Maternal and Child Health Services
Title V Block Grant

State Narrative for New York

Application for 2014
Annual Report for 2012

Document Generation Date: Monday, September 16, 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 2014, 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. During the 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. DOH reviewed the state's demographic profile and population health status and assessed progress in meeting the goals and objectives established in the PA 2008-12. 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 citizens and to close important disparities in those areas through multi-sector actions. An Ad Hoc Committee was formed to develop the PA under the direction of the PHHPC. The state health assessment information was presented at meetings of the Ad Hoc group, and used to identify five priority areas 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.

Title V staff played 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. The Action Plan was created with input from stakeholders representing sectors and organizations with an interest in improving the health of women, infants, children and families, and will serve as a road map across the public health system to improve priority health outcomes and reduce health disparities.

To make this Plan feasible, its development committee identified two to three goals for each focus area. This strategy was guided by goals of reducing racial, ethnic and economic disparities; advancing a life course perspective; and addressing social determinants of health. The areas of focus identified for PHWIC include maternal and infant health (preterm birth, breastfeeding and maternal mortality), child health (use of comprehensive well child care and prevention of dental caries), and reproductive/preconception/interconception health (prevention of adolescent and unintended pregnancy and use of preventive health care services for women of reproductive age). The PA promotes cross-sector collaboration to achieve measureable outcomes, is well aligned with Title V priorities, and fully supports DOH's work in addressing National and State MCH priorities.

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 (65.6%) 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 2011, 39.8 percent were exclusively fed breast milk in the delivery hospital. White non-Hispanic women exclusively breastfed at a higher rate than Black non-Hispanics, Asian/Pacific Islander non-Hispanic and Hispanic women.

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. However, reform in the State's public health insurance programs has been extensive with positive impacts. 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. Chlamydia morbidity has continued to increase since reporting began in 2000 making it the most commonly reported communicable disease.

The statewide rates of early and adequate prenatal care decreased slightly 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 continued to decline from 34.5 percent in 2010 to 34.3 percent in 2011, the second consecutive year with a decline in more than a decade.

New York continues to make slow progress in some areas related to racial/ethnic disparities. The racial/ethnic disparity in early prenatal care as well as rates of infants less than 2500 grams at birth have improved slightly since 2010. The rate for White non-Hispanic women was 21.8 percent higher than the rate among Black non-Hispanic, 11.9 percent higher than the rate among non-Hispanic women other than White or Black, and 16.6 percent higher than the rate among

Hispanic women. In 2011, 12.3 percent of Black non-Hispanic infants were less than 2500 grams at birth (low birthweight), 75.7 percent higher than the percentage for White non-Hispanic infants and 55.7 percent higher than the percentage for Hispanic infants. The maternal mortality (MM) rate for 2011 remained relatively consistent since 2010 (23.1 vs. 23.4 per 100,000 births respectively. Although racial disparity still exists, Black non-Hispanic MM rate decreased by 27% in 20011 (47.7 vs. 65.4 per 100,000 births in 2010). MM for White non-Hispanics increased by 21% in 2011 (15.5 per 100,000 births) compared to 2010 (12.8 per 100,000 births). This resulted in a reduction in the Black non-Hispanic-to-White non-Hispanic ratio of 5.1 to 1 to 3.1 in 2011. These rates are based on 18 deaths among African American women and 18 deaths among Caucasians. However, the small numbers of deaths annually can greatly impact trends from year to year.

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 2012, NY was the 3rd largest state after California and Texas, with a population of 19,378,102. NY leads the nation in numbers of immigrants from across the world. Since 2000, over 820,000 immigrants made NY their home while over 800,000 New Yorkers migrated to other parts of the nation.

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 Commissioner Nirav Shah, 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 is a daunting task. This task continues to be complicated by New York's economic and fiscal challenges. Both financial and human resources continue to be limited to accomplish 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, ***/2014/2012 and 2013//2014//*** budget implemented many of the MRT recommendations resulting in ***/2014/significant cost savings//2014//***. 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.

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 will enable NY 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 include:***
•Major investments to expand access to high quality primary care;
•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;
•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.//2014//

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. ***//2014//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 9inot MC in 2014.//2014//

Work continues on several additional proposals of the MRT pertaining to the MCH population, including expanding current statewide patient-centered medical homes ***/2014/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//2014//*** 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 ***/2014/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.; Tile V and OHIP staff developed a series of webinars to inform providers regarding the changes in FPBP and to promote outreach to underserved populations.//2014//***

DFH staff ***/2014/continue to work//2014//***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.

/2014/During 2012, progress was been made in several MRT proposals related to the MCH population.//2014// 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.

- ***/2014/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 are being requested 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. 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.//2014//

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. ***/2014/In the 2013 State of the State address,//2014//*** the Governor, ***/2014/once again,//2014//*** 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 Commissioner, Dr. Nirav Shah, 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 ***/2014/and School Based Health Center Dental programs.//2014//*** 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 that addresses specific risk factors associated with the leading causes of death, disability and chronic disease among New Yorkers.
•The Division of Nutrition that manages programs designed to improve the nutritional status of the residents of New York State. 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. ***/2014/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.//2014//
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). Division of Nutrition (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. The Division of Chronic Disease Prevention (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 ***/2014/Office of Quality and Patient Safety (OOQPS)//2014//*** are currently collaborating on a focused prenatal care study to establish priority areas for improvement. The ***/2014/core mission of the //2014//***Office of Quality and Patient Safety (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. Nirav Shah, the DOH 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. Shah 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 for the 2012-13 fiscal year 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 will become 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 2013 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. ***/2014/The 2013-14 Executive 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.//2014//

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 implementinga federal option called Express Lane eligibility that will allow children no longer eligible for Child Health Plusto 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.

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 plan for the use of Personal Responsibility Education Program funding has been approved and will support 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 augment 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. ***/2014/Awards for this funding have been made based on a Request for Applications that was released in 2012. //2014//***.

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. ***/2014/Nearly two-thirds of the MIECHV funding has been awarded to 2 Nurse Family Partnership and 4 Healthy Family NY programs, while***

the remainder will be awarded in 2013 based on a RFA released in 2012.//2014//

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 Executive Budget reflects the implementation of the NY Health Benefit Exchange that will serve as a centralized marketplace for the purchase and sale of health insurance, in accordance with the ACA. Once the Exchange is implemented, one million more New Yorkers will have health insurance, and individuals and small businesses will see reductions in the cost of health insurance premiums. The Budget conforms eligibility and benefits of public health insurance programs, including Medicaid, Child Health Plus (CHP), Family Health Plus (FHP) and Healthy New York, to better align and coordinate with the Exchange.//2014//***
•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 advise and make 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. ***/2014/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 for the Exchange In Person Assistor/Navigator Program that will 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.//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 (MHSP), 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. ***/2014/Over the past year, DOH//2014//*** 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

/2014/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.1 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.//2014//

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. ***/2014/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//2014//.*** 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 Department'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, 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 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 (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 /2013/SS2522-2528, 364-i and 365-k of Social Service Law.//2013// 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 /2013/PHL relating to hospitals is//2013// 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 50 agencies in 197 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 over 350,000 women and men per year. The Family Planning Extension Program (FPEP), added in 1998 ***/2014/as an 1115 waiver demonstration project,//2014//***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 ***/2014/as an 1115 waiver demonstration project//2014//*** and provides MA coverage for family planning services to individuals with incomes at or below 200 percent of the federal poverty level. 2014/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 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.//***2014//.***

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. 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, and to support an enhancement project targeting youth in foster care, developed in consultation with OCFS /2014/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.//2014//
Supporting Healthy Transitions to Adolescence is a new 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 will utilize grant funds to 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. A RFA for this initiative was released in 2012.***/2014/ and awards were made to 17 community-based agencies//2014//***

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 ***/2014/a subsequent 4 years//2014//***. HRSA required NY to provide $673,000 annually of NYS' $4.1 million award to a Rochester project previously directly funded by the Administration for Children and Families.
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.

/2014/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.//2014// 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 2012-13and 2013-14 budget includes $2 million in TANF funding to support NFP.

/2014/Comprehensive Prenatal-Perinatal Services Networks (CPPSNs) are community-based organizations that mobilize the service system at the local level to improve perinatal

health. The scope of service provided by these networks includes coalition building, conducting outreach and education to high-risk populations, and provider education on special topics, such as screening for substance abuse among pregnant women, or cultural sensitivity. Each of the 14 perinatal networks targets a region, ranging in size from several health districts in NYC to large multi-county regions in rural upstate//2014//

Community Health Worker Program (CHWP) - In 23 programs statewide, one-on-one outreach, education and home visiting services are provided to pregnant women who are at highest risk for poor birth outcomes, such as low birth weight infants or infant mortality. The CHWP is targeted towards specific communities with high rates of infant mortality, out-of-wedlock births, late or no prenatal care, teen pregnancies and births, and births to low-income women. Services are provided by trained paraprofessionals recruited from the target communities.

Healthy Mom/Healthy Baby (HMHB) is designed to improve the health of mothers and infants through the development and implementation of organized county systems of perinatal health and home visiting services. Six LHDs in the highest need areas of the state receive funding to plan and develop a system of perinatal health and home visiting services, outreach and identification, home visiting for high-risk pregnant/postpartum women, and improved access to related health and human services. The program seeks to improve pregnancy outcomes and infant health and development by identifying high-risk pregnant women and postpartum women and their newborns, assessing their need for services, and assisting them in obtaining appropriate services, including home visiting.

/2014/NY is committed to focusing on elimination of health disparities, and improving birth outcomes for all New Yorkers using evidence-based, sustainable models of care. Through the Maternal and Infant Health RFA, released in 2012, DOH aims to improve maternal and infant health outcomes for high-need women and reduce racial, ethnic and economic disparities in those outcomes. Funded programs will work to improve specific maternal and infant health outcomes including preterm birth, low birth weight, infant mortality and maternal mortality rates through implementation of evidence-based and/or best practice strategies across the reproductive life course. This initiative integrates and replaces DOH's current community-based perinatal health programs -including the CPPSNs, the CHWPs and the HMHB initiative -to develop multi-dimensional community-wide systems of integrated and coordinated community health programs and services to improve maternal and infant health outcomes. It is anticipated that awards will be made during 2013.//2014//

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 130 birthing hospitals, including: 51 Level 1 hospitals; 26 Level 2 hospitals; 35 Level 3 hospitals; and, 18 hospitals constituting 15 RPCs. Through the NYS State Perinatal 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***/2014/ in NYS approved specialty care centers.//2014//***

Newborn Hearing Screening Program (NBHS) - Since October 2001, all 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 is engaged in the development and implementation of an information system to collect hearing data statewide.

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 ***/2014/to more than 500,000 women and children//2014//*** 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 ***/2014/health care systems change.//2014//*** The NYS Smoker's Quitline (1-866-NY QUITS (1-866-697-8487)) continues to be a key evidence-based component of the ***/2014/Bureau's//2014//*** cessation efforts.

School-Based Health Center Program (SBHC) -- Through ***/2014/226//2014//*** SBHCs sponsored by 51 ***/2014/health care facilities,//2014//*** the SBHCs provide preventive***/2014/, acute, chronic disease management//2014//*** and mental health services to more than 158,000 students living in high-need areas ***/2014/annually.//2014//*** SBHCs are extension clinics of Article 28 hospitals and/or diagnostic and treatment centers that ***/2014/are located in school buildings//2014//***..

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. ***/2014/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.//2014//***

Supplemental Fluoride Program is a school-based fluoride mouth rinse program, which serves elementary school children and includes a preschool preventive tablet program that serves three- and four-year-olds in Head Start centers in fluoride-deficient areas. More than 120,000 children are participating in these programs.

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, ***/2014/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.//2014//***

/2014/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.//2014//

Diabetes Prevention and Control - To address the obesity and type 2 diabetes epidemic, the Diabetes Prevention and Control Program (DPCP), in collaboration with the Obesity Prevention Program and Division of Nutrition's Eat Well Play Hard Program, has developed the Creating Healthy Places to Live Work and Play program, supporting 22 innovative projects implementing evidenced based and sustainable policy, systems and environmental change strategies in communities and worksites for individuals to be more physically active and eat more healthy foods.

Childhood Asthma Coalitions - ***/2014/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.//2014//

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. ***/2014/During the past year, 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//2014//***

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 55 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.

/2014/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.//2014//

Physically Handicapped Children's Program (PHCP) operates in ***/2014/35/2014// 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) /2014/NY's IDEA Part C Program,//2014// 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 growth or development, learning skills, speech and language development) 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 70,000 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. ***/2014/Through grant funding, DOH is also updating the Clinical Practice Guidelines for Autism and Pervasive Developmental Disorders that was originally developed in 1999.//2014//***

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 (OMH) 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 required to prepare and distribute biennially. OMH is a statewide resource for effecting elimination of health disparities across all populations. Among the key goals is formation of partnerships with government systems, public/private sectors, communities and individuals to strengthen the health care delivery system and access to the services needed by all.
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.The Health Disparities Research Dissemination Project is a joint effort between OMH-HDP and the Minority Health Council focused on sharing findings of health disparities research with local community members.

As a follow-up to the Minority Health Disparities Conference in 2009, OMH initiated a webinar series to spotlight minority populations in NYS. The webinars featured presenters with practical experience designing and implementing programs with the minority group highlighted A major focus of the PA is to ensure all New Yorkers have access to quality health care and ethnic and racial disparities can be addressed. In April, 2010, LHDs 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. ***/2014/In 2012,//2014//*** 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 ***/2014/and birth outcomes//2014//*** , disparities continue to exist due to increasing numbers of immigrant and hard to reach ***/2014/populations//2014//***.

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.
•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.
•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, ***/2014/requires that SBHCs have//2014//*** a community advisory council to assure that the views of the community members are reflected in ***/2014/ each SBHC's//2014//*** policies priorities and plans. The Perinatal Networks have community coalitions that include community organizations, including individuals from the community served to guide program outreach and development.

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 ***/2014/released//2014//*** recommendations in ***/2014/February 2013. Recommendations related to consolidating state agency functions such as IT and purchasing functions have already been accomplished.//2014//***

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, Nirav Shah, MD, MPH, 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 ***/2014/3,264//2014//*** filled positions ***/2014/and 1960 filled positions//2014//*** 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 /2013/Bradley Hutton, MPH//2013//, the Center conducts programming through four Divisions: the Division of Chronic Disease and Injury 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), ***/2014/is led by Kristine Mesler, M.P.A., B.S.N., who was appointed to the position of Director in November, 2012.//2014//*** Rudy Lewis ***/2014/continues to serve as the assistant//2014//*** 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:
oPerinatal Regionalization, including Regional Perinatal Centers and affiliate hospitals, and the NYS Perinatal Quality Collaborative.
-Maternal, Infant and Early Childhood Home Visiting Program
-Community Health Worker Program
-Healthy Mom, Healthy Baby home visiting systems initiative
-Nurse Family Partnership
-Comprehensive Prenatal Perinatal Services Networks
-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
-Supporting Healthy Transitions to Adolescence
-ACT-for Youth Center of Excellence
-Adolescent HIV Prevention
-Act for Youth Healthy Transitions

•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.
-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 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 and cognitive 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 and the State Implementation Grant for Improving Services for Children with Autism Spectrum Disorders.

The Bureau of Dental Health, under the leadership of Jay 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
•Supplemental Fluoride Program
•Dental Rehabilitation Program
•Preventive Dentistry Program for Deaf/Adolescent Children
•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. Additional OMD programs include:

•Children with Special Health Care Needs;
•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
•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. There are currently ***/2014/130//2014 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 /2014and currently serves//2014//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 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

/2014/For the past several years//2014//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 ***/2014//retired in May 2013 and the funding cycle ends in December. DOH awaits information regarding whether new SSDI funds will be available for subsequent years.//2014//*** For the remainder of the SSDI grant cycle, 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.

/2014/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.//2014//

Rudy Lewis, M.S., has served as the Assistant Director of the BMCH (formerly BWH) since 2007 and has extensive experience with MCH programs and worked in several areas, including prenatal care, family planning, and perinatal regionalization. He has extensive experience with surveillance and data systems, in the design, development and implementation of information systems for public health programs, and with program evaluation.

Susan Slade, RN, MS, ***/2014/who serves as NYS's Children with Special Health Care Needs Director,//2014//*** 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, the

oral health initiative, and targeted oral health service systems for women and children. Brenda Knudson Chouffi and Donna Noyes 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. ***/2014/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//2014//*** Donna Noyes joined the NYSDOH in 1989. Most recently, Dr. Noyes served as the Associate Director for Clinical Policy contributing to significant program development initiatives. ***/2014/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 four grants related to improving early identification and intervention services for young children with autism spectrum disorders and their families.//2014//***

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. NYSED also collaborates with NYSDOH on the Supplemental Fluoride Distribution Program. 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. 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 ***/2014/continues to dialogue with SED regarding reproductive health in NY's schools.//2014//*** 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.

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. The Bureau of Maternal and Child Health maintains a Memorandum of Understanding with the SUNY School of Public Health that facilitates calling upon the resources of the school for training and education of professionals, such as perinatal hospitals, family planning providers, prenatal care providers, etc. Title V staff coordinate the MCH Graduate Assistant Program, under which twelve - fourteen graduate students per semester (fall, spring and summer) are supported by ***/2014/Title V//2014//*** 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, ***/2014/NY's IDEA Part C Program,//2014//*** the Department has letters of agreement with the Office of Mental Health (OMH), the Office of People with Developmental Disabilities (OPWD), the State Education Department (SED), and the Office of Alcohol and Substance Abuse Services (OASAS) to coordinate the implementation and operation of this program.

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 ***/2014/OCFS operates Healthy Families New York, an evidence-based paraprofessional home visiting model based on Healthy Families America. DOH and OCFS are jointly reviewing proposals submitted for home visiting services for MIECHV funds that will be awarded in 2013.//2014//***

For the past 3 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 NYCDHMH, Onondaga DOH and Monroe County DOH Nurse Family Partnership Programs. The Department 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 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.

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 ***/2014/11 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.//2014//

The New York State 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 New York State. 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-- the Early Childhood Advisory Council (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. 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 ofthe 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, the Department'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 Early Childhood Advisory Council, 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.) ***/2014/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.//2014//*** 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,***/2014/ increasing access to evidenced-based parenting//2014//*** 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.***/2014/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 New York City Department of Health and Mental Hygiene, 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.//2014//
In 2009, DOH, with the CCF, OMH and OCFS, successfully applied to 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.

/2014/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.//2014//

/2014/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 New York whose mission is to enhance parenting skills, knowledge and behavior through the promotion of parenting education. Title V staff serves 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.//2014//

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 (NYCDOH&MH) 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 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 MHSP). The CHAs described the needs and resources to meet those needs in the community, while the MHS Plans 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. ***/2014/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 MHSP. 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.//2014//*** Title V staff will continue to provide technical assistance to local health departments in ***/2014/development, implementation and evaluation of public health activities targeted to the MCH population.//2014//***

/2014/LHDs are also key stakeholders in the development and implementation of the Prevention Agenda as described in Section IIIA Overview of the State.//2014// Because local health departments 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 New York State.

First, the Department 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 650 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 Department 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.

NYS also partners closely with the American Congress of Obstetricians and Gynecologists, 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 Department of Health. 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 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. ***/2014/In conjunction//2014//*** with a subgroup of the Expert Workgroup, ***/2014/DOH has developed//2014//*** clinical guidelines for the management of hypertension in pregnancy. The guidelines will be finalized in 2013.

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.

New York State 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.

Three Federal Healthy Start grantees are also grantees of New York State Department of Health under the Comprehensive Prenatal/Perinatal Services Network initiative. While the Networks, initially funded under Title V, have moved onto a different source of funding, the need for coordination with Title V programs continues. The Comprehensive Prenatal/Perinatal Services Networks collectively have formed the Association of Perinatal Networks (APN) that meets regularly with the Department of Health.

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 State Health Department 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 is working with AHECs and local rural health networks to improve access to primary dental care in rural areas.

In 2012, the Bureau of Dental Health held a series of oral health stakeholder meetings involving ***/2014/representatives from academia,//2014//*** school based dental health center staff, and Head Start/Early Head Start ***/2014/providers and other key/2014// stakeholders for the purpose of /2014/providing input to the scope of the statewide Oral Health Plan (2013-2017). The plan, that will be finalized in 2013, 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.//2014//*** The Dental Bureau also engaged an expert panel to consider the scientific evidence related to oral care during pregnancy and in early childhood and this panel participated in formulating practice guidelines for New York State dentists and obstetrical care providers. The guidelines have been distributed, and are available on the NYSDOH website at http://www.health.state.ny.us/prevention/dental/

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	58.1	61.3	56.3	52.1	52.1
Numerator	7022	7502	6507	6059	6059
Denominator	1208495	1223080	1155822	1163580	1163580
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
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.

Notes - 2010
Data Source: Statewide Planning and Research Cooperative System (SPARCS). 2010 data have been updated and finalized since NYS's previous MCH block grant application submission. Data updated May of 2013

Narrative:
Over the past 10 years, the rate of children hospitalized for asthma fluctuated, but overall, declined from the 2002 rate of 62.9/10,000 to the 2011 rate of 52.1/10,000. During 2002-2011, the 0 to 4 year (YR) age group had the highest asthma-related hospital discharge rate & between 2009-2011, children aged 0 to 4 had the highest asthma-related emergency department (ED) visit rate (230.7/10,000).

According to the BRFSS Asthma Call-Back Survey, for 2006-2010, the asthma prevalence rate was 7.3% for 0-to-4-YR-olds, 13.7% for 5- to 9-YR-olds, 11.4% for 10 to 14-YR-olds, and 9.5% for 15- to 17-YR-olds. The 2006-2010 prevalence of current asthma was higher in non-Hispanic Black children (14.3%) compared to non-Hispanic White (8.5%) & Hispanic children (11.7%). NYC children had a similar prevalence when compared to those living in the rest of NYS (10.3% vs. 10.5%). Between 2006-2010 children from households with an annual income of $15,000-$24,999 had the highest current asthma prevalence (14.9%).

DOH is working with an array of partners to reduce or control asthma. Regional Asthma Coalitions (RACs) administered by DOH are working with local partners in high asthma burden areas to implement population-based system level changes within primary care, hospitals, schools, pharmacies & human service agencies. The initiative aims to increase the quality of life among individuals with asthma & decrease the number of asthma-related hospitalizations, ED visits & school/work days lost. Resources to support the RACs were re-distributed in 2012 to strategically target geographic areas & populations with the highest rates of asthma-related hospital discharge & ED visit rates.

To increase access to quality asthma self-management support services & improve outcomes for individuals with asthma, NY MA provides coverage for asthma self-management services provided by health care professionals who are Certified Asthma Educators (AE-Cs). DOH is leading efforts to further develop the AE-C workforce & integrate AE-Cs into health care systems serving low-income children & families.

NY MRT recommended that DOH provide reimbursement for home-based asthma education & assessment services, DOH has requested support from CMS to demonstrate the impact of providing asthma self-management education & environmental asthma trigger assessment in the home settings of individuals with poorly controlled asthma.

Implemented system changes have resulted in improvements in asthma care processes within targeted service areas. Continuous progress towards aligning policies to support the transformation of health care systems will support the success of efforts to control asthma.

