awardees are located in high-need areas of NYC and two are located in high-need upstate communities.

Supporting Healthy Transitions to Adolescence (STYA) is an initiative supported by $2.99 million in federal funding through the federal Abstinence Education Grant Program. NYS previously declined this federal funding due to significant restrictions on use of the funding. Under revised guidance, states have considerable flexibility to target younger youth and to focus on elements of programming determined to meet the needs of the selected populations. NYS utilizes grant funds to support an initiative that will funds community-based mentoring, counseling and adult supervision programs designed to delay the initiation of sexual behavior among young people, ages 9-12, residing in high-risk communities. A RFA for this initiative was released in 2012 and awards were made to 17 community-based agencies.

/2015/Maternal and Infant Health Initiative (MIH)- The overall goal of the MIH Initiative is to improve outcomes of pregnancy by ensuring access to quality prenatal care and related services by MA-eligible as well as other high-need pregnant women. Outcomes include increasing the proportion of babies carried to full term and reducing the rates of low birth weight and neonatal and maternal mortality and morbidity. The MIH initiative represents a redesign of DOH's community-based maternal and infant health programs, which was needed to positively impact stagnant maternal and infant health outcomes and disparities.

The MIH Initiative was procured through a RFA effective October 1, 2013. The supported Maternal and Infant Community Health Collaboratives (MICHC), which integrated and replaced three previous community-based perinatal health initiatives: Comprehensive Prenatal-Perinatal Services Networks (CPPSN), Community Health Worker Program (CHWP), and Healthy Mom--Healthy Baby (HMHB). MICHC supports collaborative development, implementation and coordination of evidence-based and/or best practice strategies to achieve a set of performance standards focused on improving outreach to find and engage high need women and their families in health insurance, health care and other supportive services; timely identification of needs and risk factors and coordinated follow-up to address risks identified; the coordination of services within larger community systems; and the promotion of healthy behaviors across the lifespan. A total of 24 MICHC awards were made, serving a total of 33 counties.

Another component of the MIH RFA supported the expansion of additional evidence-based Maternal Infant and Early Childhood Home Visiting (MIECHV) sites as described below. Informed by the 2010 NYS needs assessment that identified highest-risk areas at the county level, applicants were required to target specific high-need neighborhoods utilizing ZIP code-level health and socio-economic data. The award methodology prioritized the 14 primary target counties, but also allowed other counties demonstrating areas with high need to apply, acknowledging that there are pockets of extreme need in other communities across the state. Formula-based funding was awarded to 5 applicants for three years, October 1, 2013 to September 29, 2016, including 4 Nurse Family Partnership programs and 1 Healthy Families NY program.//2015//

Maternal, Infant, and Early Childhood Home Visiting Program (MIECHVP) is supported by a grant from HRSA designed to improve health and developmental outcomes for at-risk children through implementation of evidence-based home visiting programs. To receive funding, states were required to complete a number of steps including an initial funding application and a statewide needs assessment.

NY's MIECHVP targets high risk communities with gaps in home visiting services as defined by the state home visiting needs assessment, and in accordance with the requirements of a home visiting state plan recently issued by HRSA. To date NYS has been awarded $4,111,834 for FY 2010, and an additional $5,604,010 for a subsequent 4 years. ***/2015/However, funding for the last 2 years was reduced to $5,366,978 due to sequestration.//2015//***

The purpose of the statewide needs assessment was to identify communities with high rates of maternal, infant and child health risk indicators and the existing home visiting programs and supportive resources in those communities. With input and assistance from a group of state agency partners, the DOH collected and analyzed a set of 23 indicators based on HRSA criteria and additional state-defined criteria. For the initial needs assessment, county was used as the geographic unit of analysis.

MIECHVP will provide NY with an opportunity to maximize and coordinate the various models of home visiting services in NYS (listed below) to better serve the MCH population.

Nurse Family Partnerships (NFP) is an evidence-based home visiting program that improves the health and self-sufficiency of low-income, first time parents and their children. NFP is a nurse-led model in which nurses promote the personal health of mothers, parental care of the child, environmental health, support systems for mother and infant, and parent's life course development. For 2010 and 2011, the Office of Temporary and Disability Assistance provided DOH with $5,000,000 in federal TANF funding via a Memorandum of Understanding to expand NFP programs. The three approved programs funded to provide services are: the NYC Department of Health and Mental Hygiene, Onondaga DOH and Monroe County DOH NFP Programs. The OHIP has also obtained state plan approval to provide MA funding support to two of these programs in Monroe County and NYC as targeted case management programs. The enacted 2012-13 and 2013-14 budget includes $2 million in TANF funding to support NFP; ***/2015/that amount was increased to $3 million in the enacted 2014-15 State budget.//2015//***

Regional Perinatal Centers (RPC) - NYS's system of regionalized perinatal services includes a hierarchy of four levels of perinatal care provided by the hospitals within a region and led by a RPC. The regional systems are led by RPCs capable of providing all the services and expertise required by the most acutely sick or at-risk pregnant women and newborns. RPCs provide or coordinate maternal-fetal and newborn transfers of high-risk patients from their affiliate hospitals, and are responsible for support, education, consultation, and improvements in the quality of care in the affiliate hospitals within their regions. RPC quality assurance activities are supported by the Statewide Perinatal Data System that provides affiliate hospital data to them.
There are currently 129 birthing hospitals, including: ***/2015/50//2015//***51 Level 1 hospitals;

/2015/25//2015// 26 Level 2 hospitals; ***/2015/36//2015//*** 35 Level 3 hospitals; and, ***/2015/17//2015//*** hospitals constituting 15 RPCs. Through the NYS State Perinatal Quality Collaborative, the DOH, RPC s and other key partners are working together on significant quality initiatives to improve birth outcomes.

Newborn Metabolic Screening Program (NBSP) -- PHL 2500(a) requires that all newborns are screened for 46 congenital conditions, and ensures all screen positive infants receive follow-up in NYS approved specialty care centers.

Newborn Hearing Screening Program (NBHS) - Since October 2001, all birthing facilities caring for newborn infants are required to have in place a newborn hearing screening program to conduct hearing screenings all babies born in NYS, and to refer for further evaluation and follow-up services when necessary. Effective January, 2011 NYS PHL was amended to require the submission of individual level hearing screening and follow up data on all infants up to the age of six months. DOH has developed and implemented a system to collect hearing data statewide.

/2015/Critical Congenital Heart Defect Screening of the Newborn -- During 2013, Section 2500-a of PHL was amended to require all hospitals to conduct pulse oximetry screening on all newborns born in NYS for critical congenital heart defects. The law also requires that testing, recording of test results, tracking and follow-up as well as education to be performed as prescribed by the DOH. All obstetrical hospitals in NYS have been notified of this new requirement and provided with guidance regarding screening and follow-up procedures.//2015//

Medicaid Prenatal Care provides comprehensive prenatal care for women up to 200% of the FPL based on in accordance with current standard of obstetrical care. Since 2012, comprehensive standards apply to all prenatal care providers serving Medicaid clients The Medicaid Obstetrical and Maternal Services (MOMS) Program was developed to provide comprehensive prenatal care services to low-income women in rural settings. Prenatal care is provided in doctors' offices, while ancillary services such as health education, psychosocial and nutritional screening are provided by qualified Health Supportive Services Providers. Over 3,000 physicians are enrolled in the MOMS program. The Title V programs works closely with the OHIP to ensure women across NYS have access to prenatal care services.

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides supplemental food, participant-centered nutrition education/counseling, breastfeeding support, and linkages with health and social services for low-income eligible women and children at no cost. WIC's purpose is to improve pregnancy outcomes, promote optimal growth and development for infants and children and influence lifetime nutrition and health behaviors. The NYS WIC program provides services to more than 500,000 women and children via 93 local agency direct service providers at 500 WIC clinic sites.

The Bureau of Tobacco Control administers a comprehensive, coordinated program that seeks to prevent initiation of tobacco use, reduce current use of tobacco products, eliminate exposure to secondhand smoke and reduce the social acceptability of tobacco use. The program consists of community and statewide activities supported by surveillance and evaluation. NYSDOH issues grants for programs such as local tobacco control, youth action, tobacco enforcement and prevention, and health care systems change. The NYS Smoker's Quitline (1-866-NY QUITS (1-866-697-8487)) continues to be a key evidence-based component of the Bureau's cessation efforts.

School-Based Health Center Program (SBHC) -- Through 226 SBHCs sponsored by 51 health care facilities, the SBHCs provide preventive, acute, chronic disease management and mental health services to more than 158,000 students living in high-need areas annually. SBHCs are extension clinics of Article 28 hospitals and/or diagnostic and treatment centers that are located in

school buildings.

School-Based Health Center Dental Program ensures those students with limited or no access to care may have access to preventive dental care through SBHC dental sites. The program provides dental services with mobile vans, portable equipment or in a fixed facility within the school. Students are enrolled with parental consent. Where applicable, the SBHC Dental Program works with the students' primary dental providers to coordinate services and referrals.

Preventive Dentistry for High-Risk Underserved Populations Program addresses the problems of excessive occurrence of dental disease among children who reside in communities with a high proportion of persons living below 185 percent of the federal poverty level. The application of dental sealants, an extremely effective caries-prevention agent, in combination with a program of dental screening, referral and other preventive services significantly improves the dental health of children in underserved communities. Organizations providing preventive dental services under this program include LHDs, dental schools, hospitals and diagnostic and treatment centers, rural health networks and SBHCs. A total of 31 projects provide preventive and dental services to an estimated 50,000 children statewide. Funded projects provide school-based preventive services, sealants, mobile services, fluoride varnish, case management, screening, education and access for children with special health care needs.

Community Water Fluoridation (CWF) Program is focused on four key activities: education and trainings; resource development; support for communities; and surveillance, evaluation and research. These activities include: training sessions for water operators and professionals on CWF; management and development of new content for fluoridation websites including FluorideScience.org and NewYork.ILikeMyTeeth.org; development and dissemination of fluoride resources to CWF stakeholders; working with representatives from public, private, and not-for-profit organizations to promote fluoridation in the State; providing technical assistance and support to water systems; and monitoring fluoride levels in drinking water to ensure quality.

Child and Adult Care Food Program (CACFP) improves the nutritional quality of meals and snacks served in participating day care programs by establishing minimum standards for items served, providing reimbursement for qualifying meals and snacks, and mandating ongoing monitoring of food service programs and training of program staff. The goal of CACFP is to ensure that nutritious and safely prepared meals and snacks are available to children age 18 and under and to functionally impaired adults and senior citizens participating in eligible day care programs.

Eat Well Play Hard in Child Care Settings (EWPHCCS) is an obesity prevention program that targets low income child care centers. EWPHCCS improves the nutritional and physical activity environments in child care, and educates pre-school children, their families, and child care center staff on how to adopt healthy lifestyle behaviors.

Creating Healthy Places to Live, Work and Play-- Twenty-two contractors maximize the impact on the prevention of obesity and type 2 diabetes by promoting the implementation of policies, systems and environmental change that will create healthy places for people to live, work, and play. Targeted strategies include: increasing availability of places to be physically active; creating community landscapes conducive to physical activity; increasing the availability of fresh fruits and vegetables; and increasing the healthful quality of foods offered for sale.

Overweight and Obesity Prevention Program was established to increase physical activity and improve nutrition among residents of NYS, with a focus on the prevention of childhood obesity. Program goals are achieved through policy, systems and environmental interventions in early child care, school health care and community settings. In the early child care setting, statewide partners work together to improve regulations and policies that increase physical activity, reduce screen time and improve nutrition.

The Healthy Schools New York Program provides technical assistance and resources to schools and school districts to develop, implement and support adherence to comprehensive school health policies for physical activity and nutrition. In the health care sector, contractors use a learning collaborative approach for large scale systems change with pediatric primary care practices to improve outcomes for the prevention of obesity, including linkages to community resources and programs. Improving breastfeeding rates is a key obesity prevention focus. In collaboration with the National Initiative for Children's Healthcare Quality (NICHQ), the Breastfeeding Quality Improvement in Hospitals (BQIH) learning collaborative is used to make policy, systems and environmental changes to better support new mothers to exclusively breastfeed their infants in the all NYS hospitals and beyond.

Childhood Asthma Coalitions - Eight asthma coalitions, serving geographic regions with a high burden of asthma, are funded to bring healthcare and community systems together (including hospitals, clinics, primary care health providers, asthma specialists, health plans, schools, community organizations, public health, businesses and other public and private groups) to develop, implement, spread and sustain policy and system level changes. Asthma coalition interventions aim to: decrease the number of hospitalizations due to asthma; decrease the number of emergency department visits due to asthma; decrease the number of school/work days lost due to asthma; decrease the number of clinic/provider office urgent care visits due to asthma; and increase the quality of life among people living with asthma.

Immunization Program works to prevent the occurrence and transmission of vaccine-preventable diseases by ensuring the delivery of vaccines to children and adults. The program assures that: all children have access to vaccines irrespective of financial status; adequate vaccine supplies are available for all primary health care providers; and that health care providers are aware of immunization standards of practice.

Child Mortality Review/SIDS Prevention Program - In collaboration with other state agencies, the program is working to develop a more comprehensive statewide child death review and prevention initiative. By partnering with these agencies the program helps coordinate child safety initiatives aimed at reducing the risk for future deaths. The program also provides public outreach and education about risk factors associated with SIDS..

Lead Poisoning Prevention Program (LPPP) - The goal of the LPPP is to reduce the occurrence and consequences of childhood lead poisoning throughout the state /2014/through primary prevention, surveillance, care coordination and environmental management.//2014// Due to a significant decrease in funding from CDC, as well as CDC's refocusing of the program into a new Healthy Home and Community Environments model, major responsibility for the LPPP was transitioned to the Center for Environmental Health, with continued close collaboration by Title V staff. Significant CDC funding cuts present a major challenge to these efforts. Elimination of CDC lead poisoning prevention grant funding to DOH has resulted in the loss of nine program staff. This presents a serious challenge to maintaining Leadweb, the state's lead poisoning care coordination and surveillance database through a unique linkage with NYSIIS, invaluable information on individual lead screening information in Leadweb is shared directly with pediatricians. Program staff continue to support contracts with local health departments to maintain local services for prevention of lead poisoning, care coordination and exposure management.

Children with Special Health Care Needs (CSHCN) Program works closely with internal partners and LHDs, community-based and professional organizations to develop and implement systems initiatives to improve quality of services for children with special health care needs. The CSHCN Program has ***/2015/54//2015//*** contracts with LHDs to provide services to children with special health care needs birth to 21 and their families. With funding and technical assistance from the department, the local CSHCN Programs develop community-based resources to: assist families in accessing necessary health care and related services; promote "medical homes" for the provision of high-quality health care services that meet the needs of children and families; and,

develop partnerships with families of children with special health care needs that involve them in program planning and policy development.

In 2012, the administration of the statewide network of Article 28 specialty centers that accept referrals of infants with positive newborn screens for endocrine, metabolic, cystic fibrosis or hemoglobinopathy disorders was transitioned to NY's Wadsworth Laboratories Newborn Screening Program.

Physically Handicapped Children's Program (PHCP) operates in ***/2015/32//2015//*** 35 of 58 counties in NYS. The program provides reimbursement for specialty health care for severe chronic illness or physically handicapping conditions in children. Medical equipment, office visits, hospitalizations, pharmaceuticals, and other health-related services can be reimbursed for children meeting county financial and medical eligibility criteria.

Early Intervention Program (EIP) NY's IDEA Part C Program, is a statewide service delivery system for infants and toddlers (birth to three years) with disabilities and their families. Its mission is to identify and evaluate those children whose healthy development is compromised and provide appropriate interventions to improve child and family development. To be eligible for services, infants and toddlers must have a delay in one or more areas of development (physical, cognitive, communication, social/emotional or adaptive) or a physical or mental diagnosis that impacts on development (such as cerebral palsy or Down syndrome). The EIP, created in 1993, currently provides services to more than 68,000 infants and toddlers and their families statewide. The DOH has been awarded grants to improve awareness and identification of autism to ensure children are identified and receive services as early as possible. ***/2015/Through grant funds, DOH is continuing the process to update the Clinical Practice Guidelines for Autism and Pervasive Developmental Disorders that was originally developed in 1999.//2015//*** This project should be completed by February, 2015.

Dental Rehabilitation Program (DRP) provides children with physically-handicapping malocclusions access to appropriate orthodontic services. Operated in some LHDs under the auspices of the PHCP, the DRP provides both diagnostic/evaluative and treatment services. The program is open to children under the age of 21 who have congenital or acquired severe malocclusions. Over 10,000 children receive services annually.

3) Capacity to Provide Culturally Competent Care
The NYS Office of Minority Health ***/2015/and Health Disparities Prevention (OMH-HDP)//2015//*** was established by an amendment to the NYS PHL in 1992 and became operational in 1994. PHL SS 240-243 outlines the duties and responsibilities of the office, responsibilities and membership appointments of the NYS Minority Health Council, and specifies the contents of a minority health report which NYSDOH is ***/2015/legislatively mandated.//2015//***

/2015/In December of 2011, the OMH was expanded to become the Office of Health Disparities Prevention (OMH HDP) to build on the work that the OMH had begun, to focus more broadly on cross-cutting issues. OMH-HDP serves as a statewide resource for effecting the elimination of health disparities across all impacted populations by ensuring that everyone, regardless of ethnic or racial background or the community in which they live, has access to the resources and services they need to be healthy.
OMH HDP has four major goals including:
-To fulfill legislative mandates by identifying "Section SS240 Minority Areas" (service areas with non-white populations of 40% or more) and target resources to those areas; and, reviewing the impact of programs, regulations, and health care reimbursement policies on minority health services.
-To work across DOH's programs to support initiatives towards eliminating health disparities such as assisting with the redesign of the MA program by serving on the health disparities and data collection workgroups; supporting the PA public health goals; and working with government systems, public and private partners, and communities to

continue progress towards achieving health equity.
-To support community-driven interventions that improve individual and community health and promote sustained social change.
-To work alongside the Minority Health Council to advise the Commissioner on matters relating to the improvement of minority health.//2015//

Unequal access to high quality health care is a problem that has been documented for many racial and ethnic minorities. It has also been shown that when access is available, many populations face barriers which prevent them from utilizing health care.

/2015/In 2012, DOH OMH released the NYS Minority Health Surveillance Report that provides an overview of the health status of racial and ethnic populations in NYS and is a critical component in addressing health disparities in NY. The report is based on more than 100 health-related and socio-demographic indicators which illustrates significant differences in the health and well-being of racial and ethnic minorities compared to the general population and shows the relationship between socio-economic status, quality of life and disease. In preparation for the 2014 report, OMH-HDP reviewed the limitations of the previous reports including the current practice of utilizing county or zip code level data to identify high disparity populations and determined that collecting data by Minor Civil Divisions (MCDs) would achieve a higher level of granularity that would better identify and target populations most in need. The advantage of using Minor Civil Divisions (MCD's) or Tracts over Zip codes are that County level analysis dilutes the number and distribution of "Minority Areas" that meet the statute and can mask or understate areas that meet SS240-Minority Areas statutory requirements.

Subsequently, OMH-HDP convened a Geocoding Workgroup to develop a plan and recommendations for a collaborative movement toward geocoding all departmental health data sets, and providing information by MCDs for the 2014 health disparities report that will better inform programs and policies to reduce health disparities and improve overall health outcomes in NYS. //2015//
In April, 2010, LHDs and DOH experts in specific topic areas (teen pregnancy prevention, prenatal care and obesity prevention) met to discuss local strategies to improve health outcomes and address disparities in selected health outcomes. These discussions focused on local public and private agencies that could partner to address specific issues, and evidence-based interventions and promising practices to address health issues, including health disparities. In 2012, DOH released the NYS Minority Health Surveillance Report: County Edition that assesses socio-demographic and health indicators for each county by race/ethnicity. LHDs can use these data to identify issues and plan effective public health interventions. Title V staff will continue to promote partnerships to improve the health outcomes of NY's diverse community.

DOH is also making a concerted effort to provide services and resources to the highest need areas of the state. For example, although New York's outcomes in many areas are improving, in areas such as adolescent pregnancy and birth outcomes, disparities continue to exist due to increasing numbers of immigrant and hard to reach populations. Extensive data analyses have been completed to target the highest need areas and provide better utilization of resources. DOH also provided statewide training to current and potential providers on evidence based programming and community coordination of resources, and outreached to providers in the hardest to reach areas to ensure there will be a pool of agencies positioned to apply for funds to address the need in the highest need areas of the state. In addition, all requests for applications now specifically identify high risk groups as a priority including specific minority populations, youth in foster care or those otherwise not engaged in the service system. All programs developed by the Bureaus and Divisions within the Center for Community of Health work with the communities they serve to assure that their programs meet community needs. The following processes help to ensure ongoing improvements in cultural competency:

-The Request of Applications process used to select contractors requires applicants to

demonstrate competence in serving the target populations including linguistic and cultural competency.
-DOH provides programs with health risk data, enabling programs to tailor their programs to the community. Data are provided by major race/ethnicity categories, when available, and at the lowest feasible geographic unit, e.g., zip code.
-All programs are required to include outreach plans and activities to ensure the services are reaching the high risk, diverse populations in their catchment areas. This includes the LHD CSHCNs programs as well.
-The Child Health Information Integration Project (CHI²) that aims to develop an integrated data system that will improve quality of care, reduce medical errors, collect individual data for activities such as Newborn Hearing Screening, provide seamless flow of information between jurisdictions, link events of public health significance in a child's life (e.g. immunizations) and enable bi-directional data sharing. Ultimately health care providers will have access to child health information to ensure they have a complete picture of the child's health history and needs, which will benefit those high risk children who may access health care through a variety of settings and clinics.
-Programs use community-based organizations with diverse staff, representative of the racial and ethnic backgrounds of the communities.
-Programs that serve non-English speaking populations must have staff to deliver services who are fluent in the predominant foreign languages spoken in the community and/or provide access to a telephone language line.
-Programs are encouraged to hire staff that is from communities and populations served. For example, the CHWP uses paraprofessional home visitors indigenous to the communities and populations served.
-Written and outreach materials are translated, adapted and/or provided in alternate formats based on the needs and preferences of the population served.
-Programs actively engage the community on an ongoing basis. The SBHC program, for example, requires that SBHCs have a community advisory council to assure that the views of the community members are reflected in each SBHCs policies priorities and plans.

C. Organizational Structure

This section reviews the general format of New York State government and provides further details regarding the placement of the Title V program within the DOH and its constituent components as they relate to the administration of NY's Title V Program. Significant detail regarding the placement of the Title V program within the DOH is contained in Section III.A.

The structure of the government of NYS mirrors that of the federal government, with three independent branches. The legislative branch consists of a bicameral Legislature, including a 62 member Senate and 150 member Assembly representing the nearly 20 million citizens of the State. All members are elected for two-year terms. The judicial branch comprises a range of courts (from trial to appellate) with various jurisdictions (from village and town courts to the State's highest court - the Court of Appeals). The Judiciary functions under a Unified Court System, which has responsibility for resolving civil claims, family disputes, and criminal accusations, as well as providing legal protection for children, mentally-ill persons and others entitled to special protections. The executive branch consists of 20 departments that is the maximum number allowed by the State Constitution. The DOH is one of those 20 departments.

To increase government efficiencies, Governor Cuomo created the Spending and Government Efficiency Commission (SAGE) to streamline State government. This Commission is charged with reviewing the State's organizational structure, identifying improvements, creating meaningful

metrics, and identifying non-critical activities. The commission released recommendations in February 2013. Recommendations related to consolidating state agency functions such as IT and purchasing functions have already been accomplished.

Four statewide government officers are directly elected including:
•The Governor, who heads the Executive Department, and Lieutenant Governor (who are elected on a joint ballot).
•The State Comptroller, who heads the Department of Audit and Control.
•The Attorney General, who heads the Department of Law.

With a few exceptions, the Governor appoints the heads of all State departments and agencies of the executive branch. One important exception is the Commissioner of the State Education Department, who is appointed by and serves at the pleasure of the State Board of Regents.

Geographically, NYS is divided into 62 counties (five of which are boroughs of NYC). Within these counties are 62 cities (including NYC), 932 towns, 556 villages and 697 school districts. In addition to counties, cities, towns and villages, more than a thousand "special districts" meet local needs for fire and police protection, sewer and water systems or other services. Local governments are granted the power to adopt local laws that are not inconsistent with the provisions of the State Constitution or other general law.

Under the direction of the Commissioner, who is appointed by the Governor, DOH meets its responsibilities through the Office of Health Insurance Programs (OHIP), the Office of Long Term Care (OLTC), the centers located in the Office of Public Health (OPH), and the Office of Health Systems Management (OHSM). The OHIP is responsible for Medicaid, Family Health Plus, Child Health Plus, Elderly Pharmaceutical Insurance Coverage, and the AIDS Drug Assistance Program. The OTLC oversees the integration of planning and program development for services related to long term care. The OPH and the OHSM provide policy and management direction to a system of regional offices, whose staff conduct health facility surveillance, monitor public health, provide direct services and oversee county health department activities. Additionally, DOH is responsible for five health care facilities. DOH has a workforce of 3,264 filled positions and 1960 filled positions in DOH's health care facilities.

The OPH led by Guthrie Birkhead, MD, MPH, brings together all DOH public health programs under one organizational mantle. The Office's programs include: the biomedical research, public health science, and quality assurance of clinical and environmental laboratories of the Wadsworth Center; the counseling, education, prevention, health care and supportive services of the AIDS Institute; the protection of human health from environmental contaminants in air, water and food through regulation, research and/or education by staff of the Center for Environmental Health; the nutrition, health screening, immunization, tobacco control, maternal and child health programs and the public health surveillance and disease control activities of the Center for Community Health (CCH); the support and oversight of local health departments and the efforts to help build public health workforce capacity of the Office of Public Health Practice; and, the comprehensive all-hazards preparedness and response activities of the Office of Public Health Preparedness.

The programs providing services to the maternal and child health population are spread throughout the Department, but are mainly focused in the CCH. CCH responsibilities touch practically every aspect of public health in NYS. Under the direction of Bradley Hutton, MPH, the Center conducts programming through four Divisions: the Division of Chronic Disease Prevention; the Division of Nutrition; the Division of Epidemiology; and, the Division of Family Health. Each addresses a major component of the Department's public health mission, and all are involved in carrying out MCHSBG-related activities.

The Division of Family Health (DFH), directed by Rachel de Long, MD, MPH (who also serves as the Director of the NYS Title V Program), promotes the health of families by assessing needs, promoting healthy behaviors and providing services to support families. Dr. de Long assumed the

director position upon the retirement of Barbara McTague in 2011. The division's primary focus is to improve the health of women, children and adolescents. Its programs touch new mothers, adolescents including those considering sexual activity, children, including those with disabilities, rape victims and children with lack of access to dental services. Programs promote healthy behaviors while also assuring access to quality health care. The division provides access to primary medical and dental care and preventive health services for migrant farmworkers and Native Americans living in reservation communities. The Division provides the central focus for NYS's Title V MCH programming, and consists of three program bureaus and the Office of the Medical Director:

The Bureau of Maternal and Child Health (BMCH), is led by Kristine Mesler, M.P.A., B.S.N., who was appointed to the position of Director in November, 2012. Rudy Lewis continues to serve as the assistant. The BMCH administers a variety of programs that focus on the prevention of adverse health conditions and promotion of health and wellness in women, children and youth, and consists of the following functional units:
-Perinatal Health Unit is comprised of Article 28-based programs and community-based initiatives that support the direct delivery of clinical health care and supportive services to achieve outcomes related to the accessibility, quality, and sustainability of perinatal services for NY's women and babies. These programs have substantial commonalities in terms of their focus on improving birth outcomes. Consolidating these programs within a common unit facilitates the establishment and implementation of more consistent and effective systems and standards to address these common issues. Programs included in the Perinatal Health Unit are:
•Perinatal Regionalization, including Regional Perinatal Centers and affiliate hospitals, and the NYS Perinatal Quality Collaborative.
•Maternal, Infant and Early Childhood Home Visiting Program
•Maternal and Infant Health Initiative
•Nurse Family Partnership
•Growing Up Healthy Hotline
•Infertility Demonstration Program
•Osteoporosis Prevention and Education.

-The Adolescent Health Unit is comprised of community-based programs that focus on prevention and health promotion strategies to achieve outcomes related to healthy behaviors and health outcomes at the personal, family and community levels. These programs have substantial commonalities in terms of primary and secondary prevention strategies, emerging federal priorities and funding opportunities, and local partnerships to promote and improve health. Consolidating these programs supports use of evidence-based prevention strategies across programs, allows for alignment and ongoing meaningful collaboration between programs with similar target groups and outcomes, and facilitates the establishment and implementation of more consistent systems for program management and improvement. The Adolescent Health Unit includes:
Comprehensive Adolescent Pregnancy Prevention (CAPP) Program
•Personal Responsibility and Education Program
•//2015/Successfully Transitioning Youth to Adolescence//2015//
•ACT-for Youth Center of Excellence

-The Community-Based Health Care Unit is comprised of programs that provide comprehensive family planning and reproductive health care services to underserved populations, and the largest School Based Health Center program in the country that provides primary and preventive health care services to many of NY's most vulnerable children and adolescents.
•Family Planning and Reproductive Health
•School Based Health Center program.

-The Rape Crisis and Sexual Violence Prevention Unit is comprised of programs that promote sexual violence prevention education and provide direct services to victims of rape and sexual violence.

•Sexual Violence Prevention and Rape Crisis Services.
•Hospital Sexual Assault Forensic Examiner (SAFE) program.

-Data Analysis, Research and Surveillance Unit that consolidates the data systems, research and data analysis activities and staff currently housed within individual programs, including the Statewide Perinatal Data System, and Rape Crisis program data system. Consolidating these functions within a single unit facilitates important peer support between research staff and promotes consistent approaches to use of data to support ongoing program development, implementation and evaluation.

The Bureau of Early Intervention, is co-directed by Brenda Knudson Chouffi, MS Ed. and Donna Noyes, PhD, as the director position was vacated by Bradley Hutton, MPH. The Bureau is responsible for two major programs for young children with, or who may be at risk for physical, cognitive, communication, social/emotional or adaptive developmental delays or disabilities. The EIP is a statewide service delivery system for infants and toddlers (birth to three years) with disabilities and their families. Its mission is to identify and evaluate those children whose healthy development is compromised and provide appropriate interventions to improve child and family development. The Bureau also administers DOH's Newborn Hearing Screening Program, as well as the MCH Autism Intervention Research Grant which will end 8/14 and the FAR Fund grant related to updating clinical practice guidelines and providing physician training.

The Bureau of Dental Health, under the leadership of Jayanth Kumar, DDS, MPH, implements and monitors a broad range of statewide dental health programs that prevent, control and reduce dental diseases and other oral health conditions, and promote healthy behaviors. In addition to maintaining the focus on children, programs promote dental health among adult populations. The Bureau's dental health programs include:
•Preventive Dentistry for High-Risk Underserved Populations Program
•Dental Rehabilitation Program
•Dental Health Education
•Dental Public Health Residency Program
•Research and Epidemiology
•State Oral Disease Prevention Program
•School-Based Health Center Dental Program

The Office of the Medical Director provides medical leadership for the DFH. Under the direction of Marilyn Kacica, MD, MPH, physicians in the office provide medical consultation and support to all division programs; support policy development and programmatic initiatives; and provide advice on emerging medical issues. OMD leads the NYS Perinatal Quality Collaborative, an initiative of NY's Regional Perinatal Centers (RPCs), the DOH and the National Initiative for Children's Healthcare Quality. The goals are to improve maternal and newborn outcomes and increase patient safety by applying evidence-based system change interventions, and to establish capacity within RPCs for ongoing QI activities. The Obstetrical intervention focuses on reducing scheduled deliveries performed without indication in women 36 0/7 to 38 6/7 weeks gestation. The Neonatal intervention focuses on enteral feeding practices for neonatal care patients/2015/and preventing central line associated blood stream infections/2015//. Additional OMD programs include:
-Children with Special Health Care Needs/2015/Program and Critical Congenital Heart Disease Initiative/2015// ;
-Physically Handicapped Children's Programs; and,
-Other cross-systems early childhood initiatives, including parenting education projects and the current federal Project LAUNCH grant. Consistent with the framework for public health MCH services, these programs and activities are characterized by a blend of public health approaches including population-based public and professional outreach and education, targeted care coordination and other enabling services, and gap-filling direct health care services.
-CHI2
-Child Mortality Review/SIDS Prevention Program
-Maternal Mortality Review Program/2015/and associated morbidity prevention initiatives/2015//

-American Indian Health Program
-Migrant and Seasonal Farmworker Health Program
-Statewide Systems Development Initiatives.

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

As stated previously, the Division of Family Health (DFH) has responsibility for coordinating MCH-related programs and directly managing many MCHSBG-funded initiatives. ***/2015/The DFH leads the State's public health efforts to improve birth outcomes, promote healthy children, youth and families throughout the lifespan, and build healthy communities through community engagement, public-private partnerships, policy analysis, education, and advocacy.//2015//*** There are currently 130 filled Title V-funded positions within NYSDOH, with additional non-Title V-funded positions performing Title V-related activities. Positions are located within DOH's central, regional and district offices. Staff cover the full range of MCH activities, including child and adolescent health, women's health, sexual violence prevention, perinatal health, oral health, local health services, nutrition, child safety, injury control, laboratory operations, human genetics, congenital malformations, data and information systems infrastructure, health communications, managed care and facility surveillance.

Rachel de Long, M.D., M.P.H., was appointed the Director of the DFH and Director of the NYS Title V Maternal and Child Health Services Program in the DOH in December 2011 upon the retirement of Barbara McTague. Dr. de Long formerly served as Director of the Bureau of Child and Adolescent Health (BCAH), and then Bureau of Maternal and Child Health (BMCH) (formed due to a merger of the Bureau of Women's Health (BWH) and BCAH) since 2005, and served as BCAH's Medical Director from 2003 to 2004. Dr. de Long is on the faculty of the SUNY at Albany School of Public Health in the Department of Health Policy, Management, and Behavior. She earned a B.S. in Rural Sociology from Cornell University, M.D. from University of Wisconsin Medical School, and M.P.H. from SUNY Albany School of Public Health. She completed a medical internship in Family Practice at the Guthrie Clinic and residency in Preventive Medicine at SUNY Albany/NYSDOH, and is Board-Certified in Preventive Medicine and Public Health. Dr. de Long provides policy and program direction and administrative oversight for the Division's bureaus, including the Bureau of Maternal and Child Health, the Bureau of Dental Health, the Bureau of Early Intervention and the Office of the Division's Medical Director which includes the Migrant Health and Indian Health Programs, as well as several quality initiatives.

Wendy Shaw, M.S., B.S.N., has served as Associate Director of the DFH since August, 2007. She previously served as the Director of the Bureau of Women's Health (BWH). Ms. Shaw served as Director of the Perinatal Health Unit within the BWH from 2000 through 2002, when she became Assistant Director. Her previous experience in the Early Intervention Program provides her with further valuable knowledge in her role within the DFH.

With a Bachelor's degree in nursing from the State University of New York at Albany, and a Master of Science degree from Russell Sage College, Ms. Shaw started her career as a public health nurse working with high-risk maternal and child health families and later moved to Labor and Delivery nursing before moving to state service. She is also a graduate of the Leadership Program in Public Health from Harvard University School of Public Health in Boston. As a registered nurse with extensive clinical and administrative experience, she has her feet both in the world of administration and hands-on health care--remaining as a Labor and Delivery nurse at an area hospital.

Under the direction of Marilyn Kacica, M.D., M.P.H., the Office of the Medical Director provides leadership and collaborates closely with the Bureaus in the Division. Dr. Kacica is a graduate of St. Louis University and received her M. D. from the St. Louis University Medical School. She completed pediatric residency training at the Cardinal Glenon Children's Hospital, subspecialty

training in pediatric infectious disease at the Children's Hospital of Cincinnati, and her preventive medicine residency at NYSDOH. Her M.P.H. was awarded from the State University of New York at Albany, School of Public Health, where she is currently a Clinical Associate Professor of Epidemiology. She is board-certified in Pediatrics and is a fellow of the American Academy of Pediatrics. Prior to moving to the DFH, she served as the Director of the Healthcare Epidemiology Program in the Division of Epidemiology's Bureau of Communicable Disease Control. She is providing leadership on a myriad of clinical, epidemiological, data utilization and quality improvement issues within the Division, was the co-chair of the AMCHP Emergency Preparedness Committee, the Adolescent Health Committee of the Emerging Issues Committee and currently serves as the Vice Chair of the Emerging Issues Committee. She leads preparedness efforts being made on behalf of NY's maternal and child health population. Dr. Kacica serves as the Principal Investigator (PI) to the ***/2015/Perinatal Quality Collaborative/2015//State Systems Development Initiative and the NBS Effective Follow-up grants. In addition, she is the Program Director for the NYSDOH's Child Health Integration Initiative which is focusing on the integration of child health information for both public health and provider benefit. She is also leading quality improvement initiatives focusing on School-based health centers and perinatal health.***

Christopher Kus, M.D., M.P.H., serves as Associate Medical Director for the DFH, and provides medical consultation to the Division. He is a graduate of Michigan State University and the Wayne State University School of Medicine. He received his M.P.H. from University of North Carolina at Chapel Hill. He is a developmental pediatrician who worked with the New Hampshire and Vermont Departments of Health prior to coming to NY. He has been with the NYSDOH for over ten years. A board-certified pediatrician and a fellow of the American Academy of Pediatrics, Dr. Kus is a Past President of the Association of Maternal Child Health Programs (AMCHP). He serves as co-chair of the AMCHP Legislative and Finance Committee. He was a member of the Early Childhood Expert Panel involved in developing the Third Edition of Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (2008). Dr. Kus serves as the Association of State and Territorial Health Officials (ASTHO) liaison to the HRSA Secretary's Advisory Committee on Heritable Disorders in Newborns and Children (ACHDNC). He is a member of the National Academy for State Health Policy

For the past several years New York's State Systems Development Initiative (SSDI) grant was coordinated by Ms. Cathy Tucci-Catalfamo in the Office of the Medical Director. The goal of the SSDI grant is to foster an infrastructure to improve data linkages among multiple data sources for child health information to assure program and policy development for material and child health. Ms. Tucci-Catalfamo retired in May 2013. /2015/Ms. Megan Gallagher joined the OMD as the SSDI Project Coordinator. Ms. Gallagher is a Research Scientist who was formerly of DOH's Information Systems and Health Statistic Group. Ms. Gallagher brings her data analysis experience associated with the Newborn Screening Program and the State Perinatal Data System to her new activities related to MCHBG data collection and analysis. SSDI//2015// staff will continue to play a key role in the CHI2 Project as well as other programs to assist Title V with building data linkages and infrastructure.

Kristine Mesler, M.P.A., B.S.N., was appointed to the position of Director of the Bureau of Maternal and Child Health in November, 2012. Ms. Mesler brings a wealth of experience in the field of maternal and child health to this position. She has worked in the Department for over 16 years, with progressively increasing responsibilities across a number of maternal and child health programs including perinatal health, adolescent health, children with special health care needs and early intervention. Ms. Mesler graduated from the State University of New York at Albany with a Bachelor's degree in nursing, and a Master of Public Administration from Rockefeller College of Public Affairs and Policy. Ms. Mesler also has previous experience as both a public health nurse and a labor and delivery nurse. Most recently, she served for the last five years as Associate Director for the Bureau of Maternal and Child Health and former Bureau of Child and

Adolescent Health. She has provided outstanding leadership in the development, implementation and management of a number of high visibility public health initiatives, including extensive collaboration with other public health programs, state and federal agency partners.

Rudy Lewis, M.S.,***/2015/who//2015//*** served as the Assistant Director of the BMCH (formerly BWH) since 2007 ***/2015/retired in May 2014 and has not as yet been replaced.//2015//***

Susan Slade, RN, MS, who serves as NYS's Children with Special Health Care Needs Director, is a very experienced clinical and public health nurse and public health administrator. She has worked in the NYSDOH since 1987, with over ten years of that time in the Bureau of Maternal and Child Health (formerly the Bureau of Child and Adolescent Health). Ms. Slade oversees several public health programs, including the Children with Special Health Care Needs Program and is leading the development of Children's Health Homes, as well as non categorical activities related to health care provider and parenting education. She's been involved with pediatric quality improvement initiatives related to developmental screening, standards development for pediatric specialty centers, and transition activities related to adolescents with special health care needs. In addition to being a licensed Registered Nurse, Ms. Slade is also a Certified Health Education Specialist.

Jayanth Kumar, DDS, MPH, is the Director of the Bureau of Dental Health. He has served the Department since 1980 and most recently as Director of the Research and Epidemiology unit of the Bureau of Dental Health. He is also Associate Professor, School of Public Health, University at Albany. Dr. Kumar is a board-certified specialist in dental public health and a former director and president of The American Board of Dental Public Health. He has served as a consultant to many national and international organizations including the Centers for Disease Control & Prevention (CDC), National Institute of Dental & Craniofacial Research, NIH, Health Resources Services Administration (HRSA), the American Dental Association (ADA) and the National Research Council (NRC). He is project director for the Centers for Disease Control & Prevention's co-operative agreement to strengthen state's infrastructure. Dr. Kumar oversees the Department's fluoridation and other public health dental programs targeting high-risk underserved women and children, the supplemental fluoride program for preschool and school-aged children residing in non-fluoridated areas of the State, the Dental Rehabilitation Program for children with physically-handicapping malocclusions. Other Bureau activities and programs include Dental Health Education, the Dental Public Health Residency Program, research and epidemiology, oral health surveillance, the school-based health and dental health integration project and the Perinatal Oral Health Quality Improvement Project. .

Brenda Knudson Chouffi, MS.Ed. and Donna Noyes, PhD were recently appointed Co-directors of the Bureau of Early Intervention as the position was vacated by Bradley Hutton, M.P.H. since his appointment as the Director of the CCH in 2011. Ms. Knudson Chouffi has been with BEI for 12 years, most recently as the Assistant Director of EIP. In this position, she assisted in the oversight of 50+ staff with responsibility for the management and administration of NYS's Early Intervention Program. She has also served as NYS's Early Intervention Hearing Detection Intervention Coordinator and the PI on the Universal Newborn Hearing Screening and Intervention Grant and the Early Hearing Detection and Intervention Grant. Ms. Knudson Chouffi received a Master's of Education/Educational Psychology from the State University of New York at Albany and holds permanent teacher certification in Special Education. Prior to her work with the Department, she provided special education services under the EIP, Committee of Preschool Special Education and Committee of Special Education. Dr. Noyes joined the NYSDOH in 1989 and has been with the EI Program since its implementation. Dr. Noyes, has held several positions in EI, including as Director of the Program. Most recently, Dr. Noyes served as the Associate Director for Clinical Policy contributing to significant program development initiatives including development of program regulations and clinical practice guidelines, reimbursement policies and methodologies, development and launching of the New York Early Intervention System (NYEIS), and implementation of a child and family outcomes system to evaluate the impact of early intervention services on program participants. Dr. Noyes has a doctorate in developmental psychology from the State University of New York at Stony Brook. Dr. Noyes is

the PI on three grants related to improving early identification and intervention services for young children with autism spectrum disorders and their families.

E. State Agency Coordination

As mentioned earlier, PHL SS2500 specifies that the Commissioner shall, "cooperate with other state departments having jurisdiction over matters affecting the health of mothers and children, to the end that existing activities may be coordinated and duplication of effort avoided. He shall cooperate with and stimulate local agencies, public and private, in promoting such measures and undertakings as may be designed to accomplish the purposes of this section." The Department has developed strong formal and informal relationships with other state agencies, local public health agencies, federally-qualified health centers, tertiary care facilities, academic institutions and the non-profit voluntary sector, all of which enhance the capacity of the Title V program to carry out its mission.

1) State Agencies -- Bilateral Agreements

State agencies are coordinated at the level of the Governor's cabinet. The Department of Health is a party to several written agreements or memoranda of understanding with other state agencies. These agreements serve to formalize collaborative activities between DOH and partner agencies.

The State Education Department (NYSED) is a key partner in needs assessment and priority setting for services relating to the school-aged population. NYSED and DOH have formal planning structures related to youth risk behavior surveillance, comprehensive school health, HIV prevention and workforce and scope of practice issues. The Early Intervention Program and the Children with Special Health Care Needs Program regularly interact with SED's Vocational and Educational Services for Individuals with Disabilities (VESID) Program. NYSED is responsible for general supervision of all educational institutions in the State, for operating certain educational and cultural institutions, for certifying teachers, and for certifying or licensing practitioners of thirty-eight professions, including physicians and nurses and dentists and dental hygienists. NYSED's supervisory activities include chartering all schools, libraries and historical societies; developing and approving school curricula; accrediting colleges and university programs; allocating state and federal financial aid to schools; and providing coordinating vocational rehabilitation services. The Youth Risk Behavior Surveillance System is administered by NYSED in collaboration with NYSDOH. /2014/The Department//2014// also works with the Education Department on issues such as placement of automated external defibrillators in schools, administration of fluoride rinse programs, healthcare/public health workforce matters, scope of practice issues, transition from early intervention to preschool programs, and continues to dialogue with SED regarding reproductive health in NY's schools. Comprehensive School Health and Wellness Centers help school districts across the State create positive learning environments for their students. Schools that model and encourage students to engage in healthy behaviors create an atmosphere for academic success and individual growth.

Beginning in 2013, DOH entered into a formal Memorandum of Agreement (MOA) with the NYS Education Department (SED). The MOA is in effect through June 30, 2018. The MOA outlines roles and responsibilities of DOH and SED staff to collaborate across agencies on the use of the Youth Risk Behavior Survey and School Health Profiles Data and in support of policy and program improvements with a focus on coordinating comprehensive physical activity and nutrition program efforts.

/2015/Over the past year, DOH and other appropriate State agencies participated in a workgroup to develop the Community Schools concept to better coordinate resources

across agencies, programs and funding. In the Fall of 2013, SED in partnership with the Governor's Office, issued a Request for Proposals for Community Schools defined as competitive grants to eligible school districts for plans that target school buildings as 'community hubs to deliver co-located or school-linked academic, health, mental health, nutrition, counseling, legal and/or other services to students and their families in a manner that will lead to improved educational and other outcomes." These "Community Schools" are public schools that emphasize family engagement and are characterized by strong partnerships and additional supports for students and families designed to counter environmental factors that impede student achievement. Community Schools coordinate and maximize public, non-profit and private resources to deliver critical services to students and their families, thereby increasing student achievement and generating other positive outcomes. Awards have been announced and Title V program staff will continue to work with SED and Community School grantees to ensure the maternal and child health supports and services are well coordinated in the Community School initiatives.//2015//

The University at Albany School of Public Health is jointly sponsored by the University and the Department, which serves as the laboratory for graduate students working shoulder-to-shoulder with practicing professionals in the state health department and in local health departments. DOH and Title V staff serve as faculty and advisors to the school, and serve on the School's Continuing Education Advisory Board and on the advisory council for the North East Public Health Leadership Institute. Title V staff coordinate the MCH Graduate Assistant Program, under which twelve - fourteen graduate students per semester (fall, spring and summer) are supported by Title V funds to work on priority MCH research and planning projects. This arrangement attracts bright, motivated individuals who are interested in gaining theoretical and practical knowledge of public health and maternal and child health, enhances the Department's research capacity, and improves the availability of pertinent and timely educational offerings for practicing public health professionals in the region. The School of Public Health sponsors the Northeast Public Health Leadership Institute (NEPHLI). Several Title V staff have attended the Institute, and several graduates serve Title V in other states and at the New York City Department of Health. Title V staff and Dr. Birkhead serve on their advisory council.

As the lead agency for the Early Intervention Program, NY's IDEA Part C Program, the Department has letters of agreement with the Office of Mental Health (OMH), the Office of People with Developmental Disabilities (OPWDD), the State Education Department (SED), and the Office of Alcohol and Substance Abuse Services (OASAS) to coordinate the implementation and operation of this program.

NYS's Early Intervention Coordinating Council (EICC) has established a Joint Task Force on Social Emotional Development in collaboration with NYS's Early Childhood Advisory Council (ECAC). The charge of the Task Force is to develop guidance on evaluation tools, intervention strategies and referrals to appropriate services. The diverse membership of individuals from the EICC /ECAC brings a wealth of knowledge and perspective to the work of this task force. The final product will include recommendations that pertain specifically to the EIP, in addition to any broader recommendations that may be developed.

Department Title V staff work with the Office of Children and Family Services (OCFS) on health care of children in foster care, family planning and on issues related to the health and safety of infants and children in child care. The Early Intervention Program collaborated with OCFS in the development of a guidance document entitled, "Protocols for Children in Foster Care Who Participate in the Early Intervention Program." In 2008 the Department and OCFS entered into a partnership to expand and improve child fatality review and prevention in NYS. The partnership works to improve the collection and examination of information generated by local fatality reviews. OCFS also sponsors, with partners such as DOH, the SUNY Distance Learning Project and the New York State Child and Family Trust Fund, monthly satellite broadcasts on child health and safety topics such as SIDS and Risk Reduction. OCFS is a critical partner in the DOH led MIECHV initiative OCFS operates Healthy Families New York, an evidence-based

paraprofessional home visiting model based on Healthy Families America. DOH and OCFS are jointly reviewed proposals submitted for home visiting services for MIECHV funds that were awarded in 2013.

For the past ***/2015/four//2015//***years, the State Legislature allocated funding from the federal Temporary Assistance to Needy Families (TANF) Block Grant to the Department of Health for. Nurse Family Partnership (NFP), an evidence-based home visiting program that improves the health and self-sufficiency of low-income, first time parents and their children. The three approved programs funded to provide services are: the NYCDOHMH, Onondaga DOH and Monroe County DOH NFP Programs. DOH has entered into a Memorandum of Understanding with the Office of Temporary and Disability Assistance (OTDA) to provide for the transfer of these funds to the Department.

2) State Agencies -- Multi-Agency Activities
The Department ***/2015/'s Title V staff/2015//participates on the Fetal Alcohol Spectrum Disorders (FASD) Interagency Workgroup, led by Council on Children and Families and the Office for Children and Family Services, whose mission is to increase awareness and advance the effective prevention and treatment of FASD in NYS through interagency collaboration and coordination. Each participating agency is charged to examine policies, practices, regulations and laws, to determine how it can positively impact the goals of eliminating alcohol use during pregnancy. /2015/Title V staff have promoted FASD prevention messages to health care providers statewide through DOH's secure, electronic messaging system.//2015//***

The Council on Children and Families (CCF) facilitates collaboration among the child-serving state agencies and partners to create a high-quality and seamless system of care with shared accountability for cross-systems youth, who have complex, co-occurring medical, , social emotional, developmental, substance abuse and/or educational needs that require collaboration and coordination, and heightened integration among multiple service systems

The 11 Council member agencies that represent health, education and human services identified a common set of goals and objectives that lead to improved outcomes for children and families--the New York State Touchstones. The NYS Touchstones vision is that all children, youth and families will be healthy and have the knowledge, skills and resources to succeed in a dynamic society. The Touchstones framework is organized by six major life areas that offer a cross-system perspective of child well-being: economic security; physical and emotional health; education; citizenship; family; and community.

Indicators that measure the Touchstone goals and objectives are accessible through the Kids' Well-Being Indicators Clearinghouse (KWIC). The KWIC website (www.nyskwic.org) is a data resource that allows advocates, policy makers, planners and others to monitor the circumstances and status of New York's children within each county. KWIC augments the annual New York State Touchstones KIDS COUNT Data Book and the Annie E. Casey KIDS COUNT Data Book--two additional data sources on child well-being.

The NYS Youth Development Team is a partnership established in 1998 by more than two dozen public and private organizations. The partnership has lead efforts to develop and promote youth development strategies across health and human services systems in NYS. Agency team members include all major state agencies serving youth (health, mental health, education, public assistance, juvenile justice, substance abuse, labor), as well as a wide variety of professional and public advocacy organizations. The Team's vision is for families, schools and communities partnering to promote the development of healthy, capable and caring youth. The Youth Development team has guided the creation of several cutting edge products, events and initiatives, including a resource notebook. For more details, see: http://www.health.state.ny.us/community/youth/development/ .

To respond to the federal requirement to establish or designate State Advisory Councils on Early Childhood Education and Care, New York established the ECAC. The ECAC includes individuals with early childhood expertise who represent early care and education, health care, child welfare, and mental health programs, as well as state agencies, advocacy organizations, foundations, higher education, unions, and others involved in the provision of services to young children and their families. ***/2015/The ECAC is working to increase collaboration through a number of initiatives designed to achieve three goals: 1) raise the quality of services of each program through the development and implementation of a quality rating and improvement system; 2) establish a common foundation for early childhood education professional development and create the infrastructure needed to support pre-service education and ongoing education, training, and skill development; and 3) link the wide range of supports and services that young children and their families need and make them more accessible through a variety of mechanisms.//2015//*** The ECAC focuses on addressing the structural issues that have impeded the development of a comprehensive system of early childhood supports and services. The Director of the Title V program, Dr. Rachel de Long, and the Co-Director of the Bureau of Early Intervention are ECAC members, and several Title V staff participate on ECAC workgroups. The ECAC established the Promoting Healthy Development Work Group to address issues related to the healthy development of young children including: supporting professionals working with young children meet the social-emotional needs of young children; supporting early care and education efforts to promote good nutrition, increase physical activity, and prevent obesity; ensure that all children receive routine developmental screenings; work with the Quality Improvement Work Group to develop program standards that support healthy development and identify resources to support programs efforts to meet those standards; and increase participation of early care and education programs in low-income communities in the Child and Adult Care Food Program.

From 2003 through May of 2009, DOH's Title V Program was the recipient of a federal Early Childhood Comprehensive Systems (ECCS) grant. The early years of the grant focused on cross-systems strategic planning, and resulted in a comprehensive early childhood plan. Recent years have focused on incremental implementation of the plan, with a strong emphasis on building state level cross-systems infrastructure for early childhood work. The overarching goal of the NYS ECCS plan is to support families and communities in nurturing the healthy development of children ages 0-5. The plan outlines goals, objectives and strategies within four cross-sector focus areas: Healthy Children, Strong Families, Early Learning, and Supportive Communities/ Coordinated System. A major emphasis and accomplishment in recent years has been to align the ECCS initiative with the work of the ECAC, accomplished in part by transferring administration of the State's ECCS grant to the NYS Council on Children and Families in 2010. (The Council also administers and provides staff support to the ECAC.) The integration of the ECCS initiative with the ECAC is evidenced by the ECCS plan, becoming the foundation for ECAC's work to develop a comprehensive system of supports and services for young children. In addition, significant progress has been made by ECCS partners across a wide range of program areas, including enrollment of young children in health insurance programs, expanded mental health screening for children, increasing access to evidenced-based parenting education programs, funding for universal pre-kindergarten, significant work to coordinate and expand home visiting programs to serve at-risk families, quality improvement projects to improve developmental screening of young children with medical homes, completion and dissemination of a comprehensive data report on the health and development of children birth to five years of age. The ECCS interagency group also promoted QUALITYstarsNY as the tiered quality rating and improvement system for early care and education programs in NYS. Based on standards that were developed to apply to programs and providers under the regulation of one of NY's public agencies -- OCFS, SED or the NYCDOHMH, ratings are assigned based on four categories of standards -- Learning Environment; Family Engagement; Qualifications and Experience; and Leadership and Management. Participating programs and providers can be assigned up to 100 points total. The number of points earned will determine a site's placement in the five-star level system. Participation is voluntary on the part of providers, OCFS will be developing an on-line site in order for parents to identify the QUALITYstarsNY rating of child care providers across NYS.

DOH, including the state's Title V Program, plays an integral role in promoting the health and well-being of NY's children and families through a comprehensive array of supports and services. DOH actively partners with CCF, OCFS and the ECAC on a number of initiatives designed to improve access to and the quality of services. This includes but is not limited to:
•Partnering on the development and implementation of the Early Childhood Comprehensive Services plan;
•Serving as a member of the ECAC and its Steering Committee;
•Providing content expertise and serving as a training development and delivery resource for nutrition, physical activity, screen time and infant feeding/breastfeeding support standards.
•Working to increase enrollment in the Child and Adult Care Food Program (CACFP), a program that ensures that nutritious and safely-prepared meals and snacks are available to children and adults in day care settings, and it provides reimbursement for qualifying meals and snacks served in child or adult day care centers, outside-school-hours care programs, family day care homes, and homeless shelters
•Provide training to both CACFP participating programs and providers and those not participating to ensure adherence to CACFP meal nutrition and physical activity guidelines including water availability.
•Recruit and support early childhood education programs and providers in the achievement of Breastfeeding Friendly Child Care Designation.
•Develop and provide professional development on the importance of limiting screen time and establishing curricula that supports active play including outdoor play.
•Facilitate linkages to new and ongoing public health initiatives related to enrollment in health insurance, coordination with primary health care providers/medical home and prevention of injuries.
•Support the development of curricula for Child Care Health Consultant trainings including the development of care plans for children with special health care needs.
In 2009, DOH, with the CCF, OMH and OCFS, successfully applied to the Substance Abuse and Mental Health Services Administration (SAMHSA) for a Project LAUNCH grant in partnership with Open Door Family Medical Centers, representing Westchester County's Community Network, a unique countywide wrap-around service system for children and families, to collaboratively enhance early childhood systems to demonstrate how different municipalities can support a holistic approach to childhood wellness. The goals of Project LAUNCH are consistent with ECCS goals to build cross system support for healthy development, including the social emotional development, of young children. ***/2015/The local grant partner, Open Door Family Medical Center, has strengthened the integration of behavioral health into primary care at the community health center. Other community stakeholders have linked with Open Door to provide parenting education and home visiting for families and children identified and referred by the community health center//2015//***.

The Council on Children and Families facilitates and supports cross-systems approaches to serving children with special emotional and behavioral services needs that builds upon previously enacted legislation codifying cross-systems service designs including the Coordinated Children's Service Initiative (CCSI) and NYS Children's Plan. These efforts promote strength-based approaches; meaningful family involvement, engagement and support and the pursuit of creative, flexible decision-making and funding strategies. Council involvement includes the development and delivery of information and communication tools plus convening, consultation, training and technical assistance to support and sustain local systems of care. Newer activities aim to better aid parents, youth and family members/caregivers to more successfully and efficiently navigate multiple service systems. In these and additional ways, the Council continues its charge to help improve services for children with cross-systems needs and their families.

The NYS Parenting Education Partnership (NYSPEP) is a statewide network of various agencies, including the NYS OCFS, the NYS CCF, the NYS OMH, the NYS Department of Education, DOH, and Prevent Child Abuse NY whose mission is to enhance parenting skills, knowledge and behavior through the promotion of parenting education. Title V staff serve as a member of

NYSPEP and is the co-chair of the New Parent Kit work group. The New Parent Kit work group has plans to develop and/or adapt a set of universal materials which provide parents with guidance on parenting, direct links to in-depth resources on relevant parenting and family health topics and information on how to access and navigate NYS family support services.

DOH, with the Center for Public Health Continuing Education at the School of Public Health at the University at Albany, the New York State Community Health Partnership and the New York State Association of County Health Officials, sponsors monthly Public Health Live Webcast Services (PHLive; formerly the Third Thursday Breakfast Broadcasts (T2B2). PHLive provides statewide continuing education opportunities covering a variety of emerging public health issues. This credit-bearing program is now hosted as a monthly Live Webcast, and subsequently archived. Interested parties can access the live programs by visiting the UA-SPH-CPHCE website: http://www.albany.edu/sph/cphce/phl.shtml. Continuing medical and nursing education credits are available.

3) Local Health Departments (LHDs)

County and city (NYCDOHMH) health departments play an essential role in the assurance of high-quality, accessible maternal and child health services. They assess the needs of their local communities, work with their communities to design and implement programs that meet those needs, and evaluate the effects of those programs on their communities. Under Article 6 of the New York State Public Health Law, local health departments (LHDs) extend the powers of the state health commissioner. Previously, under Article 6, local health departments performed comprehensive community health assessments, and subsequently produced Community Health Assessments and Municipal Public Health Service Plans (MPHSP). The CHAs described the needs and resources to meet those needs in the community, while the MPHSPs addressed the needs of the maternal and child health population in health education, infant mortality prevention, child health, family planning, chronic disease prevention, injury control, disease control and nutrition, and environmental health programs such as public water supply protection and community sanitation and food protection. Recently enacted legislation amended the process for LHDs to access State Aid funding for public health activities. Article 6 law still requires a Community Health Assessment to identify local issues, needs and resources, but no longer requires a specific MPHSP. Municipal public health responsibilities are outlined in law, and DOH staff, including Title V staff, are collaborating to develop a more streamlined process for LHD submission of public health activities. Title V staff will continue to provide technical assistance to local health departments in development, implementation and evaluation of public health activities targeted to the MCH population.

LHDs are also key stakeholders in the development and implementation of the Prevention Agenda as described in Section IIIA Overview of the State. Because LHDs know local systems and community needs, play a critical role in fostering local collaborations and locally addressing disparities in health outcomes.

4) Provider and Academic Communities

Numerous private not-for-profit groups and educational institutions are consulted and enlisted in planning, developing, providing and evaluating maternal and child health services in NYS.