Improving outdoor air quality, reducing indoor asthma triggers, reducing tobacco use & 2nd hand smoke exposure, promoting the use of evidence-based care management & culturally relevant chronic disease self-management education for asthma & other chronic diseases are all priority goals for the 2012-17 Prevention Agenda.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	77.6	76.3	77.3	77.6	76.3
Numerator	117580	116490	113092	114770	111519
Denominator	151439	152710	146242	147852	146249
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 - 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).

Notes - 2010
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:
Medicaid (MA) rates for children's health measures generally have increased over time & often surpass national average rates. Data above reflect steady capacity in this area over the last several years. 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 5 years. Title V staff participate in NY's MA Redesign initiative to support development & implementation of potential recommendations related to improving access to care & improved quality of care for infants/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 & 15 months & 77% had 5 or more visits by 15 months. The 2011 rates continue to demonstrate improvement from the 2009 rates of 97% & 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 MA, Title V and MMC plans. In 2012, NY's quality incentive for MMC plans included the well visit measure for children between 0 & 15 months as part of plan performance. All but 6 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; &, lack of parent understanding of the importance of well child visits (WCVs). Health plans educate members & providers through newsletters and mailings: annual "birthday cards" as reminders; & physician profiling to identify members who are due for a preventive visit. Health plans have encouraged providers to use standardized forms to document WCVs, conduct on-site visits to review records for compliance, & 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 newborn needs, develop care plans & assist members in obtaining care, including WCVs.

Title V staff monitor access to local services & work with OHIP to identify & solve access issues. DOH's home visiting services provide community outreach & direct services to high-risk women & families, & promote well baby visits, assisting women with keeping these visits after the baby is born. The CHWP, Healthy Mom-Healthy Baby program & NFP 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 issued a RFA to award MIECHV funds to promote evidence-based home visiting & will establish/expand NFP and Healthy Families NY in targeted high need communities. Use of well child care was also included as a priority focus area in the 2013-17 Prevention Agenda.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	99.2	99.3	99.4	99.5	99.5
Numerator	1136	1580	1900	2151	2151
Denominator	1145	1591	1911	2161	2161
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 - 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.

Notes - 2010
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. This measure is collected on a rotating basis, so new data is not available for all years. 2009 data are used as a proxy for 2010. 2010 data will be reported in late 2011. Data Source is the Quality Assurance Reporting Requirements (QARR).

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 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 2011 is 99.53.

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 is 87% for calendar year 2011, 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.

Community-based public health programs, such as the Community Health Worker Program and Nurse Family Partnership, promote healthy behavior in families, including the promotion of primary and preventive care for children. The Growing Up Healthy Hotline, NY's 24/7 MCH hotline, provides information and referral to a myriad of health and supportive services, including to public health insurance programs and health care providers.

Use of well child care was also included as a priority focus area in the 2013-17 Prevention Agenda.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	65.5	66.0	66.9	66.6	66.6
Numerator	124528	148291	152108	150950	150950
Denominator	190222	224556	227334	226640	226640
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 - 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

Notes - 2010
Source: NYSDOH Vital Records
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

Narrative:
This data has remained relatively consistent over time. Most recent data show 66% of pregnant women achieved the objective and the indicator held steady when compared with the rate from the previous year. Racial, ethnic and regional disparities continue to be reflected. The index was 73.2% for White non-Hispanic compared with 53.4% and 60% for Black non-Hispanic and Hispanics, respectively. Regionally, 64.4% of pregnant women in NYC and 67.6% in the rest of NYS achieved the target.

NYS has undertaken major efforts to improve access to prenatal care. OHIP assumed responsibility for NY's former Prenatal Care Assistance Program (PCAP). OHIP, in collaboration with the DFH, revamped PCAP, which provides prenatal care to women up to 200% FPL. All MA enrolled Article 28 prenatal care providers perform presumptive eligibility determinations and assist with the full MA application and managed care plan selection; this allows women to immediately receive care while awaiting determination.

DOH oversees programs to improve access to prenatal care including the CPPSN program, community-based organizations whose mission is to organize the service system at the local level. CHWP provides outreach & home visiting (HV) services to pregnant women who are at highest risk for poor birth outcomes. The HM-HB program in LHDs serves 6 highest need counties of NYS. The goal is to develop a systems approach to perinatal health, including early identification of women not engaged in prenatal care, identification of risk factors, coordination of HV services & referrals. The NFP program is funded to improve outcomes for 1st time mothers in 3 high need communities. In 2012, DOH issued a Maternal and Infant Health Initiative RFA that integrates and replaces DOH's current community based perinatal health programs to develop multi-dimensional community-wide systems approach, as well as evidence-based HV to improve

maternal and infant health outcomes. Program implementation for grantees is targeted for 10/1/2013.

A Text4Baby media campaign encouraging women to access prenatal services was developed in areas with the highest rates of adverse perinatal outcomes. Customization of messages allowed DOH to include state-specific messages.

Improving health outcomes for women and families is a priority for the 2013-17 Prevention Agenda (PA), aligning with goals of the state's MA and Title V program. There is increasing recognition that a 'life course' perspective is needed to promote health & prevent disease across the lifespan. The PA addresses 3 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 NY's Prevention Agenda.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	90.0	90.7	87.4	87.0	86.8
Numerator	1805488	1876851	1878851	1910587	1979928
Denominator	2006098	2068245	2150748	2196077	2280280
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 - 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).

Notes - 2010
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, and that the

proportion has remained constant (within 1/2 percent) over the past 3 years. 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 and 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 increased by 2.3% in FFY011 & 3% in FFY 2012. 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.

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 6.6% in 2011. 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 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 and/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 this program, 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 for insurance become enrolled.

Improving the health of NY's children is a priority of the 2013-17 Prevention Agenda (PA). For example, use of well child care and oral health services were included as a priority focus area in the 2013-17 PA.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	46.4	50.1	51.1	52.5	52.5
Numerator	166217	186258	200375	212043	212043
Denominator	358116	371495	391812	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?				Final	Provisional

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

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

Notes - 2010
Source: NYS DOH Center for Medicare/Medicaid Services.

Narrative:
The proportion of 6-9 year olds enrolled in the Medicaid (MA) Program receiving dental services is expected to show a moderate increase for 2012 based on annual trends since 2003. Out of 13,982 active dentists in NYS, only 4812 (34%) are enrolled in MA. According to a survey conducted by the University of Albany's Center for Health Workforce Studies, over half of NY dentists report not treating any patients with MA, while 10% of dentists indicate more than 60% of their patient population is MA-eligible.

School-based dental health clinics are effective in providing oral health services to low income children who would otherwise not have access. 55 school-based programs provide oral health services in more than 953 schools across NY, with the DOH providing grant support to 31 programs. Under a grant from HRSA, DOH funds a special project to integrate oral health prevention & treatment services into existing school health center programs.

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 is identified as a priority. The PA is NYS's health improvement plan for 2013 through 2017, developed by the NYS Public Health & Health Planning Council, in partnership with more than 140 organizations across NYS. 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 & businesses whose activities can influence the health of individuals & communities & address health disparities.

There are several statewide initiatives to ensure children have the resources needed to achieve & maintain optimal oral health. Open mouth exams on a representative sample of 3rd grade students, initiated in 2010, are continuing. Compared to children in the high-income group, low-income children continue to have more caries experience & untreated caries, fewer dental visits, fewer sealants & lower utilization of fluoride tablets. One of the goals in the PA is to reduce the % of untreated decay in 3rd grade children to 21.6% (Baseline 24%).
Effective 9/2008 a dental health certificate was requested for children in grades K, 2, 4, 7, & 10 as a way to increase access to oral health care & identify children in need of treatment services. Difficulties finding dentists willing to complete the certificate prompted bills to be accepted in the Senate and House that authorize registered dental hygienists to sign a DHC.

Annual claims for fluoride varnish (FV) continue to increase since MA's approval of applications of FV by dental & child health care professionals for children under age 7. More low-income infants & children are now receiving oral health services & timely identification & treatment of early signs of dental caries disease.

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	2008	2009	2010	2011	2012
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 - 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.

Notes - 2010
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:
In NYS, all social security income (SSI) beneficiaries 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). Children with special health care needs (CSHCN) who have severe, handicapping conditions and who 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 addition to the MA benefit, SSI provides income to help families obtain needed services to care for their disabled child.

In 2010 and 2011, 1.6% and almost 1% respectively of the children whose families received referral services through the CSHCN Program had SSI at initial contact. In FFY 2012, 53 CSHCN (3%) had SSI at time of initial contact. In FFY 2012, local CSHCN Program staff referred 42 CSHCN (2 %) to SSI. Fourteen percent of the 2012 referrals to SSI were accepted, 19% percent were rejected, almost 67% were pending at the end of the fiscal year, and 12% of outcomes were not reported. The large number of pending referrals reflects the lengthy SSI eligibility process. 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 work with local CSHCN Programs to improve data quality, i.e. follow up and documentation of outcomes for this measure.

DOH also oversees the largest Early Intervention Program (EIP) in the nation. EIP is a statewide service delivery system for infants and toddlers (birth to three years) with disabilities and their families. Its mission is to identify and evaluate those children whose healthy development is compromised and provide appropriate interventions to improve child and family development. The EIP, created in 1993, currently provides services to more than 70,000 infants and toddlers and their families statewide. As of 4/1/13, for children in the Early Intervention Program (EIP) who have SSI, the local EIP pays for services if MA does not cover the rehabilitative service. As a future activity, Title V staff, in conjunction with OHIP and EIP, will assess if it is feasible to determine the percent of children who access rehabilitative services.

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)	2011	other	8.3	7.9	8.1

Notes - 2014
Data Source: Vital Records/Births.

Narrative:
The percent of low birth weight has decreased slightly from 2006 for the entire NYS population (8.1%), the Medicaid (MA) population (8.3%) and for the Non-MA population (7.9%). A focus of DOH's efforts to reduce low birth weight is a systems-wide effort to improve early entry into prenatal care and services offered through DOH's perinatal programs.

NYS has a well-organized system of regionalized perinatal care which ensures appropriate hospital care is provided to women and newborns, including a hierarchy of 3 levels of perinatal care provided by hospitals within a region and led by a Regional Perinatal Center (RPC). Women at highest risk for poor birth outcomes are referred to RPCs.

MA requires all Article 28 facilities offering prenatal care to provide Presumptive Eligibility to pregnant women to expand access to prenatal care. MA Redesign recommendations were adopted to expedite enrollment of MA-eligible women into managed care plans to promote earlier entry into prenatal care and increase utilization of care management.

Although NYS has made great strides in access to prenatal care, it is widely recognized that the health of women prior to pregnancy significantly impacts birth outcomes. A preconception care packet, including a checklist and Guide for Optimizing Pregnancy Outcomes, was developed in collaboration with ACOG and distributed to over 16,000 health professionals. The materials are designed to encourage health professionals 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.

In 2010 HRSA awarded DOH a First Time Motherhood--New Parents Initiative grant to increase awareness of preconception/interconceptional health to improve perinatal outcomes, focusing on high-risk Black adolescents. Activities include the implementation of community preconception health planning in 6 high need areas of NY resulting in the development of reproductive life

planning booklets; preconception health radio and movie theater ads; brochures and trainings; and social media pages. In 2012, NY implemented a Text4baby campaign with over 13,000 participants receiving messages customized for NY. DOH is also promoting web-based modules on preconception and interconception care to health professionals across the state.

Improving health outcomes for women, infants and children is a priority for the NYS Prevention Agenda (PA), aligning with goals of the state's MA and Title V program. 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 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 NY's PA.

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	2010	other	6.4	4.2	5.3

Notes - 2014
Data Source: Vital Records 2010 matched birth death file. Infant Death rate/1,000 by Payor Source from birth certificate, NYS.

Narrative:
Although the infant mortality rate has decreased as a whole, there was an increase in the MA population. NYS's capacity to reduce infant mortality includes a number of surveillance, community-based and clinical activities, services and supports. Early access to prenatal care remains a cornerstone of promoting infant well-being. Major elements of NY's system include: MA standards for prenatal care; a requirement that all enrolled Article 28 prenatal care providers perform presumptive eligibility, assist with the full MA application and managed care plan selection; home visiting programs including Community Health Worker, Nurse Family Partnership, Healthy Mom-Healthy Baby and the MIECHV Home Visiting initiative; consumer outreach and education; and the Growing Up Healthy Hotline. In addition, preconception and interconception health is increasingly emphasized across all programs as critical for impacting birth outcomes.

NY is committed to the elimination of health disparities, and improving birth outcomes using evidence-based, sustainable models of care. Through the Maternal and Infant Health RFA, released in 2012, DOH aims to improve maternal and infant health outcomes for high-need women and reduce racial, ethnic and economic disparities in those outcomes. Funded programs 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. This initiative integrates and replaces DOH's current community-based perinatal health programs to develop community-wide systems of integrated and coordinated community health programs and services to improve outcomes.

Efforts have also focused on promotion of safe sleep and reduction of SIDS, including risk reduction education. In 2011, DOH launched the Keeping NY Kids Alive program which focuses on increasing the number of county based child death review teams; expanding the scope of

cases reviewed; standardizing data collection and submissions; and enhancing local prevention measures and system improvements. The DFH also collaborates with other partner programs, including WIC, Injury Prevention, and Healthy Families New York (a home visiting program administered by the NYS OCFS for the prevention of child abuse), to address factors that contribute to infant mortality.

Improving health outcomes for women, infants and children is a priority for the NYS Prevention Agenda, aligning with goals of the state's MA and Title V program. The NYS 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 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 NY's Prevention Agenda.

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	2011	other	63.6	80.8	72.9

Notes - 2014
Data Source: Vital Records/Births.

Narrative:
Capacity in this area is closely related to that described for HSCI 04. Medicaid (MA) populations generally fare less favorably than privately insured populations for this and other perinatal health measures, although there has been a slight improvement in the MA population in 2011. MA prenatal care increases access for high risk women to high-quality prenatal care that includes standardized risk assessment, medical and supportive services. Establishing consistent standards in the MA prenatal care program and requiring all MA prenatal care 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, which is expected to promote earlier entry into prenatal care and increase utilization of care management for high risk women.

A variety of public health strategies engage high risk pregnant women in early prenatal care. DOH developed a state plan for new federal MIECHV funds, based on an extensive needs assessment process 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. NY's work in the MIECHV will support further coordination of services, and maximization of resources to improve birth outcomes. All of these programs are targeted to communities with highest needs. The statewide Growing Up Healthy Hotline links women to needed services, with periodic public awareness media campaigns conducted to direct women to the hotline. In 2012, DOH issued a Maternal and Infant Health Initiative Request for Applications

(RFA) that integrates and replaces current 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. The MIECHV component of this RFA supports the expansion, enhancement and/or establishment of evidenced-based home visiting programs specifically Nurse Family Partnership and Healthy Families New York (HFNY). The Title V program collaborates with state Office of Children and Family Services for its HFNY home visiting program. Implementation of the initiative is targeted for 2013.

Improving health outcomes for women, infants and children is a priority for the NYS Prevention Agenda, aligning with goals of the state's MA and Title V program. The NYS 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 home visiting (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 NY's Prevention Agenda.

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])	2011	other	58.8	73.2	67.3

Notes - 2014
Data Source: Vital Records/Births.

Narrative:
A variety of strategies are used to engage high risk pregnant women in early prenatal care and support ongoing utilization of services throughout pregnancy. These include home visiting (HV) programs such as the Community Health Worker Program (CHWP), Nurse Family Partnership (NFP), and the Healthy Mom--Healthy Baby (HM-HB) Prenatal and Postpartum Home Visiting Program, designed to establish a county system of perinatal health services, with a strong focus on outreach to engage pregnant women in early prenatal care. All programs are targeted to communities with highest needs. NYS was awarded funds through the MIECHV program to support the development of evidence-based home visiting programs in high-risk communities. NYS's work in the MIECHV will support further coordination of services, and maximization of resources to improve birth outcomes. In 2012, DOH issued a Request for Applications (RFA) Maternal and Infant Health Initiative (MIH initiative) that replaces and integrates DOH's current community-based perinatal health programs including Comprehensive Prenatal-Perinatal Services Networks, CHWP and the HM-HB Prenatal and Postpartum HV initiative to develop multi-dimensional community-wide systems of integrated and coordinated community health programs and services to improve maternal and infant health outcomes.

Public health programs that serve at-risk adolescents - including School-Based Health Center (SBHC), Family Planning 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. Within the SBHC program, staff may provide prenatal care services directly, coordinate services with another provider or refer pregnant students for appropriate prenatal care, with follow-up to ensure that there is continuity of care. Where indicated, referrals are made for additional services.

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

Improving health outcomes for women, infants and children is a priority for the NYS Prevention Agenda, aligning with goals of the state's MA and Title V program. The NYS 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 home visiting (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 NY's Prevention Agenda.

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)	2012	200
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)	2012	200

Narrative:
Access to insurance, which is imperative for improved health outcomes & to mitigate racial & ethnic disparities, is a priority of NYS. Access to continuous health care coverage is a critical priority for CSHCN. The Office of Health Insurance Programs (OHIP) administers the MA & Child Health Plus (CHPlus) programs. CHPlus is NYS's CHIP program. Eighty-eight percent of all NYS 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 200% of the Federal Poverty Level (FPL) & 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 1st birthday. Coverage for children aged 0-1 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 200%, but under 400% of the FPL & meet other eligibility criteria would be eligible for CHPlus at a subsidy. In 2014, these children would also be 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 & family size. CHPlus coverage for those children with household incomes under 160% FPL is free. The premium for families with household incomes between 160% & 222% FPL is $9 per child per month, with a maximum of $27 per family per month. Families with household incomes between 222% & 250% FPL contribute $15 per child per month, with a maximum of $45 per family. Families with household incomes between 251% & 300% FPL contribute $30 per child per month, with a maximum of $90 per family. Families with household incomes between 301% & 350% FPL contribute $45 per child per month, with a maximum of $135 per family. Families with household incomes between 351% & 400% FPL contribute $60 per child per month, with a maximum of $180 per 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.

NYS has partnered with community-based organizations, faith groups & health & human service providers for a "Connections to Coverage" outreach campaign which promotes the availability of public health insurance coverage for all uninsured children & eligible adults & to links uninsured children to facilitated enrollment in their communities. Refer to HSC 07A for a description of recent outreach activities.

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 5) (Age range 6 to 18) (Age range to)	2012	 133 100
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 5) (Age range 6 to 18) (Age range to)	2012	 133 100

Narrative:
The Office of Health Insurance Programs (OHIP) 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 133% 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' CHIP 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 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	No
New York State Youth Tobacco Survey	3	Yes

Notes - 2014

Narrative:
DOH uses data from two different sources to determine the percentage of adolescents In grades 9 through 12 who report using tobacco in the past month. The NYS Education Department (NYSED) conducts the Youth Risk Behavior Survey (YRBS) every other year on odd numbered years. DOH conducts the Youth Tobacco Survey (YTS) every other year on even numbered years. Both surveys are conducted in schools in the spring of their respective years and fully document tobacco use by high school age adolescents.

Current YTS data demonstrates smoking rates among high school students in 2012 are down to 11.9%, the lowest in NY since health officials began keeping track in 1997. Also, the overall trend in high school youth smoking is down from 2000 to 2012 by 56%, a significant decline.

The capacity for DOH to conduct the YTS is problematic as the Bureau of Tobacco Control (BTC) has no current independent evaluation contract, the mechanism by which it conducted the YTS for the past two administrations. The YTS has been dependent upon the independent evaluation contract. The current evaluation contract expired in January 2013 and the re-procurement process has been delayed, leaving the BTC currently without a contract. Since preparation for the 2014 YTS should begin in the fall of 2013, this could put the next YTS administration in jeopardy.

Additionally, BTC's budget has experienced significant reductions over time which results in a reduction in deliverables for the independent evaluator contract and, hence, a less robust evaluation plan.

The YRBS is currently conducted by NYS Education Department (NYSED); this agency has conducted it continually since the mid to early 1990s and will continue to so.

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, 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 helth 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, which builds on the previous DOH-funded Safe Motherhood Initiative. DOH redesigned the previous process, in which ACOG was funded to conduct reviews of a selected sub-set of maternal deaths on a voluntary basis, to 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. ***/2014/Analysis was completed on medical records for 126 deaths from 2006 to 2008//2014//*** showed the leading causes of death to be: ***/2014/cardiovascular issues (31%),//2014//***hypertension***/2014/(17%//2014//***), hemorrhage (17%) and embolism (12%). Chronic illness, obesity and prenatal risk factors were identified. ***/2014/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. A preliminary review of data in 2012 //2014//***resulted in identification of several priorities including management of hypertension, obesity and embolism/DVT for development of clinical guidelines. Management of hypertension during pregnancy was selected as the first topic for development. During the past year, 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 ***/2014/finalized by DOH. The guidelines will be disseminated to all healthcare providers who care for pregnant women in a variety of clinical settings and posted on the DOH website.//2014//***

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 has implemented the NYS Perinatal Quality Collaborative (NYSPQC) - a joint initiative of DOH, New York's Regional Perinatal Centers (RPCs) 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. ***/2014/Initiated in 2010,//2014//***initial RPC Obstetrical Intervention teams activities 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. Significant progress has been shown including: a 67% decrease in scheduled deliveries without medical indication; an 86% decrease in inductions; a 62% decrease in c-sections; and, a 66% decrease in primary c-sections. ***/2014/DOH 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 18 RPCs and 80 affiliates.//2014//***

The Neonatal learning collaborative focuses on optimizing early enteral nutrition in preterm babies in the NICU. 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. ***/2014/The percentage of newborns discharged below the 10th percentile decreased from 32.6% in 2010 to 31.5% in***

2011 without engendering harm.//2014//

Building on the initial success of these activities, DOH was awarded a competitive CDC Perinatal QI grant to expand activities to additional obstetrical hospitals, in partnership with the NYS Partnership for Patients.***/2014/Affiliate hospitals reported a 41% decrease in scheduled deliveries without medical indication, which included a 72% decrease in inductions, a 28% decrease in cesarean sections, and a 13% decrease in primary cesarean sections.//2014//***

B. State Priorities

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

DOH 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. This effort has including 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. Funds have been awarded to expand home visiting programs in three target areas. ***/2014/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. This initiative will build on the success of , and replace the current CPPSN, HMHB and CHWP.//2014//*** This RFA will award funds to support additional maternal and infant health initiatives in high risk communities in NYS was released in 2012 ***/2014/and awards will be made later in 2013//2014//*** 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.***/2014/Refer to NPM 18 for further information.//2014//***

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. ***/2014/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.//2014//*** All MCHSBG-funded programs are expected to facilitate public insurance enrollment for eligible children. In particular, 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. 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. ***/2014/Title V staff facilitated meetings with partners to develop recommendations for pediatric Health Homes (HH). OHIP will utilize these recommendations as a basis for engaging additional stakeholder input and securing approval by CMS of enrollment of children in HH.//2014//*** 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) ***/2014/and have remained relatively consistent.//2014//*** 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. 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 ***/2014/and remains significantly higher than the HP 2020 goal of 82.5%.//2014//***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. ***/2014/As part of the federal MIECHV initiative, DOH issued a RFA for the MIHI, 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.//2014//***

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. ***/2014/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.//2014//***

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. 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. ***/2014/The Successfully Transitioning Youth to Adolescents RFA was released in 2012 and 17 awards have been made.//2014//*** 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. ***/2014/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.//2014//*** 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. ***/2014/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.//2014//***

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. ***/2014/The statewide percentage of women smoking during the last 3 months of pregnancy declined dramatically statewide from 8.2% in 2008 to 6.9%***

in 2010.//2014// 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. ***/2014/MA provides coverage for smoking cessation counseling for pregnant and postpartum women and adolescents to age 21.//2014//***

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 ***/2014/(SBHC-D)//2014//*** 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 second year of the Oral Health, Physical Activity and Nutrition (OPAN) survey of 3rd grade children in upstate New York; over 5,000 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 ***/2014/was initiated to assess the potential impact through this collaboration.//2014//*** 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. ***/2014/The MA Prenatal Care standards include a requirement that health care providers assess oral health and refer for services.//2014//***BDH staff continue to collaborate with OHIP on a MRT proposals to support community fluoridation.