First, the DOH provides the bulk of its services through contracts with community-based providers, including hospitals, diagnostic and treatment centers, community-based organizations, colleges and universities. These contracts are specific about the services to be provided and the outcomes expected. All of the nearly ***/2015/500//2015//*** contracts maintained by the Division of Family Health to perform Title V and related services represent collaborations to provide high quality services to the people of the state, and the commitment of those contractors is extraordinary. The interactions of the DOH with our service providers represent collaborative relationships of the highest order on behalf of health of our maternal and child population.

The Family Champions Project engages parents of children with special health care needs in training on planning, policy and advocacy. Family Champions assisted Title V by participating in

consumer focus groups and testifying before the Maternal and Child Health Services Block Grant Advisory Council. Family Champions will continue to be engaged in program planning and policy development initiatives with the Children with Special Health Care Needs Program. ***/2015/Although the initial cohort of Family Champions has not been engaged in several years, one Family Champion continues to participate as a member of the MCHBG Advisory Committee. The Children with Special Health Care Needs Program staff has a working relationship with the NY Family to Family Health Information Center staff. Title V supported a Family Scholar's application to the 2014 AMCHP conference.//2015//***

NYS also partners closely with the American Congress of Obstetricians and Gynecologists (ACOG), District II, on a number of maternal initiatives, including the Maternal Mortality/Safe Motherhood initiative, which attempts to identify each maternal death in New York State and use reviews of these deaths to help inform policy decisions, in conjunction with the DOH. Due to the voluntary nature of Safe Motherhood, hospitals were hesitant to report deaths and many deaths were not reviewed.

DOH recognized that it was imperative to redesign the process for maternal death reviews to ensure a comprehensive review of the factors leading to maternal deaths in NYS, and to have sufficient information to develop strategies to decrease the risk of these deaths. To that end, the DFH, in collaboration with the Office of Health Systems Management (OHSM) developed a process for the statewide Maternal Mortality Review Process. Through the New York Patient Occurrence Reporting and Tracking Systems (NYPORTS), as well as birth, death and Statewide Planning and Research Cooperative System (SPARCS) file matching, all pregnancy associated deaths will be identified for review. Using the DOH's Maternal Mortality case abstraction tool, all cases will be reviewed to identify the pregnancy related deaths. A multidisciplinary Expert Workgroup will review de-identified data and develop strategies to improve patient safety and prevent future deaths. In conjunction with a subgroup of the Expert Workgroup, DOH has developed clinical guidelines for the management of hypertension in pregnancy. The guidelines will be finalized in 2013. ***/2015/The guidelines were finalized in May 2013, distributed to NYS hospitals, and placed on the DOH website. Continued dissemination plans for the guidelines include production of a webinar for health care providers and further translation of materials through a small grant awarded to DOH by the Association of Maternal and Child Health Programs. //2015//***.

In addition, this collaboration with ACOG as well as other professional organizations on the Expert Workgroup leads to training initiatives that are implemented across the state to improve the hospital-based and prenatal care of pregnant women.

NYS has a long-established system of highly specialized Regional Perinatal Centers (RPCs), described in Section III B. Starting in 2009, RPCs began a collaborative initiative with the DOH and the National Initiative for Children's Healthcare Quality (NICHQ) to implement several learning collaborative projects to improve newborn and maternal outcomes, reduce health care costs and establishes the state's capability for ongoing quality improvement/transformation in heath care.

/2015/Several//2015// Federal Healthy Start grantees are also grantees of DOH under the ***/2015/Maternal and Infant Health Community Collaborative initiative. This promotes enhanced coordination of services and resources.//2015//***

Area Health Education Centers (AHECs) work to recruit, retain, and support health professionals to practice in communities with health provider shortages, developing opportunities and arranging placements for future health professionals to receive their clinical training in underserved areas, and providing continuing education and professional support for professionals in these communities. They encourage local youth to pursue careers in health care. The MCH Advisory Council, the DOH and the AHECs are mutually concerned about the aging of the health care workforce; the aging of nursing and dental faculty; current and future shortages in certain key

health professions; and in interesting young people in health careers early in their student careers. The Bureau of Dental Health (BDH) is working with ***/2015/the NYS Dental Association,//2015//*** AHECs and local rural health networks to improve access to primary dental care in rural areas.

In 2012, the BDH held a series of oral health stakeholder meetings involving representatives from academia, school based dental health center staff, and Head Start/Early Head Start providers and other key stakeholders for the purpose of providing input to the scope of the statewide Oral Health Plan (2013-2017). The plan addresses priority issues related to oral health in NYS today and will serve as a guide for partners statewide to mobilize resources to facilitate improvements in oral health. BDH also participated in an expert committee convened by the Health Resources Services Administration (HRSA) to consider the scientific evidence related to oral care during pregnancy and in early childhood and this committee participated in formulating the national consensus statement for dentists and child health and obstetrical care providers. This is based on the NYS e-guidelines available on the DOH website at http://www.health.state.ny.us/prevention/dental/. BDH has received a grant from HRSA to develop a best practice model for improving the oral health of pregnant women and infants ***/2015/and is working in conjunction with the BMCH to implement this model in a selected Maternal and Infant Health Community Collaborative to integrate quality practices in high need communities.//2015//***

F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	61.3	56.3	52.1	55.5	55.5
Numerator	7502	6507	6059	6418	6418
Denominator	1223080	1155822	1163580	1155822	1155822
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
Data Source: SPARCS 2012 data are being used as a proxy for 2013 data.

Notes - 2012
Data Source: Statewide Planning and Research Cooperative System (SPARCS). 2011 Provisional Data are being used as a proxy for 2012

Notes - 2011
Data Source: Statewide Planning and Research Cooperative System (SPARCS). 2011 data updated May 2013 although provisional.

Narrative:
Over 10 years, the rate of children age 0 to 4 years hospitalized for asthma fluctuated, but declined overall from the 2003 rate of 77.1/10,000 children to the 2012 rate of 51.6/10,000. During 2003-2012, the 0-to-4-year age group had the highest asthma-related hospital discharge rate.

DOH administers the Regional Asthma Coalitions (RACs) to convene local partners in high asthma burden areas. RACs plan & implement population-based, system level changes in health care & community-based settings to increase quality of life among individuals with asthma & decrease the # of asthma-related: hospitalizations, Emergency Department (ED) visits & school/work days lost. RACs strategically target geographic areas & populations with highest rates of asthma-related hospital discharge & ED visits.

Through a combination of state appropriations & federal grant funding, DOH provides infrastructure support to RACs. DOH provides training, coaching & tools to support use of evidenced-based models & methods to increase RACs' capacity to implement & sustain a population-based, system change response to reduce asthma-related hospitalizations in their regions. RACs identify populations with the greatest burden of asthma & focus efforts on reducing identified disparities. Additional resources would allow RACs to bring successful interventions to other areas & reach a broader population in high need catchment areas.

Through the Asthma Partnership of NY (APNY), DOH has engaged & organized numerous partners who share a common goal to improve asthma outcomes. APNY mobilizes partner efforts to plan, implement & evaluate strategies to improve asthma outcomes. APNY Steering Committee manages overall planning & organizational policy setting; members include representatives from stakeholder groups defined in the NYS Asthma Plan. The committee meets quarterly & is directly involved in planning, implementing & monitoring of the plan that includes the RACs.

RACs partner with DOH around implementation of the Asthma Outcomes Learning Network (AOLN). A new cohort of teams is enrolled in AOLN annually. 13 new health care & community partnership teams attended a course in 10/12 designed to support their capacity to plan, test & implement changes in their systems to improve health outcomes for people with asthma.

Some reinvestment strategies initially included in the MA Redesign Team Waiver Amendment will now be implemented through a statewide plan comprised of multiple Delivery System Reform Incentive Payment (DSRIP) programs with the goal of reducing avoidable hospitalizations & ED use by 25% over the next 5 years. The DSRIP plan includes a home-based asthma assessment & education program whose objective is to ensure implementation of asthma self-management skills including home environmental trigger reduction, self-monitoring, medication use & medical follow-up to reduce avoidable ED & hospital use. Special focus is on children where asthma is a major driver of avoidable hospital use.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 02 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	76.3	77.3	77.6	76.3	89.5
Numerator	116490	113092	114770	111519	119371
Denominator	152710	146242	147852	146249	133416

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2013
Methodology change: Used "total eligivle for ESPDT for 90 continuous days" as the denominator as the numerator is the total eligible receiving at least one initial or period screen for those continuously eligible for at least 90 days. Data Source: Center for Medicare/Medicaid Services.

Notes - 2012
Data Source: Center for Medicare/Medicaid Services. Denominator=Total eligible for ESPDT.

Notes - 2011
Data are for children enrolled in both MA Fee-For-Service and MA Managed Care.
Source: NYS DOH Center for Medicare/Medicaid Services (CMS-416).

Narrative:
MA rates for children's health measures have generally increased over time and often surpass national average rates. Data above reflect steady capacity in this area with some variation. The majority of NY's children (88%) are enrolled in a MMC plan. Through the efforts of MA redesign, all children are anticipated to be enrolled in MMC within five years. Title V staff participate in NY's MA Redesign initiative to support development and implementation of recommendations related to improving access to care and improved quality of care for children.

A related measure is collected for MMC plans through NY's Quality Assurance Reporting Requirements. For calendar year 2011, 99.5% of the children continuously enrolled in MMC had at least one well child visit between birth and 15 months and 77% had 5 or more visits by 15 months. The 2011 rates continue to demonstrate improvement from the 2009 rates of 97% and 72% respectively. The NCQA's 2009 national average for MA plans for 5 or more well care visits measure was 76%.

Improving the quality and frequency of preventive care for NY children is a priority of DOH. In 2012, NY's quality incentive for MMC plans included the well visit measure for children between 0 and 15 months as part of plan performance. All but six MMC plans qualified for the incentive.

MMC plans' quality improvement efforts address barriers including: delays in processing newborn MA identification numbers; lack of provider reminder systems; non-standardized medical record documentation; and, lack of parent understanding of the importance of well child visits (WCVs). Health plans educate members and providers through newsletters and mailings: annual "birthday cards" as member reminders; and physician profiling to identify members who are due for a preventive visit. Health plans encouraged providers to use standardized forms to document WCVs, conduct on-site visits to review records for compliance, and some plans offered providers financial incentives to improve their WCV rates. Plans offer case management for high risk newborns to assist in the assessment of needs, develop care plans and assist members in obtaining care, including WCVs. An increase in well child visits for publicly insured children is also a goal of the PA.

Title V staff monitor access to local services and work with the OHIP to identify access issues. DOH's public health home visiting (HV) services provide community outreach and direct services to high-risk families. These programs promote well baby visits, assisting women with keeping these visits after the baby is born. The CHW and the NFP programs ensure that new mothers

have a well-baby visit within 4 weeks of delivery. These efforts will be further developed through NY's federal MIECHV initiative. NY awarded $1.18 million MIECHV funds to establish/expand NFP and another HV Program (Healthy Families NY) in targeted high need communities. (Refer to HSCI 04 for further details.)

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 03 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	99.3	99.4	99.5	99.2	99.2
Numerator	1580	1900	2151	2100	2100
Denominator	1591	1911	2161	2117	2117
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
Data Source: Quality Assurance Reporting Requirements (QARR) Managed Care Program Reports. Note: Results are for children continuously enrolled in managed care plans who are 15 months of age in the calendar year 2012. 2012 data are being used as a proxy for 2013 data.

Notes - 2012
Data Source: Quality Assurance Reporting Requirements (QARR). Data are based on calendar years. Results are for children continuously enrolled in managed care plans who are 15 months of age in the calendar year. 2011 data are being used as a proxy for 2011.

Notes - 2011
Results are for children continuously enrolled in managed care plans who are 15 months of age in the calendar year. 2007 data excluded invalid data from one plan, resulting in a smaller denominator. Reliable data for Child Health Plus enrollees specifically under age one is not available. As a proxy, the percentage of children under age 15 months who received at least one well child or preventive health visit is used. Data reported for 2006 was the percentage of children who received five or more well child visits by age 15 months. Data Source is the Quality Assurance Reporting Requirements (QARR). 2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

Narrative:
Child Health Plus (CHPlus), New York State's State Child Health Insurance Plan, is exclusively a managed care product. Data on provision of well child visits for children aged 15 months is reported by plans through the state's Quality Assurance Reporting Requirements (QARR). For children continuously enrolled in CHPLus plans, the percent of children with at least one well child visit by age 15 months rose from 98% in 2003 to 99% between 2007 and 2010. The rate for 2012 is 99.2, a slight drop from 2011.

A more meaningful measure of capacity and performance used for QARR is a subset of this age group, the percent of children with five or more well child visits in the first 15 months, which was

92% for calendar year 2012, up from 82% in 2009. (Data not shown).

Improving the frequency of all children receiving preventive care within a medical home is a priority for NY's Office of Health Insurance Programs and Title V Programs. Numerous quality improvement efforts, including quality payment incentives for Medicaid Managed Care plans, have addressed timely provision of well child care. An increase in well child visits for publicly insured children is also a goal of the PA. Community-based public health programs that target high-need communities and promote utilization of primary and preventive health care for children are described in HSCI 02 and 04.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 04 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	66.0	66.9	66.6	67.5	67.5
Numerator	148291	152108	150950	152870	152870
Denominator	224556	227334	226640	226483	226483
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
Date Source: Vital Records/Births. 2012 data is being used as a proxy for 2013 data.

Notes - 2012
Data source: Vital Records/Births. 2011 Data are being used as as proxy for 2012.

Notes - 2011
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.
Source: NYSDOH Vital Records

Narrative:
Recent data show 67.5% of pregnant women achieved the objective which is an increase from 2011 & the indicator held steady when compared with the previous year. Data reflects racial, ethnic & regional disparities, with 73.2% for White non-Hispanic versus 56.9% & 62.8% for Black non-Hispanic & Hispanics, respectively. 65.7% of pregnant women in NYC & 69.1% in the rest of NYS achieved the target.

Over the past few years, NY has made important systems changes to improve access to prenatal care. OHIP assumed responsibility for the Prenatal Care Assistance Program (PCAP). All MA prenatal care providers are required to provide care in accordance with the same comprehensive standards. MA enrolled Article 28 prenatal care providers also perform presumptive eligibility determinations & assist with the full MA application & managed care plan selection, allowing women to receive care pending final determination.

DOH developed several community-based programs to improve access to prenatal care,

including the Comprehensive Prenatal-Perinatal Services Networks which organized the local service system; Community Health Worker Program which provided outreach & home visiting (HV) services to high risk pregnant women; the Healthy Mom-Healthy Baby program to develop a system of early identification & service coordination for high risk women in 6 counties; & the Nurse Family Partnership (NFP) program to improve outcomes for first time mothers in high need communities.

Based on the aforementioned initiatives, recognizing the need to focus efforts to better address disparities, DOH established the Maternal & Infant Community Health Collaboratives (MICHC) in 2013 which integrates & replaces these community based perinatal health programs to develop multi-dimensional community-wide systems approach. MICHC includes 22 new projects in 33 high-risk counties that seek implement evidence-based &/or best practice strategies across the reproductive life course to improve maternal & infant health outcomes. The Maternal, Infant & Early Childhood Home Visiting program supports 5 NFP & 5 Healthy Families New York programs in 6 high-risk counties.

Improving health outcomes for women & families is a priority for the 2013-17 Prevention Agenda (PA), aligning with goals of NYS' MA & Title V programs. With the recognition that a life course perspective is needed to promote health & prevent disease, the PA addresses 3 key life course periods--maternal & infant health, child health & reproductive/preconception/inter-conception health--with goals, objectives & indicators for each, including implementation of evidence-based HV as a strategy to reach high-risk families.

DOH implemented a statewide social marketing campaign promoting the National HM-HB Coalition's text4baby text messaging service for pregnant & newly parenting women, providing customized messages with NYS-specific resources & information. Over 19,000 subscribers receive messages customized for NYS.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 07A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	90.7	87.4	87.0	86.8	87.9
Numerator	1876851	1878851	1910587	1979928	2074894
Denominator	2068245	2150748	2196077	2280280	2359718
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2013
Data are the number and percent of enrolled children who received services paid by Medicaid.

Notes - 2012
Data Source: Denominator came from the CMS-416 Report by the Center for Medicare/Medicaid Services.

Notes - 2011
The number of potentially eligible children is based on the number of children enrolled in Medicaid.
Source: NYS DOH Center for Medicare/Medicaid Services (CMS-416).

Narrative:
This indicator offers a crude approximation of the extent of health care utilization by the population of children enrolled in MA in NYS. It tells us that a large proportion of Medicaid (MA)-enrolled children access at least one MA-paid service of any kind each year & that the proportion has remained relatively constant over the past 3 years, & has experienced an increase during this reporting year. The data does not inform us why children obtained services, such as for a preventive/well child or sick visit. The data does not indicate whether there are racial or ethnic disparities & age differences in utilization & is also silent on the breadth, quantity & quality of services rendered to those children.

The number of children ever enrolled in NY MA/SCHIP has steadily increased. NY's high participation rate is likely due to its considerable effort to help ensure that eligible children are enrolled in MA & once enrolled that they access health services-especially preventive & primary care services-in a manner that contributes to their health & well-being. An increase in well child visits for publicly insured children is also a priority of the PA.

Over the last 5 years, NY has seen a 19% decline in uninsured children under age 18 years. In 2006, 8.1% of the NY's population of children less than 18 years was uninsured compared to 6% in 2013. For those children living in poverty, NY is doing better at getting children insured than the nation as a whole. In 2011, the percent of uninsured NY children under age 19 years living at or below 200% of the poverty level was 4.1 % compared to 6.4% for the nation.

NY has made it easier for families to apply for public insurance. NYS of Health (NY's Exchange) became operational on 10/1/13 & provides easier access to health insurance in NYS for all New Yorkers, including children. through 1 application that can be used to apply for Child Health Plus, Family Health Plus, MA & the Family Planning Benefit Program. The application is available electronically on NY's website in English & Spanish. A screening tool on this site, informs individuals which program they &/or their children are eligible for based upon the information they have provided. Facilitated enrollers are available in local neighborhoods to help individuals apply & answer their questions.

NY has responded to Secretary Sebelius' Connecting Kids to Coverage Challenge by selecting a specific state target market for a media campaign & PSAs. In collaboration with the CMS, NY is focusing on 18 upstate counties to help raise awareness among potentially eligible families about children's health coverage under MA & CHPlus & increase enrollment & retention. Through the campaign, materials have been provided to a Regional Food Bank for the school back program in which families receive information about insurance in their child's book bag that has been stocked with healthy foods. These targeted efforts help to ensure that those children eligible become enrolled.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 07B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	50.1	51.1	52.5	52.5	52.5
Numerator	186258	200375	212043	212043	212043
Denominator	371495	391812	403816	403816	403816

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2012
2011 Data are being used as proxy for 2012.

Notes - 2011
Source: NYS DOH Center for Medicare/Medicaid Services.

Narrative:
The proportion of 6 to 9 year old children enrolled in the Medicaid (MA) Program receiving dental services decreased slightly from 2011 (51.9%) to 2012 (51.2.)

Strategies for improving access to dental care are addressed in the Prevention Agenda (PA) 2013 and the NYS Oral Health Plan. The prevention of tooth decay in children and increase in the proportion of children who receive dental sealants and regular dental care are 3 priority areas in the PA. School-based dental health (SBDH) clinics are effective strategies under the PA for providing oral health services to low income 6 to 9 year old children who would otherwise not have access to services. Currently, 58 school-based programs provide oral health services to over 68,000 children in 1,045 schools across NYS, with DOH providing grant support to 30 programs under the MCH Block Grant. In addition to the MCH-funded SBDH clinic program, one program also receives a separate HRSA grant from DOH for a special project to integrate oral health prevention and treatment services into existing school health center programs. This particular project is currently in the process of collecting data on 6 to 9 year olds through electronic dental records to determine the impact of the program on improving access to dental care.

Two of the goals under the PA are to increase the utilization of dental services among 3rd grade children & to reduce their percentage of untreated decay. Open mouth exams on a representative sample of 3rd grade students were initiated in 2010 and are continuing. Based on results to date, the proportion of 3rd grade children who had any dental services in the prior year was greater in 2009-2011 (80.1%) compared to 2002-2004 (73.4%) and increased more among low income children (from 60.9% to 73.0% respectively) than among high income children (86.9% to 89.4%, respectively). Untreated caries also decreased between the 1st and 2nd surveys (from 33.1% to 24.8%) and decreased slightly more among low income children (from 40.8% to 31.8%, respectively) than among higher income individuals (from 23.1% to 15.1%, respectively).

Effective 09/2008, a dental health certificate (DHC) was requested for children in Kindergarten, and grades 2, 4, 7 and 10 as a way to increase access to oral health care and identify children in need of treatment services. Difficulties finding dentists willing to complete the certificate prompted the passage of the Dental Hygienist Collaborative Practice that authorizes registered dental hygienists to sign the DHC. This law is effective January 2015. Title V staff continue to work with key stakeholders to promote oral health services for all NYS's children.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 08 - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	0	0	0	0	0
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2013
This measure is not applicable to NYS as all SSI beneficiaries are categorically eligible for Medicaid which covers rehabilitative services.

Notes - 2012
This measure is not applicable to NYS as all SSI beneficiaries are categorically eligible for Medicaid which covers rehabilitative services.

Notes - 2011
NYS has two Title V public health programs that assist families of children with special health care needs (CSHCN) access services and supports. The state CSHCN Program, through its local contractors, provides families of CSHCN with linkages and referrals to services and assistance programs, including SSI. The State Physically Handicapped Children's Program (PHCP), administered by Local Health Departments, provides reimbursement of medical services for children who are uninsured or underinsured. In NYS, all SSI beneficiaries are categorically eligible for Medicaid which provides a more comprehensive benefit package than PHCP and provides rehabilitative services. As a result, CSHCN on SSI in NYS access their rehabilitative services through Medicaid instead of the State's PHCP.

Narrative:
All SSI beneficiaries in NYS are categorically eligible for Medicaid (MA), which is a more generous health care insurance package than the Physically Handicapped Children's Program (PHCP), a gap-filling program for children with special health care needs (CSHCN) who are uninsured or underinsured. As a result, CSHCN on SSI in NYS access their rehabilitative services through MA instead of NYS' PHCP. In addition to the MA benefit, SSI provides income to help families obtain needed services to care for their disabled children.

In 2013, 103,739 children under age 16 years had SSI. MA paid for rehabilitative services for 194 of these children.

NYS' public health programs assist families of children with special health care needs (CSHCN) access services and supports. The NYSCSHCN Program, through its local contractors, provides families of CSHCN with linkages and referrals to services and assistance programs, including SSI. CSHCN who have severe, handicapping conditions and whose families contact the CSHCN Program are referred to SSI. The assessment and referral activity of the CSHCN Program is significant as it demonstrates that staff recognizes the benefit SSI can provide families and accurately refers those children most likely to be determined eligible for SSI.

In FFY 2012, 53 CSHCN (3%) whose families received referral services through the CSHCN Program had SSI at the time of initial contact compared to 61 CSHCN (4.1%) in FFY 2013. The data from FFY 2012 and 2013 demonstrate slightly higher percentages of children reported to be on SSI at initial contact with the CSHCN Program compared to 2010(1.6%) and 2011 (1%) respectively.

In FFY 2012, local CSHCN Program staff referred 42 CSHCN (2%) to SSI as compared to 61 CSHCN (3%) referrals in FFY 2013. Twenty-six percent of 2013 referrals to SSI were accepted, 43% were rejected, and 31% were pending at the end of the fiscal year. The significant percentage of pending referrals at the end FFY reflects the lengthy SSI eligibility process.

In 09/13, the NYC CSHCN Program contractor held an education forum for families on "Social Security Benefits for Children with Disabilities." This forum educated the public on accessing this important benefit for children with severe handicapping conditions. The forum evaluation indicated that attendees expressed favorable reviews and learned a great deal about SSI.

The CSHCN Program will continue to fund and provide technical support to local CSHCN Program contracts whose staffs perform information and referral activities. Title V staff will continue work with local CSHCN Programs to improve data quality (i.e., follow up and documentation of outcomes) for this measure.

As of 04/01/13, the local EIP pays for services for children in the Early Intervention Program (EIP) who have SSI if MA does not cover the rehabilitative service.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2012	payment source from birth certificate	8.2	7.7	7.9

Notes - 2015
Methodology Revision: Definition of births paid for/reimbursed using Medicaid funds has been revised to include secondary payor in addition to the primary payor. The revision changes the state Medicaid/non-Medicaid totalls by .1 percent. If we were to revise earlier years using the same meghodology, we expect to obtain similar percent differences as seen with 2012 data.

Narrative:
The low birth weight (LBW) rate decreased slightly from 2006 for the NYS population (8.0%) and the Medicaid (MA) population (8.2%) but remained consistent at 7.8% for the Non-MA population. Efforts to reduce LBW are systems-wide to improve early entry into prenatal care and supports and services offered through perinatal and home visiting programs.

NYS's system of regionalized perinatal care ensures appropriate hospital care is provided to women and their newborns. The system includes a hierarchy of 3 levels of perinatal care provided by hospitals in a region and led by a Regional Perinatal Center (RPC). Women at highest risk for poor birth outcomes are referred to RPCs and supportive health and social services.

The MA requirement that Article 28 facilities offering prenatal care provide Presumptive Eligibility to pregnant women has expanded prenatal care access and MA coverage. MA Redesign recommendations adopted in 2011 to expedite enrollment of MA-eligible women into managed care plans promote earlier entry into prenatal care and increase utilization of care management for high risk women. Title V staff participate in the MA Redesign initiative to support development

and implementation of recommendations to improve access to and quality of care for infants and children.

A woman's health prior to pregnancy significantly impacts birth outcomes. A preconception care packet, including a checklist and a Guide for Optimizing Pregnancy Outcomes, was developed in collaboration with the American Congress of Obstetricians and Gynecologists NY and widely distributed to obstetricians, nurse practitioners and pediatricians. Medical professionals were encouraged to ask women about reproductive intentions at every visit, assess risk of an unplanned pregnancy and counsel women on appropriate health behaviors to optimize pregnancy outcomes.

Healthy First NY, a HRSA-funded First Time Motherhood-New Parents Initiative, has taken a comprehensive approach to preconception/inter-conception health and parent support messages and resources. Through a community action planning process in 6 high risk areas, a needs and resource assessment was designed to engage local stakeholders to identify barriers and strengths to develop and implement preconception health action plans.

Materials developed included: reproductive life plan booklets, brochures, palm cards, radio/movie theater ads and video; a presentation to promote integration of a life-course approach into DOH; a statewide social marketing campaign promoting the Healthy Mothers Healthy Babies Coalition's text4baby messaging service for pregnant and newly parenting women; the promotion of the Preconception Health web-based training developed by DOH for paraprofessionals working with women and men of child-bearing age; and collaboration with internal and external groups to identify and disseminate supports and materials to help couples transition to parenthood and to increase families' awareness of the services.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2011	matching data files	5.9	3.9	4.9

Narrative:
NYS's capacity to reduce infant mortality includes a number of surveillance, community-based, & clinical activities, services & supports. Early access to prenatal care remains a cornerstone of promoting infant well-being. Major elements of NYS's system include: Medicaid (MA) standards for prenatal care together with the requirement that all enrolled Article 28 prenatal care providers perform presumptive eligibility & assist with the full MA application & managed care plan selection; home visiting programs including the evidence-based Maternal Infant and Early Childhood Home Visiting initiative (NFP and HFNY); consumer outreach & education; & the Growing Up Healthy Hotline. In addition, preconception & interconception health is increasingly emphasized across all programs as critical for impacting birth outcomes.

NYS is committed to the elimination of health disparities & improving birth outcomes using evidence-based, sustainable models of care. Through the new Maternal & Infant Community Health Collaboratives (MICHC) initiative, DOH aims to improve maternal & infant health outcomes for high-need women & reduce racial, ethnic & economic disparities in those outcomes. The 22 MICHC projects will work to improve specific maternal & infant health outcomes through

implementation of evidence-based &/or best practice strategies across the reproductive life course. This initiative integrates & replaces DOH's current community-based perinatal health programs to develop community-wide systems of integrated & coordinated community health programs & services to improve outcomes. NY will also participate in the upcoming COIN Infant Mortality Summit sponsored by HRSA.

Efforts have also focused on promotion of safe sleep & reduction of Sudden Infant Death Syndrome, including risk reduction education. DOH's Keeping NY Kids Alive program focuses on increasing the number of county-based child death review teams; expanding the scope of cases reviewed; standardizing data collection & submissions; & enhancing local prevention measures & system improvements. Division of Family Health also collaborates with other partner programs, including WIC, Bureau of Occupational Health & Injury Prevention & Healthy Families New York (a home visiting program administered by the NYS Office of Children & Family Services for the prevention of child abuse), to address factors that contribute to infant mortality.

Improving health outcomes for women, infants & children is a priority for the NYS Prevention Agenda (PA), aligning with goals of the state's MA & Title V program. The NYS PA's State Health Improvement Plan addresses 3 key life course periods--maternal & infant health, child health & reproductive/preconception/inter-conception health--with goals, objectives & indicators for each, including implementation of evidence-based home visiting as a strategy to reach high-risk families. Title V staff will continue to work with key stakeholders to improve MCH outcomes as defined in NYS's PA.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2012	payment source from birth certificate	65.5	81.9	73.9

Notes - 2015
Methodology Revision: Definition of Births paid for/reimbursed using Medicaid funds has been revised to include secondary payor in addition to the primary payor. The revision changes the state Medicaid/non-Medicaid totalbs by .1 percent. If we were to revise earlier years using the same methodology we expect to obtain similar percent differences as seen with 2012 data.

Narrative:
Capacity in this area is closely related to that described for HSCI 04. MA populations generally fare less favorably than privately insured populations for this and other perinatal health measures, although there was a slight improvement in the MA population in 2011 as well as 2012. MA prenatal care (PC) increases access for high risk women to high-quality PC that includes standardized risk assessment, medical and supportive services. Establishing consistent standards in the MA PC program and requiring all MA PC providers to provide care in conformance to these standards increase access to high quality, comprehensive prenatal care. MA Redesign recommendations were adopted in 2011 to expedite enrollment of MA-eligible women into managed care plans to promote earlier entry into PC and increase utilization of care

management for high risk women.

A variety of public health strategies engage high risk pregnant women in early PC. DOH's state plan for federal Maternal, Infant and Early Childhood Home Visiting (MIECHV) funds is based on an extensive needs assessment process to identify communities with high rates of maternal, infant and child health risk indicators, the existing home visiting (HV) programs and supportive resources in the communities. NYS's work in the MIECHV supports further coordination of services and maximization of resources to improve birth outcomes. These programs target communities with highest needs. The statewide Growing Up Healthy Hotline links women to services. Periodic public awareness media campaigns direct women to the hotline.

In 2013, through a competitive procurement process, DOH established the Maternal and Infant Community Health Collaboratives (MICHC) which integrated and replaced existing community-based perinatal health programs to develop multi-dimensional community-wide systems of coordinated community health programs and services to improve maternal and infant health outcomes. 22 MICHC projects were awarded in 33 counties across NYS. The competitive procurement also resulted in the expansion, enhancement and/or establishment of evidence-based HV programs by awarding MIECHV funding to 3 Nurse Family Partnership (NFP) and 1 Healthy Families New York (HFNY) projects. This is in addition to the current 6 MIECHV projects (2 NFPs and 4 HFNYs). The Title V program collaborates with the Office of Children and Family Services related to its HFNY HV program.

Improving health outcomes for women, infants and children is a priority for the NYS PA, aligning with goals of the state's MA and Title V programs. The NYS PA's State Health Improvement Plan addresses 3 key life course periods--maternal and infant health, child health and reproductive/preconception/inter-conception health--with goals, objectives and indicators, including implementation of evidence-based HV as a strategy to reach high-risk families. Title V staff will continue to work with key stakeholders to improve MCH outcomes as defined in NYS's PA.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2012	payment source from birth certificate	60.4	74.3	67.5

Notes - 2015
Methodology Revision: Definition of Births paid for/reimbursed using Medicaid funds has been revised to include secondary payor in addition to the primary payor. The revision changes the state Medicaid/non-Medicaid totalbs by .1 percent. If we were to revise earlier years using the same methodology we expect to obtain similar percent differences as seen with 2012 data.

Narrative:
Several strategies are used to engage high risk pregnant women in early prenatal care (PC) & support ongoing utilization of services throughout pregnancy. These include home visiting (HV) programs, such as Nurse Family Partnership, designed to establish a county system of perinatal health services, with a strong focus on outreach to engage pregnant women in early PC. All programs target high need communities.

NYS was awarded funds through the Maternal, Infant & Early Childhood Home Visiting (MIECHV) program to support the development of evidence-based HV programs in high-risk communities. NYS's MIECHV work will support coordination of services and maximization of resources to improve birth outcomes.

In 2012, DOH issued a Maternal & Infant Health Initiative Request for Applications that replaced & integrated DOH's existing community-based perinatal health programs, including Comprehensive Prenatal-Perinatal Services Networks, CHWP & the HM-HB program, to develop multi-dimensional community-wide systems of integrated & coordinated community health programs & services to improve maternal & infant health outcomes. As a result, 22 Maternal and Infant Community Health Collaboratives (MICHC) were established in 33 counties across NYS. MICHCs will work to identify high-risk pregnant women & ensure they have health insurance & are engaged in PC & other supportive services including HV.

Public health programs that serve at-risk adolescents, including School-Based Health Center (SBHC), Family Planning & Community-Based Adolescent Pregnancy Prevention Programs, include provisions for preventive health services, pregnancy prevention & prompt referral of pregnant teens to PC. SBHCs may provide PC services directly, coordinate services with another provider, or refer pregnant students for appropriate PC, with follow-up to ensure continuity of care. Referrals are made for additional services.

NYS will continue to promote access to early, continuous & comprehensive quality PC services through outreach to identify & engage high-risk women; implementation of comprehensive standards & reimbursement for promotion of MA PC services; & steps to enroll MA-eligible pregnant women in managed care plans as early as possible to assure optimal PC management.

Improving health outcomes for women, infants & children is a priority for the NYS Prevention Agenda (PA), aligning with goals of NYS's MA & Title V program. The PA's State Health Improvement Plan addresses 3 key life course periods--maternal & infant health, child health & reproductive/preconception/inter-conception health--with goals, objectives & indicators, including implementation of evidence-based HV as a strategy to reach high-risk families. Title V staff will continue to work with key stakeholders to improve MCH outcomes defined in NYS's PA.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2013	223
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2013	100

Narrative:

Access to insurance, which is imperative for improved health outcomes and to mitigate racial and ethnic disparities, is a priority of NYS. . An increase in well child visits for publicly insured children is also a goal of the PA. Access to continuous health care coverage is also a critical priority for CSHCN. The OHIP administers the Medicaid (MA) and Child Health Plus (CHPlus) programs. CHPlus is NYS's Child Health Insurance Program (CHIP). 90% of all individuals, including children, who are enrolled in MA receive their services through a managed care (MC) plan while all children who are covered by CHPlus are enrolled in a MC plan.

Infants up to age 1 whose household incomes are at or below 223% of the Federal Poverty Level (FPL) and who meet other eligibility criteria are eligible for MA. Those infants born to women covered by MA continue to be eligible for coverage until the end of the month of their first birthday. Coverage for children aged 0 to 1 year enrolled in MA is free.

CHPlus insures children who are ineligible for MA due to household income or immigration status provided that they meet all other program eligibility requirements. Infants whose household incomes are over 223%, but under 400%, of the FPL and meet other eligibility criteria would be eligible for CHPlus at a subsidy. These children are also eligible to purchase a Child only Qualified Health Plan (QHP) with no tax credit. In NYS, the Affordable Care Act reforms will not change CHPlus income eligibility criteria.

Families with children aged 0 to 1 year enrolled in CHPlus may be required to pay a monthly premium contribution based on their household income and family size. CHPlus coverage for those children with household incomes under 160% FPL is free. The premium for families with household incomes between 160% and 222% FPL is $9/child/month, with a maximum of $27/family/month. Families with household incomes between 222% and 250% FPL contribute $15/child/month, with a maximum of $45/family. Families with household incomes between 250% and 300% FPL contribute $30/child/month, with a maximum of $90/family. Families with household incomes between 300% and 350% FPL contribute $45/child/month, with a maximum of $135/family. Families with household incomes between 350% and 400% FPL contribute $60/child/month, with a maximum of $180/family. The monthly fee is capped at 3 children for families with incomes up to 400%. For those with household incomes above 400% of the FPL, CHPlus is available to families at the full premium charged by the health plan. There are no co-payments for CHPlus services.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2013	154
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 1) (Age range to) (Age range to)	2013	400

Narrative:
The Office of Health Insurance Programs administers the Medicaid (MA) and Child Health Plus (CHPlus) programs within DOH. Access to insurance coverage for all NYS residents is a priority of NYS. Currently, children aged 1 through 18 years of age are eligible for MA if their household incomes are at or below 154% of the Federal Poverty Level (FPL) for 12 months of continuous coverage, even if the household income exceeded eligibility levels during that year.

Children in families ineligible for MA due to household income or immigration status are eligible for subsidized health insurance coverage under CHPlus, NYS' Child Health Insurance Program, if their household income is up to 400% of the FPL. CHPlus is available at the full premium cost for children in families whose household incomes are above 400% of the FPL. There are no co-payments for CHPlus.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2013	223
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2013	100

Notes - 2015
Pregnant women in NYS are not eligible for SCHIP.

Narrative:
Pregnant women with household incomes < 223% of the FPL who can demonstrate NYS residency & provide proof of income, identity & pregnancy (including estimated date of confinement) are potentially eligible for MA, an increase from the previous eligibility criteria of < 200%. Pregnant women who meet these criteria & have household incomes < 100% of the FPL are eligible for the full array of MA services. Eligible pregnant women with household incomes >100% & = 223% receive a limited MA benefit covering prenatal care only unless a pregnant woman is enrolled into a MC health plan which entitles her to all the benefits & services that are covered by that health care plan, regardless of her income.

In 1998 legislation extended family planning (FP) benefits for 26 months after the end of a pregnancy to women who had previously been on MA while pregnant & were not eligible for MA or Family Health Plus (regardless of the individual's income or citizenship/immigration status.) under the Family Planning Extension Program (FPEP.) The federal government approved NYS's MA 1115 waiver to expand FP services resulting in the implementation of the Family Planning Benefit Program (FPBP) on 10/01/02. The FPBP provides MA coverage for FP services for individuals with household incomes up to 200% of the FPL who are U.S. citizens or have satisfactory immigration status, regardless of previous MA eligibility or pregnancy.

Recommendations adopted through the state's MA Redesign process in 2011 converted the authority for the FPBP from the 1115 waiver to the MA State Plan in 2012. As a result, transportation was added to the FPBP benefit package, age edits were removed to allow participation by all applicants of child bearing age with the option to request & be approved for up to 3 months of retroactive FPBP coverage prior to the application date.

The authority under the MA State Plan allows Presumptive Eligibility (PE) for FP. An individual who screens as presumptively eligible by a FP Provider will receive a card & FPBP services from the date of screening until DOH makes a determination on an FPBP application filed by an applicant. If no application is filed, the individual is covered by PE for FPBP until the last day of the month following the month in which the screening was completed.

The State Plan allows the systemic enrollment of women who were pregnant & received MA during their pregnancy who are 60 days from the end date of the pregnancy & not eligible for ongoing MA to receive an additional 24 months of FP services coverage through FPBP, FPEP, or a combination of the 2 programs, regardless of their income, citizenship/immigration status or whether they completed & returned a renewal form. System enhancements also include processing FPEP services electronically via eMedNY payment file.

Future enhancements will allow increased capacity as categorical MA eligibility for pregnant minors is implemented and count only the applicant's income for FPBP eligibility.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2015

Narrative:
The SSDI continues to support the development and implementation of CHI², a long-term DOH initiative to integrate MCH-related data systems that will bring together Newborn Screening (NBS), Newborn Hearing Screening (Immunization, Early Intervention, WIC, MA, Vital Statistics and other data sources. This system has the potential to dramatically increase the public health efficiency of many DOH programs. DOH will gain the ability for bi-directional sharing of its MCH data with external partners leading to improved patient care. The CHI² will continue to coordinate with other Health Information Exchange planning initiatives within DOH such as the exchange of data elements using service-oriented architecture and web services using an enterprise service bus.

Under the NBS Effective Follow-up Grant and CHI2 Initiative, data transfer agreements and linkages are being developed between NBS and MCH Programs. NBS will share data with MCH for the CHI2. MCH and NBS staff are working together to provide data mapping between Vital Records, Immunization, and other program areas.

The linkage of NYSIIS and the lead registry allows sharing of immunization and lead test history to authorized users (including health care providers, WIC Programs, health plans, DOH and local health departments). With future enhancements, the system will allow DOH to access relevant data to identify children by practice level who have not been tested for lead as per NYS requirements.

The BDH uses PRAMS data to generate reports on use of dental services by pregnant women. BDH and PRAMS staffs are collaborating on the inclusion of additional survey questions designed to better assess the oral health status of pregnant women.

BDH works closely with MA and CHPlus to produce county and age specific reports on dental claims and expenditures for specific preventive and treatment procedures. The data are used to determine oral health status, level of utilization of dental services by the MCH population and areas of unmet need and assess the impact of fluoridation on dental caries in children; improvements in age one dental visits; use of fluoride varnish for children under age 7; and disparities in oral health status and use of services within different NYS regions. These data provide the basis for determining where services, TA, outreach and education are most needed.

The CSHCN Program will improve quality of data reported to DOH by revising the local quarterly report form. Local CSHCN programs will be required to use the new form, leading to the ability to generate annual statewide surveillance data for statewide and possibly local reports.

BMCH collects information on babies admitted to a NYS NICU. The NICU data base is being updated to include a link to the upstate birth certificate system; this will enable direct incorporation of identifying and medical information common to systems, diminishing the need for redundant data entry and enhancing data quality.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2015

Narrative:
DOH uses two different data sources to determine the percentage of adolescents in grades 9 through 12 who report tobacco use in the past month. The NYS Education Department (NYSED) conducts the Youth Risk Behavior Surveillance System (YRBS) in odd numbered years. DOH conducts the Youth Tobacco Survey (YTS) in even numbered years. Data from the 2013 YRBS are not available yet; CDC will release results in the early summer of 2014. The most recent data are from the 2012 YTS. 21.8% adolescents in grades 9 through 12 reported using any tobacco product on at least one day in the past 30 days. From 2000 to 2012, use of any tobacco products for high school students has decreased by 33%. This is a statistically significant downward trend that DOH expects to continue through the efforts of the NYS comprehensive tobacco control program.

The Bureau of Tobacco Control's (BTC) independent evaluation contractor administers the YTS; despite a delay in re-procuring this contract, the survey is moving forward. The administration of the 2014 YTS is proceeding on schedule.

BTC is in the procurement process for a new, statewide five-year contract, "Advancing Tobacco-Free Communities," to foster environments that support policies that expand the tobacco-free norm in NYS. Contractors will support the prevention and reduction of tobacco use through community engagement and youth action. This evidence-based, systems approach to chronic disease prevention uses strategies that include community education, community mobilization, government policy-maker education and advocacy with organizational decision makers to create local environments that demand policy change. The work will focus on populations with low-income, low educational attainment or serious mental illness who have significantly higher smoking rates. Contractors will work with local communities to increase the number of smoke-free multi-unit housing complexes, particularly low-income housing, and tobacco-free outdoor spaces to reduce or eliminate exposure to secondhand smoke and reinforce the social norm of a tobacco-free New York. The youth element, branded "Reality Check" (RC) will cover every county in the State. In the RC element, contractors will engage, educate and mobilize youth, communities and youth-focused organizations to reduce the impact of retail tobacco marketing on youth, tobacco imagery in youth-rated movies, and tobacco industry presence on social media.

For a description of additional specific program initiatives related to this area, please see SPM 06: Percent of high school students who smoked cigarettes in the last month and NPM 15: Percentage of women who smoke in the last three months of pregnancy.

IV. Priorities, Performance and Program Activities

A. Background and Overview

This section profiles NY's maternal and child health priorities, selected performance measures and program activities and discusses the extent to which National and State objectives were met in the program year. Summaries have been included at the beginning of each section to provide an overview of general state progress on measures.

As previously described in the Needs Assessment Summary section, NY's priority setting process included a review of the needs of the MCH populations, input from maternal and child health stakeholders throughout NYS, discussions with stakeholders through the Prevention Agenda planning process, ***/2015/continuing collaboration with the Public Health Committee of the Public Health and Health Planning Council,//2015//*** an examination of evidence-based practice where available and existing program priorities and realignment of the priorities to address new identified needs to the extent that resource permit. Performance related to program priorities were assessed to ensure MCH programming results in real improvement in the health and well-being of the MCH populations in NYS.

NY's progress on Federal and State Performance Measures and Outcome Measures are tracked on Forms 11 and 12.

A summary of the state's progress related to implementation of state priorities and outcomes measures is included in Section IV B.

Determining what should be identified as a state priority in NY's 5-year application for 2011-2016 and how those priorities should be ranked was based upon a number of factors including degree of stakeholder input identifying an issue as a priority; current capacity to meet identified needs, whether the need related to a health disparity/disparities, as well as other factors. The following are revised State Priorities for the 2011 through 2016 MCHBG grant cycle:

1. State Priority: To improve access to early, adequate and high quality prenatal care, with a specific focus on eliminating health disparities
2. State Priority: To improve access to comprehensive, high quality primary and preventive health care for children and adolescents, consistent with the medical home model, including children with special health care needs
3. State priority: To eliminate disparities in health outcomes, especially with regard to low birth weight and infant mortality
4. State Priority: To prevent and reduce the incidence of overweight and obesity for infants, children and adolescents, with a focus upon reducing health disparities
5. State Priority: To reduce unintended pregnancies in adults and adolescents and improve adolescent sexual health and development, with a focus upon reducing health disparities
6. State Priority: To reduce or eliminate tobacco, alcohol and substance use among children and pregnant women
7. State Priority: To improve oral health, particularly for pregnant women, mothers and children, and among those with low income
8. State Priority: To eliminate childhood lead poisoning
9. State Priority: To improve diagnosis and appropriate treatment of asthma in the maternal and child health population.
10. State Priority: To increase the percentage of infants who are breastfed for at least six months.

In addition to the 10 State priority measures, /2014/progress continues on//2014// two outcome measures selected for this period:

1. State Outcome Measure: Maternal mortality rate per 100,000 births

2. State Outcome Measure: The percentage of elective deliveries, both cesarean sections and inductions, performed without appropriate indication between 36 and 38 6/7 weeks gestation.

A summary of the state's progress related to addressing the State's outcome measures is as follows:
1. State Outcome Measure: The maternal mortality rate per 100,000 births - In 2010, the Department implemented a new Maternal Mortality Review Initiative a DOH-led comprehensive process to systematically review all maternal deaths, in conjunction with IPRO and an expert committee that includes representation from ACOG and other professional groups/experts. The updated initiative is intended to ensure a comprehensive review of factors leading to maternal deaths in NYS, and to have sufficient information to develop strategies and measures to decrease the risk of these deaths. The first meeting of the expert committee included a review of preliminary 2006-2008 data on 70 maternal deaths. Analysis was completed on medical records for 126 deaths from 2006 to 2008 showed the leading causes of death to be: /2014/cardiovascular issues (31%), hypertension (17%), hemorrhage (17%) and embolism (12%). Chronic illness, obesity and prenatal risk factors were identified. At least one risk factor was documented in 67% of the charts. 45% were overweight or obese. The largest race/ethnic group was Black, non-Hispanic with 47% of the reviewed deaths, followed by White, non-Hispanic and Hispanic with 24% and 18%, respectively. Women 30-39 years accounted for 60% of the deaths. The highest ratio of deaths per live births occurred in women over 35 years. ***/2015/The//2015//***review of data resulted in identification of several priorities including management of hypertension, obesity and embolism/DVT. ***/2015/A final report is being prepared.//2015//***
Management of hypertension during pregnancy was selected as the first topic for development. A multidisciplinary subcommittee and DOH worked with the OHIP, IPRO and the subcommittee to develop guidelines on the diagnosis, evaluation, and management of Hypertensive Disorders in Pregnancy. The full Expert Review Committee reviewed and commented on the guidelines before finalized by DOH. ***/2015/The Guidance Document has been posted on the DOH website and disseminated to hospitals across NYS. DOH is in the process of translating the guidelines into Action through a webinar, an online training as well as guidance implementation tools.//2015//***

2. State Outcome Measure: The percentage of elective deliveries both cesarean sections and inductions performed without appropriate indication between 36 and 38 6/7 weeks -To address concerns regarding elective preterm deliveries, DOH implemented the NYS Perinatal Quality Collaborative (NYSPQC) - a joint initiative of DOH, New York's Regional Perinatal Centers (RPCs), ***/2015/RPC-affiliate birthing hospitals//2015//*** and the National Initiative for Children's Healthcare Quality (NICHQ). The collaborative strives to improve maternal and newborn outcomes through the use of evidence-based healthcare improvement interventions to reduce the number of scheduled, elective deliveries performed without appropriate indication in women of 36 0/7 to 38 6/7 weeks gestation. Initiated in 2010, DOH ***/2015/has since//2015//*** expanded efforts from the RPCs, to all interested birthing hospitals NYS. To date, 98 out of 131 (75%) birthing facilities are participating in the project, including 17 RPCs and 81 affiliates. ***/2015/Ongoing//2015//*** Obstetrical Intervention teams activities have included: collecting and submitting data on scheduled inductions and Caesarian deliveries without medical indication; revising admitting practices; employing "hard stop" processes to ensure that only elective deliveries with acceptable medical indicators are scheduled; and educating providers and patients. ***/2015/Among participating RPC hospitals, from September 2010 to February 2014 there was a 90%//2015//*** decrease in scheduled deliveries without medical indication; an 86 95% decrease in inductions; an ***/2015/88%//2015//*** decrease in c-sections; and, an ***/2015/84%//2015//*** decrease in primary c-sections. ***/2015/Among affiliate hospitals, there was an 83%//2015//*** decrease in scheduled deliveries without medical indication; an ***/2015/82%//2015//*** decrease in inductions; an ***/2015/84%//2015//*** decrease in c-sections; and, a 61% decrease in primary c-sections.

The Neonatal learning collaborative focuses on optimizing early enteral nutrition in preterm

babies in the NICU ***/2015/to reduce the incidence of postnatal growth restriction. Through participation in the collaborative, RPCs were asked to promote earlier initiation of feedings and attainment of full enteral feedings.//2015//*** The percentage of newborns discharged below the 10th percentile decreased from 32.6% in 2010 to ***/2015/28.3% in 2012//2015//*** without engendering harm. It ***/2015/is being expanded to include all interested Level III NICU hospitals in NYS.//2015//*** Ultimately, the goals of the Learning Collaborative are to improve care in the participating RPCs, as well as care in their affiliate hospitals. Both arms of the collaborative utilize data collected by DOH to analyze success in achieving collaborative objectives. RPC teams will learn and apply formal strategies to expand their findings from these QI projects to perinatal hospitals in their regions through the RPC QI role with their affiliate

B. State Priorities

As discussed previously, stakeholder perceptions of state priorities for the MCHBG five year needs were very aligned with priorities identified by the Department. The Department has already begun significant efforts to address these priorities.

The Department is very committed to reducing health disparities. This commitment is reflected in the priorities for the current 5-year MCHBG grant. Although health disparities have narrowed in several MCH performance areas, health disparities at unacceptable levels continue to persist. These disparities may be caused by a number of factors, including socioeconomic and environmental factors, barriers related to access and quality of care, differences in health literacy, immigration status, linguistic and cultural differences which create barriers to access to health care, health literacy, as well as a variety of other factors. Addressing these disparities must begin with data analysis at finer level of stratification, a process which is currently underway in the Department. Program services are increasingly targeted to communities with health disparities and poor outcomes. Programs must be representative of the communities they serve, both in terms of board members and staff that provide services. Existing programs are evaluated and modified if they are ineffective in addressing issues of health disparities. The following is a brief implementation status related to state priorities identified in the 2011 needs assessment.

1. State Priority: To improve access to early, adequate and high quality prenatal care, with a specific focus on eliminating health disparities - A major focus continues to be the expansion and enhancement of home visiting activities for high-risk pregnant women to improve birth outcomes, which includes a focus on identifying and engaging women early in pregnancy. ***/2015/In prior years,//2015//*** this effort has included a number of initiatives, including the DOH-developed Healthy Mom-Healthy Baby systems-building initiative supporting local health departments serving six highest need counties; the Community Health Worker (CHW) program that provides outreach and paraprofessional home visiting services to pregnant women at high risk for poor birth outcomes; and, the Nurse Family Partnership (NFP) programs in three high-need communities. NYSDOH was designated as the State lead and has developed a comprehensive, statewide needs assessment and state plan related to the provision of evidenced-based home visiting services in response to the Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visitation (MIECHV) implemented by HRSA ***/2015/In 2012,//2015//*** DOH developed a Request for Applications to develop contracts with agencies to establish Maternal and Infant Community Health Collaboratives (MICHC) in high-need communities to develop community-wide systems of integrated and coordinated evidence-based and/or best practice strategies targeted to high-need women and infants. ***/2015/In 2013, DOH awarded contracts to fund 22 MICHC projects in 33 high-risk counties to implement evidence-based &/or best practice strategies across the reproductive life course to improve maternal and infant health outcomes as well as 5 NFP and 5 HFNY programs in 6 high-risk counties.//2015//***. MCH staff program have worked closely with the Department's Office of Health Insurance Programs (OHIP) related to a Medicaid Redesign Team (MRT) proposal to expedite enrollment of MA-eligible women into managed care plans to promote earlier entry into prenatal care and increase utilization of care management for high risk women and to support and assess

implementation of comprehensive standards for MA prenatal care. Refer to NPM 18 for further information.

2. State Priority: To improve access to comprehensive, high quality primary and preventive health care for children and adolescents, consistent with the medical home model, including children with special heath care needs. There has been a significant expansion in health insurance eligibility for children in NYS, including expansion of Child Health Plus (NYS S-CHIP program) to 400% FPL in 2009 and expansion of Medicaid (MA) coverage for children aged 6 to 18 to 133% FPL in late 2011. Since 2010, NY has made incentivized payments to medical providers enrolled in MA for offering a higher level of coordinated primary care as recognized by the National Committee for Quality Assurance's (NCQA) Patient Centered Medical Homes (PCMH). In 2011, incentivized payments were offered to medical providers enrolled in CHPlus for offering PCMH. At the end of 2011, 97,000 children enrolled in CHPlus received their primary care from a PCMH. As of the third quarter of 2012, over 112,000 children in CHPlus received their primary care from a PCMH. ***/2015/A priority of the PA is to increase the percent of children enrolled in public health insurance managed care plans who receive their care through a PCMH. NY's health exchange became fully operational in October 2013.//2015//*** All MCHSBG-funded programs are expected to facilitate public insurance enrollment for eligible children ***/2015/and to refer families to DOH-funded Navigators to assist them in insurance enrollment when needed.//2015//*** The Title V CSHCN program provides grant funds to local health departments that include assistance in helping families of CSHCN who are uninsured or underinsured access health insurance, including Medicaid waiver programs. ***/2015/Title V staff will be submitting an application for HRSA's State Implementation Grants for Enhancing the System of Services for CYSHCN through Systems Integration to enhance the system of services that exist in NYS to improve a coordinated system for NY's CSHCN and their families.//2015//*** Title V staff have worked with OHIP to advance policies to improve access to health care for children and CSHCN, including participation in MRT efforts related to expansion of Medicaid Managed Care to additional MA-eligible populations (including children and youth in foster care); expanding the state's Patient-Centered Medical Home Program; and, implementing Health Home (enhanced care coordination services) for high-need MA enrollees, including the development of Child Health Homes. Title V staff facilitated meetings with partners to develop recommendations for pediatric Health Homes (HH) ***/2015/and continue to be engaged in these planning discussions.//2015//*** OHIP will utilize these recommendations as a basis for engaging additional stakeholder input and securing approval by CMS of enrollment of children in HH. The Title V program continues to operate the largest School-Based Health Center Program in the nation, with over 50 hospitals and community health centers sponsoring 218 clinics within schools across the state. Title V staff have implemented quality improvement initiatives related to improving pediatric care, including developmental screening, autism screening and follow-up, and blood lead screening.

3. State Priority: To eliminate disparities in birth outcomes especially with regard to low birth weight and infant mortality -- Improving birth outcomes requires a multi-pronged approach including clinical and community-based efforts. In the past decade, the NYSDOH MCH Program has worked to develop a highly structured, statewide system of regionalized perinatal care organized around regional perinatal centers (RPCs). RPCs provide care to the highest risk mothers and babies and provide quality improvement services to a network of affiliated hospitals offering varying levels of perinatal care. This year, the impact of perinatal regionalization on neonatal mortality among very low birth weight (VLBW) infants has been assessed. Regionalization has had a positive impact in NYS with VLBW babies more likely to be born at RPC and Level III hospitals and more likely to survive post-regionalization (2004-2006) than pre-regionalization (1996-2001) and have remained relatively consistent. NYS's risk-adjusted VLBW neonatal mortality rate declined from 13.03 per 100 during 1996-2001 to 10.63 per 100 during 2004-2009 ***/2015/and 10.5 per 100 during 2010 - 2012.//2015//*** Improvements were noted by region, NYC (13.45/100 to 10.81/100) and Rest of State (12.49/100 to 10.42/100), and hospital level, RPCs (12.52/100 to 9.86/100) and Level IIIs (13.41/100 to 11.22/100). NYS is first among 10 states that met the 2010 goal of 90% of VLBW infants delivered at a Level III or higher hospital

and remains significantly lower than the HP 2020 goal of 82.5%. NY's work in the MIECHV initiative other long standing community-based programs will support expansion of evidence-based home visiting services to improve birth outcomes. As part of the federal MIECHV initiative, DOH issued a RFA for the MIHI, to support community-based programs to improve maternal and infant health outcomes for high-need women and families and to reduce racial, ethnic and economic disparities in those outcomes. ***/2015/In 2013, DOH awarded contracts to fund 22 MICHC projects in 33 high-risk counties to implement evidence-based and/or best practice strategies across the reproductive life course to improve maternal and infant health outcomes as well as 5 NFP and 5 HFNY programs in 6 high-risk counties.//2015//***

4. State Priority: To prevent and reduce the incidence of overweight and obesity for infants, children and adolescents with a focus upon reducing health disparities - DOH also continued work on the Overweight and Obesity Prevention Program focused on increasing physical activity and improving healthy eating, including breastfeeding, among residents of NYS, with a primary focus on the prevention of childhood obesity. The program supports a variety of initiatives including, funding for three Centers for Best Practices to address age-specific overweight and obesity prevention issues and a statewide center and coalition for obesity prevention, healthy eating and active living (Designing a Strong and Healthy New York). In addition, a new initiative was developed, Creating Healthy Places that was designed to promote the implementation of policies, systems and environmental change that will create healthy places for people to live, work, and play. Nine new contracts have been established for obesity prevention systems change in pediatric primary care settings. Contractors will contribute to state and regional capacity building, collaboration and planning by networking with local health departments and groups implementing nutrition, physical activity and obesity prevention programs / interventions to facilitate patient / family referrals to existing community resources and improve self-management of obesity and/or obesity-related health conditions. Over the past year, over 70 contractors implemented evidence- based chronic disease prevention interventions promoting policy systems and environmental approaches to improve physical activity and nutrition for children and adolescents.

5. State Priority To reduce unintended pregnancies in adults and adolescents and improve adolescent sexual health and development, with a focus upon reducing health disparities - In January 2011, BMCH launched a new $17.5 million 5-year Comprehensive Adolescent Pregnancy Prevention CAPP initiative that includes a significant focus on implementation of evidence-based sexual health education and reducing racial and ethnic disparities. Grants were awarded to 50 community-based organizations that focus on the prevention of pregnancies, STDs and HIV among male and female adolescents ages 10 to 21 years. BMCH applied for and received federal funding for the Personal Responsibility Education Program (PREP) initiative which is closely aligned with CAPP and this funding supports additional awards to organizations that were approved but not funded under CAPP, as well as to supporting an enhancement project targeting youth in foster care. ***/2015/In 2013, CAPP and PREP programs provided services to over 25,000 adolescents.//2015//*** BMCH also applied for and received $2.99 million in federal funding for the Abstinence Education Grant Program (AEGP) which will support a new initiative that will fund community-based mentoring, counseling and adult supervision programs designed to delay the initiation of sexual behavior among young people, ages 9-12, residing in high-risk communities. The Successfully Transitioning Youth to Adolescents RFA was released in 2012 and 17 awards have been made. Through NY's Family Planning Program, funding was awarded in a competitive application to 49 agencies operating more than 200 clinic sites to provide comprehensive family planning and reproductive health care services targeted to the highest need communities and populations to address health disparities. Services were expanded to several locations in the state. In addition to the clinical programs, the State is also supporting a new Statewide Center of Excellence (COE) for Family Planning and Reproductive Health Services that will partner with the Department of Health to develop and promote a comprehensive system of high quality family planning services. A performance management initiative was implemented by DOH with the assistance of the FP COE, which provided training, education and technical assistance to 50 agencies on improving the percentage of clients leaving with an

effective contraceptive method. MCH Staff partnered with OHIP related to an MRT proposal to convert the state's programs that provide expanded access for family planning services from waiver programs to a State Medicaid plan service. DOH received CMS approval to transform the Family Planning Benefit Program and Family Planning Extension Program from 1115 waiver demonstration projects into MA State Plan services that includes presumptive eligibility for services, enabling clients to receive immediate access to services ***/2015/and ensures reimbursement to providers for provision of services while final eligibility is determined. Preliminary data indicate that the change has resulted in a significant increase in the number of people whose family planning (FP) services are covered through FPBP.//2015//***

6. State Priority: To reduce or eliminate tobacco, alcohol and substance use among children and pregnant women - NYS exceeds the Healthy People 2020 baseline and target goals of 26% and 21% respectively for this indicator. In 2010, 12.6% of high school students smoked cigarettes on one or more days during the past month (2010 YTS), compared to 2000, when 27.1% of high school students were smokers. ***/2015/From 2000 to 2012, use of any tobacco products for high school students has decreased by 33%.//2015//*** The statewide percentage of women smoking during the last 3 months of pregnancy declined dramatically statewide from 8.2% in 2008 to 6.9 6.2% in 20110. The New York Tobacco Control Program (NYTCP) approach to tobacco control is built on the social norm change model, in which reductions in tobacco use are achieved by creating a social environment and legal climate in which tobacco becomes less desirable, less acceptable, and less accessible. The success in reducing youth smoking is attributable to high tobacco product taxes, a statewide clean indoor air law, and DOH's comprehensive tobacco control effort. The program increases access to effective cessation services, including support for the NYS Smokers' Quitline, and supports media campaigns designed to increase public awareness of the dangers of tobacco use. NYTCP supports a range of local programs designed to build and support tobacco-free communities, including Reality Check, a youth engagement program which works to counter the tobacco industry influence in communities. Exposure to tobacco marketing in stores is a primary cause of youth smoking. Over the past year, NYTCP continues to focus on action to reduce the impact of tobacco industry marketing on youth. MA provides coverage for smoking cessation counseling for pregnant and postpartum women and adolescents to age 21.

7. State Priority: To improve oral health, particularly for pregnant women, mothers and children, and among those with low income - According to a Pew report titled The State of Children's Dental Health: Making Coverage Matter, New York State met five of eight policy benchmarks aimed at addressing children's dental health needs. The overall performance improved from a C grade in 2010 to a B grade in 2011. The Bureau of Dental Health (BDH) continues to grow its School-Based Health Center-Dental (SBHC-D) program, with programs in a quarter of high-risk schools offering preventive services. The Bureau awarded $1.5 million for 31 applications for preventive dental services in school-based/school-linked programs, with a primary objective to increase the prevalence of dental sealants in second and third grade children. BDH has completed the ***/2015/third//2015//*** year of the Oral Health, Physical Activity and Nutrition (OPAN) survey of 3rd grade children in upstate New York; over ***/2015/6,700//2015//*** 3rd grade children have been screened for this project to date. BDH collaborated with OHIP related to developing Medicaid reimbursement for physicians, dentists, and nurse practitioners for the application of fluoride varnish to teeth in children younger than 7 years of age. BDH is educating and encouraging medical providers to incorporate oral health screening, anticipatory guidance, caries risk assessment, and where indicated, the application of fluoride varnish into well child visits as a routine standard of care for children, including development of a partnerships between WIC and local pediatricians. A WIC Fluoride Varnish Pilot Project was initiated to assess the potential impact through this collaboration. The BDH assisted the New York State Oral Health Coalition in re-establishing its Prenatal/Perinatal Committee to improve oral health education for pregnant women. The MA Prenatal Care standards include a requirement that health care providers assess oral health and refer for services. BDH staff continue to collaborate with OHIP on a MRT proposals to support community fluoridation. ***/2015/Refer to SPM 7 for further information.//2015//***

8. State Priority: To eliminate childhood lead poisoning - The Department continues to address the problem of childhood lead poisoning through multiple primary and secondary prevention strategies. ***/2015/This includes//2015//*** the promotion of lead testing through linkage of lead registry with the NYS Immunization Information System (NYIIS). This linkage will reinforces and promotes timely lead testing by practitioners, and improve the Department's ability to survey screening rates, by allowing physician offices to review lead test histories for their patients, submit reports of point-of-care lead tests, receive automatic reminders for testing or follow-up, and access to reports that enable providers, plans and state and local health departments to assess lead testing practices and target quality improvement activities. NYSDOH has issued new guidelines for the blood lead testing of refugee children and pregnant women and updated guidelines for counseling, testing and follow-up of children and pregnant women. The reduction in Federal funding continues to present a significant challenge to NY's ability to address this priority

9. State Priority: To improve diagnosis and treatment of asthma in the maternal and child health population - DOH continued to fund 11 regional asthma coalitions across NYS with the goal of reducing asthma related morbidity and mortality. Resources supporting the RACs were re-distributed to target populations with the highest rates of asthma-related hospital discharge and ED visit rates. The coalitions, representing organizations that serve a pediatric population disproportionately affect by asthma, continue to implement and spread education and systems changes intervention through participation in the NYS Asthma Outcomes Learning Network (AOLN), a quality improvement initiative led by the NYS Asthma program, with assistance from the National Initiative for Children's Health Care Quality (NICHQ). Among teams measuring ED visits for asthma, all reported a decrease in the percentage of patients served who had had an asthma-related ED visit in the past six months. Managed care plans and health practices which provide benefits and services to African Americans with asthma are implementing interventions to improve asthma outcomes in the Eliminating Disparities in Asthma Care (EDAC) initiative. A partnership has been established to work on the development of culturally/linguistically appropriate mobile phone information systems to provide asthma self-management support to consumers. To increase access to quality asthma self-management support services, Medicaid has provided coverage for asthma self-management services when provide by a Certified Asthma Educator. DOH is leading an initiative to further develop the Certified Asthma Educator workforce and their integration into clinical practice, including an analysis to understand Certified Asthma Educator workforce supply. ***/2015/During the past year, the RACs conducted Asthma Education Institutes resulting in a 50% increase in the number of Certified Asthma Educators in NYS.//2015//***

10. State Priority: To increase the percentage of infants who are breastfed for at least six months - NY continues to make progress in the area of exclusive breastfeeding. ***/2015/Breastfeeding at 6 months increased from 47.7% in 2010 to 52.6% in 2013. Exclusive breastfeeding at 6 months increased from 13.7% in 2011 to 16.5% in 2013.//2015//*** Significant cross organizational efforts to improve breastfeeding rates continue, including promoting the development of Baby Friendly Hospitals and breastfeeding quality improvement in hospitals through a structured, data-driven, breastfeeding quality improvement learning collaborative, a joint initiative with the NICHQ. Twelve hospitals that provide maternity care services outside of NYC were recruited and have been engaged in the NYS Breastfeeding QI in Hospitals (NYS BQIH) Learning Collaborative. ***/2015/In 2013 DOH began Great Beginnings NY, The Future Starts with BF, which focuses on strategies to increase exclusive BF rates.//2015//***. NYCDOHMH also worked with 13 hospitals in NYC to improve support to breastfeeding mothers. DOH and Regional Perinatal Centers (RPCs) offered the 18 hour Ten Steps to Successful Breastfeeding Online course to staff in 125 obstetrical hospitals in NYS. ***/2015/2,345 individuals participated in this training over the past year.//2015//*** The NYSDOH WIC Program received a performance award of $1.6 million from the USDA to recognize its high rate of breastfeeding initiation. A statewide media campaign was funded, targeted to low income communities to increase awareness and support of breastfeeding, "Breastfeeding -For My Baby, For Me", which featured advertising via television, internet, bus shelters and bus interiors. Medicaid Prenatal

Care Standards, revised in 2010, required providers to counsel and educate women during prenatal visits and immediately postpartum regarding infant feeding choices. The Maternity Information leaflet, required by state law, provides patients information on maternity-related procedures performed at each hospital. The law has now been expanded to also require that information on infant feeding practices at each hospital be included in this publication. A priority of the MIHI ***/2015/ Collaboratives funded in 2013//2015//*** is to promote and support breastfeeding.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	88.5	89.4
Annual Indicator	88.1	86.8	86.8	98.8	97.9
Numerator	15853	3300	3300	2988	2906
Denominator	17985	3800	3800	3024	2967
Data Source	Newborn Screening	Newborn Screening	Newborn Screening	Newborn Screening	Newborn Screening
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	99	99	99	99	99

Notes - 2013
As shown in the table, the numerator is the number of closed cases with documentation of an evaluation, diagnostic testing and a diagnosis as appropriate. The denominator is the number of screen positive newborns for the year. The program follows all screen positive newborns to ensure they receive appropriate follow-up.

Notes - 2012
As shown in the above table, the numerator is the number of closed cases of screen positive newborns with documentation of an evaluation, diagnostic testing and a diagnosis as appropriate. The denominator is the number of screen positive newborns for the year. The program follows all screen positive newborns to ensure they receive appropriate follow-up.

The remaining open 2011 cases represent complicated patients with ongoing diagnostic evaluations. The Newborn Screening (NBS) Program has obtained confirmation that the patients are in care, but a definitive diagnosis is not available. The annual indicator improved significantly from 2010 to 2011 because routine meetings to review open cases were initiated. The number of lost-to-follow-up cases, where documentation of an ongoing evaluation, diagnostic testing and a diagnosis could not be obtained, remained consistent between 2010 (365 cases) and 2011 (381 cases).

2012 data is pending because the standard diagnostic evaluation for some of the disorders takes up to 6 months; therefore, the annual indicator would not be reliable if reported at this time. 2011 data are used as a proxy for 2012. 2012 data will be available in late 2013.

Notes - 2011
As shown in the above table, the numerator is the number of closed cases with documentation of an evaluation, diagnostic testing and a diagnosis as appropriate. The denominator is the number of screen positive newborns for the year. The program follows all screen positive newborns to ensure they receive appropriate follow-up.

The annual indicator is lower for 2010 than 2009 because in some cases, a definitive diagnosis is pending, but confirmation of an ongoing evaluation has been obtained by the Program. Lost-to-follow-up cases, where documentation of an evaluation, diagnostic testing and a diagnosis could not be obtained, remained consistent between 2009 (317 cases) and 2010 (365 cases). Therefore, it is anticipated that the annual indicator for 2010 will increase once the pending cases are resolved.

2011 data is pending because the standard diagnostic evaluation for some of the disorders takes up to 6 months; therefore, the annual indicator would not be a reliable if reported at this time. 2010 data are used as a proxy for 2011. 2011 data will be available in late 2012.

a. Last Year's Accomplishments
-Newborn screening (NBS) is performed by the state public health laboratory, Wadsworth Center at the DOH. In 2013, 238,412 infants were screened for 45 congenital conditions, including 30 core conditions, most secondary conditions, and HIV and Krabbe disease (both unique to NY). Screening for hyperammonemia/ hyperornithinemia/homocitrullinemia was suspended in 2012. The number of conditions rose to 46 when X-linked adrenoleukodystrophy (ALD) was added 12/30/13.
? Infants screened in 2013 were confirmed with the following conditions:
- 29 cases of amino acid disorders
- 11 cases of congenital adrenal hyperplasia
- 90 cases of primary congenital hypothyroidism
- 258 cases of hemoglobinopathies
- 27 cases of organic acid disorders
- 18 cases of fatty acid oxidation disorders
- 2 cases of biotinidase deficiency
- 34 cases of Cystic Fibrosis (CF)
- 2 cases of galactosemia
- 9 cases of T cell lymphopenia, including SCID*
- 2 infants were found to be at high risk for Krabbe disease.

-The NBS program followed all screen positive newborns to ensure they received appropriate follow-up. For each screen positive newborn, a phone call is made to the hospital of birth, primary care provider and appropriate specialist to report the abnormal screen. Specialists direct Specialty Care Centers (SCCs) that are approved and monitored based on established clinical standards. A follow-up phone call is made to the specialist 1 week after notification to ensure that the infant has been located. Over a 13-week period, 3 sets of forms are sent to the specialists, birth hospital and primary care provider to gather data on the outcome of the

diagnostic evaluation. A call is also made to the specialist four weeks after the newborn entered into care to determine the outcome of the diagnostic evaluation. When the final diagnosis is received, a review team meets to ensure that appropriate follow-up was done.
-The NBSP certifies SCCs for newborns with out of range test results.
-NBS educational materials were developed and maintained. The brochures "The Family Connection" for carriers of sickle cell trait and hemoglobin C trait were rewritten and redesigned.
-The "For Your Baby's Health" brochure was translated into Korean and Italian.
-An updated training video on proper specimen collection was made available to nurseries and clinical providers.
-Through the NY NBS and NY Mid-Atlantic Consortium for Genetic and Newborn Screening Services (NYMAC) websites, individuals can access educational resources about genetics services or specialty care or identify clinical services providers, support groups and other services.
-The NBS Program has 24 hospitals currently submitting demographic data electronically.
-The NBS Program developed an online tool for hospitals, health officers and specialists, called the internet case management system (iCMS). Currently, about 15 hospitals are routinely entering case updates into the system.
-One Cystic Fibrosis Specialty Care Center is piloting entering diagnostic data into the iCMS.
-A Severe Combined Immunodeficiency (SCID) diagnostic form has been created in the internet case management system.
-Prenatal Genetics Services were provided to 18,769 pregnant women in 2013. Clinical Genetics Services were provided to an additional 26,282 individuals through genetics services grantees in 2013 through genetic services grantees.
-NBS staff worked with Inherited Metabolic Disease (IMD) Specialty Centers, Endocrine Specialty Centers and Neurologists to develop diagnostic and follow-up algorithms for x-linked ALD.
-NBS staff worked with IMD Specialty Centers to define data elements for long-term follow-up of ALD.
-NBS staff developed, validated, and implemented a three tier assay to screen for ALD.
-The NBSP performed enzyme testing on dried blood spots for lysosomal storage disorders (Pompe disease, Fabry disease, Niemann-Pick Type A and B and Gaucher disease) as part of a subcontract for a pilot study for newborn screening for these disorders.
-Based on revised Hemoglobinopathy Specialty Care Center criteria, 8 existing and 2 new Centers were certified. Additional re-certifications are pending. Based on the new SCID Specialty Center criteria, one Specialty Center was certified and additional certifications are pending.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. In 2013, the NBS Program screened 238,412 infants for 45 congenital conditions. 482 babies were diagnosed with a condition.			X	X
2. The NBS program followed all screen positive newborns to ensure they received appropriate follow-up.	X	X		
3. The NBS Program developed standards for SCID. In 2013 1 new SCID and 2 new Hemoglobinopathy Centers were certified. Eight Hemoglobinopathy Centers were re-certified and 1 is pending re-certification.	X			X
4. Prenatal Genetics Services were provided to 18,769 pregnant women in 2013. Clinical Genetics Services were provided to an additional 26,282 individuals through genetics services grantees in 2013 through genetic services grantees.	X	X	X	X
5. Through the NY NBS and NYMAC websites, individuals can access educational resources about genetics services or		X	X	X

specialty care or identify clinical services providers, support groups and other services.				
6. NBS staff worked with Metabolic Specialty Centers, Endocrine Specialty Centers and Neurologists to develop diagnostic and management protocols for X-linked ALD.			X	X
7. NBS staff worked with IMD Specialty Care Centers to define data elements for long-term follow-up of X-linked ALD.			X	X
8. The NBS Program implemented ALD screening.	X		X	X
9. The NBS Program screened DBS for lysosomal storage disorders as part of a pilot study.	X		X	X
10. The NBS Program implemented iCMS.	X	X	X	X

b. Current Activities

-Wadsworth Center conducts bloodspot screening on 100% of suitable specimens from NY's newborns for 46 conditions. Almost 98% of referred infants are followed to confirmation. This figure fluctuates from year to year due to the considerable time it takes for follow-up to better ensure diagnosis and follow-up.
-The NBS Program is reviewing unresolved cases to discuss ways to increase the percent of infants who receive timely follow-up.
-There are currently 23 active genetic grant awards.
-NY houses and is a member of NYMAC for Genetic and Newborn Services.
-The NBS Program is piloting the SCID diagnostic form in iCMS.
-The NBS Program required turn around time plans from each hospital in an effort to ensure specimens are received within 48 hours.
-The NBS Program communicates unsuitable specimen rates to birth hospitals quarterly; works to make improvements
-The NBS Program is working to implement statewide screening for Pompe disease.
-The NBSP website (www.wadsworth.org/newborn) is currently undergoing a content and design update.

c. Plan for the Coming Year

-The NBS Program will continue to screen all newborn blood spots that are received in suitable condition.
-Education and outreach to decrease the number of samples received that are unsuitable will continue.
-The program will continue to ensure appropriate follow-up of all screen positive newborns.
-We will continue to develop methodology for second tier genetic testing for hemoglobinopathies.
-The Program will also continue to work with the Association of Public Health Laboratories' quality improvement initiative, Newborn Screening Technical assistance and Evaluation Program to evaluate new diagnostic criteria for endocrine disorders and cystic fibrosis in conjunction with the specialty care centers.
-Staff will also continue implementation of the internet case management system for remote diagnostic entry with CF Specialty Centers, SCID Specialty Centers and IMD Specialty Treatment Centers.
-Article 28 hospitals will be monitored for their success as SCCs.
-The NBS Program will implement long-term follow-up for SCID, fatty acid oxidation disorders and ALD.
-Starting July 1, 2014 NY will provide grant awards to 22 genetic centers across NY to provide diagnostic services, laboratory testing, genetic counseling, and referral to treatment centers. These awards are based on a request for applications distributed October 31, 2013.
-Individuals concerned with genetics or specialty care can access educational resources or identify clinical services providers, support groups and other public health resources through both the NY NBS and NYMAC websites: www.wadsworth.com/newborn; www.wadsworth.org/newborn/nymac.

-The NBS Program will continue to send out quarterly reports for turnaround times and unsuitable specimens.
-The NBS Program will work with United Parcel Service (UPS) to reduce transport issues impacting the timely receipt of specimens. The NBS Program will implement the use of UPS quantum View to monitor the status of inbound specimen envelopes.
-The NBS Program will continue to work with hospitals and birthing centers to insure the timely receipt of specimens. The Program will work with UPS to provide hospitals with the UPS CampusShip product in order to enhance tracking of hospital shipments.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**238412**					
Reporting Year:	**2013**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	238412	100.0	33	22	22	100.0
Congenital Hypothyroidism (Classical)	238412	100.0	580	291	291	100.0
Galactosemia (Classical)	238412	100.0	9	2	2	100.0
Sickle Cell Disease	238412	100.0	114	113	113	100.0
Biotinidase Deficiency	238412	100.0	2	1	1	100.0
Cystic Fibrosis	238412	100.0	893	35	35	100.0
Homocystinuria	238412	100.0	3	0	0	
Maple Syrup Urine Disease	238412	100.0	6	3	3	100.0
Other	238412	100.0	46	53	53	100.0
Tyrosinemia Type I	238412	100.0	5	3	3	100.0
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	238412	100.0	5	1	1	100.0
Isovaleric Acidemia	238412	100.0	6	0	0	
Carnitine Uptake Defect	238412	100.0	10	0	0	
3-Methylcrotonyl-	238412	100.0	29	12	12	100.0

CoA Carboxylase Deficiency						
Multiple Carboxylase Deficiency	238412	100.0	63	6	6	100.0
Glutaric Acidemia Type I	238412	100.0	7	0	0	
Isobutyryl-CoA Dehydrogenase Deficiency	238412	100.0	10	6	6	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	238412	100.0	243	10	10	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	238412	100.0	21	14	14	100.0
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	238412	100.0	2	0	0	
Methylmalonic Acidemia (Mutase Deficiency)	238412	100.0	2	2	2	100.0
Hemoglobin C Disease	238412	100.0	25	22	22	100.0
Malonic acidemia	238412	100.0	2	2	2	100.0
Krabbe Disease	238412	100.0	44	2	2	100.0
Severe Combined Immunodeficiency	238412	100.0	233	34	34	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60	62	59.6	65.7	66.3
Annual Indicator	59	59	64.4	64.4	64.4
Numerator					
Denominator					
Data Source	CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving					

average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	67	67.6	68.3	69	69

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
-According to the 2009-2010 National Survey of Children with Special Health Care Needs (NSCSHCN), 64.4% of NY families of CSHCN report they are partners in shared decision making about their child's health and are satisfied with the services they receive.
-NYS is committed to family engagement in their child's care and satisfaction with this care at the individual and community level. DOH promotes shared family professional decision making through medical homes and public health program activities. In the Early Intervention Program (EIP), families were engaged in decision making through Individual Family Service Plans (IFSP); the IFSP identifies families' concerns, priorities, and objectives for their child's development.
-The New York Children with Special Health Care Needs (NYCSHCN) Program provides contracts to 55 local health departments (LHDs) to provide families of CSHCN with assistance in navigating systems of care.
-One of the NYCSHCN Program's goals for contractors is to perform program activities that are responsive to the needs of families and youth in their locality. Local CSHCN Programs are asked to elicit family and youth satisfaction with services provided by their programs using a standardized survey tool. The NYCSHCN Program's goal was to receive 10 completed surveys per locality, or a state cohort of over 500 responses. While this goal was not met, the program received 304 survey responses, of which 287 were complete enough to use for data analysis purposes.
-In 04/13, the NYCSHCN Program assessed the survey response rate for each locality.

Individualized reports were created and shared with local NYCSHCN Programs together with a tailored email either congratulating them on their performance or notifying them of the need to improve their performance. Those local contractors needing improvement were asked to provide an explanation of their process for obtaining family input to and received technical assistance from NYCSHCN staff as needed or desired.
-In 03/13 and 04/13, NYCSHCN Program staff distributed NYS Parent to Parent (P2P) information links to local NYCSHCN Programs to share with families. These website links are a wealth of information about insurance, empowerment and family support for families of NYCSHCN. P2P is an organization for parents with CHSHCN that helps them gain knowledge of care service systems.
-The Resource Directory for NYCSHCN is posted on the DOH website and distributed free of charge to consumers and providers.
-Hands & Voices (HAV) of NY, a chapter of the national HAV organization, continues to grow. This parent-professional collaborative offers support to families of children with significant hearing loss regardless of the communication modality the family chooses for the child. NY HAV's Advisory Board has parent representatives. The DOH Early Hearing Detection and Intervention Program provided seed money to establish the chapter but since that initial startup, the chapter has been self-sustaining. The chapter achieved 501(c) (3) status and recently received approval for permanent chapter status from the national organization. The Early Hearing Detection and Intervention Advisory Board includes parent representatives.
-Family members were active participants in the Maternal and Child Health Services Block Grant Advisory Council, state Early Intervention Coordinating Council (EICC), and the Navigating Multiple Systems Advisory Group. There are five parent positions on the EICC. Currently four are filled and one is vacant.
-Title V staff participated in Medicaid (MA) redesign discussions with OHIP that relate to NYCSHCN and Health Homes.
-The Office of Health Insurance Programs (OHIP) is the lead for the planning for and implementation of the expansion of children's Health Homes. Title V staff met with OHIP staff to transition the leadership role and will continue to be active participants in development of Health Homes expansion for children.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 55 local NYCSHCN Programs work with families to identify and refer them to appropriate services for their child and assist in navigating systems of care. Local NYCSHCN program staff also assess family satisfaction with LHD services.		X		X
2. DOH promotes shared family professional decision making through medical homes and public health program activities.		X		X
3. Early Intervention Program (EIP) families were engaged in decision making through IFSPs; the IFSP identifies families' concerns, priorities, and objectives for their child's development.	X			X
4. Family members were active participants in the Maternal and Child Health Services Block Grant Advisory Council, state Early Intervention Coordinating Council and the Navigating Multiple Systems Advisory Group.				X
5. Title V staff participated in Medicaid (MA) redesign discussions with OHIP that relate to NYCSHCN and Health Homes.				X
6. HAV of NY a chapter of the national organization, continues to grow. This parent-professional collaborative offers support to families of children w/significant hearing loss regardless of		X		

communication modality family chooses for the child.				
7. LHDs perform NYCSHCN Program activities that are responsive to the needs of families and youth.		X		
8. The Resource Directory for NY CSHCN is posted on the DOH website and distributed free of charge to consumers and providers.			X	
9. NYCSHCN Program staff distributed NYS P2P information links to local CSHCN Program to share with families.			X	
10. Title V staff met with OHIP staff to transition the leadership role and will continue to be active participants in development of Health Homes expansion for children.				X

b. Current Activities

-Staff analyzed family satisfaction data for local NYCSHCN services. Local reports were created to provide feedback about how services have been helpful or need to improve. 16% of programs met the 10 completed survey target; up from 14.5% last year. The percentage of programs with < 5 responses at 6 months that improved their performance after a reminder is 11%. 96% of respondents were either very satisfied/satisfied with services and 4% were not satisfied/somewhat satisfied. Families reported on the benefits of finding help with services; receiving information about community programs; and having staff connect them with insurance and/or waiver programs and securing appointments when they were having difficulty.
-NYCSHCN funds paid for family attendance at workshops/meetings to support families as partners in decision making. Meeting topics included autism/behavioral disorders, advocacy and family support. A local program provided no cost CPR training for parents.
-NY HAV will provide the EHDI Program with updates including achieving permanent Chapter status and increased membership. NY HAV has achieved permanent chapter status. Increased membership is a goal identified by the Executive Board in the 2014 Strategic Planning meeting.
-Title V continues to seek opportunities to involve families in decisions impacting supports and services. A Family Voices representative attended the 2014 AMCHP conference. Title V provided a letter of support for the Family Scholar.

c. Plan for the Coming Year

-The NYCSHCN Program will continue its quality improvement efforts by sharing local data with local contractors. Efforts to elicit more family satisfaction survey responses will take the form of email and telephone technical assistance. The program is considering adding a reminder to local contractors at the 11 month mark of the FFY to solicit more responses before the survey closes. The results of the survey continue to be utilized to assess how responsive local NYCSHCN Programs are to the needs of families.
-NY HAV will continue to promote and expand membership across NYS.
-The program will continue to support parent membership on the Early Hearing Detection and Intervention Advisory Board. The NY HAV Advisory Board will continue to have two parent representatives.
-Title V staff will be submitting an application for HRSA's State Implementation Grants for Enhancing the System of Services for CYSHCN through Systems Integration to enhance the system of services that exist in NYS to improve a coordinated system for NY's CSHCN and their families.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	46	48	45.7	39.2	39.6
Annual Indicator	45.2	45.2	38.4	38.4	38.4
Numerator					
Denominator					
Data Source	CSHCN survey	CSHCN survey	CSHCN survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	39.9	40.3	40.7	50.1	50.4

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used

to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments

-2009-2010 data from NSCSHCN indicated that 38.4% of families report their children receive coordinated care within a medical home. NYS's policy & program efforts have remained strong in this area. It is anticipated that the number of Children & Youth with Special Health Care Needs with medical homes will continue to grow & that the next NSCSHCN survey will reflect these efforts.
-Over 5 million enrollees & 13,000 primary care providers participate in NYS's Medicaid (MA) program. Given these large numbers, MA has the ability to make a significant contribution to improving New Yorkers' health through better coordination & integration of care.
-NYS's incentive programs demonstrate its commitment to providing a medical home for MA enrollees. Since 2010, NYS has made incentivized payments to MA medical providers who offer a higher level of coordinated primary care as recognized by the National Committee for Quality Assurance's Patient Centered Medical Home (PCMH). Payments are made either through increased capitation of MA Managed Care (MMC) plans or fee-for-service PCMH "add-ons" for qualifying visits. Nearly 4,500 NYS providers are recognized by NCQA as PCMH, the largest number in any state.
-The number of MMC enrollees increased from 1,395,000 in 06/12 to 1,439,000 in 06/13. As of 6/30/13, 40% of MMC members were assigned to a PCMH-recognized primary care provider as compared to 39% in 06/12. 49% of those MA enrollees assigned to PCMH in 06/13 were children under 21 years. This percentage represents a slight increase from 48% seen in 06/12. About 76,210 unique MA fee-for-service enrollees had a qualifying visit that triggered an add-on payment with PCMH-recognized providers.
-In 2011, NYS incentivized payments to medical providers enrolled in Child Health Plus (CHPlus) (NYS's CHIP) for offering PCMH. At the end of 2011, 97,000 children enrolled in CHPlus received their primary care from a PCMH. As of the 2nd quarter of 2013, over 104,431 children in CHPlus received their primary care from a PCMH. The penetration rates of CHPlus enrollees in PCMH increased from 32% in 2011 to 36% in 6/30/13.
-During Summer/Fall 2012, Title V staff participated with other DOH staff, Office of Persons with Developmental Disabilities staff, pediatric specialty providers & family representatives to develop recommendations for a report to the Governor & legislature on Medically Fragile Children (MFC). The report, released in 02/13, addressed MA payments to certain pediatric providers who serve MFC; appropriate models of care coordination for MFC; & the transition of the pediatric nursing home benefit & population to managed care. The report recommended utilizing the Health Home (HH) model to provide care coordination for MFC, & prioritizing assignment of children who are eligible for HH services but not currently receiving care coordination services.
-Local Health Departments (LHD) receive funds to administer local CSHCN Programs. A work plan responsibility includes an assessment for the presence of a primary provider & health insurance. LHDs report this data quarterly to NY.
-NYS completed its statewide 2011-2012 CSHCN Program report based upon LHD data. In 07/13, Title V staff provided an overview of statewide 2011-2012 CSHCN data to local contractors. Local contractors had improved in the completeness of reporting regarding status of primary care provider for each child. Staff continue to monitor progress in this area through the review of quarterly reports.
-The Early Intervention Program (EIP) assesses the presence of a primary provider at referral & at Individualized Family Service Plan (IFSP) reviews & assists with linkages for insurance coverage as necessary. EIP provided training & education to physicians on early identification of infants & toddlers with conditions such as hearing loss & autism spectrum disorders & the importance of referrals to early intervention & ongoing involvement in children's & family's IFSP.
-The Office of Health Insurance Programs (OHIP) has taken the lead in developing programmatic

recommendations for enhancing pediatric enrollment in HH. Prior to the transfer of administrative responsibility, Title V staff discussed a set of programmatic recommendations with Executive staff in Public Health & OHIP. OHIP will utilize these recommendations as a basis for engaging additional stakeholder input & securing approval by Centers for Medicare & MA Services of enrollment of children in HH.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. DOH will promote and maintain patient centered medical homes in MA and CHPlus.	X			X
2. OHIP has taken the lead in developing programmatic recommendations for enhancing pediatric enrollment in HH. Title V staff developed programmatic recommendations and will collaborate with OHIP for development of health homes for children.				X
3. NYS's incentive programs demonstrate its commitment to providing a medical home for MA enrollees. NYS has made incentivized payments to MA and CHPlus providers who offer a higher level of coordinated primary care.			X	X
4. Title V staff participated with DOH and Office of Persons with Developmental Disabilities staff, pediatric specialty providers & family representatives to develop recommendations for a report on Medically Fragile Children.				X
5. LHDs receive funds to administer local CSHCN Programs. A work plan responsibility includes an assessment for the presence of a primary provider & health insurance. LHDs report this data quarterly to NY		X		
6. The EIP assesses the presence of a primary provider a referral and at IFSP reviews & assists with linkages for insurance coverage as necessary.		X		
7. EIP provided training & education to MDs on early identification of infants & toddlers with conditions such as hearing loss & autism spectrum disorders & the importance of referrals to early intervention & ongoing involvement in the IFSP.				X
8.				
9.				
10.				

b. Current Activities

-NYS continues to fund LHDs to administer local CSHCN Programs in 54 of 58 counties. Assessing for the presence of a primary provider and health insurance for each child served by the program continues as a work plan responsibility for LHDs. Title V staff will continue to monitor quarterly reports submitted by local programs for sustained activities to promote a child's connection with insurance and a medical home.

-Title V staff completed its annual report of 2012-2013 local CYSCHN Program data. The percentage of CYSHCN reported by local CSHCN Programs to have a primary care provider has improved from 87% in FFY 2012 to 89% in FFY 2013.

-Title V continues to be actively involved in HH policy development activity through input provided at meetings and conference calls hosted by OHIP.

-The EIP continues to assess the presence of a primary provider at referral and at IFSP reviews and assists with linkages for insurance coverage as necessary.

c. Plan for the Coming Year
-NYS Title V will continue to discuss plans regarding funding of the local CSHCN Programs.
-Assessing for the presence of a primary provider and health insurance for each child served by the program will continue as a work plan responsibility for LHDs. NY Title V will continue to monitor progress in this area through the review of quarterly reports.
-NYS will continue to provide incentives to medical providers to expand MA/CHPlus enrollees who receive care in National Committee Quality for Quality Assurance (NCQA) PCMH.
-Title V staff will continue to be involved with the OHIP in policy efforts for HH for children.
-Bureau of Early Intervention staff will identifying ways to continue physician training and education activities, including potential resources to support this work.
-Title V staff will be submitting an application for HRSA's State Implementation Grants for Enhancing the System of Services for CYSHCN through Systems Integration to enhance the system of services that exist in NYS to improve a coordinated system for NY's CSHCN and their families.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	64	64	62.7	57.9	58.5
Annual Indicator	62.1	62.1	56.8	56.8	56.8
Numerator					
Denominator					
Data Source	CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	59.1	59.6	60.2	60.7	61.6

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. Due to the data generated by the new survey, previously established performance objectives prior to 2011 are not realistic and targets for upcoming years were decreased. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
-According to national survey data (NSCSHCN 2009-2010), approximately 8% of NYS families of Children with Special Health Care Needs (CSHCN) reported their child was uninsured at some point during the year. Thirty-eight percent of NYS families reported their insurance coverage was inadequate to meet their child's needs. Any gap in health insurance coverage poses significant threats to the health and well-being of a CSHCN.
-NY funds 55 Local Health Departments (LHD) to administer local CSHCN Programs. A key work plan deliverable for these local programs is to assess a child's insurance status and to refer uninsured children to insurance and appropriate gap filling services. In FFY 2012-2013, 5% of children were reported as without insurance upon initial assessment. This percentage has remained stable when compared to the 5% rate of uninsured Children and Youth with Special Health Care Needs (CYSHCN) in the 2011-2012 data. However, significant improvement of LHDs' efforts to refer and document referrals of uninsured children occurred. The documented rate of referrals went from 71% in 2011-2012 to 96 % in 2012-2013. This change may have been the result of quality improvement efforts made by NYS and local CYSYCN Programs over the last year. During a 07/13 webinar about 2011-2012 CYSHCN data, the importance of insurance status documentation and referral was discussed amongst state and local CYSHCN staff.
-During the initial encounter with families of CSHCN, local CSHCN Program staffs inquire about the child's insurance status and the type of financial assistance needed for their child. Local staffs refer families to health insurance, cash assistance programs and gap-filling programs. In FFY 2012-2013, 643 NYS families of CSHCN who contacted a local program responded to this question about the type of financial assistance needed. The most common reasons families reported for requesting financial assistance are: the service or item was not covered by their insurance (71.9%); need help with copayment (13.3%); need help with item or service that exceeds the benefit amount (11.0%); need help with deductible (2.5%); and need help with insurance premium (0.8%.)
-The Resource Directory for CSHCN, a comprehensive document for consumers and providers about state financial assistance programs and support is displayed on the DOH website in English and seven other languages, is available on the DOH website.
-In keeping with an Executive Order that ensures language access is implemented for essential public documents, the Resource Directory was translated into three additional languages (Korean, Polish and Italian) and updates were made to the English, Spanish, Chinese, French and Russian versions.
-The Bureau of Early Intervention's (BEI) NYS Early Intervention Program (EIP) provided

comprehensive services, including services coordination, to infants and toddlers with developmental delay or disabilities. A child's insurance is billed first for these services when policies are subject to state insurance law; if the child's insurance is inadequate or unavailable, the locality provides payment for the authorized services with a 49% share reimbursement from the State. Approximately 70,000 children and families received early intervention services in FFY 2012-13.
-The NYS Physically Handicapped Children's Program (PHCP) provides reimbursement to providers for diagnostic evaluations and state aid reimbursement to localities for gap filling medical and dental treatment services provided to children age birth to 21 years. This program assists families of CSHCN pay for services that health insurance does not cover or partially covers and provides payment if the child is uninsured. Continued declining participation by LHDs in this voluntary program & benefits of health care reform have lessened the need for this public program for some families. Other families continue to contact the program about high out-of-pocket expenses such as copayments & deductibles.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. NY funds 55 local CSHCN Programs to provide information and referral services to assist families to locate insurance and/or financial assistance.		X		X
2. Families of CSHCN stated the most common reasons for asking for financial assistance: service/item wasn't covered by insurance, or they needed help with the copayment, the item/service exceeding benefit amount, the deductible, or the premium		X		
3. NY PHCP provides reimbursement to providers for diagnostic evaluations and state aid reimbursement to localities for gap filling treatment services.		X		
4. The Resource Directory for CSHCN is available to consumers and professionals on the DOH web site for information about state financial assistance programs and supports for families.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
-NYS funds LHDs to support 54 local CSHCNPs.
-In 2013, 157 children received a diagnostic evaluation & 657 received treatment services through PHCP. Major service categories & % of funds expended are orthodontia: 75%; medications: 9%; medical-surgical supplies: 3%; durable medical equipment: 3%; & hearing aids: 2%.
-CSHCNP recommended that Office of Health Insurance Programs include a definition of pediatric medical necessity to strengthen NYS's Qualified Health Plans.
-Effective 4/01/13, under reforms enacted with NYS's 2012-13 budget, BEI transitioned fiscal management of the EIPs from local governments to DOH's State Fiscal Agent (SFA), including termination of local contracts with service providers & establishment of State-agreements with them. SFA manages claiming of commercial insurance & Medicaid on behalf of providers, who receive payment directly from these payers. Families receive EIP services free; if insurance is unavailable or inadequate to cover EIP services, providers are paid from an escrow account

funded by local governments with 49% reimbursement to localities for the State share.
-Effective 1/1/14, insurance law requires insurers to cover Diagnostic & Treatment services for individuals of all ages with autism spectrum disorders, including Applied Behavior Analysis (ABA) services. BEI collaborated with Department of Financial Services on emergency regulations establishing standards for EIP providers of ABA services to ensure coverage for these services.

c. Plan for the Coming Year
-A limited printing of The Resource Directory for CSHCN will be considered for those families who may not have Internet access.
-Title V staff will encourage LHDs to assist families of CSHCN to understand eligibility for public insurance programs, and to link families with facilitated enrollers and the NY web eligibility determination tool and application.
-Title V staff will continue to monitor program data and provide technical assistance to local staff to ensure all uninsured children are referred to the health insurance exchange or available gap-filling programs.
-Title V staff will continue to participate in Medicaid redesign efforts involving children, including those with special health care needs.
-EIP will continue to provide comprehensive services, including services coordination, to infants and toddlers with developmental delays or disabilities. BEI will continue to work with its SFA and EIP providers to claim third party payers for EIP services and to increase reimbursements from these payers.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	92	92	91.5	66.9	67.6
Annual Indicator	90.6	90.6	65.6	65.6	65.6
Numerator					
Denominator					
Data Source	CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	68.2	68.9	69.5	70.2	70.2

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001

CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. Due to the data generated by the new survey, previously established performance objectives prior to 2011 are not realistic and targets for upcoming years were decreased. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
-In the 2009-10 NSCSHCN, NYS scored slightly higher than the national average of 65.1%. Almost sixty-six (65.6%) percent of NYS families reported they can easily access community-based services. However, there is room for significant improvement in family satisfaction with access to services. Beginning in 2012 and continuing each federal fiscal year, the Children with Special Health Care Needs (CSHCN) Program asks families via a survey monkey tool about their experience with local CSHCN Program services.
-DOH provides grants to 55 local CSHCN Program contractors to help families access services for CSHCN from birth to 21 years of age. Local program staff link families to appropriate state and community health-related programs and services and help identify and resolve gaps and barriers to care for CSHCN. The programs received year four funding in a five year funding cycle.
-The work plan requirements for local CSHCN programs are standardized to assure that all contractors are addressing a core set of program requirements. The local program requirements are closely aligned with the maternal and child health core outcomes.
-DOH provided funding to 55 local health departments (LHDs) to provide preventive outreach and education and to coordinate follow-up of medical, educational and environmental services for children identified with lead poisoning.
-DOH is developing a process to enhance enrollment of children and youth with special health care needs (CYSHCN) into Health Homes. Currently, only children with HIV/AIDS are enrolled in Health Homes (HH). As CYSHCN are enrolled in HH, case managers will help families navigate the health care system and access services for their child.
-The Early Intervention Program (EIP) provided service coordination to approximately 70,000

infants and toddlers and their families.
-The Bureau of Early Intervention (BEI) conducted an annual Family Survey (FS) to determine the extent to which early intervention services help families to achieve desired outcomes for their child and family, including the extent to which families are able to access and participate in community services and the extent to which early intervention services assist families in communicating their child's and family's needs to service providers. The annual FS includes an Impact on Families scale designed to measure the extent to which families perceive EIP services to be helpful to achieve three specified outcomes related to knowing their rights, helping them communicate their child's needs, and helping their child to develop and learn. Of the 227 families who responded to the survey, 70.4% indicated that participating in early intervention services (EIS) has helped their family know their rights; 68.2% stated that participating in EIS has helped their family effectively communicate their child's needs; and 78.85% responded that participating in EIS has helped their family help their child to develop and learn.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. DOH provided funding to 55 LHDs for the CSHCN Program to link families to state/community health programs and services, and to identify and resolve gaps/barriers to care for children ages 0-21 years.		X		X
2. The CSHCN Program uses a standardized work plan for the CSHCN Program to assure all contractors are attesting to and working on a core set of program requirements.				
3. DOH provided funding to 58 LHDs for administration of the EIP.		X		X
4. The EIP provided service coordination to approximately 71,000 infants and toddlers and their families.		X		
5. The BEI conducted an annual FS to determine the extent to which early intervention services help families to achieve desired outcomes for their child and family				X
6. DOH is developing a process to enhance enrollment of CYSHCN into health homes.		X		X
7.				
8.				
9.				
10.				

b. Current Activities
-Title V analyzed FS data about local CSHCN services. Families were asked "How easy is it to get information & help from CSHCN staff when needed?" 85% stated always easy; 16% stated sometimes easy & almost 1% stated never easy. Title V provided contractors with 2112-2013 mid-year summary data as part of quality improvement,
-Title V analyzes data trends for gaps & barriers. A 2012-13 CSHCN data report showed that almost 75% of children with a dental diagnosis had Child Health Plus (CHPlus) which has limited orthodontia services. Title V staff recommended that DOH modify its Qualified Health Plan benefits to cover orthodontia at the more comprehensive Medicaid (MA) level.
-Title V staff participate in the MA Redesign process for enrollment of children in HH.
-Title V & Family Voices participate on NYS's Navigating Multiple Systems (NMS) Advisory Council which provides input to the NMS project to develop a statewide cross-systems website for families & consumers about services, programs & supports.
-EIP provided service coordination for referred & eligible infants & toddlers & their families.
-BEI conducted its annual FS.

-BEI completed data collection for its HRSA Maternal and Child Health Bureau study to evaluate the impact of early intervention services on children & families with autism spectrum disorders & their families. Data analyses will examine the extent to which factors such as access to community services contribute to improved child & family outcomes.

c. Plan for the Coming Year

-Title V staff will continue to collaborate with the Office of Health Insurance Programs in the implementation of Children's HH to enhance coordination of care for CSHCN.
-Title V staff will participate in an interagency children's Behavioral Work Group that is considering recommendations for the transition of children with mental health/substance abuse conditions into managed care.
-Title V staff will continue to monitor progress towards removal of barriers to care for CSHCN and transmit information to appropriate DOH staff and other state agencies to improve the systems of care.
-Local CSHCN Programs will continue to assess family satisfaction with services. Title V staff will continue to analyze data and provide summary data to localities to assist with quality improvement.
-Early intervention service coordination will continue to be provided to those children referred and found eligible for the EIP.
-The Bureau of Early Intervention, under requirements for the State Performance Plan/Annual Performance Report, will be completing extensive data analyses for the new C-11 indicator, State Systemic Improvement Plan. The purpose of the analysis is to identify factors that contribute to achievement of outcomes for infants and toddlers participating in the program. Data from the annual family survey, including the family-centered services scale and access to community services, will be analyzed to identify factors that contribute to achievement of outcomes for infants and toddlers as a result of receiving early intervention services.
-Title V staff will be submitting an application for HRSA's State Implementation Grants for Enhancing the System of Services for CYSHCN through Systems Integration to enhance the system of services that exist in NYS to improve a coordinated system for NY's CSHCN and their families.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	40	40	38.8	40.5	40.9
Annual Indicator	38.4	38.4	39.7	39.7	39.7
Numerator					
Denominator					
Data Source	CSHCN survey	CSHCN survey	CSHCN survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving					

average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	41.3	41.7	42.1	42.3	42.3

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

CDC current schedule for the next data collection of these data are in 2014.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator the 2009-10 survey. Therefore, the 2005-06 and 2009-10 surveys can be compared. Due to NY's success in achieving this performance measure, the annual performance objective has been increased over previously established targets. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. 2011 data is being used as a proxy for 2012.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
-NYS's performance on this core measure is equal to the national performance of 40%. Efforts continue on the state Title V and local level to address this important area for Children and Youth with Special Health Care Needs (CYSHCN). The Title V staff are part of the state Navigating Multiple Systems Advisory Group. The Advisory Group is chaired by the state Council on Children

and Families for the purpose of providing input into the development of a comprehensive website for consumers and those professionals assisting families and individuals who are navigating multiple systems. A key project goal is to "reduce frustration faced by family members, caregivers and youth requiring services and supports from multiple systems (e.g. mental health, education, substance abuse etc.) by providing necessary information at times of greatest need for information." Transition information is acknowledged as being an important topical area.
-Fifty-four (54) Local Health Departments receive grant funds to administer a local Children with Special Health Care Needs (CSHCN) Program that assists children, adolescents and families in obtaining information and referrals they need. The CSHCN Program work plan for local contractors includes a transition goal, objectives, and activities. Helping families with transition issues, including providing appropriate information related to maintaining and seeking health insurance for the young adult and accessing supports, is an important part of the work of local contractors.
-Several localities held workshops on the topic of transition. In 11/2012, one of the local CSHCN contractors in the metropolitan area held a forum on "Transitioning Pediatric to Adult Health Care." Feedback from attendees at this meeting indicated that 100% of the participants learned new skills to help manage health care transition; increased their knowledge of resources and tools for transition planning; and felt more prepared as a parent for their child's transition out of school. In 05/2013, a rural county hosted two transition workshops entitled Transition 101 and Transition 201.
-In 01/2013, Title V staff hosted a webinar on health care transition resources for local CSHCN Program staff. A parent partner from the Family to Family Health Information Center of NYS Parent to Parent was the featured speaker. Fifty-four per cent of webinar participants responded to the evaluation survey. One hundred percent of these respondents indicated that the webinar increased their knowledge on health care transition resources for young adults with special health care needs.
-The hand-held portable health summary Health Information Document (H.I.Doc) developed by Title V Program staff and Youth Champions is available through the DOH Distribution Center for use by consumers and providers. Local CSHCN Programs are required to provide the transition tool to youth ages 14 or older and their families who contact their local CSHCN Program.
-The Office of Health Insurance Programs (OHIP) is taking the lead in the development of recommendations for pediatric Health Homes. Title V staff regularly provide input to OHIP during intra-agency planning discussions and meetings with external stakeholders.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The work plan for 54 local health department CSHCN Program contractors includes transition activities as a required deliverable.		X		X
2. The hand-held portable health summary continue to be available through the DOH Distribution Center for consumers and providers.			X	
3. Title V staff are involved in development of recommendations for pediatric Health Homes.	X	X		X
4. Title V staff are on the NYS Navigating Multiple Systems Advisory Group which provides input into the development of a comprehensive website for consumers & professionals assisting families & individuals who are navigating multiple systems.				X
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

-All local CSHCN contractors are required to disseminate information about the Healthy Transitions website (http://www.healthytransitionsny.org and offer the pocket-sized health summary document to adolescents and their families who contact the program for assistance.
-The Navigating Multiple Systems Advisory Board is discussing plans for a Youth Transition Component on its proposed website. An individual planning tool has been discussed for possible development that would help prepare youth, families and caregivers for transitions. The tool will provide transition information, such as employment training opportunities and housing information, with step-by-step instructions to meet specific goals. Workgroups are being formed to help work on content development.
-Title V staff participate in NYS's Medicaid redesign process as part of the workgroup developing recommendations for Health Homes for children. Topics discussed include adolescent consent for release of information for care coordination and transition of medical/behavioral care from pediatric to adult specialists.
-H.I. Doc., a health information summary tool for adolescents and young adults, continues to be in demand by support groups, hospitals, and case managers working with youth/young adults.
-Updates to the CSHCN page on DOH's website related to transition resources have been made.

c. Plan for the Coming Year

-The CSHCN Program staff will continue to participate with the OHIP in NYS's Medicaid Redesign process, including expansion of Health Homes for children. This activity involves participation in conference calls and meetings with OHIP and stakeholders to discuss eligibility, standards and quality measures. The schedule for enrollment of children in Health Homes is anticipated to begin in January 2015.
-The work plan for local CSHCN Program contractors will continue to include a goal and activities related to transition. Contractors will be required to provide transition information to youth age 14 years and older and their families who contact the local program.
-The CSHCN Program staff will review and update, as needed, the transition resources, on the Special Health Care Needs section of the DOH website: http://www.healthytransitionsny.org.
-Although updates to the CSHCN page on DOH's website have been made, a more thorough review of the transition resources will be conducted.
-Title V staff will be submitting an application for HRSA's State Implementation Grants for Enhancing the System of Services for CYSHCN through Systems Integration to enhance the system of services that exist in NYS to improve a coordinated system for NY's CSHCN and their families.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	80	80	72.9	73.6	74.4

Annual Indicator	72.2	71.3	74.2	72.9	72.9
Numerator					
Denominator					
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	75.1	75.8	76.5	77.2	77.2

Notes - 2013
2012 data are being used as a proxy for 2013 data.

Notes - 2012
Data is from the National Immunization Survey, 2001, conducted by the CDC. Although NYS as a whole has improved statewide, NYC is 75.9 and Rest of State at 72.6, and is below the national average of 78.7. However, these results may be impacted, in part, due to changes in the survey methodology. Decreasing prevalence of families with land lines (the NIS is a telephone survey) and a small sample size contribute to the variability of the results. 2011 data are used as a proxy for 2012 data.

Notes - 2011
The National Immunization Survey rates have decreased, in part, due to changes in the survey methodology. Decreasing prevalence of families with land lines (the National Immunization Survey is a telephone survey) and a small sample size contribute to the variability of the results. 2010 data are used as a proxy for 2011 data. It is estimated that final 2011 immunization data will be available from CDC in late 2012 or early 2013. NYS exceeds the HP 2020 baseline of 68% for the proportion of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and PCV vaccines but is below the target of 80%.

a. Last Year's Accomplishments
-The National Immunization Survey (NIS) rates appear to be leveling off. Although NYS continues to exceed the Healthy People 2020 baseline of 68% for the proportion of children aged

19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and PCV vaccines, it remained below the annual performance objective for last year.
-The Bureau of Immunization (BI) provided vaccines through the NY Vaccines for Children (VFC) Program; assessed immunization rates and worked to improve them; provided technical assistance (TA) to providers; disseminated educational materials; assisted local health departments (LHD) with disease surveillance and outbreak control activities; and continued to expand the statewide immunization registry. CDC categorical grants and State and Local Assistance dollars were used to provide staffing in both central and regional DOH offices and to purchase vaccines. LHDs assist in recruiting VFC providers.
-Under the Assessment, Feedback, Incentives and eXchange (AFIX) initiative, LHD staff visited health care providers to assess their patients' medical records for compliance with immunization schedules. Data is assessed through an extract of the New York State Immunization Information System (NYSIIS) and entered into CDC-developed software- Comprehensive Clinic Assessment Software Application (CoCASA). CoCASA calculates the providers' immunization rates and identifies opportunities for improvement in immunization practices. Approximately 400 AFIX visits were conducted last year. A review of AFIX best practices and evaluation of the program were completed and recommendations were generated for use by LHDs to further improve immunization rates in NY.
-Article 6 State Aid to Localities funds reimbursed LHDs for the infrastructure that supports immunization surveillance; tracking; parent and provider education; and special studies.
-The WIC program screens all infants and children until all marker immunizations are received. Infants and children who are not adequately immunized must be referred to a health care provider or immunization clinic.
-Child care providers in NYS are required to check immunizations and refer as appropriate. Continued updates to the appropriate immunization schedules and number of doses necessary to bring children up-to-date have been made. Surveys of child care providers continued to assess vaccination rates in children attending child care settings and schools.
-The Perinatal Hepatitis B Program provided on-site record review for quality assurance and to monitor compliance with public health law at NYS birthing hospitals. Site visits provided the opportunity to review hepatitis B birth dose policies and offer training to hospital staff regarding immunization of parents and health care personnel. Surveys of NYS birthing hospitals were completed to identify best practices for implementing the hepatitis B vaccine birth dose. This information was distributed to birthing hospitals.
-The DOH Perinatal Hepatitis B Program and Albany Medical Center were recognized by the Immunization Action Coalition (IAC) and CDC for achieving high birth dose rates. NYS has more than twice the number of hospitals on the IAC Honor Roll than any other state.
-NYSIIS tracks all childhood immunizations administered in NYS. NYSIIS made several enhancements, including improvements to blood lead reporting and newborn hearing screening reporting, and targeted providers not yet actively participating in order to assist with compliance. NYSIIS contains more than 4.7 million patients and 65.5 million immunizations.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The BI provided vaccines through the NY VFC Program, assessed immunization rates, worked to improve them, provided TA to providers, disseminated educational materials, assisted providers		X	X	X
2. Under the AFIX Initiative, county staff visited pediatric providers and assessed immunization records.			X	X
3. The Perinatal Hepatitis B Program increased the universal birth dose rate in all birthing hospitals outside NYC to 84% by providing free vaccine for all children regardless of insurance coverage.			X	X

4. NYSIIS tracks childhood immunizations and experienced significant growth in this area along with increased numbers of registered and active pediatric providers.				X
5. Child care providers in NY are required to check immunizations and refer as appropriate. Surveys of child care providers continued to assess vaccination rates in children attending child care settings and schools.				X
6. Article 6 State Aid to Localities funds reimbursed LHDs for the infrastructure that supports immunization surveillance, tracking, parent and provider education and special studies.			X	X
7. The WIC Program reviewed immunization records and infants and referred children who are not up-to-date are referred to health-care providers or immunization clinics.		X	X	X
8.				
9.				
10.				

b. Current Activities

-Several changes are being made to NYSIIS including: enhancing the clinical decision support tool and interoperability activities, adding a temperature log and billing functionality, and starting online VFC provider ordering. Data is being assessed for completeness and timeliness of reporting. Results will determine the need for additional immunization related activities.
-The Perinatal Hepatitis B Program continues to promote the universal birth dose of hepatitis B vaccine for all newborns in NYS.
-The amendments to PHL 2164, Subpart 66-1 (School Immunization Requirements) were approved on 2/19/14 and are effective 7/1/14. The updated school immunization requirements comply with recommendations of the Advisory Committee on Immunization Practice (ACIP). The ACIP immunization schedules (both the recommended schedule for persons aged 0- to 18- years old and the catch-up schedule for persons aged 4 months to 18 years) have been incorporated into the regulations. NYSIIS and NYC's Citywide Immunization Registry (CIR) were updated to comply with the NYSIIS/CIR statute.
-BI was awarded a 15 month $870,000 grant by CDC to increase human papillomavirus (HPV) vaccination rates in adolescents in NYS. Grant activities include: a communication campaign targeting parents of 11- to 12- year olds, educating providers on HPV as well as how to decrease missed vaccination opportunities, and sending out reminder-recall letters to adolescents due for or behind on their HPV vaccinations.

c. Plan for the Coming Year

-BI will continue to provide vaccines through the VFC Program, assess school immunization rates and work to improve them, provide TA to providers, disseminate educational materials, and assist local health departments with disease surveillance and outbreak control activities.
-BI will continue to enhance NYSIIS. Upcoming enhancements include implementation of barcoding functionality; better coordination with BI's AFIX and VFC activities; new linkage with childhood data; and continued interoperability activities.
-The NYSDOH school survey and instruction booklet will be updated to be consistent with the new School Immunization requirement regulations.
-Daycare and other child care provider yearly survey forms will be updated to incorporate ongoing changes in the immunization schedules as appropriate. Spanish translation of forms will assist in improvement of timely and accurate reporting of immunization information.
-Immunization-related information on childhood vaccines on the DOH website will be revised and increased to assist providers and parents to have children vaccinated in accordance with the ACIP schedule.
-BI will continue its activities related to its HPV grant in an effort to increase adolescent HPV vaccination rates.

-NYS has multiple disease surveillance reporting systems, both mechanical and electronic, to identify infants born to women with chronic hepatitis B. Currently there is a 46% gap between National Health and Nutrition Examination Survey results and the number of HBsAg positive pregnant women identified by NYS's multiple reporting systems. The 46% gap between the CDC 2009 estimates and actual NYS cases managed from 2008-2010 is largely unexplained and further study for data confirmation will be explored. A preliminary review of findings outlining rationale for discrepancies and recommendations to close the 46% gap in epidemiological surveillance indicates the gap may be a result of CDC calculation methodology. Further study is indicated.
-BI will identify and distribute best practices for promoting Tdap vaccination of parents and caregivers of newborns to prevent the transmission of pertussis to newborns too young to be vaccinated. The practice known as "cocooning" will be promoted during prenatal care. The promotion of Tdap cocooning will assist birthing hospitals to be in compliance with revisions to NYS title 10 regulation section 2805-h mandating offering the Tdap vaccine to all parents and caregivers.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	12.5	12.3	12	11	10
Annual Indicator	12.1	11.2	10.1	9.5	9.5
Numerator	4687	4330	3811	3500	3500
Denominator	386720	386890	376774	369426	369426
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	9.4	9.3	9.2	9.1	9

Notes - 2013
2012 data are being used as a proxy for 2013 data.

Notes - 2012
2011 Data are being used as a proxy for 2012.