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. A major recent accomplishment was the promotion of lead testing through linkage of lead registry with the NYS Immunization Information System (NYIIS). This linkage will reinforce and promote 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. This year, the program has been successfully transitioned to the Center for Environmental Health with continued collaboration with Title V. 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. ***/2014/Resources supporting the RACs were re-distributed to target populations with the highest rates of asthma-related hospital discharge and ED visit rates.//2014/***/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.

10. State Priority: To increase the percentage of infants who are breastfed for at least six months - 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. The average prevalence of infants exclusively fed breastmilk across all hospitals in the project was 44.5% in August 2011, up from June 2010 baseline of 37.1%. NYCDOHMH also worked with 13 hospitals in NYC to improve support to breastfeeding mothers. DOH and Regional Perinatal Centers (RPCs) are offering the 18 hour Ten Steps to Successful Breastfeeding Online course to staff in 125 obstetrical hospitals in NYS. 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. /2014/A priority of the MIHI RFA released in 2012 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	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	88.5
Annual Indicator	76.0	88.1	86.8	86.8	86.8
Numerator	3238	15853	3300	3300	3300

Denominator	4263	17985	3800	3800	3800
Data Source	Newborn Screening Program data set	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?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	89.4	90.3	91.1	92	92.4

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.

Notes - 2010
Data in the cells for 2007 and 2008 numerators and denominators represent only screen positives or referrals. In previous years, these numbers represented all newborns screened. For 2007-2008. as shown in the above table, the numerator is the number of cases closed and the denominator is the number of screen positive newborns for the year. The annual indicator is the number of closed cases divided by number of screen positive cases reported as a percent. A case is considered closed when all predetermined closure criteria are met, including the newborn having an evaluation, any diagnostic testing, and a diagnosis has been made regarding the condition for which the newborn was referred. The program follows all screen positive newborns to ensure they receive appropriate follow-up, including an evaluation, diagnostic testing and a diagnosis as appropriate.

For 2009, the numerator is the number of referrals (previously called screen positives) plus the number of babies with a presumptive positive screen. Presumptive positive screens are those infants with slightly out of range results; a repeat specimen is required, and follow-up staff ensures a repeat sample is received, tested, and reported appropriately. Data for 2009 are cases opened and closed that calendar year. There are still instances where the annual indicator will increase as some infants have cases remaining open until a firm diagnosis is made by the clinician. The diagnosis may not be made by the clinician until the following year; therefore the 2009 data is provisional. 2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

a. Last Year's Accomplishments
Newborn screening (NBS) is performed by DOH's Wadsworth Center's NBS Program. In 2012, 241,622 infants were screened for 46 congenital conditions, including 30 core conditions, most secondary conditions, and HIV and Krabbe disease (both unique to NY).

Infants screened in 2012 were confirmed with the following conditions:
- 21 amino acid disorders
- 15 congenital adrenal hyperplasia
- 83 primary congenital hypothyroidism
- 228 hemoglobinopathies
- 30 organic acid disorders
- 25 fatty acid oxidation disorders
- 1 biotinidase deficiency
- 31 Cystic Fibrosis (CF)
- 12 galactosemia
- 21 T cell lymphopenia, including SCID
- 1 infant was 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 are located in 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 4 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 NBS Program assumed the responsibility of approving SCCs for newborns with out of range test results.

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 NY Mid-Atlantic Consortium for Genetic and NBS Services (NYMAC) websites: www.wadsworth.com/newborn; www.wadsworth.org/newborn/nymac. NBS educational materials were developed and maintained. The "For Your Baby's Health" brochure was translated into Korean and Italian.

DOH received a 3-year grant from HRSA entitled Effective Follow-up in Newborn Screening (NBS EFU) which ended in 8/12 to improve NBS short-term follow-up via enhanced health information exchange. Specific activities include electronic data transmission, electronic submission of diagnostic data and electronic collection of long-term follow-up data. Twenty-two hospitals are currently submitting demographic newborn screening data electronically.

NBS EFU staff worked with Inherited Metabolic Disease (IMD) Specialty Centers to define data elements for long-term follow-up.

NBS EFU staff worked with the CF Foundation Patient Registry (CFFPR) to obtain existing data on Specialty Care Center service utilization for program surveillance. Greater than 95% of patients diagnosed with CF in NYS from 2003 to 2010 had at least one encounter in the CFFPR after diagnosis by a CF Specialty Center. Several potential false negative cases were identified.

EFU grant staff performed a data matching analysis of vital records data and newborn screening data. Matched data will be used to locate infants that require follow-up of abnormal newborn screen results.

Specimens collected and shipped during Hurricane Sandy, particularly in Manhattan, Brooklyn, Queens, Long Island, and Westchester County, were tracked by program staff to ensure they arrived in time and suitable for testing.

The NBS Program is participating in a state-to-state emergency preparedness project with New Jersey. In 2012, the NYS NBS Program successfully received and tested specimens from New Jersey.

The NBS Program began testing newborns from Missouri on 8/31/12 for Krabbe disease.

Prenatal Genetics Services were provided to 18,604 pregnant women in 2012. Clinical Genetics Services were provided to an additional 28,067 individuals through genetics services grantees in 2012.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. In 2012, DOH's Wadsworth Center's NBS Program screened 241,622 infants for 46 congenital conditions.			X	X
2. The NBS program followed all screen positive newborns to ensure they received appropriate follow-up.	X	X		
3. DOH received a grant from HRSA entitled NBS EFU. This 3-year grant ended in 8/12. Its goal was to improve NBS short-term follow-up via enhanced health information exchange.				X
4. The NBS Program certifies specialty care centers and continued to monitor standards for Endocrine, Hemoglobinopathy, CF and IMD Specialty Centers. In 2012, standards were developed for SCID SCCs and 2	X			X

Hemoglobinopathy Centers were re-certified.				
5. Prenatal Genetics Services were provided to 18,604 pregnant women in 2012. Clinical Genetics Services were provided to an additional 28,067 individuals through genetics services grantees in 2012 through genetic services grantees.	X	X	X	X
6. In 2012, the NYS Newborn Screening Program successfully received and tested specimens from New Jersey as part of emergency preparedness.			X	X
7. Through the NY NBS and NYMAC websites, individuals can access educational resources about genetics services or specialty care or identify clinical services providers, support groups and other services.		X	X	X
8. NBS EFU staff worked with the CFFPR to obtain existing data on SCC service utilization for program surveillance.			X	X
9. EFU grant staff performed a data matching analysis of vital records data and newborn screening data. Matched data will be used to locate infants that require follow-up of abnormal newborn screen results.			X	X
10. NBS EFU staff worked with IMD SCCs to define data elements for long-term follow-up.			X	X

b. Current Activities

-Wadsworth Center conducts bloodspot screening on 100% of suitable specimens from NY's newborns for 46 conditions. More than 90% of referred infants are followed to confirmation.
-The NBS Program is reviewing unresolved cases to discuss ways to increase the percent of infants who receive timely follow-up.
-DOH provides grant awards to 24 genetic centers across NYS to provide diagnostic services, laboratory testing, genetic counseling, and referral to treatment centers.
-DOH is a member of NYMAC for Genetic and Newborn Services.
-DOH continued work from the CDC Cooperative Agreement for RuSH, the Registry and Surveillance System for Hemoglobinopathies. Additional clinical outcome data will be collected and final data analysis will occur.
-Hemoglobinopathy criteria for specialty centers were reviewed. Two specialty centers were re-certified based on the resulting standards. Additional re-certifications are pending.
-A bill is under consideration by the NYS Senate that would mandate the screening of all newborns for adrenoleukodystrophy (ALD). In preparation, the NBS Program is evaluating different methods to screen for ALD using mass spectrometry and Ribonucleic/Deoxyribonucleic acid techniques.
-The NBS Program provided outreach to several hospitals to reduce their unsuitable specimen rate including 2 site visits to large birthing centers.

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.
-The NBS Program 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, NBS Technical assistance and Evaluation Program (NEW-STEPs) to evaluate new diagnostic criteria for endocrine disorders and CF in conjunction with the specialty care centers.
-Staff will also implement use of the internet case management system for remote diagnostic

entry with CF Specialty Centers, SCID Specialty Centers and IMD Specialty Treatment Centers.
-The Program will move towards implementation of newborn screening for adrenoleukodystrophy, ensuring appropriate follow-up measures are in place.
-Article 28 hospitals will be monitored for their success as SCCs.
-Wadsworth Center will continue to operate a state-of-the-art clinical and environmental laboratory evaluation program to ensure that laboratories offering tests to NY residents meet appropriate quality requirements and can pass proficiency tests.
-The NBS Program plans to send samples to New Jersey as part of emergency preparedness planning.
-The NBS Program will investigate the possible false negative CF cases identified in the data matching with the CFFPR.
-The NBS Program will perform 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.
-An updated training video on proper specimen collection will be made available to nurseries and clinical providers.

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:	**241621**					
Reporting Year:	**2012**					
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)	241621	100.0	25	18	18	100.0
Congenital Hypothyroidism (Classical)	241621	100.0	672	334	334	100.0
Galactosemia (Classical)	241621	100.0	18	12	12	100.0
Sickle Cell Disease	241621	100.0	74	70	70	100.0
Biotinidase Deficiency	241621	100.0	2	1	1	100.0
Cystic Fibrosis	241621	100.0	898	35	35	100.0
Homocystinuria	241621	100.0	7	0	0	
Maple Syrup Urine Disease	241621	100.0	6	0	0	
beta-ketothiolase deficiency	241621	100.0	1	1	1	100.0
Tyrosinemia Type I	241621	100.0	11	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	241621	100.0	21	3	3	100.0
Argininemia	241621	100.0	2	2	2	100.0
Citrullinemia	241621	100.0	10	2	2	100.0
Isovaleric Acidemia	241621	100.0	3	0	0	
Propionic Acidemia	241621	100.0	44	8	8	100.0
Carnitine Uptake Defect	241621	100.0	12	2	2	100.0
Glutaric Acidemia Type I	241621	100.0	0	0	0	

Isobutyryl-CoA Dehydrogenase Deficiency	241621	100.0	17	2	2	100.0
Sickle Cell Anemia (SS-Disease)	241621	100.0	135	145	145	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	241621	100.0	191	17	17	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	241621	100.0	18	13	13	100.0
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	241621	100.0	3	2	2	100.0
3-Hydroxy-3-methylglutaryl-CoA lyase deficiency	241621	100.0	39	21	21	100.0
Short-Chain Acyl-CoA Dehydrogenase Deficiency	241621	100.0	17	9	9	100.0
Hemoglobin C Disease	241621	100.0	19	21	21	100.0
Malonic acidemia	241621	100.0	0	0	0	
Krabbe Disease	241621	100.0	41	1	1	100.0
Severe Combined Immunodeficiency	241621	100.0	249	24	24	100.0
Carnitine palmitoyltransfearase I deficiency	241621	100.0	0	0	0	
Carnitine palmitoyltransfearase II deficiency	241621	100.0	14	2	2	100.0
2,4-Dienoyl-CoA reductase deficiency	241621	100.0	0	0	0	
Medium-/short-chain hydroxyacyl-CoA dehydrogenase deficiency	241621	100.0	0	0	0	
Hemoglobin Disorders	241621	100.0	40	47	47	100.0
Hyperammonemia/hyperorninthinemia/homocitrullinemia	241621	100.0	0	0	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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	66	60	62	59.6	65.7
Annual Indicator	59	59	59	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
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	66.3	67	67.6	68.3	69

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.

Notes - 2010
Data reported for 2007, 2008 and 2009 are from the National Survey of Children with Special Health Care Needs (CSHCN) conducted by HRSA and CDC in 2005-2006. 2009 data are used as a proxy for 2010 data. 2010 data will be available in the fall of 2011. Nationally, 57.4% of families with CSHCN report satisfaction with the services they need.

a. Last Year's Accomplishments
-According to the 2009-2010 NS-CSHCN 64.4% of NY families of Children with Special Health Care Needs (CSHCN) report they are partners as shared decision makers in matters regarding their child's health, an increase of 9% from the previous survey completed in 2005-6.
-NY is committed to family engagement in their child's care and satisfaction with this care at the individual and community level. The NY CSHCN Program provides funding through contracts with 55 local health departments (LHDs) to provide families of CSHCN with assistance in navigating systems of care. One of the NY CSHCN 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 assess family and youth satisfaction with services provided by their programs using a standardized survey tool.
-The Family Satisfaction Survey was finalized 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. The survey was also translated into Spanish. The state CSHCN Program's goal was to have received 10 completed surveys per locality or a state cohort of over 500 responses.
-In August 2012, CSHCN Program staff distributed NYS P2P information links to local CSHCN Program for sharing with families. These website links are a wealth of information about insurance, empowerment and family support for families of CYSHCN.
-NYS administers the largest Early Intervention Program in the nation, serving approximately 70,000 infant and toddlers age 0-3 and their families annually. Parents play a significant role in their child's and family's services as participants in the Individualized Family Service Plan process.
-Early Intervention Program (EIP) families were engaged in decision making through the Individualized Family Service Plan (IFSP). The IFSP identifies family's concerns, priorities, and objectives for their child's development.
-The Bureau of Early Intervention conducts an annual survey of families whose children are exiting the program. The family survey consists of three scales to measure child outcomes, family outcomes, and family-centered services. Each of the scales includes a question regarding satisfaction with child and family outcomes and services received. Data consistently indicate that among all items included across the three scales, families are most likely to highly agree that EIP services helped their child/family achieve positive outcomes and that they are satisfied with services
-The DOH Early Hearing Detection and Intervention (EHDI) Program established a NYS Chapter of Hands and Voices (HAV), a national parent professional collaborative offering unbiased support to families of children with significant hearing loss. The group has achieved provisional Chapter status as a 501c3.
-Family members were active participants in the Maternal and Child Health Services Block Grant

(MCHSBG) Advisory Council and state Early Intervention Coordinating Council (EICC) and state Lead Poisoning Prevention Advisory Council.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Local CSHCN Programs work with families to identify and refer them to appropriate services for their child.		X		X
2. DOH promotes shared family professional decision making through medical homes and public health program activities.		X		X
3. The state CSHCN Program convened a workgroup of outside partners (LHD and family organization representatives) to assist in the development of CSHCN family satisfaction tool for statewide distribution.				X
4. Early Intervention Program (EIP) families were engaged in decision making through the Individualized Family Service Plan (IFSP). The IFSP identifies family's concerns, priorities, and objectives for their child's development.		X		
5. Parents of CSHCN are represented on the MCHSBG Advisory Council and the EICC and serve as representatives on several other state level advisory groups.				X
6. Title V staff participated in MA redesign discussions that relate to CSHCN.				X
7. A CSHCN work plan goal for LHDs was to perform program activities that are responsive to the needs of families and youth.		X		X
8. The Resource Directory for CSHCN is posted on the DOH website and distributed free of charge to consumers and providers.			X	
9. CSHCN Program staff distributed P2P information links to local CSHCN Program to share with families.			X	
10.				

b. Current Activities

-Title V staff reviewed data obtained through the family satisfaction surveys implemented by the local CSHCN Program. The review was completed at the mid and endpoint of the grant year. Individual reports were shared with CSHCN Programs. 65.6% of families responded they were "very satisfied" with CSHCN program support and services, while 27.1% responded they were "satisfied". 65.6% responded they were "very satisfied" that the program meets their needs while 27.1% responded they were "satisfied". Families most frequently requested assistance with information regarding health insurance, financing medical expenses not covered by insurance, followed by identification of medical specialists, dental specialists and other supports and resources.

-Title V staff contacted local CSHCN Programs that did not have any family satisfaction survey responses at mid-year to determine possible reasons why and provided technical assistance to improve performance resulting in a 72 % increase in the number of those localities receiving responses.

-CSHCN Program funds supported family attendance at workshops and meetings that will enable them to become full partners in decision making for their children.

-HAV will continue to provide the EHDI Program with updates including achieving permanent Chapter status and increased membership.

-Title V staff will continue to seek opportunities to involve families in decisions impacting supports and services.

c. Plan for the Coming Year
-NY will continue funding local CSHCN Program activities in 2013-2014.
-CSHCN Program will continue its quality improvement efforts with local programs to assess family satisfaction survey responses and provide technical assistance to help programs integrate those comments when planning and evaluating their program services. Title V staff will be conducting webinars with all local CSHCN programs to discuss survey results. The focus of the webinars will be to ensure data are collected accurately, local programs understand the data for their county and potential strategies to improve survey response rates as well as improving family satisfaction with their supports and services.
-The EIP will continue to promote parent involvement in IFSP development and measure family satisfaction with services upon transition from the EIP.
-The EHDI Program's established NYS HAV plans to achieve permanent Chapter status.
-NYS HAV continues to promote and expand membership across the state.
-Continue to support parent membership on the EHDI Advisory Board.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	58	46	48	45.7	39.2
Annual Indicator	45.2	45.2	45.2	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
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	39.6	39.9	40.3	40.7	50.1

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.

Notes - 2010
Data reported for 2007, 2008 and 2009 are from the National Survey of Children with Special Health Care Needs (CSHCN) conducted by HRSA and CDC in 2005-2006. 2009 data are used as a proxy for 2010 data. 2010 data will be available in the fall of 2011. NYS is below the national average of 47.1%, as well as the target for the HP 2020 goal of 54.8% of CSHCN (under age 18) who have access to a medical home. However, NYS exceeds the HP 2020 target for CSHCN who receive their care in family-centered, comprehensive, coordinated systems. For children 0 – 11years, the HP 2020 target is 22.4%, and for children 12-17 years of age the target is 15.2%

a. Last Year's Accomplishments
-The NS-CSHCN 2009-2010 data indicated that 38.4% of families reported their children receive coordinated care within a medical home. This is a decrease from 2010. This measure however is a priority of NYS. NY's policy and program efforts have continued strong in this area as reflected in Section III State Overview of this application. It is anticipated that the next NS-CSHCN survey will reflect these efforts.
-NY is committed to providing a medical home for individuals insured by Medicaid (MA) so as to improve health outcomes through better coordination and integration of care. NYS law enacted in 2009 authorizes DOH to incentivize patient centered medical homes (PCMH). 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) PCMH. The number of MA managed care enrollees increased from 1.3 million in December 2011 to 1.395 million in the third quarter of 2012. This represents a PCMH penetration rate of 40% in the third quarter of 2012. Almost half (48%) of those MA enrollees assigned to PCMH in June 2012 were children under 21 years.
-In 2011, incentivized payments were offered to medical providers enrolled in Child Health Plus (CHPlus) (NYS's child health insurance program) 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. The penetration rates of CHPlus enrollees in PCMH increased from 32% in 2011 to 39% in 2012.
-Local Health Departments (LHD) receive funds to administer local Children with Special Health Care Needs (CSHCN) Program. The scope of their responsibility includes an assessment to determine if the CSHCN has a primary health care provider and health insurance, and facilitating addressing those needs if applicable. LHDs report this data quarterly to NY.
-Through NY's School Based Health Centers (SBHCs), children and adolescents, including Children with Special Health Care Needs (CSHCN) receive preventive and chronic disease management health care services.
-NY completed the development of a statewide 2010-2011 CSHCN Program report based upon LHD data reportedly quarterly. The information gleaned during this report formed the basis of a

webinar conducted in September 2012 for LHD CSHCN Program staff. Title V staff provided an overview of statewide 2010-2011 CSHCN data and the areas where improvements in reporting were needed, i.e. reporting of client's insurance and primary care provider status. Title V 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 health care provider at referral and at Individualized Family Service Plan (IFSP) development and reviews, and assists with linkages for insurance coverage as necessary.
-Title V staff chaired nine meetings (February through August 2012) with internal DOH partners and external state agency partners to develop programmatic recommendations for pediatric Health Homes (HH). HH builds upon the medical home model by providing reimbursement for enhanced care coordination for high need/high cost individuals enrolled in MA. In August 2012, a set of programmatic recommendations were discussed with Executive staff in Public Health and the Office of Health Insurance Programs (OHIP). OHIP will utilize these recommendations as a basis for engaging additional stakeholder input and securing approval by Centers for Medicare and Medicaid Services (CMS) of enrollment of children in HH.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote and maintain patient centered medical homes in MA and CHPlus.	X			X
2. Continue payments to MA and CHPlus providers that meet NCQA standards for PCMH.				X
3. Assess presence of a primary care provider at referral and at IFSP reviews and assists with linkages for insurance coverage in the EIP and CSHCN Programs.		X		X
4. Title V is collaborating with the OHIP regarding HH for children				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
-NY continues to fund LHDs to administer a local CSHCN Program. Assessing for the presence of a primary provider and health insurance for each child served by the program is a primary responsibility for LHDs. Following the webinar for LHDs in September 2012, Title V staff noted an improvement in the quality of the data collection and reporting for primary care provider and health insurance in the 4th quarter of 2012. Title V staff continue to monitor quarterly reports submitted by local programs.
-Title V staff continue to be involved in medical home/HH policy development activity. During 2012, Title V staff participated with other DOH staff, OPwDD staff, and external stakeholders (providers that specialize in the care of pediatric patients and family representatives) to develop recommendations for a report to the Governor and legislature on Medically Fragile Children (MFC). The report, released in February 2013, addressed MA payments to certain pediatric providers that serve MFC; appropriate models of care coordination; and the transition of the pediatric nursing home benefit and population to managed care. The report recommended utilizing the HH model to provide care coordination for MFC, and prioritizing assignment of children who are eligible for HH services but are not currently receiving care coordination services.

c. Plan for the Coming Year

-The NSCSHCN survey measures are established as composite measures using responses from multiple questions. Title V staff is interested in further assessing NY's performance on this measure based on responses to specific questions and have reached out to CDC for further information.

-NY will continue to fund LHDs to administer a local CSHCN Program. 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. Title V will continue to monitor progress in this area through the review of quarterly reports.

-The Early Intervention Program will continue to support and promote ensuring infants and toddlers in the program are connected with health insurance and a primary health care provider.

-NY will continue incentives to medical providers to expand MA/CHP enrollees who receive care in NCQA PCMH.

-Title V staff will continue to be involved with OHIP in policy efforts for HH for children.

-As part of New York State's Medicaid Redesign initiative, SBHC services will transition from a fee-for-service to a managed care financing structure effective October 2014. It is anticipated that this will result in improved coordination of care for students served by SBHCs including CSHCNs. DOH will work with a group of SBHC stakeholders in the coming year to identify issues and solutions that the transition into Medicaid managed care presents.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	72	64	64	62.7	57.9
Annual Indicator	62.1	62.1	62.1	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
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	58.5	59.1	59.6	60.2	60.7

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.