Notes - 2011
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

a. Last Year's Accomplishments
-Vital Statistics data for 2012 demonstrated continued accomplishments and challenges in teen pregnancy and birth rates. NYS's teen pregnancy rate has declined by 56.8% from its peak in 1993 of 95.3 pregnancies per 1,000 15- to 19-year olds to 41.1 in 2012. While significant

geographic, racial and ethnic disparities in teen pregnancy rates exist, the magnitude of the disparities is declining.
-The birth rate for teens aged 15 to 17 declined to a new low of 9.5 per 1000 15- to 17-year olds. This represents 311 fewer births for teens age 15 to 17 in 2012 than in 2011.
-According to an analysis done by the National Campaign to Prevent Teen Pregnancy, the reduction of adolescent births over the past decade in NYS has resulted in taxpayer savings of an estimated $581 million in 2010 alone.
-Fifty Comprehensive Adolescent Pregnancy Prevention (CAPP) and eight federally funded Personal Responsibility Education Programs (PREP) continued activities targeted to high-risk youth including implementing evidenced-based programs (EBP); ensuring access to reproductive health and family planning services; increasing skill-building opportunities for teens; and promoting community efforts to improve adolescent sexual health. In 2013, CAPP and PREP programs provided services to over 25,000 adolescents.
-An additional project funded through PREP was approved by Health and Human Services (HHS) as a national evaluation project to support one adolescent pregnancy prevention program designed specifically for the needs of youth in foster care. The project will also serve youth with emotional and behavioral problems.
-Federal Abstinence Education Grant Program (AEGP) funding supported a new competitive procurement, the Successfully Transitioning Youth to Adolescence (STYA) Request for Applications that funds 17 programs across the state to implement mentoring and adult-supervised programs for high-risk youth ages 9 to 12.
-In conjunction with DOH, the Assets Coming Together for Youth Center of Excellence (ACT COE) provided technical assistance (TA), webinars, regional trainings, and a statewide provider meeting for CAPP, PREP and STYA providers. TA and training are developed based on the providers' needs and are designed to improve performance in all areas of the initiatives.
-NY Promoting and Advancing Teen Health (NYPATH) provided training opportunities on adolescent sexual health for health care providers in the state that included development of a new web site. The website is designed for medical practitioners who provide healthcare services to adolescents and want evidence-based information and resources about adolescent sexual and reproductive health, and other primary health care issues. Continuing Medical Education modules developed in 2013 include topics related to caring for lesbian, gay, bisexual and transgender youth and male adolescent sexual reproductive health.
-In 2013, fifty DOH-grant funded family planning providers reported that a total of 344,916 clients were served. Nineteen per cent of the clients served were adolescents between the ages of 13 to 19. The programs continued to provide comprehensive reproductive health clinical, education and outreach services to low-income and uninsured/under-insured residents of NYS.
-Bureau of Maternal and Child Health (BMCH), with the assistance of the Family Planning Center of Excellence (FPCOE), conducted a performance management initiative with the grant-funded programs. The initiative focused on increasing the number of female family planning clients who leave a clinic with an effective contraceptive method. As a result of this initiative, preliminary data submitted by the local programs indicate an increase in the percent of female family planning clients, including adolescents, who leave a clinic with an effective contraceptive method is increasing.
-Changes to NYS's Medicaid Family Planning Benefit Program (FPBP) implemented in 2012 included a period of presumptive eligibility for family planning services. This change enables clients to receive immediate access to reproductive health services and reimbursement to providers for provision of those services while final eligibility is determined. Preliminary data indicate that the change has resulted in a significant increase in the number of people whose family planning (FP) services are covered through FPBP.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CAPP/PREP programs continued activities targeted to over		X	X	

25,000 high risk youth including implementing EBPs; ensuring access to FP; increasing skill-building opportunities; promoting community efforts to improve adolescent sexual health.				
2. DOH receives funding from HHS for development of a PREP adolescent pregnancy prevention enhancement project targeting youth in foster care and youth with behavioral and emotional problems.		X	X	
3. AEGP funding supported a new competitive procurement which funds 17 programs to implement mentoring and adult-supervised programs for high-risk youth ages 9-12 to begin in 2013.		X	X	
4. NYPATH provided training opportunities on adolescent sexual health for health care providers including webinars and development of a web site.				X
5. 50 FP agencies with 182 clinics provided free or low cost reproductive health services to nearly 345,000 women, men and adolescents; 19% of the people served were teens.	X	X	X	X
6. BMCH, with the assistance of FPCOE, conducted a performance management initiative with FP programs focusing on increasing the number of female family planning clients who leave a clinic with an effective contraceptive method.			X	X
7. Changes to FPBP implemented in 2012 included a period of presumptive eligibility for FP services. Preliminary data indicate that the change has resulted in a significant increase in the number of people whose FP services are covered through FPBP.			X	X
8.				
9.				
10.				

b. Current Activities

-CAPP/PREP conduct activities to implement EBPs; ensure access to FP; increase skill-building opportunities for teens; and promote community efforts to improve adolescent sexual health.
-The ACT COE provides training and technical assistance to the CAPP, PREP and STYA programs and works with DOH to develop the evaluation for these projects.
-DOH began planning and development of a PREP enhancement project targeting youth in foster care and youth with behavioral and emotional problems.
-17 STYA programs began implementing community projects focused on the use of mentoring, counseling and adult supervised activities to support a healthy transition to adolescence, including delaying the onset of sexual activity, for children ages 9 to12 in high need communities.
-The FP COE continues to work with grant-funded FP programs on improvement activities designed to increase the percent of female clients who leave a clinic with an effective/highly effective contraceptive method. DOH tracks the programs' performance on this measure on a quarterly basis. Preliminary data indicate that the programs are having success at increasing the percent of female clients who receive effective/highly effective methods.
-BMCH collaborates with the Office of Health Insurance Programs on statewide implementation of the changes to FPBP. Activities include educational webinars for providers and increasing the number of programs that are approved to be FPBP enrollment sites.

c. Plan for the Coming Year

-Ongoing program activities to support a wide range of clinical and community-based services will continue.
-A new performance measure will be implemented for CAPP and PREP providers to assess if

100% of the youth participants in EBPs complete 75% or more of the program. The ACT COE will monitor performance and report to DOH quarterly.
-The ACT COE will continue to provide training and technical assistance to the CAPP and PREP programs on the implementation of evidence-based programming with fidelity and has begun work on the development of the evaluation for these projects. The COE will also provide training and technical assistance to community-based programs funded through the federal AEGP funded STYA initiative, and conduct the evaluation of these programs.
-The COE evaluation will be used to inform future adolescent pregnancy prevention procurements.
-17 STYA programs will continue work focused on the use of adult mentoring, supervision and counseling to support healthy transition to adolescence, including delaying the onset of sexual activity, for children ages 9 to12 years in targeted high-need communities.
-NYPATH will continue to provide training opportunities on adolescent sexual health and other adolescent health topics for health care providers throughout NYS; and continue enhancements to their web site.
-BMCH will assess the grant-funded FP programs' performance in several key measures related to improving access to family planning services for teens, as well as increasing the quality of the services provided. These measures include: increasing the utilization of FPBP to engage and retain teens into FP services; increasing the use of effective and highly effective contraceptive methods by teens; and assessing programs' outreach efforts to engage teens into services. With the assistance of the COE, BMCH will deliver webinars, regional training workshops, a statewide provider meeting, and an intensive learning collaborative designed to improve programs' performance in all these areas.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	28	39	40.9	42.7	43.5
Annual Indicator	38.1	41.9	41.9	42.6	42.6
Numerator	3414			2881	2881
Denominator	8960			6758	6758
Data Source	NYS 3rd Grade Dental Survey	NYS 3rd Grade Dental Survey	NYS 3rd Grade Dental Survey	NYS 3rd Grade Surviellance Survey	NYS 3rd Grade Or Health Surveillance Project
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

	2014	2015	2016	2017	2018
Annual Performance Objective	44.4	45.3	46.2	47	47

Notes - 2013
The NY 3rd Grade Oral Health Surveillance Project (OHSP) is ongoing in both Upstate and NYC schools. Analysis of the data on 6,750 open mouth examinations as part of the second cycle has been completed. A report for the 2009-2012 cycle is being compiled. 2012 data is being used as a proxy for 2013 data.

Notes - 2012
The NY 3rd Grade oral health surveillance project is currently underway in NYC schools. The Upstate NY component of the surveillance project, which had originally been completed in early 2011, is continuing, with additional schools being surveyed. Data for 2011 and 2012 are provisional as a result of continuation of the 3rd Grade Oral Health Surveillance Project. Data for 2010 are used as a proxy for 2011 since an updated analysis of the data is not available. Data show that the prevalence of sealants in Upstate school children has increased. However, it falls short of the national performance measure. Due to NY's success in achieving this performance measure in ROS, annual performance objectives were increased over previously established targets by approximately 2% per year. These increases are consistent with the NYS Prevention Agenda, which sets as a target a 10% increase in sealant utilization over a five-year period.

Notes - 2011
The NY 3rd Grade oral health surveillance project is currently underway in New York City (NYC) schools. The upstate NY component of the surveillance project was completed in 2011.
*Weighted to reflect the population distribution

Data show that the prevalence of sealants in Upstate school children has increased. However, it falls short of the national performance measure.

a. Last Year's Accomplishments
-The 3rd Grade Oral Health Surveillance Project continued throughout the year at elementary schools in both NYC and upstate counties.
-Analysis of all of the data collected to date in the 3rd Grade OHSP was conducted. An interim report summarizing results, graphs and tables was prepared.
-The prevalence of sealants among 3rd grade children increased from 27% to 40.1% between 2002-2004 and 2009-2012 3rd grade OHSP and exceeds the Healthy People 2020 target of 28.1%.
-The annual performance objective of 42.7% of 3rd grade children receiving protective sealants on at least one permanent molar tooth was met in upstate counties (42.9%) but not in NYC (26.5%) or statewide (40.1%) based on data collected to date in the NYS 3rd Grade OHSP. Low income children were found to have the greatest increase in the use of sealants (from 17.8% in 2002-2004 to 34.7% in 2009-2011) compared to high income children (from 41.4% to 44.8%, respectively). Sealant use in schools surveyed in upstate counties increased from 38.1% to 42.9% from 2002-2004 to 2009-2011, compared to 12.2% to 26.5%, respectively, in NYC schools.
-School-based sealant programs are an effective means of providing low income children with needed services. Based on the results of the 2000-2012 3rd grade OHSP to date, 58.6% of low income 3rd grade children attending schools with a sealant program had dental sealants, compared to only 31.5% of 3rd grade students in schools without a sealant program.
-The Bureau of Dental Health (BDH) funded 30 of 58 programs for SBDH services to provide dental health services in high risk, underserved areas of NYS. A total of 1,045 schools had a School Based Dental Health (SBDH) program during the 2012-2013 school year, serving approximately 68,000 children in high need areas. Among those receiving services, 39% of all visits were for the placement of protective sealants, with an average of 3.2 sealant applicants per child.

-Dental sealants were available at 29% of all schools eligible for a sealant program.
-23.8% of Medicaid (MA)-eligible children aged 6-to-9-years-old (when sealants are most frequently applied) receiving dental services in 2013 under Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services had a sealant placed on a permanent molar; this represents a slight increase from 2012 (22.4%) 2011 and is below the 2013 national average of 26.9%.
-The percentage of dentists in NYS actively providing services to MA recipients ($10,000 or more a year in paid claims) remains low, leaving many vulnerable children without access to services.
-The Dental Hygiene Collaborative Practice bill (DHCP) was passed to allow registered dental hygienists to provide oral health preventive services (assessments, prophylaxis, sealants, and fluoride varnish (FV)) and to sign the dental health certificate (DHC) in collaboration with a licensed dentist under a collaborative agreement.
-Information on the public website on finding a dental provider continued to be updated. http://www.nyssmiles.org/)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. SBDH clinics provided services at 1,045 schools.	X		X	
2. Oral health screening services were provided to approximately 68,000 children in high need areas throughout NY through SBDH clinic programs.	X		X	
3. 30 contracts to provide SBDH services at high need schools throughout NY continued.			X	X
4. Information on the public website on finding a dental provider continued to be updated. http://www.nyssmiles.org/		X		
5. The 3rd grade OHSP is ongoing at NYS elementary schools in both upstate counties and in NYC.			X	X
6. The DHCP bill passage allows registered dental hygienists to provide oral health preventive services (assessments, prophylaxis, sealants, and FV) and to sign the DHC in collaboration with a licensed dentist under a collaborative agreement.	X	X	X	X
7.				
8.				
9.				
10.				

b. Current Activities
-Oral health preventive services, including the application of sealants, continue to be provided to eligible students at schools in high need areas across NYS.
-BDH continued to fund 30 of 58 programs for SBDH services to provide dental health services in high risk, underserved areas of NYS. Between the funded and unfunded programs, services are available at 1,045 schools in high need areas.
-The 2013 NYS Oral Health Plan and the DOH Prevention Plan both target the reduction of dental caries disease among third grade children.
-The HRSA SBHC dental clinic grant to integrate oral health services into existing school-based health centers operated by the North Country Family Health Center funded implementation of electronic dental records and a quality improvement quarterly monitoring tool. In addition, the clinic is in the process of completing an oral health education video and refining outreach materials.

c. Plan for the Coming Year

-DOH will continue to encourage implementation of policies and systems changes that promote twice a day tooth brushing with fluoride toothpaste; good oral health habits including appropriate feeding and snacking habits and healthy dietary practices, the provision of anticipatory guidance, risk assessment and fluoride varnish by child healthcare professionals and referral to dental providers as early as eruption of first tooth; encourage visits to a dental provider on a regular basis; increase the availability of fluoride through community water fluoridation or a supplemental fluoride program; promote school-based interventions ranging from the dental health certificate, oral health education, dental sealants, case finding and referral to dental care providers; enhance access to affordable insurance coverage; ensure an adequate supply of oral health providers, especially in underserved areas; and integrate oral health as part of programs, policies and overall health screenings.

-BDH will continue to monitor the utilization of dental services by children and adolescents and the types of services received.

-BDH will continue to advocate for interdisciplinary oral health training programs for child healthcare providers (e.g., pediatricians and nurse practitioners) to screen and provide preventative dental services and FV applications.

-BDH will continue to work with MA managed care organizations to implement policy change to allow reimbursement of preventative dental services and FV applications by non-dental professionals.

-A program management quality improvement tool will be developed for school-based dental programs using the FADE (focus, analyze, execute) model in order to improve the overall management of the program and increase the utilization of dental services by the target population.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	1.3	1.2	1	1.3	0.8
Annual Indicator	1.0	1.3	0.8	1.2	1.2
Numerator	37	47	29	43	43
Denominator	3633448	3531233	3515032	3508643	3508643
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	1	0.9	0.9	0.8	0.7

Notes - 2013

2012 data are being used as a proxy for 2013 data.

Notes - 2012

The number of motor vehicle deaths is based on the definition used by the DOH Bureau of Biometrics and Health Statistics and includes pedestrians and cyclists. The definition changed in 2004; prior to that time, pedestrians and cyclists were not included. 2011 data are being used for a proxy for 2012 data; 2012 data will be available in May 2014.

Notes - 2011
The number of motor vehicle deaths is based on the definition used by the DOH Bureau of Biometrics and Health Statistics and includes pedestrians and cyclists. The definition changed in 2004; prior to that time, pedestrians and cyclists were not included.

2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

a. Last Year's Accomplishments
-A 15-second video Public Service Announcement (PSA) & print ad were developed to encourage tweens to ride restrained in the back seat of motor vehicles. The video was shown in theaters in 6 counties with high rates of crashes involving children ages 8 to 12 riding in the front seat for 14 weeks during summer 2013. Ear bud music download cards with a link to the DOH website were distributed to moviegoers in select theaters. 3 social media posts were also developed & posted on the DOH Facebook page targeting parents aged 25 to 54 in the 6 pilot counties. A formal evaluation of the campaign showed that the media posts reached nearly 110,000 Facebook users. Parent feedback was solicited at 2 free public outdoor movie events in Albany.
-The Bureau of Occupational Health & Injury Prevention (BOHIP) convened a meeting of the NY Partnership for Teen Driving Safety (NYPTDS) in 04/13. Staff presented an update on national & state initiatives & NYPTDS activities & an overview of the 2013 NYPTDS strategic plan. NYPTDS is a state workgroup created to support initiatives & programs to reduce teen driving crashes, fatalities, & injuries on NYS's roadways through a multi-agency approach & promote the implementation of effective education, enforcement, & promising practices.
-BOHIP staff participated in a multi-disciplinary team led by the NYS Department of Transportation (DOT) to develop & implement pedestrian safety strategies along targeted corridors in NYS. The corridor projects implement education, engineering & enforcement strategies to reduce injuries. In 2013, the Central Avenue & State Street corridor in Albany & Schenectady Counties was identified as a target for activities. DOH & NYS Governor's Traffic Safety Committee (GTSC) led the team's Education Committee. Several committee meetings were convened to discuss driver & pedestrian contributing factors associated with pedestrian injuries & deaths; identify key messages for educational materials; consider potential media for messaging; & recruit key partners to assist with educational outreach efforts.
-DOH developed & produced See! Be Seen! pedestrian safety educational campaign materials. Key partners were convened to assist with the distribution & outreach plan. Campaign materials include a poster, mini poster, 2-sided tip card for pedestrians & drivers, & a window cling. Approximately 150 interior bus placards were developed by the DOH & printed by Capital District Transportation Authority for display on bus routes on Central Avenue & State Street.
A Quick Reference Guide to Vehicle & Traffic Pedestrian Laws was also created by GTSC, produced by DOH & provided to law enforcement agencies in Albany, Schenectady, Colonie & Niskayuna to encourage increased enforcement & education by traffic police. Over 5,000 pieces of educational material were distributed to partners for use in state & local pedestrian safety efforts. BOHIP & GTSC staff made in-person contact with establishments along the corridor including grocery stores, eateries, colleges, pharmacies & shopping plazas to ensure that See! Be Seen! materials were displayed in areas with increased pedestrian foot traffic. Presentations about pedestrian safety were provided to local church groups & materials were given to 56 churches in the Schenectady Inner City Ministry. These materials are available statewide.
-BOHIP staff assisted in planning & participated in a Pedestrian Safety for Law Enforcement Training conducted in 4 counties across NYS in partnership with GTSC, educates law enforcement officers about pedestrian vehicle & traffic laws & engages them in pedestrian safety activities.
-BOHIP staff participated in Bike to School Day events & provided technical support & educational materials. The events were organized in partnership with the GTSC, DOT, Traffic

Safety Boards, NYS Safe Kids, local AAA offices & school districts. Students received bicycle safety education & materials with an emphasis on the importance of helmet use & visibility.
-BOHIP staff participated in several bicycle safety rodeos & helmet distribution events during May, Bicycle Safety Month. Children were fitted with new bicycle helmets & participated in hands-on bicycle safety instruction. City officials and law enforcement representatives provided support. BOHIP staff also trained local partners to conduct bicycle helmet distribution events & to fit helmets. A properly fitted helmet reduces traumatic brain injury risk by up to 88%.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. A 15 second PSA & print ad were developed to encourage children age 12 & under to ride restrained in the back seat.			X	
2. BOHIP convened a meeting of NYPTDS, a state workgroup created to support initiatives & programs to reduce teen driving crashes, fatalities, & injuries on NYS's roadways through a multi-agency approach & promote effective & promising practices.				X
3. BOHIP staff continued to participate in a multi-disciplinary team led by DOT to develop & implement pedestrian safety strategies along targeted corridors in NYS.			X	X
4. The "See! Be Seen!" pedestrian safety educational campaign materials were developed, produced and distributed by DOH.			X	
5. BOHIP staff assisted in planning and participated in a Pedestrian Safety for Law Enforcement Training conducted throughout NYS in partnership with the GTSC.				X
6. BOHIP staff participated in and provided technical support and educational materials to "Bike to School" Day events.			X	
7. BOHIP participated in several bicycle safety rodeos and helmet distribution events during May, Bicycle Safety Month.			X	
8.				
9.				
10.				

b. Current Activities

-2012 data indicate an increase in deaths from the previous year. BOHIP continues to work to address this area.
-BOHIP partnered with the NYS Thruway Authority to show the tween passenger safety video PSA on televisions in each of the 27 travel plazas for 8 weeks beginning 12/10/13.
-BOHIP planned & executed a statewide Click it-Front & Back campaign during National Teen Driver Safety Week (10/20-26 2013) to raise awareness of the importance of safety belt use. 45 schools participated. Schools selected activities from a DOH-developed resource guide & received a supply of flashlight key chains to distribute to reinforce the buckle-up message. A press event was held in Cicero, NY.
-BOHIP hosted an Injury Community Planning Group meeting for traffic safety stakeholders to enhance NYS's injury infrastructure. The Child Injury Prevention Policy Subgroup also met. A major goal of this subgroup is to educate decision makers/public health professionals about safety benefits for children ages 12 & under to ride properly restrained in the back seat of a motor vehicle. NYS law requires children to be properly restrained but does not require them to be in the back seat.
-BOHIP provided GTSC with fact sheets demonstrating the injury burden for unrestrained passengers for all NYS counties. The fact sheets will be distributed to law enforcement in the counties & posted on the NYS Police Intranet. This is part of the May Seat Belt Mobilization around the importance of proper restraint use.

c. Plan for the Coming Year
-BOHIP staff will continue to participate in a multi-disciplinary team led by the DOT to develop and implement pedestrian safety strategies along targeted corridors in NYS.
-The Injury Community Planning Group will continue to meet to enhance injury infrastructure in NYS, including childhood and motor vehicle safety and the continued development of the NY Injury Action Plan.
-The Child Injury Prevention Policy Subgroup will continue to meet.
-BOHIP staff continued to participate in a multi-disciplinary team led by DOT to develop and implement pedestrian safety strategies along targeted corridors in NYS.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	44.5	45.5	47.9	48.3	53.9
Annual Indicator	47.4	47.7	47.7	53.7	52.6
Numerator					
Denominator					
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance	54	54.2	54.6	54.8	53.8

Objective					

Notes - 2013
Data Source: National Immunization Survey

Notes - 2012
2010 data represents the 2008 birth cohort. 2011 data represents the 2009 birth cohort. 2012 data represents the 2010 birth cohort.

Notes - 2011
2010 data are being used as a proxy for 2011 data. 2010 data represents the 2008 birth cohort. 2011 data will be available by May 2013.

a. Last Year's Accomplishments
-Breastfeeding (BF) at 6 months has shown some fluctuations, but has been increasing in NYS from 47.7% in 2010 to 52.6% in 2013. These percentages exceed the U.S. National averages in 2010 (43.0%), and 2012 (49 %.) (BF Report Card--United States, 2010 and 2012). During this time period, NY WIC increased BF at 6 months among NY WIC increased from 38.4% (10/2012) to 39% 09/2013). Exclusive breastfeeding at 6 months is slowly increasing from 13.7% in 2011 to 16.5% in 2013.
-Infant feeding during birth hospitalization data, as reported on infant birth certificates, were analyzed and used to rank hospitals on three indicators (percent of infants fed any breast milk, percent of infants fed exclusively breast milk and percent of breastfed infants also fed formula). Each hospital was informed of its performance relative to other hospitals. Infant feeding indicators for 2011 were posted on the DOH webpage in 11/2012.
-Ten Steps to Successful BF: An Online Course was offered to staff in 92 hospitals (exclusive of NYC) providing maternity care services. To date, 2,345 staff have completed this course which meets the staff education requirement for Baby Friendly Hospital (BFH) Designation.
-Making it Work: Returning to Work Toolkit to support hourly wage earners, which was developed from field research conducted in businesses and WIC agencies, was completed and posted on http://www.breastfeedingpartners.org/ and the DOH webpage.
-NY's Medicaid (MA) State Plan Amendment for coverage of individual and group lactation counseling services was approved by CMS and implemented in 04/2013 for NY MA Fee-for Service and in 5/2013 for NY MA Managed Care Plans. Structured education and lactation counseling is recommended by the United State Preventive Services Task Force (USPTF) (grade B) as an evidence-based intervention to increase BF initiation, exclusivity and duration. In addition, minimum breast pump specifications were developed and implemented; they must be met for coverage by NY MA.
-Hospital BF policies were collected and scored for compliance with NY Hospital regulations and law. Each hospital was informed whether their policy included all required components. 97 of the 129 hospitals providing maternity care had all 28 required components in their written policy; the remaining hospitals were asked to revise their policies and resubmit.
-WIC developed and conducted new trainings with 292 participating staff to enhance their competencies in BF assessment and counseling: 112 staff attended Building Skills: Assessing and Counseling BF Mothers; and 180 staff attended Specialized BF: Understanding Baby's Feeding Cues.
-WIC collaborated with the State University of New York at Albany School of Public Health and funded the BF Grand Rounds, It Takes a Village: Promoting BF at the Community Level.
-A new initiative, Great Beginnings NY, The Future Starts with BF, which focuses on and increasing exclusive BF rates began in 07/2013. Hospital leaders at maternity hospital committed to implement strategies to restrict the distribution and/or promotion of infant formula.
-The CHWP home visitors promoted breastfeeding to approximately 2,000 pregnant women. Of these women, 75.4% breastfed at the time of hospital discharge, 59.2% continued to breastfeed six weeks later, and 32.4% continued at six months.
-The NFP home vising program educated and promoted breastfeeding to clients, with 86.4% of

clients initiating breastfeeding.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Hospitals were ranked on three BF indicators (fed exclusively breast milk, fed any breast milk, and breastfed infants also fed formula in the hospital).				X
2. DOH continued offering the Ten Steps to Successful BF: An Online Course to staff at 92 hospitals providing maternity care services.			X	
3. Hospital BF policies were reviewed. Hospitals were notified of inclusion of required components. Hospitals that did not include all of the required components were asked to revise their policies and resubmit them to DOH.			X	X
4. The Making it Work: Returning to Work Toolkit to support hourly wage earners, which was developed from field research conducted in WIC agencies and businesses, was completed and posted to websites.		X	X	X
5. WIC revised breastfeedingpartners.org to reflect up-to-date information, including the Making it Work: Returning to Work Toolkit and participant focus.		X		X
6. DOH's MA coverage of lactation education and counseling was approved and implemented. Minimum breast pump specifications were developed and implemented.	X	X		
7. A new voluntary initiative, Great Beginnings NY, The Future Starts with BF, which focuses on increasing exclusive BF rates, was launched.		X	X	
8. WIC developed and conducted new trainings training to enhance staff competencies in BF assessment and counseling.		X		
9.				
10.				

b. Current Activities

-A community demonstration initiative was implemented in Erie County focusing on increasing community-based BF support postpartum among low income women; it includes coalition building and targets community organizations, child care settings, and pediatric and OB practices.
-DOH is working with hospitals which have non-compliant BF policies.
-66 hospitals outside of NYC have joined the Great Beginnings NY initiative and committed to changing BF practices.
-DOH will develop a CME course of four one-hour webcasts designed to increase knowledge/skills for physicians and other health care providers to support successful BF.
-DOH is working with MA to submit a State Plan Amendment to CMS to allow IBCLCs who do not have a professional NYS license to provide lactation counseling.
-CHWPs provide home visiting services to high risk pregnant women and families and a myriad of information and support, including BF support.
-Nurse Family Partnership provides services to first time mothers to improve healthy behaviors including BF support.
-WIC is implementing policies to improve exclusive BF, i.e., assessing the BF dyad, prenatal BF promotion, revising the breast pump policy and enhancing staff competencies.
-WIC BF support includes 300 peer counselors; 39 agencies with hospital visitation; and improved communication with new technology, e.g., text messaging.
-Loving Support thought Peer Counseling: A Journey Together curriculum and handbook was

distributed to all WIC agencies.

c. Plan for the Coming Year
-MA data will be reviewed to determine usage of the MA benefit for lactation counseling and breast pumps.
-WIC is emphasizing improvement of exclusive BF rates through training staff and modifying food packages to further support BF policy.
-WIC will work with a training contractor to continue training to improve competencies of WIC local agency staff in breastfeeding assessment, support, counseling and critical thinking.
-WIC will offer a Learning Community for WIC management staff focused on exclusive BF and BF promotion for prenatal participants.
-WIC will implement planned changes to WIC food packages for partial BF participants by providing minimal formula to BF infants and focusing on BF support.
-DOH will work to increase the number of pediatric, family practice and obstetric/gynecologic practices that have received the NYS BF Friendly Practice Designation.
-DOH will continue to work with hospitals participating in Great Beginnings NY to improve maternity care practices.
-DOH will continue to work with key partners to ensure that private insurers provide lactation counseling services that meet or exceed the benefit provided by the MA program and that breast pumps provided meet the minimum breast pump standards set by MA.
-DOH will work to ensure that lactation counseling services provided by the Managed Care Programs participating in the NY Health Benefit Exchanges meet or exceed the benefit provided by the MA program and that breast pumps provided meet the minimum breast pump standards set by MA program.
-DOH will revise the NYS Model Hospital Breastfeeding Policy and Implementation Guide to better align with the BFH Initiative and incorporate recommendations from professional associations.
-DOH will examine and evaluate lessons learned and best practices from the community- based interventions in Erie County and spread this work to other communities throughout the state.
-DOH will work with the Department of Labor to support compliance with Labor Law 206c which provides time and space to express breast milk in the workplace.
-DOH and NYCDOHMH staff will collaborate to educate providers, assist hospitals with the implementation of baby friendly policies and practices, and link women with home visiting programs to educate and assist with support for BF.
-DOH home visiting programs will continue to educate and provide support to pregnant and postpartum women on the benefits of breastfeeding

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	99.1	99.6	99.5	84.1	84.1
Numerator	244545	239116	229377	201126	201126
Denominator	246647	240169	230608	239224	239224
Data Source	Newborn Hearing Screening	Newborn Screening	Newborn Screening	Newborn Hearing Screening	Newborn Hearing Screening

	Program				Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	100	100	100	100	100

Notes - 2013
2012 data are being used as a proxy for 2013 data.

Notes - 2012
Due to the lag in data collection and reporting, 2011 data are used as a proxy for 2012 data. These data are incomplete. Ten hospitals have not submitted their quarterly aggregate data. Therefore, approximately 8,000 to 10,000 births are missing hearing screening data and therefore, 2010 data cannot be compared with 2011 data. Hospitals are no longer required under NY public health law to submit aggregate reports. New York Early Hearing Detection and Intervention (NYEHDI) is transitioning to the collection of individual level hearing screening data.

Notes - 2011
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

a. Last Year's Accomplishments
-Beginning this reporting period, individual data on initial hearing screening for newborns in birthing facilities has been reported to DOH via the NYC and NYS (exclusive of NYC) vital records information systems. The percentage of NYS newborns screened for hearing before hospital discharge (84.1%) exceeds the Healthy People 2020 baseline (82%) but does not meet the target (90.2%) indicator for screening newborn at no later than 1 month of age. For this reporting period, the method of data collection changed from aggregate data self-reported by hospitals to data obtained from children's birth records. The percent of children with hearing screening reported on their birth records is lower than previous years using the aggregate, self-reported results. Based upon initial review of individual level data, the change is largely due to deficiencies in documentation, not screening.
-Hearing follow-up and interventions typically occur after the birth certificate has been submitted through the vital records information systems; therefore this information cannot be captured in the same way that the initial hearing screening is reported. The New York Early Hearing Detection and Intervention Information System (NYEHDI-IS) application was developed, using CDC funding, to allow for the manual data entry of diagnostic follow-up tests, and early intervention, including amplification, for children in need.
-NYEHDI-IS application integrates initial hearing screening results reported in the NYC and NYS (exclusive of NYC) vital records information systems.
-NYEHDI-IS also integrates information from the NYS Immunization Information System (NYSIIS), which allows for updates of child demographic and contact information, as well as relationships with primary care providers for children.
-The deployment of NYEHDI-IS has been completed in a stepwise fashion. In 12/12, DOH

launched NYEHDI-IS to birthing hospitals outside of NYC. In 09/13, DOH launched the information system to all audiologic and primary care providers outside of NYC. The next phase of deployment in the next reporting period targets hospitals and audiologic and primary care providers in NYC
-DOH received grant funding from HRSA to assure quality developmental outcomes for infants identified with hearing loss. Data from NYEHDI-IS have been used to provide targeted outreach and technical assistance to improve completeness of reporting and reduce loos to follow-up.
-Parents of infants and children who have significant hearing loss and other interested professionals established a chapter of Hands &Voices, a nationally recognized family support group for individuals who have been diagnosed with significant hearing loss and their families. The Hands & Voices Executive Board was established. The group obtained 501c3 status as a not-for-profit organization and was recognized by the national organization as a provisional chapter. The final leadership training was held in 07/13 and all other necessary documents were provided to the national organization to attain permanent status. The group expects to achieve this status in the next reporting period. Hands & Voices of NY provides valuable support to families of newly identified infants as they seek early intervention for their infants.
-A committee comprised of physicians and audiologists was established to create a teaching module (on DVD) for pediatric medical residents. The goal for this module is to educate future pediatricians on issues related to EHDI, to highlight the importance of early identification and intervention, and to provide reporting updates specific to NYS. The DVD, entitled NYEHDI: Pediatricians Can Make the Difference, which was originally produced for practicing physicians, was edited for medical residents and supplemental materials are being created. A medical residency program in the NYC area is interested in piloting the medical residency training.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Individual data on initial hearing screening for newborns in birthing facilities has been reported to DOH via the NYC and NYS (exclusive of NYC) vital records information systems.			X	
2. DOH received CDC funding to develop the NYEHDI-IS application to capture hearing screening, follow-up, and interventions if needed.				X
3. NYEHDI-IS application integrates initial hearing screening results reported in the NYC and NYS (exclusive of NYC) vital records information systems.				X
4. NYEHDI-IS integrates information from the immunization registry information system for updates of child demographic, contact information, and primary care providers.				X
5. DOH launched NYEHDI-IS to birthing hospitals, audiologists and primary care providers outside of NYC.				X
6. DOH received grant funding from HRSA to expand and improve the Universal NBHS and Intervention program to assure quality developmental outcomes for infants identified with hearing loss.			X	X
7. A parent support group for families of infants who have significant hearing loss attained not-for-profit status and was named a provisional state chapter of Hands &Voices, affiliated with the national association.			X	X
8. DOH has edited the DVD entitled NYEHDI: Pediatricians Can Make the Difference," which was originally produced for practicing physicians, to educate medical residents.				X
9.				

10.				

b. Current Activities

-A concerted effort is underway to provide targeted technical assistance to improve the completeness of the hearing results reported on birth records. Data from birth records and NYEHDI-IS are being used to prepare routine reports to track completeness of results by hospital. These reports will identify any hospitals where reporting completeness declines or is not complete. Quality improvement activities, utilizing plan-do-study-act cycles, will be implemented to address any deficiencies in reporting.
-DOH is working to assure that vital record information from NYC is complete and updated in NYEHDI-IS. Two critical dependencies for NYEHDI-IS are the NYS (exclusive of NYC) and NYC vital record systems. DOH is working closely with NYC vital records to integrate birth record information from the Electronic Vital Events Registration System. During this time period, NYEHDI-IS will be deployed to NYC birthing hospitals and then to audiology and primary care providers.
-NYEHDI-IS will be enhanced to include practice and hospital level reports. The user community has been engaged to understand the need for this information. Business requirements, functional specifications, and the technical design will be developed during this reporting period.
-A full-time, follow-up coordinator will be hired to assist with DOH's effort to reduce the loss to follow up/documentation issue.

c. Plan for the Coming Year

-DOH will review data at the facility level to assess both completeness and accuracy. Targeted technical assistance will be provided to facilities with any deficiencies.
-DOH will systematically review the NYEHDI-IS data to determine NYS's adherence to the Healthy People 2020 guidelines for best practice regarding early hearing detection and intervention. Staff will perform gap analysis and will employ quality improvement methodology to address identified shortcomings.
-The NYEHDI-IS system will be enhanced as needed, to improve usability and usefulness of the application for hospitals, birthing facilities, audiologists, and primary care physicians.
-NYEHDI will participate in DOH efforts to integrate children's health information across programs, such as immunization, lead screening, newborn blood spot screening, and newborn hearing screening, to allow for the creation of a virtual child health profile for primary care providers.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	8.5	8.4	7.4	7.4	6.5
Annual Indicator	7.5	7.9	6.6	5.6	5.6
Numerator	335000	350000	284000	240000	240000
Denominator	4465000	4418000	4291000	4267000	4267000
Data Source	Current Population Survey	Current Population Survey	Current Population Survey	Current Population Survey	US Census Current Population Survey
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	6.4	6.3	6.2	6.1	6.1

Notes - 2013
2012 data are being used as a proxy for 2013 data.

Notes - 2012
2011 Data is being used as a proxy for 2012.

Notes - 2011
2010 data are being used as a proxy for 2011 data. 2011 data will be available in early 2013.

a. Last Year's Accomplishments
-The percentage of NYS children in 2012 without health insurance (5.6%) is significantly lower than the national percentage of 9.4% and has improved from 6.6% in 2011.
-All uninsured children and teens are eligible for comprehensive and affordable health insurance through either Medicaid (MA) or Child Health Plus (CHPlus).
-Over the last five years, NYS has seen a 19% decline in uninsured children under age 18 years. In 2006, 8.1% of the NY's population of children less than 18 years was uninsured as compared to 5.6% in 2012. The number of uninsured NYS children is steadily declining from 434,000 in 2007 to 240,000 in 2012.
-Facilitated Enrollers (FEs) provided application assistance to those who were seeking MA or CHPlus, accounting for over 475,000 applications submitted annually. FEs provide assistance to applicants in 60 languages. Currently, 40 community-based organizations and 13 health plans serve as FEs. The FE program ended October 2013 and was replaced by the In-Person Assistor (IPA) and Navigator program
-The New York Health Benefit Exchange (Exchange) released a Request for Application (RFA) for the IPA and Navigator Program in 02/2013. This program will provide in-person enrollment assistance to individuals, families, small businesses and their employees who apply for health insurance through the Exchange.
-Conditional grants were awarded to 49 IPA and Navigator organizations, including one urban Indian organization in 07/2013. These 49 organizations will be supported by 96 subcontractors including more than 430 individual IPAs/Navigators who will provide services in 48 languages. The Grantees represent a diverse group of organizations that will provide high-quality enrollment assistance in all 62 counties of the state. There are at least two IPA/Navigator agencies in all but one county in NYS and multiple agencies in each of the NYC Boroughs.
-All Maternal and Child Health Services Block Grant (MCHSBG) funded programs are required to assist with enrollment in public insurance programs.
•The Community Health Worker Program (CHWP) assists any child or member of an enrolled family to access health insurance.
•Many Comprehensive Prenatal/Perinatal Services Networks (CPPSN) are facilitated enrollers for health insurance programs.
•Insurance status for students enrolled in school-based health centers (SBHC) is determined as

part of the initial enrollment process. SBHC staff works with students/parents/guardians without insurance to connect them to MA and/or CHPlus.
•Children with special health care needs (CSHCN) whose families are referred to or contact the CSHCN Program are connected with MA and/or CHPlus if they do not have a source of insurance. CSHCN Program staff follows up with families who receive information and referral to determine if they obtain insurance coverage for their children.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. FEs provided application assistance in 60 languages to those who were seeking MA or CHPlus, accounting for over 475,000 applications submitted annually. 40 community-based organizations and 13 health plans served as FEs.		X	X	X
2. The Exchange released a RFA for the IPA and Navigator Program to provide in-person enrollment assistance to individuals, families, small businesses and their employees who apply for health insurance through the Exchange.		X	X	X
3. Conditional grants were awarded to 49 IPA and Navigator organizations. These organizations will be supported by 96 subcontractors including more than 430 individual IPAs/Navigators to provide services in 48 languages.		X	X	X
4. FEs provided application assistance MA or CHPlus in 60 languages, accounting for over 475,000 applications submitted annually		X	X	X
5. All MCHSBG-funded programs are required to facilitate enrollment in public insurance programs.		X	X	X
6. Many CPPSNs are facilitated enrollers for health insurance programs.			X	X
7. CSHCN whose families are referred to or contact the CSHCN Program are connected with MA and/or CHPlus if they do not have a source of insurance.			X	X
8. CHWPs assist any child or member of an enrolled family to access health insurance.		X		X
9. Insurance status for students enrolled in SBHCs is determined as part of the initial enrollment process. SBHC staff works with students/parents/guardians without insurance to connect them to MA and/or CHPlus.		X		
10.				

b. Current Activities
-NYS provides insurance to nearly 2.2 million (46%) children. MA covers >1.9 million; CHPlus covers almost 300,000.
-NYSOH, a web-based eligibility & health insurance enrollment Marketplace (MP), opened 10/1/13 for enrollments effective 1/1/14. Individuals, families & businesses can apply & enroll in MA, CHPlus & Qualified Health Plans & receive Advance Premium Tax Credits/Cost Sharing Reductions, if eligible. Open enrollment ended 3/1/15.
-New enrollments from social services departments & authorized health plans for MA & CHPlus, respectively, transitioned to MP effective 1/1/14.
-ACA made changes to waiting periods (WP) for CHPlus effective 1/1/14. The WP was reduced from 6 mos to 90 days. NYS added 3 exceptions to its WP: child has special health care needs; child lost coverage due to divorce or cost of family coverage is > 9.5% of household income. Based on responses to application questions, the MP determines if a child qualifies for an

exception.
-Subdivision 7 of SS2510 of the NYS PHL was amended to add coverage for outpatient blood clotting factor concentrates & other necessary treatments/services for persons with hemophilia under CHPlus effective 4/1/14.
-NYSOH trained & certified more than 6,000 people to provide free in-person enrollment assistance in applying for coverage. Navigators assist individuals & small employers; brokers work with 1 or both markets & Certified Application Counselors only assist individuals.

c. Plan for the Coming Year
-NYS will continue to work to meet the requirements of the Affordable Care Act (ACA) and full operation of the Exchange.
-The proposed Open Enrollment Period for Qualified Health Plans for coverage starting in 2015 is 11/15/14--02/15/15. Individuals may also qualify for Special Enrollment Periods outside of Open Enrollment, if they experience certain events. Individuals and Families eligible for MA or CHPlus may apply at any time during the year.
-MA and CHPlus renewals currently processed by the local departments of social services and health plans, respectively, are expected to be transitioned to NYSOH in the last quarter of 2014.
-MCHSBG funded programs including the MICHC and evidence-based home visiting programs will continue to assess insurance status of children served and will assist with enrollment in public insurance and referral to the Exchange.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	29	29	31.5	31.2	30.3
Annual Indicator	31.8	31.5	31.2	30.4	29.6
Numerator	71274	70636	72042	58819	61456
Denominator	224130	224243	230903	193464	207856
Data Source	PedNSS	PedNSS	PedNSS	PedNSS	PedNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	29.4	29.2	29	29	29

Notes - 2011
2010 data are being used as a proxy for 2011 data. 2011 data will be available in early 2013.

a. Last Year's Accomplishments
-Analysis of linked Pediatric Nutrition Surveillance System (PedNSS) and PNSS data provided longitudinal records of mother/child pairs to examine perinatal factors associated with infant and child weight status. Results showed that early prenatal participation in WIC was associated with

reduced risk of the infant experiencing rapid infant weight gain, a risk factor for child obesity. The paper was published in the 02/2014 American Journal of Public Health.
-DOH continued its collaboration with Columbia University and Public Health Solutions on First Steps WIC, a 5 year evaluation of NY WIC obesity prevention initiatives. Results of a cross-sectional analysis of child participants' records indicated that changes to the WIC prescribed foods did change what children eat and the percent of child WIC participants who are obese declined from pre to post food package changes. These findings were published in the 07/2013 issue of the journal Obesity.
-WIC developed a breastfeeding (BF) assessment guide and new trainings to enhance staff competencies in BF assessment and counseling. 1188 WIC staff were trained to enhance competencies in BF assessment, counseling and participant-centered nutrition assessment through nine trainings conducted on 66 training days.
-A statewide needs assessment of NYS WIC nutrition staff revealed a gap between their receiving training and implementing the key skills associated with conducting a participant-centered nutrition assessment (PCNA). DOH implemented the 2013 WIC Manager's Learning Community; through this initiative, 13 local agencies worked together to develop, implement and evaluate a management framework and associated core activities to improve the delivery of PCNA. Improvement strategies at over 25 WIC sites reached approximately 90,000 WIC participants.
-Through a collaboration between DOH and the Office of Children and Family Services (OCFS), newly proposed state child care regulations specify requirements for meals and beverages; feeding practices; physical activity for infants and children; screen time and content; and identify related provider training topics for continuing education credits.
-Eat Well Play Hard in Child Care Settings (EWPHCCS), a practice-tested intervention that increases the consumption of vegetables and low-fat milk, continued in 235 low-income Child and Adult Care Feeding Program (CACFP)-participating centers and 14 NYC elementary schools reaching 15,298 children. EWPHCCS implemented a Farm to Preschool pilot project at three child care centers. In follow-up surveys, most parents and staff indicated that since shopping at the on-site farmers market, they purchased and consumed more fruits/vegetables.
-Eat Well Play Hard in Day Care Homes (EWPH-DCH) targets day care home providers, children and parents. Providers focused on increasing the variety of fruits and vegetables offered and opportunities for adult-led structured play. From 01/2012 - 09/30/2013 EWPH-DCH trained 175 day care home providers. Registered Dietitians (RDs) conducted 871 in-home training visits that resulted in 5369 (duplicated) RD contacts with children.
-From 2005 to 2013, 139 child care centers and 538 family day care homes participating in CACFP earned the "Breastfeeding Friendly" designation.
-DOH staff provided TA to the Early Childhood Advisory Council (ECAC) Promoting Healthy Development workgroup to develop resource support and training for implementation of QUALITYstarsNY (NYS's early childhood quality rating improvement system) nutrition and physical activity standards.
-DOH engaged nine contractors to work with high need primary care practices to implement the Expert Committee Recommendations for Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity. The Obesity Prevention in Pediatric Health Care Settings (OPPHCS) Learning Collaborative teams will use the Institute for Healthcare Improvement (IHI) Breakthrough Series to (implement system change within recruited practices to improve obesity screening assessment and prevention at well child visits for children ages 2 to18.
-The State Health Commissioner's Pediatric Obesity Prevention Workgroup continued to mobilize a cross agency effort to prioritize, implement and evaluate proven population based, policy, systems and environmental strategies in multiple sectors to prevent and control early childhood obesity.
-DOH strengthened nutrition standards for the NYS WIC Food Package.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Assessment of trends in Body Mass Index (BMI) through the PedNSS continued. A continuation in the decline in obesity prevalence among child WIC participants was observed.				X
2. Implementation of the WIC Retention Promotion Study continued, including site visits to assess level of intervention implementation and qualitative analysis of focus group information.		X	X	X
3. DOH continued its collaboration with Columbia University and Public Health Solutions on First Steps WIC, a 5 year evaluation of NY WIC obesity prevention initiatives.		X		X
4. Continue to strengthen nutrition standards for the NYS WIC Food Package through the selection of acceptable foods for the new food card which reinforce nutrition messages and improve the nutritional content.				X
5. DOH staff provided technical assistance resources to support implementation of QUALITYstarsNY standards re: nutrition, physical activity, screen time and breastfeeding support.				X
6. DOH collaborated with OCFS to develop proposed child care regulations consistent with obesity prevention best practices specified in Caring for Our Children- 3rd Edition.				X
7. Implemented EWPHCCS in 225 additional low-income CACFP participating centers and 16 NYC elementary schools, reaching 11,078 children and EWPHDCH 128 homes reaching 1,000 children. Increased the number of BF friendly child care providers.		X	X	
8. DOH staff established primary care learning collaboratives to build system capacity to provide guideline concordant care for the prevention of pediatric overweight and obesity.				X
9. The Commissioner's Pediatric Obesity Prevention Workgroup continued to mobilize and coordinate cross agency efforts to prevent and control childhood obesity.				X
10. DOH implemented the 2013 WIC Manager's Learning Community; through this initiative, 13 local agencies worked together to develop, implement and evaluate a management framework and associated core activities to improve the delivery of PCNA.				X

b. Current Activities

-Replicate CDC methodology to monitor trends through PedNSS/PNSS in overweight/obesity, BF and TV time for children and pre-pregnancy weight status/pregnancy weight gain. Analyze linked mother/infant data to assess association of maternal WIC participation with BF initiation/duration. Utilize linked data to assess pre vs. post changes to WIC food package and association with infant/child feeding behaviors and weight status.

-First Steps WIC: Continue analysis of physical activity data. Finalize the longitudinal analysis of infants enrolled before and after implementation of the new WIC food package.

-Implement change package and data measurement plan for the OPPHCS Learning Collaborative and test changes and identify best practices across domains of the Chronic Care Model for obesity screening, assessment and prevention at well child visits.

-Convene the Obesity Prevention in Child Care Partnership to guide and support obesity prevention strategies in child care settings.

-Provide training and resources to implement QUALITYstarsNY standards for nutrition, physical activity, screen time and BF.

-Train and deploy Early Childhood Physical Activity Specialists to provide training and technical assistance in the child care system.

-Support the adoption and implementation of proposed OCFS child care regulations for meal and beverage standards, child feeding, physical activity and screen time.
-Expand environmental change strategies in EWPHCCS.

c. Plan for the Coming Year
-Produce PedNSS and PNSS data reports consistent with CDC methodology and disseminate results with a focus on indicators of child and maternal obesity.
-WIC Retention Promotion Study: Prepare and submit final grant report to the United States Department of Agriculture detailing quantitative and qualitative results. Results will be used by the WIC program to make policy and procedure changes to provision of WIC services if warranted.
-First Steps WIC: Disseminate the results of the longitudinal analysis and of the analysis of survey data.
-Based on a WIC local agency staff training needs assessment conducted in 2012, add new trainings in 2013-2014 to address BF support and growth monitoring for infants and children.
-Evaluate and assess effectiveness of WIC training modalities focused on obesity prevention and healthy lifestyles.
-Assess options for new foods in the recently released Final Rule on WIC Foods to enhance the cultural acceptability and nutritional value of the WIC food package.
-Revise WIC nutrition policies, based on best practices and evidence based strategies, to strengthen participant-centered nutrition assessment and education, and promotion of BF for WIC participants.
-Conduct training for WIC state and regional staff on participant-centered counseling and skills to enhance the overall effectiveness of nutrition education and WIC services and improve the health of WIC participants.
-Work with OCFS to develop and provide training on Healthy Beverage regulations which were adopted into law in 10/2013. Develop materials to share information with parents on healthy meal and beverage choices.
-Implement the EWPHCCS statewide sustainability plan called EWPHCCS Champions.
-Complete the evaluation of the two-year pilot EWPHDCH project in partnership with Altarum Research Institute. EWPH-DCH will continue through a two-year Team Nutrition Grant.
-Expand the EWPHCCS Farm to Preschool project to four EWPHCCS grantees.
-OPPHCS contractors will recruit an additional cohort of practices for a 12-month collaborative to improve obesity prevention and assessment at the well child visit for children ages 2 to18, and integrate the 10 Steps to a Breastfeeding Friendly Practice.
-Revise and refine the change package, data measurement plan, and tools associated with the OPPHCS Learning Collaborative and disseminate information statewide.
-Evaluate and modify the Early Childhood Physical Activity Specialist model and for implementation through additional Child Care Resource and Referral Agencies.
-Develop training and technical assistance resources to support the adoption of county policies that increase CACFP participation by legally exempt child care providers.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	13	12	8.1	7.1	6.9
Annual Indicator	7.6	6.9	6.2	6.2	6.2
Numerator					
Denominator					

Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	6	5.8	5.8	5.8	5.8

Notes - 2013
2011 data are being used as a proxy for 2012 and 2013 data. 2012 data are delayed until December 2014.

Notes - 2012
2010 data is being used as a proxy for 2011 & 2012. 2012 data will be available the end of May 2013.

Notes - 2011
Numerator and denominator data are not available (survey data). Previous data reported for 2006-2007 were for NYS (Excluding NYC). CDC has recently provided statewide statistics for this indicator. The comparble NYS percentages for 2006 and 2007 are 8.5% and 9.1%, respectively. 2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

a. Last Year's Accomplishments
-The percentage of women who smoke in the last three months of pregnancy has continued on a downward trend. The evidence- and population-based strategies that the DOH Bureau of Tobacco Control (BTC) uses to advance the tobacco-free norm benefit this population.
-Community Partnerships (CP) contractors worked to increase the number of smoke-free multi-unit rentals in NYS, especially for persons with low-incomes. More than 30 multi-unit housing properties, totaling more than 4,000 rental units, have adopted smoke-free policies.
-CP contractors continue to work to increase smoke-free public spaces; more than 440 NYS municipa-ties have passed regulations restricting smoking or tobacco use in parks, playgrounds, near municipal buildings and entryways, and on village/town grounds.
-193 employers have implemented tobacco- or smoke-free grounds and entryways.
-Youth action contractors, branded as "Reality Check (RC)" work with middle and high school youth to engage in civic actions to deglamorize and denormalize tobacco use, restrict tobacco marketing at the point of sale and restrict tobacco imagery in the media, especially in movies and on social media.
-Cessation Center (CC) contractors work with health care organizations, including federally qualified health centers (FQHCs) and community health centers (CHC), to implement systems that assess every patient at every visit for tobacco use and provide tobacco dependence treatment to persons who report tobacco use.
-The NYS Smokers' Quitline provides free quit coaching and support to quitline callers and quit site visitors, free starter kits of nicotine replacement therapy (NRT) to eligible New Yorkers, and smoking cessation cards for discounted cessation medications for all New Yorkers.
-Quitline coaches received continuing education including coaching for pregnant clients and NRT use during pregnancy.
-BTC places evocative and graphic paid media that accurately depict the negative consequences of smoking. Repeated studies show that these types of ads dramatically reduce smoking initiation by youth, motivate adult smokers to make more quit attempts, increase calls to quitlines and reduce relapse among former smokers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. NYS funded free tobacco use cessation assistance to all New Yorkers through the Quitline. During the intake interview to enroll for services, 358 women (5.5% of all clients) stated they were pregnant.		X		
2. Continuing education was provided to Quitline quit coaches, including coaching for pregnant clients and NRT use during pregnancy.				X
3. DOH ran paid television ads. Two ads featured women with smoking-related illnesses being cared for by their children. A third ad featured a mother talking about the serious, ill effects of secondhand smoke on her young son.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

-The evidence- and population-based strategies that the BTC uses continue to benefit women of childbearing age (ages 15-44).
-Eleven municipalities passed ordinances prohibiting smoking or all tobacco use on municipal grounds and building entryways, bringing the total to 440 NY municipalities that have passed tobacco-free outdoor policies.
-Five major employers enacted smoking- or tobacco-free outdoor policies.
-Five low-income housing complexes, encompassing 748 rental units, implemented no smoking policies. NYC and Cayuga County enacted Pont of Sale laws.
-Jamestown Primary Care and Chautauqua Physical and Occupational Therapy implemented the policy-driven Opt-to-Quit™ program, a systems approach to identify and provide tobacco dependence treatment to all tobacco-using patients.
-The Quitline received 32,496 calls and distributed 17,722 NRT starter kits. Quitsite visits totaled 218,131 and 6,906 clients registered for NRT.
-Statewide media has been placed; these ads drive calls to the Quitline and increase quit attempts.
-After a two-year effort, a contractor workgroup succeeded in convincing the National Board of Medical Examiners to include tobacco-related questions on the United States Medical Licensing Examination(r). This will ensure that tobacco use dependence treatment will be taught nationally in medical schools.
-Contractors held a webinar for health care professionals, "Treating Pregnant Women's Tobacco Use and Dependence" on 3/5/14.

c. Plan for the Coming Year

-The current five-year Community Partnerships and Reality Check contracts expire June 30, 2014. BTC is in the process of procuring a new, five-year contract that contains both elements, providing coverage to every county in NYS. The procurement focuses on promoting tobacco-free norms and reducing exposure to secondhand smoke through community policy change.
-In addition, DOH is procuring a new contract for health systems that will focus on providing

systems changes, especially for persons with low income, low educational attainment or severe mental illness.
-BTC will incorporate new and applicable recommendations from the CDC's 2014 Best Practices for Comprehensive Tobacco Control Programs to all contractors' activities. BTC will provide contractors professional development to fine-tune skills and knowledge to ensure the highest possible level of efficaciousness.
-As funding allows, BTC will continue to place hard-hitting and evocative media, including television ads that are proven to drive callers to quitlines and increase cessation attempts, while reducing youth initiation and smoking relapses.
-Through various assessment methods, including the Youth Tobacco Survey and assessment of performance standards, BTC will evaluate contractor activities and provide programmatic guidance as indicated, and measure the impact of media campaigns.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	3.8	3.8	4.2	4.5	5.9
Annual Indicator	4.2	4.6	6.1	6.0	6.0
Numerator	58	63	81	78	78
Denominator	1366144	1366278	1324252	1307947	1307947
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	5.8	5.7	5.6	5.5	5.5

Notes - 2013
2012 data are being used as a proxy for 2013 data.

Notes - 2012
2011 data are being used as a proxy for 2012.

Notes - 2011
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

a. Last Year's Accomplishments
-2010 national data for 10 to 19 year olds show 1,926 suicides for this population (4.73/100,000). 2012 NYS data show 90 suicides in the 10-19 age group & no suicides in children age 10 & younger. 25 of the 90 completed suicides were in NYC & 65 in the rest of NYS. Reducing teen suicide & promoting mental health are one of DOH's Prevention Agenda priority areas.
-The BOHIP-led DOH ICPG is dedicated to building a stronger injury prevention infrastructure in NYS. CDC-funded Injury Control Research Center for Suicide Prevention (ICRC-S) at the

University of Rochester Medical Center & OMH staff participated in 2 ICPG meetings. NYC MHA staff presented on using Means Reduction as a method to reduce suicides & suicide attempts. Staff from BOHIP participate in ICRC-S External Advisory Board meetings.
-The Zero Suicide Collaborative continued to gain momentum since OMH published Getting to the Goal: Suicide as a Never Event in 08/13. In conjunction with release of the revised National Strategy for Suicide Prevention, OMH is heeding the Strategy's call to action for guiding suicide prevention actions statewide & nationally over the next decade. OMH has undertaken a review of suicides occurring in the public mental health system over the past several years & is using the data, in addition to the latest evidence on suicide prevention & treatment, to develop a NYS action plan.
-BOHIP & the PHIG use suicide data to perform additional analyses for planning purposes. BOHIP will continue to work closely with OMH, providing updated data & reviewing research opportunities to enhance efforts to address suicide in this population.
-OMH utilizes & promotes evidence-based practices & programs vetted by SAMSHA's National Registry & consistent with National Alliance for Suicide Prevention guidelines for framework of care.
-NYS chose 4 regional centers of excellence which are advancing & piloting a suicide prevention & care model consistent with National Alliance guidelines.
-Under OMH leadership, NYS maintains collaborative partnerships with numerous stakeholders & developed new partnerships at all levels of governmental & non-governmental agencies.
-The SPCNY operates in collaboration with & is funded by OMH; it has advanced & supported state & local actions to reduce suicide attempts & suicides in NYS & promoted the recovery of persons affected by suicide via education/training, coalition building, technical guidance & consultation.
-Creating Suicide Safety in Schools (a training program for school districts developed by SPCNY) was listed in the National Registry of Evidence-Based Programs & Practices. The program provides a framework to expand OMH's work with NYS schools & communities. This recognition will enable other states to adopt this successful model.
-Youth suicide prevention is a priority. Year 2 of the GLS grant resulted in consolidation of work begun in 2011 when 4 Youth Suicide Prevention Centers were founded; these centers are fully operational & have exceeded qualitative & quantitative state & national expectations. Under OMH leadership, they have provided or coordinated gatekeeper & clinical training for thousands of gatekeepers & clinicians in NYS.
-The GLS Caring & Competent Suicide Counties initiative includes 22 counties.
-Family Connections, a 12-week evidence-based DBT-informed support group for family members was successfully introduced. More than 40 leaders were trained & provide this course throughout NYS. Family Connections targets family members with loved ones at elevated suicide/self-injury risk & teaches them coping skills. Program data documents that family members experience a decrease in depression, burden, grief & an increase in empowerment.
-OMH engaged first responders in NYC in developing suicide prevention, intervention & postvention programs & resources for peers & family members
-SBHCs address mental health needs of enrolled students, either directly or by referral. Services may include individual mental health assessment, treatment & follow-up, crisis intervention, short & long-term counseling, group & family counseling, & psychiatric evaluation & treatment. SBHCs are monitored through regular reports & site visits to ensure mental health services are available on-site or by referral. The ability to bill MA for mental health services by licensed & master's level social workers has encouraged more SBHCs to offer this service on-site.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Under the leadership of the Office of Mental Health (OMH), the 4 Garrett Lee Smith (GLS) youth Suicide Prevention Centers have provided or coordinated gatekeeper & clinical training for			X	X

thousands of gatekeepers & clinicians throughout NYS.				
2. OMH is evaluating, utilizing & developing evidence-based/ best practices resources and programs that are vetted by SAMSHA's National Registry, & consistent with the National Alliance guidelines for framework of care.		X	X	X
3. NYS has chosen 4 regional centers of excellence, which are advancing & piloting a suicide prevention & care model consistent with National Alliance's guidelines.	X	X	X	X
4. Through Creating Suicide Safety in Schools & other interventions, OMH provided education/training, coalition building, technical guidance & consultation to schools & communities around suicide prevention, intervention & postvention.		X		
5. OMH has engaged first responders in developing suicide prevention, intervention & postvention programs & resources for peers & family members.			X	X
6. Twenty-two counties are included in the GLS "Caring & Competent Suicide Counties" initiative.			X	
7. Creating Suicide Safety in Schools has been listed in the National Registry of Evidence-Based Programs & Practices.				X
8. Family Connections, a 12 week evidence-based Dialectical Behavior Therapy (DBT)-informed support group for family members was successfully introduced, with more than 40 new leaders trained & already providing this course in various parts of NYS.		X		
9. The Zero Suicide Collaborative has continued to gain momentum since the Getting to the Goal: Suicide as a Never Event was published by OMH in 08/13.			X	X
10. The Bureau of Occupational Health & Injury Prevention (BOHIP) and the ICRC-S work together through the BOHIP Injury Community Planning Group (ICPG) & the ICRC-S External Advisory Board.				X

b. Current Activities

-Year 3 of the GLS grant has significantly impacted thousands of gatekeepers & clinicians engaged with youth, & made meaningful contributions to ongoing conversation about youth suicide prevention, including how to best meet specific cultural needs of specific groups/populations including LGBTQ & Latino youth.
-Creating Suicide Safety in Schools & Lifelines have been provided in numerous schools, schools districts, & school networks resulting, in at least 1 instance, in increased funding for an underserved rural area of NYS that experienced several suicides in 2 local high schools.
-Family Connections is bringing DBT skills to families whose loved ones engage in self injurious behavior using its network of more than 40 Family Connections leaders.
-The Center for Practice Innovations developed 3 electronic learning modules. The 1st 2 of the 3 modules focus on teaching how to use the Columbia suicide severity rating scale & safety planning; these will be available in the next few months. The 3rd module will focus on telephonic follow-up for individuals' post-acute care/ED visits.
-Using smart-phone technology, a Safety Planning Application commissioned by OMH was developed & implemented for smart phones & associated tablets.
-SBHCs continue to address the mental health needs of enrolled students, either directly or by referral.
-BOHIP continues to work closely with the OMH to develop research opportunities to enhance efforts to address suicide in this population.

c. Plan for the Coming Year

-OMH and the Suicide Prevention Center of New York State (SPCNY) are applying for another GLS grant, thus creating an opportunity for additional growth and expansion of the four youth centers.

-The four GLS site coordinators will develop their own programs/resources specifically around postvention in schools and Latino youth. Under the guidance of OMH and SPCNY, these practices will be submitted to Best Practice Recommendation for approval.

-Behavioral Health-Works, an on-line screening tool that can be administered using a tablet or laptop while the young (12-14) person is waiting to be seen by a medical professional, will be introduced to primary care settings. The tool, which measures risk and protective factors in 13 domains, including suicidality takes 7 minutes to complete. It generates an instantaneous scored report for the medical professional to use when examining the patient.

-NYS Regional Centers of Excellence will complete the piloting phase of a comprehensive suicide prevention care model being conducted in four state psychiatric hospitals. Based on evidence collected through pilot, a protocol will be developed and the model will expand to other facilities in NYS.

-OMH will continue to expand programs that are supporting families of individuals at elevated suicide/self- injury risk.

-OMH will provide DBT training and post-training ongoing support/supervision to a targeted group of clinicians who specifically serve at-risk individuals.