Notes - 2010
Data reported for 2007, 2008 and 2009 are from the National Survey of Children with Special Health Care Needs (CSHCN) conducted by HRSA and CDC in 2005-2006. 2009 data are used as a proxy for 2010 data. 2010 data will be available in the fall of 2011. Nationally, 62% of families have adequate insurance to pay for services they need.

a. Last Year's Accomplishments
-According to national survey data (NS-CSHCN 2009-2010), approximately 8% of NY families of Children with Special Health Care Needs (CSHCN) reported their child was uninsured at some point during the year. Thirty-eight percent of NY families reported their insurance coverage was inadequate to meet their child's needs (NS-CSHCN 2009-2010). Any gap in health insurance coverage poses significant threats to the health and well-being of a CSHCN. NY's policy and program efforts have continued strong in this area as reflected in Section III State Overview of this application. It is anticipated that the next NS-CSHCN survey will reflect these efforts.
-NY funds 56 Local Health Departments (LHD) to administer a CSHCN Program. One of their key responsibilities is to assess a child's insurance status and to refer uninsured children to insurance and appropriate gap filling services. In FFY 2011-2012, 8% of children were reported as without insurance upon initial assessment. 2012 data indicates that local CSHCN Programs referred 71% of uninsured children for insurance and/or gap filling assistance. Title V staff will be conducting webinars with all local CSHCN programs to discuss survey results. The focus of the webinars will be to ensure data are collected accurately, local programs understand the data for their county and potential strategies to improve referral of CSHCN for insurance coverage.
-During the initial encounter with families of CSHCN, local CSHCN Program staff asks families about the type of financial assistance they need for their child. In FFY 2011-2012, 1,207 NY families of CSHCN who contacted the local program responded to the inquiry 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 (63.6%); need help with insurance premium (16.2%); need help with item or service that exceeds the benefit amount (10.45%); need help with copayment (8.3%); and, need help with deductible (1.4%).
-The NY Early Intervention Program (EIP) provides therapeutic and supportive services, including service coordination, to infants and toddlers with developmental delay or disabilities and their families in accordance with the child's Individualized Family Service Plan. A child's insurance is billed first for these services if the insurance is licensed or regulated in NYS. Parents pay no out-out-pocket expenses for ei services. If the child's insurance is inadequate, the county and NYS provides payment for the authorized services. Approximately 71,000 children and families received early intervention services in 2012.

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. NY Physically Handicapped Children's Program (PHCP) provides reimbursement to providers for diagnostic evaluations and state aid reimbursement to localities for gap filling treatment services.		X		
3. Updated the Resource Directory for CSHCN, a comprehensive document for consumers and providers about state financial assistance programs and supports for families.			X	
4. Local EIPs will continue to provide reimbursement to EIP providers for authorized services not covered by insurance.	X			
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

-NY provides funding to 55 LHDs for the CSHCN Program.
-NY's PHCP provides for gap-filling medical and dental services to eligible children age birth to 21 years.
-In 2012, 244 children received a diagnostic evaluation and 1,225 children received treatment services through PHCP. The major categories of services and percent of funds expended are: orthodontia (71%); medications (8%); hearing aids (5%); enteral formula (4%); medical-surgical supplies (4%) and durable medical equipment (2%). Orthodontia expenditures remain high as the CHP program has a very limited orthodontia benefit.
-The Resource Directory for CSHCN, a comprehensive document for consumers and providers about state financial assistance programs and supports is displayed on the DOH's website and is available in English, Spanish, Chinese, French and Russian.
-As of 4/1/13, a child's insurance is billed directly first for these services by the EI Provider; if the child's insurance does not cover the service, the locality provides payment for the authorized services.
-Title V staff continues to expand collaborative activities with OHIP on ACA implementation strategies to ensure more children have adequate insurance coverage. These areas of focus include the provision of input into the Essential Health benefits benchmark plan selections, informing OHIP of potential issues with health care coverage for children, and the development of Health Homes.

c. Plan for the Coming Year

-The NSCSHCN survey measures are established as composite measures using responses from multiple questions. Title V staff is interested in further assessing NY's performance on this measure based on responses to specific questions and have reached out to CDC for further information to assess areas for improvement.
-The revised Resource Directory will be uploaded to the DOH website. In keeping with an Executive Order that ensures language access is implemented for essential public documents, the Directory will be translated into three additional languages (Korean, Polish and Italian). With these additional translations, the publication will be available in 8 languages.
-Title V staff will encourage LHDs to assist families of CSHCN to understand eligibility for public insurance programs, link families with facilitated enrollers and the on-line ACCESS NY Public Health Insurance Eligibility Screening Tool that helps families determine if they are may be

eligible for Medicaid, Child Health Plus, and Family Health Plus.
-Title V staff will provide technical assistance to local staff and data monitoring to ensure all uninsured children are referred to insurance or available gap-filling programs.
-In the 2013-2014 budget, PHCP was reduced by slightly more than $100,000, however, it is anticipated that the budgeted amount is sufficient to cover the anticipated gap-filling expenditures.
-Title V staff will continue to be part of Medicaid redesign and ACA implementation efforts involving children with special health care needs.
-The NY Early Intervention Program (EIP) will continue to provide comprehensive services, including services coordination, to infants and toddlers with developmental delay or disabilities.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	91	92	92	91.5	66.9
Annual Indicator	90.6	90.6	90.6	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
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	67.6	68.2	68.9	69.5	70.2

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.

Notes - 2010
Data reported for 2007, 2008 and 2009 comes from the National Survey of Children with Special Care Needs (CSHCN) conducted by HRSA and CDC in 2005-2006. 2009 data are used as a proxy for 2010. 2010 data will be available in the fall of 2011. Nationally, 89.1% of families report that community-based service systems are organized so they can easily use them.

a. Last Year's Accomplishments
-Almost sixty-six (65.6%) percent of NY families reported they can easily access community-based services. In 2009-10 NS-CSHCN, NY scored slightly higher than the national average of 65.1%. However, there is room for significant improvement in family satisfaction with access to services.
-In 2012, the CSHCN Program began asking 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 twenty-one 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 work plan requirements for local CSHCN programs are standardized to assure that all contractors are addressing a core set of program requirements, which are closely aligned with the maternal and child health performance measures.
-DOH provided funding to 55 local health departments (LHDs) to provide preventive outreach and education, and coordinate follow-up of medical, educational and environmental services for children identified with lead poisoning.
-In June 2012, the CSHCN/PHCP contact list was updated and placed on the DOH website. Updated contacts were provided to New York State Parent to Parent (P2PNYS) for posting on the Family to Family Health Information Center website to facilitate access to this information.
-Through 226 School Based Health Centers sponsored by 51 health care facilities, SBHCs provide primary and preventive health care to more than 158,000 students, including those with special health care needs, living in high need areas.
-The Early Intervention Program (EIP) provided service coordination to approximately 71,000 infants and toddlers with developmental delay and disabilities and their families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. DOH provided funding to 55 local health departments 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.				X
3. DOH provided funding to 58 LHDs for administration of the Early Intervention Program (EIP).		X		
4. The EIP provided service coordination to approximately 71,000 infants and toddlers and their families.		X		
5.				

6.				
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b. Current Activities

-Title V staff analyzed results of families' survey responses about services provided by local CSHCN Programs regarding ease in getting information and help from the CSHCN staff. Sixty-seven percent responded "always easy"; 29 % indicated "sometimes easy"; and, almost 4 % stated "never easy." Title V staff provided local programs with a summary of their data.
-Almost 77 percent of children referred to the CSHCN Program with a dental diagnosis had Child Health Plus (CHPlus) insurance. Orthodontia services are very limited in the CHPlus plan. Title V staff continues to work with DOH leadership to promote modification of the CHPlus benefit to mirror the Medicaid (MA) coverage for orthodontia.
-Title V staff participated in the state's MA Redesign process and led a work group to develop programmatic recommendations for enrollment of children in health homes, a care management model being implemented for high cost/high cost MA enrollees.
-The EIP continued to provide service coordination for referred and eligible infants and toddlers and their families.
-Title V staff provided significant support during Superstorm Sandy. Families of CSHCN were assisted through the State Command Center, Emergency Management Offices, PTP and local programs to address issues such as power outages and the impact on ventilator support, medications, housing and other necessary services. DOH posted accessible information on the DOH web regarding available resources for families with CSHCN.

c. Plan for the Coming Year

-Title V staff will continue to collaborate with OHIP in the implementation of Children's HH to enhance coordination of care for CSHCN.
-Title V staff 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 and other state agencies to improve the systems of care. Title V staff continue to advocate for expansion of orthodontia coverage in CHPlus.
-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.
-Title V staff will also continue to work with School Based Health Centers (SBHCs) and the SBHC Center of Excellence to improve SBHC care for all children, including CSHCN.
-Early intervention service coordination will continue to be provided to those children referred and found eligible for the EIP.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	40	40	40	38.8	40.5

Annual Indicator	38.4	38.4	38.4	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	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	40.9	41.3	41.7	42.1	42.3

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.

Notes - 2010
Data for 2007, 2008 and 2009 comes from the National Survey of Children with Special Health Care Needs (CSHCN) conducted by HRSA and CDC in 2005-2006. 2009 data are used as a proxy for 2010 data. 2010 data will be available in the fall of 2011. Nationally, 41.2% of youth indicated they received this service.

a. Last Year's Accomplishments

-NY's performance on this core measure is equal to the national performance of 40%; progress on this measure has been maintained. Title V staff has made significant program efforts to make improvements in the transition outcome.
-Local Health Departments (56) receive grant funds to administer a local CSHCN Program that assists children, adolescents and families in obtaining information and referrals they need. Transition is an important component of the work of local programs. The CSHCN Program assists families with transition issues, including providing appropriate information related to maintaining and seeking health insurance for the young adult and accessing supports,
-The hand-held portable health summary (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.
-In August, 2012, the NYSDOH CSHCN Program hosted a webinar for local CSHCN Program staff. The guest speaker was a parent colleague of the Family to Family Health Information Center of Parent (P2P) of NYS. Sixty-one individuals from 47 Local Health Departments and four State DOH regional office staff attended the webinar. The state CSHCN Program's short term goal for the webinar was to increase local program staff knowledge about the topical area of health care transition. Attendees were asked to complete an evaluation following the webinar. One hundred percent of respondents (54% of participants responded to the evaluation survey) indicated the webinar had increased their knowledge of how to assist adolescents and young adults with special health care needs and their families in health care transition. With increasing local CSHCN Program staff knowledge, the NYSDOH aims to more effectively achieve the MCHB core outcome related to successful youth transitions to adult health care, work and independence.
-During onsite visits to hospital specialty centers in 2012, state CSHCN Program staff inquired about transition planning for transfer of care from pediatric to adult providers. Providers described their transition planning efforts. Some have noted reluctance on the part of adult providers to accept these complex patients. Some of the patients may remain with the pediatric provider beyond age 21 years depending upon the adult specialist's familiarity with the patient's condition. The administration of the specialty center site visits was transferred to the Newborn Screening (NS) Program. Title V staff provided transition resources to NS staff to continue efforts to discuss transition planning during specialty center visits.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The CSHCN Program work plan included transition activities as a required deliverable for local health department contractors.		X		X
2. Hand-held portable health summary continued 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 HH.	X	X		X
4. The CSHCN Program hosted a webinar for Local Health Department CSHCN staff on health care transition to increase knowledge.		X		X
5. The CSHCN staff inquired about transition planning efforts at two hospital specialty center visits.	X			X
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), developed by Title V Program staff in collaboration with Youth Champions, and offer the pocket sized health summary document to adolescents and their families who contact the program for assistance.
-Information about the Healthy Transitions website was disseminated to SBHCs to share with youth they serve.
-NY State staffs continue to discuss transition plans during onsite visits with hospital specialty center providers.
-Title V staff are participating in NY's Medicaid (MA) redesign process in several domains related to children with special health care needs. Title V staff are the DOH's project lead for development of recommendations for Health Homes (HH) for children. Transition of medical/behavioral care from pediatric to adult specialists and transfer of care coordination as youths become independent have been discussed.
-In January, 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 P2P was the featured speaker. One hundred percent of respondents indicated (54% of participants responded to the evaluation survey) that the webinar increased their knowledge on health care transitions resources for young adults with special health care needs.

c. Plan for the Coming Year

-Transition activities will continue to be a required program element for local CSHCN contractors.
-The CSHCN Program staff will continue to participate with the Office of Health Insurance Programs in NY's MA Redesign process, including those initiatives relevant to children with special health care needs. It is anticipated that following additional stakeholder input in recommendations for health homes for children and finalization of these recommendations, the Department will enter into discussions with the Centers for Medicare and Medicaid (CMS) to expand the enrollment of children in HH.
-During the specialty center approval process, NYS DOH staff will continue to discuss specialists' plans for transition of their pediatric patients to adult providers and offer Healthy Transitions website (http://www.healthytransitionsny.org) and Health Information Document tools to specialists for their use with transitioning adolescents and young adults.
-The CSHCN Program staff will review and update as needed, the transition resources, on the Special Health Care Needs section of the Department's website.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	88	80	80	72.9	73.6
Annual Indicator	76.2	72.2	71.3	74.2	74.2
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
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	74.4	75.1	75.8	76.5	77.2

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%.

Notes - 2010
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

a. Last Year's Accomplishments
-A 2007-09 Hib vaccine shortage had a lasting impact on overall vaccination rates. 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 was below the annual performance objective last year.
-The Bureau of Immunization (BI) provided more than 1 million doses of vaccine to over 338,000

children through the VFC Program, assessed immunization rates and worked to improve them, provided ta to providers, disseminated educational materials, assisted LHDs with disease surveillance and outbreak control activities, and continued to expand the statewide immunization registry. Funding supports staff in central and regional DOH offices and for the purchase of vaccines.
-The BI staff work with regional and LHDs to improve pediatric immunization rates by providing ta to providers and subject-matter expertise in the form of materials on the DOH public website and through statewide webinars.
-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 NYS Immunization Information System (NYSIIS) and entered into CDC-developed software (Comprehensive Clinic Assessment Software Application (CoCASA)) that calculates the providers' immunization rates and identifies opportunities for improvement in immunization practices. Over 450 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.
-Comprehensive Prenatal Perinatal Services Networks provided education and outreach to engage children into health care and improve utilization of well child care. Some networks conducted outreach for Child Health Plus and other activities to ensure that parents are aware of the need for comprehensive immunization.
-The Community Health Worker Program educated parents about immunization, assessed the immunization status of children, referred and assisted families to obtain immunizations and followed up with families to assure they received the service. In 2011-12, 92% of the children entering the program had up-to-date immunizations. Of the children who did not have complete immunizations, 80% received immunizations while in the program.
-NFP programs ensured children receive well child care including immunizations.
-Article 6 funding reimbursed LHDs for the infrastructure that supports immunization surveillance, tracking, parent and provider education, and special studies.
-The WIC program screens all children until all marker immunizations are received. Those who are not adequately immunized must be referred to a health care provider or immunization clinic.
-Child care providers are required to check immunizations and refer as appropriate. Continued updates to the immunization schedules and number of doses necessary to bring children up-to-date have been made. Surveys of child care providers assessed vaccination rates in children attending child care settings and schools.
-The Perinatal Hepatitis B Program provided on-site record review to monitor compliance with PHL at NY birthing hospitals. Staff reviewed hepatitis B birth dose policies and offered training to hospital staff regarding immunization of parents and health care personnel. Surveys of birthing hospitals were completed to identify best practices for implementing the hepatitis B vaccine birth dose. This information was distributed to birthing hospitals.
-BI staff surveyed 17,000 NYS schools to obtain immunization rates of children in grades pre-K through twelve. Audits were also conducted of post-secondary institutions, schools, BOCES, Head Start programs, nursery schools and daycares. Many of those audited were targeted for previous remedial activity. As a result of the assessment, schools with deficiencies are identified, documented and, corrective measures are recommended.
-NYSIIS tracks all childhood immunizations administered in NYS. NYSIIS made several enhancements, including 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 4.4 million patients and 57.9 million immunizations.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. BI provided vaccines through the NY Vaccines for Children Program, assessed immunization rates and worked to improve		X	X	X

them, provided technical assistance to providers, disseminated educational materials, assisted providers.				
2. Under the AFIX Initiative, county staff visited pediatric providers and assess immunization records.			X	X
3. CPPSNs provided education and outreach to engage children into the health care system.		X	X	X
4. Article 6 State Aid to Localities reimbursed LHDs for the infrastructure that supports immunization surveillance, tracking, parent and provider education and special studies.			X	X
5. The CHWP educated parents about immunization, assessed the immunization status of children, referred and assisted families to obtain immunization, and followed-up with families to assure receipt of vaccines.		X	X	X
6. 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
7. The Perinatal Hepatitis B Program increased the universal birth dose in all birthing hospitals outside NYC to 78% by providing free vaccine for all children regardless of insurance coverage.			X	X
8. NYSIIS tracks childhood immunizations and experienced significant growth in this area along with increased numbers of registered and active pediatric providers.				X
9. 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
10.				

b. Current Activities

-Several enhancements are planned for NYSIIS, including of the clinical decision support tool, interoperability activities, a temperature log, billing functionality, and initiation of online VFC provider ordering. Data is being assessed for completeness, accuracy and timeliness and will be used to determine areas of need for additional activities.
-The Perinatal Hepatitis B Program will promote best practices for the universal birth dose of hepatitis B vaccine for all newborns.
-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 reporting of information. Online reporting of information will expand to day care centers and nursery schools for 2012-13. Feasibility of online reporting of information will be explored further to enhance reporting of immunizations.
-Immunization related information on childhood vaccines on the DOH immunization will be revised and increased to assist providers and parents to have children vaccinated in accordance with the Advisory Committee on Immunization Practices schedule.
-Public Health Law 2805-h was amended in 10/2012 to require birthing hospitals to offer Tdap vaccine to all caregivers of newborns.
-CPPSN, CHW and NFP Programs continue to promote well child care and immunization.
-Improving immunization rates was included as a priority focus area in the 2013-17 Prevention Agenda

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

LHDs with disease surveillance and outbreak control activities.
-BI will continue to enhance NYSIIS, including implementation of barcoding functionality, better coordination with BI's AFIX and VFC activities, new linkage with childhood data, and continued interoperability activities.
-Perinatal Hepatitis B Prevention Program (PHBPP) will develop and pilot test a hospital based assessment tool to assure proper storage and handling of the hepatitis B vaccine. The final tool draft will be shared with CDC for national distribution.
-NYS has multiple disease surveillance reporting systems 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 are largely unexplained and further study for data confirmation will be explored. PHBPP will draft a summary of findings outlining rationale for discrepancies and recommendations to close the 46% gap in epidemiological surveillance therefore improving the post-exposure prophylaxis care to infants born to hepatitis B chronically infected women.
-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 and will assist birthing hospitals to be in compliance with revisions to NYS regulation that mandates offering the Tdap vaccine to all parents and caregivers.
-The DOH Vaccine Program engages in ongoing policy development and updates to improve VFC provider compliance with CDC required vaccine storage and handling recommendations. Policy updates were made to The Provider Manual as well as The Fraud and Abuse Policy.
-DOH is amending the school immunization regulations to reflect current ACIP vaccine recommendations, incorporate by reference the recommended vaccination schedule, clarify medical exemptions, acceptable serology, what it means to be "in process", annual school immunization survey requirements, and also establish time limits for completion of needed immunizations.
-DOH works closely with regional and LHD staff on disease surveillance and outbreak control activities. Regional staff actively review Electronic Clinical Laboratory Reporting system (ECLRS) reports on a daily basis and are able to assess if counties have identified all positive laboratory reports and initiated an investigation when required. Once an investigation is determined to be a case, the DOH staff assesses all cases for completeness and quality of data.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	11	12.5	12.3	12	11
Annual Indicator	12.9	12.1	11.2	10.1	10.1
Numerator	5074	4687	4330	3811	3811
Denominator	392716	386720	386890	376774	376774
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
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	10	9.8	9.6	9.5	9.4

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.

Notes - 2010
2010 data have been updated and finalized since NYS's previous MCH block grant application submission. The NYS birth rate for teenagers aged 15 to17 was considerably lower than the national rate of 21.7 (2008).

a. Last Year's Accomplishments
-Vital Statistics data for 2011 demonstrated continued accomplishments and challenges in teen pregnancy and birth rates. The birth rate for teens aged 15 to17 declined to a new low of 10.1 per 1000 15 to 17 year olds. This represents 519 fewer births for teens age 15 to 17 in 2011 than in 2010. While significant geographic, racial and ethnic disparities in teen birth rates exist, the magnitude of the disparities is declining.
-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 $663 million in 2008 alone.
-Comprehensive Adolescence Pregnancy Prevention (CAPP) programs continued activities targeted to high-risk youth including implementing evidenced-based educational programs; ensuring access to Family Planning (FP); increasing skill-building opportunities for teens; and promoting community efforts to improve adolescent sexual health.
-Eight additional CAPP programs were funded through Personal Responsibility Education Program (PREP).
-DOH 's proposal was approved by Health and Human Services to use additional PREP funds to support one NYC foster care agency adolescent pregnancy prevention project designed specifically for the needs of youth in foster care. The project will also serve youth with emotional and behavioral problems.
-Abstinence Education Grant Program (AEGP) funding supported a new competitive procurement to fund 17 programs to implement mentoring and adult-supervised programs for high-risk youth ages 9-12 to begin in 2013.
-The ACT COE also 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.
-NY Promoting and Advancing Teen Health (NYPATH) provided training opportunities on adolescent sexual health for health care providers throughout the state that includes 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.
-In 2011, 50 FP providers reported that a total of 351,403 clients were served. 21% of the clients served in 2011 were adolescents between the ages of 15-19. There was a 7% increase in Hispanic as well as black adolescents (<20 years of age) using contraception. The agencies continue to provide comprehensive clinical, education and outreach services to NY's most vulnerable populations.
-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.
-Under the Affordable Care Act, DOH submitted a State Plan Amendment (SPA) to transform the

Family Planning Benefit Program (FPBP) and Family Planning Extension Program (FPEP) from 1115 waiver demonstration projects into Medicaid (MA) State Plan services. The SPA included a period of presumptive eligibility for FP services, which will enable clients to receive immediate access to reproductive health services and will reimburse providers for provision of those services while eligibility is determined; and adds medically-necessary transportation services for eligible clients. FPBP expansions will result in increased client access, especially for adolescents, who may request their information remain confidential and can apply for FPBP and FPEP based on their own income. FPEP provides MA coverage for FP services for women for a 2-year post-pregnancy period. The SPA was approved by the Centers for Medicare and Medicaid Services (CMS) in the summer of 2012.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CAPP & PREP programs continued activities targeted to high-risk youth including implementing evidenced-based programs; ensuring access to FP; increasing skill-building opportunities for teens; & promoting efforts to improve adolescent sexual health.		X	X	
2. DOHs proposal was approved by HHS to use additional PREP funds to support 1NYC foster care agency adolescent pregnancy prevention project designed specifically for the needs of youth in foster care.		X	X	
3. AEGP funding supported a new competitive procurement to fund 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 throughout NYS that includes development of a new web site. Website is designed for medical practitioners who provide healthcare services to adolescents.			X	
5. 50 FP agencies with 200 clinics provided free or low cost contraceptive services to nearly 351,403 women, men and adolescents, 21% of the population were teens.	X	X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

-CAPP and PREP conduct activities to include implementation of evidenced-based education programs; ensure access to family planning; increase skill-building opportunities for teens; and promote community efforts to improve adolescent sexual health.

-The ACT COE continues to provide training and ta to the CAPP and PREP programs on the implementation of evidence-based programming and will work with DOH to develop and conduct the evaluation for these projects, and will also provide training and technical assistance to community-based programs funded through the AEGP, and conduct the evaluation of these programs.

-DOH has begun implementation of the enhancement project targeting youth in foster care with PREP funds.

-RFA has been released and 17 awards were made to through the federal AEGP to support community projects 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 aged 9 to12 years who reside in targeted high-need communities.

-The FP COE continues to provide training, education and technical assistance to agencies on efforts to reduce unintended pregnancy by ensuring clients leave with effective contraceptive methods.
-The SPA was approved by the CMS in the summer of 2012. Maternal and Child Health will continue to collaborate with the Office of Health Insurance Programs on statewide implementation of the SPA.

c. Plan for the Coming Year
-Ongoing program activities to support a range of clinical and community-based services will continue as described under current activities.
-The ACT COE will continue to provide training and technical assistance to the CAPP and CAPP-PREP programs on the implementation of evidence-based programming 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 AEGP, and conduct the evaluation of these programs.
-COE evaluation and review of family planning focus group findings will be used to inform new adolescent pregnancy prevention procurement.
-AEGP funded community projects will begin 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 aged 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 NY; and continue enhancements to their web site..
-In collaboration with the Office of Health Insurance Programs, Maternal and Child Health will promote the FPBP and FPEP to engage clients in FP services at sites throughout the state.
-The FP COE will continue to provide training, education and technical assistance to providers to facilitate the use of best practices to improve the provision of services to adolescents.
-Reducing adolescent pregnancy rates was selected as a priority focus area in 2013-17 Prevention Agenda.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	40	28	39	40.9	42.7
Annual Indicator	27.0	38.1	41.9	41.9	41.9
Numerator	10534	3414			
Denominator	39014	8960			
Data Source	NYS 3rd Grade Dental Survey	NYS 3rd Grade Dental Survey	NYS 3rd Grade Dental Survey	NYS 3rd Grade Dental Survey	NYS 3rd Grade Surviellance 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?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	43.5	44.4	45.3	46.2	47

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.

Notes - 2010
The NYS 3rd Grade oral health surveillance project is currently in progress. 2006-2009 data is statewide data. Final 2009 and 2010 provisional data include upstate NY data only (excludes NYC.) It is anticipated that 2010 and 2011 data will be combined to increase the sample size and that this data will be released by the end of 2011.

2010 data have been updated and finalized since NYS's previous MCH block grant application submission.
Numerator and denominator data are not available.

a. Last Year's Accomplishments
-The number of schools with a School Based Dental Health (SBDH) program increased from 936 schools in 2011 to 953 schools in 2012. During the 2011-2012 school year 63,151 children in high need areas received oral health screenings through SBDH programs; 32.3% of children received protective sealants, with an average of 2.9 sealant applicants per child.
-Dental Health (DH) implemented a simple data reporting tool that can be easily administered and completed to capture data from both funded and unfunded SBDH programs on the number of children served and number receiving sealants. Data was submitted on sealant placement during the 2011-2012 school year by 45 of 55 programs (81.8%).
-Dental sealant services continue to be available at 28% of all schools eligible for a sealant program.
-The 3rd grade oral health surveillance project is continuing at elementary schools in both NYC and additional schools in Upstate counties. A draft report on the results of the 3rd grade survey for upstate NY counties and a preliminary analysis of data collected in NYC schools were completed.

-The prevalence of dental sealants among 3rd grade children continues to increase. Based on the results of the current third grade survey, 42% of children in Upstate schools had sealants, compared to 38% in the 2002-2004 survey; in NYC, 26.3% had sealants compared to 12.2% in 2002-2004.
-A stratified analysis by income showed that sealants increased from 42.5% to 44.9% among high income students and from 28.9% to 38.4% among low income groups in Upstate schools and from 15.4% to 34.7% in high income students and from 11.2% to 24.4% in low income students in NY City schools.
-The proportion of Medicaid (MA)-eligible children aged 6-to-9-years-old (when sealants are most frequently applied) receiving dental services who had a sealant placed on a permanent molar increased from 22.5% in 2010 to 23.8% in 2011.
-The percentage of dentists 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.
-Under grant funding from HRSA, a special project to integrate oral health prevention and treatment services into existing school health center programs was initiated. 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 CQI program and related assessment and evaluation forms.
-The annual performance objective of 42.7% of 3rd grade children receiving protective sealants on at least one permanent molar tooth was not met based on the data collected to date in the NYS 3rd Grade Oral Health Surveillance Project. Collectively, children in Upstate schools are close to meeting the performance objective, with 41.9% receiving sealants; the performance objective was met among high income groups (44.9%), but still has a ways to go among low income children (38.4%), despite a 38.9% increase in sealant placement since the 2004-2006 survey. Even with marked increases in sealant use among third grade children in NYC in both income groups, sealant placement continues to lag well behind that of Upstate 3rd graders.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. SBDH clinics provided services at 953 schools.	X		X	
2. Oral health screening services were provided to 63,151 children in high need areas throughout NY through SBDH clinic programs.	X		X	
3. 31 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 oral health surveillance project ongoing at NYS elementary schools in both Upstate counties and in NYC.			X	X
6. The HRSA SBHC dental clinic grant to integrate oral health services into existing school-based health centers at North County Children's Clinic in Jefferson County is operational.	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.
-Dental Health funds 31 of 55 programs for SBDH services to provide dental health services in

high risk, underserved areas of NYS. Between funded and unfunded, services are now available at 953 schools in high need areas.
-DOH is awaiting a response from the Center for Medicare/Medicaid Services (CMS) on allowable MA administrative expenses for certain costs of community water fluoridation.
-Difficulties finding dentists willing to complete the school dental certificate and provide services to Medicaid-eligible children prompted bills to be accepted in the Senate and House that authorize registered dental hygienists to sign a dental health certificate. The bills also add hygienists to the current list of dentists providing dental services on a free or reduced cost basis that schools must make available to parents upon request.
-The 2013 NYS Oral Health Plan and the DOH Prevention Plan both target the reduction of dental caries disease among third grade children.

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 (FV) 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 DHC, 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.
-Dental Health will continue to monitor the utilization of dental services by children and adolescents and the types of services received.
-Dental Health 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.
-Dental Health 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.
-Improving children's access to oral health services and increasing appropriate level of fluoridation in community water systems are priority focus areas in the 2013-27 Prevention Agenda.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	0.9	1.3	1.2	1	1.3
Annual Indicator	1.2	1.0	1.3	0.8	0.8
Numerator	43	37	47	29	29
Denominator	3604140	3633448	3531233	3515032	3515032
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
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	0.8	0.8	0.7	0.7	0.7

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.

Notes - 2010
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 have been updated and finalized since NYS's previous MCH block grant application submission.

a. Last Year's Accomplishments
-NYS had made great strides in this measure. The rates of death to children aged 14 years and younger caused by motor vehicle crashes decreased from 1.3 per 100,000 children in 2010, to 0.8 per 100,000 children in 2011.
-The Bureau of Occupational Health and Injury Prevention (BOHIP) is a lead member of the NY Child Passenger Safety Advisory Board. The Communications/Public Outreach Committee of this advisory board developed and coordinated a statewide "Sit, Click, Ride-Always Buckle Up" child passenger safety campaign targeting children ages 8-12 and their parents that was conducted during National Child Passenger Safety Week.
-BOHIP 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, motorcycle and bicycle safety.
-BOHIP participated in a workgroup to promote, develop and implement "Bike to School" Day activities on May 9th during National Bike Month and on June 1st. Staff served as the liaison between the planning committee and local public health partners and provided assistance with event planning, bicycle safety education and helmet fitting activities at several events in May.
-The DOH sponsored the 2012 "Walk/Bike New York" Symposium that took place on 9/18/12 in Glens Falls, NY. The Symposium provided a forum for over 100 public health, traffic safety, transportation, enforcement, planning and economic development partners to discuss research and best practices and highlight programs to improve pedestrian and bicycle transportation and recreation efforts statewide. Creating walkable and bikeable communities helps reduce obesity, chronic diseases and injuries and death from pedestrian and bicyclist crashes with cars. The Symposium was a great opportunity to learn how others have been able to make significant changes in these areas.
-BOHIP represented the DOH on the Hempstead Turnpike Pedestrian Safety Team that was

convened by the NYS Department of Transportation in response to the increased number of pedestrian crashes that occurred on the 16 mile stretch of roadway in Nassau County between 2008 and 2011 (232 crashes between, resulting in 17 pedestrian fatalities). The Team worked together to develop solutions for the Hempstead Turnpike utilizing a variety of engineering, education and enforcement strategies to improve pedestrian safety. Staff assisted in the identification of educational strategies and materials appropriate for this initiative. Both short and long term measures were considered and the BOHIP will continue to assist with the development and implementation of a pedestrian safety initiative that will complement the Hempstead effort. A press event s held on May 7th in Nassau County and was attended by representatives from federal, state and local partner agencies who discussed the measures that have been implemented to improve pedestrian safety on and around the Turnpike, per the recommendations of the team. A press release was also issued and included information about the formation of the team and its member agencies. It also provided background data and a description of the safety strategies that have been implemented and further plans to expand those efforts to a broader geographic region.
-The Community Health Worker (CHWP) has extensive child safety components, which stress car seat use and other infant safety measures. Parents enrolled in this program are also given extensive information about childhood safety. Homes are assessed for hazards and workers model positive parenting skills and behaviors.
-Effective January 1, 2012, NYS' Move Over Law was changed. This law protects law enforcement officers, emergency workers, tow and service vehicle operators and other maintenance workers stopped along roadways while performing their duties. Under this law, drivers must use due care when approaching an emergency vehicle that displays red and/other white emergency lighting by reducing speed and changing lanes when it is safe to do so.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Effective January 1, 2012, NY's Move Over Law was changed.			X	X
2. BOHIP promoted toolkits and fact sheets to provide up-to-date data, best practices and evidence-informed programs to reduce unintentional injuries.		X		
3. The Child Passenger Safety Advisory Board developed a statewide "Sit, Click, Ride-Always Buckle Up" child passenger safety campaign targeting children ages 8-12 and their parents that was conducted during National Child Passenger Safety Week.		X	X	
4. BOHIP participated in a workgroup to promote, develop and implement "Bike to School" Day activities on May 9th during National Bike Month and on June 1st.		X		
5. The DOH sponsored the 2012 "Walk/Bike New York" Symposium that took place on September 18th in Glens Falls, NY.		X		
6. BOHIP represented the DOH on the Hempstead Turnpike Pedestrian Safety Team that was convened by the NY Department of Transportation.		X		X
7. The CHWP has extensive child safety components, which stress car seat use and other infant safety measures.		X		
8.				
9.				
10.				

b. Current Activities

-BOHIP hosted an Injury Community Planning Group meeting for traffic safety stakeholders to enhance NY's injury infrastructure. The Child Injury Prevention Policy Subgroup also met. A major goal of this policy subgroup is to educate decision makers/public health professionals about safety benefits for children ages 12 and under to ride properly restrained in the back seat of a motor vehicle. NY law requires children to be properly restrained but does not require them to be in the back seat.
-BOHIP provided the Governors Traffic Safety Committee (GTSC) with fact sheets for all NY counties. These fact sheets demonstrate the injury burden for unrestrained passengers. The fact sheets will be distributed to law enforcement in the counties and posted on the NY State Police Intranet. This is part of the May Mobilization around the importance of proper restraint use.
-BOHIP in collaboration with the GTSC, the NYS Association of Chiefs of Police and the Federal Highway Administration began efforts to conduct Pedestrian and Bicycle Law Enforcement Training to improve pedestrian and bicycle safety throughout Nassau County. The provision of this training resulted from the efforts of the Hempstead Turnpike Pedestrian Safety Team that was formed by the NYS Department of Transportation to address the high incidence of pedestrian injuries and fatalities over the past several years.

c. Plan for the Coming Year
-The Injury Community Planning Group will continue to meet to enhance injury infrastructure in NY, including childhood and motor vehicle safety and the continued development of the NY Injury Action Plan.
-The Child Injury Prevention Policy Subgroup will continue to meet.
-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.
-BOHIP will continue to collaborate with the NY Safe Routes to School Network, the NYS Association of Traffic Safety Boards, SAFE KIDS Worldwide and the NY Bicycle Coalition to promote helmet use at a variety of traffic safety and bicycling promotion events. Staff will work with these agencies to incorporate helmet distribution, helmet fitting and bicycle safety education at a variety of annual events. Event opportunities to incorporate bicycle helmet safety may include, but are not limited to Safe Kids Week, child passenger safety check up events, or "Bike to School Day" events.
-Community-based home visiting and other maternal and infant health initiatives will continue to emphasize injury prevention and motor vehicle safety.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	51	44.5	45.5	47.9	48.3
Annual Indicator	49.4	47.4	47.7	47.7	53.7
Numerator					
Denominator					
Data Source	National	National	National	National	National

	Immunization Survey - breastfeeding suppl	Immunization Survey	Immunization Survey	Immunization Survey	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
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	53.9	54	54.2	54.6	54.8

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.

Notes - 2010
2010 data have been updated and finalized since NYS's previous MCH block grant application submission. 2010 data represents the 2008 birth cohort.

a. Last Year's Accomplishments
-Breastfeeding (BF) at 6 months increased in NYS from 47.7% in 2010 (2008 births) to 53.7% in 2011 (2009 births); both of these percentages exceed the U.S. national averages in 2010 (43.0%) and in 2011 (47.4%) (Data are from the BF Report Card--US, 2012 and 2011).
-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 percent of infants also fed formula in the hospital). Each hospital was informed of its performance relative to other hospitals. Rates were posted on the DOH webpage.
-Ten Steps to Successful Breastfeeding: An Online Course was offered to staff in 92 hospitals (exclusive of NYC) providing maternity care services; staff from all 92 hospitals completed this course which meets the staff education requirement for Baby Friendly Hospital Designation.
-DOH completed the pilot of the NYS Breastfeeding Quality Improvement in Hospitals (BQIH) Learning Collaborative with 12 hospitals outside of NYC. Hospitals learned fundamentals of

quality improvement and used the Institute for Healthcare Improvement (IHI) Breakthrough Series Methodology to improve maternity care practices. Eleven of 12 hospitals eliminated the distribution of formula samples, formula coupons, and educational materials provided by formula companies to breastfeeding mothers at the time of discharge. Nine hospitals discontinued this practice as part of their BQIH work. The average prevalence of infants who were exclusively fed breast milk across all hospitals in the project was 41.4% in November 2011, up from a June 2010 baseline of 33.8%. Over the 18 month collaborative, there was a mean increase of 22% in exclusive BF and significant increases in BF initiation and rooming-in > 18 hours/day. NYS BQIH is the foundation for the CDC's Best Fed Beginnings Initiative. In addition, the NYC Department of Health and Mental Hygiene (NYCDOHMH) engaged 9 hospitals in a Baby Friendly Hospital Learning Collaborative. DOH staff supports this collaborative through provision of faculty and coaching to hospital improvement teams.
-Making it Work: Returning to Work Toolkit to support hourly wage earners was developed from field research conducted in WIC agencies and businesses. Drafts were completed and approvals received.
-The US Department of Agriculture (USDA) Food and Nutrition Service (FNS) Loving Support through Peer Counseling: A Journey Together was implemented in the WIC Program. All state and local staff were trained on managing the program and using the new curriculum platform.
-Training offered to WIC staff on preparing for the International Board of Certified Lactation Consultants (IBCLC) exam resulted in doubling the number of WIC staff with the IBCLC credential bringing the total to 81.
-WIC revised and updates www.breastfeedingpartners.org website to be participant centered and include the most recent breastfeeding best practices.
-DOH's Medicaid (MA) Proposal for coverage of specifically trained lactation consultants was accepted. This benefit, recommended by the United States Preventive Services Task Force (USPSTF), is an evidence-based intervention to increase breastfeeding initiation, exclusivity, and duration through structured education and counseling.
-Hospital BF policies were codified and compared with the 2009 review. Hospitals were notified of inclusion of required components. Hospitals that did not include all required components were asked to revise their policies and resubmit to DOH. Eight of 132 hospitals had all 28 required components in their written policy.
-CHWP provides home visiting services to high risk pregnant and parenting families. CHWs provide a myriad of information and support, including support for breastfeeding. NFP programs provided support to first time mothers, including support for breastfeeding.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Using the Statewide Perinatal Data System (SPDS), 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 statewide.			X	
3. DOH completed the pilot of the NYS BQIH Learning Collaborative with 12 hospitals to improve policies, systems, and practices consistent with the recommended Ten Steps to Successful BF.			X	X
4. NYCDOHMH recruited and engaged 9 hospitals in a Baby Friendly Hospital Learning Collaborative using the BQIH Model.			X	X
5. Hospital BF policies were codified. Hospitals were notified of inclusion of required components. Hospitals that did not include all of the required components were asked to revise their policies				X

and resubmit to DOH.				
6. The Making it Work: Returning to Work Toolkit to support hourly wage earners was developed from field research conducted in WIC agencies and businesses. Drafts were completed and approved.		X	X	X
7. WIC state and local staff were trained on the USDA FNS Loving Support through Peer Counseling: A Journey Together curriculum		X		
8. WIC offered the IBCLC Prep Course resulting in a significant increase in staff holding the IBCLC Certification.		X		X
9. WIC revised breastfeedingpartner.org to be participant centered and include breastfeeding best practices.		X		X
10. DOH's proposal for MA Coverage of Lactation education and counseling was accepted.		X		

b. Current Activities

-Widespread dissemination of Making it Work: Returning to Work Toolkit is planned through posting to breastfeedingpartners.org & DOH public webpage. WIC and CBO staff were trained in using the toolkit. Promotional activities will be conducted including social media through DOH & the NY Statewide BF Coalition.
-USDA FNS Loving Support through Peer Counseling: A Journey Together curriculum will be completed & disseminated to WIC clinics and partners.
-DOH is implementing a large scale initiative in Erie County focusing on improving BF exclusivity & duration from hospital discharge through 6 months. This initiative includes establishing Baby Cafés, improving the system of care for Community Health Workers to ensure timely visitation for BF mothers, increasing the number of BF friendly childcare centers & homes & improving the designation process, & designing and testing tools for the NYS BF Friendly Practice Designation.
-The Community Health Worker Program provides home visiting services to high risk pregnant & parenting families. CHWPs provide a myriad of information and support, including support for BF.
-The Nurse Family Partnership (NFP) provides support & services to first time mothers. One of NFP's goals is to improve healthy behaviors by pregnant women & new mothers, including support for breastfeeding.
DOH will work with partners statewide to guide implementation of the MA State Plan Amendment for BF Education & Counseling.

c. Plan for the Coming Year

-Continued expansion of the WIC Peer Counselor program to include hospital, healthcare provider, and community visits is planned.
-Continued training to improve competencies of WIC staff in BF assessment, support and counseling will occur.
-The NYS BF Friendly Practice Designation will be spread statewide.
-DOH will continue to work with key partners to encourage coverage for BF education and counseling coverage by private insurers.
-Given the success of the NYS BQIH pilot project, a new cohort of 27 teams will be engaged in the quality improvement process.
-DOH will examine lessons learned and best practices from the community based interventions in Erie County and spread this work to other communities throughout the state.
-Collaboration will continue among Title V staff, Divisions of Nutrition and Chronic Disease and NYCDOHMH to educate providers, assist hospitals with the implementation of baby friendly policies and practice, and to link women with home visiting programs to educate and assist with support for BF.
-DOH community-based maternal and infant health programs, including home visiting will continue to promote and support BF to high-risk woman.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	98.7	99.1	99.6	99.5	99.5
Numerator	244630	244545	239116	229377	229377
Denominator	247928	246647	240169	230608	230608
Data Source	Newborn Hearing Screening Program	Newborn Hearing Screening Program	Newborn Screening	Newborn Screening	Newborn Hearing 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	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	100	100	100	100	100

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.

Notes - 2010
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

a. Last Year's Accomplishments
-The percentage of NY newborns screened for hearing loss before hospital discharge (99.4%) far exceeds both Healthy People 2020 baseline (82%) and target (90.2%) for screening newborns at no later than 1 month of age.
-DOH received the second of three years of funding from the CDC for the Early Hearing Detection

and Intervention (EHDI) Tracking, Surveillance, and Integration project. DOH is improving its mandated Newborn Hearing Screening (NBHS) Program by linking existing child health data systems within DOH to better track individual level hearing screening and audiologic data and referral information.
-State legislation was enacted on 1/11/11 which requires hospitals and other health care providers that perform or order newborn infant hearing screenings to report results through a statewide information system, authorizes the collection and storage of newborn infant hearing screening results and data in a statewide information system, and authorizes access to such data in order to increase newborn infant hearing screening rates and improve the completeness and accuracy of newborn infant hearing screening data. The data system, New York Early Hearing Detection and Intervention Information System, (NYEHDI-IS) is being developed as part of a larger Child Health Information Integration (CHI2) initiative and will contain individual, identifiable records on infants including their initial hearing screening, follow-up for those who did not pass the initial hearing screening and any diagnostic and early intervention activities deemed necessary as a result of the screenings. The information system has been designed and the actual creation of the system commenced just after the close of this reporting period.
-DOH was previously authorized to collect aggregate data on NBHS results each quarter for all infants born in NY. The collection of aggregate data alone has significantly impacted DOH's ability to follow-up on infants who potentially have a hearing loss. Since July, 2011, individual data has been reported to DOH via the Statewide Perinatal Data System (SPDS) on initial hearing screening for newborns in birthing facilities outside NYC. Since October 2011, initial screening results on infants born in NYC have been collected via the Electronic Vital Events Registration System (EVERS). These data will be linked to the NYEHDI-IS in the future.
-DOH received grant funding from HRSA to expand and improve the NYEHDI program to assure quality developmental outcomes for infants identified with hearing loss.
Focused discussions were held in various locations throughout the State in which audiologists were asked about their knowledge of new reporting requirements regarding hearing screening and follow-up as well as their preferred method for learning more about this and other issues related to NYEHDI.
-As part of this grant, parents of infants and children who have significant hearing loss were sought in order to establish a chapter of Hands &Voices, a nationally recognized family support group for individuals who have been diagnosed with significant hearing loss and their families. An Executive Board was established and a 2-day training was presented by the National organization on the steps necessary to establish a State chapter. Provisional chapter status was achieved during this reporting period.
-An upstate EHDI Symposium was held in Syracuse in February 2012 to educate pediatricians and audiologists on the importance of early identification and intervention and other issues related to EHDI program and updates specific to NYEHDI.
-In an effort to further educate pediatricians on issues related to EHDI, the importance of early identification and intervention, and new reporting requirements, a one-hour training in DVD format was produced. The NYEHDI program manager and one of the New York State Academy of Pediatrics' Chapter Champions narrated the DVD, which was distributed to approximately 10,000 pediatricians and family practitioners within NYS

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 statewide perinatal data system (SPDS) outside NYC and EVERS within NYC.			X	
2. DOH received CDC funding for the EHDI Tracking, Surveillance, and Integration project to improve its EHDI Program.				X

3. DOH is improving this program by linking existing child health data systems within DOH to better track individual level screening and audiologic data and referral information.				X
4. DOH received grant funding from HRSA to expand and improve the EHDI program to assure quality developmental outcomes for infants identified with hearing loss.			X	X
5. Discussions were held with audiologists in three locations in the State to assess their knowledge of EHDI and their new reporting responsibilities for infant hearing screening and follow-up.				X
6. An Executive Board was established for a family support group for families who have infants with hearing loss. National office provided training on essential activities needed to start the chapter.			X	X
7. A Symposium was held to educate pediatricians and audiologists on issues related to EHDI and updates specific to NYEHDI.				X
8. A DVD was produced to educate pediatricians and family practitioners on the importance of early identification and intervention for patients with significant hearing loss.				X
9. DVD was distributed to approximately 10,000 primary care providers in NYS.				X
10.				

b. Current Activities

-The DVD is being used to create a learning module training on EHDI for pediatric medical residents.