-OMH will expand the paradigm for suicide prevention by focusing on modifying 'upstream' risk with programs such as Sources of Strength (SOS.) SOS builds socio-ecological protective influences among youth to reduce the likelihood that vulnerable high school students will become suicidal.

-All SBHCs continue to address the mental health needs of enrolled students, either directly or by referral.

-BOHIP, OMH, and ICRC-S will continue collaborate to further suicide prevention initiatives in NYS.

-The ICPG will continue to meet to enhance the injury infrastructure in NYS, including suicide prevention.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	94	94	91	91.3	91.7
Annual Indicator	90.6	90.5	90.7	88.6	88.6
Numerator	3356	3270	3131	3104	3104
Denominator	3704	3614	3453	3505	3505
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

	2014	2015	2016	2017	2018
Annual Performance Objective	92	92.4	92.8	93.2	93.2

Notes - 2013
2012 data are being used as a proxy for 2013 data.

Notes - 2012
2011 data are being used as a proxy for 2012.

Notes - 2011
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

a. Last Year's Accomplishments
-NYS continues to exceed both the Healthy People 2020 baseline and target goals (75% & 82.5% respectively) for this indicator.
-NYS has been a national leader in the development of a statewide system of perinatal regionalization (PR). All obstetrical hospitals have been designated by DOH as a Level I, II, III or Regional Perinatal Center (RPC) based on standard criteria included in state regulation. Regulations require lower level hospitals to consult with RPCs and determine the need for transfer of high-risk mothers & newborns.
-88.6% of all very low birth weight (VLBW) infants were delivered at RPC and Level III facilities.
-Over 88% of deliveries of high-risk newborns at appropriate level hospitals demonstrates the effectiveness of PR.
-RPCs remain the hub of the PR system. RPCs conduct Quality Assurance visits at affiliate hospitals and work to improve perinatal quality and outcomes, including review of complex cases. RPCs also conduct on-site educational programs to enhance affiliates' ability to provide quality perinatal services.
-RPCs conduct numerous activities to obtain consumer/parent/family input & to enhance provider/parental relationships; these activities include, but are not limited to: development of Family Advisory Councils to improve outcomes; the use of the Press-Ganey Satisfaction Survey; monthly Neonatal Intensive Care Unit (NICU)-Avatar patient satisfaction surveys; provider "call-backs" to parents after NICU discharge; provision of Cardiac Pulmonary Resuscitation (CPR) instruction to all parents of infants discharged from the NICU; and formation of Perinatal Bereavement Teams, Bereavement Support Groups and Teen Prenatal Parenting groups.
-Presentations are being made about the NYS Perinatal Quality Collaborative (NYSPQC) activities at state and national conferences, including the Association of Maternal and Child Health Programs (AMCHP), American Academy of Pediatrics (AAP) and Pediatric Academic Societies. NYSPQC works with hospitals to provide the best and safest care for women and infants by preventing and minimizing harm through the use of evidence-based practice interventions. NYSPQC projects focused on: assuring that all initiations of labor or cesarean sections performed on women who are not in labor between 36 0/7 and 38 6/7 weeks gestation occur only when medically indicated; optimizing early enteral nutrition in newborns of <31 weeks gestational age to minimize discharge from a NICU below the 10th percentile on the Fenton growth scale; and preventing central line associated blood stream infections (CLABSIs) in NICUs. Birthing hospitals across NYS are working with DOH on one or more of these projects.
-The Statewide Perinatal Data System (SPDS) - NYS's electronic birth certificate - captures data on why VLBW infants were born at lower level hospitals. The majority of these births are due to unavoidable events, such as inability to transfer the woman to a higher level hospital due to advanced stage of labor or instability of the patient.
-DOH staff continued to collaborate with the RPCs, National Initiative for Children's Healthcare Quality (NICHQ) and NYS hospital associations to implement interventions designed to improve perinatal outcomes.
-Continued implementation of a range of public health initiatives to improve birth outcomes include the system of PR; efforts to increase access to early and continuous prenatal care; community-based programs that target high-risk areas to identify and address gaps in needed services; and home visiting programs, such as the Nurse Family Partnership (NFP), Healthy

Families New York (HFNY) and the Community Health Worker Program (CHWP),
-As part of the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative, DOH issued a Request for Applications for the Maternal and Infant Health Initiative (MIHI) in 10/12 which will support community-based programs to improve maternal and infant health outcomes for high-need women and families and to reduce racial, ethnic and economic disparities in those outcomes.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. NYS has been a national leader in the development of a statewide system of PR. All obstetrical hospitals have been designated as Level I, II, III or RPC based on standard criteria included in state regulation.	X	X	X	X
2. Through the hospital system of PR, quality assurance visits are conducted to improve perinatal quality and outcomes, including review of complex cases and whether cases should have been transferred to regional centers.		X		
3. RPCs are the hub of the PR system. RPCs conducted educational programs at affiliates & through grand rounds on programs such as stabilization of VLBW & Extremely LBW Infants in preparation for transfer, to prepare affiliates for emergency cases.		X		
4. Consumer/patient/family input occurs at the RPCs and affiliates through family advisory councils, satisfaction surveys, provider call-backs, support groups, and education and training programs.		X		
5. DOH staff continued to collaborate with the RPCs, NICHQ and NYS hospital associations to implement interventions designed to improve perinatal outcomes.				X
6. DOH has implemented a range of public health initiatives to improve perinatal outcomes in NYS, including home visiting programs to increase access for early and continuous prenatal care and PR.		X		X
7. Numerous presentations are being made regarding NYSPQC activities at state and national conferences, including the AMCHP, AAP and Pediatric Academic Societies.				X
8. NYSPQC works with hospitals to provide the best and safest care for women and infants by preventing and minimizing harm through the use of evidence-based practice interventions.			X	X
9.				
10.				

b. Current Activities

-RPCs remain the hub of the perinatal regionalization system and conduct quality improvement (QI) visits at affiliate hospitals and work to improve perinatal quality and outcomes, including review of complex cases. RPCs conduct on-site educational programs to affiliates.
-DOH's oversight role to identify and address appropriateness of care issues continues. DOH continues QI activities through the CDC State Based Perinatal Quality Collaborative.
-NYSPQC continues promoting perinatal interventions to improve outcomes in hospitals statewide. NYSPQC has partnered with NICHQ, the Hospital Association of NYS, Greater NY Hospital Association and other NYS DOH offices to optimize efforts to reduce avoidable preterm births of 36-38 weeks gestation. A CLABSI reduction initiative was initiated in RPC & Level III

NICUs, complementing the ongoing QI initiative to improve nutrition & growth among very preterm neonates.
-DOH supports public health initiatives to increase access to prenatal care; support community-based programs that target high-risk areas to identify and address gaps in needed services; and assessment and referral of high-risk women to appropriate level of services.
-The MIHI was initiated on 10/1/13 to improve maternal and infant health outcomes for high-need women and families and to reduce racial, ethnic and economic disparities in those outcomes. 22 community-based programs participate, along with 5 NFP and 5 HFNY programs via the MIECHV initiative.

c. Plan for the Coming Year
-DOH staff will continue to work closely with the RPCs and affiliate hospitals to monitor and support effective use of the established system of perinatal regionalization.
-Consumer/parent/family input will continue at RPCs and affiliates through family advisory councils, satisfaction surveys, provider call-backs, support groups, and education and training programs.
-DOH will continue the NYSPQC with the RPCs to implement selected obstetric and neonatal interventions designed to improve perinatal outcomes. NYSPQC will continue to expand obstetric and neonatal interventions to perinatal affiliate hospitals throughout NYS to improve specifically identified perinatal outcomes.
-DOH will maintain efforts related to access to prenatal care services and community-based initiatives designed to identify and engage pregnant women in early and continuous prenatal care.
-DFH will support the NY Medicaid Redesign Team recommendations to address health disparities which include recommendations for prevention programs for all women and adolescents of reproductive age on Medicaid, particularly those women and teens with chronic health conditions which a have high potential for adverse impact on pregnancies.
-Through Medicaid Redesign, Health Information Technology (HIT) projects will be developed in high need areas of NYS to demonstrate the effective use of HIT to coordinate perinatal services, reduce costs by streamlining fragmented and redundant systems, increase patient access to medical records, and improve quality of care. Poor perinatal outcomes are major cost drivers for health care institutions and the Medicaid program.
-NYS's work in the MIECHV and other community-based maternal and infant health initiatives will continue to support evidence-based home visiting services, further coordination of services, and maximization of resources to improve birth outcomes.
-The statewide Growing Up Healthy Hotline will continue to link women to needed services, with periodic public awareness media campaigns conducted to direct women to the hotline.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	80	81	74	74.8	75.5
Annual Indicator	73.3	73.2	72.9	73.8	73.8
Numerator	167503	169190	167091	171806	171806
Denominator	228517	231137	229052	232710	232710
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Check this box if you cannot report					

the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	76.2	77	77.7	78.4	78.4

Notes - 2013
2012 data are being used as a proxy for 2013 data. Methodology Change: calculation of trimester has been revised to incorporate the clinical gestation date for records with unknown PNC start date. As the result – 2,000 records were added to the calculation of the indicators.

Notes - 2012
2012 data are being used as a proxy for 2012

Notes - 2011
The denominator is the total number of births for which prenatal care initiation is known and excludes births where trimester of entry into prenatal care is unknown. 2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

a. Last Year's Accomplishments
-The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester has been relatively unchanged since 2009. NYS is performing above the Healthy People 2020 baseline of 70.8% for this indicator.
-NYS's maternal and infant health programs employ a comprehensive, multi-level strategy which integrates broad-based systems approaches involving regional and local planning; one-on-one outreach and support; population-based education; public health insurance and clinical practice standards; and extensive surveillance to support public health planning and clinical quality improvement efforts.
-The Growing Up Healthy Hotline (GUHH) is available 24/7, provides information and referral in English and Spanish and in other languages via the AT&T language line, and is used in media campaigns to promote early and continuous access to prenatal care and other services. In 2013, GUHH responded to 37,514 calls including 2,429 calls requesting referral and information related to pregnancy testing and/or prenatal care, and 3,081 calls related to health insurance.
-Medicaid (MA) prenatal care providers continued to promote early enrollment in prenatal care and provided presumptive MA eligibility to ensure women were able to begin prenatal care immediately pending eligibility determination. All MA-enrolled Article 28 prenatal care providers are required to perform presumptive eligibility determinations and assist with completion of the full MA application and MA managed care plan selection.
-15 Comprehensive Prenatal-Perinatal Services Networks (CPPSNs) continued to use local toll-free numbers, web sites, and resource directories to provide pregnant women with information and referral to prenatal care services. CPPSNs identify gaps and barriers to the service system, and in collaboration with community stakeholders, work to improve accessibility and the quality of local perinatal service systems.
-23 Community Health Worker Programs (CHWP) conducted outreach to engage pregnant women in early and consistent prenatal care and ensure access to needed services. In 2013, the CHWP served 3,000 families. Of the pregnant women enrolled in the CHWP who were not already in prenatal care, 78% entered prenatal care in the first trimester, 18% in the second and 3% in third.
-Six Healthy Mom-Healthy Baby (HM-HB) programs continued to engage key stakeholders to develop county perinatal health systems to identify high-risk pregnant women early in pregnancy, assess their risks and healthcare needs and refer them to appropriate services including home

visiting.
-DOH issued a Maternal and Infant Health Initiative (MIH) Request for Applications (RFA) that replaced and integrated the existing community-based perinatal health programs, including Comprehensive Prenatal-Perinatal Services Networks, CHWP and the HM-HB program to develop multi-dimensional community-wide systems of integrated and coordinated community health programs and services to improve maternal and infant health outcomes. As a result of the RFA, 22 Maternal and Infant Community Health Collaboratives (MICHC) have been established in 33 counties across the state. MICHCs will work to identify high-risk pregnant women and ensure they have health insurance, and are engaged in prenatal care and other supportive services including home visiting (HV).
-Through a Memorandum of Understanding (MOU) with the NY Office of Temporary and Disability Assistance (OTDA), DOH continued to support the expansion/enhancement of the state's 3 Nurse Family Partnership (NFP) programs to provide home visiting services to Temporary Assistance for Needy Families (TANF)-eligible pregnant women. In 2013, the NFP programs served 800 TANF-eligible women.
-School-based Health Centers (SBHC) provided pregnancy testing and reinforced the need for early prenatal care for parents choosing to continue pregnancy.
-Family Planning Programs (FPP) made early referrals for women testing positive for pregnancy, thereby improving rates for early access to prenatal care in the population served.
-Through the Community Action for Prenatal Care Program (CAPC), CAPC lead agencies coordinate a comprehensive service network, recruit pregnant women into prenatal care and case management through enhanced outreach and referrals from community agencies, link substance-using women to treatment programs, navigate client to appointments, and engage in community planning.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The GUHH, available 24/7, provided information and referral in multiple languages via the AT&T language line. The number is used in media campaigns to promote early and continuous access to prenatal care and other services.			X	
2. CPPSN programs have local toll-free numbers, resource directories, and websites to provide pregnant women with information and referral to prenatal care.			X	
3. MA prenatal care providers encouraged early enrollment in prenatal care, and provided presumptive MA eligibility to ensure that women were able to begin prenatal care immediately pending determination of MA eligibility.	X			
4. SBHCs provided pregnancy testing and reinforced the need for early prenatal care. Access is provided either on-site or through referral to the back-up facility.	X			
5. FPP made early referrals for women testing positive for pregnancy, thereby improving rates for early access to prenatal care in the populations served.	X			
6. DOH supported NFP programs in Monroe & Bronx counties & HFNY programs in Erie & Bronx counties to provide evidence-based HV services to high risk families. NYS's 3 NFP programs delivered HV services to TANF eligible pregnant first-time mothers.		X	X	X
7. Outreach efforts conducted through the CHWP and consumer awareness strategies implemented through the CPPSNs continued with a central focus on identifying and engaging		X	X	

women to seek early and continuous prenatal care.				
8. 8. CAPC agencies coordinate inclusive svc networks, recruit pregnant women into prenatal care/case management via enhanced outreach & referrals from community agencies, link substance-using women to treatment programs & navigate them to appointments.		X		
9. DOH's six HM-HB programs continued to engage key stakeholders to develop county perinatal health systems to identify, assess and refer high-risk pregnant women to services early in their pregnancies.				X
10. 22 MICHCs have been established in 33 counties to identify high-risk pregnant women & ensure they have health insurance, & are engaged in prenatal care & other supportive services including home visiting.		X	X	X

b. Current Activities

-The Title V program collaborates with OHIP to ensure comprehensive prenatal care services are available to high risk populations.
-The MIH RFA that replaced and integrated the existing community-based perinatal health programs, including CPPSNs, CHWP and the HM-HB program, enabled DOH to establish and implement the MICHC Initiative and expand the Maternal, Infant and Early Childhood Home Visiting Initiative (MIECHV).
-MICHC includes 22 new projects in 33 high-risk counties that work to improve maternal and infant health outcomes through implementation of evidence-based and/or best practice strategies across the reproductive life span.
-Through MIECHV funding, DOH awarded 3 NFP and 1 HFNY program and now supports 5 NFP and 5 HFNY programs offering HV services in 6 high-risk counties.
-Contracts continue with 2 existing NFP programs in Bronx and Monroe counties and 4 HFNY projects in Bronx and Erie counties under the MIECHV initiative.
-Through its MOU with OTDA, DOH supports NYS's 3 NFP programs through TANF funding to provide nurse HV services to TANF-eligible pregnant women.
-A Request for Proposals was released in spring 2014 to establish an MIH Center of Excellence to provide MICHC and MIECHV grantees with technical assistance, training, data management and evaluation support.
-DOH continues to promote the national HM-HB Coalition's Text4babies text messaging services in NYS.

c. Plan for the Coming Year

-NYS's work in the MIECHV and other community-based maternal and infant health initiatives will continue to support evidence-based home visiting services, further coordination of services, and maximization of resources to improve birth outcomes.
-DOH will continue to promote the Text4baby initiative through its maternal and infant health partners. A targeted media campaign will be implemented. Customization of messages allows DOH to include state-specific information and referral resources including the GUHH.
-The statewide GUHH will continue to link women to needed services, with periodic public awareness media campaigns conducted to direct women to the hotline.
-Public health programs that serve at-risk adolescents - SBHC, FPP and Community-Based Adolescent Pregnancy Prevention Programs - include provisions for preventive health services, pregnancy prevention, and, when needed, prompt referral of pregnant teens to prenatal care.
-BMCH and MA staff will collaborate to ensure compliance with MA prenatal care standards.
-Title V staff will continue to participate in NYS's ongoing MA Redesign initiative to support development and implementation of potential recommendations related to improving access to prenatal care for all high risk populations.

D. State Performance Measures

State Performance Measure 1: *The percentage of infants born to Black and Hispanic women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			64.9	65.6	66.2
Annual Indicator	64.3	64.6	65.2	66.7	66.7
Numerator	58055	59319	58996	60402	60402
Denominator	90226	91838	90516	90533	90533
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	66.9	67.5	68.2	68.5	68.5

Notes - 2013
2012 data are being used as a proxy for 2013 data.

Notes - 2012
2011 data are being used as a proxy for 2012 data. 2012 data will be available in May 2014.

Notes - 2011
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

a. Last Year's Accomplishments
-While NYS experienced an improvement in this measure, the disparity remained significant, with 65.2% of infants born to Black and Hispanic women receiving prenatal care beginning in the first trimester in 2011, as compared to 73.4% of infants born to White women. Recognizing the need to refine efforts to engage NYS's highest risk women into prenatal care to promote progress in this performance measure, Title V redesigned NY's perinatal initiatives (refer to Maternal & Infant Health (MIH) RFA discussed under B-Current Activities-below.
-State law requires all Medicaid (MA) enrolled Article 28 prenatal care providers to perform presumptive eligibility determinations and assist with completion of the full MA application and managed care plan selection, allowing women to immediately receive care while awaiting full MA eligibility determination.
-Comprehensive Prenatal/Perinatal Services Networks (CPPSN) facilitate access to comprehensive prenatal care targeting at-risk pregnant women not engaged in health care or other supportive services, particularly low income African American and Hispanic women.
-A priority of DOH's home visiting (HV) initiatives is to promote healthy behaviors, including engaging women into early prenatal care.
-In 2013, the Maternal, Infant & Early Childhood Home Visiting (MIECHV) initiative served approximately 1,555 clients, of whom 40% were Black and 47% Hispanic women; of these women, 78% entered prenatal care in their first trimester. The MIECHV initiative supports five Nurse Family Partnership (NFP) and five Healthy Families NY (HFNY) programs in six high-risk counties.
-Community Health Worker Programs (CHWP) provided outreach and HV services to high-risk

pregnant women. In 2013 CHWP served 3,000 clients, of whom 99.9% were female, 31% were Black and 44% Hispanic, with 78% of the women entering prenatal care in their first trimester. CHWs, indigenous to the communities served, conducted outreach efforts targeting local health departments, WIC sites, cultural/ethic organizations, community centers, local department of social services, door-to-door canvassing, health fairs, community events, and places where high-risk populations may congregate such as laundromats, markets, churches, hair salons, transit stops, housing projects, and community centers.
-Through a MA State Plan Amendment, DOH provides MA reimbursement for Targeted Case Management (TCM) activities to NFP programs in Monroe and Onondaga Counties, and New York City. MA billing data shows 40% of TCM clients served in NYS 2013 were Black and 42% were Hispanic
-Healthy Mom-Healthy Baby (HM-HB) programs supported development of organized community systems of perinatal health and HV services to improve birth outcomes for MA eligible pregnant and postpartum women and newborns through early identification, outreach, risk assessment, and referral to appropriate services including home visiting.
-Through a Memorandum of Understanding (MOU) with the Office of Temporary Disability Assistance (OTDA), DOH supported enhancement/expansion of NYS's three NFP programs to provide HV services to Temporary Assistance for Needy Families (TANF) eligible first-time mothers. TANF-funded NFP programs served approximately 800 TANF-eligible pregnant women.
-Under the First Time Motherhood/New Parents Initiative, six CPPSNs convened community stakeholders and developed and implemented preconception health community action plans. Action plans proposed evidence-based and promising practices to increase awareness of and supports for preconception health and use of healthcare services.
-The statewide Growing Up Healthy Hotline (GUHH) links women to needed services, and is staffed 24/7 with both English and Spanish-speaking trained
tele-counselors, a Text Telephone (TTY) for the hearing impaired, and the AT&T Language Line which extends access to callers speaking over 20 additional languages.
-DOH promoted Text4baby through maternal and infant health partners. Customization of messages allowed inclusion of state-specific information and referral resources such as the GUHH. Outreach included a media campaign consisting of posters and digital media targeting young African-American pregnant women or new mothers in 8 high risk areas. Marketing materials were disseminated statewide and the Text4baby text messaging service was promoted on the DOH Website and social media sites.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MA Article 28 prenatal care providers must perform presumptive eligibility determinations & assist with completion of the MA application & managed care plan selection, allowing women to immediately receive care while awaiting determination.	X			X
2. CPPSNs are community-based organizations whose goal is to organize the service system at the local level to improve early and continuous prenatal care, targeting at-risk pregnant women not engaged in services.		X	X	X
3. CHWPs provide outreach and home visiting services to pregnant women who are at highest risk for poor birth outcomes.		X	X	
4. HM-HB programs support development of organized community systems of perinatal health and home visiting services to identify pregnant and postpartum women early, provide outreach, assess risk, and make appropriate referrals.	X	X	X	X
5. MIECHV contracts were established with 2 NFP and 4 HFNY projects. Projects began program implementation including hiring of home visiting staff, outreach and recruitment to high-risk		X	X	X

clients, and provision of services to families.				
6. First Time Motherhood/New Parents Initiative promoted preconception health community action plans which utilized evidence-based & promising practices to increase awareness of preconception health & use of healthcare services.		X	X	X
7. Through an MOU with the OTDA, DOH supported enhancement/expansion of NY's 3 NFP programs to provide home visiting services to TANF-eligible first-time mothers.	X	X		
8. Through a MA State Plan Amendment, DOH provides MA reimbursement for targeted case management activities to NFP programs in Monroe County, Onondaga County, and NYC.		X	X	
9. The statewide GUHH links women to needed services. and is staffed 24/7 with both English and Spanish-speaking trained tele-counselors, a TTY and the AT&T Language Line providing access to over 20 additional languages.		X		
10.				

b. Current Activities

-The 2013-17 Prevention Agenda addresses three key life course periods -- maternal and infant health, child health and reproductive/ preconception/ inter-conception health -- with goals, objectives and indicators for each.
-As a result of the Maternal and Infant Health Initiative (MIH) Request for Applications (RFA) that replaced and integrated the existing community-based perinatal health programs, the DOH established and implemented the Maternal and Infant Community Health Collaboratives Initiative (MICHC) and expanded the Maternal, Infant and Early Childhood Home Visiting Initiative (MIECHV). MICHC includes 22 new projects in 33 high-risk counties that will work to improve specific maternal and infant health outcomes through implementation of evidence-based and/or best practice strategies across the reproductive life course. Through MIECHV funding, the DOH awarded an additional 4 programs, and now supports 5 NFP programs and 5 HFNY programs in 6 high-risk counties.
-An RFP to establish an MIH Center of Excellence to provide MICHC and MIECHV grantees with technical assistance and training, and coordinate data management and evaluation activities was released in February 2014.
-DOH continues to support 3 NFP programs to provide services to TANF-eligible first time mothers.
-NYS' text4baby initiative conducted a fall 2013 social marketing campaign in eight high-need areas of the state. There are approximately 19,500 text4baby subscribers.

c. Plan for the Coming Year

-Activities and services noted in the "Current Activities" sections will continue.
-Improving health outcomes for women, infants and children is a priority for the Prevention Agenda, aligning with goals of the state's MA and Title V program. Maternal and child health encompass a broad scope of health conditions, behaviors and service systems. There is increasing recognition that a 'life course' perspective is needed to promote health and prevent disease across the lifespan. The Prevention Agenda's State Health Improvement Plan addresses three key life course periods--maternal and infant health, child health and reproductive/ preconception/ inter-conception health--with goals, objectives and indicators for each, including implementation of evidence-based HV as a strategy to reach high-risk families. Title V staff will continue to work with key stakeholders to improve MCH outcomes as defined in the Prevention Agenda.
-A Text4baby spring/summer outreach campaign will include a targeted media campaign for young African-American pregnant women or new mothers in eight high risk areas. The campaign will consist of posters and digital media, including the dissemination of marketing materials statewide and the promotion of the text messaging service on the DOH Website and social media

sites (i.e. Facebook, Twitter).
-DOH participates on the NY Parenting Education Partnership which is currently developing resources to be distributed to all new parents to promote positive parenting through knowledge and skill development in accessing appropriate resources and supports, and building stronger parent-child relationships.
-Through MA Redesign, DOH will implement an initiative to demonstrate effective and efficient use of Health Information Technology between hospitals, health care systems and community-based organizations to improve care coordination for pregnant women. The intent is to coordinate services, reduce fragmentation and redundancy, increase patient's access to health records and care engagement, improve quality and reduce costs. It is expected that identifying and addressing risks in a timely manner can contribute to significant reductions in MA costs while improving health outcomes. Title V staff are leading this workgroup.

State Performance Measure 2: *The percentage of Medicaid enrolled children between the ages of 3 and 6 years who had a well-child and preventive health visit in the past year*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			79.5	79.9	80.4
Annual Indicator	79	79	80	83	82
Numerator					
Denominator					
Data Source	NYS Quality Assurance Reporting Requirements	NYS Quality Assurance Reporting Requirements	NYS Quality Assurance Reporting Requirements	NYS Quality Assurance Reporting Requirements	NYS Quality Assurance Reporting Requirements
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	80.9	81.4	83.7	84	84

Notes - 2013
These data represent children in this age group who are enrolled in the Medicaid Managed Care (MMC) which includes 88% of all children enrolled in Medicaid. Information on children enrolled in Medicaid fee-for-service is not included. Numerator and denominator data are not available (survey data).

Notes - 2012
These data represent children in this age group who are enrolled in the Medicaid Managed Care (MMC) which includes 88% of all children enrolled in Medicaid. Information on children enrolled in Medicaid fee-for-service is not included. Numerator and denominator data are not available (survey data).

Notes - 2011
These data represent children in this age group who are enrolled in the Managed Care type of Medicaid coverage which includes 87% of all children. Information on children enrolled in Medicaid fee-for-service is not included.

Numerator and denominator data are not available (survey data).

a. Last Year's Accomplishments
-For care delivered in 2012, the statewide average of 18 Medicaid Managed Care (MMC) Plans' performance for the measure of well-child and preventive health visits for children between the ages of three and six years was 83%. NY exceeds the national average of 72%. Well-child and preventive health visits in first 15 months of life were also included in 2012. The plans' performance for this measure was also 83%. A national average is not available for this measure.
-Use of well child care is a priority focus area in the 2013-17 Prevention Agenda.
-DOH annually monitors the level of access and availability of Primary Care Physician (PCP) panels (number of primary care physicians in a practice) serving the MMC and Child Health Plus (CHPlus) populations. To do this, the Office of Health Insurance Programs (OHIP) analyzes the number of enrollees in a county compared to the number of PCPs. As specified in the 1115 waiver Terms and Conditions for the Partnership Plan and in the MMC contract, DOH established limits of panel size that plan practices are required to meet.
Providers are also monitored for access and availability to see if the practice meets acceptable time standards for appointment availability by type of visit (urgent, non-urgent sick, routine and well child care). This is done by using a 'secret shopper' methodology of calling the practice and posing as an enrollee who needs one of the four types of visit. If the proportion of calls that are given a visit within the acceptable time frame is 75% or less, the plan must submit a plan of correction.
-During the time period 10/1/12 -9/30/13, DOH conducted 16 Article 44 operational on-site surveys of managed care plans that serve Medicaid, CHPlus and Family Health Plus members, and three surveys of commercial managed care plans. The surveys include a review of the MCO's processes to ensure that participating providers comply with Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirements and prenatal standards; requirements for foster children and child protective services; and coordination with local public health agencies.
-Managed care (MC) organization provider networks for Medicaid, CHPlus and Family Health Plus are submitted quarterly and commercial networks are submitted annually to DOH for review. DOH considers the number of participating pediatricians and family practitioners when determining the adequacy of primary care provider (PCP) networks. Of the reviews performed during the time period 10/1/12 -9/30/13, 100% of the MCOs had adequate PCP networks.
-Health plans pursue quality improvement (QI) activities to increase well child preventive health visit rates for children age 3 to 6 by contacting parents whose child has not had a well-child visit to urge them to schedule an appointment; contacting non-compliant children's PCPs and asking them to reach out to families to schedule an appointment; offering gift cards or other incentives to encourage members to schedule a visit; and publishing articles in member newsletters and on the health plans' websites to remind parents of the importance of a well-child visit.
-The measure "well-child visits (WCVs) in the 3rd, 4th, 5th and 6th year" was included in the 2013 Quality Incentive methodology. The Quality Incentive uses quality measures of Effectiveness of Care, Access and Availability and Use of Services. Other measures in the incentive include consumer satisfaction, rates of Preventive Quality Indicators and compliance measures. Plans are ranked by overall points and receive per member per month quality incentive payments. For the 2013 Quality Incentive, three plans did not receive an incentive.
-Community-based public health (PH) programs, such as the Community Health Worker Program (CHWP) and Nurse Family Partnership (NFP), promote healthy behavior in families, including the promotion of pediatric primary and preventive care for children.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Health plans which participate in MMC pursued several quality improvement activities to increase their well child preventive health visit rates.		X		
2. HPs pursue QI activities to increase well child preventive health visit rates for children age 3 to 6-contacting PCPs who have non-compliant patients, offering incentives to encourage members to schedule visits & contacting non-compliant members.		X		
3. Health plans publish articles in member newsletters and on their websites to remind parents of the importance of a well-child visit.			X	
4. DOH monitored access and availability of PCPs which serve the MMC, CHPlus and commercial populations.				X
5. DOH conducted Article 44 operational on-site surveys of managed care organizations.				X
6. The measure “well-child visits in the 3rd, 4th, 5th and 6th year” was included in the 2013 Quality Incentive methodology.				X
7. Community-based PH programs, such as the CHWP and NFP, promote healthy behavior in families, including the promotion of pediatric primary and preventive care for children.		X		
8.				
9.				
10.				

b. Current Activities

-DOH monitors access & availability of PCP panels serving MMC/CHPlus populations. Plans with scores < 75% must submit an action plan. DOH examines MMC client/provider ratio. Providers with a high ratio are called to determine if appointment wait times meet plan standards.
-DOH conducts surveys to review plans' processes for ensuring providers comply with: prenatal standards; EPSDT/foster children requirements; child protective services; & coordinate with local PH.
-Plans target members to increase WCVs by contacting families of children lacking WCVs to schedule appointments; sending reminder cards/incentives; arranging transportation; educating about WCVs during postpartum calls; surveying parents about barriers; placing articles in newsletters & on websites; & educating members on how camp/sports physicals & comprehensive WCVs differ.
-Plans engage PCPs to increase WCVs by requesting they contact families; providing incentives for meeting thresholds; educating practice managers in preventive guidelines to promote compliance; educating PCPs on coding clinical guidelines about WCVs; mailing co-branded or co-signed letters from plan/provider to members; using eligibility check messaging to assist PCPs with gap in care information; & encouraging PCPs to conduct a comprehensive WCV when a child presents for an episodic office visit.
-Plans, DOH, WIC & academia collaboratively explore regional barriers to care & develop a joint approach to educating members on WCV importance.

c. Plan for the Coming Year

-DOH will conduct annual monitoring of the level of access and availability of PCP serving the MMC and CHPlus populations. Any plan with a score of less than 75% will be required to submit an action plan for improvement.
-DOH will conduct Article 44 operational on-site surveys of Managed Care Organizations'

processes to ensure participating providers comply with EPSDT requirements and prenatal standards; requirements for foster care and child protective services; and coordination with local PH agencies.
-Health plans will continue to pursue a variety of quality improvement activities with members and providers to increase their well child preventive health visit rates for children age three to six years.
-Community-based PH programs, such as the home visiting programs, will conduct outreach via telephone calls/home visits to promote healthy behavior in families and provide reminders and education about the need for WCVs.

State Performance Measure 3: *The ratio of the Black infant low birth weight rate to the White infant low birth weight rate*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			1.9	1.9	1.8
Annual Indicator	1.9	1.9	1.8	1.8	1.8
Numerator	13	12.9	12.6	12.3	12.3
Denominator	6.9	6.8	6.9	6.7	6.7
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	1.8	1.8	1.8	1.8	1.8

Notes - 2012
2011 data are being used as a proxy for 2012 data. 2012 data will be available by May 2014. Data are based on rates of low birth weight for White non-Hispanic and Black non-Hispanic births.

Notes - 2011
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013. Data are based on rates of low birthweight for White non-Hispanic and Black non-Hispanic births.

a. Last Year's Accomplishments
-The ratio of Black/White infant low birthweight is slowly improving. Recognizing the need to refine efforts to better ensure continued progress on this and other disparity measures, DOH redesigned NYS's perinatal initiatives and developed the Maternal and Infant Health (MIH) Request for Applications (RFA); this represents a transformation of the current Community Health Worker Program (CHWP), Comprehensive Prenatal-Perinatal Services Networks (CPPSN) and the Healthy Mom-Health Baby (HM-HB) programs. Through the RFA, DOH will establish Maternal and Infant Community Health Collaboratives (MICHC) in high-need communities to develop community-wide systems of integrated and coordinated evidence-based and/or best practice strategies targeted to high-need women and infants. The Collaboratives are designed to achieve a set of performance standards including: enrollment in health insurance; engagement in health care and other supportive services; identification of risk factors and coordinated referrals and follow-up; and promotion of community supports and opportunities to be engaged in and maintain healthy behaviors. Specific priority outcomes for this initiative include reductions in preterm birth, low birth weight, infant mortality and maternal mortality.
-DOH oversees a range of community-based public health initiatives to improve early and

continuous prenatal care for high-risk women not currently engaged in health care, particularly African Americans and Hispanic, including: CPPSNs which identify gaps and barriers in the service system, and in collaboration with community stakeholders, work to improve accessibility and the quality of the local perinatal service system; CHWPs which provide outreach and home visiting services to pregnant women who are at highest risk for poor birth outcomes; and HM-HB programs which support development of organized community systems of perinatal health services through early identification, outreach, risk assessment, and referral to appropriate services including home visiting.
-In 2013, CHWPs served approximately 3,000 clients of whom 31% were Black and 44% were Hispanic women
-In 2013, Maternal, Infant & Early Childhood Home Visiting (MIECHV) served approximately 1,555 clients, of whom 40% were Black and 47% Hispanic women. The MIECHV initiative supports five Nurse Family Partnership (NFP) and five Healthy Families NY (HFNY) programs in six high-risk counties.
-In 2013, Temporary Assistance for Needy Families (TANF)-funded NFP programs served approximately 800 TANF-eligible pregnant women.
-Through a Medicaid (MA) State Plan Amendment, DOH provides MA reimbursement for Targeted Case Management (TCM) activities to NFP programs in Monroe and Onondaga Counties, and New York City. MA billing data shows 40% of TCM clients served in NYS in 2013 were Black and 42% were Hispanic.
-Through the First Time Motherhood/New Parents Initiative, six CPPSNs convened stakeholders to develop and implement community action plans to increase awareness of and supports for preconception health through evidence-based and promising strategies.
-NYS has been a national leader in the development of a statewide system of perinatal regionalization. All obstetrical hospitals have been designated by DOH as a Level I, II, III or Regional Perinatal Center (RPC) based on standard criteria included in state regulation, which require lower level hospitals to consult with RPCs and determine the need for transfer of high-risk mothers and newborns. RPCs conducted quality assurance visits to affiliate hospitals to improve perinatal quality and outcomes.
-Approximately 88.6% of all very low birth weight (VLBW) infants were delivered at RPC and Level III facilities. Conversely, less than 9.3% of VLBW infants were delivered at Level I and II hospitals. Data on why VLBW infants were born at lower level hospitals indicate the majority of these births are due to unavoidable events, such as inability to transfer the woman to a higher level hospital due to advanced stage of labor.
-In October 2011, NYS was awarded a CDC State-Based Perinatal Quality Collaborative Grant for a NY Perinatal Quality Collaborative (NYSPQC). Since 2010 DOH has worked with RPCs on obstetric and neonatal interventions to improve specifically identified perinatal outcomes.
-Public awareness materials are available to promote early entry into prenatal care
-The statewide Growing Up Healthy Hotline (GUHH) links women to needed services.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Public health initiatives were implemented, including perinatal regionalization, to increase access to early & continuous prenatal care, targeting high-risk areas to identify & address gaps in needed services & improve perinatal outcomes.		X		X
2. RPCs conducted quality assurance visits to affiliate hospitals to improve perinatal quality and outcomes, including review of complex cases and determination as to whether cases should have been transferred to regional centers.		X		X
3. HM-HB programs support development of organized community systems of perinatal health services through early identification, outreach, risk assessment, and referral to		X	X	X

appropriate services.				
4. CPPSNs in collaboration with community stakeholders, worked to improve accessibility and the quality of the local perinatal service system.		X	X	X
5. CHWP provided outreach and home visiting services to pregnant women who are at highest risk for poor birth outcomes.		X	X	
6. DOH supported NYS's 3 NFP programs to provide nurse home visiting services to TANF-eligible first time mothers.		X	X	
7. Through a MA State Plan Amendment, DOH provides MA reimbursement for targeted case management activities to NFP programs in Monroe County and NYC. MA billing data for NYS show 40% of clients served were Black and 42% Hispanic in 2013.		X		X
8. Public awareness materials were available to promote early entry into prenatal care.		X		
9. First Time Motherhood/ New Parents Initiative developed and implemented community action plans to increase awareness of and supports for preconception health through evidence-based and promising strategies.		X	X	X
10. DOH issued a Request for Applications to establish a new MICHC initiative. MICHCs will work to address disparities in birth outcomes.			X	X

b. Current Activities

-Regional Perinatal Centers (RPCs) remain the hubs of the perinatal regionalization system. RPCs conduct QA visits at affiliate hospitals and work to improve perinatal quality and outcomes, including review of complex cases.
-NYS was awarded a CDC State-Based Perinatal Quality Collaborative Grant for a NYSPQC. DOH is working with the RPCs to expand obstetric and neonatal interventions to affiliate hospitals to improve specifically identified perinatal outcomes.
-TANF funding continued to support NY's three NFPs to provide nurse home visiting services to TANF-eligible first time mothers.
-DOH established 22 MICHC projects to improve maternal and infant health outcomes for high-need women and reduce racial, ethnic and economic disparities in those outcomes.
-DOH awarded three new NFP programs and one new HFNY program for a total of 10 (five NFP and five HFNY) MIECHV programs in six high-risk counties.
-A Text4baby media campaign was implemented. Customization of messages allows DOH to include state-specific messages and referral resources such as the 24/7 GUHH.
-Improving preterm birth was included as a priority focus area in the 2013-17 Prevention Agenda emphasizing a 'life course' perspective to promote health and prevent disease across the lifespan.

c. Plan for the Coming Year

-DOH staff will continue to work closely with RPCs and affiliate hospitals to monitor and support effective use of the established system of perinatal regionalization.
-Consumer/parent/family input will continue to be obtained at RPCs and affiliates through family advisory councils, satisfaction surveys, provider call-backs, and education and training programs.
-DOH continues the NYSPQC with RPCs to implement selected obstetric and neonatal interventions designed to improve perinatal outcomes. NYSPQC is expanding obstetric and neonatal interventions to affiliate hospitals, including current interventions for reducing scheduled deliveries without medical indication in women of 36 0/7 to 38 6/7 weeks gestation; optimize early enteral nutrition in newborns of <31 weeks gestational age, and reducing central line-associated blood stream infections in neonatal intensive care units.

-Through the MA Redesign process, DOH will implement an initiative to demonstrate effective and efficient use of Health Information Technology (HIT) between hospitals/health care systems and community-based health organizations to improve health care delivery for women and infants through use of uniform screening criteria for perinatal risks. The intent is to coordinate services, reduce fragmentation and redundancy, increase patient's access to health records and care engagement, improve quality and reduce costs. Four HIT demonstration projects (Monroe, Onondaga, Westchester and Kings Counties) have been established and will be implemented in the current year.
-Text4baby will be promoted in 14 high-risk counties during summer 2014.

State Performance Measure 4: *The percentage of high school students who were overweight or obese*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			26.3	26.1	25.8
Annual Indicator	26.6	26.6	25.7	25.7	25.7
Numerator					
Denominator					
Data Source	YRBS	YRBS	YRBS	YRBS	YRBS
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	25.5	25.3	25	25	25

Notes - 2013
Data not updated yet. 2012/2013 data will be available in June 2014

Notes - 2012
The YRBS is conducted biannually. Numerator and denominator data from this survey are not available. 2011 data are being used as a proxy for 2012 data.

Notes - 2011
Data are from the 2011 Youth Risk Behavior Suvey. Numerator and denominator data are not available (survey data).

a. Last Year's Accomplishments
-The national percentage of high school students who were overweight or obese has increased slightly from 2009 (28.2% from 27.8%) based on 2011 Youth Risk Behavior Surveillance (YRBS) data. The YRBS data for NYS is lower than the national average (25.7%, down from 26.6% in 2009.) These figures are based on self-reported information (often underestimated). NYS's student weight status category reporting surveillance is based on directly measured data. The percentage of public school students in grades 7 and 10 who were overweight or obese, exclusive of NYC, for the period of 2010 through 2012 was substantially higher at 35%.
-DOH released the 2010-2012 school district-level, county-level, and statewide (excluding NYC) student weight status category reporting (SWSCR) survey results and posted them on the DOH website. New features include the ability to view and filter data in a variety of file types. The plan to identify an external vendor to conduct statistical analysis of student weight status data was discontinued due to the determination that the capacity existed within DOH.
-The statewide center for obesity prevention, policy research, and training for healthy eating and active living, Designing a Strong and Healthy New York (DASH-NY), continued to provide technical assistance (TA) on the retail food environment and active transportation to DOH contractors. DASH-NY released a mandatory recess implementation guide and fact sheet for local use.

-The Healthy Schools New York (HSNY) initiative, has been implemented by18 contractors to reach school districts with free/reduced price meal participation of 50% or more. The contractors provided TA and resources to 60 high need school districts to adopt and implement physical activity, including physical education, and nutrition policies. 160 new policy elements for physical activity and nutrition have been developed by these school districts. In total, HSNY contractors worked with 130 school districts, over 695 school buildings, and provided TA to more than 1,773 school personnel, reaching over 382,000 students in grades K-12.
-The Community Transformation Grant (CTG)-Small Communities population of focus is children 0 to 18 years old within 8 high need school district areas across three rural counties. Accomplishments included: In Broome and Chautauqua Counties, the Optional Program Standard in Child and Family Services Plan was approved by the Office of Child and Family Services. The Optional Program Standard is a method for increasing enrollment in the Child and Adult Care Food Program (CACFP). In Cattaraugus County, the Gowanda Central School District terminated its contract with Coca-Cola and the district's food service director is taking over all of the vending machines. In Chautauqua County, a campaign aimed at educating teens about the damaging health effects of consuming unhealthy beverages ran on cable television and local radio stations.
-More than 70 contractors from multiple initiatives implemented evidence- and practice-based chronic disease prevention interventions; these interventions promoted sustainable policy, system, and environmental strategies to increase and improve physical activity and nutrition opportunities, including breastfeeding, for children and adolescents across a variety of settings (child care, schools, communities, and health care) to prevent obesity and related chronic diseases.
-Nine Obesity Prevention in Pediatric Health Care Settings (OPPHCS) contractors continued local collaboratives with 31 practices to foster delivery of guideline-concordant care for the assessment, prevention and treatment of child and adolescent overweight and obesity. Participating practices showed sustained improvement in screening for body mass index, weight classification and blood pressure measurement.
-The NYS Health Commissioner's Pediatric Obesity Prevention Workgroup (POPW) continued to convene to mobilize and coordinate a cross agency effort to prioritize, implement and evaluate proven population based, policy, systems and environmental strategies to prevent and control childhood obesity.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The DOH released the 2010-2012 student weight status category reporting results.			X	X
2. The statewide center for obesity prevention, policy research & training around healthy eating & active living, DASH-NY, delivered obesity prevention training (policy, system & environmental changes) to NY residents & DOH contractors.			X	X
3. HSNY delivered TA/training to school districts with the purpose of establishing or improving policies for physical activity & physical education, & nutrition.			X	X
4. CTG implemented a cross-section of physical activity & nutrition policy strategies in early child care, school, and community settings to reach children 0-18 years of age.			X	X
5. The Obesity Prevention Program distributed funding directly and in combination with other programs to prevent obesity and related chronic diseases with intervention investments in child care, school, communities and health care settings.			X	X
6. OPPHCS contractors continued local collaboratives to				X

promote the delivery of guideline-concordant care for the assessment, prevention & treatment of child and adolescent overweight and obesity.				
7. The Commissioner's POPW continued to meet to mobilize and coordinate cross agency efforts to prevent and control childhood obesity.				X
8.				
9.				
10.				

b. Current Activities

-The NYS Health Commissioner's POPW expanded to include representation from nine other state agencies and DASH-NY to further mobilize and coordinate efforts, and accelerate DOH Prevention Agenda goals and objectives for pediatric obesity prevention.
-HSNY continues to provide training and TA to school districts to assess the federally mandated local school wellness policies and develop or strengthen key policies, regulations, and practices. HSNY contractors received one multi-day training and monthly TA webinars on physical activity, physical education, healthy eating strategies and resources for policy adoption and implementation.
-CTG communities continue to implement policy strategies in their communities and provide ongoing TA on strategies addressing active living, healthy living, and tobacco-free environments.
-DOH received new funding to support, among other activities, obesity prevention and school health promotion activities. This funding has resulted in a formal agreement with NYS Education Department for collaborative planning around coordinated nutrition and physical activity school health programs and data sharing.
-Two national broadcasts on improving the school environment through healthy school meals and comprehensive school physical activity programs were conducted, both of which included statements of endorsement from the NYS Health Commissioner.

c. Plan for the Coming Year

-OPPHCS contractors will begin their third cohort of local collaboratives during this period, using monthly data to make small tests for change and inform practice.
-Multiple multi-year chronic disease prevention contracts will conclude their interventions in this period. DOH will release a request for applications (RFA) to fund a coordinated, multi-sector effort to increase demand for and access to healthy food and opportunities for physical activity, to reduce the risk of obesity in high-need communities and school districts. Under this RFA, DOH will seek to fund local-level agencies to implement sustainable policy, system, and environmental changes in selected high-need school districts and the communities where the students and their families live.
-CTG grantees will systematically distribute timely and comprehensive information and knowledge to multiple stakeholders on the successes of CTG. The potential to expand this project into other NYS counties is being explored.
-The 2012-2014 school district-level, county-level, and statewide (excluding NYC) student weight status category reporting (SWSCR) survey results will be released and posted on the DOH website.
-Further expansion of the NYS Health Commissioner's POPW to include additional state agencies will be explored. Current state agency representatives will be engaged in the work of sub-workgroups addressing pediatric obesity prevention by sector or strategy.

State Performance Measure 5: *The ratio of the Hispanic teen (ages 15-17) pregnancy rate to the non-Hispanic White teen (ages 15-17) pregnancy rate*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			5.2	4.5	4.5
Annual Indicator	5.3	4.6	4.5	4.4	4.4
Numerator	58.3	48.6	42		
Denominator	11	10.6	9.3		
Data Source	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	4.4	4.4	4.3	4.3	4.3

Notes - 2013
2012 data is being used as a proxy for 2013 data.

Notes - 2012
2011 data is being used as a proxy for 2012 data. 2012 data will be available in May 2014.

Notes - 2011
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

a. Last Year's Accomplishments
-NYS has experienced a continuous decline in adolescent pregnancy rates over the past two decades. NYS's rate of adolescent pregnancy is the sixth lowest in the U.S. According to a report from the National Center for Health Statistics, when adjusted for race and ethnicity, NYS has the 2nd lowest pregnancy rate for Black adolescents and the 5th lowest for Hispanic adolescents. Despite this positive trend, NYS continues to have striking regional and racial/ethnic disparities in adolescent pregnancy rates.
-Adolescent pregnancy rates are among the most racially and ethnically disparate public health outcomes that DOH monitors. Pregnancy and sexually transmitted disease (STD) rates are consistently almost three times higher for Black and Hispanic teens than for white teens. In 2011, the white teen pregnancy rate of 13.1 per 1,000 females age 15 to17 was much lower than the rate for black (45.8) and Hispanic (41.9) females of the same age; however, the actual magnitude of the disparity is decreasing.
-DOH funds 50 Comprehensive Adolescent Pregnancy Prevention (CAPP) and eight Personal Responsibility Education Program (PREP) community-based projects that focus on decreasing the incidence of adolescent pregnancy and STD/HIV and reducing racial and ethnic disparities among adolescents aged 10 to 21; this is achieved by providing evidenced-based sexual health education; ensuring access to family planning; increasing skill-building opportunities; and promoting community efforts to improve adolescent sexual health. During the third year of the CAPP initiative, over 7,800 Hispanic youth and 9,000 black youth participated in comprehensive sexual health evidence-based programs.
-Reducing racial and ethnic disparities in pregnancy rates and other sexual health outcomes is a central purpose of the CAPP and PREP initiatives. Preference in the selection process was given to organizations that have staff and Boards representative of racial and ethnic populations they propose to serve, and that have experience serving minority populations.
-Forty-five of the 58 CAPP/PREP projects specifically focus on serving Hispanic youth. Funded programs are expected to have staff and Boards representative of racial and ethnic populations they serve, and have experience serving minority populations.
-Eligible target communities for the CAPP procurement were identified through the Adolescent

Sexual Health Needs Index (ASHNI). ASHNI is a ZIP-code level indicator that provides a single, multidimensional measure that incorporates multiple factors including the size of adolescent population, number of adolescent pregnancies and STD cases, and demographic and community factors that are significantly associated with adverse sexual health outcomes.
-Federal Abstinence Education Grant Program (AEGP) funding supports 17 programs focused on implementing mentoring and adult-supervised activities for at-risk preteen youth ages 9 to 12, including youth in foster care, to ease their transition into adolescence and delay the onset of sexual activity.
-DOH-funded New York Promoting and Advancing Teen Health (NYPATH) at Columbia University continues to provide adolescent sexual health education to health care providers serving at-risk youth. Training was provided to 475 health care providers in 2013.
-Fifty DOH-funded family planning agencies with 182 clinics provided free or low cost reproductive health services to nearly 333,000 women, men and adolescents; 18.2% of the people served were teens; 31.4% were Hispanic.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. DOH funds 50 CAPP and eight PREP community-based projects that focus on decreasing the incidence of adolescent pregnancy and STD/HIV and reducing racial and ethnic disparities among adolescents aged 10 to 21.		X	X	
2. 45 of 58 CAPP/PREP projects specifically focus on serving Hispanic communities. Programs are expected to have staff and Boards representative of racial and ethnic populations they serve, and that have experience serving minority populations.		X	X	
3. Eligible communities for CAPP were identified using ASHNI, a ZIP-code level indicator that provides a measure incorporating multiple factors including demographic/community factors significantly associated with adverse sexual health outcomes.			X	
4. DOH funds Columbia University to provide professional education and resources statewide for community healthcare providers serving at-risk youth. Training was provided to 475 health care providers in 2013.				X
5. Federal AEGP funding supports 17 programs focused on implementing mentoring and adult-supervised activities to delay the onset of sexual activity for high-risk youth ages 9-12 living in high-need communities.		X		
6. Fifty DOH-funded family planning agencies with 182 clinics provided free or low cost reproductive health services to nearly 333,000 women, men and adolescents; 18.2% of the people served were teens; 31.4% were Hispanic.	X	X	X	X
7.				
8.				
9.				
10.				

b. Current Activities
-CAPP and CAPP-PREP program activities focus on decreasing the incidence of adolescent pregnancy and STD/HIV and reducing racial and ethnic disparities among adolescents aged 10 to 21. Activities include implementing evidenced-based education programs; ensuring access to family planning; increasing skill-building opportunities for teens; and promoting community efforts to improve adolescent sexual health.

-Federal AEGP funding supports the initiative, the Successfully Transitioning Youth to Adolescence (STYA) program, which funds 17 programs across the state to implement mentoring and adult-supervised programs for high-risk youth ages 9 to 12.
-DOH-funded family planning providers received intensive training on improving their performance in contraceptive coverage. The programs reported that 78.3% of their Hispanic clients who had a negative pregnancy test received an effective contraceptive method in 2013; an increase from 76.4% in 2011. These programs also report a significant increase in the percent of their clients who are Hispanic, from 25.6% in 2011 to 29.3% in 2013.

c. Plan for the Coming Year
-NY's comprehensive approach to adolescent pregnancy prevention targeting high-risk youth across NYS as described in sections a. and b. above will continue, with an emphasis on decreasing racial and ethnic disparities.
-Training and technical assistance will be provided to DOH-funded family planning providers on best practices to increase the number of teen clients and clients from racial and ethnic minority communities.

State Performance Measure 6: *Percent of High School Students Who Smoked Cigarettes in the Last Month*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	5	5	12.5	12.3	12.2
Annual Indicator	14.9	12.6	12.5	11.9	11.9
Numerator					
Denominator					
Data Source	YRBS	NYS Youth Tobacco Survey	YRBS	NYS Youth Tobacco Survey	NYS Youth Tobacco Survey
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	12.1	12	11.8	11.6	11.6

Notes - 2013
2012 data are being used as a proxy for 2013.

Notes - 2012
The YRBS and YTS are conducted biannually in alternating years. The numerator for each year and both surveys is the number of high school students who reportedly smoked on one or more days in the past 30 days. The denominator for each year and both surveys is the total number of students in grades 9 through 12.

Notes - 2011
Data are from the 2011 Youth Risk Behavior Survey. Numerator and denominator data are not available (survey data).

a. Last Year's Accomplishments

-The percentage of high school students in NYS who smoke continued to decline from 14.9% in 2009 to 11.9% in 2012 (latest year data are available), which exceeds the Healthy People 2020 target goal of 16% for this measure.
-NY's cigarette excise tax of $4.35 per pack is the highest state tax in the nation. Evidence is sufficient to conclude that increases in cigarette prices reduce the initiation, prevalence, and intensity of smoking among youth and young adults.
-The DOH-funded 2012 Independent Evaluation Report of the New York State Tobacco Control Program (TCP) was published. The report evaluated youth tobacco use, current point of sale (POS) and tobacco marketing practices, and support for potential policies.
-DOH continued to contract with a policy center that provided education, outreach and technical assistance in policy development to DOH, contractors and the NY tobacco control community to explore, develop and advance lasting and broad-based community-norm change to reduce youth tobacco use initiation and progression. Work focused on youth tobacco use, POS and emerging tobacco products.
-As of January 1, 2013, the Adolescent Tobacco Use Prevention Act (ATUPA) was amended to prohibit the sale of electronic cigarettes (e-cigarettes) to minors (individuals less than 18 years of age). E-cigarettes and other electronic nicotine delivery systems (ENDS) have not been fully studied and are unregulated. Tobacco control experts have concerns that offering flavors that appeal to youth, such as cotton candy, bubble gum and root beer float, may lead to youth initiation, nicotine addiction, and use of combustible cigarettes and other tobacco products that are known to cause disease and death.
-Over 440 municipalities in NY have passed regulations restricting tobacco use in outdoor recreational areas, protecting youth and all visitors from secondhand smoke exposure.
-More than 30 multi-unit housing properties in NY, totaling more than 4,000 rental units, have adopted smoke-free policies, preventing exposure to secondhand smoke and reinforcing the tobacco-free norm. The 2012 Youth Tobacco Survey (YTS) noted a significant downward trend in the average number of days high school students reported exposure to indoor secondhand smoke from the past seven days in NY and regionally. In 2000, the average number of days exposed to indoor secondhand smoke in the past 7 days was 3.1 days, compared with 1.5 days in 2012.
-Reality Check (RC) contractors engaged middle and high school youth to inform their communities and local decision and policy makers that tobacco advertising and promotional efforts cause the initiation and progression of tobacco use among youth (2012 Surgeon General's Report, page 10.)
-Five downstate Bureau of Tobacco Control (BTC)-funded contractors participated in a National Cancer Institute-funded POS study to evaluate the impact of policies that counteract POS marketing to more effectively implement and regulate POS policies.
-TCP placed evocative and graphic paid media that accurately depict the negative consequences of smoking. Repeated studies show that these types of ads dramatically reduce smoking initiation by youth, as well as motivate adult smokers to make more quit attempts, increase calls to quitlines and reduce relapse among former smokers.
-From 10/1/12-9/30/13, the Quitline (phone and web) served 91 unique clients under 18 years old (0.15% of total clients) and 6,140 (8.5%) clients between 18 and 24 years old. Over 86% of all clients reported being very or mostly satisfied with services. The Quitline's social media presence increased: over 50,000 unique engaged users visited its Facebook page and Twitter followers increased 73% over the reporting period.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The DOH-funded 2012 Independent Evaluation Report of the New York State Tobacco Control Program was published. The report evaluated youth tobacco use, current POS and tobacco marketing practices, and support for potential policies.				X

2. The NY Adolescent Tobacco Use Prevention Act was amended, effective January 1, 2013, to prohibit the sale of electronic cigarettes (e-cigarettes) to minors (individuals less than 18 years of age).				X
3. DOH contracted with a policy center that serves as an expert resource on tobacco policy change, including youth tobacco use, POS and emerging tobacco products, including e-cigarettes for DOH, contractors and the NY tobacco control community.			X	X
4. RC contractors and youth educated local communities, decision makers and policy makers about the harms of tobacco use, tobacco industry POS tactics that cause youth to start and continue tobacco use, and potential harms of e-cigarettes.			X	
5. Five downstate BTC-funded contractors participated in a National Cancer Institute-funded POS study to evaluate the impact of policies that counteract point of sale marketing to more effectively implement and regulate POS policies.				X
6. Contractors and RC youth educated local community members, decision makers and government policy makers about how high taxes reduce the initiation, prevalence, and intensity of smoking among youth and young adults.			X	
7. Community contractors educated local government policy makers and community members about the public health and social harms caused by secondhand smoke exposure, leading to over 440 municipal smoke- or tobacco-free outdoor policies.				X
8. Contractors educated housing authorities and landlords (particularly of low-income housing) about secondhand smoke exposure, leading to the adoption of smoke-free policies in >30 multi-unit complexes, totaling >4,000 rental units.				X
9. DOH funded the Quitline that provides free cessation services to individuals, businesses to create healthier workplaces and health care systems to implement tobacco use dependence treatment policies in clinical practice.		X	X	X
10. TCP placed evocative and graphic paid media that accurately depict the negative consequences of smoking that studies show dramatically reduce smoking initiation by youth, increase calls to quitlines and reduce relapse among former smokers.				X

b. Current Activities

-BTC has conducted the NY Youth Tobacco Survey (YTS) biennially since 2000; it will be conducted during this reporting period. Indicators assessed by the YTS include middle and high school youths' tobacco use, secondhand smoke exposure, social network influences, prevalence of cigarette smoking on school property, purchasing locations and exposure to pro-tobacco messages.

-BTC funded 16 RC contractors who engage middle and high school youth to counter tobacco industry marketing practices.

-RC youth flagged tobacco imagery on youth-oriented YouTube videos and reported them to the NYS attorney general's office to discuss with YouTube.

-BTC used its limited media dollars to place evocative and graphic paid media that accurately depict the negative consequences of smoking. Repeated studies show that these types of ads dramatically reduce smoking initiation by youth, motivate adult smokers to make more quit attempts, increase calls to the NY Smokers' Quitline and reduce relapse among former smokers.

-In 2012, 9% of callers to the NYS Smokers' Quitline were under the age of 24. The Quitline counseled 82,776 current and former tobacco users, and distributed 71,717 starter kits of NRT. A total of 732,497 visits were made to the quitsite in 2012, of which 8,549 were from mobile

devices. Over 45,000 Facebook users visited the Quitline's Facebook page in 2012 and 572 users "liked" the page.

c. Plan for the Coming Year

-The current five-year RC contract expires June 30, 2014. BTC is in the procurement process for a new statewide five-year contract, "Advancing Tobacco-Free Communities," that will foster environments supportive of policies that expand the tobacco-free norm in New York State. Contractors will support the prevention and reduction of tobacco use through two elements: community engagement and youth action, branded "Reality Check". This evidence-based, systems approach to chronic disease prevention uses strategies that include community education, community mobilization, government policy maker education and advocacy with organizational decision makers to create local environments that demand policy change. The combined work of the two elements will have the aim of improving the health status of communities by changing community policies and norms about tobacco and tobacco use. Contractors' efforts and activities will focus on populations known to have significantly higher smoking rates: persons with low-income, low educational attainment or serious mental illness.
-Community contractors will work with local communities to increase the number of smoke-free multi-unit housing complexes, particularly low-income housing, and tobacco-free outdoor spaces to reduce or eliminate exposure to secondhand smoke and reinforce the social norm of a tobacco-free New York.
-This new contract will expand RC coverage to every county in the state. The RC element will engage a core group of youth, ages 13 to18, from diverse economic and cultural backgrounds, in civic action and the development of leadership skills. Through evidence-based activities that denormalize and deglamorize smoking in their communities, contractors and youth will continue to drive down youth smoking rates. RC initiatives will include community education linked to social action, media advocacy, media and community events, and advocacy with organizational decision makers to shift the social environment through policy changes. RC youth will take action to reduce or eliminate the tobacco industry's deceptive marketing practices, tobacco imagery in youth-rated movies and tobacco industry presence on social media.
-BTC will incorporate new and applicable recommendations from the CDC's 2014 Best Practices for Comprehensive Tobacco Control Programs to contractor workplans.
-BTC will provide contractors professional development to fine-tune skills and knowledge to ensure the highest possible level of efficaciousness.
-Through various methods, including the YTS and assessment of performance standards, BTC will assess and evaluate contractor activities and provide programmatic guidance as indicated.