-The base application of the NYEHDI-IS has been developed and tested. It is being adapted to accommodate vital records for facilities outside of NYC and the data are uploaded nightly. At this time, the system is being used by birthing hospitals outside of NYC only. SPDS data are pre-populating the initial hearing screening result when available. Extensive training and outreach has occurred with this user group.

-The work to establish Hands & Voices of NY as a self-sustaining parent support group continues. 501 (c)(3) status has been achieved. An Executive Board has been established and meets regularly.

c. Plan for the Coming Year

-NYEHDI continues to show strong performance in the provision of initial hearing screening at birthing hospitals for all babies prior to discharge. More than 99% of babies have been screened prior to discharge. NYEHDI is committed to ensuring that all babies who miss their initial screening or did not pass the initial screening receive follow-up screening as quickly as possible to insure that they receive early intervention.

-The progressive launch of the NYEHDI-IS continues. Audiologists and primary care providers outside of NYC will begin reporting soon.

-DOH is preparing a Notice of Proposed Rulemaking seeking to change regulations for the Early Hearing Detection and Intervention Program to conform with the legislation passed in 2012. These revised regulations will include changes needed to collect individual level data and other corrections which have been learned over the last decade of working closely with hospitals to improve screening performance to support improved practices by facilities.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	8	8.5	8.4	7.4	7.4
Annual Indicator	7.1	7.5	7.9	6.6	6.6
Numerator	310000	335000	350000	284000	284000
Denominator	4373000	4465000	4418000	4291000	4291000
Data Source	Current Population Survey	Current Population Survey	Current Population Survey	Current Population Survey	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
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	6.5	6.4	6.3	6.2	6.1

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.

Notes - 2010
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

a. Last Year's Accomplishments
-The percentage of NY children in 2011 without health insurance (6.6%) is significantly lower than the national percentage of 9.4% and has improved from 7.9% in 2010.
-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, 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 6.6% in 2011. The number of uninsured NY children is steadily declining from 434,000 in 2007 to 284,000 in 2011.
-Effective 11/1/11, NY expanded MA eligibility for children age 1 through 18 to 133% and used Express Lane Eligibility to transition these children from CHPlus to MA.
-Facilitated Enrollers (FEs) provided application assistance to those who were seeking MA or CHPlus which accounted for over 460,000 applications submitted annually. FEs provide assistance to applicants in 60 languages. Currently, 40 community-based organizations and 13 health plans serve as FEs.

-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. NY expanded MA eligibility for children age 1 through 18 to 133% and used Express Lane Eligibility to transition these children from CHPlus to MA			X	X
2. All MCHSBG- funded programs are required to facilitate enrollment in public insurance programs. Facilitated enrollers provided application assistance MA or CHPlus in 60 languages, accounting for over 460,000 applications submitted annually.		X	X	X
3. Many CPPSNs are facilitated enrollers for health insurance programs.			X	X
4. 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	X
5. The CHWP assists any child or member of an enrolled family to access health insurance.		X		
6. 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		X
7.				
8.				
9.				
10.				

b. Current Activities

-NY provides insurance to nearly 2.0 million (46%) children. MA covers over 1.7 million; CHPlus covers almost 290,000.
-NY is building a Health Benefit Exchange; a web based eligibility and enrollment system. The Exchange will help individuals, families and businesses shop and enroll in health insurance and make Advance Premium Tax Credit /Cost Sharing Reduction eligibility determinations.
-The Call Center for MA/CHPlus/FHPlus is adding counties for renewal processing including mail in and phone applications for some populations outside NYC.
-Forty CBOs and 13 health plans perform FE.
-NYSDOH recently released a RFA for Assistor/Navigator Program to provide in-person culturally competent, linguistically appropriate and disability accessible insurance application assistance to begin 2013 and replace FE.
-CHPlus increased benefits for children with autism spectrum disorders.
-Connections to Coverage campaign will continue. The purpose is to increase awareness of public health insurance through community/provider partnerships to link uninsured

children/families to FE.
-All MCHSBG-funded programs assist with public insurance enrollment of children.
-Federal law prohibits children with access to state health benefits from enrolling in the Children's Health Insurance Program. An ACA provision allows states to cover these children if they meet 1of 2 maintenance of effort provisions. NY is exploring this option to better ensure health care coverage for all NY's children.

c. Plan for the Coming Year
-Effective 10/1/13, open enrollment for health insurance purchased through the Exchange will begin for coverage effective January 1, 2014.
-New York will continue to work to meet the requirements of the Affordable Care Act (ACA) and full operation of the Exchange.
-MCHSBG funded programs will continue to assess insurance status of children served and with assist with enrollment in public insurance and referral to the Exchange.
-Through the Connections to Coverage campaign, NY will continue to increase awareness of the availability of public insurance programs and enrollment support through unique collaborations with community-based organizations, faith-based organizations, schools and health and human service providers.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	30	29	29	31.5	31.2
Annual Indicator	32.0	31.8	31.5	31.2	30.4
Numerator	67108	71274	70636	72042	58819
Denominator	209713	224130	224243	230903	193464
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
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	30.3	30.2	30.1	29.9	29.6

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

Notes - 2010
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

a. Last Year's Accomplishments

-Annual pediatric nutrition indicators and trends were posted to the DOH website. Obesity prevalence among child WIC participants continued to decline. The PedNSS and PNSS records were linked to create individual records of mother child pairs to examine perinatal factors associated with infant and child weight status.
-The NYS WIC Program continued implementation of a 3 year Special Projects Grant WIC Retention Promotion Study (RPS) from USDA to identify and develop innovative strategies for retaining eligible participants in the WIC program. Three strategies to increase the percentage of families with infants who continue participation beyond age 1 year were developed and are being tested in selected agencies.
-DOH is collaborating with Columbia University and Public Health Solutions on 1st Steps, a 5 year evaluation of WIC obesity prevention initiatives. Results of a cross-sectional analysis of child participants' records indicated that changes to the prescribed foods did change what children eat and the percent of child participants who are obese declined from pre to post food package changes.
-WIC staff evaluated labels for > 2,700 foods for an updated acceptable foods card with the goal of reducing sodium, sugar and saturated fat and increasing whole grains.
-To support achievement of QUALITYstarsNY standards for nutrition, physical activity, screen time reduction and breastfeeding support, the Obesity Prevention Program (OPP) and Child and Adult Care Feeding Program (CACFP) worked with the Early Childhood Advisory Council/Promoting Healthy Development Workgroup to compile on-line tools and resources to assist Early Childhood Education providers in achieving the standards.
-Collaborated with the Office of Children and Family Services (OCFS) to develop policy proposals, including possible regulatory changes for meal and beverage standards, physical activity for infants and children, and screen time and content in child care settings.
-Eat Well Play Hard in Child Care Settings (EWPHCCS), a practice-tested intervention, continued in 225 low-income CACFP-participating centers and 16 NYC elementary schools, reaching 11,078 children. EWPHCCS has been shown to increase daily consumption of vegetables, child-initiated vegetable snacking and use of low-fat milk at home.
-Eat Well\Play Hard in Day Care Homes (EWPHDCH) targets day care home providers as the primary audience and the children and their parents as secondary target audiences. Providers focus on increasing the variety of fruits and vegetables offered and increasing opportunities for adult-led structured play. EWPHDCH reaches 128 day care homes serving approximately 1,000 children/year.
-From 2005 to 2012, 135 child care centers and 372 family day care homes participating in CACFP earned the "Breastfeeding Friendly" designation and all 500 Head Start programs in NYS are working towards earning the designation.
-The OPP completed a 5 year implementation of the Nutrition and Physical Activity Self-Assessment for Child Care (NAPSACC) to model adoption of obesity prevention best practices in child care and conducted 2 evaluations. Over the 5 years NAPSACC was implemented in 254 child care centers and homes with an estimated reach of 2,247 staff and 11,435 children. Evaluation results indicated that providers who completed the NAPSACC intervention improved practices. Sustained improvements at 2 and 3 years post-intervention were associated with having written policies. The utility of the NYS-developed Media Reduction Module was demonstrated in day care homes, but not in day care centers, as centers had already eliminated or reduced screen media use.
-DOH engaged 9 contractors to work with 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 IHI Breakthrough Series to implement system change within recruited practices to improve obesity screening assessment and prevention at well child visits for children ages 2-18.
-NYS Health Commissioner established a Pediatric Obesity Prevention Workgroup to mobilize a cross agency effort to prioritize, implement and evaluate proven population based, policy, systems and environmental strategies to prevent and control childhood obesity.

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 development of resources and site visits to assess level of intervention implementation.		X	X	X
3. Implementation of First Steps WIC evaluation study in collaboration with Columbia University and Public Health Solutions.		X		X
4. Continued to strengthen nutrition standards for the NYS WIC Food Package through the analysis of sodium, sugar, saturated fat, and whole grain levels of potential foods for the WIC acceptable foods list.				X
5. Provided technical assistance resources to support implementation of QUALITYstarsNY standards re: nutrition, physical activity, screen time and breastfeeding support.				X
6. Collaborated with the OCFS to develop proposed child care regulations consistent with obesity prevention best practices specified in Caring for Our Children- 3rd Ed.				X
7. Completed 5-year implementation of NAPSACC and evaluated sustainability of practice improvements and utility of media reduction module.				X
8. Implemented EWPHCCS in 225 additional low-income CACFP participating centers &16 NYC elementary schools, reaching 11,078 children & EWPHDCH in 128 homes reaching 1,000 children. Increased the number of Breastfeeding Friendly child care providers.		X	X	
9. Established primary care learning collaboratives to build system capacity to provide guideline concordant care for the prevention of pediatric overweight and obesity.				X
10. A Commissioner's Pediatric Obesity Prevention Workgroup was convened to mobilize and coordinate cross agency efforts to prevent and control childhood obesity.				X

b. Current Activities

-Monitor trends through PedNSS and PNSS in overweight/obesity, breastfeeding and TV time for children and pre-pregnancy weight status/pregnancy weight gain; analyze linked mother/ infant data.
-WIC RPS: Implement strategies to improve WIC families' shopping experience and facilitate using all WIC benefits.
-First Steps: Analyze the Actical data and complete a longitudinal analysis of infants enrolled prior to and following implementation of the new WIC food package.
-Develop a change package and data measurement plan for the OPPHCS Learning Collaborative to be used by practices to test changes and identify best practices to improve screening, assessment and prevention of obesity at well child visits.
-Convene the Obesity Prevention in Child Care Partnership to provide guidance and recommend strategies to support obesity prevention in child care settings.
-Provide training and resources for the implementation of Quality Stars NY standards including nutrition, physical activity, screen time/content limits and breastfeeding.
-Deploy Early Childhood Physical Activity Specialists to provide physical activity training and TA in the child care system.

-Work with OCFS to support the adoption and implementation of proposed child care regulations for meal and beverage standards, physical activity, and screen time/content.
-Expand environmental change strategies in EWPHCC.
-Reducing childhood obesity was included as a priority area of focus in the 2013-17 Prevention Agenda.

c. Plan for the Coming Year
-Continue to produce PedNSS and PNSS data reports and disseminate results with a focus on indicators of child and maternal obesity.
-Analyze and interpret qualitative and quantitative data, with a focus on the measureable outcomes check utilization and retention rates, from the WIC Retention Promotion Study. Results will be used by the WIC program to make policy and procedure changes to provision of WIC services if warranted.
-Analyze survey data and disseminate the results of the longitudinal analysis of the First Steps initiative.
-Based on a WIC local agency staff training needs assessment conducted in 2012, add new trainings in 2013-2014 to address breastfeeding support and growth monitoring for infants and children.
-Evaluate and assess effectiveness of WIC training modalities focused on obesity prevention and healthy lifestyles.
-Revise WIC nutrition policies, based on best practices and evidence based strategies, to strengthen participant centered nutrition assessment and education, and promotion of breastfeeding for WIC participants.
-Continue to assess WIC local agency needs and provide guidance, technical assistance and peer support in providing obesity prevention strategies and healthy lifestyles.
-Work with OCFS to provide training and technical assistance to licensing staff and child care providers on proposed nutrition, physical activity, and TV/screen time child care regulations.
-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- 18.
-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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	14	13	12	8.1	7.1
Annual Indicator	8.2	7.6	6.9	6.9	6.9
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
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	6.9	6.8	6.8	6.7	6.7

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.

Notes - 2010
Data source is the Pregnancy Risk Assessment and Monitoring Survey (PRAMS). Numerator and demonminator data are not available. Data reported for 2006 and 2007 were for NYS (excluding NYC). CDC recently provided statewide statistics for this indicator. Statewide 2006 and 2007 data are therefore now available. The comparable statewide percentages for 2006 and 2007 are 8.5% and 9.1% accordingly. 2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

a. Last Year's Accomplishments
-From 2004 to 2012 the statewide percentage of women smoking during the last 3 months of pregnancy declined dramatically statewide.
-Efforts to reduce smoking in pregnant women are a part of DOH's multi-pronged efforts to reduce smoking in the general public and included a coordinated set of evidence-based activities implemented primarily by the Tobacco Control Program (TCP), in partnership with other public health programs, including Title V programs, and external partners.
-Community Partnerships worked to change the community environment to support the tobacco free norm for all community members, Youth Action partners worked with youth activists to change community norms and de-glamorize and de-normalize tobacco use, and Cessation Centers worked with health care organizations to implement systems to screen patients for tobacco use and provide help.
-Statewide media and counter marketing provided education about the health risks of tobacco use and the dangers of second hand smoke, motivating tobacco users to stop, and promoting use of the NY Smokers' Quitline and Quitsite (1-866-NY-QUITS, www.nysmokefree.com). Educational materials for pregnant women were disseminated.
-Counter-marketing efforts sought to expose marketing practices of the tobacco industry, de-glamorize tobacco use, and build and sustain a tobacco-free norm.
-MA continued to provide coverage for smoking cessation counseling for pregnant and postpartum women and adolescents to age 21. Smoking cessation counseling complements existing MA covered benefits for prescription and non-prescription smoking cessation products and programs. Education and outreach activities to prenatal care providers were conducted to inform them of this new coverage.
-MA prenatal care providers continued to promote healthy behaviors during pregnancy and provide information regarding the impact of smoking on the pregnant woman and the fetus and have developed various programs to deal with smoking, including individual counseling and referrals to group or other programs that support smoking cessation.
-All SBHCs screened for tobacco use as part of the initial health assessment of all enrolled students. Students (and in particular pregnant students) who use tobacco are either referred to a tobacco cessation program within the community or receive such services directly from SBHC

staff.
-CPPSNs continued to provide education and training to health and human services providers on ways to assist women to enhance healthy behaviors, including smoking cessation. Activities included Baby and Me Tobacco Free Smoking Cessation Programs, Text Message Smoking Cessation Support for Teens, and online training on Smoking Cessation for Women.
-The CHWP provided education for pregnant and postpartum women to increase their understanding of risky behaviors, including the use of tobacco, and provision of appropriate referrals for those seeking assistance in this area. Nurse Family Partnership (NFP) also promoted healthy behaviors in first time mothers, including smoking cessation.
-Family Planning (FP) Programs screened for tobacco use and referred for smoking cessation.
-Migrant and Seasonal Farm Worker Health programs and American Indian Health Program (AIHP) providers screened for tobacco use and made appropriate referrals.
-SBHC- dental staff screened all enrollees, including pregnant adolescents, for tobacco-use, provided counseling and made appropriate referrals.
-Local WIC agencies are required by policy to screen all prenatal, postpartum and breastfeeding participants regarding their use of tobacco.
-Consumer input in all program areas is garnered through satisfaction surveys, education and training programs, and support groups such as Baby and Me Tobacco Free Smoking Cessation Programs.
-MRT recommendations to address Health Disparities included an analysis that a $10 investment per person per year in prevention programs has the potential to save $1.3 billion annually, and have resulted in lower rates of diseases related to smoking, nutrition and physical activity. The MRT also recommended providing MA coverage for a dedicated preconception visit for MA-eligible women and adolescents of reproductive age, particularly those with chronic health conditions that can adversely impact pregnancy.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Prenatal care providers provided information on the impact of smoking and developed programs to deal with smoking, including individual counseling and referrals to group or other programs that support smoking cessation.		X	X	
2. MA prenatal care providers provided information regarding the impact of smoking on the pregnant woman and the fetus and MA covers cessation counseling and prescription and non-prescription smoking cessation products.			X	
3. CPPSN provided education and training to health and human services providers on ways to assist women to enhance healthy behaviors, including smoking cessation.			X	
4. CHWP staff provided education for pregnant and postpartum women to increase their understanding of behaviors that pose a risk to health, including the use of tobacco, and provision of appropriate referrals.			X	
5. Migrant and Seasonal Farm Worker Health programs and AIHP providers screened for tobacco use and made appropriate referrals.	X	X	X	
6. SBHC staff screened all enrollees, including pregnant adolescents, for tobacco-use, provided counseling and made appropriate referrals.	X			
7. Local Women, Infants and Children (WIC) agencies are required by policy to screen all prenatal, postpartum and BF	X	X		

participants regarding their use of tobacco.				
8. Education and outreach activities to prenatal care providers and community based programs were conducted to inform them of MA coverage for smoking cessation for pregnant and postpartum women and adolescents to age 21.		X		X
9. Consumer input occurs through satisfaction surveys, education and training programs, and support groups such as Baby and Me Tobacco Free Smoking Cessation Programs.		X		
10.				

b. Current Activities

-The multi-pronged activities described for the 2011-2012 year have continued.
-Consumer input continues to occur through satisfaction surveys, education and training programs and support groups such as Baby and Me Tobacco Free Smoking Cessation Programs.
-The TCP contracts with an independent evaluator to evaluate programmatic efforts.
-Education and outreach activities to prenatal care providers continue to inform them of MA coverage for smoking cessation for pregnant and postpartum women and adolescents up to age 21 continue.
-Reducing preterm births and reducing tobacco use was selected as a priority are of focus in the 2013-27 Prevention Agenda.

c. Plan for the Coming Year

-The multi-pronged activities described for the 2011-2012 and 2012-2013 years will continue.
-Consumer input will continue through satisfaction surveys, education and training programs, and support groups such as Baby and Me Tobacco Free Smoking Cessation Programs.
-Education and outreach activities to promote the availability of Medicaid coverage for smoking cessation for pregnant and postpartum women and adolescents to age 21 will continue to ensure that as many pregnant women as possible who use tobacco receive counseling and associated services.
-Title V staff will continue to support the 2011 MRT recommendations to Address Health Disparities for prevention programs and preconception health for all women and adolescents of reproductive age on MA, particularly those women and teens with chronic health conditions that have high potential for adverse impact on pregnancy.
-The Tobacco Control Program conducts several media campaigns each year motivating smokers to quit by using graphic and emotionally evocative messages that demonstrate the health and social consequences of smoking, including the effects on infants, children, women and families.
-This year's efforts will highlight successes achieved since the 2003 passage of the Clean Indoor Act Law.
-NY is committed to focusing on improving healthy behaviors, eliminating of health disparities, and improving birth outcomes for all New Yorkers using evidence-based, sustainable models of care. Through the Maternal and Infant Health RFA, released in 2012, DOH aims to improve maternal and infant health outcomes for high-need women and reduce racial, ethnic and economic disparities in those outcomes. Funded programs will work to improve specific maternal and infant health outcomes including preterm birth, low birth weight, infant mortality and maternal mortality rates through implementation of evidence-based and/or best practice strategies across the reproductive life course. This initiative integrates and replaces DOH's current community-based perinatal health programs -including the CPPSNs, the CHWPs and the HMHB initiative -to develop multi-dimensional community-wide systems of integrated and coordinated community health programs and services to improve maternal and infant health outcomes. It is anticipated that awards will be made during 2013.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	4	3.8	3.8	4.2	4.5
Annual Indicator	3.3	4.2	4.6	6.1	6.1
Numerator	46	58	63	81	81
Denominator	1403050	1366144	1366278	1324252	1324252
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
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	5.9	5.8	5.7	5.6	5.5

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.