State Performance Measure 7: *The percentage of Medicaid enrolled children and adolescents between the ages of 2-21 years who had at least one dental visit within the last year*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			41.4	41.8	42.2
Annual Indicator	40.2	41.0	41.8	44.2	45.4
Numerator	746153	797681	835106	814503	873813
Denominator	1854115	1946654	1996387	1841199	1924213
Data Source	Bur of MA Statistics	Bur of MA Statistics	Bur of MA Statistics	Bureau of MA	Bureau of Mediciad

				Statistics	Statistics & Program Analysis
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	42.6	43.1	43.5	43.7	44.1

Notes - 2012
This indicator is based on data for all Medicaid recipients, including managed care and family health plus paid claims as of June 2012

Notes - 2011
This indicator is based on information from both Managed Care and Fee-for- Sevice Medicaid Programs.

a. Last Year's Accomplishments
-The percentage of Medicaid (MA)-eligible children and adolescents in NYS between 2 and 21 years of age having at least one dental visit during the year increased between 2011 (41.8%) and 2012 (42.2%).
-The proportion of low-income children and adolescents (aged 2 through 18 years) participating in MA Managed Care (MC) Programs who had at least one dental visit within the year increased from 55% in 2012 to 59% in 2013.
-The percentage of children and adolescents aged 2 through 18 years covered under the Child Health Plus (CHPlus) MC Programs who saw a dentist during the year remained unchanged between 2012 and 2013 at 64%.
-Data on the utilization of dental services by low income children and adolescents were used to update the State's oral disease burden document, evaluate accomplishments under the CDC Cooperative Agreement, craft the 2013 State Oral Health Plan, and establish goals and objectives for the NYS Prevention Agenda (PA) 2013-2017 State Improvement Plan.
-BDH funds 30 of 58 programs for School Based Dental Health (SBDH) services to provide dental health services in high risk, underserved areas of NYS.
-Between funded and unfunded programs, services were provided at 1,045 schools in high need areas during the 2012-2013 school year. SBDH programs are available at 29% of all schools eligible for a sealant program.
-The Bureau of Dental Health (BDH) is continuing its survey of 3rd grade children selected from a sample of schools in Upstate counties and NYC to assess the oral health status of school age children and monitor progress toward oral health objectives.
-DOH is in the third year of a 4 year ($200,000/year) HRSA school-based health center (SBHC) dental clinic grant to integrate oral health services into existing SBHCs. DOH is collaborating with North County Children's Clinic (NCFHC) in rural Jefferson County on the project. The goal of this project is to improve the coordination of services. Accomplishments to date include a combined, streamlined application for enrollment in school-based health and dental programs; combined program outreach and promotion; and final drafts of the strategic plan and Continuous Quality Improvement (CQI) program and related assessment and evaluation forms. During 2012, NCFHC expanded its capacity with the addition of 1,001 students to the existing school-based dental program (from 6545 to 7546 students, representing a 15% increase)
-BDH continued to focus on promoting healthy behaviors, reducing barriers to care and utilizing personal and population-based oral health services and to partner with local health departments (LHDs), perinatal and rural health networks, educational institutions, and professional and provider organizations.
-The Fluoride Varnish (FV) Project implemented at the Albany Medical College WIC Program continued throughout the year. A total of 177 children aged 6 months to 4 years were seen in 2011-2012, 40.1% of whom were found to have untreated decay. Among those with untreated

caries, 49.3% had severe decay and were referred for urgent dental treatment. A total of 94.4% of all infants and children seen received a fluoride varnish application.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitoring of the utilization of dental services by low-income children and adolescents participating in the MA Program continued.			X	X
2. BDH funds 30 of 58 programs for SBDH services to provide dental health services in high risk, underserved areas of NYS. Services were provided at 1,045 schools, reaching 29% of all schools eligible for a sealant program.			X	X
3. BDH continued the survey of 3rd grade children selected from a sample of schools to assess oral health status of school age children and monitor progress toward oral health objectives.			X	X
4. Focus on promoting healthy behaviors, reducing barriers to care & utilizing personal/population-based oral health services & partner with LHDs/perinatal & rural health networks/educational institutions/professional & provider organizations.		X	X	X
5. DOH is in the 3rd year of a 4 year HRSA grant to integrate oral health services into existing school-based health centers. During 2012, 1,001 students were added to the existing SBDH program, expanding capacity by 15%.	X		X	X
6. The Fluoride Varnish (FV) Project implemented at the Albany Medical College WIC Program continued throughout the year.	X	X		X
7.				
8.				
9.				
10.				

b. Current Activities

-Difficulties finding dentists to complete school dental health certificates and provide services to MA-eligible children prompted passage of the Dental Hygienist Collaborative Practice bill which allows dental hygienists to sign a dental health certificate. Impact of the bill will be monitored through SBDH Programs and the Third Grade Oral Health Surveillance Project (3rd Grade OHSP).

-The 2013 NYS Oral Health Plan and PA target reduction of dental caries in 3rd grade children. The PA also targets increasing the number of children receiving regular dental care and low-income children enrolled in MA who had at least one dental visit the prior year. Caries reduction and increased utilization of dental services will be monitored by SBDH Programs, the 3rd Grade OHSP, and MA early periodic screening, diagnosis and treatment data.

-A tool kit on oral health for children with special health care needs for dental providers, parents, and key stakeholders is under development to advance the oral health of this high risk population.

-SBDH Programs will continue to be established in high need areas with monitoring of participation and oral health services.

-The 3rd Grade OHSP is continuing; additional schools will be added to the data base.

-Operations and accomplishments of the HRSA Integration Grant continue to be monitored and evaluated.

-The Fluoride Varnish Project at the Albany Medical College WIC Program is continuing.

c. Plan for the Coming Year

-DOH will continue to encourage implementation of policies and systems changes that: (1) promote twice a day tooth brushing with fluoride toothpaste; (2) promote good oral health habits including appropriate feeding and snacking habits and healthy dietary practices, the provision of anticipatory guidance, risk assessment and FV by child healthcare professionals and referral to dental providers as early as eruption of first tooth; (3) encourage visits to a dental provider on a regular basis; (4) increase the availability of fluoride through community water fluoridation or a supplemental fluoride program; (5) promote school-based interventions ranging from the DHC, oral health education, dental sealants, case finding and referral to dental care providers; enhance access to affordable insurance coverage; (6) ensure an adequate supply of oral health providers, especially in underserved areas; and (7) integrate oral health as part of programs, policies and overall health screenings.

-The BDH will work with key stakeholders and members of the NYS Oral Health Coalition on continued implementation of the 2013 NYS Oral Health Plan and the DOH PA as related to oral health. The tool kit chapter on oral health for CSHCN will be finalized and distributed to key stakeholders and resources be made available on the DOH public website. Additional chapters for the tool kit covering early childhood caries and the oral health of school-aged children and adolescents will also be developed.

-The utilization of dental services by children and adolescents and the types of services received will continue to be monitored.

-The NCFHC HRSA-funded integration project will be completing its final year and an evaluation report will be prepared along with lessons learned and recommendations.

-Data will continue to be collected on the FV Project at the Albany Medical College WIC Program and an evaluation report of this initiative will be prepared.

State Performance Measure 8: *Percentage of children who were tested for lead two or more times before the age of three.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			51	51.5	52
Annual Indicator	50.5	53.0	55.0	57.6	57.6
Numerator	125763	133960	137431	142143	142143
Denominator	249182	252662	249655	246592	246592
Data Source	NYS Lead Program	NYS Lead Program	NYS Lead Program	NYS Lead Program	NYS Lead Program
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	52.5	53	53.5	54	54

Notes - 2012

Data are reported for children turning three years of age in the year reported – i.e., data reported for 2011 are for children born in 2008. Data are statewide, including NYC. 2011 data are used as a proxy for 2012. 2012 data will be available in May 2014.

Notes - 2011

Data are reported for children turning three years of age in the year reported – i.e., data reported for 2010 are for children born in 2007. Data is statewide, including NYC.
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

a. Last Year's Accomplishments

-Lead surveillance data for 2012 demonstrates over a 3% increase in the number of children tested for lead two or more times by age three. This improvement is due to the application of strong policy and program efforts to enforce state regulations for lead testing at ages one and two.

-Revisions to state regulations, effective 06/09, authorized private physician office laboratories (POLs) and limited services registrant laboratories to conduct blood lead testing using point-of-care (POC) testing devices. More than 500 devices had been purchased in NYS as of the end of 2013, and nearly 300 laboratories were contacted and trained on how to report the results.

-Reporting mechanisms for POLs were streamlined in 2009 when Public Health Law (PHL) was amended to authorize linkage of the DOH childhood blood lead registry (LeadWeb) and the NYS Immunization Information System (NYSIIS). In 09/10, the linkage was completed and a NYSIIS lead module was implemented to allow POLs to enter lead test results. As of the end of 2013, 1.8 million lead tests have been added and are available for POLs to view.

-Additional improvements have been made to the NYSIIS lead module. These include allowing providers the ability to view a child's lead testing history in NYSIIS; the addition of pertinent care coordination reminders; and electronic availability of management guidelines to help reinforce compliance with PHL and regulations.

-NYSIIS List Reports were made available for providers, local health departments (LHDs), and health plans to identify children requiring a 1- or a 2-year old test, children overdue for testing, and those requiring a re-test.

-Provider Performance Reports were released in NYSIIS. State and LHD staff have begun using the reports to direct outreach to providers with low testing rates. Health care providers and health plans are also able to access reports on their patients.

-The Office of Health Insurance Programs (OHIP) and Lead Poisoning Prevention Program (LPPP) staff developed a contract requirement for managed care plans mandating an annual assessment of enrollees' lead testing status. LPPP staff educated health plans on how to use the reports available to them in NYSIIS.

-Dissemination of the updated Guidelines for the Prevention, Identification & Management of Lead Poisoning in Pregnant and Postpartum Women was postponed due to the release of the CDC guidelines and the CDC's adoption of the recommendations of the federal Advisory Committee on Childhood Lead Poisoning Prevention.

-The longstanding CDC funding for lead poisoning prevention has been eliminated, representing a loss of approximately $1 million to NYSDOH and $1 million to the New York City Department of Health and Mental Hygiene (NYCDOHMH). This funding reduction resulted in a loss of 9 staff directly working in the program.

-The administration of the NYS LPPP is completely located in the Bureau of Community Environmental Health and Food Protection, Center for Environmental Health (CEH). This transition includes the management of the lead registry, NYSIIS Lead module, laboratory reporting of children's blood lead tests, contract management, public education and outreach and quality improvement activities.

-CEH received a Health Homes (HH) grant on 9/1/2011 to develop a comprehensive and holistic approach to addressing a broad range of housing hazards associated with lead poisoning, asthma, and injury prevention. Activity on the grant deliverables continues.

-LHDs continued to receive grant funds to support statewide delivery of a comprehensive LPPP, and to contract with 3 Regional Lead Resource Centers (RLRCs) in 5 teaching hospitals throughout NYS to provide expert clinical support, education and outreach to LHDs and health care providers to improve lead testing and other preventive practices.

-The Childhood Lead Poisoning Primary Prevention Program (CLPPPP) inspected 8,504 housing units for lead based paint hazards in 2012. The program targets high risk housing to perform inspections, before a child is exposed to lead, in communities with a high incidence of lead poisoning.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Revised state regulations authorized private POLs & limited service registrant laboratories to conduct blood lead testing using POC devices. In 2013, more than 500 devices were purchased & almost 300 laboratories trained how to report results.		X	X	
2. Reporting mechanisms for POLs were streamlined in 2009 when PHL was amended to authorize linkage of the NYSDOH childhood blood lead registry and NYSIIS. By 12/31/13,1.8 million lead tests have been added and are available for POLs to view.		X		X
3. NYSIIS lead module improvements include enabling providers to view a child's lead testing history; addition of pertinent care coordination reminders, & electronic availability of management guidelines to reinforce PHL & regulatory compliance		X	X	
4. Provider Performance Reports were released in NYSIIS 04/12. State & LHD staff are using the reports to direct outreach to health care (HC) providers with low testing rates. HC providers & health plans can access reports on their patients.		X	X	X
5. LHDs received funds to support statewide delivery of a comprehensive LPPP & to contract with 3 RLRCs in 5 teaching hospitals for clinical support, education/outreach to LHDs & HC providers to improve lead testing & preventive practices.		X	X	X
6. CEH received a HH grant in 9/11 to develop a comprehensive & holistic approach to address a broad range of housing hazards associated w/lead poisoning, asthma, & injury prevention. Activity on the grant deliverables continued in 2012-2013.	X	X	X	X
7. The CLPPPP inspected 8,504 housing units for lead based paint hazards in 2012. The program targets high risk housing to perform inspections, before a child is exposed to lead, in communities with a high incidence of lead poisoning.	X	X	X	
8. NYSIIS List Reports were made available for providers, local health departments and health plans to identify children requiring a 1- or a 2-year old test; children overdue for testing; and those requiring a re-test.		X	X	
9. OHIP and LPPP staff developed a contract requirement for managed care plans mandating an annual assessment of enrollees' lead testing status. LPPP staff educated health plans on how to use the reports available to them in NYSIIS.			X	X
10.				

b. Current Activities

-Ongoing activities to work with physician office laboratories (POLs) and limited service laboratories (LSLs) which conduct blood lead testing using point-of-care blood lead testing devices continue. The LPPP program currently trains POLs and LSLs on how to accurately report the blood lead test results to DOH. The use of point-of-care testing has decreased one of the barriers in performing the required lead testing at ages 1- and 2-years-old by physicians.
-The DOH would like to look at and improve the overall quality and performance of the LeadWeb system and is seeking a Business Analyst to review its current functions and consider the future direction planned for the statewide system.
-CEH recently awarded 13 Healthy Neighborhood grants to LHDs through a competitive RFA process. The new programs will develop comprehensive and holistic approach to addressing a broad range of housing hazards associated with lead poisoning, asthma, and injury prevention within their targeted communities. This new grant cycle will continue to build forward on the

previous knowledge learned and best program practices from the previous HH grant award.

c. Plan for the Coming Year
-There will be continued efforts to work with physician office laboratories (POLs) and limited service laboratories which are conducting blood lead testing using point-of-care devices. This activity also improves the screening rates of children in the targeted age groups of 1- and 2-years-old who are required by state regulation to be tested for lead.
-Based on the previous year, there have been an increased number of requests from the field for a streamlined, automated data exchange to include blood lead test results in Electronic Medical Record (EMR) information sent to NYSIIS. Currently, there is no mechanism for an EMR file sent directly to NYSIIS to include blood lead test results. The Lead Program intends to begin the process of developing this capability.
-Based on the previous year's work with and recommendations of the Business Analyst reviewing the LeadWeb system, there will be qualitative recommendations for the growth and design of the LeadWeb system. Activities related to the recommendations are expected to involve quality improvement and will improve the flow of child-based data both coming into and going out of LeadWeb.

State Performance Measure 9: *Hospitalization Rate for Asthma in Children Ages 0 to 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			31	26.5	26.4
Annual Indicator	31.1	26.7	26.5	26.8	26.8
Numerator	13781	11552	11341	11406	11406
Denominator	4424083	4324929	4286008	4263154	4263154
Data Source	SPARCS	SPARCS	SPARCS	SPARCS	SPARCS
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	26.3	26.2	26	25.7	25.7

Notes - 2013
2012 data are being used as a proxy for 2013 data.

Notes - 2012
2011 data are being used as a proxy for 2012 data. 2012 data will be available by May 2014

Notes - 2011
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

a. Last Year's Accomplishments
-Since 2009, there has been an overall decrease in the rate of children ages 0-17 hospitalized for asthma (ICD-9 Codes: 493.0-493.9). However, from 2011 to 2012, the number of children ages 0-17 years hospitalized for asthma increased slightly from 26.5/10,000 to 27.3/10,000. The annual performance objective for this measure was not met, pointing to a need to strategically align resources to address the most high need areas of the state. Accordingly, DOH re-distributed funding to the Regional Asthma Coalition (RAC) in 2012, targeting geographic areas with high rates of asthma-related hospital discharge rates and Emergency Department (ED) utilization.
-DOH continued to implement and monitor the NYS Asthma Plan through collaboration with a

network of partners, to include an agency-wide, multi-disciplinary infrastructure to address asthma along with the Asthma Partnership of NY (APNY), an external public/private collaboration.
-Funding for the RACs was awarded to areas of high need across NYS, as defined by county-level asthma-related hospital discharge and ED visit data. The coalitions bring together health care and community partners to plan, test, and implement population-based, system change interventions. Interventions are aimed at improving asthma care processes and decreasing asthma-related: hospitalizations, ED visits, and school/work days lost. The individual coalitions were directed to identify populations with the greatest burden of asthma within their regions and to focus their efforts on reducing identified disparities.
-The RACs delivered Asthma Educator Institutes to support efforts to expand the Certified Asthma Educator (AE-C) workforce and its integration into clinical practice settings serving individuals with asthma who are enrolled in Medicaid (MA). These efforts resulted in a 50% increase in the number of clinically licensed AE-Cs in NYS.
-DOH implemented the Asthma Outcomes Learning Network (AOLN); 26 participating teams (primary care, hospitals, schools, pharmacies, and community-based organizations (CBO)) planned, tested and implemented system changes to improve asthma care processes and health outcomes.
-Current NY asthma surveillance data was made available to the coalitions and other partners via the NYS Asthma Surveillance Summary Report; the DOH public website, where data is provided by region, county and zip code; and other reports and data summary documents produced by DOH. Focused technical assistance (TA) was provided to the coalitions to assist in their access and utilization of this data. Performance across a core set of required process measures was monitored on a monthly basis.
-The "Clinical Guideline for the Diagnosis, Evaluation and Management of Adults and Children with Asthma", a NYS consensus asthma guideline decision support tool for health care providers, was updated with medication-related changes made in consultation with the DOH Consensus Asthma Guideline Expert Panel. DOH continued to make the tool available in hard copy and electronically, at no cost, to all health care providers, educators and health plans throughout the state. More than 4500 hard copies of the asthma guideline tool were distributed to health care providers, health plans, asthma educators, and community-based partners across NYS.
-The Eliminating Disparities in Asthma Care (EDAC) intervention, focused on improving asthma care for African American individuals with asthma who are enrolled in NY MA managed care, entered the final stages of implementation. This population-based, system change intervention was led by DOH and implemented in partnership with health care practices and MA managed care plans serving individuals with asthma in Central Brooklyn, a high asthma burden area of NYS.
-A proposal was drafted and included in a waiver request to the Center for Medicaid Services. I\in response to the NYS Medicaid Redesign Team's (MRT) recommendation to provide reimbursement for home-based asthma education and assessment services. The proposal outlined a demonstration project to explore the efficacy of providing asthma self-management education and environmental asthma trigger assessment in the home setting of individuals with poorly controlled asthma.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintained Comprehensive Asthma Surveillance System; disseminated asthma surveillance data; provided TA and guidance around utilizing surveillance information.				X
2. Administered the RAC initiative – A Systems Approach to Decreasing the Burden of Asthma in NYS.			X	X
3. Delivered Asthma Educator Institutes though the RACs to support efforts to expand the AE-C workforce and its integration into clinical practice settings serving individuals with asthma who			X	X

are enrolled in MA.				
4. Implemented the AOLN; 26 participating teams (primary care, hospitals, schools, pharmacies, and CBOs) planned, tested and implemented system changes to improve asthma care processes and health outcomes.			X	X
5. Updated and distributed the "Clinical Guideline for the Diagnosis, Evaluation and Management of Adults and Children with Asthma", an asthma guideline decision support tool for health care providers			X	X
6. Implemented and monitored the EDAC project.			X	X
7. Expanded the AE-C workforce, AE-C integration into clinical practice setting, and AE-C enrollment in NY MA program.			X	X
8. Advanced the MRT recommendation to provide reimbursement for home-based asthma self-management education and assessment services.				X
9. Continued to implement and monitor the NYS Asthma Plan through collaboration with a network of partners, to include an agency-wide, multi-disciplinary infrastructure to address asthma along with the APNY, an external public/private collaboration.			X	X
10.				

b. Current Activities

-Guided by the APNY, the process to update the NYS Asthma Plan was completed. The updated plan, with revised strategic objectives & evidenced-based strategies & interventions, will be published & implemented in 2014.
-A comprehensive NYS asthma surveillance system is being maintained. An updated NYS Asthma Surveillance Summary Report is complete & will be published in 2014. A series of Asthma Data to Action Reports are complete & posted on the DOH website.
-Reinvestment strategies initially included in the MRT Waiver Amendment will be implemented through a statewide plan comprised of multiple Delivery System Reform Incentive Payment (DSRIP) programs with the goal of reducing avoidable hospitalizations & ED use by 25% over the next 5 years. A home-based asthma assessment & education program is included in the DSRIP plan. The objective of this program is to ensure implementation of asthma self-management skills including home environmental trigger reduction, self-monitoring, medication use & medical follow-up to reduce avoidable ED & hospital use. Special focus is on children for whom asthma is a major driver of avoidable hospital use.
-Data collection for the EDAC project is complete & a comprehensive evaluation report of the intervention is being drafted; findings will be disseminated to stakeholders.
-The NYS consensus asthma guideline decision support tool & the Asthma in the Primary Care Setting course are continually available to the public.

c. Plan for the Coming Year

-DOH will continue to administer and monitor the RAC initiative. As the RACs expand their efforts to include new systems and reach broader populations, they will continue to implement an approach based on translating the national guidelines for asthma care into practice utilizing evidence-based improvement methods. RAC performance across a core set of measures will be monitored on a monthly basis, with changes being tested and implemented in response to project-level data.
-The Clinical Guideline for the Diagnosis, Evaluation and Management of Adults and Children with Asthma, a NYS consensus asthma guideline decision support tool, and the Asthma in the Primary Care Setting course will be updated as appropriate and will continue to be made available to the public at no charge. Opportunities to further develop culturally appropriate self-management tools, such as translation of existing paper tools into mobile applications, will be

explored.
-Successes from the 2012 and 2013 AOLN teams will be expanded to additional systems of care and broader populations. DOH will convene the 2014 AOLN to include the provision of training and TA to a new cohort of project teams. A minimum of 16 new AOLN projects, aimed at improving asthma care processes and health outcomes, will be implemented and monitored in collaboration with the RACs.
-DOH will develop data and information systems to provide information about asthma prevalence rates and presence of asthma triggers at the school building and school district levels across the state. This information will be utilized to guide the planning and prioritizing of school-based asthma management activities in 2015.
-Several policy initiatives and interventions will be continued or expanded to increase access to quality, culturally and linguistically appropriate, asthma self-management support services:
DOH will partner with the RACs to implement strategies to increase the integration of clinically licensed AE-Cs into practice to provide services to high risk patients with asthma.
•DOH will support the implementation of the DSRIP home-based asthma assessment and education program.
•Additional strategies for increasing access to home-based asthma services will be explored.
•Hard copy asthma self-management support tools will continue to be provided to the public.
•While the initial steps of converting high-demand paper tools into mobile applications have been completed, additional resources are required to complete this process. If resources are secured, the mobile tool will be developed.

State Performance Measure 10: *The percentage of infants who were exclusively fed breast milk between birth and hospital discharge*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			43.1	43.6	44
Annual Indicator	42.7	43.5	39.8	40.6	40.6
Numerator	96080	95511	86126	87554	87554
Denominator	224903	219503	216625	215852	215852
Data Source	Statewide Perinatal Data System	Statewide Perinatal Data System	Statewide Perinatal Data System	Statewide Perinatal Data System	Statewide Perinatal Data System
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	44.4	44.8	45.4	45.4	45.4

Notes - 2013
2012 data are being used as a proxy for 2013 data.

Notes - 2012

2011 data is being used as a proxy for 2012 data. 2012 data will be available in May 2014. The denominator includes all live born infants, excluding infants who were admitted to the NICU or transferred in or out of the hospital. The method the infant is fed is recorded on the Certificate of Live Birth and is defined as the period between birth and discharge from the hospital, up until 5 days of age (when NYS law requires report of live births). Infants are classified as being fed exclusively breast milk if they were fed only breast milk, and no other liquids or solids except for drops or syrups consisting of vitamins, minerals or medications.

It should be noted that the percentage of infants exclusively fed breast milk in the delivery hospital appears to have decreased from 43.5% in 2010 to 39.8% in 2011. Efforts were made to improve and standardize the reporting for the infant feeding variables, including exclusively fed breast milk. Guidance from the National Center for Health Statistics, that newborn infant feeding data should be reported for the entire period spent in the delivery hospital (i.e., between birth and discharge), was shared with hospitals. Some hospitals had been reporting infant feeding based only on the last 24 hours or the last day of hospitalization. This change in reporting resulted in a reduction in the percentage of infants reported as being exclusively fed breast milk.

Notes - 2011
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

a. Last Year's Accomplishments
-Infant feeding data during birth hospitalization, taken from infant birth certificates, were analyzed. Hospitals were ranked using three indicators (percent of infants fed any breast milk, percent of infants fed exclusively breast milk, and, among infants fed any breast milk, the percent of infants who were also fed formula in the hospital). Each hospital was informed of its performance relative to other hospitals. Infant feeding indicators for 2011 were posted on the DOH webpage November 2012.
-The New York City Department of Health and Mental Hygiene (NYCDOHMH) engaged 9 hospitals in a Baby Friendly Hospital (BFH) Learning Collaborative. DOH staff supports this collaborative by providing faculty and coaching to hospital improvement teams.
-Ten Steps to Successful Breastfeeding: An Online Course was offered to staff in 92 hospitals (exclusive of NYC) providing maternity care services. To date, 2,345 staff have completed this course which meets the staff education requirement for BFH Designation.
-NY's Medicaid (MA) State Plan Amendment for coverage of individual and group lactation counseling services by International Board Certified Lactation Consultants (IBCLCs) who are registered professionals was approved by CMS and implemented in April 2013 for NY MA Fee-for Service and in May 2013 for NY MA Managed Care Plans. Structured breastfeeding (BF) education and lactation counseling has a grade B recommendation from the United States Preventive Services Task Force (USPTF) as an evidence-based intervention to increase BF initiation, exclusivity and duration. In addition, minimum breast pump specifications were developed that must be met for breast pumps to be reimbursed by NYS MA.
-Hospital BF policies were collected and reviewed for compliance with NY hospital regulations and laws. Ninety-seven (97) of the 129 hospitals providing maternity care had BF policies that included all 28 required components; the remaining hospitals were notified and asked to revise their policies and resubmit to DOH.
-WIC developed and conducted training in BF counseling for local agency staff.
-DOH continued to support Latch On NYC, a hospital-based initiative to support mothers choosing to BF and to minimize hospital practices that interfere with that choice. The goal of Latch On NYC is to increase BF initiation and duration, and exclusive BF, and decrease non-medically indicated formula supplementation. Twenty-eight of 40 NYC hospitals participate in this initiative.
-A new initiative, Great Beginnings NY, The Future Starts with Breastfeeding, which aims to increase exclusive BF was announced. Hospital Leaders committed to implementing strategies to restrict the distribution and/or promotion of infant formula.
-DOH conducted an analysis of linked mother/infant data to assess whether the timing (prenatal/postpartum) of maternal WIC participation is associated with BF initiation and duration.

-WIC is implementing policies focused on improving exclusive BF, i.e., assessing the BF dyad, BFpromotion for the prenatal participant, revising the breast pump policy and improving staff competencies.
-WIC updated information on http://www.breastfeedingpartners.org/. This site includes designated peer counselor login and information on BF support after delivery.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Using vital statistics data, hospitals were ranked based on 3 indicators (fed exclusively breast milk, fed any breast milk, and breastfed infants also fed formula in the hospital).				X
2. DOH continued offering the Ten Steps to Successful Breastfeeding: An Online Course to staff at 92 hospitals providing maternity care services.			X	
3. Hospital BF policies were reviewed. Hospitals were notified of inclusion of required components. Hospitals that did not include all of the required components were asked to revise their policies and resubmit to DOH.			X	X
4. WIC revised http://www.breastfeedingpartners.org/which focuses on exclusive BF and maternity practices that support BF after delivery.		X		
5. WIC developed and conducting training for local agency staff on BF counseling.		X		X
6. DOH supported Latch On NYC to support mothers choosing to breastfeed. Twenty-eight of 40 hospitals in NYC are participating in this initiative.			X	X
7. NYCDOHMH engaged 9 hospitals in a BFH Learning Collaborative.			X	X
8. DOH's MA coverage of lactation education and counseling was approved and implemented. Minimum breast pump specifications were developed and implemented.			X	X
9. A new voluntary initiative, Great Beginnings NY, The Future Starts with Breastfeeding, was announced.		X	X	
10. DOH conducted an analysis of linked mother/infant data to assess the association of maternal WIC participation with BF initiation and duration.			X	

b. Current Activities
-Hospital BF indicators are updated yearly and posted to the DOH webpage.
-DOH expects to recruit a cohort of hospitals to engage in a 15-month learning collaborative to improve maternity care practices.
-DOH is implementing a Breastfeeding Friendly Practice Designation for OB/GYN, Pediatricians, and Family Practice Physicians. A cohort of practices in Erie County participates in a virtual learning network to inform the designation process.
-DOH works with hospitals with non-compliant BF policies.
-66 maternity care hospitals have joined the Great Beginnings NY initiative and committed to changing breastfeeding practices. They participate in webinars and share successes and challenges.
-DOH developed a CME course consisting of four one-hour webcasts to increase knowledge/skills for physicians and other health care providers to support successful BF. This is being disseminated to hospitals, physicians and other stakeholders.
-Data will be reviewed to determine usage of the MA benefit for lactation counseling and breast

pumps.
-DOH is working with NYS MA to allow the provision of community-based preventive services (lactation counseling) by IBCLCs without a professional NYS license. This will require submission of a State Plan Amendment to CMS for approval.
-DOH continues to offer the Ten Steps to Successful BF: Online Course to hospitals providing maternity care.
-WIC continues to train local WIC staff in BF counseling.

c. Plan for the Coming Year
-WIC is emphasizing improvement of exclusive BF rates through training staff and modifying food packages to further support BF policy.
-WIC will work with a training contractor to continue to improve competencies of WIC local agency staff in BF assessment, support, counseling and critical thinking.
-DOH will work to increase the number of pediatric, family practice and obstetric/gynecologic practices that have received the NYS BF Friendly Practice Designation.
-DOH will continue to work with hospitals participating in Great Beginnings NY to improve maternity care practices.
-DOH will continue to work with key partners to ensure that private insurers provide lactation counseling services that meet or exceed the benefit provided by the NYS MA program and that breast pumps provided meet the minimum breast pump standards set by NYS MA.
-DOH will work to ensure that lactation counseling services provided by the Managed Care Programs participating in the New York Health Benefit Exchanges meet or exceed the benefit provided by the NYS MA program and that breast pumps provided meet the minimum breast pump standards set by NYS MA program.
-DOH will revise the NYS Model Hospital BF Policy and Implementation Guide to better align with the BFH Initiative and incorporate recommendations from professional associations.
-DOH will examine and evaluate lessons learned and best practices from the community- based interventions in Erie County and spread this work to other communities throughout the state.
-DOH and NYCDOHMH staff will continue to collaborate to educate providers, assist hospitals with the implementation of baby friendly policies and practice, and link women with home visiting programs to educate and assist with support for BF.

E. Health Status Indicators

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	8.2	8.2	8.1	7.9	7.9
Numerator	20226	19910	19417	18935	18935
Denominator	246360	242693	239498	238982	238982
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
Data Source: Vital Records/Births. 2012 data are being used as a proxy for 2013 data.

Notes - 2012
2011 Data are being used as a proxy for 2012

Notes - 2011
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.
Source: NYS DOH Vital Records

Narrative:
NYS's low birth weight rate (LBW) was unchanged between 2008 and 2010, at a rate of 8.2% which is greater than the HP 2020 goal of 7.8%. However, NY continues to improve in this indicator. There was a slight decrease in 2011 to 8.1% and another decrease to 7.9% in 2012. NY's experience mirrors the national trend; in 2012, data indicates that 7.99% of births nationally were LBW. NY is making progress in this area related to disparities. The ratio of Black White infant LBW is slowing improving.
DOH administers a number of programs and initiatives that collectively aim to provide a comprehensive, integrated set of services to support optimal perinatal outcomes for both mothers and babies. These programs are located in the DFH and are part of an integrated effort to reduce health disparities in affected communities by increasing access to and utilization of comprehensive prenatal care and other services through outreach, early identification, enrollment and referral of pregnant women into prenatal care, home visiting and other needed services.

Recognizing the need to refine efforts to better ensure continued progress in this area, over the past couple years Title V redesigned NY's perinatal initiatives and established Maternal and Infant Health Collaboratives in high-need communities to develop evidence-based and/or best practice strategies targeted to high-need women and infants, designed to achieve a set of performance standards including: enrollment in health insurance; engagement in health care and other supportive services; identification of risk factors and coordinated referrals and follow-up; and promotion of community supports and opportunities to be engaged in and maintain healthy behaviors. This effort emphasizes a life course approach, recognizing that the health of a woman throughout the life span prior to pregnancy has a significant impact on the outcome of the pregnancy. Specific priority outcomes for this initiative include preterm birth, low birth weight, infant mortality and maternal mortality. Title V also supports evidence-based home visiting services in high need areas of the state including NFP and HFNY.

NYS has also been a national leader in the development of a statewide system of perinatal regionalization. NYS has a well-organized system of regionalized perinatal care that ensures that appropriate hospital care is provided to women and their newborns.

Various PA Goals also support NY's effort to improve low birth weight, including impacting disparities.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01B - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	6.2	6.2	6.1	6.0	6.0
Numerator	14587	14489	14118	13830	13830
Denominator	236463	233203	230108	229787	229787

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
Data Source: Vital Records/Births. 2012 data are being used as a proxy for 2013 data.

Notes - 2012
2011 Data are being used as a proxy for 2012.

Notes - 2011
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.
Source: NYS DOH Vital Records

Narrative:
When LBW rates for total births are compared to those for singleton births, the rates among singletons are consistently better. Very low and LBW births occur more frequently during multiple births. There has been an increase in the past decade in multiple births, due in part to advances in assisted reproduction technology, where multiple births are more common. From 1999 through 2012 there was a slow rise in the percentage of all babies born who were either twins or higher order multiples. In 1999 the rate of non-singleton babies born was 3.5%, and in 2012 the rate was 3.8%. The singleton LBW rate of 6.0 percent in 2012 represents a slight decrease from 2011 (6.1 percent). Issues such as access to comprehensive prenatal care, substance use and other health and social issues can impact birth outcomes. Within the Title V Program, and in collaboration with a wide range of internal and external partners, the DOH administers a number of programs and initiatives that collectively aim to provide a comprehensive, integrated set of services to support optimal perinatal outcomes for mothers and babies. These programs are part of an integrated effort to reduce health disparities in affected communities by increasing access to and utilization of comprehensive and continuous early prenatal care and other services through early identification, enrollment and referral of pregnant women into prenatal care, home visiting and other needed services.

DOH recognizes that to improve birth outcomes, efforts need to be made to improve the health of women prior to pregnancy as it significantly impacts birth outcomes. Under the previously HRSA-funded First Time Motherhood/New Parents Initiative, DOH supported 6 CPPSN programs to convene key stakeholders to develop community action plans to increase consumer and provider awareness of CDC's Recommendations to Improve Preconception Health and Health Care. Information gleaned from this initiative were incorporated into the newly funded MICH Collaboratives. One of the priorities of the MIH Collaboratives is to promote a life course approach to improve the health of women before and between pregnancies. Strategies focus on improving outreach to find and engage high-need women in health care and other needed services across the life course. DOH also entered into an agreement with the National Healthy Mothers-Healthy Baby Coalition and implemented the national Text4baby initiative in NY. A public awareness campaign will be implemented in high risk communities of the state with the most disparate birth outcomes.

NYS has also been a national leader in the development of a statewide system of perinatal regionalization. All obstetrical hospitals have been designated by the DOH as a Level I, II, II or Regional Perinatal Center (RPC) based on standard criteria included in state regulation. Regulations require lower level hospitals to consult with RPCs and determine the need for

transfer of high-risk mothers and newborns.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	1.5	1.5	1.5	1.5	1.5
Numerator	3763	3683	3526	3504	3504
Denominator	246360	242693	239498	238982	238981
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
Data Source: Vital Records/Births 2012 data are being used as a proxy for 2013 data.

Notes - 2012
2011 Data are being used as a proxy for 2012

Notes - 2011
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.
Source: NYS DOH Vital Records

Narrative:
The percent of very low birthweight births (<1500 grams) in New York State was 1.5% in 2012, unchanged form 2011. The rate has been virtually unchanged since 1999, and slightly higher than the Healthy People 2020 goal of 1.4%. The VLBW rate has shown little variation over the past decade. As stated in Health Status Indicator 1A and 1B, the Title V Program has made significant efforts to improve birth outcomes through the development, implementation and oversight of a number of programs and initiatives that collectively aim to provide a comprehensive, integrated set of services to support optimal perinatal outcomes. Efforts made to ensure that all VLWB babies are born at facilities with services commensurate with their more complex needs have resulted in the vast majority of these babies being born at Level III hospitals and Regional Perinatal Centers. Regionalization has had a positive impact in NYS with VLBW babies more likely to be born at RPC and Level III hospitals and more likely to survive post-regionalization (2004-2006) than pre-regionalization (1996-2001). Regionalization continues to have a positive impact in NYS with VLBW babies remaining more likely to be born at RPC and Level III hospitals and survive since hospital levels were redesignated in 2003. NYS's risk-adjusted VLBW neonatal mortality rate declined from 11.0 per 100 during 2004-2009 to 10.5 per 100 during 2010-2012. Improvements were noted by region, NYC (11.4/100 to 10.5/100) and Rest of State (10.5/100 to 10.4/100), and hospital level, RPCs (10.5/100 to 10.0/100) and Level IIIs (11.0/100 to 10.0/100). NYS is first among 10 states that met the 2010 goal of 90% of VLBW infants delivered at a Level III or higher hospital and, remains significantly above the HP 2020 goal of 82.5%.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02B - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	1.1	1.1	1.1	1.1	1.1
Numerator	2611	2670	2548	2520	2520
Denominator	236463	233203	230108	229787	229787
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
Data Source: Vital Records/Births 2012 data are being used as a proxy for 2013 data.

Notes - 2012
2011 Data are being used as a proxy for 2012.

Notes - 2011
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.
Source: NYS DOH Vital Records

Narrative:
When comparing low birth weight rates for total births to those for singleton births, the rates among singletons are consistently better. The percent of singleton very low birth weight births (<1500 grams) in NYS has decreased slightly since 2006, but remained relatively consistent since that time. Very low and low birth weight births occur more frequently during multiple births. The ten-year trends of very low birth weight for both singleton and total births are similar, and have been basically unchanged over the past 10 years. Refer to 1A, 1B and 2A above for further information on New York's efforts.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 03A - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	3.4	3.8	3.0	3.9	3.9
Numerator	123	135	107	138	138
Denominator	3633448	3531233	3515032	3508643	3508643
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
Data Source: Vital Records/Deaths 2012 data are being used as a proxy for 2013 data.

Notes - 2012
2011 Data are being used as a proxy for 2012

Notes - 2011
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.
Source: NYS DOH Vital Records

Narrative:
The death rate for unintentional injuries among children aged 14 years and younger increased slightly from 3.0 per 100,000 in 2011 to 3.9 in 2012. DOH's Bureau of Occupational Health and Injury Prevention (BOHIP) continues to devote significant efforts to decrease these injuries. BOHIP is a lead member of the NY Child Passenger Safety Advisory Board. Over the past year, the BOHIP partnered with the NYS Thruway Authority to show the tween passenger safety video PSA on televisions in each of the 27 travel plazas for 8 weeks and planned and executed a statewide Click it-Front & Back, too campaign during National Teen Driver Safety Week to raise awareness of the importance of safety belt use. Schools continue to be a target for safety activities. BOHIP hosted an Injury Community Planning Group meeting for traffic safety stakeholders to enhance NYS's injury infrastructure.

BOHIP also built successful coalitions for injury prevention at the local level, reaching out to diverse segments of the community to ensure that the community is well informed on issues related to childhood injury prevention, and promoted toolkits and fact sheets to provide up-to-date data, best practices and evidence-informed programs to reduce unintentional injuries, particularly those that are traffic-related, for medical providers, researchers, educators and consumers. The toolkits include child passenger safety, Shaken Baby Syndrome prevention, fire safety, falls prevention, motorcycle and bicycle safety.

Title V Programs such as home visiting initiatives all have extensive child safety components, which stress car seat use and other infant safety measures. Parents who are enrolled programs are also given extensive information about childhood safety. DOH is also spearheading the Text4baby initiative. Three free text messages will be delivered each week, timed to the woman's due date or baby's date of birth. The messages focus on maternal and child health topics, including birth defects prevention, immunization, nutrition, seasonal flu, mental health, oral health, and safe sleep. Text4baby messages also connect women to prenatal and infant care, and other services and resources. Messages related to child safety are incorporated into these messages.
The Keeping NY Kids Alive program is focusing on expanding and improving local multidisciplinary teams that review child deaths and develop strategies to prevent future child deaths. In collaboration with the OCFS, the program is focusing on the increasing the number of county based child death review teams, expanding the number and scope of cases reviewed, standardizing data collection and submissions and enhancing local prevention measures and system improvements.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 03B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	1.0	1.3	0.8	1.2	1.2
Numerator	37	47	29	43	43
Denominator	3633448	3531233	3515032	3508643	3508643

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
Data Source: Vital Records/Deaths 2012 data are being used as a proxy for 2013 data.

Notes - 2012
2011 Data are being used as a proxy for 2012

Notes - 2011
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.
Source: NYS DOH Vital Records

Narrative:
The death rate for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes increased over the past year from 0.8 in 2011 to 1.2 in 2012. As stated in NPM 10, DOH's Bureau of Occupational Health and Injury Prevention (BOHIP) has devoted significant effort in promoting efforts to decrease these injuries. BOHIP will continue to collaborate with the NY Child Passenger Safety Advising Board to continue to develop outreach messages increase the number of children riding properly restrained in a motor vehicle. Refer to 3A above for further information.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 03C - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	9.5	9.2	7.8	8.5	8.5
Numerator	258	255	216	235	235
Denominator	2714522	2777213	2756593	2752157	2752157
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
Data Source: Vital Records/Deaths 2012 data are being used as a proxy for 2013 data.

Notes - 2012
2011 Data are being used for a proxy for 2012

Notes - 2011

2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.
Source: NYS DOH Vital Records

Narrative:
The death rates for unintentional injuries due to motor vehicle crashed among youth aged 15 through 24 years increased in the past year from 7.8 per 100,000 in 2011 to 8.5 per 100,00 in 2012. Refer to NPM 10 for further information.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 04A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	244.7	246.1	231.7	219.3	219.3
Numerator	8892	8691	8145	7694	7694
Denominator	3633448	3531233	3515032	3508643	3508643
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
Data Source: Statewide Planning & Research Cooperative System (SPARCS). 2012 data are being used as a proxy for 2013 data.

Notes - 2012
2011 Data are being used as a proxy for 2012

Notes - 2011
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.
Source: Statewide Planning & Research Cooperative System (SPARCS - Hospital Discharge Data)

Narrative:
The rate of nonfatal injuries among children aged 14 years and younger has declined significantly in the past few years. In 2008 the rate was 253 per 100,000 which decreased to 246.1 in 2010, 231.7 per 100,000 in 2011 and 219.3 per 100,000 in 2012. Refer to NPM 10 and HSI 3A and 3B for further information.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 04B - Multi-Year Data

Annual Objective and Performance	**2009**	**2010**	**2011**	**2012**	**2013**

Data					
Annual Indicator	23.0	22.7	20.6	22.9	22.9
Numerator	835	802	725	802	802
Denominator	3633448	3531233	3515032	3508643	3508643
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
Data Source: Statewide Planning & Research Cooperative System (SPARCS). 2012 data are being used as a proxy for 2013 data.

Notes - 2012
2011 Data are being used as a proxy for 2012.

Notes - 2011
Non-fatal MV related injuries include pedestrians and cyclists
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.
Source: Statewide Planning & Research Cooperative System (SPARCS - Hospital Discharge Data)

Narrative:
The rate for nonfatal injuries among children aged 14 years and younger due to motor vehicle crashes has been steadily decreasing. In 2009 the rate was 23 per 100,000, while in 2010 it was 22.7 and 2011 it further declined to 20.6. Refer to NPM 10 and HSI 3A and 3B for further information

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 04C - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	103.0	96.1	92.9	91.0	91.0
Numerator	2796	2670	2561	2505	2505
Denominator	2714522	2777213	2756593	2752157	2752157
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
Data Source: Statewide Planning & Research Cooperative System (SPARCS). 2012 data are being used as a proxy for 2013 data.

Notes - 2012
2011 Data are being used for a proxy for 2012

Notes - 2011
Non-fatal MV related injuries include pedestrians and cyclists.
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.
Source: Statewide Planning & Research Cooperative System (SPARCS - Hospital Discharge Data)

Narrative:
The rate for nonfatal injuries due to motor vehicle crashed among youth aged 15 through 24 years has also been on the decline. In 2009 the rate was 103 per 100,000 as compared with 96.1 in 2010, 92.9 in 2011 and 91 per 100,000 in 2012. Refer to HSI 3C for further information

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 05A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	36.1	38.0	39.2	36.1	36.1
Numerator	24085	25326	25366	23115	23115
Denominator	667979	666730	646710	640786	640786
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
Data Source: Numerator/Bureau of STD Prevention & Epidemiology, Denominator: Bridged race file. 2012 data are being used as a proxy for 2013 data.

Notes - 2012
2011 Data are being used as a proxy for 2012

Notes - 2011
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.
.Source: NYS Bureau os Sexually Transmitted Disease Prevention.

Narrative:
The rate of Chlamydia for women 15 through 19 years of age increased significantly since 2008 when the rate was 33.7 per 10,000, but experienced a significant decline from 39.2 per 1,000 in 2011 to 36.1 per 1,000 in 2012. Women are disproportionately affected by Chlamydia. NYS law requires health care providers and laboratories to report positive Chlamydia results to local health departments to ensure follow-up and treatment and provides for Expedited Partner Therapy that allows a health care provider to prescribe medication to the sexual partner(s) of a person diagnosed with Chlamydia without a medical appointment, thereby increasing the chances of treatment and decreasing the likelihood of further infection.

The provision of reproductive health care services is a public health priority in NYS. The Family Planning Program provides comprehensive reproductive health care to assist low income, uninsured and underinsured women, racial and ethnic minorities, adolescents and men in determining their reproductive futures and in avoiding STIs and unintended pregnancy. In 2013, the Family Planning Program served 332,540 individuals including 62.7% minority and 80.7% under 150% of the Federal Poverty Level. 176,065 individuals were tested for Chlamydia in family planning clinics including 157,245 women and 18,820 males.

The Title V Programs supports an array of adolescent health programs. The Comprehensive Adolescent Pregnancy Prevention (CAPP) initiative supports programs that implement evidence-based sexuality education; ensure access to reproductive services; expand educational, social, vocational and economic opportunities; and, engage adults to advance community efforts to improve environments for young people. A Personal Responsibility Education Program funded initiative focuses on implementation of evidence-based sexual health education and preparation of youth for successful transition to adulthood to reduce adolescent pregnancy. The Abstinence Education Grant Program initiative funds Successfully Transitioning Youth to Adolescence (STYA), community-based mentoring, counseling and adult supervision programs designed to delay the initiation of sexual behavior among young people, ages 9-12, residing in high-risk communities. All this funding supports adolescent health programming in high risk communities to improve health and social outcomes for NY's young people.

The Bureau of Communicable Disease Control administers STD clinics throughout NYS and oversees a significant public awareness and education campaign targeted to NY's most vulnerable individuals.
One of the PA Goals related to 5A and 5B is to decrease STD morbidity.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 05B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	11.1	11.9	12.3	12.5	12.5
Numerator	37183	40244	41715	42504	42504
Denominator	3354554	3381217	3385604	3396934	3396934
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
Data Source: Numerator: Bureau of STD Prevention & Epidemiology, Denominator: Bridged race file 2012 data are being used as a proxy for 2013 data.

Notes - 2012
2011 Data are being used as a proxy for 2012

Notes - 2011

.Source: NYS Bureau os Sexually Transmitted Disease Prevention.
2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

Narrative:
The rate of Chlamydia increased significantly in 2006, and has remained relatively consistent since that time. The rate for women 20- 44 years in 2008 was 10.6 per 1,000, increasing to 11.9 in 2010, 12.3 in 2011 and 12.5 per 1,000 in 2012 . As stated previously, NY is committed to ensuring all men and women of reproductive age have access to comprehensive family planning and reproductive health care services, and information and counseling to make informed choices about their reproductive health. Refer to 5A above for further information.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	237068	157080	56239	3532	20217	0	0	0
Children 1 through 4	930117	635035	202552	13962	78568	0	0	0
Children 5 through 9	1154466	800168	242257	17171	94870	0	0	0
Children 10 through 14	1186992	822488	255545	16966	91993	0	0	0
Children 15 through 19	1307947	909231	279553	18014	101149	0	0	0
Children 20 through 24	1444210	979256	310915	19955	134084	0	0	0
Children 0 through 24	6260800	4303258	1347061	89600	520881	0	0	0

Notes - 2015
Data in the Asian Column is a combination of Asian and Pacific Islander.

Narrative:
19,651,127 people live in New York State making it the third most populous state in the nation behind California and Texas. Both the population residing in Rest of State and New York City's population experienced a modest gain between 2008 and 2009. New York was the second most populous state until the late 1990's, when its population growth slowed to less than 1%. New York is now the third most populous state, behind California and Texas. Six percent of the US population lives in New York. New York City contains 43% of the State's population, with over 8 million people. NY is one of the top five states in the nation in numbers of immigrants from across the world.

New York's population reflects diverse race and ethnicity as it is more diverse than the nation as a whole. New York has higher percentages of non-Hispanic Black residents, Hispanic residents and non-citizen immigrant residents than the U.S. average. According to the American Community Survey conducted by the US Census Bureau, New York ranks second of all states in foreign born, with 22% of its total population being foreign born in 2012. Almost 90% of New

York's non-citizen immigrants live in New York City.

This diversity is of course reflected in NY's children. Over 31% or 6,260,800 of NY's population is 0--24 years of age. 1% is under age 1, 4.7%1-4 years of age, 5.8 % 5-9 years of age, 6.2% 10-14 years of age, 6% 15-19 years of age, and 7.3% 20-24 years of age. Out of this age group, 22.7% are Hispanic, while 77.3% are non-Hispanic. NY has a higher percentage of children living in immigrant families (35% as compared to 24% nationally). There are over 160 languages spoken by children in NY public schools receiving limited English proficient services. One in five children or 23% in NYS live in poverty.

This diversity necessitates the focus on ensuring that programs and activities developed and implemented by DOH are targeted to the maternal and child health population served and are not only available, but are accessible by being ethnically and culturally sensitive. Taking a life course approach to public health programs and supports better ensures healthy New Yorkers. The application clearly describes NY's successes in engaging women into quality prenatal care, the role of home visiting, ensuring children have health insurance coverage, are engaged in a medical home and receive primary and preventive health care, including oral health care, have access to nutritious food and are protected from injury, among others. Focusing on diversity to eliminate disparities is paramount in improving NY's health outcomes as the diversity of the population increases. Many of the PA Goals specifically address improvement in disparity where applicable.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	175042	62026	0
Children 1 through 4	695122	234955	0
Children 5 through 9	882525	271941	0
Children 10 through 14	926658	260334	0
Children 15 through 19	1026320	281627	0
Children 20 through 24	1129049	315161	0
Children 0 through 24	4834716	1426044	0

Notes - 2015

Narrative:
Refer to Health Status Indicator 06A.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	179	72	65	1	5	0	0	36

Women 15 through 17	3500	1708	1050	22	41	0	0	679
Women 18 through 19	9054	4715	2581	60	210	0	0	1488
Women 20 through 34	177630	108447	31125	569	19697	0	0	17792
Women 35 or older	48855	31028	7633	91	6115	0	0	3988
Women of all ages	239218	145970	42454	743	26068	0	0	23983

Notes - 2015

Narrative:
There were 239,224 births in NYS in 2012. Of these, 121,745 (49%) were to residents of NYC and the remaining 124,847 were to Upstate residents. The birth rate in NYS has been steadily decreasing. In 2008 there were 249,655 births. Most all of the decline in the number of births was among NYC residents. In 2012, births to white mothers accounted for 61% of all births & births to Black mothers represented 19% of the total. 20% of births were in the "other" category. This includes births to persons of multiple races, as well as all other races. Births to Hispanic mothers accounted for almost 24% of all births.

Live births to mothers under 20 years of age have been steadily decreasing. In 2008, women less than 15 accounted for 242 live births, 15-17 years accounted for 5,074 live births & 18-19 year olds accounted for 9,054 live births. In 2012, births for those age groups dropped to 179, 3,500 & 9,868 respectively. The majority of births occurred to women between the ages of 20 & 39. Although racial disparities related to birth outcomes have persisted over the past few years, the ratio of Black White infant low birthweight is slowing improving

The diversity of age as well as race present significant challenges to NYS. Addressing adolescent pregnancy is a priority of DOH & the Title V program. Adolescents are less likely to seek early prenatal care, therefore risking poor birth outcomes, & are also more likely to live in poverty. NY's adolescent health initiatives & comprehensive family planning program as discussed, in this application, strive to address this issue. NYS's perinatal programs employ a comprehensive, multi-level strategy, which integrates broad based systems approaches, involving county & local planning efforts through the MICH Collaboratives, with one-on-one outreach through community health workers & engagement through evidence-based home visiting programs to assess, intervene & address the perinatal health needs of residents in high risk communities.

DOH administers a number of programs & initiatives that collectively aim to provide a comprehensive, integrated set of services to support optimal perinatal outcomes for both mothers & babies. These programs are part of an integrated effort to reduce health disparities in affected communities by increasing access to & utilization of comprehensive & continuous early prenatal care & other services through early identification, enrollment & referral of pregnant women into prenatal care, home visiting & other needed services.

NYS has also been a national leader in the development of a statewide system of perinatal regionalization. All obstetrical hospitals have been designated by the DOH as a Level I, II, II or Regional Perinatal Center (RPC) based on standard criteria included in state regulation. Regulations require lower level hospitals to consult with RPCs & determine the need for transfer of high-risk mothers & newborns.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	101	78	0
Women 15 through 17	1904	1595	1
Women 18 through 19	5682	3361	11
Women 20 through 34	135373	41758	499
Women 35 or older	39782	8929	144
Women of all ages	182842	55721	655

Notes - 2015

Narrative:
Refer to Health Status Indicator 07A for information.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	1191	638	369	5	57	7	5	110
Children 1 through 4	182	117	46	0	7	4	1	7
Children 5 through 9	108	71	26	0	4	0	1	6
Children 10 through 14	152	97	38	0	6	1	0	10
Children 15 through 19	413	267	115	1	18	0	1	11
Children 20 through 24	927	617	247	9	22	0	1	31
Children 0 through 24	2973	1807	841	15	114	12	9	175

Notes - 2015

Narrative:
The infant mortality rate has been slowly declining in NYS. The 2012 infant mortality rate was 4.9/1,000 live births which represents a 16.6% decline form a rate of 5.96 per 1,000 live births in 2002. The infant mortality rate declined most dramatically during the early 90's & at a slower pace in recent years. NYS has exceeded the HP 2020 goal for infant mortality (6.0) & is working toward meeting NYS's 2013 Prevention Agenda Objective of no more than 4.5 infant deaths/100,000 live births.

Hispanic & White infant mortality rates have continued to be about half the rate for Black infants. The infant mortality rate among black non-Hispanic infants declined from 11.8/1,000 live births in 2008 to 8.96 in 2012. In 2012, the white non-Hispanic infant mortality rate was 3.7/1,000 live births as compared to the 2008 rate of 4.2/1,000 live births. Asian/Pacific Islander non-Hispanic infants experienced the lowest rate of infant mortality in 2012, at 3.54/1,000 live births. Infant mortality among Hispanic infants was 5.27/1,000 in 2012. Even though rates have been declining, Black infant mortality rates are still significantly higher than rates for white non-Hispanics, Asian/Pacific Islander non-Hispanics & Hispanics.
NY's neonatal mortality rate mimics that of infant mortality. The postneonatal mortality rate in NYS has changed very little over the past decade. The disparities in rates between Blacks & Whites & Hispanics that were seen in both infant & neonatal mortality rates are also seen in postneonatal mortality.

Within the Title V Program, there are specific projects to monitor & analyze mortality data, including infant mortality data to guide the development of priorities & interventions. Based on 2012 vital statistics data, the three leading causes of infant death were prematurity, congenital malformation & cardiovascular disorders originating in the perinatal period. In addition to enhanced perinatal activities, efforts to reduce infant mortality have focused on promotion of safe sleep & reduction of SIDS, including extensive risk reduction education for SIDS & other sleep related deaths, education & support for families through home visiting programs, & work with local child fatality review & data collection activities to better understand the contributing factors to sleep related, other accidental deaths & homicides. In addition, the Title V program collaborates with other partner programs including WIC, Injury Prevention & others to address factors that contribute to infant mortality.

The Title V program, in collaboration with the state's OCFS implemented the Keeping NY Kids Alive program that is focused on expanding & improving the quality of the child fatality review process. The initiative will assist in improving the skills of local officials who work in the child fatality review process to promote improved community services delivery & the development of local public health risk reduction & safety focused prevention programs.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	935	247	9
Children 1 through 4	144	36	2
Children 5 through 9	83	25	0
Children 10 through 14	123	29	0
Children 15 through 19	333	80	0
Children 20 through 24	757	168	2
Children 0 through 24	2375	585	13

Notes - 2015

Narrative:

Refer to Health Status Indicator 08A for information.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	4816590	3232683	964255	58849	357051	7460	196292	0	2012
Percent in household headed by single parent	36.0	22.0	65.0	0.0	15.0	0.0	45.0	0.0	2012
Percent in TANF (Grant) families	4.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2013
Number enrolled in Medicaid	2359718	0	0	0	0	0	0	2359718	2013
Number enrolled in SCHIP	304566	0	0	0	0	0	0	304566	2013
Number living in foster home care	18889	0	0	0	0	0	0	18889	2013
Number enrolled in food stamp program	1208700	0	0	0	0	0	0	1208700	2012
Number enrolled in WIC	713043	322328	192827	96498	66365	10808	24217	0	2013
Rate (per 100,000) of juvenile crime arrests	2306.0	0.0	0.0	0.0	0.0	0.0	0.0	2306.0	2013
Percentage of high school drop-outs (grade 9 through 12)	2.7	0.0	0.0	0.0	0.0	0.0	0.0	2.7	2011

Notes - 2015
Data Source: 2012 Vintage Census Bridged

Data Source: National KIDS COUNT Program

CY TANF Report as of 1/23/14. Based on 202,850 average children (numberator) in TANF families Preliminary Calendar year average is based on data January 2013 through September 2013, Published: March 11, 2014

Data not broken out by ethnicity - therefore reported as more other and unknown.

Narrative:
New York's commitment to its citizens, including children 0 through 19 years of age, is demonstrated by the significant supports and services available to New York's most vulnerable population. Through the various health and human service programs offered by DOH, as well as sister agencies, such as health care services funded by public insurance programs, the development of Children's Health Home, family planning and reproductive health care, and the array of adolescent health initiatives, including youth development activities, New York strives to support its youth to decrease health disparities, reach the high risk populations, such as those children living in poverty and foster care, and foster self sufficiency and youth development in order that all youth become healthy, productive citizens.

As discussed in Section IIIE of this application, NYS developed the Early Childhood Advisory Council (ECAC) that includes individuals with early childhood expertise who represent early care and education, health care, child welfare, and mental health programs, as well as state agencies, advocacy organizations, foundations, higher education, unions, and others involved in the provision of services to young children and their families. The ECAC focuses on addressing the structural issues that have impeded the development of a comprehensive system of early childhood supports and services.

Information regarding extensive supports and services for this population are described in detail in Section III State Overview section of the application as well as Section IV Priorities, Performance and Program Activities. Several PA Goals also relate directly to improving the health of NY's children.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	3705667	1110923	0	2012
Percent in household headed by single parent	0.0	56.0	0.0	2012
Percent in TANF (Grant) families	0.0	0.0	4.2	2012
Number enrolled in Medicaid	0	0	2359718	2013
Number enrolled in SCHIP	0	0	304566	2013
Number living in foster home care	0	0	18889	2013
Number enrolled in food stamp program	0	0	1208700	2012
Number enrolled in WIC	452257	260768	0	2013
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	2306.0	2012
Percentage of high school drop-outs (grade 9 through 12)	0.0	0.0	2.7	2011

Notes - 2015

Narrative:
New York's population reflects diverse race and ethnicity as it is more diverse than the nation as a whole. New York has higher percentages of non-Hispanic Black residents, Hispanic residents

and non-citizen immigrant residents than the U.S. average. New York's commitment to its citizens, including children 0 through 19 years of age, is demonstrated by the significant supports and services available to New York's most vulnerable population. Through their various health and human service programs offered by the DOH, as well as sister agencies, such as health care services funded by public insurance programs, family planning and reproductive health care, and the array of adolescent health initiatives, including youth development activities, New York strives to support its youth to decrease health disparities, reach the high risk populations, such as those children living in poverty and foster care, and foster self sufficiency and youth development in order that all youth become healthy, productive citizens.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	18243409
Living in urban areas	18243409
Living in rural areas	1407718
Living in frontier areas	0
Total - all children 0 through 19	19651127

Notes - 2015

Narrative:
These data show that a large majority of New York's children aged 0 through 19 years resides in urban and metropolitan areas of the state, with a much smaller number in rural New York State. Population density often determines the number and types of health services that an area can support. The US Census shows that in 2010 there were 411.2 persons per square mile in New York State, compared to 87.4 persons per square mile in the US. New Yorkers are more likely to live in urban areas than residents of other states. Population density within New York varies widely. 7.2% of New York's population live in rural areas while the remainder (92.8%) live in urban areas. New York City is 104 times more densely populated than the rest of the state. New York City comprises over 40% of New York State's population, and the counties immediately north of New York City (Orange and Westchester Counties) and Long Island (Nassau and Suffolk Counties) comprise an additional 21% of the state's population. Other population centers are Buffalo (Erie County), Rochester (Monroe County), Syracuse (Onondaga County) and Albany (Albany County), though population in these upstate urban areas has been slightly declining over the past few years. Many areas of New York are also rural. Twenty-six percent of New Yorkers live in rural areas, compared to 36% nationwide.

This presents a significant challenge in ensuring quality services are available in diverse areas of the state, while maximizing limited resources. DOH often uses Vital Records data to identify areas where significant needs and health disparities exist. Areas are rank ordered on multiple indicators through zip code level analyses of rates of adverse outcomes to ensure provision of services to residents living in the highest risk communities, with the intent of reducing health disparities and improving outcomes. Vital Records and program data are routinely assessed to determine the impact on stated goals and to identify areas for quality improvements efforts. For example, adolescent health initiatives are targeted to the highest areas of risk including teen pregnancy rate, STIS, among others.

DOH funded providers are also required to identify areas of need within high risk areas, identify gaps, barriers and challenges, and address those issues for their programs services. These issues may include proximity of services to the population served, and marketing those services

to the high risk population.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	19155876
Percent Below: 50% of poverty	7.4
100% of poverty	17.3
200% of poverty	35.9

Notes - 2015

Narrative:
These data highlight NY's challenge of addressing supports and services for individuals at or below 200% of fpl. According to the 2013 Current Population Survey, 35.9% of New Yorkers are at 200% of the fpl and below. 17.3% of these individuals are at 100% of the fpl or below, and 7.4% of these individuals are below 50% of the fpl. Poverty is highly associated with poor health outcomes, especially for women and children, and is most common in families headed by single females. Single-female headed households with children are more likely than other families to be living below poverty. This is true regardless of race or ethnicity.
NY is committed to ensuring services are available to provide health care and support for NY's most vulnerable children and families.

Universal health care coverage is a priority in NYS. Over the last 5 years, NY has seen a 19% decline in uninsured children under age 18 years. In 2006, 8.1% of the NY's population of children less than 18 years was uninsured compared to 5.6% in 2012, down from 6.6% in 2011.

In October 2013, NY implemented the NY State of Health, NY's Health Benefit Exchange which has made it easier for NY's families to apply for health insurance, including public health insurance. In-Person Assistors and Navigators are located throughout NYS to assist individuals to enroll in an appropriate health insurance plan. A priority of Title V programs is to ensure all individuals are engaged in comprehensive health care coverage.

MA redesign efforts have focused on achieving greater efficiency without creating barriers to enrollment or reducing benefits for those eligible for MA services. These reforms fully support the mission of NY's Title V program in ensuring primary and preventive health and support services to the maternal and child health population, including children with special health care needs. NY's overall goal is to expand enrollment in the MA Managed Care Program (MMCP) by requiring many of the high need populations previously exempted or excluded to enroll in a managed care plan. The MMCP provides an organized system of care, an accountable entity and the ability to coordinate and manage care.

Birth spacing and timing of births are significant in improving birth outcomes and allowing individuals to determine their reproductive future. Delaying pregnancy may help women in poverty further their education and become more gainfully employed. Comprehensive family planning and reproductive health care services provide reproductive health care services throughout NYS.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	19155876
Percent Below: 50% of poverty	9.6
100% of poverty	24.3
200% of poverty	45.3

Notes - 2015

Narrative:
As stated previously, poverty is highly associated with poor health outcomes, especially for women and children. Poverty is most common in families headed by single females, and single-female headed households with children are more likely than other families to be living below poverty. This is true regardless of race or ethnicity. Given this, NY continues its commitment to reduce rates of teen pregnancy and out-of-wedlock births and to provide poor heads of households with jobs. According to the 2013 Current Population Survey, 45.3% of NY's children ages 0-19 years were below the fpl. Of these, 24.3% were below 100% and 9.6% of these were below 50%.

NY is committed to ensuring services are available to provide health care and support for NY's most vulnerable families as described in detail in Section III State Overview section of the application as well as Section IV Priorities, Performance and Program Activities. The PA 2013-2017 demonstrates DOH's commitment to improving health outcomes for all NY's families.

F. Other Program Activities

With the exception of injuries to young children, all MCH activities fall within State priorities for the MCHBG 2011-2016 grant cycle. Injury prevention for young children continues to be a priority for the Department, however, it could not be subsumed readily under the new priorities. Department efforts to address injury prevention in children and adolescents are described in various performance measures.

The Bureau of Maternal and Child Health supervises the operation of the toll-free Growing Up Healthy Hotline (1-800-522-5006 and TTY 800-655-1789). The hotline provides information to pregnant women, mothers, children and adolescents on over thirty topics, and helps to ensure access to needed maternal and child health services. It operates 24 hours per day/seven days per week, with both English- and Spanish-speaking trained tele-counselors. Answering services are contracted to the Association for the Blind and Visually Impaired, Goodwill Inc., a not-for-profit telecommunications group that specializes in community information and referral services. A requirement of the contract is that callers will be immediately connected to an information specialist, with no busy signal or answering tape, at least 94% of the time. The contractor actually achieves 98%, which is one of the best performances in the nation. In order to maximize its usefulness, the Growing Up Healthy Hotline provides services for the hearing-impaired and to people who are not English- or Spanish-speaking through the AT&T Language Line, extending access to referral services to callers speaking over twenty additional languages.
In 2012 the Growing Up Healthy Hotline provided information to 45,758 callers on a variety of maternal and child health issues, including information on eligibility for programs and the location of the nearest services. Of these, 2,947 were for provision of pregnancy-related information and

services. Over seven percent (3,306) of calls required handling in languages other than English. Of these calls, 3,090 were from Spanish-speaking callers and 216 of the calls were in languages other than English or Spanish. Seventy- nine percent of callers were female, 21% mal. There was a 6% increase in the total number of calls to the hotline in 20129 compared to 2011. /2014/The Summer Food Program noted the largest increase in calls with 5,240 over 3,392 more than in 2011.//2014//

Last year, callers requested assistance in the following areas: adult insurance 0.52%, Child Health Plus 1.08%, child/adult care food program 2.5%, dental/orthodontia .09%, early intervention 2.15%, educational materials 0.14%, Family Health Plus 0.5%, family planning 2.5%, farmer's market 8.31%, food and nutrition programs 0.6%, health department programs 0.89%, immunizations 0.1%, Medicaid for adults 5.33%, Medicaid for children 0.88%, newborn screening 0.36%, pregnancy care 6.31%, social services 5.82%, summer food program 11.45%, WIC 40.26%, WIC complaints 2.11%, and other 4.01%. /2014/The hotline was also asked to monitor the number of calls received for WIC information in the wake of Hurricane Sandy. Nine hundred ninety-four calls were received from November to December 2012.//2014//

The hotline number is published in local telephone directories and used in public information campaigns directed at the maternal and child health population throughout the state. The most frequent sources of reference to the hotline are community organizations, the internet, WIC, doctor's offices, friends or relatives, pamphlets, insurance company materials, hospitals, letters, telephone book, bus/train/subway placard, and farmer's markets.

When appropriate, callers are also given toll-free hotline numbers where they may have questions answered about AIDS, child abuse, domestic violence, substance abuse, and assistance for people with disabilities.

Title V staff test the availability and accuracy of the hotline at various times, with positive results.

G. Technical Assistance

Programs have not identified any technical assistance needs for this cycle. We do, however, reserve the option to request technical assistance as necessary during the year.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2013		FY 2014		FY 2015	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	40033023	36320452	37919712		38909810	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	62208171	62208171	62208171		29200000	
4. Local MCH Funds *(Line4, Form 2)*	271491225	322617868	271646100		22198393	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	314762086	234990131	236737888		12794604	
7. Subtotal	688494505	656136622	608511871		103102807	
8. Other Federal Funds *(Line10, Form 2)*	57643011	49857001	62905602		54870832	
9. Total *(Line11, Form 2)*	746137516	705993623	671417473		157973639	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2013		FY 2014		FY 2015	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	37033896	31935016	36745187		9542179	
b. Infants < 1 year old	17701104	20053687	44527916		3986586	

c. Children 1 to 22 years old	93767071	89903101	125809244		29073295	
d. Children with Special Healthcare Needs	503301337	472326431	367279334		45325089	
e. Others	34804474	40138685	32206795		11965599	
f. Administration	1886623	1779702	1943395		3210059	
g. SUBTOTAL	688494505	656136622	608511871		103102807	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	270000		0		0	
b. SSDI	85000		74835		91045	
c. CISS	0		0		0	
d. Abstinence Education	2841809		2802179		2634308	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	806338		808146		466938	
j. Education	23867174		23178502		23178502	
k. Home Visiting	5604010		11208020		5604010	
k. Other						
DHHS ACF					2821117	
DHHS PHS Title X	10290042		11088112		9571185	
DHHS SAMHSA					850000	
HRSA			800005		914145	
Medicaid Match	9081530		9034268		8739582	
DHHS ACF	3102520		3061535			
DHHS SAMSA	850000		850000			
DHHS HRSA	844588					

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2013		**FY 2014**		**FY 2015**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	491943772	467968899	386244310		50691595	
II. Enabling Services	36683291	38080760	53993385		9195719	
III. Population-Based Services	72912918	70336064	85630526		20301286	
IV. Infrastructure Building	86954524	79750899	82643650		22914207	

Services						
V. Federal-State Title V Block Grant Partnership Total	688494505	656136622	608511871		103102807	

A. Expenditures

Completion of Budget Forms: Please refer to budget columns on Forms 2, 3, 4, and 5 for a summary of state, local, federal and program income as it contributes to the MCH Partnership.

Principles for Allocation: Also, please refer to the Principles for Allocation of Maternal and Child Health Services Block Grant Funds in the block grant

Historical Note: Budgeted and expended amounts are shown on Form 3 within Line 1 only based on guidance provided by HRSA in FFY 2006. The total Federal allocation is committed to program services.

Program managers prepare a report on the population served by pyramid level. Expenditure reports are generated for the appropriate period and distributions by population and pyramid level are then calculated.

For FFY09, total partnership expenditures were 1.31% less than the budgeted allocation. A number of factors contributed to this reduction: the MCHSBG allocation was $592,411 less than the application budget amount; the implementation of new and enhanced initiatives was delayed; and, NYS's response to its budget deficit resulted in state funding reductions of numerous appropriations.

/2013/For FFY11, partnership expenditures were $954,204,077, approximately 10% greater than what was budgeted. This is primarily due to the reported program income from counties for their early intervention services. //2013//

/2014/ For FFY12, expenditures for the Federal-State partnership was approximately 13% less than budgeted. This is attributable to two factors, a decrease in the MCHSBG award amount and a decrease in the reported Early Intervention Program local and program income. While we have not been able to ascertain the cause of the local and program income decreases, there have been fluctuations in the past.//2014//

/2015// For FFY13 expenditures for the Federal-State partnership was approximately 5 percent less than budgeted. This is attributable to a decrease in the MCHSBG award (7.7 percent less than budgeted in last year's application) as well as lower reported income (25 percent less than budgeted in last year's application.) This is mainly attributed to an over-budget in last year's application of program income as well as a decrease in program income related to early intervention. NY saw a decrease in children in the EIP due to a revision of eligibility criteria for children with communication delays as well as a decrease in reimbursement rates.

B. Budget

The FFY 2011 partnership budget is $ 864,447,463. NYS's allocation of $336,529,505 demonstrates a continued obligation of funds above our statutory maintenance of effort level from FY1989 of $58,268,752. This level of state funding budgeted includes a State Match ($3 state for every $4 federal) of $30,777,603 for the $41,036,806 of Federal MCH Block Grant funds and an overmatch of $305,751,902.

This budget reflects New York State's commitment to Title V programs and services. New York more than meets the maintenance of effort requirements of Section 505 (a) (4) and match requirements for FFY 2011 which assures continuation of essential maternal and child health services.

Obvious variances in the FY 2011 amount from the FY 2010 amount can be attributed to increased levels of review and assessment of the populations being served and the type of service being provided by initiative; and, in light of the state's budget situation, ensuring that resources are being targeted for unmet needs. For example, the American Indian Health program, for which 50 percent of their state funding is attributable to maternal and child health, had previously been identified as "Population-based Services". Under NYS Public Health Law, the state provides for the ambulatory medical care of Native Americans living on reservations in NYS, as such, the majority of the services are "Direct Health Care". This discrepancy was identified and corrected. The Department has increased efforts to identify and match state dollars for appropriate initiatives; a result of this has been a decrease or elimination of those dollars in the MCHSBG application. Although these dollars are no longer included, the maternal and child health related services continue to be provided by the state at the same level. The re-evaluation of service delivery has resulted in a budget that more closely aligns with the FY2009 expenditures being reported.

The MCHSBG Advisory Council assists the Department in determining program priorities and is instrumental in seeking public input into the application process. The "Principles and Guidelines for the Use of Block Grant Funds", developed and revised as necessary by the Advisory Council, continues to be used. Effort is made to match funding to the level of unmet need, and to address the four layers of the MCH pyramid and the three target populations. Because funded programs often take more than one structural approach to targeted needs and populations, program appropriations are proportioned out to reflect percentage of effort in infrastructure-building, population-based services, enabling services and direct health care services. Program appropriations also take into account the "30-30-10" requirements of Title V. The State more than meets "30-30-10 Requirements" for 30% allocation to primary and preventive care to children ($13,634,547, 33.23%), for 30% for children with special health care needs ($12,467,244, 30.38%) and under 10% for administration ($2,274,958 or 5.54%) for block grant distribution.

New York State plans to use its Federal MCH funds for the following programs:
The Adolescent Health Initiative, including Centers for excellence and Youth Risk Behavior Surveillance; American Indian Health Program Community Health Workers; Asthma Coalitions; Children with Special Health Care Needs Program, including the Physically Handicapped Children's Program Diagnostic and Evaluation Program; Community-Based Adolescent Pregnancy Prevention; Family Planning; The Genetics Program and Newborn Metabolic Screening; SUNY School of Public Health MCH Graduate Assistantship Program; Health Communications; Infant and Child Mortality Review; Lead Poisoning Prevention; Migrant and Seasonal Farmworker Health; Statewide Dental Technical Assistance Center; Osteoporosis Prevention; Parent and Consumer Focus Groups; Public Health Information/Community Assessment infrastructure; Preventive Dentistry Initiatives; the Dental Residency Program; Dental Supplemental Fluoride Program, School-Based Health Centers; STD Screening and Education; and, Diabetes Prevention in Children.

The state share for MCH services is considerable, more than meeting the requirements for state match. New York State-funded programs dedicated to MCH include:

Early Intervention; Family Planning; Genetic Screening and Human Genetics; Immunization, Vaccine Distribution and State Aid for Immunization; Lead Control and Prevention, Lead Poisoning Prevention and Lead Regional Resource Centers; Physically Handicapped Children's Treatment Program; Migrant and Seasonal Farmworker Health Program; Community Health Worker; Comprehensive Prenatal-Perinatal Services Networks, Perinatal Regionalization;

Statewide regional perinatal systems; Infertility services; School-Based Health Centers; SIDS and Infant Death, Child's Asthma Program, Diabetes (Type II) Prevention in Children Program, HPV Vaccine, Growing Up Health Hotline, Healthy Mom, Healthy Babies Home Visitation Program, State HIV-related appropriations included in previous applications as match are no longer being included as those dollars are used as match for other federal grants. However, services continue to be a component of the NYS MCH related programming.

The methodology used to identify State expenditures for MCH-related programs has also not changed from prior years:

• Appropriate cost centers, representing specific areas of activity related to MCH, are identified.
• Data for the appropriate fiscal periods are obtained from the Office of the State Comptroller
• Data for selected cost centers are extracted on a quarterly basis.
• Data is compiled from relevant cost centers to reflect expenditures made during the federal grant award period.
• All expenditure data represent payments made on a cash (vs. accrual) basis.
• Transactions associated with specific grants are identified and tracked through appropriation, segregation, encumbrance & reporting processes to permit proper and complete recording of the utilization of available funds.
• Identifying codes are assigned to record these transactions by object of expense within each cost center.

The Department and the Office of the State Comptroller maintain budget documentation for Block Grant funding and expenditures consistent with Section 505(a) and Section 506(a) (1) for the purpose of maintaining an audit trail. Reporting requirements and procedures for each particular grant are instituted to comply with conditions specified within each notice of grant award.

Federal sources of MCH targeted dollars other than the block grant included: Centers for Disease Control and Prevention (Lead, Immunization, Public Health Information Infrastructure; Oral Health), Department of Education, IDEA Part C; Family Planning Title X; STD/fertility; SPRANS Grants; HRSA -- Ryan White HIV/AIDS Treatment Modernization Act of 2006; Oral Health; SSDI Funds; TANF Funds; Early Childhood Comprehensive Systems planning grant.

/2013/The FFY2013 partnership budget is $688,494,505. While this is 27.8% less than FFY2012, the commitment to support MCH services in NYS continues. The state's allocation of $62,208,171 meets the statutory maintenance of effort level, $58,268,752, and the match requirement of $30,024,768 ($3 state for every $4 federal) for the $40,033,023 grant anticipated for FFY13. The overmatch reflected in this application is considerable less than previous years however the state's funding for the MCHS initiatives remains fairly consistent.

The 27.8% difference in the FY2013 and FY2012 amount is attributable to two changes: (1) the department's efforts to maximize funding by identifying initiatives eligible for match funding resulting in a decrease in the overmatch demonstrated in the grant; and, (2) changes in reimbursement to the counties for general public health services. The department reimburses counties for defined basic health services at a prescribed percentage of the county's net cost. Until June 2012, counties were also reimbursed for certain optional services. As a result of the elimination of optional service reimbursements, state aid funding will decrease and fiscal information from counties on the optional services cost will no longer be collected.

For FFY13, NYS will continue federal MCH funding for the following initiatives: American Indian Health Community Health Workers, Asthma Coalitions, Children with Special Health Care Needs including Physically Handicapped Children's Diagnostic and Evaluation Program, Community-Based Adolescent Pregnancy Prevention, Family Planning, Genetics Program and Newborn Metabolic Screening, SUNY School of Public Health MCH Graduate Assistantships, Health Communications, Child Mortality Review, Lead Poisoning Prevention, Migrant and Seasonal Farm Worker Health, Dental Technical Assistance Center, Osteoporosis Prevention, Parent and

Consumer Focus Groups, Public Health Information/Community Assessment infrastructure, Preventive Dentistry Initiatives, Dental Residency, Dental Supplemental Fluoride Program, School-Based Health Centers, STD Screening and Education; and, Diabetes Prevention in Children.

The following NYS funded initiatives continue to be included in the MCHS budget for FFY13: Assets Coming Together for Youth (ACT) Center of Excellence, Childhood Asthma, Childhood Lead Poisoning Prevention including Safe Housing and Resource Centers, Comprehensive Adolescent Pregnancy Prevention, Family Planning, Genetic Services, Healthy Heart, American Indian Health, Maternal Mortality, Migrant Health, Osteoporosis Prevention and Education, Physically Handicapped Children's Treatment, School-based Health Centers and Keeping Kids Alive/Sudden Unexplained Infant Deaths.

As in prior years, additional state funded initiatives have been identified as potential sources to leverage increased funding for dwindling resources and increasing needs. For FFY13, the following initiatives are not included in the MCHSBG application budget but continue to be NYS funded and remain a component of the state's maternal and child health services: HIV related counseling and testing, Early Intervention, Community Health Worker Program, Comprehensive Prenatal Perinatal Services Networks, "Growing Up Healthy" Hotline, Perinatal Regionalization, Statewide Perinatal Data Systems, Healthy Mom Healthy Babies Home Visiting, Nurse Family Partnerships, Immunization, Infertility and General Public Health Work support to counties. Collectively, the state appropriations for these initiatives total approximately $243 million. //2013//

/2014/ The partnership is facing an 11% reduction, which is a combination of a result of the anticipated MCHSBG grant award reduction and implemented changes to county reporting. While it is anticipated that counties will continue to provide the services, the department will no longer be collecting the information. Therefore we will have no mechanism to project the budget and verify the expenditure. In spite of the approximately 5.5% reductions to many state appropriations, the state share of the partnership has not changed.//2014//

/2015/NY continues to be committed to providing services to the maternal and child health population. The decrease in the partnership budget reflected in this application is due to the fact that New York is seeking other opportunities to match dollars in order to maximize funds and increase opportunities to enhance supports and services to New York's most underserved mothers, infants and families and address ethnic and racial disparities. This in no way reflects a decrease of financial support or decrease in supports and services to this most needy population.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.

Title V Block Grant Application
Forms (2-21)
State: NY
Application Year: 2015

FORM 2

MCH BUDGET DETAILS FOR FY 2015

[Secs. 504 (d) and 505(a)(3)(4)]

STATE: NY

1. FEDERAL ALLOCATION
(Item 15a of the Application Face Sheet [SF 424]) $ 38,909,810
Of the Federal Allocation (1 above), the amount earmarked for:

A.Preventive and primary care for children:

$ 12,291,609 (31.59 %)

B.Children with special health care needs:

$ 11,949,203 (30.71 %)

(If either A or B is less than 30%, a waiver request must accompany the application)[Sec. 505(a)(3)]

C.Title V admininstrative costs:

$ 3,210,059 (8.25 %)

(The above figure cannot be more than 10%)[Sec. 504(d)]

2. UNOBLIGATED BALANCE (Item 15b of SF 424) $ 0

3. STATE MCH FUNDS (Item 15c of the SF 424) $ 29,200,000

4. LOCAL MCH FUNDS (Item 15d of SF 424) $ 22,198,393

5. OTHER FUNDS (Item 15e of SF 424) $ 0

6. PROGRAM INCOME (Item 15f of SF 424) $ 12,794,604

7. TOTAL STATE MATCH (Lines 3 through 6) $ 64,192,997
(Below is your State's FY 1989 Maintainence of Effort Amount)
$ 58,268,752

8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP (SUBTOTAL) $ 103,102,807
(Total lines 1 through 6. Same as line 15g of SF 424)

9. OTHER FEDERAL FUNDS
(Funds under the control of the person responsible for the administration of the Title V program)

a. SPRANS:	$ 0
b. SSDI:	$ 91,045
c. CISS:	$ 0
d. Abstinence Education:	$ 2,634,308
e. Healthy Start:	$ 0
f. EMSC:	$ 0
g. WIC:	$ 0
h. AIDS:	$ 0
i. CDC:	$ 466,938
j. Education:	$ 23,178,502
k. Home Visiting:	$ 5,604,010
l. Other:	
DHHS ACF	$ 2,821,117
DHHS PHS Title X	$ 9,571,185
DHHS SAMHSA	$ 850,000
HRSA	$ 914,145
Medicaid Match	$ 8,739,582

10. OTHER FEDERAL FUNDS (SUBTOTAL of all Funds under item 9) $ 54,870,832

11. STATE MCH BUDGET TOTAL $ 157,973,639
(Partnership subtotal + Other Federal MCH Funds subtotal)

Form Notes for Form 2

New York's match has been decreased in order to maximize the use of these funds for other match, e.g., Medicaid Match. This enables New York to have the potential to increase access to funds for New York's underserved mothers, infants and families. This does not represent any decrease in New York's commitment or efforts targeted to this population.

Field Level Notes

None

Form 3

State MCH Funding Profile

[Secs. 505(a) and 506((a)(I-3)]

State: NY

	FY 2010		FY 2011		FY 2012	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation *(Line1, Form 2)*	$ 41,043,769	$ 40,947,507	$ 41,036,806	$ 40,508,072	$ 41,036,806	$ 40,036,911
2. Unobligated Balance *(Line2, Form 2)*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
3. State Funds *(Line3, Form 2)*	$ 363,695,631	$ 373,396,439	$ 336,529,505	$ 337,120,805	$ 144,502,296	$ 153,566,602
4. Local MCH Funds *(Line4, Form 2)*	$ 299,499,317	$ 327,468,560	$ 313,430,367	$ 323,234,192	$ 301,048,616	$ 272,432,651
5. Other Funds *(Line5, Form 2)*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
6. Program Income *(Line6, Form 2)*	$ 176,715,455	$ 240,879,389	$ 173,450,785	$ 253,341,008	$ 404,365,207	$ 305,333,730
7. Subtotal	$ 880,954,172	$ 982,691,895	$ 864,447,463	$ 954,204,077	$ 890,952,925	$ 771,369,894
	(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)					
8. Other Federal Funds *(Line10, Form 2)*	$ 45,901,844	$ 44,374,026	$ 75,196,798	$ 73,646,798	$ 63,259,202	$ 55,450,663
9. Total *(Line11, Form 2)*	$ 926,856,016	$ 1,027,065,921	$ 939,644,261	$ 1,027,850,875	$ 954,212,127	$ 826,820,557
	(STATE MCH BUDGET TOTAL)					

Form 3

State MCH Funding Profile

[Secs. 505(a) and 506((a)(I-3)]

State: NY

	FY 2013		FY 2014		FY 2015	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation *(Line1, Form 2)*	$ 40,033,023	$ 36,320,452	$ 37,919,712	$	$ 38,909,810	$
2. Unobligated Balance *(Line2, Form 2)*	$ 0	$ 0	$ 0	$	$ 0	$
3. State Funds *(Line3, Form 2)*	$ 62,208,171	$ 62,208,171	$ 62,208,171	$	$ 29,200,000	$
4. Local MCH Funds *(Line4, Form 2)*	$ 271,491,225	$ 322,617,868	$ 271,646,100	$	$ 22,198,393	$
5. Other Funds *(Line5, Form 2)*	$ 0	$ 0	$ 0	$	$ 0	$
6. Program Income *(Line6, Form 2)*	$ 314,762,086	$ 234,990,131	$ 236,737,888	$	$ 12,794,604	$
7. Subtotal	$ 688,494,505	$ 656,136,622	$ 608,511,871	$ 0	$ 103,102,807	$ 0
	(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)					
8. Other Federal Funds *(Line10, Form 2)*	$ 57,643,011	$ 49,857,001	$ 62,905,602	$	$ 54,870,832	$
9. Total *(Line11, Form 2)*	$ 746,137,516	$ 705,993,623	$ 671,417,473	$ 0	$ 157,973,639	$ 0
	(STATE MCH BUDGET TOTAL)					

Form Notes for Form 3

None

Field Level Notes

1. **Section Number:** Form3_Main
   Field Name: FedAllocExpended
   Row Name: Federal Allocation
   Column Name: Expended
   Year: 2013
   Field Note:
   this is a test
2. **Section Number:** Form3_Main
   Field Name: FedAllocExpended
   Row Name: Federal Allocation
   Column Name: Expended
   Year: 2012
   Field Note:
   Grant award for FFY12 was $40,036,911; 2.4% less than originally budgeted.
3. **Section Number:** Form3_Main
   Field Name: LocalMCHFundsExpended
   Row Name: Local MCH Funds
   Column Name: Expended
   Year: 2013
   Field Note:
   Local increase is specific to systems improvement for more timely reporting of expenditures. .
4. **Section Number:** Form3_Main
   Field Name: ProgramIncomeExpended
   Row Name: Program Income
   Column Name: Expended
   Year: 2013
   Field Note:
   The reported decrease in program income is attributable to the Early Intervention Program. This could possibly be due to systems changes and the fact that claiming backlogs have greatly diminished,
5. **Section Number:** Form3_Main
   Field Name: ProgramIncomeExpended
   Row Name: Program Income
   Column Name: Expended
   Year: 2012
   Field Note:
   The program income reduction is attributable to the Early Intervention program. The aggregate amount reported in the State's Early Intervention Program Fiscal System by counties is significantly less than budgeted. The initial budget project was not adjusted for NYC's increased effort to for submission of prior years' lagged reporting.
6. **Section Number:** Form3_Main
   Field Name: OtherFedFundsExpended
   Row Name: Other Federal Funds
   Column Name: Expended
   Year: 2013
   Field Note:
   A protracted procurement process delayed the development of contracts which resulted in large underexpenditures for the Abstinence and ACA Home Visiting grants.
7. **Section Number:** Form3_Main
   Field Name: OtherFedFundsExpended
   Row Name: Other Federal Funds
   Column Name: Expended
   Year: 2012
   Field Note:
   There were no Abstinence grant expenditures and reduced expenditures for Personal Responsibiity Education Program and the Maternal, Infant and Early Childhood Home Visiting Programs. In many cases these new grants required the development and implementation of procurements for distribution of funding.

Form 4

Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds (II)

[Secs 506(2)(2)(iv)]

State: NY

	FY 2010		FY 2011		FY 2012	
I. Federal-State MCH Block Grant Partnership	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
a. Pregnant Women	$ 77,507,975	$ 72,021,720	$ 70,606,837	$ 67,384,532	$ 47,653,244	$ 47,402,457
b. Infants < 1 year old	$ 67,645,380	$ 71,848,320	$ 38,939,501	$ 45,243,057	$ 35,366,730	$ 42,613,258
c. Children 1 to 22 years old	$ 121,371,304	$ 108,027,577	$ 109,314,803	$ 110,836,789	$ 127,701,617	$ 162,245,544
d. Children with Special Healthcare Needs	$ 506,821,678	$ 621,643,203	$ 566,769,437	$ 652,809,843	$ 612,613,715	$ 434,299,598
e. Others	$ 94,488,959	$ 96,538,075	$ 70,749,273	$ 70,444,023	$ 64,329,713	$ 81,251,555
f. Administration	$ 13,118,876	$ 12,613,000	$ 8,067,612	$ 7,485,833	$ 3,287,906	$ 3,557,482
g. SUBTOTAL	$ 880,954,172	$ 982,691,895	$ 864,447,463	$ 954,204,077	$ 890,952,925	$ 771,369,894
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	$ 150,000		$ 0		$ 0	
b. SSDI	$ 568,638		$ 93,713		$ 101,303	
c. CISS	$ 0		$ 0		$ 0	
d. Abstinence Education	$ 0		$ 0		$ 2,991,440	
e. Healthy Start	$ 0		$ 0		$ 0	
f. EMSC	$ 0		$ 0		$ 0	
g. WIC	$ 0		$ 0		$ 0	
h. AIDS	$ 0		$ 0		$ 0	
i. CDC	$ 1,334,619		$ 1,724,830		$ 900,000	
j. Education	$ 23,831,850		$ 50,238,349		$ 23,765,113	
k. Home Visiting	$ 0		$ 0		$ 0	
l. Other						
DHHS ACF TANF	$		$		$ 4,500,000	
DHHS ACF	$		$		$ 3,236,330	
DHHS HRSA	$		$		$ 6,624,047	
DHHS PHS Title X	$		$		$ 11,644,517	
DHHS SAMSA	$		$		$ 850,000	
Medicaid Match	$ 9,503,861		$ 8,546,452		$ 8,646,452	
HRSA	$		$ 1,131,973		$	
TANF	$		$ 2,500,000		$	
Title X	$		$ 10,961,481		$	
Title X-Fam Planning	$ 10,512,876		$		$	
III. TOTAL	$ 45,901,844		$ 75,196,798		$ 63,259,202	

Form 4

Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds (II)

[Secs 506(2)(2)(iv)]

State: NY

	FY 2013		FY 2014		FY 2015	
I. Federal-State MCH Block Grant Partnership	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
a. Pregnant Women	$ 37,033,896	$ 31,935,016	$ 36,745,187	$	$ 9,542,179	$
b. Infants < 1 year old	$ 17,701,104	$ 20,053,687	$ 44,527,916	$	$ 3,986,586	$
c. Children 1 to 22 years old	$ 93,767,071	$ 89,903,101	$ 125,809,244	$	$ 29,073,295	$
d. Children with Special Healthcare Needs	$ 503,301,337	$ 472,326,431	$ 367,279,334	$	$ 45,325,089	$
e. Others	$ 34,804,474	$ 40,138,685	$ 32,206,795	$	$ 11,965,599	$
f. Administration	$ 1,886,623	$ 1,779,702	$ 1,943,395	$	$ 3,210,059	$
g. SUBTOTAL	$ 688,494,505	$ 656,136,622	$ 608,511,871	$ 0	$ 103,102,807	$ 0
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	$ 270,000		$ 0		$ 0	
b. SSDI	$ 85,000		$ 74,835		$ 91,045	
c. CISS	$ 0		$ 0		$ 0	
d. Abstinence Education	$ 2,841,809		$ 2,802,179		$ 2,634,308	
e. Healthy Start	$ 0		$ 0		$ 0	
f. EMSC	$ 0		$ 0		$ 0	
g. WIC	$ 0		$ 0		$ 0	
h. AIDS	$ 0		$ 0		$ 0	
i. CDC	$ 806,338		$ 808,146		$ 466,938	
j. Education	$ 23,867,174		$ 23,178,502		$ 23,178,502	
k. Home Visiting	$ 5,604,010		$ 11,208,020		$ 5,604,010	
l. Other						
DHHS ACF	$		$		$ 2,821,117	
DHHS PHS Title X	$ 10,290,042		$ 11,088,112		$ 9,571,185	
DHHS SAMHSA	$		$		$ 850,000	
HRSA	$		$ 800,005		$ 914,145	
Medicaid Match	$ 9,081,530		$ 9,034,268		$ 8,739,582	
DHHS ACF	$ 3,102,520		$ 3,061,535		$	
DHHS SAMSA	$ 850,000		$ 850,000		$	
DHHS HRSA	$ 844,588		$		$	
III. TOTAL	$ 57,643,011		$ 62,905,602		$ 54,870,832	

Form Notes for Form 4

None

Field Level Notes

1. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: PregWomenBudgeted
   Row Name: Pregnant Women
   Column Name: Budgeted
   Year: 2012
   Field Note:
   This year's budgeted amount reflects adjustments to the local share's state aid to localities "preventive health care" services being directed for children birth through age twenty. County reporting will not capture expenditures for pregnant women.
2. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: PregWomenExpended
   Row Name: Pregnant Women
   Column Name: Expended
   Year: 2013
   Field Note:
   A 54% decrease in reported local costs for prenatal and family planning appears to the cause of the decreased expenditures for Pregnant women.
3. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: Children_0_1Expended
   Row Name: Infants <1 year old
   Column Name: Expended
   Year: 2013
   Field Note:
   Attributable to understimated budget and and 66% increase in reported local revenues over the estimated budget.
4. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: Children_0_1Expended
   Row Name: Infants <1 year old
   Column Name: Expended
   Year: 2012
   Field Note:
   Increase in reported expenditures for primary and preventive health care local costs and Early Intervention local costs.
5. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: Children_1_22Expended
   Row Name: Children 1 to 22 years old
   Column Name: Expended
   Year: 2012
   Field Note:
   Increase in expenditures for Local primary and preventive health care and reported program income
6. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: CSHCNExpended
   Row Name: CSHCN
   Column Name: Expended
   Year: 2012
   Field Note:
   Expenditures less than budgeted predominately due to early intervention program income reported and Local early intervention reported.
7. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: AllOthersExpended
   Row Name: All Others
   Column Name: Expended
   Year: 2013
   Field Note:
   Attributable to understimated budget and and 66% increase in reported local revenues over the estimated budget.
8. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: AllOthersExpended
   Row Name: All Others
   Column Name: Expended
   Year: 2012
   Field Note:
   Expenditure exceeds budgeted due to reported family planning program income.

Form 5

State Title V Program Budget and Expenditures by Types of Services

[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

State: NY

Type of Service	FY 2010		FY 2011		FY 2012	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	$ 549,101,044	$ 681,730,785	$ 581,216,529	$ 668,679,951	$ 633,765,886	$ 503,328,135
II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.)	$ 73,676,681	$ 68,342,121	$ 59,929,280	$ 61,322,226	$ 49,755,348	$ 58,853,435
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$ 114,544,747	$ 109,677,635	$ 88,451,645	$ 87,046,529	$ 85,056,641	$ 95,803,170
IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	$ 143,631,700	$ 122,941,354	$ 134,850,009	$ 137,155,371	$ 122,375,050	$ 113,385,154
V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.)	$ 880,954,172	$ 982,691,895	$ 864,447,463	$ 954,204,077	$ 890,952,925	$ 771,369,894

Form 5

State Title V Program Budget and Expenditures by Types of Services

[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

State: NY

Type of Service	FY 2013		FY 2014		FY 2015	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	$ 491,943,772	$ 467,968,899	$ 386,244,310	$	$ 50,691,595	$
II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.)	$ 36,683,291	$ 38,080,760	$ 53,993,385	$	$ 9,195,719	$
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$ 72,912,918	$ 70,336,064	$ 85,630,526	$	$ 20,301,286	$
IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	$ 86,954,524	$ 79,750,899	$ 82,643,650	$	$ 22,914,207	$
V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.)	$ 688,494,505	$ 656,136,622	$ 608,511,871	$ 0	$ 103,102,807	$ 0

Form Notes for Form 5

None

Field Level Notes

1. **Section Number:** Form5_Main
   Field Name: DirectHCBudgeted
   Row Name: Direct Health Care Services
   Column Name: Budgeted
   Year: 2012
   Field Note:
   Increase in direct health care services attributable to increased program income reporting for Early Intervention and the reassessment of American Indian Health services as direct health care.
2. **Section Number:** Form5_Main
   Field Name: DirectHCExpended
   Row Name: Direct Health Care Services
   Column Name: Expended
   Year: 2012
   Field Note:
   Early intervention reported for Local and Program Income significantly less than budgeted.
3. **Section Number:** Form5_Main
   Field Name: EnablingExpended
   Row Name: Enabling Services
   Column Name: Expended
   Year: 2012
   Field Note:
   Expenditures higher than budgeted due to reported local primary and preventive health care
4. **Section Number:** Form5_Main
   Field Name: PopBasedExpended
   Row Name: Population-Based Services
   Column Name: Expended
   Year: 2012
   Field Note:
   Expenditures higher than budgeted due to reported costs for Local primary and preventive health services, local physically handicapped children's program costs and family planning reported revenues.

Form 6

Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

Sect. 506(a)(2)(B)(iii)

State: NY

Total Births by Occurrence: 238,412 | Reporting Year: 2013

Type of Screening Tests	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%			No.	%
Phenylketonuria	238,412	100	33	22	22	100
Congenital Hypothyroidism	238,412	100	580	291	291	100
Galactosemia	238,412	100	9	2	2	100
Sickle Cell Disease	238,412	100	114	113	113	100
Other Screening (Specify)						
Biotinidase Deficiency	238,412	100	2	1	1	100
Cystic Fibrosis	238,412	100	893	35	35	100
Homocystinuria	238,412	100	3	0	0	
Maple Syrup Urine Disease	238,412	100	6	3	3	100
Other	238,412	100	46	53	53	100
Tyrosinemia Type I	238,412	100	5	3	3	100
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	238,412	100	5	1	1	100
Isovaleric Acidemia	238,412	100	6	0	0	
Carnitine Uptake Defect	238,412	100	10	0	0	
3-Methylcrotonyl-CoA Carboxylase Deficiency	238,412	100	29	12	12	100
Multiple Carboxylase Deficiency	238,412	100	63	6	6	100
Glutaric Acidemia Type I	238,412	100	7	0	0	
Isobutyryl-CoA Dehydrogenase Deficiency	238,412	100	10	6	6	100
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	238,412	100	243	10	10	100
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	238,412	100	21	14	14	100
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	238,412	100	2	0	0	

Methylmalonic Acidemia (Mutase Deficiency)	238,412	100	2	2	2	100
Hemoglobin C Disease	238,412	100	25	22	22	100
Malonic acidemia	238,412	100	2	2	2	100
Krabbe Disease	238,412	100	44	2	2	100
Severe Combined Immunodeficiency	238,412	100	233	34	34	100

Screening Programs for Older Children & Women (Specify Tests by name)

(1) Use occurrent births as denominator.
(2) Report only those from resident births.
(3) Use number of confirmed cases as denominator.

Form Notes for Form 6

None

Field Level Notes

None

FORM 7

NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED) UNDER TITLE V (BY CLASS OF INDIVIDUALS AND PERCENT OF HEALTH COVERAGE)

[Sec. 506(a)(2)(A)(i-ii)]

STATE: NY

Number of Individuals Served - Historical Data by Annual Report Year

Types of Individuals Served	2008	2009	2010	2011	2012
Pregnant Women	391,034	385,884	378,814	372,588	376,621
Infants < 1 year old	246,824	250,282	247,880	231,872	239,452
Children 1 to 22 years old	5,583,705	5,456,881	5,560,739	5,602,979	5,710,762
Children with Special Healthcare Needs	542,758	486,192	570,508	660,565	835,972
Others	511,395	434,102	690,441	748,361	643,032
Total	7,275,716	7,013,341	7,448,382	7,616,365	7,805,839

Reporting Year: 2013

	TITLE V	PRIMARY SOURCES OF COVERAGE				
Types of Individuals Served	(A) Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private/Other %	(E) None %	(F) Unknown %
Pregnant Women	377,831	45.8	0.0	51.4	1.7	1.1
Infants < 1 year old	239,673	44.8	1.0	51.4	1.7	1.1
Children 1 to 22 years old	5,725,463	30.8	6.9	54.4	7.9	0.0
Children with Special Healthcare Needs	829,853	37.2	6.9	52.8	3.1	0.0
Others	644,014	21.4	0.0	61.9	16.7	0.0
TOTAL	7,816,834					

Form Notes for Form 7

None

Field Level Notes

None

FORM 8

DELIVERIES AND INFANTS SERVED BY TITLE V AND ENTITLED TO BENEFITS UNDER TITLE XIX (BY RACE AND ETHNICITY)

[SEC. 506(A)(2)(C-D)]

STATE: NY

Reporting Year: 2012

I. UNDUPLICATED COUNT BY RACE

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than one race reported	(H) Other and Unknown
DELIVERIES								
Total Deliveries in State	234,590	142,865	41,649	735	24,691	1,801	4,977	17,872
Title V Served	234,590	142,865	41,649	735	24,691	1,801	4,977	17,872
Eligible for Title XIX	113,776	69,290	20,200	356	11,975	873	2,414	8,668
INFANTS								
Total Infants in State	237,068	157,080	56,239	3,532	0	20,217	0	0
Title V Served	237,068	157,080	56,239	3,532	0	20,217	0	0
Eligible for Title XIX	114,978	76,184	27,276	1,713	0	9,805	0	0

II. UNDUPLICATED COUNT BY ETHNICITY

				HISPANIC OR LATINO (Sub-categories by country or area of origin)				
	(A) Total NOT Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(B.1) Mexican	(B.2) Cuban	(B.3) Puerto Rican	(B.4) Central and South American	(B.5) Other and Unknown
DELIVERIES								
Total Deliveries in State	178,944	55,646	0	0	0	0	0	55,646
Title V Served	178,944	55,646	0	0	0	0	0	55,646
Eligible for Title XIX	86,788	2,699	0	0	0	0	0	2,699
INFANTS								
Total Infants in State	175,042	62,026	0	0	0	0	0	62,026
Title V Served	175,042	62,026	0	0	0	0	0	62,026
Eligible for Title XIX	8,490	30,083	0	0	0	0	0	30,083

Form Notes for Form 8

Breakdown of infants by ethnicity as requsted in columns D, E, F and G is not available.

Field Level Notes

1. **Section Number:** Form8_I. Unduplicated Count By Race
   Field Name: InfantsTotal_All
   Row Name: Total Infants in State
   Column Name: Total All Races
   Year: 2015
   Field Note:
   Data Source: Census Population Estimates
2. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
   Field Name: InfantsTotal_TotalNotHispanic
   Row Name: Total Infants in State
   Column Name: Total Not Hispanic or Latino
   Year: 2015
   Field Note:
   Data Source: Census Population Estimates

Form 9
State MCH Toll-Free Telephone Line Data Form (Optional)
[Secs. 505(a)(E) and 509(a)(8)]
State: NY

	FY 2015	FY 2014	FY 2013	FY 2012	FY 2011
1. State MCH Toll-Free "Hotline" Telephone Number					
2. State MCH Toll-Free "Hotline" Name					
3. Name of Contact Person for State MCH "Hotline"					
4. Contact Person's Telephone Number					
5. Contact Person's Email					
6. Number of calls received on the State MCH "Hotline" this reporting period	0	0	0	0	0

FORM 9
STATE MCH TOLL-FREE TELEPHONE LINE DATA FORM
[SECS. 505(A)(E) AND 509(A)(8)]
STATE: NY

	FY 2015	FY 2014	FY 2013	FY 2012	FY 2011
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 522-5006	(800 522-5006	(800) 522-5006	(800) 522-5006	(800)522-5006
2. State MCH Toll-Free "Hotline" Name	The Growing Up Healthy Hotline	The Growing Up Healthy Hotline	The Growing Up Healthy Hotline	The Growing Up Healthy Hotline	The Growing Up Healthy Hotline
3. Name of Contact Person for State MCH "Hotline"	Michael Acosta	Michael Acosta	Michael Acosta	Michael Acosta	Michael Acosta
4. Contact Person's Telephone Number	(518) 474-1911	(518) 474-1911	(518) 474-1911	(518) 474-1911	(518)474-3664
5. Contact Person's Email	Michael.acosta@health.ny.gov	maa04@health.state.ny.us	maa04@health.state.ny.us	maa04@health.state.ny.us	maa04@health.state.ny.us
6. Number of calls received on the State MCH "Hotline" this reporting period	0	0	37514	45758	43130

Form Notes for Form 9

None

Field Level Notes

1. **Section Number:** Form9_Main
   Field Name: calls_2
   Row Name: Number of calls received On the State MCH Hotline This reporting period
   Column Name: FY
   Year: 2013
   Field Note:
   Based on 2013 annual data, 37,514 calls were responded to for information and referrals for WIC (45%), Prenatal Care Programs (6.4%), Farmers Market (6.74%), Medicaid (7.01%), Summer Food (9.85%) programs and Family Planning (2.71%)

Form 10
Title V Maternal & Child Health Services Block Grant
State Profile for FY 2015
[Sec. 506(a)(1)]
State: NY

1. State MCH Administration:
(max 2500 characters)

The New York State Department of Health's Division of Family Health administers the Title V program in New York State. The DFH leads the State's public health efforts to improve birth outcomes, promote healthy children, youth and families throughout the lifespan, and build healthy communities through community engagement, public-private partnerships, policy analysis, education, and advocacy. Funds support public health/infrastructure, population-based, enabling and gap-filling primary and preventive health care services for those with limited access to high quality, continuous health care. The Division of Family Health encompasses three Bureaus (Maternal and Child Health, Dental Health, and Early Intervention), and is supported by the Office of the Medical Director. The Division works closely with the Department's Office of Health Insurance Programs (OHIP), which oversees the state's Medicaid program and is taking the lead in implementing the provision of the ACA, and the Office of Health Systems Management, which licenses and monitors hospitals and and clinics throughout the state as well as other Divisions within DOH and other state agencies such as the Office of Children and Family Services, Office of Victims' Services, State Education Department, Office of Mental Health and others to improve the health status of New York's most vulnerable families. NY continues to show a strong commitment to the needs of the MCH population through significant state funding that far exceeds HRSA's matching requirement for NY.

Block Grant Funds	
2. Federal Allocation (Line 1, Form 2)	$ 38,909,810
3. Unobligated balance (Line 2, Form 2)	$ 0
4. State Funds (Line 3, Form 2)	$ 29,200,000
5. Local MCH Funds (Line 4, Form 2)	$ 22,198,393
6. Other Funds (Line 5, Form 2)	$ 0
7. Program Income (Line 6, Form 2)	$ 12,794,604
8. Total Federal-State Partnership (Line 8, Form 2)	$ 103,102,807

9. Most significant providers receiving MCH funds:

- Family Planning
- School Based Health Centers
- Comprehensive Adolescent Pregnancy Prevention
- Childhood Lead Poisoning Prevention

10. Individuals served by the Title V Program (Col. A, Form 7)

a. Pregnant Women	377,831
b. Infants < 1 year old	239,673
c. Children 1 to 22 years old	5,725,463
d. CSHCN	829,853
e. Others	644,014

11. Statewide Initiatives and Partnerships:

a. Direct Medical Care and Enabling Services:
(max 2500 characters)

School-based health centers, family planning and reproductive health, early intervention, regional perinatal centers, home visiting programs such as nurse/family partnership and extensive community outreach through the community health worker program, primary health and dental care for migrant and season farmworkers and their families, genetic services, care coordination, children with special health care needs program, services to native american women and children, physically handicapped children diagnosis and evaluation, dental rehabilitation program and patient education, translation and transportation.

b. Population-Based Services:
(max 2500 characters)

Maternal and Infant Community Health Collaboratives, lead poisoning prevention, newborn genetics and hearing screening, population-based health education campaigns, including prenatal outreach and education, breastfeeding promotion, the Growing Up Healthy Hotline, injury prevention, sexual violence prevention, immunization, health information media, overweight prevention, nutrition and physical activities programs for children and adolescents, comprehensive adolescent pregnancy prevention and youth development, maternal mortality reviews, SIDS and child death prevention, and reproductive health education.

c. Infrastructure Building Services:
(max 2500 characters)

Statewide Perinatal Data System, strategic planning efforts, NYS Perinatal Collaborative, hospital discharge data system (SPARCS) and quality assurance reporting, statewide immunization registry (NYSIIS), surveillance and public health information, state systems development initiative, child health information integration, community health assessments, public health workforce development, evaluation and monitoring, contract management, emergency preparedness,

standards and guidelines development. State aid to localities, and intra and interagency partnerships such as the Early Childhood Council. Education-related activities include the Preventive Medicine and Dental Public Health residency programs, public health nurse continuing education, the MCH Graduate Assistantship program, monthly satellite broadcasts, Act for Youth Center of Excellence, the Statewide Oral Health Technical Assistance Center, participation in regional training centers, national meetings and organizations.

12. The primary Title V Program contact person:

Name	Rachel M deLong, MD
Title	Director, Division of Family Health
Address	Empire State Plaza Tower, Rm 890
City	Albany
State	New York
Zip	12237
Phone	518-474-6968
Fax	518-4732015
Email	Rachel.deLong@health.ny.gov
Web	

13. The children with special health care needs (CSHCN) contact person:

Name	Susan Slade
Title	CSHCN Director
Address	Empire State Plaza Tower, Rm 984
City	Albany
State	New York
Zip	12237
Phone	518-473-9883
Fax	518-474-1420
Email	Susan.Slade@health.ny.gov
Web	

Form Notes for Form 10

None

Field Level Notes

None

Form 11
Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]
State: NY

Form Level Notes for Form 11

The methodology for collecting these data changed in 2012 from aggregate to individual-level data. The significant decrease in newborns screened is more than likely attributed to this new requirement.

Performance Measure # 01

The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	100	100	100	88.5	89.4
Annual Indicator	88.1	86.8	86.8	98.8	97.9
Numerator	15,853	3,300	3,300	2,988	2,906
Denominator	17,985	3,800	3,800	3,024	2,967
Data Source	Newborn Screening	Newborn Screening	Newborn Screening	Newborn Screening	Newborn Screening
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	99	99	99	99	99
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #1
   Field Name: PM01
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   As shown in the table, the numerator is the number of closed cases with documentation of an evaluation, diagnostic testing and a diagnosis as appropriate. The denominator is the number of screen positive newborns for the year. The program follows all screen positive newborns to ensure they receive appropriate follow-up.

2. **Section Number:** Form11_Performance Measure #1
   Field Name: PM01
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   As shown in the above table, the numerator is the number of closed cases of screen positive newborns with documentation of an evaluation, diagnostic testing and a diagnosis as appropriate. The denominator is the number of screen positive newborns for the year. The program follows all screen positive newborns to ensure they receive appropriate follow-up.

   The remaining open 2011 cases represent complicated patients with ongoing diagnostic evaluations. The Newborn Screening (NBS) Program has obtained confirmation that the patients are in care, but a definitive diagnosis is not available. The annual indicator improved significantly from 2010 to 2011 because routine meetings to review open cases were initiated. The number of lost-to-follow-up cases, where documentation of an ongoing evaluation, diagnostic testing and a diagnosis could not be obtained, remained consistent between 2010 (365 cases) and 2011 (381 cases).

   2012 data is pending because the standard diagnostic evaluation for some of the disorders takes up to 6 months; therefore, the annual indicator would not be

reliable if reported at this time. 2011 data are used as a proxy for 2012. 2012 data will be available in late 2013.

3. **Section Number:** Form11_Performance Measure #1
   Field Name: PM01
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   As shown in the above table, the numerator is the number of closed cases with documentation of an evaluation, diagnostic testing and a diagnosis as appropriate. The denominator is the number of screen positive newborns for the year. The program follows all screen positive newborns to ensure they receive appropriate follow-up.

   The annual indicator is lower for 2010 than 2009 because in some cases, a definitive diagnosis is pending, but confirmation of an ongoing evaluation has been obtained by the Program. Lost-to-follow-up cases, where documentation of an evaluation, diagnostic testing and a diagnosis could not be obtained, remained consistent between 2009 (317 cases) and 2010 (365 cases). Therefore, it is anticipated that the annual indicator for 2010 will increase once the pending cases are resolved.

   2011 data is pending because the standard diagnostic evaluation for some of the disorders takes up to 6 months; therefore, the annual indicator would not be a reliable if reported at this time. 2010 data are used as a proxy for 2011. 2011 data will be available in late 2012.

PERFORMANCE MEASURE # 02

The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	60	62	59.6	65.7	66.3
Annual Indicator	59	59	64.4	64.4	64.4
Numerator					
Denominator					
Data Source	CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	67	67.6	68.3	69	69
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Section Number:** Form11_Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

3. **Section Number:** Form11_Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

PERFORMANCE MEASURE # 03

The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	46	48	45.7	39.2	39.6
Annual Indicator	45.2	45.2	38.4	38.4	38.4
Numerator					
Denominator					
Data Source	CSHCN survey	CSHCN survey	CSHCN survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	39.9	40.3	40.7	50.1	50.4
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM3. However, the same questions were used to generate the NPM3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Section Number:** Form11_Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM3. However, the same questions were used to generate the NPM3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Section Number:** Form11_Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM3. However, the same questions were used to generate the NPM3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

PERFORMANCE MEASURE # 04

The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	64	64	62.7	57.9	58.5
Annual Indicator	62.1	62.1	56.8	56.8	56.8
Numerator					
Denominator					
Data Source	CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	59.1	59.6	60.2	60.7	61.6
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Section Number:** Form11_Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. Due to the data generated by the new survey, previously established performance objectives prior to 2011 are not realistic and targets for upcoming years were decreased. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Section Number:** Form11_Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

PERFORMANCE MEASURE # 05

Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	92	92	91.5	66.9	67.6
Annual Indicator	90.6	90.6	65.6	65.6	65.6
Numerator					
Denominator					
Data Source	CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	68.2	68.9	69.5	70.2	70.2
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Section Number:** Form11_Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. Due to the data generated by the new survey, previously established performance objectives prior to 2011 are not realistic and targets for upcoming years were decreased. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Section Number:** Form11_Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

PERFORMANCE MEASURE # 06

The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	40	40	38.8	40.5	40.9
Annual Indicator	38.4	38.4	39.7	39.7	39.7
Numerator					
Denominator					
Data Source	CSHCN survey	CSHCN survey	CSHCN survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	41.3	41.7	42.1	42.3	42.3
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

   CDC current schedule for the next data collection of these data are in 2014.

2. **Section Number:** Form11_Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM6 indicator the 2009-10 survey. Therefore, the 2005-06 and 2009-10 surveys can be compared. Due to NY's success in achieving this performance measure, the annual performance objective has been increased over previously established targets. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. 2011 data is being used as a proxy for 2012.

3. **Section Number:** Form11_Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording

changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

PERFORMANCE MEASURE # 07

Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	80	80	72.9	73.6	74.4
Annual Indicator	72.2	71.3	74.2	72.9	72.9
Numerator					
Denominator					
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	75.1	75.8	76.5	77.2	77.2
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form11_Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data is from the National Immunization Survey, 2001, conducted by the CDC. Although NYS as a whole has improved statewide, NYC is 75.9 and Rest of State at 72.6, and is below the national average of 78.7. However, these results may be impacted, in part, due to changes in the survey methodology. Decreasing prevalence of families with land lines (the NIS is a telephone survey) and a small sample size contribute to the variability of the results. 2011 data are used as a proxy for 2012 data.

3. **Section Number:** Form11_Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   The National Immunization Survey rates have decreased, in part, due to changes in the survey methodology. Decreasing prevalence of families with land lines (the National Immunization Survey is a telephone survey) and a small sample size contribute to the variability of the results. 2010 data are used as a proxy for 2011 data. It is estimated that final 2011 immunization data will be available from CDC in late 2012 or early 2013. NYS exceeds the HP 2020 baseline of 68% for the proportion of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and PCV vaccines but is below the target of 80%.

PERFORMANCE MEASURE # 08

The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	12.5	12.3	12	11	10
Annual Indicator	12.1	11.2	10.1	9.5	9.5
Numerator	4,687	4,330	3,811	3,500	3,500
Denominator	386,720	386,890	376,774	369,426	369,426
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	9.4	9.3	9.2	9.1	9
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form11_Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2011 Data are being used as a proxy for 2012.

3. **Section Number:** Form11_Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

PERFORMANCE MEASURE # 09

Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	28	39	40.9	42.7	43.5
Annual Indicator	38.1	41.9	41.9	42.6	42.6
Numerator	3,414			2,881	2,881
Denominator	8,960			6,758	6,758
Data Source	NYS 3rd Grade Dental Survey	NYS 3rd Grade Dental Survey	NYS 3rd Grade Dental Survey	NYS 3rd Grade Surviellance Survey	NYS 3rd Grade Or Health Surveillance Project
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	44.4	45.3	46.2	47	47
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The NY 3rd Grade Oral Health Surveillance Project (OHSP) is ongoing in both Upstate and NYC schools. Analysis of the data on 6,750 open mouth examinations as part of the second cycle has been completed. A report for the 2009-2012 cycle is being compiled. 2012 data is being used as a proxy for 2013 data.

2. **Section Number:** Form11_Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The NY 3rd Grade oral health surveillance project is currently underway in NYC schools. The Upstate NY component of the surveillance project, which had originally been completed in early 2011, is continuing, with additional schools being surveyed. Data for 2011 and 2012 are provisional as a result of continuation of the 3rd Grade Oral Health Surveillance Project. Data for 2010 are used as a proxy for 2011 since an updated analysis of the data is not available. Data show that the prevalence of sealants in Upstate school children has increased. However, it falls short of the national performance measure. Due to NY's success in achieving this performance measure in ROS, annual performance objectives were increased over previously established targets by approximately 2% per year. These increases are consistent with the NYS Prevention Agenda, which sets as a target a 10% increase in sealant utilization over a five-year period.

3. **Section Number:** Form11_Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   The NY 3rd Grade oral health surveillance project is currently underway in New York City (NYC) schools. The upstate NY component of the surveillance project was completed in 2011.
   *Weighted to reflect the population distribution

   Data show that the prevalence of sealants in Upstate school children has increased. However, it falls short of the national performance measure.

PERFORMANCE MEASURE # 10

The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	1.3	1.2	1	1.3	0.8
Annual Indicator	1.0	1.3	0.8	1.2	1.2
Numerator	37	47	29	43	43
Denominator	3,633,448	3,531,233	3,515,032	3,508,643	3,508,643
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	1	0.9	0.9	0.8	0.7
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form11_Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The number of motor vehicle deaths is based on the definition used by the DOH Bureau of Biometrics and Health Statistics and includes pedestrians and cyclists. The definition changed in 2004; prior to that time, pedestrians and cyclists were not included. 2011 data are being used for a proxy for 2012 data; 2012 data will be available in May 2014.

3. **Section Number:** Form11_Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   The number of motor vehicle deaths is based on the definition used by the DOH Bureau of Biometrics and Health Statistics and includes pedestrians and cyclists. The definition changed in 2004; prior to that time, pedestrians and cyclists were not included.