Notes - 2010
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

a. Last Year's Accomplishments
-Suicide is the third leading cause of death for young people ages 10-24 in NYS. The suicide rate in this age range increased significantly between 2008 and 2011.
-The CDC funded Injury Control Research Center for Suicide Prevention at the University of Rochester Medical Center became a member of the BOHIP Injury Community Planning Group. The group is dedicated to building a stronger injury prevention infrastructure in NY. The CDC created the program in 1987 to develop centers that conduct high quality research and help translate scientific discoveries into practice for the prevention and control of fatal and nonfatal injuries, violence and related disabilities and serve as training and information centers for the public.
-The DOH Bureau of Occupational Health and Injury Prevention (BOHIP) and the Public Health Information Group use data on suicides to perform additional analyses for planning purposes. BOHIP has and will continue to work closely with the Office of Mental Health (OMH), providing updated data and reviewing research opportunities to enhance efforts to address suicide in this population.
-Under the leadership of OMH, in collaboration with numerous partners and stakeholders, NY has mounted a major Suicide Prevention (SP) Initiative that seeks to include stakeholders at all levels

of government and every community in the state. The SP Center of NY, which works in collaboration with and is fully funded by OMH advances and supports local actions via education, training, consultation and coalition building to reduce suicide attempts and suicides in NYS and to promote recovery of persons affected by suicide. Prevention of youth suicide is a critical priority of this initiative.
-OMH continued to evaluate the evidence-based SP Intervention and Postvention programs from the SAMSHA's National Registry of Evidence-Based Programs (NREBP) and Practices and the SP Resource Center/American Foundation for SP best practice registry to determine how they might be used in the agency's Comprehensive SP Strategy. OMH continued to expand its work with schools and communities in SP intervention and postvention.
-OMH received a grant award in 2011 to launch a Youth SP Program focusing on 4 interventions: (1) building youth SP capacity through the development of 4 regional training centers at existing child service agencies; (2) providing early identification/gatekeeper training for caregivers through these centers; (3) improving suicide risk assessments, management and treatment for providers using evidence based practices; and (4) providing resiliency training for adolescents. Cultural competence to ethnic, sexual orientation and military culture issues have been built into each intervention Over 13,000 people were trained in implementing these interventions during year one. OMH has developed MOUS and contracts with the 4 Youth SP Centers which have been operating since December 2011 and has expanded the initiative to work with 16 counties to build coalitions and develop "caring and competent suicide prevention counties."
-Comprehensive Adolescence Pregnancy Prevention (CAPP) programs continued activities targeted to high-risk youth including implementing evidenced-based educational programs; ensuring access to Family Planning (FP); increasing skill-building opportunities for teens; and promoting community efforts to improve adolescent sexual health and promote positive youth development. Eight additional CAPP programs were funded through Personal Responsibility Education Program (PREP).
-Abstinence Education Grant Program (AEGP) funding supported a new competitive procurement to fund 17 programs to implement mentoring and adult-supervised programs for high-risk youth ages 9-12 to begin in 2013.
-Rape Crisis and Sexual Violence Prevention Programs provided 2,555 multi-session educational programs to 20,784 young people at schools, colleges and community locations. Topics included prevention of bullying, healthy relationships, gender roles, self-esteem, communication skills, role of the bystander and other prevention topics.
-Effective 7/1/11, School-Based Health Centers (SBHCs) became eligible to bill Medicaid (MA) for mental health counseling provided by licensed clinical social workers or by licensed master social workers. This new funding stream strengthened SBHCs' ability to provide on-site mental health services to students including routine psycho-social assessments and individual and group counseling.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. BOHIP and the Public Health Information Group make suicide data available and are able to perform additional analyses for use in planning.				X
2. The Injury Control Research Center for SP became a member of the BOHIP Injury Community Planning Group.				X
3. Under the leadership of the NY OMH, in collaboration with numerous partners and stakeholders, NY has mounted a major SP Initiative. Prevention of youth suicide is a critical priority of this initiative.			X	X
4. OMH is evaluating and utilizing existing evidence-based SP Intervention and Postvention programs from SAMSHA for SP best practice registries to determine how they might be used in		X		X

the agency's Comprehensive SP Strategy.				
5. OMH continued to expand its work with schools and communities in SP, intervention and postvention.		X		
6. OMH developed MOUS and contracts with the 4 Youth SP Centers which have been operational since 12/2011 and has expanded to work with 16 counties to build coalitions and develop "caring and competent SP counties."				X
7. 50 Rape Crisis Programs at 72 sites provided 2,555 multi-session prevention education programs to 20,784 young people at schools, colleges and community locations and 1,004 professional trainings to 18,545 professionals.		X		
8.				
9.				
10.				

b. Current Activities

-The BOHIP continues to work closely with the OMH to develop research opportunities to enhance efforts to address suicide in this population.
-Under the leadership of OMH, NY will continue a major Suicide Prevention (SP) Initiative. OMH will continue to provide Prevention, Intervention and Postvention Curriculum to schools throughout NYS.
-OMH is adding Nassau and Suffolk Counties to its GLS "Caring and Competent Suicide Prevention Counties."
-OMH has added a major behavioral health provider, Federation Education Guidance Services, to its Zero Suicide Collaborative; this agency serves over 40,000 children and families in NYC and Long Island
-OMH is working with the NY Army National Guard (NYANG) family readiness groups to improve family awareness of suicide prevention, intervention and postvention supports.
-OMH is providing Creating Suicide Safety in Schools workshops and its Lifelines program.
-All SBHCs continue to address the mental health needs of enrolled students, either directly or by referral.
-The RCSVPP developed and distributed a toolkit which provides an overview of existing programs and resources designed for youth that utilize the bystander intervention approach.
-Reducing teen suicide and promoting mental health were selected as priority areas of focus in the 2013-17 Prevention Agenda.

c. Plan for the Coming Year

-BOHIP, OMH, and Injury Control Research Center for SP will continue collaborate to further suicide prevention initiatives in NY.
-The Injury Control Planning Group will continue to meet to enhance the injury infrastructure in NY, including suicide prevention.
-OMH is adding Life is Precious (SP and intervention outreach for Latina adolescents) and Projecta Vida (family suicide prevention support for Hispanic families) to eastern Suffolk county communities in the North and South Forks of Long Island.
-OMH is working with the NYANG family readiness groups to improve family awareness of suicide prevention, intervention and postvention supports.
-OMH will expand both Creating Suicide Safety in Schools workshops and its Lifelines program, both of which are currently provided. Lifelines is an evidence-based (SAMHSA NREBP registry) comprehensive Suicide Awareness and Responsiveness program for schools. This is a whole school program made up of 3 components: Lifelines Prevention, Lifelines Intervention and Lifelines Postvention. Research has indicated that an informed community can help vulnerable youth from ending their lives.
-OMH will provide Prevention, Intervention and Postvention Curriculum to schools throughout NYS.

-OMH will continue to work with the NYANG family readiness groups to improve family awareness of suicide prevention, intervention and postvention supports.
-All SBHCs will continue to address the mental health needs of enrolled students, either directly or by referral. Services may include individual mental health assessment, treatment and follow-up, crisis intervention, short and long-term counseling, group and family counseling, and psychiatric evaluation and treatment. SBHCs will be monitored through regular reports and 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 and master's level social workers may encourage more SBHCs to offer this service on-site.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	92	94	94	91	91.3
Annual Indicator	90.0	90.6	90.5	90.7	90.7
Numerator	3281	3356	3270	3131	3131
Denominator	3646	3704	3614	3453	3453
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
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	91.7	92	92.4	92.8	93.2

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.

Notes - 2010
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

a. Last Year's Accomplishments
-NY continues to exceed both the Healthy People 2020 baseline and target goals (75% and 82.5% respectively) for this indicator.
-NY 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. Regulations require lower level hospitals to consult with RPCs and determine the need for transfer of high-risk mothers and newborns.
-RPCs remain the hubs of the perinatal regionalization 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.
-90.7% of all very low birth weight (VLBW) infants were delivered at RPC and Level III facilities. Conversely, 9.7% of VLBW infants were delivered at Level I and II hospitals.
-Over 90% of deliveries of high-risk newborns at appropriate level hospitals demonstrates the effectiveness of perinatal regionalization.
-The Statewide Perinatal Data System (SPDS) -- NY'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.
-RPCs conduct numerous activities to obtain consumer/parent/family input and 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 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.
-Continued implementation of a range of public health (PH) initiatives including the system of perinatal regionalization; 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), to improve birth outcomes.
-As part of the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative, in October 2012 DOH issued a Request for Applications for the Maternal and Infant Health Initiative (MIHI), 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. Through the hospital system of perinatal regionalization, 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		
2. RPCs conducted educational program at affiliates and through grand rounds on programs such as stabilization of VLBW and Extremely Low Birth Weight infants in preparation for transfer, to prepare affiliates for emergency cases.		X		
3. 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		
4. DOH staff continued to collaborate with the RPCs, and the NICHQ to implement interventions designed to improve perinatal outcomes (NYSPQC).				X
5. DOH has implemented a range of PH initiatives to improve perinatal outcomes in NY, including home visiting programs to increase access for early and continuous prenatal care.		X		X
6. Abstracts regarding neonate enteral feeding were accepted for presentation at the 4/28/12-5/1/12 meeting of the Pediatric				X

Academic Societies.				
7.				
8.				
9.				
10.				

b. Current Activities

-RPCs remain the hub of the perinatal regionalization system and conduct QI visits at affiliate hospitals and work to improve perinatal quality and outcomes, including review of complex cases. RPCs also continue to conduct on-site educational programs to affiliates.
-DOH's oversight role to identify and address appropriateness of care issues continues. In 2012/13 DOH is continuing improvement activities through the CDC State Based Perinatal Quality Collaborative.
-NYSPQC will continue the work begun through the 2010 NYSONQC initiative. DOH is working with the RPCs to continue and expand obstetric and neonatal interventions to perinatal affiliate hospitals throughout NY to improve specifically identified perinatal outcomes.
-DOH will continues to support PH initiatives to increase access to prenatal care; to support community-based programs that target high-risk areas to identify and address gaps in needed services; and the assessment and referral of high-risk women to appropriate level of services.
-The MIHI Request for Applications (RFA) was issued in 10/2012. The RFA will support awards to 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. As part of the federal MIECHV initiative, awards NFP and HFNY programs will also be made through this RFA. Applications are due on 3/15/13 with contracts to begin on 10/1/13.

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 expand obstetric and neonatal interventions to perinatal affiliate hospitals throughout NY to improve specifically identified perinatal outcomes.
-Data analysis for the NYSPQC Neonatal Initiative optimizing early enteral nutrition in preterm newborns is continuing. Presentation of an abstract at the 2014 meeting of the Pediatric Academic Societies is anticipated.
-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 (MRT) 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.
-NY's work in the MIECHV and other community-based maternal and infant health initiatives will support evidence-based home visiting services, further coordination of services, and maximization of resources to improve birth outcomes. The RFA issued in 2012 will result in implementation of the MIHI on October 1, 2013.

-The statewide Growing Up Healthy Hotline (GUHH) 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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	79	80	81	74	74.8
Annual Indicator	72.3	73.3	73.2	72.9	72.9
Numerator	165813	167503	169190	167091	167091
Denominator	229467	228517	231137	229052	229052
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
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	75.5	76.2	77	77.7	78.4

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.

Notes - 2010
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 have been updated and finalized since NYS's previous MCH block grant application submission.

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. NY is performing above the Healthy People 2020 baseline of 70.8% for this indicator. However, disparities remains 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 72.9% of infants born to all women.
-NY'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 2012 GUHH responded to 53,529 calls including 2,878 calls requesting referral and information related to pregnancy testing and/or prenatal care, and 3,805 calls related to health insurance.
-Medicaid (MA) prenatal care providers continued to promote early enrollment in prenatal care and provide 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 2012, the CHWP served 3,509 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.
-6 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.
-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 2012, the NFP programs served 818 TANF-eligible women. Maternal, Infant and Early Childhood Home Visiting funds were also allocated to these 3 NFPs.
-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.
-Recognizing the need to refine efforts to engage NY's highest risk women into prenatal care to promote progress in this performance measure, 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, 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. The RFA was released in October 2012.

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 is supporting NFP programs in Monroe & Bronx Co. & HFNY programs in Erie & Bronx Co. to provide evidence-based home visiting (HV) services to high risk families. 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 women to seek early and continuous prenatal care		X	X	
8. Through CAPC, lead agencies coordinate a comprehensive service network, recruit pregnant women into prenatal care & case management through enhanced outreach and referrals from community agencies.		X		
9. DOH's 6 HM-MB 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.				

b. Current Activities

-The Title V program continues to collaborate with OHIP to ensure comprehensive prenatal care services are available to high risk populations.
-DOH will continue to promote early entry to prenatal care through outreach and case finding strategies to identify high risk pregnant women early and ensure engagement in comprehensive prenatal care.
-A RFA for maternal and infant health programs, including MIECHV was issued to redesign these programs. Through the RFA, DOH will establish MICHC in high-need communities (as discussed above) to address preterm birth, low birth weight, infant mortality and maternal mortality. The MIH RFA also procured an expansion of DOH's MIECHV initiative, supporting establishment or enhancement/expansion of additional NFP and/or HFNY programs effective October 1, 2013.
-Under the HRSA-funded First Time Motherhood/New Parents Initiative, DOH continues to support 6 CPPSN programs convening key stakeholders to increase awareness of CDC's Recommendations to Improve Preconception Health and Health Care. Programs will develop community action plans to increase consumer awareness of preconception health.
-DOH entered into an agreement with the National HM-HB Coalition and implemented the national Text4baby initiative in NY.
-DOH supports 2 NFP programs in Bronx and Monroe counties and 4 HFNY projects in Bronx and Erie counties under the MIECHV initiative, and 3 NFP programs through TANF.

c. Plan for the Coming Year

-A RFA will be released as a companion to the MIH-RFA to establish a new MIH Center of Excellence to support MICHC and MIECHV grantees with the provision of technical assistance, training and coordination of data management and evaluation activities. It is anticipated this RFA

will be released summer 2013, with the goal of implementing the MIH Center of Excellence in conjunction with the MIH Initiative.
-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.
-Public health programs that serve at-risk adolescents - SBHC, FP 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.
-The statewide GUHH will continue to link women to needed services, with periodic public awareness media campaigns conducted to direct women to the hotline.
-MCH 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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				64.9	65.6
Annual Indicator	62.4	64.3	64.6	65.2	65.2
Numerator	58091	58055	59319	58996	58996
Denominator	93114	90226	91838	90516	90516
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	66.2	66.9	67.5	68.2	68.5

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.

Notes - 2010
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

a. Last Year's Accomplishments
-While NY 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 NY's highest risk women into prenatal care to promote progress in this performance measure, Title V redesigned NY's perinatal initiatives (refer to MIH RFA discussed

below).
-State law requires all 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.
-A priority of DOH's home visiting initiatives is to promote healthy behaviors, including engaging women into early prenatal care. Approval to award funding to 2 NFP programs in Bronx and Monroe counties, and 4 HFNY projects in Bronx and Erie counties was obtained. Contracts with the MIECHV funded NFP and HFNY projects were established. They recruited, hired and trained qualified home visiting staff, and were at or near full staffing by April 1, 2012 and established referral agreements with prenatal care providers, health and social services agencies, community-based organizations and other home visiting programs, and began outreach and recruitment activities. Projects began serving clients April 1, 2012.
-CPPSNs 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.
-CHWPs provided outreach and home visiting services to high-risk pregnant women. In 2012, CHWP served 3,281 clients, including 99.9% female, 31% Black and 44% Hispanic. CHWPs are indigenous to the communities served. Outreach targets 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 laundry mats, markets, churches, hair salons, transit stops, housing projects, and community centers.
-Healthy Mom-Healthy Baby (HM-HB) programs supported development of organized community systems of perinatal health and home visiting 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 an MOU with OTDA, DOH supported enhancement/expansion of NY's 3 NFP programs to provide home visiting services to TANF-eligible first-time mothers.
-DOH has approval from CMS for a MA State Plan Amendment to provide MA reimbursement for Targeted Case Management (TCM) activities of NFP programs in Monroe County and NYC. TCM includes assessment of medical, education, social and other needs; development of a care plan to engage in preventive health practices; and referral, follow-up and assistance in accessing needed services. NFP programs began MA billing in 1/11. MA billing data show 48% of clients served were Black and 33% Hispanic.
-Under the First Time Motherhood/New Parents Initiative, 6 CPPSNs convened community stakeholders and develop and implement 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 for the hearing impaired, and the AT&T Language Line which extends access to callers speaking over twenty additional languages.
-DOH is promoting Text4baby through maternal and infant health partners. Customization of messages allows inclusion of state-specific information and referral resources such as the GUHH. A Text4baby media campaign was developed, with targeted media in areas with the highest rates of adverse birth outcomes.
-Public awareness materials are available to promote early entry into prenatal care. All materials are printed in multiple languages, tested with populations they are targeting, and disseminated to better reach the target population.

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 clients, and provision of services to families.		X	X	X
6. First Time Motherhood/New Parents Initiative developed & implemented 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 supports enhancement/expansion of NY's 3 NFP programs to provide home visiting services to TANF-eligible first-time mothers.	X	X		
8. NFP programs began MA billing in 1/11 for TCM activities. MA billing data show 48% of clients served were Black and 33% Hispanic.		X	X	
9. Public awareness materials are available to promote early entry into prenatal care. All materials are printed in multiple languages, tested with populations they are targeting, and disseminated to better reach target populations.		X		
10. The statewide GUHH linked 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		

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.

-Support of NY's 3 NFP programs to provide nurse HV services to TANF-eligible first time mothers continues.

-DOH issued a Maternal and Infant Health (MIH) RFA, a redesign of the current CHWP, CPPSN and HMHB programs. Through the RFA, DOH will establish MIH Community Health Collaboratives in high-need communities to develop community-wide systems of coordinated evidence-based and/or best practice strategies targeted to high-need women and infants, designed to achieve a set of mch performance standards. The MIH RFA also procured an expansion of DOH's MIECHV initiative, supporting establishment or enhancement/expansion of additional NFP or HFNY programs in the 14 high-need communities identified in the MIECHV needs assessment and as indicated in the MIECHV State Plan.

-DOH continues to promote Text4baby. As of 2/2013, approximately 13,000 participants are receiving DOH customized messages. An outreach campaign will include: a targeted media campaign for young African-American pregnant women or new mothers in 6 high risk areas consisting of posters and digital media; the dissemination of Text4baby marketing materials

statewide and the promotion of Text4baby text messaging service on the DOH Website and social media sites (i.e. Face book, Twitter).

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 NYS 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 NYS 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 home visiting (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 NY's Prevention Agenda.
-A RFP will be released in summer 2013 as a companion to the MIH-RFA to establish a new MIH Center of Excellence to support MICHC and MIECHV grantees including provision of technical assistance, training and coordination of data management and evaluation activities.
-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 build stronger parent-child relationships.
-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 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. 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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				79.5	79.9
Annual Indicator	81	79	79	80	83
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
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	80.4	80.9	81.4	83.7	84

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).

Notes - 2010
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. Comparison between 2007/2008 and 2009/2010 are not possible due to the fact that different methods of data collection were used in developing the measure rate.

2009 data are used as a proxy for 2010. This indicator is collected on a biannual basis. Numerator and denominator data are not available (survey data).

a. Last Year's Accomplishments
-For care delivered in 2011, 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%.
-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.
-In 2012, DOH conducted 17 Article 44 operational on-site surveys of managed care plans that serve Medicaid, ChPlus and Family Health Plus, and four surveys of commercial managed care plans. The surveys include a review of the MCO's processes to ensure that participating providers comply with 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 in 2012, 100% of the MCOs had adequate PCP networks.

-Health plans pursue quality improvement activities to increase well child preventive health visit rates for children age 3 to 6 through: 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 2012 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 2012 Quality Incentive, six plans did not receive any incentive increase.
-Community-based public health (PH) programs, such as the Community Health Worker (CHW) Program and Nurse Family Partnership (NFP), promote healthy behavior in families, including the promotion of 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. Health plans contacted PCPs who have non-compliant patients.		X		
3. Health plans offered gift cards or other incentives to encourage members to schedule visits.		X		
4. Health plans contacted non-compliant members.		X		
5. Health plans published information on the importance of well child visits in their newsletters and on their websites.			X	
6. DOH monitored access and availability of PCPs which serve the MMC, CHPlus and commercial populations.				X
7. DOH conducted Article 44 operational on-site of managed care organizations.				X
8. DOH monitored the number of PCPs/pediatricians serving the 3- to 6-year old population.				X
9. The measure “well-child visits in the 3rd, 4th, 5th and 6th year” was included in the 2012 Quality Incentive methodology.				X
10.				

b. Current Activities
-DOH monitors the access and availability of PCP panels serving MMC/CHPlus populations. DOH examines MMC client/provider ratio. Providers with a high ratio are called to determine if an appointment wait time meets plan standards. A plan with a score of < 75% must submit an action plan.
-DOH conducts surveys to review plan's processes for ensuring providers comply with prenatal standards, requirements for EPSDT/foster children, child protective services; and coordinate with local PH.
-Plans target members to increase WCVs by: contacting family of a child lacking a WCV to schedule appointment; sending reminder cards/incentives; arranging transportation; educating about WCVs during postpartum calls; surveying parents about barriers; and placing articles in newsletters and on websites.
-Plans engage providers to increase WCVs by: contacting PCPs and asking them to contact the family; providing incentives for meeting thresholds; educating practice managers in preventive

guidelines to promote compliance; educating providers on coding, clinical guidelines about WCVs; and mailing co-branded or co-signed letters (from plan/provider) to members with gaps in WCVs.
-Plans, DOH, WIC and academia collaboratively explore regional barriers to care and develop a joint approach to educating members on the importance of WCVs.
-The CHW Program and NFP promote pediatric primary/preventive care.
-Use of well child care was included as a priority focus area in the 2013-17 Prevention Agenda.

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 MCOs' processes to ensure participating providers comply with EPSDT requirements and prenatal standards; requirements for foster care and child protective services; and coordination with local public health 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 public health programs, such as the CHW Program and NFP will 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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				1.9	1.9
Annual Indicator	1.9	1.9	1.9	1.8	1.8
Numerator	13	13	12.9	12.6	12.6
Denominator	6.8	6.9	6.8	6.9	6.9
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
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.

Notes - 2010

White and Black race groups do not include Hispanics.
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

a. Last Year's Accomplishments

-The ratio of Black White infant low birthweight is slowing improving. Recognizing the need to refine efforts to better ensure continued progress on this and other disparity measures, Title V redesigned NY's perinatal initiatives and developed the Maternal and Infant Health (MIH) RFA, a redesign of the current CHWP, CPPSN and HMHB programs. Through the RFA, DOH will establish MIH 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, 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 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 to 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 Healthy Mom-Healthy Baby (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 2012, CHWP served 3,509 clients, including 99.8% female, 31% Black and 44% Hispanic. CHWPs are indigenous to the communities served.
-Through a Memorandum of Understanding (MOU) with the NY Office of Temporary and Disability Assistance (OTDA), DOH supports the expansion/enhancement of the state's 3 Nurse Family Partnership (NFP) programs to provide home visiting services to TANF-eligible pregnant women. In 2012, the NFP programs served 818 TANF-eligible women.
-Through a MA State Plan Amendment, DOH provides MA reimbursement for Targeted Case Management (TCM) activities to NFP programs in Monroe County and New York City. MA billing data shows 48% of clients served were Black and 33% Hispanic in 2012.
-MIECHV funds have been awarded to NFPs in Monroe and Bronx counties and HFNYs in Erie and Bronx counties under NY's MIECHV State Plan. A RFA to award additional funds was released in 2012.
-Through the First Time Motherhood/New Parents Initiative, 6 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. Regulations require lower level hospitals to consult with RPCs and determine the need for transfer of high-risk mothers and newborns.
-Approximately 90.5% of all very low birth weight (VLBW) infants were delivered at RPC and Level III facilities. Conversely, less than 9.5% of VLBW infants were delivered at Level I and II hospitals. The trend towards delivery of over 90% of high-risk newborns at appropriate level hospitals suggests the effectiveness of perinatal regionalization.
-The Statewide Perinatal Data System (SPDS) 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.
-In October 2011 NY was awarded a CDC State-Based Perinatal Quality Collaborative Grant for a NY Perinatal Quality Collaborative (NYSPQC). DOH works 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 in NY.		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 appropriate services.		X	X	X
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 NY'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 TCM activities to NFP programs in Monroe County and NYC. MA billing data show 42% 48% of clients served were Black and 37% Hispanic in 2012.		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 developed an Updated State Plan for a State Home Visiting Program under the MIECHV initiative.		X	X	X

b. Current Activities
-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.
-DOH's oversight role to identify and address appropriateness of care issues continues.
-NY continued the CDC State-Based Perinatal Quality Collaborative to implement evidence based interventions for improving neonatal and maternal outcomes, focusing on reducing scheduled deliveries, including scheduled inductions and cesarean deliveries, without documented medical indication at 36 0/7 to 38 6/7 weeks gestation while the Neonatology team continued the focus on optimizing early enteral nutrition in preterm newborns of <31 weeks gestational age in the NICU.
-TANF funding continued to support NY's 3 NFPs to provide nurse home visiting services to TANF-eligible first time mothers.
-DOH issued the Maternal and Infant Health (MIH) RFA. The MIH RFA also procured an expansion of DOH's MIECHV initiative, supporting establishment or enhancement/expansion of 2 to 4 additional NFP and/or HFNY programs effective 10/1/13.