   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

PERFORMANCE MEASURE # 11

The percent of mothers who breastfeed their infants at 6 months of age.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	44.5	45.5	47.9	48.3	53.9
Annual Indicator	47.4	47.7	47.7	53.7	52.6
Numerator					
Denominator					
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	54	54.2	54.6	54.8	53.8
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source: National Immunization Survey

2. **Section Number:** Form11_Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2010 data represents the 2008 birth cohort. 2011 data represents the 2009 birth cohort. 2012 data represents the 2010 birth cohort.

3. **Section Number:** Form11_Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2010 data are being used as a proxy for 2011 data. 2010 data represents the 2008 birth cohort. 2011 data will be available by May 2013.

PERFORMANCE MEASURE # 12

Percentage of newborns who have been screened for hearing before hospital discharge.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	100	100	100	100	100
Annual Indicator	99.1	99.6	99.5	84.1	84.1
Numerator	244,545	239,116	229,377	201,126	201,126
Denominator	246,647	240,169	230,608	239,224	239,224
Data Source	Newborn Hearing Screening Program	Newborn Screening	Newborn Screening	Newborn Hearing Screening	Newborn Hearing Screening Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	100	100	100	100	100
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #12
   Field Name: PM12
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form11_Performance Measure #12
   Field Name: PM12
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Due to the lag in data collection and reporting, 2011 data are used as a proxy for 2012 data. These data are incomplete. Ten hospitals have not submitted their quarterly aggregate data. Therefore, approximately 8,000 to 10,000 births are missing hearing screening data and therefore, 2010 data cannot be compared with 2011 data. Hospitals are no longer required under NY public health law to submit aggregate reports. New York Early Hearing Detection and Intervention (NYEHDI) is transitioning to the collection of individual level hearing screening data.

3. **Section Number:** Form11_Performance Measure #12
   Field Name: PM12
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

PERFORMANCE MEASURE # 13

Percent of children without health insurance.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	8.5	8.4	7.4	7.4	6.5
Annual Indicator	7.5	7.9	6.6	5.6	5.6
Numerator	335,000	350,000	284,000	240,000	240,000
Denominator	4,465,000	4,418,000	4,291,000	4,267,000	4,267,000
Data Source	Current Population Survey	Current Population Survey	Current Population Survey	Current Population Survey	US Census Current Population Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	6.4	6.3	6.2	6.1	6.1
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form11_Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2011 Data is being used as a proxy for 2012.

3. **Section Number:** Form11_Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2010 data are being used as a proxy for 2011 data. 2011 data will be available in early 2013.

PERFORMANCE MEASURE # 14

Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	29	29	31.5	31.2	30.3
Annual Indicator	31.8	31.5	31.2	30.4	29.6
Numerator	71,274	70,636	72,042	58,819	61,456
Denominator	224,130	224,243	230,903	193,464	207,856
Data Source	PedNSS	PedNSS	PedNSS	PedNSS	PedNSS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	29.4	29.2	29	29	29
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #14
   Field Name: PM14
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2010 data are being used as a proxy for 2011 data. 2011 data will be available in early 2013.

PERFORMANCE MEASURE # 15

Percentage of women who smoke in the last three months of pregnancy.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	13	12	8.1	7.1	6.9
Annual Indicator	7.6	6.9	6.2	6.2	6.2
Numerator					
Denominator					
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	6	5.8	5.8	5.8	5.8
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   2011 data are being used as a proxy for 2012 and 2013 data. 2012 data are delayed until December 2014.

2. **Section Number:** Form11_Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2010 data is being used as a proxy for 2011 & 2012. 2012 data will be available the end of May 2013.

3. **Section Number:** Form11_Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Numerator and denominator data are not available (survey data). Previous data reported for 2006-2007 were for NYS (Excluding NYC). CDC has recently provided statewide statistics for this indicator. The comparble NYS percentages for 2006 and 2007 are 8.5% and 9.1%, respectively. 2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

PERFORMANCE MEASURE # 16

The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	3.8	3.8	4.2	4.5	5.9
Annual Indicator	4.2	4.6	6.1	6.0	6.0
Numerator	58	63	81	78	78
Denominator	1,366,144	1,366,278	1,324,252	1,307,947	1,307,947
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	5.8	5.7	5.6	5.5	5.5
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form11_Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2011 data are being used as a proxy for 2012.

3. **Section Number:** Form11_Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

PERFORMANCE MEASURE # 17

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	94	94	91	91.3	91.7
Annual Indicator	90.6	90.5	90.7	88.6	88.6
Numerator	3,356	3,270	3,131	3,104	3,104
Denominator	3,704	3,614	3,453	3,505	3,505
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	92	92.4	92.8	93.2	93.2
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form11_Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2011 data are being used as a proxy for 2012.

3. **Section Number:** Form11_Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

PERFORMANCE MEASURE # 18

Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	80	81	74	74.8	75.5
Annual Indicator	73.3	73.2	72.9	73.8	73.8
Numerator	167,503	169,190	167,091	171,806	171,806
Denominator	228,517	231,137	229,052	232,710	232,710
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	76.2	77	77.7	78.4	78.4
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   2012 data are being used as a proxy for 2013 data. Methodology Change: calculation of trimester has been revised to incorporate the clinical gestation date for records with unknown PNC start date. As the result – 2,000 records were added to the calculation of the indicators.

2. **Section Number:** Form11_Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2012 data are being used as a proxy for 2012

3. **Section Number:** Form11_Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   The denominator is the total number of births for which prenatal care initiation is known and excludes births where trimester of entry into prenatal care is unknown. 2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

Form 11
Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]
State: NY

Form Level Notes for Form 11

The methodology for collecting these data changed in 2012 from aggregate to individual-level data. The significant decrease in newborns screened is more than likely attributed to this new requirement.

State Performance Measure # 1 - Reporting Year

The percentage of infants born to Black and Hispanic women receiving prenatal care beginning in the first trimester.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			64.9	65.6	66.2
Annual Indicator	64.3	64.6	65.2	66.7	66.7
Numerator	58,055	59,319	58,996	60,402	60,402
Denominator	90,226	91,838	90,516	90,533	90,533
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	66.9	67.5	68.2	68.5	68.5
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #1
   Field Name: SM1
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form11_State Performance Measure #1
   Field Name: SM1
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2011 data are being used as a proxy for 2012 data. 2012 data will be available in May 2014.

3. **Section Number:** Form11_State Performance Measure #1
   Field Name: SM1
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

State Performance Measure # 2 - Reporting Year

The percentage of Medicaid enrolled children between the ages of 3 and 6 years who had a well-child and preventive health visit in the past year

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			79.5	79.9	80.4
Annual Indicator	79	79	80	83	82
Numerator					
Denominator					
Data Source	NYS Quality Assurance Reporting Requirements	NYS Quality Assurance Reporting Requirements	NYS Quality Assurance Reporting Requirements	NYS Quality Assurance Reporting Requirements	NYS Quality Assurance Reporting Requirements
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	80.9	81.4	83.7	84	84
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #2
   Field Name: SM2
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   These data represent children in this age group who are enrolled in the Medicaid Managed Care (MMC) which includes 88% of all children enrolled in Medicaid. Information on children enrolled in Medicaid fee-for-service is not included. Numerator and denominator data are not available (survey data).

2. **Section Number:** Form11_State Performance Measure #2
   Field Name: SM2
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   These data represent children in this age group who are enrolled in the Medicaid Managed Care (MMC) which includes 88% of all children enrolled in Medicaid. Information on children enrolled in Medicaid fee-for-service is not included. Numerator and denominator data are not available (survey data).

3. **Section Number:** Form11_State Performance Measure #2
   Field Name: SM2
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   These data represent children in this age group who are enrolled in the Managed Care type of Medicaid coverage which includes 87% of all children. Information on children enrolled in Medicaid fee-for-service is not included.

   Numerator and denominator data are not available (survey data).

STATE PERFORMANCE MEASURE # 3 - REPORTING YEAR

The ratio of the Black infant low birth weight rate to the White infant low birth weight rate

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			1.9	1.9	1.8
Annual Indicator	1.9	1.9	1.8	1.8	1.8
Numerator	13	12.9	12.6	12.3	12.3
Denominator	6.9	6.8	6.9	6.7	6.7
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	1.8	1.8	1.8	1.8	1.8

Annual Indicator
Numerator
Denominator

Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #3
   Field Name: SM3
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2011 data are being used as a proxy for 2012 data. 2012 data will be available by May 2014. Data are based on rates of low birth weight for White non-Hispanic and Black non-Hispanic births.

2. **Section Number:** Form11_State Performance Measure #3
   Field Name: SM3
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013. Data are based on rates of low birthweight for White non-Hispanic and Black non-Hispanic births.

State Performance Measure # 4 - Reporting Year

The percentage of high school students who were overweight or obese

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			26.3	26.1	25.8
Annual Indicator	26.6	26.6	25.7	25.7	25.7
Numerator					
Denominator					
Data Source	YRBS	YRBS	YRBS	YRBS	YRBS
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	25.5	25.3	25	25	25
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #4
   Field Name: SM4
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data not updated yet. 2012/2013 data will be available in June 2014

2. **Section Number:** Form11_State Performance Measure #4
   Field Name: SM4
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The YRBS is conducted biannually. Numerator and denominator data from this survey are not available. 2011 data are being used as a proxy for 2012 data.

3. **Section Number:** Form11_State Performance Measure #4
   Field Name: SM4
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data are from the 2011 Youth Risk Behavior Suvey. Numerator and denominator data are not available (survey data).

State Performance Measure # 5 - Reporting Year

The ratio of the Hispanic teen (ages 15-17) pregnancy rate to the non-Hispanic White teen (ages 15-17) pregnancy rate

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			5.2	4.5	4.5
Annual Indicator	5.3	4.6	4.5	4.4	4.4
Numerator	58.3	48.6	42		
Denominator	11	10.6	9.3		
Data Source	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	4.4	4.4	4.3	4.3	4.3
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #5
   Field Name: SM5
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   2012 data is being used as a proxy for 2013 data.

2. **Section Number:** Form11_State Performance Measure #5
   Field Name: SM5
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2011 data is being used as a proxy for 2012 data. 2012 data will be available in May 2014.

3. **Section Number:** Form11_State Performance Measure #5
   Field Name: SM5
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

STATE PERFORMANCE MEASURE # 6 - REPORTING YEAR

Percent of High School Students Who Smoked Cigarettes in the Last Month

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	5	5	12.5	12.3	12.2
Annual Indicator	14.9	12.6	12.5	11.9	11.9
Numerator					
Denominator					
Data Source	YRBS	NYS Youth Tobacco Survey	YRBS	NYS Youth Tobacco Survey	NYS Youth Tobacco Survey
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	12.1	12	11.8	11.6	11.6
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   2012 data are being used as a proxy for 2013.

2. **Section Number:** Form11_State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The YRBS and YTS are conducted biannually in alternating years. The numerator for each year and both surveys is the number of high school students who reportedly smoked on one or more days in the past 30 days. The denominator for each year and both surveys is the total number of students in grades 9 through 12.

3. **Section Number:** Form11_State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data are from the 2011 Youth Risk Behavior Survey. Numerator and denominator data are not available (survey data).

STATE PERFORMANCE MEASURE # 7 - REPORTING YEAR

The percentage of Medicaid enrolled children and adolescents between the ages of 2-21 years who had at least one dental visit within the last year

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			41.4	41.8	42.2
Annual Indicator	40.2	41.0	41.8	44.2	45.4
Numerator	746,153	797,681	835,106	814,503	873,813
Denominator	1,854,115	1,946,654	1,996,387	1,841,199	1,924,213
Data Source	Bur of MA Statistics	Bur of MA Statistics	Bur of MA Statistics	Bureau of MA Statistics	Bureau of Mediciad Statistics & Program Analysis
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	42.6	43.1	43.5	43.7	44.1
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #7
   Field Name: SM7
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   This indicator is based on data for all Medicaid recipients, including managed care and family health plus paid claims as of June 2012

2. **Section Number:** Form11_State Performance Measure #7
   Field Name: SM7
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   This indicator is based on information from both Managed Care and Fee-for- Sevice Medicaid Programs.

STATE PERFORMANCE MEASURE # 8 - REPORTING YEAR

Percentage of children who were tested for lead two or more times before the age of three.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			51	51.5	52
Annual Indicator	50.5	53.0	55.0	57.6	57.6
Numerator	125,763	133,960	137,431	142,143	142,143
Denominator	249,182	252,662	249,655	246,592	246,592
Data Source	NYS Lead Program	NYS Lead Program	NYS Lead Program	NYS Lead Program	NYS Lead Program
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	52.5	53	53.5	54	54
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #8
   Field Name: SM8
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data are reported for children turning three years of age in the year reported – i.e., data reported for 2011 are for children born in 2008. Data are statewide, including NYC. 2011 data are used as a proxy for 2012. 2012 data will be available in May 2014.

2. **Section Number:** Form11_State Performance Measure #8
   Field Name: SM8
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data are reported for children turning three years of age in the year reported – i.e., data reported for 2010 are for children born in 2007. Data is statewide, including NYC.
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

State Performance Measure # 9 - Reporting Year

Hospitalization Rate for Asthma in Children Ages 0 to 17 years.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			31	26.5	26.4
Annual Indicator	31.1	26.7	26.5	26.8	26.8
Numerator	13,781	11,552	11,341	11,406	11,406
Denominator	4,424,083	4,324,929	4,286,008	4,263,154	4,263,154
Data Source	SPARCS	SPARCS	SPARCS	SPARCS	SPARCS
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	26.3	26.2	26	25.7	25.7
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #9
   Field Name: SM9
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form11_State Performance Measure #9
   Field Name: SM9
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2011 data are being used as a proxy for 2012 data. 2012 data will be available by May 2014

3. **Section Number:** Form11_State Performance Measure #9
   Field Name: SM9
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

STATE PERFORMANCE MEASURE # 10 - REPORTING YEAR

The percentage of infants who were exclusively fed breast milk between birth and hospital discharge

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			43.1	43.6	44
Annual Indicator	42.7	43.5	39.8	40.6	40.6
Numerator	96,080	95,511	86,126	87,554	87,554
Denominator	224,903	219,503	216,625	215,852	215,852
Data Source	Statewide Perinatal Data System	Statewide Perinatal Data System	Statewide Perinatal Data System	Statewide Perinatal Data System	Statewide Perinatal Data System
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	44.4	44.8	45.4	45.4	45.4
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #10
   Field Name: SM10
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form11_State Performance Measure #10
   Field Name: SM10
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2011 data is being used as a proxy for 2012 data. 2012 data will be available in May 2014. The denominator includes all live born infants, excluding infants who were admitted to the NICU or transferred in or out of the hospital. The method the infant is fed is recorded on the Certificate of Live Birth and is defined as the period between birth and discharge from the hospital, up until 5 days of age (when NYS law requires report of live births). Infants are classified as being fed exclusively breast milk if they were fed only breast milk, and no other liquids or solids except for drops or syrups consisting of vitamins, minerals or medications.

   It should be noted that the percentage of infants exclusively fed breast milk in the delivery hospital appears to have decreased from 43.5% in 2010 to 39.8% in 2011. Efforts were made to improve and standardize the reporting for the infant feeding variables, including exclusively fed breast milk. Guidance from the National Center for Health Statistics, that newborn infant feeding data should be reported for the entire period spent in the delivery hospital (i.e., between birth and discharge), was shared with hospitals. Some hospitals had been reporting infant feeding based only on the last 24 hours or the last day of hospitalization. This change in reporting resulted in a reduction in the percentage of infants reported as being exclusively fed breast milk.

3. **Section Number:** Form11_State Performance Measure #10
   Field Name: SM10
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

Form 12
Tracking Health Outcome Measures
[Secs 505 (a)(2)(B)(iii) and 506 (a)(2)(A)(iii)]
State: NY

Form Level Notes for Form 12

None

Outcome Measure # 01

The infant mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	5.5	5.4	5.2	5.2	5.1
Annual Indicator	5.3	5.1	5.1		
Numerator	1,296	1,227	1,227		
Denominator	246,592	242,913	242,913		
Data Source	Vital Records	Vital Records	Vital Records		
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?					

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	5.1	5	5		
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 1
   Field Name: OM01
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Infant deaths for a given year are used as numerator data, and the births in that year are used as the denominator number. The resulting rate may be slightly different that a rate derived from matched birth-death files.
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

Outcome Measure # 02

The ratio of the black infant mortality rate to the white infant mortality rate.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	1.3	1.3	2.6	2.5	2.5
Annual Indicator	2.6	2.7	2.7		
Numerator	10.9	10.2	10.2		
Denominator	4.2	3.8	3.8		
Data Source	Vital Records	Vital Records	Vital Records		
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?					

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	2.5	2.5	2.4		
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 2
   Field Name: OM02
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Black and White race categories exclude Hispanics for data reported for 2008-2010. For 2006-2007, Black and White race categories included Hispanics whose race was White or Black. Infant deaths for a given year are used as numerator data, and births for the same year as denominator data. The resulting rate may differ somewhat from a rate based on matched birth-death files

   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

Outcome Measure # 03

The neonatal mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	3.7	3.7	3.6	3.5	3.5
Annual Indicator	3.6	5.1	5.1		
Numerator	886	1,227	1,227		
Denominator	246,592	242,913	242,913		
Data Source	Vital Records	Vital Records	Vital Records		
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?					

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	3.5	3.4	3.4		
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 3
   Field Name: OM03
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Vital statistics data are used to determine the rate: infants who died within 28 days of birth in the target year constitute the numerator, and births for that same year are used as the denominator. The rate may vary somewhat from a rate derived from matched birth-death files.
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

Outcome Measure # 04

The postneonatal mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	1	1	1.7	1.7	1.6
Annual Indicator	1.7	1.5	1.5		
Numerator	410	372	372		
Denominator	246,592	242,913	242,913		
Data Source	Vital Records	Vital Records	Vital Records		
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?					

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	1.6	1.6	1.6		
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Postneonatal mortality rates are determined using infant deaths from 28d-1y in a given year, divided by infant births from the same year. This rate may vary marginally from a rate calculated using matched birth-death certificates.
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

Outcome Measure # 05

The perinatal mortality rate per 1,000 live births plus fetal deaths.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	5.3	5.2	5.6	5.5	5.5
Annual Indicator	5.6	5.5	5.5		
Numerator	1,397	1,348	1,348		
Denominator	247,266	243,570	243,570		
Data Source	Vital Records	Vital Records	Vital Records		
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?					

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	5.4	5.4	5.3		
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 5
   Field Name: OM05
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   The numerator is derived from the number of infant deaths in the perinatal period plus fetal deaths, as reported on death and fetal death certificates for the year. The denominator is all births plus fetal deaths for the same year. This gives a rate that may vary somewhat from a rate calculated using matched birth-death files plus fetal deaths.
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

Outcome Measure # 06

The child death rate per 100,000 children aged 1 through 14.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	9.5	9.4	13.8	13.6	13.5
Annual Indicator	13.9	13.0	13.0		
Numerator	470	428	428		
Denominator	3,385,568	3,299,361	3,299,361		
Data Source	Vital Records	Vital Records	Vital Records		
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?					

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	13.3	13.2	13.1		
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 6
   Field Name: OM06
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

Form 12
Tracking Health Outcome Measures
[Secs 505 (a)(2)(B)(iii) and 506 (a)(2)(A)(iii)]
State: NY

Form Level Notes for Form 12

None

State Outcome Measure # 1 - Reporting Year

Maternal Mortality Rate per 100,000 Live Births

	Annual Objective and Performance Data				
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	18.5	18	28.1	20.3	20.1
Annual Indicator	20.7	23.1	23.4	18.8	18.8
Numerator	51	56	56	45	45
Denominator	246,592	242,913	239,736	239,224	239,224
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Is the Data Provisional or Final?				Final	Provisional

	Annual Objective and Performance Data				
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	19.9	19.7	19.5	19.3	
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Form12_State Outcome Measure 1
   Field Name: SO1
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form12_State Outcome Measure 1
   Field Name: SO1
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2011 Data are being used as a proxy for 2012.

3. **Section Number:** Form12_State Outcome Measure 1
   Field Name: SO1
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   The maternal mortality definition has been revised to be consistent with the definition used by the World Health Organization ((ICD-10 codes O00-95, O98-O99, and A34) . The previous definition used by NYSDOH (ICD 10 codes: O00-O99) to report maternal mortality included deaths that occurred outside this time period (ICD 10 codes: O96 and O97).
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

State Outcome Measure # 2 - Reporting Year

The percentage of elective deliveries, both cesarean sections and inductions, performed without appropriate indication between 36 and 38 6/7 weeks gestation

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			18.1	18.1	18
Annual Indicator	18.2	17.5	16.7	16.7	
Numerator	12,886	11,803	10,856	10,856	
Denominator	70,639	67,530	64,893	64,893	
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	
Is the Data Provisional or Final?				Provisional	

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	17.9	17.8	17.7	17.2	
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_State Outcome Measure 2
   Field Name: SO2
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2011 Data are being used as a proxy for 2012 data. 2012 data will be avaialbe in May 2014.

2. **Section Number:** Form12_State Outcome Measure 2
   Field Name: SO2
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

Form 13
Characteristics Documenting Family Participation in CSHCN Programs
State: NY

1. Family members participate on advisory committee or task forces and are offering training, mentoring, and reimbursement, when appropriate.

2

2. Financial support (financial grants, technical assistance, travel, and child care) is offered for parent activities or parent groups.

2

3. Family members are involved in the Children with Special Health Care Needs elements of the MCH Block Grant Application process.

1

4. Family members are involved in service training of CSHCN staff and providers.

2

5. Family members hired as paid staff or consultants to the State CSHCN program (a family member is hired for his or her expertise as a family member).

0

6. Family members of diverse cultures are involved in all of the above activities.

3

Total Score: 10

Rating Key
0 = Not Met
1 = Partially Met
2 = Mostly Met
3 = Completely Met

Form Notes for Form 13

None

Field Level Notes

None

Form 14
List of MCH Priority Needs

[Sec. 505(a)(5)]

State: NY FY: 2015

Your State's 5-year Needs Assessment should identify the need for preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children and services for Children with Special Health Care Needs. With each year's Block Grant application, provide a list (whether or not the priority needs change) of the top maternal and child health needs in your state. Using simple sentence or phrase ,list below your State's needs. Examples of such statements are: "To reduce the barriers to the delivery of care for pregnant women, " and "The infant mortality rate for minorities should be reduced."

MCHB will capture annually every State's top 7 to 10 priority needs in an information system for comparison, tracking, and reporting purposes; you must list at least 7 and no more than 10. Note that the numbers listed below are for computer tracking only and are not meant to indicate priority order. If your State wishes to report more than 10 priority needs, list additional priority needs in a note at the form level.

1. To improve access to early, adequate and high quality prenatal care, with a specific focus on eliminating health disparities.
2. To improve access to comprehensive, high quality primary and preventive health care for children and adolescents, consistent with the medical home model, including children with special health care needs.
3. To eliminate disparities in health outcomes, especially with regard to low birth weight and infant mortality.
4. To prevent and reduce the incidence of overweight and obesity for infants, children and adolescents, with a focus upon reducing health disparities.
5. To reduce unintended pregnancies in adults and adolescents and improve adolescent sexual health and development, with a focus upon reducing health disparities.
6. To reduce or eliminate tobacco, alcohol and substance abuse among children and pregnant women.
7. To improve oral health, particularly for pregnant women, mothers and children, and among those with low income.
8. To eliminate childhood lead poisoning.
9. To improve diagnosis and treatment of asthma in the maternal and child health population.
10. To increase the percentage of infants who are breastfed for at least six months.

Form Notes for Form 14

None

Field Level Notes

None

Form 15
Technical Assistance (TA) Request

STATE: NY **APPLICATION YEAR: 2015**

No.	Category of Technical Assistance Requested	Description of Technical Assistance Requested *(max 250 characters)*	Reason(s) Why Assistance Is Needed *(max 250 characters)*	What State, Organization or Individual Would You suggest Provide the TA (if known) *(max 250 characters)*
1.	**General Systems Capacity Issues** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: N/A	NY would benefit from discussions with states the size and complexity of NY regarding the current and future role of public health, and MCH in particular, in light of the implementation of the ACA.	States need to have a clear, coordinated approach and message on the local, state and federal level to ensure an understanding of the role of public health to protect the services and funding.	HRSA can facilitate periodic conference calls with states the size and complexity of NY such as California and Texas.
2.	**Other** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: N/A	States need the new format and requirements for the 2016 Title V application and report asap, but no later than late summer.	The transformation of MCH Title V and the new application format will necessitate more time and effort to ensure a quality application.	HRSA needs to finalize and release the guidance. HRSA and AMCP can provide guidance and webinars to assist states to better understand new requirements and approaches.
3.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
4.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
5.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
6.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
7.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
8.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
9.	If you selected State or National			

	Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
10.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
11.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
12.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			

Form Notes for Form 15

None

Field Level Notes

None

FORM 16
STATE PERFORMANCE AND OUTCOME MEASURE DETAIL SHEET
STATE: NY

SP() # 1

PERFORMANCE MEASURE:	The percentage of infants born to Black and Hispanic women receiving prenatal care beginning in the first trimester.
STATUS:	Active
GOAL	Increase the percentage of Black and Hispanic women recieving early prenatal care.
DEFINITION	Percentage of births to Black non-Hispanic and Hispanic women who started prenatal care during their first trimester. **Numerator:** Number of births to Black non-Hispanic and Hispanic women who started prenatal care during their first trimester. **Denominator:** Number of births to Black non-Hispanic and Hispanic women (excluding births with unknown prenatal care start dates). **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	NYS Vital Records
SIGNIFICANCE	It is essential that women, especially high risk women, receive early prenatal care where their needs can be assessed, and they can be provided with necessary health and psychosocial supports. While health disparities related to early entry prenatal care have improved somewhat in the last decade, they still remain significant, highlighting the specific importance of monitoring prenatal care for minority populations.

SP() # 2

Performance Measure:	The percentage of Medicaid enrolled children between the ages of 3 and 6 years who had a well-child and preventive health visit in the past year
Status:	Active
Goal	To increase the percent of chldren in the 3-6 age group who have an annual preventive health visit
Definition	The percentage of Medicaid enrolled children ages 3-6 years with a well child and preventive health visit in the past year. **Numerator:** Number of medicaid enrolled children (ages 3-6) who have had a well child preventive health visit **Denominator:** Number of medicaid enrolled children (ages 3-6) years. **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	
Data Sources and Data Issues	Source: The NYS Quality Assurance Reporting Requirements (QARR)- report of managed care plan performance. Data only include information for enrollies in managed care programs.
Significance	Having health insurance alone does not assure access to or utilization of necessary health care services. Well child preventive visits are an essential component of high quality health care.

SP() # 3

Performance Measure:	The ratio of the Black infant low birth weight rate to the White infant low birth weight rate
Status:	Active
Goal	To reduce the disparity between the White and Black low birth weight rates.
Definition	Ratio of Black to White low birth weight rates **Numerator:** The percent of Black infants born weighting less than 2500 grams **Denominator:** The percent of White infants born weighing less than 2500 grams **Units:** 1 **Text:** Ratio
Healthy People 2020 Objective	
Data Sources and Data Issues	NYS Vital Records
Significance	Elimination of health disparities is a high priority for the Department and the Governor and permeates the work of the department. The Black low birth weight rate in NYS is about double the rate of the White rate.

SP() # 4

Performance Measure:	The percentage of high school students who were overweight or obese
Status:	Active
Goal	To reduce the percentage of adolescents who are overweight or obese
Definition	The percentage of high school students who were overweight or obese (i.e., at or above the 85th percentile for body mass index, by age and sex) **Numerator:** The number of high school students with BMIs above the 85th percentile by age and sex. **Denominator:** The number of high school students **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	
Data Sources and Data Issues	The NYS Youth Risk Behavior Survey
Significance	Research indicates that adult morbidity and mortality are increased by childhood obesity, even if the condition does not persist into adulthood. However, in general, overweight and obesity tend to track or persist from childhood into adolescence and adulthood. The older the child/adolescent and the greater the obesity, the more likely that child/adolescent obesity will persist.

SP() # 5

Performance Measure:	The ratio of the Hispanic teen (ages 15-17) pregnancy rate to the non-Hispanic White teen (ages 15-17) pregnancy rate
Status:	Active
Goal	To reduce the disparity in teen pregnany rates between Hispanic and non-Hispanic White teen girls.
Definition	The ratio of the Hispanic teen (ages 15-17) pregnancy rate to the non-Hispanic White teen (ages 15-17) pregnancy rate **Numerator:** The rate of pregnancies (including abortions, spontaneous fetal deaths, and births) to Hispanic females aged 15-17 years old. **Denominator:** The rate of pregnancies (including abortions, spontaneous fetal deaths, and births) to non-Hispanic White females aged 15-17 years old. **Units:** 1 **Text:** Ratio
Healthy People 2020 Objective	
Data Sources and Data Issues	Vital Records are the source for data on mothers' age and pregnancies. Population numbers are estimated by the Bureau of Biometrics, NYS Health Department.
Significance	Adolescent sexual activity can have life-changing or life-threatening consequences; unintended pregnancy and infection with sexually transmitted diseases or HIV. Teen parenting is associated with non-completion of high school. While NYS has been successful in reducing teen pregnancies over the past decade, rates of pregnancy among Hispanic teens is more than double the rate for White teens.

SP() # 6

Performance Measure:	Percent of High School Students Who Smoked Cigarettes in the Last Month
Status:	Active
Goal	To reduce smoking among adolescents.
Definition	The rate of current smoking among high school students. **Numerator:** The number of high school students that reported smoking at least one cigarette during the last month. **Denominator:** The number of high school students **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	
Data Sources and Data Issues	The New York State Youth Risk Behavior Survey
Significance	Tobacco is an addictive substance. Tobacco causes more disease and death in NYS than any other pathogen. Tobacco causes 30% of all cancer deaths, 82% of all deahts due to pulmonary disease, and 21% of deaths due to chronic cardiac disease. More than 1,500 fire deaths and 4,600 injuries in the US are attributable to cigarettes. Most (89%)of adult smokers initiated their habit while young, under the ate of 18. 71% of adult smokers reported thay they began smoking daily before age 18.

SP() # 7

Performance Measure:	The percentage of Medicaid enrolled children and adolescents between the ages of 2-21 years who had at least one dental visit within the last year
Status:	Active
Goal	To increase dental visits among children and adolescents living in low income households.
Definition	The percentage of Medicaid enrolled children and adolescents between the ages of 2-21 years who had at least one dental visit within the last year **Numerator:** Medicaid enrolled children and adolescents(ages 2-21) who had at least one dental visit in the last year **Denominator:** Medicaid enrolled children and adolescents (ages 2-21) **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	
Data Sources and Data Issues	Source: The NYS Quality Assurance Reporting Requirements (QARR)- report of managed care plan performance. Data only include information for enrollies in managed care programs.
Significance	Tooth decay, the most common chronic childhood disease impacts children's functioning, including eating, growth and speaking and learning. In the US, children are estimated to lose over 51 million school hours annually because of dental problems and dental visits.

SP() # 8

Performance Measure:	Percentage of children who were tested for lead two or more times before the age of three.
Status:	Active
Goal	To identify all children who have been exposed to high levels of lead.
Definition	Percentage of children who were tested for high lead levels two or more times before the age of three. **Numerator:** Number of children in the birth year cohort who have been screened two or more times for high blood lead levels before the age of three. **Denominator:** Number of children in the birth year cohort **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	
Data Sources and Data Issues	NYS Heavymetals and Childhood Lead Registry, the data base for the NYS Childhood Lead Poisoning Prevention Program, is the source for these data. The NYSDOH Bureau of Biometrics provides population estimates.
Significance	Childhood lead poisoning is a serious health problem that can have devastating permanent effects on children's physical, social, behavioral and cognitive development, with serious social and economic repercussions for society as a whole.

SP() # 9

Performance Measure:	Hospitalization Rate for Asthma in Children Ages 0 to 17 years.
Status:	Active
Goal	To reduce asthma morbidity among children.
Definition	Rate of asthma hospitalizations per 10,000 children ages 0 to 17. **Numerator:** Number of hospitalizations for asthma (ICD9 493)among children ages 0 to 17. **Denominator:** Number of children ages 0 to 17 **Units:** 10000 **Text:** Rate
Healthy People 2020 Objective	1-9. Hospitalization for ambulatory-care-sensitive conditions 1-9a. Reduce hospitalization rates for pediatric asthma (persons under age 18 years) to no more than 17.3 per 10,000 persons aged less than 18 years.
Data Sources and Data Issues	The NYS SPARCS Data System is the source for the hospitalization data. The NYSDOH Bureau of Biometrics provides population estimates.
Significance	Increased asthma prevalence among children and the associated morbidity due to exacerbations and persistent symptoms present a huge burden to affected individuals and their families. In the US, over 10 million school days are lost anually by children with asthma. Consequently lost productivity of their parents was almost $1M. Patients with inadequately controlled severe asthma have high expenditures in health care costs, especially in terms of hospitalizations. The social and economic burdens of asthma can be alleviated through appropriate asthma preventin and management strategies.

SP() # 10

Performance Measure:	The percentage of infants who were exclusively fed breast milk between birth and hospital discharge
Status:	Active
Goal	To increase the rate of infants who are exclusively fed breast milk
Definition	The percentage of infants who were exclusively fed breast milk between birth and hospital discharge **Numerator:** The number of in-born infants, excluding those transferred to the neonatal intensive care unit, who are exclusively fed breast milk between birth and discharge **Denominator:** The total number of in-born infants who are not transferred to neonatal intensive care unit. **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	
Data Sources and Data Issues	Statewide Perinatal Data System
Significance	The U.S. Surgeion General recommends that babies be fed only breast milk for the first six months of their lives. The public health benefits of breastfeeding have long been recognized. Human milk is uniquely adapted to the nutritional needs of infants and provides for optimal growth and development. Breast milk is easy to digest and contains antibodies that help reduce the infants risk of infection.

SO() # 1

Outcome Measure:	Maternal Mortality Rate per 100,000 Live Births
Status:	Active
Goal	To reduce the number of maternal deaths
Definition	Deaths from causes related to pregnancy **Numerator:** Number of deaths occurring to women from causes related to pregnancy (ICD10:A34,O00-O95,O98-O99) **Denominator:** Number of Live Births **Units:** 100000 **Text:** Rate
Healthy People 2020 Objective	Reduce the maternal mortality rate to no more than 3.3 per 100,000 live births
Data Sources and Data Issues	Source: Vital Records Issues: Maternal deatsh as cause of death are under reported. More aggressive case ascertainment results in what appear to be higher rates.
Significance	Due to general improvement in social and economic conditions and medical practices, maternal deaths are rare occurrences. However, in recent years in both the U.S. and in New York State, the rate of maternal deaths has been increasing. New York State is revising its protocol for maternal mortality reviews with a focus upon prevention of future deaths. It is critical to continue to track the rate of maternal deaths to determine whether this effort will have a positive effect on reducing mortality.

SO() # 2

Outcome Measure:	The percentage of elective deliveries, both cesarean sections and inductions, performed without appropriate indication between 36 and 38 6/7 weeks gestation
Status:	Active
Goal	To reduce the rate of elective deliveries performed without indication
Definition	Rate of elective deliveries per 100 performed without appropriate indication among women between 36 and 38 6/7 weeks gestation. **Numerator:** Number of elective deliveries performed without appropriate indication among women between 36 and 38 6/7 weeks gestation. **Denominator:** Number of elective deliveries performed among women between 36 and 38 6/7 weeks gestation. **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	
Data Sources and Data Issues	Statewide Perinatal Data System
Significance	Cesarean section rates have risen nationally over the past decade. Between 1996 and 2005, the national c-section rate rose by 46% due, in part, to increases in the percent of women having first time c-section deliveries and a reduction in the percentage of vaginal births after c-section. The c-section rate in NYS reflects the national trend.

Form Notes for Form 16

None

Field Level Notes

None

Form 17
Health Systems Capacity Indicators
Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data
State: NY

Form Level Notes for Form 17

None

Health Systems Capacity #01

The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	61.3	56.3	52.1	55.5	55.5
Numerator	7,502	6,507	6,059	6,418	6,418
Denominator	1,223,080	1,155,822	1,163,580	1,155,822	1,155,822
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source: SPARCS 2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form17_Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Statewide Planning and Research Cooperative System (SPARCS). 2011 Provisional Data are being used as a proxy for 2012

3. **Section Number:** Form17_Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Statewide Planning and Research Cooperative System (SPARCS). 2011 data updated May 2013 although provisional.

HEALTH SYSTEMS CAPACITY #02

The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

	Annual Indicator Data				
	2009	**2010**	**2011**	**2012**	**2013**
Annual Indicator	76.3	77.3	77.6	76.3	89.5
Numerator	116,490	113,092	114,770	111,519	119,371
Denominator	152,710	146,242	147,852	146,249	133,416
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #02
   Field Name: HSC02
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Methodology change: Used "total eligivle for ESPDT for 90 continuous days" as the denominator as the numerator is the total eligible receiving at least one initial or period screen for those continuously eligible for at least 90 days. Data Source: Center for Medicare/Medicaid Services.

2. **Section Number:** Form17_Health Systems Capacity Indicator #02
   Field Name: HSC02
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Center for Medicare/Medicaid Services. Denominator=Total eligible for ESPDT.

3. **Section Number:** Form17_Health Systems Capacity Indicator #02
   Field Name: HSC02
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data are for children enrolled in both MA Fee-For-Service and MA Managed Care.
   Source: NYS DOH Center for Medicare/Medicaid Services (CMS-416).

HEALTH SYSTEMS CAPACITY #03

The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	99.3	99.4	99.5	99.2	99.2
Numerator	1,580	1,900	2,151	2,100	2,100
Denominator	1,591	1,911	2,161	2,117	2,117
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source: Quality Assurance Reporting Requirements (QARR) Managed Care Program Reports. Note: Results are for children continuously enrolled in managed care plans who are 15 months of age in the calendar year 2012. 2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form17_Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Quality Assurance Reporting Requirements (QARR). Data are based on calendar years. Results are for children continuously enrolled in managed care plans who are 15 months of age in the calendar year. 2011 data are being used as a proxy for 2011.

3. **Section Number:** Form17_Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Results are for children continuously enrolled in managed care plans who are 15 months of age in the calendar year. 2007 data excluded invalid data from one plan, resulting in a smaller denominator. Reliable data for Child Health Plus enrollees specifically under age one is not available. As a proxy, the percentage of children under age 15 months who received at least one well child or preventive health visit is used. Data reported for 2006 was the percentage of children who received five or more well child visits by age 15 months. Data Source is the Quality Assurance Reporting Requirements (QARR). 2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

HEALTH SYSTEMS CAPACITY #04

The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	66.0	66.9	66.6	67.5	67.5
Numerator	148,291	152,108	150,950	152,870	152,870
Denominator	224,556	227,334	226,640	226,483	226,483
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #04
   Field Name: HSC04
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Date Source: Vital Records/Births. 2012 data is being used as a proxy for 2013 data.

2. **Section Number:** Form17_Health Systems Capacity Indicator #04
   Field Name: HSC04
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data source: Vital Records/Births. 2011 Data are being used as as proxy for 2012.

3. **Section Number:** Form17_Health Systems Capacity Indicator #04
   Field Name: HSC04
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.
   Source: NYSDOH Vital Records

HEALTH SYSTEMS CAPACITY #07A

Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

	Annual Indicator Data				
	2009	**2010**	**2011**	**2012**	**2013**
Annual Indicator	90.7	87.4	87.0	86.8	87.9
Numerator	1,876,851	1,878,851	1,910,587	1,979,928	2,074,894
Denominator	2,068,245	2,150,748	2,196,077	2,280,280	2,359,718
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #07A
   Field Name: HSC07A
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data are the number and percent of enrolled children who received services paid by Medicaid.

2. **Section Number:** Form17_Health Systems Capacity Indicator #07A
   Field Name: HSC07A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Denominator came from the CMS-416 Report by the Center for Medicare/Medicaid Services.

3. **Section Number:** Form17_Health Systems Capacity Indicator #07A
   Field Name: HSC07A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   The number of potentially eligible children is based on the number of children enrolled in Medicaid.
   Source: NYS DOH Center for Medicare/Medicaid Services (CMS-416).

HEALTH SYSTEMS CAPACITY #07B

The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	50.1	51.1	52.5	52.5	52.5
Numerator	186,258	200,375	212,043	212,043	212,043
Denominator	371,495	391,812	403,816	403,816	403,816
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #07B
   Field Name: HSC07B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2011 Data are being used as proxy for 2012.

2. **Section Number:** Form17_Health Systems Capacity Indicator #07B
   Field Name: HSC07B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source: NYS DOH Center for Medicare/Medicaid Services.

HEALTH SYSTEMS CAPACITY #08

The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	0	0	0	0	0
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   This measure is not applicable to NYS as all SSI beneficiaries are categorically eligible for Medicaid which covers rehabilitative services.

2. **Section Number:** Form17_Health Systems Capacity Indicator #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   This measure is not applicable to NYS as all SSI beneficiaries are categorically eligible for Medicaid which covers rehabilitative services.

3. **Section Number:** Form17_Health Systems Capacity Indicator #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   NYS has two Title V public health programs that assist families of children with special health care needs (CSHCN) access services and supports. The state CSHCN Program, through its local contractors, provides families of CSHCN with linkages and referrals to services and assistance programs, including SSI. The State Physically Handicapped Children's Program (PHCP), administered by Local Health Departments, provides reimbursement of medical services for children who are uninsured or underinsured. In NYS, all SSI beneficiaries are categorically eligible for Medicaid which provides a more comprehensive benefit package than PHCP and provides rehabilitative services. As a result, CSHCN on SSI in NYS access their rehabilitative services through Medicaid instead of the State's PHCP.

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #05
(MEDICAID AND NON-MEDICAID COMPARISON)
STATE: NY

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
a) *Percent of low birth weight (< 2,500 grams)*	2012	Payment source from birth certificate	8.2	7.7	7.9
b) *Infant deaths per 1,000 live births*	2011	Matching data files	5.9	3.9	4.9
c) *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*	2012	Payment source from birth certificate	65.5	81.9	73.9
d) *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*	2012	Payment source from birth certificate	60.4	74.3	67.5

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #06(MEDICAID ELIGIBILITY LEVEL)
STATE: NY

INDICATOR #06 *The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.*	YEAR	PERCENT OF POVERTY LEVEL MEDICAID (Valid range: 100-300 percent)
a) *Infants (0 to 1)*	2013	223
b) *Medicaid Children* (Age range 1 to 18) (Age range to) (Age range to)	2013	154
c) *Pregnant Women*	2013	223

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #06(SCHIP ELIGIBILITY LEVEL)
STATE: NY

INDICATOR #06 *The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, SCHIP and pregnant women.*	YEAR	PERCENT OF POVERTY LEVEL SCHIP
a) *Infants (0 to 1)*	2013	100
b) *Medicaid Children* (Age range 1 to 1) (Age range to) (Age range to)	2013	400
c) *Pregnant Women*	2013	100

Form Notes for Form 18

None

Field Level Notes

1. **Section Number:** Form18_Indicator 06 - SCHIP
   Field Name: SCHIP_Women
   Row Name: Pregnant Women
   Column Name:
   Year: 2015
   Field Note:
   Pregnant women in NYS are not eligible for SCHIP.
2. **Section Number:** Form18_Indicator 05
   Field Name: LowBirthWeight
   Row Name: Percent of ow birth weight (<2,500 grams)
   Column Name:
   Year: 2015
   Field Note:
   Methodology Revision: Definition of births paid for/reimbursed using Medicaid funds has been revised to include secondary payor in addition to the primary payor. The revision changes the state Medicaid/non-Medicaid totalls by .1 percent. If we were to revise earlier years using the same meghodology, we expect to obtain similar percent differences as seen with 2012 data.
3. **Section Number:** Form18_Indicator 05
   Field Name: CareFirstTrimester
   Row Name: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester
   Column Name:
   Year: 2015
   Field Note:
   Methodology Revision: Definition of Births paid for/reimbursed using Medicaid funds has been revised to include secondary payor in addition to the primary payor. The revision changes the state Medicaid/non-Medicaid totalbs by .1 percent. If we were to revise earlier years using the same methodology we expect to obtain similar percent differences as seen with 2012 data.
4. **Section Number:** Form18_Indicator 05
   Field Name: AdequateCare
   Row Name: Percent of pregnant women with adequate prenatal care
   Column Name:
   Year: 2015
   Field Note:
   Methodology Revision: Definition of Births paid for/reimbursed using Medicaid funds has been revised to include secondary payor in addition to the primary payor. The revision changes the state Medicaid/non-Medicaid totalbs by .1 percent. If we were to revise earlier years using the same methodology we expect to obtain similar percent differences as seen with 2012 data.

FORM 19
HEALTH SYSTEMS CAPACITY INDICATOR - REPORTING AND TRACKING FORM
STATE: NY

HEALTH SYSTEMS CAPACITY INDICATOR #09A (General MCH Data Capacity)
(The Ability of the State to Assure MCH Program Access to Policy and Program Relevant Information)

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3) *	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES		
Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS		
Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

*Where:
1 = No, the MCH agency does not have this ability.
2 = Yes, the MCH agency sometimes has this ability, but not on a consistent basis.
3 = Yes, the MCH agency always has this ability.

FORM 19
HEALTH SYSTEMS CAPACITY INDICATOR - REPORTING AND TRACKING FORM
STATE: NY

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)*	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
Other:		

*Where:
1 = No
2 = Yes, the State participates but the sample size is not large enough for valid statewide estimates for this age group.
3 = Yes, the State participates and the sample size is large enough for valid statewide estimates for this age group.

Notes:

1. HEALTH SYSTEMS CAPACITY INDICATOR #09B was formerly reported as Developmental Health Status Indicator #05.

Form Notes for Form 19

None

Field Level Notes

None

Form 20
Health Status Indicators #01-#05
Multi-Year Data
State: NY

Form Level Notes for Form 20

None

Health Status Indicator #01A

The percent of live births weighing less than 2,500 grams.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	8.2	8.2	8.1	7.9	7.9
Numerator	20,226	19,910	19,417	18,935	18,935
Denominator	246,360	242,693	239,498	238,982	238,982
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #01A
   Field Name: HSI01A
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source: Vital Records/Births. 2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form20_Health Status Indicator #01A
   Field Name: HSI01A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2011 Data are being used as a proxy for 2012

3. **Section Number:** Form20_Health Status Indicator #01A
   Field Name: HSI01A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.
   Source: NYS DOH Vital Records

HEALTH STATUS INDICATOR #01B

The percent of live singleton births weighing less than 2,500 grams.

	Annual Indicator Data				
	2009	**2010**	**2011**	**2012**	**2013**
Annual Indicator	6.2	6.2	6.1	6.0	6.0
Numerator	14,587	14,489	14,118	13,830	13,830
Denominator	236,463	233,203	230,108	229,787	229,787
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #01B
   Field Name: HSI01B
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source: Vital Records/Births. 2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form20_Health Status Indicator #01B
   Field Name: HSI01B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2011 Data are being used as a proxy for 2012.

3. **Section Number:** Form20_Health Status Indicator #01B
   Field Name: HSI01B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.
   Source: NYS DOH Vital Records

HEALTH STATUS INDICATOR #02A

The percent of live births weighing less than 1,500 grams.

	Annual Indicator Data				
	2009	**2010**	**2011**	**2012**	**2013**
Annual Indicator	1.5	1.5	1.5	1.5	1.5
Numerator	3,763	3,683	3,526	3,504	3,504
Denominator	246,360	242,693	239,498	238,982	238,981
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #02A
   Field Name: HSI02A
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source: Vital Records/Births 2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form20_Health Status Indicator #02A
   Field Name: HSI02A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2011 Data are being used as a proxy for 2012

3. **Section Number:** Form20_Health Status Indicator #02A
   Field Name: HSI02A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.
   Source: NYS DOH Vital Records

HEALTH STATUS INDICATOR #02B

The percent of live singleton births weighing less than 1,500 grams.

	Annual Indicator Data				
	2009	**2010**	**2011**	**2012**	**2013**
Annual Indicator	1.1	1.1	1.1	1.1	1.1
Numerator	2,611	2,670	2,548	2,520	2,520
Denominator	236,463	233,203	230,108	229,787	229,787
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #02B
   Field Name: HSI02B
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source: Vital Records/Births 2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form20_Health Status Indicator #02B
   Field Name: HSI02B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2011 Data are being used as a proxy for 2012.

3. **Section Number:** Form20_Health Status Indicator #02B
   Field Name: HSI02B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.
   Source: NYS DOH Vital Records

HEALTH STATUS INDICATOR #03A

The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

	Annual Indicator Data				
	2009	**2010**	**2011**	**2012**	**2013**
Annual Indicator	3.4	3.8	3.0	3.9	3.9
Numerator	123	135	107	138	138
Denominator	3,633,448	3,531,233	3,515,032	3,508,643	3,508,643
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source: Vital Records/Deaths 2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form20_Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2011 Data are being used as a proxy for 2012

3. **Section Number:** Form20_Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.
   Source: NYS DOH Vital Records

Health Status Indicator #03B

The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	1.0	1.3	0.8	1.2	1.2
Numerator	37	47	29	43	43
Denominator	3,633,448	3,531,233	3,515,032	3,508,643	3,508,643
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source: Vital Records/Deaths 2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form20_Health Status Indicator #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2011 Data are being used as a proxy for 2012

3. **Section Number:** Form20_Health Status Indicator #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.
   Source: NYS DOH Vital Records

HEALTH STATUS INDICATOR #03C

The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

	Annual Indicator Data				
	2009	**2010**	**2011**	**2012**	**2013**
Annual Indicator	9.5	9.2	7.8	8.5	8.5
Numerator	258	255	216	235	235
Denominator	2,714,522	2,777,213	2,756,593	2,752,157	2,752,157
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #03C
   Field Name: HSI03C
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source: Vital Records/Deaths 2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form20_Health Status Indicator #03C
   Field Name: HSI03C
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2011 Data are being used for a proxy for 2012

3. **Section Number:** Form20_Health Status Indicator #03C
   Field Name: HSI03C
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.
   Source: NYS DOH Vital Records

HEALTH STATUS INDICATOR #04A

The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	244.7	246.1	231.7	219.3	219.3
Numerator	8,892	8,691	8,145	7,694	7,694
Denominator	3,633,448	3,531,233	3,515,032	3,508,643	3,508,643
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source: Statewide Planning & Research Cooperative System (SPARCS). 2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form20_Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2011 Data are being used as a proxy for 2012

3. **Section Number:** Form20_Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.
   Source: Statewide Planning & Research Cooperative System (SPARCS - Hospital Discharge Data)

HEALTH STATUS INDICATOR #04B

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

	Annual Indicator Data				
	2009	**2010**	**2011**	**2012**	**2013**
Annual Indicator	23.0	22.7	20.6	22.9	22.9
Numerator	835	802	725	802	802
Denominator	3,633,448	3,531,233	3,515,032	3,508,643	3,508,643
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source: Statewide Planning & Research Cooperative System (SPARCS). 2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form20_Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2011 Data are being used as a proxy for 2012.

3. **Section Number:** Form20_Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Non-fatal MV related injuries include pedestrians and cyclists
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.
   Source: Statewide Planning & Research Cooperative System (SPARCS - Hospital Discharge Data)

HEALTH STATUS INDICATOR #04C

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

	Annual Indicator Data				
	2009	**2010**	**2011**	**2012**	**2013**
Annual Indicator	103.0	96.1	92.9	91.0	91.0
Numerator	2,796	2,670	2,561	2,505	2,505
Denominator	2,714,522	2,777,213	2,756,593	2,752,157	2,752,157
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #04C
   Field Name: HSI04C
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source: Statewide Planning & Research Cooperative System (SPARCS). 2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form20_Health Status Indicator #04C
   Field Name: HSI04C
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2011 Data are being used for a proxy for 2012

3. **Section Number:** Form20_Health Status Indicator #04C
   Field Name: HSI04C
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Non-fatal MV related injuries include pedestrians and cyclists.
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.
   Source: Statewide Planning & Research Cooperative System (SPARCS - Hospital Discharge Data)

HEALTH STATUS INDICATOR #05A

The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.

	Annual Indicator Data				
	2009	**2010**	**2011**	**2012**	**2013**
Annual Indicator	36.1	38.0	39.2	36.1	36.1
Numerator	24,085	25,326	25,366	23,115	23,115
Denominator	667,979	666,730	646,710	640,786	640,786
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #05A
   Field Name: HSI05A
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source: Numerator/Bureau of STD Prevention & Epidemiology, Denominator: Bridged race file. 2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form20_Health Status Indicator #05A
   Field Name: HSI05A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2011 Data are being used as a proxy for 2012

3. **Section Number:** Form20_Health Status Indicator #05A
   Field Name: HSI05A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.
   .Source: NYS Bureau os Sexually Transmitted Disease Prevention.

HEALTH STATUS INDICATOR #05B

The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	11.1	11.9	12.3	12.5	12.5
Numerator	37,183	40,244	41,715	42,504	42,504
Denominator	3,354,554	3,381,217	3,385,604	3,396,934	3,396,934
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #05B
   Field Name: HSI05B
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source: Numerator: Bureau of STD Prevention & Epidemiology, Denominator: Bridged race file 2012 data are being used as a proxy for 2013 data.

2. **Section Number:** Form20_Health Status Indicator #05B
   Field Name: HSI05B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2011 Data are being used as a proxy for 2012

3. **Section Number:** Form20_Health Status Indicator #05B
   Field Name: HSI05B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   .Source: NYS Bureau os Sexually Transmitted Disease Prevention.
   2010 data are being used as a proxy for 2011 data. 2011 data will be available by May 2013.

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: NY

HSI #06A - Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*
For both parts A and B: Reporting Year: 2012 Is this data from a State Projection? No Is this data final or provisional? Final

CATEGORY TOTAL POPULATION BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	237,068	157,080	56,239	3,532	20,217	0	0	0
Children 1 through 4	930,117	635,035	202,552	13,962	78,568	0	0	0
Children 5 through 9	1,154,466	800,168	242,257	17,171	94,870	0	0	0
Children 10 through 14	1,186,992	822,488	255,545	16,966	91,993	0	0	0
Children 15 through 19	1,307,947	909,231	279,553	18,014	101,149	0	0	0
Children 20 through 24	1,444,210	979,256	310,915	19,955	134,084	0	0	0
Children 0 through 24	6,260,800	4,303,258	1,347,061	89,600	520,881	0	0	0

HSI #06B - Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and ethnicity. (Demographics)*

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	175,042	62,026	0
Children 1 through 4	695,122	234,955	0
Children 5 through 9	882,525	271,941	0
Children 10 through 14	926,658	260,334	0
Children 15 through 19	1,026,320	281,627	0
Children 20 through 24	1,129,049	315,161	0
Children 0 through 24	4,834,716	1,426,044	0

Form 21
Health Status Indicators
Demographic Data
State: NY

HSI #07A - Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

For both parts A and B: Reporting Year: 2012 Is this data from a State Projection? Yes Is this data final or provisional? Final

CATEGORY TOTAL LIVE BIRTHS BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Women < 15	179	72	65	1	5	0	0	36
Women 15 through 17	3,500	1,708	1,050	22	41	0	0	679
Women 18 through 19	9,054	4,715	2,581	60	210	0	0	1,488
Women 20 through 34	177,630	108,447	31,125	569	19,697	0	0	17,792
Women 35 or older	48,855	31,028	7,633	91	6,115	0	0	3,988
Women of all ages	239,218	145,970	42,454	743	26,068	0	0	23,983

HSI #07B - Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and ethnicity. (Demographics)*

CATEGORY TOTAL LIVE BIRTHS BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Women < 15	101	78	0
Women 15 through 17	1,904	1,595	1
Women 18 through 19	5,682	3,361	11
Women 20 through 34	135,373	41,758	499
Women 35 or older	39,782	8,929	144
Women of all ages	182,842	55,721	655

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: NY

HSI #08A - Demographics (Total deaths) *Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

For both parts A and B: Reporting Year: 2012 Is this data from a State Projection? Yes Is this data final or provisional? Final

CATEGORY TOTAL DEATHS BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	1,191	638	369	5	57	7	5	110
Children 1 through 4	182	117	46	0	7	4	1	7
Children 5 through 9	108	71	26	0	4	0	1	6
Children 10 through 14	152	97	38	0	6	1	0	10
Children 15 through 19	413	267	115	1	18	0	1	11
Children 20 through 24	927	617	247	9	22	0	1	31
Children 0 through 24	2,973	1,807	841	15	114	12	9	175

HSI #08B - Demographics (Total deaths) *Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and ethnicity. (Demographics)*

CATEGORY TOTAL DEATHS BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	935	247	9
Children 1 through 4	144	36	2
Children 5 through 9	83	25	0
Children 10 through 14	123	29	0
Children 15 through 19	333	80	0
Children 20 through 24	757	168	2
Children 0 through 24	2,375	585	13

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: NY

HSI #09A - Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

Is this data final or provisional? Final

CATEGORY Miscellaneous Data BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown	Specific Reporting Year
All children 0 through 19	4,816,590	3,232,683	964,255	58,849	357,051	7,460	196,292	0	2012
Percent in household headed by single parent	36.0	22.0	65.0	0.0	15.0	0.0	45.0	0.0	2012
Percent in TANF (Grant) families	4.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2013
Number enrolled in Medicaid	2,359,718	0	0	0	0	0	0	2,359,718	2013
Number enrolled in SCHIP	304,566	0	0	0	0	0	0	304,566	2013
Number living in foster home care	18,889	0	0	0	0	0	0	18,889	2013
Number enrolled in food stamp program	1,208,700	0	0	0	0	0	0	1,208,700	2012
Number enrolled in WIC	713,043	322,328	192,827	96,498	66,365	10,808	24,217	0	2013
Rate (per 100,000) of juvenile crime arrests	2,306.0	0.0	0.0	0.0	0.0	0.0	0.0	2,306.0	2013
Percentage of high school drop-outs (grade 9 through 12)	2.7	0.0	0.0	0.0	0.0	0.0	0.0	2.7	2011

HSI #09B - Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by ethnicity.(Demographics)*

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported	Specific Reporting Year
All children 0 through 19	3,705,667	1,110,923	0	2012
Percent in household headed by single parent	0.0	56.0	0.0	2012
Percent in TANF (Grant) families	0.0	0.0	4.2	2012
Number enrolled in Medicaid	0	0	2,359,718	2013
Number enrolled in SCHIP	0	0	304,566	2013
Number living in foster home care	0	0	18,889	2013
Number enrolled in food stamp program	0	0	1,208,700	2012
Number enrolled in WIC	452,257	260,768	0	2013
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	2,306.0	2012

Percentage of high school drop-outs (grade 9 through 12)	0.0	0.0	2.7	2011

Form 21
Health Status Indicators
Demographic Data
State: NY

HSI #10 - Demographics (Geographic Living Area) *Geographic living area for all resident children aged 0 through 19 years old. (Demographics)*

Reporting Year: 2013 Is this data from a State Projection? No Is this data final or provisional? Final

GEOGRAPHIC LIVING AREAS	TOTAL
Living in metropolitan areas	18,243,409
Living in urban areas	18,243,409
Living in rural areas	1,407,718
Living in frontier areas	0
Total - all children 0 through 19	19,651,127

Note:
The Total will be determined by adding reported numbers for urban, rural and frontier areas.

Form 21
Health Status Indicators
Demographic Data
State: NY

HSI #11 - Demographics (Poverty Levels) *Percent of the State population at various levels of the federal poverty level. (Demographics)*

Reporting Year: 2012 Is this data from a State Projection? No Is this data final or provisional? Final

POVERTY LEVELS	TOTAL
Total Population	19,155,876
Percent Below: 50% of poverty	7.4
100% of poverty	17.3
200% of poverty	35.9

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: NY

HSI #12 - Demographics (Poverty Levels) *Percent of the State population aged 0 through 19 at various levels of the federal poverty level. (Demographics)*

Reporting Year: 2012 Is this data from a State Projection? No Is this data final or provisional? Final

POVERTY LEVELS	TOTAL
Children 0 through 19 years old	19,155,876
Percent Below: 50% of poverty	9.6
100% of poverty	24.3
200% of poverty	45.3

Form Notes for Form 21

Zero (0) indicates data not available

Field Level Notes

1. **Section Number:** Form21_Indicator 06A
   Field Name: S06_Race_Infants
   Row Name: Infants 0 to 1
   Column Name:
   Year: 2015
   Field Note:
   Data in the Asian Column is a combination of Asian and Pacific Islander.
2. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_Children
   Row Name: All children 0 through 19
   Column Name:
   Year: 2015
   Field Note:
   Data Source: 2012 Vintage Census Bridged
3. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_SingleParentPercent
   Row Name: Percent in household headed by single parent
   Column Name:
   Year: 2015
   Field Note:
   Data Source: National KIDS COUNT Program
4. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_TANFPercent
   Row Name: Percent in TANF (Grant) families
   Column Name:
   Year: 2015
   Field Note:
   CY TANF Report as of 1/23/14. Based on 202,850 average children (numberator) in TANF families Preliminary Calendar year average is based on data January 2013 through September 2013, Published: March 11, 2014
5. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_MedicaidNo
   Row Name: Number enrolled in Medicaid
   Column Name:
   Year: 2015
   Field Note:
   Data not broken out by ethnicity - therefore reported as more other and unknown.