-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 at RPCs and affiliates through family advisory councils, satisfaction surveys, provider call-backs, and education and training programs.
-DOH will continue the NYSPQC with RPCs to implement selected obstetric and neonatal interventions designed to improve perinatal outcomes. NYSPQC will expand 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; and to optimize early enteral nutrition in newborns of <31 weeks gestational age.
-Through MIH procurement, 20-25 MICHC programs and 2-6 new NFP or HFNY projects will be funded for a three-year term starting October 1, 2013, and will be expected to be fully staffed and approaching full caseload by March 31, 2014.
-A RFP will be released as a companion to the MIH-RFA to establish an MIH Center of Excellence to support community-based grantees including provision of technical assistance, training and coordination of data management and evaluation activities.
-Through the MA Redesign process, DOH will implement an initiative to demonstrate effective and efficient use of Health Information Technology between hospitals/health care systems and community-based health organizations to improve 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. Title V staff are leading this workgroup.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				26.3	26.1
Annual Indicator	27.2	26.6	26.6	25.7	25.7
Numerator					
Denominator					
Data Source	YRBS	YRBS	YRBS	YRBS	YRBS
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	25.8	25.5	25.3	25	25

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).

Notes - 2010
2009 data are being used as a proxy for 2010. The YRBS is conducted bi-annually. The next survey was in 2011 with results available in 2012. Numerator and denominator data are not available (survey data).

DOH also collects data on the percentage of students in Pre-Kindergarten, Kindergarten and grades 2, 4, 7 and 10 in NYC (exclusive of NYC) who are overweight or obese: (32.0% for 2008-2010). The source of this data is the DOH Student Weight Status Category Report.

a. Last Year's Accomplishments
-The national percentage of high school students overweight or obese is up slightly from 2009 (27.8%) to (28.2%) based on the 2011 YRBS data and is higher than the percentage for NYS (25.7%, down from 26.6% in 2009.) These national 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 who were overweight or obese in grades 7 and 10, exclusive of NYC, for the period of 2008 through 2010 was substantially higher at 34%.
-The 2008-2010 school district-level, county-level, and statewide (excluding NYC) student weight status category reporting (SWSCR) survey results were released and posted on the DOH website.
-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), provided statewide training for DOH contractors and others in public health. Training emphasized environmental, policy and systems approaches to increasing physical activity and healthy eating. This training, "Strong and Healthy Communities: Placemaking and Health" was offered in 5 sites across the state. Follow-up surveys showed that participants were able to apply what they learned to their work. DASH-NY also began providing ta on the retail food environment and active transportation (e.g., bicycling, walking, etc.) to DOH contractors.
-The Healthy Schools New York (HSNY) initiative, implemented by 18 contractors in school districts with free/reduced price meal participation of 50% or more, provided ta and resources to approximately 50 high-need school districts to adopt and implement physical activity, including physical education, and nutrition policies. An estimated 22 school districts adopted new policy elements for physical activity and nutrition. Contractors met their annual objective for working with 5-6 school districts at a time. HSNY contractors worked with a total of 92 school districts, over 275 school buildings, and provided ta to over 580 school personnel, reaching over 300,000 students in grades K-12.
-Over 70 contractors from multiple initiatives implemented evidence- and practice-based chronic disease prevention interventions promoting policy systems and environmental approaches to improve physical activity and nutrition for children and adolescents and to support healthy eating including breastfeeding, or a combination thereof, across a variety of settings to achieve improved health outcomes. Funding is distributed 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.
-Nine Obesity Prevention in Pediatric Health Care Settings (OPPHCS) contractors began 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. A guidance team of representatives from clinical and behavioral medicine, community, MMC and professional societies informed the development of a change package and data measurement plan.
-DOH established a Pediatric Obesity Prevention Workgroup (POPW) 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.
-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 and practices.

Community activities included: the development of preconception health materials (i.e., reproductive life plans, brochures, palm cards, and bookmarks), community and school-based workshops and trainings, and promotional marketing through media, including radio, theater, and social media sites. Healthy weight prior to, and during pregnancy has a significant impact on birth outcomes.
-School-based Health Clinics (SBHCs) are required to document the weight of enrolled students based on Body Mass Index-for-age percentile.
-In partnership with the ACT COE and Cornell Cooperative Extension, DOH developed "Guidelines for Healthy Food and Beverages" for use by funded adolescent health programs.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The DOH released the 2008-2010 student weight status category reporting results.			X	X
2. The statewide center for obesity prevention, policy research and training around healthy eating and active living, DASH-NY, delivered obesity prevention training (policy, system and environmental changes) to NY residents and DOH contractors.			X	X
3. The HSNY delivered technical assistance/training to school districts with the purpose of establishing or improving policies for physical activity and physical education, and nutrition.				X
4. The Obesity Prevention Program distributed funding directly & in combination with other programs to over 70 contractors to prevent obesity and related chronic diseases.				X
5. OPPHCS contractors established local learning collaboratives to promote the delivery of guideline-concordant care for the assessment, prevention and treatment of child and adolescent overweight and obesity.				X
6. A Commissioner's POPW was convened to mobilize and coordinate cross agency efforts to prevent and control childhood obesity.				X
7. School-based health Clinics documented the weight of enrolled students based on Body Mass Index-for-age percentile.		X		
8. The First Time Motherhood/New Parents Initiative convened stakeholders to develop and implement community action plans to increase awareness of and supports for preconception health through evidence-based and promising strategies and practices.				X
9.				
10.				

b. Current Activities
-School district local wellness policy coding continues in partnership with the NYS Education Department. Policies are rated for comprehensiveness & strength. Results can be compared with SWSCR results and school health initiatives to observe changes over time.
-HSNY contractors received one multi-day training & monthly TA webinars on physical activity, including physical education and healthy eating strategies and resources for policy adoption & implementation. Contractors are working in 115 school districts, 638 school buildings & providing TA to over 1400 staff.
-Two webinars were held for LHD & school district staff on use of SWSCR results for action.
-DASH-NY continues to provide TA & training to DOH contractors and others in public health and is convening the first annual statewide coalition meeting on disparities. Quarterly workgroups are convened around multiple obesity prevention topics.

-OPPHCS contractors are working with the first cohorts of local collaboratives using monthly data to make small tests of change & inform practice. Contractors & staff participate in monthly calls to facilitate the collaborative learning process.
-SBHCs document the weight of enrolled students based on Body Mass Index-for-age percentile.
-A Text4baby media campaign is being developed with targeted media in areas with the highest rates of adverse birth outcomes.
-Reducing obesity was included as a priority focus area in the 2013-17 Prevention Agenda.

c. Plan for the Coming Year
-OPPHCS contractors will begin either second or third cohorts of local collaboratives in the coming year, using monthly data to make small tests of change and inform practice.
-HSNY is working at full capacity and will continue to provide training and technical assistance to school districts to advance the adoption of the federally mandated local school wellness policies.
-DASH-NY will provide technical assistance and training to DOH contractors and other public health practitioners and will convene the first annual DASH-NY statewide coalition meeting.
-Competitive bids will be solicited to identify a vendor to work with DOH on: statistical analysis of student weight status data; developing school district, county-level and statewide reports on student weight status category data and obesity-related health conditions; and developing an application for school and school district personnel to summarize and display data they collect and process through the Student Weight Status Category Reporting System.
-Several strategic directions are being implemented through the recently awarded, two-year Community Transformation Grant-Small Communities project. The project's population of focus is children, 0 to 18 years. One of the three settings for intervention is within 8 high need school districts in three rural counties. Two of the strategies in that setting include increasing access to Safe Routes to School for walking and biking, and developing regional food procurement initiatives (i.e., food purchasing consolidation, menu standardization) to promote healthy weight. The potential for scalability of these strategies for further policy development is being explored.
-The Commissioner's POPW is expected to be expanded to include representation from external state agencies to enhance mobilization and coordination, and accelerate DOH Prevention Agenda goals and objectives for pediatric obesity prevention.
-DOH is applying for new funding to support obesity prevention and school health promotion activities. If successful, this work will demand a formal agreement with the NYS Education Department for collaborative planning around coordinated nutrition and physical activity school health programs and data sharing.
-School-based Health Clinics will continue to document the weight of enrolled students based on Body Mass Index-for-age percentile.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				5.2	4.5
Annual Indicator	5.6	5.3	4.6	4.5	4.5
Numerator	64.3	58.3	48.6	42	42
Denominator	11.4	11	10.6	9.3	9.3
Data Source	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics
Is the Data Provisional or				Final	Provisional

Final?					
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	4.5	4.4	4.4	4.3	4.3

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.

Notes - 2010
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

a. Last Year's Accomplishments
-NY has experienced a continuous decline in adolescent pregnancy rates over the past two decades and has the sixth lowest rate in the U.S. According to a report from the National Center for Health Statistics, when adjusted for race and ethnicity, NY has the second lowest pregnancy rate for Black adolescents and the fifth lowest for Hispanic adolescents. Despite this positive trend, NY 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 STD rates are consistently almost three times higher for Black and Hispanic teens than for white teens. Racial and ethnic disparities in teen pregnancy rates continue, although the actual magnitude of the disparity is decreasing. Rates for all race/ethnicity groups continue to decline.
-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 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 second year of the CAPP initiative, over 5,000 Hispanic youth and 6,000 Black youth participated in evidence-based sexual health education programs.
-Forty-five of the 58 CAPP/PREP projects focus on serving Hispanic youth. Funded programs are expected to have staff and Boards representative of racial/ethnic populations they serve, and 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.
-In 2011, 50 FP providers reported that a total of 351,403 clients were served. This represents a 2.3% increase from the number of clients served in 2010. 21% of the clients served in 2011 were adolescents between the ages of 15-19. There was a 7% increase in Hispanic as well as black adolescents (<20 years of age) using contraception. The agencies continue to provide comprehensive clinical, education and outreach services to NY's most vulnerable populations.
-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. Statewide, 61% females served by the program leave with an effective method; 62.7% of 15-17 year olds; 70.9% White non-Hispanics and 51.6% of Black non-Hispanics.
-Under the Affordable Care Act, DOH submitted a State Plan Amendment (SPA) to transform the Family Planning Benefit Program (FPBP) and Family Planning Extension Program (FPEP) from 1115 waiver demonstration projects into Medicaid (MA) State Plan services. The SPA included a

period of presumptive eligibility for FP services, which will enable clients to receive immediate access to reproductive health services and will reimburse providers for provision of those services while eligibility is determined; and adds medically-necessary transportation services for eligible clients. FPBP expansions will result in increased client access, especially for adolescents, who may request their information remain confidential and can apply for FPBP and FPEP based on their own income. FPEP provides MA coverage for FP services for women for a 2-year post-pregnancy period. The SPA was approved by the Centers for Medicare and Medicaid Services (CMS) in the summer of 2012.
-DOH funded NY Program for Appropriate Technology in Health (PATH) at Columbia University continues to provide adolescent sexual health education to health care providers.
-Abstinence Education Grant Program (AEGP) funding supported a new competitive procurement to fund 17 programs to implement mentoring and adult-supervised programs for high-risk youth ages 9-12 to begin in 2013.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. DOH funds 50 CAPP 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		
2. 40 of 50 CAPP projects specifically focus on serving Hispanic communities.Funded 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 funded Columbia University to provide professional education and resources statewide for community healthcare providers.				X
5. DOH was awarded $2.8 million in Federal Section 510 Abstinence Education Grant Program (AEGP) funds to support community projects for 9 to12 year-olds focused on adult mentoring and supervision to delay the onset of sexual activity.		X		
6. 50 family planning agencies with 200 clinics provided free or low cost contraceptive services to nearly 351,403 women, men and adolescents, 21% of the population were teens.	X	X	X	X
7.				
8.				
9.				
10.				

b. Current Activities
-CAPP and CAPP-PREP program activities that focus on decreasing the incidence of adolescent pregnancy and STD/HIV and reducing racial and ethnic disparities among adolescents aged 10 to 21 will continue. Activities include implementation of evidenced-based education programs; ensuring access to family planning; increasing skill-building opportunities for teens; and promoting community efforts to improve adolescent sexual health.
-DOH will fund up to fifteen programs that focus on mentoring, and adult-supervised activities for preteen youth ages 9 to 12 who reside in targeted high-need communities to support a healthy transition into adolescence. Funding for this initiative is through AEGP.

-DOH-funded family planning providers' performance regarding increasing the number of adolescent clients and clients from racial/ethnic minority communities will be monitored. Training around best practices for improving program performance in these areas will be developed and provided.
-Efforts continue to analyze available data and focus CAP and family planning efforts on the highest need population of the state.
-A significant area of focus for the Prevention Agenda is prevention of unintended and adolescent pregnancy and use of preventive health services by women of reproductive age. Title V staff continue to work with internal and external partners to improve these outcomes, especially related to disparities.

c. Plan for the Coming Year
-NY's comprehensive approach to adolescent pregnancy prevention as well as the provision of comprehensive family planning services targeting high-risk youth across NY as described above will continue, with an emphasis on decreasing 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/ethnic minority communities.
-Title V staff will continue to seek opportunities to work with key stakeholders to promote the evidence-based and promising practices for the Prevention Agenda: NY's State Improvement Plan for 2013-2017.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	5	5	5	12.5	12.3
Annual Indicator	13.8	14.9	12.6	12.5	11.9
Numerator					
Denominator					
Data Source	YRBS	YRBS	NYS Youth Tobacco Survey	YRBS	NYS Youth Tobacco Survey
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	12.2	12.1	12	11.8	11.6

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).

Notes - 2010
2010 data are from the NYS 2010 Youth Tobacco 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 continues to decline from 14.6% in 2008 to 11.9% in 2012. The annual performance objectives will be adjusted down in 2013 if the YRBS shows similar declines in next year's data.
-NY exceeds the Healthy People 2020 target goal of 16% for this measure.
-NY's cigarette excise tax is $4.35 per pack, which remains the highest state tax in the nation. Raising the price of cigarettes especially discourages youth smoking.
-Much of the reduction in youth smoking is due to changing social norms about the acceptability, accessibility, and desirability of smoking among youth. One way this is accomplished is through paid media that is emotionally evocative and graphically depicts the negative impact of smoking on health. The Bureau of Tobacco Control (BTC) has used its limited media dollars as effectively as possible selecting ads from the National Tobacco Campaign. "Tips from Former Smokers" are graphic representations of the outcomes of smoking.
-Changing social norms is also accomplished through policy change such as enforcement of a strong indoor air law, banning smoking in public places, including restaurants and bars.
-Over 200 municipalities in NY have passed smoke-free outdoor air policies at locations such as parks, playgrounds and beaches.
-BTC uses a population-based policy approach to establish a tobacco-free NY. BTC contracts with a policy center that provides tobacco policy expertise to DOH and community contractors to support development and implementation of strategies at the local level aimed at adopting policies that denormalize tobacco use and create systems change
-BTC contractors use a Community Transformation Framework to alter social norms and increase support and demand for strong tobacco control policies. This fosters communities in which tobacco use is less desirable, acceptable, and accessible. The framework consists of community education about the continued burden of youth tobacco use creating demand for solutions; community mobilization that engages local organizations to become active in tobacco control; government policy maker education about the continued burden of tobacco control on the local community and the health care system; and advocating with organizational decision makers to change the local environment and policy solutions
-BTC continued to fund Reality Check (RC) Partners to engage youth to counter the tobacco industry and its marketing practices. These 16 programs engage middle and high school youth in activities aimed at de-glamorizing and de-normalizing tobacco use in their communities. RC has been successful in getting YouTube to consider amending their policy on use of tobacco imagery on youth-accessible videos.
-BTC funded local Tobacco Control Community Partnerships (CP) in every county of the state. These partnerships work to advance community polices that support the tobacco-free norm by implementing a coordinated set of strategies to build public, political and organizational support for tobacco control policies. By effectively educating and mobilizing the public, and educating government and organizational policy-makers, communities become receptive to or even demand strong tobacco control policies. The Village of Haverstraw brought national attention to point of sale (POS) initiative when it passed the nation's first ever ban on tobacco displays. Tobacco companies sued the village and the ban was repealed; however, the ban brought the tobacco industry's targeted marketing to youth to the nation's attention.
-NY makes smoking cessation assistance available through a toll-free hotline, which provides free coaching and nicotine replacement therapy to eligible callers. In 2011, the most recent year data is available, the hotline assisted over 168,000 callers attempting to quit smoking.
-BTC conducts the Youth Tobacco Survey (YTS) in New York biennially and has since 2000. The survey documents tobacco related behavior, knowledge and attitudes in middle school age and high school age youth. Key indicators from the YTS include cigarette and other tobacco use, secondhand smoke exposure, exposure to tobacco industry marketing and tobacco control countermarketing, and attitudes towards tobacco control policy.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 16 Reality Check (RC) Partners engaged youth to counter the tobacco industry and its marketing practices by engaging middle and high school youth in activities aimed at de-glamorizing and de-normalizing tobacco use in their communities.			X	
2. BTC funded Tobacco Control CP in every NYS county; they work to advance community polices supporting the tobacco-free norm by implementing a coordinated set of strategies to build public, political & organizational support.			X	
3. BTC funded contractors' work with local leaders to educate them on the tobacco-related public health problems that can be addressed by local communities and possible policy solutions that exist.			X	
4. Over 200 municipalities in NY have passed smoke-free outdoor air policies at locations such as parks, playgrounds and beaches.			X	
5. NY continued to make smoking cessation assistance available through a toll-free hotline, which provides free coaching and nicotine replacement therapy to eligible callers.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

-Reality Check contractors continue to work to change smoke-free media policies. Contractors, youth, parents and other community members are implementing strategies that urge major movie studios to eliminate pro-tobacco imagery from youth-rated movies. Four parent companies now have smoke-free media policies.

-Contractors and youth continue to identify, flag and compile information about the presence of youth-accessible tobacco imagery on social media websites and YouTube. Findings are disseminated to organization decision makers, local media and governmental entities to garner support to eliminate pro-tobacco imagery on the Internet. RC contractors and youth continue to work on reducing the impact of tobacco product marketing on youth in retail establishments. Contractor efforts in working with community members and local governments have resulted in over 300 municipalities passing smoke-free outdoor air policies at locations such as parks, playgrounds and beaches and momentum to establish the smoke-free norm continues to grow.

-BTC continues to work interdepartmentally to create policy change. BTC worked with OHIP to help develop Medicaid cessation services and National Response Team benefit for the Medicaid Managed Care population.

-Reducing tobacco use was selected as a priority focus are in the 2013-17 Prevention Agenda.

c. Plan for the Coming Year

-BTC will continue to implement a multi-pronged, evidence-based approach to achieving a smoke free NYS as outlined in the two sections above. Smoking reduction in high school aged youth will occur (as it has been) by de-normalizing smoking amongst all community members. Youth will continue to be engaged as activists towards this goal.

-The policy priority for the BTC in the coming year relative to youth who smoke will be to educate

communities, policy makers, and media-related organizations on the need for smoke free media and the role it plays in reducing youth smoking.
-BTC will utilize evaluation methods (such as YTS and contractor performance standards) to assess effectiveness of contractor activities.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				41.4	41.8
Annual Indicator	37.3	40.2	41.0	41.8	40.7
Numerator	667090	746153	797681	835106	846457
Denominator	1790400	1854115	1946654	1996387	2080698
Data Source	Burea of MA Statistics	Bur of MA Statistics	Bur of MA Statistics	Bur of MA Statistics	Bureau of MA Statistics
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	42.2	42.6	43.1	43.5	43.7

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.

Notes - 2010
This indicator is based on information from both Managed Care and Fee-for- Sevice Medicaid Programs.

a. Last Year's Accomplishments
The percentage of MA-eligible children and adolescents in NY between 2 and 21 years of age having at least one dental visit during the year continues to increase. In 2011, 41.8% of eligible children had at least one dental visit, compared to 42.4% in 2012.
-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 54% in in 2011 to 55% in 2012.
-The percentage of children and adolescents aged 2 through 18 years covered under the CHPlus MC Programs who saw a dentist during the year increased from 63% in 2011 to 64% in 2012.
-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 2013-2017 State Improvement Plan.
-DOH is awaiting guidance from the Center for Medicare/Medicaid Services (CMS) on allowable MA administrative expenses for certain costs of community water fluoridation. Title V in

collaboration with Children's Dental Health Project, developed a background paper on why the use of MA funds for infrastructure development of public water fluoridation systems would be consistent with CMS guidelines.
-Title V funds 31 of 55 programs for School Based Health Center-Dental services to provide dental health services in high risk, underserved areas of NYS.
-Between funded and unfunded programs, services were provided at 953 schools in high need areas during the 2011-2012 school year. SBDH programs are available at 28% of all schools eligible for a sealant program.
-Dental Health 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 was awarded a $200,000/year HRSA school-based health center (SBHC) dental clinic grant for a four year period to integrate oral health services into existing SBHCs and is collaborating with North County Children's Clinic 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 CQI program and related assessment and evaluation forms.
-Dental Health 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, perinatal and rural health networks, educational institutions, and professional and provider organizations.
-Albany Medical Center WIC program and Albany Medical Center Pediatrics are working in collaboration to provide a Fluoride Varnish Project for children ages 6 months to 4 years. Offering oral health risk assessments, oral health education for parents, and fluoride varnish application to children's teeth to help to prevent cavities, this is being offered as a preventive service by a qualified health care professional. BDH worked in partnership with AMC and the division of nutrition to assist in program approval, provided technical assistance for program development, and developed and presented WIC staff education. This project began as a pilot project in September 2011 and continues to provide services 2-4 hours a week at the Albany WIC program.

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. Dental Health 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
3. Targeted outreach and education to underserved low-income age groups was conducted.		X	X	X
4. A $200,000/year HRSA SBHC dental clinic grant for a four year period to integrate oral health services into existing school-based health centers was implemented.	X		X	X
5. DOH awaiting response from CMS on use of MA funds for certain costs of community water fluoridation equipment.			X	X
6. The WIC FV Pilot Project continued.	X	X		X
7.				
8.				
9.				

10.				

b. Current Activities

-Difficulties finding dentists willing to complete the school dental certificate and provide services to MA-eligible children prompted bills to be accepted in the Senate and House that authorize registered dental hygienists to sign a dental health certificate. The bills also add hygienists to the current list of dentists providing dental services on a free or reduced cost basis that schools must make available to parents upon request.
-The 2013 NYS Oral Health Plan and the NY's Prevention Agenda both target the reduction of dental caries disease among children.

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 FV 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 DHC, 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.
-Dental Health will work with key stakeholders and members of the NYS Oral Health Coalition on implementation of the 2013 NYS Oral Health Plan and NY's Prevention Agenda, both of which target the reduction of dental caries disease among third grade children.
-The utilization of dental services by children and adolescents and the types of services received will continue to be monitored.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				51	51.5
Annual Indicator	47.5	50.5	53.0	55.0	53.8
Numerator	116544	125763	133960	137431	134431
Denominator	245402	249182	252662	249655	249655
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
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	52	52.5	53	53.5	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.

Notes - 2010
This is a new performance measure that replaces and updates a previous measure that captured the percentage of children tested for lead at least once by age two years. The measure was revised to align with the state universal lead testing requirements that all children be tested for lead at both ages one year and two years, and to align with current statewide surveillance reports. While there are several separate metrics currently tracked for lead testing in state surveillance reports, this measure is the best stand-alone composite measure of performance in this area.

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 have been updated and finalized since NYS's previous MCH block grant application submission.

a. Last Year's Accomplishments
-Lead surveillance data for 2011 demonstrates an almost 3% increase in the number of children tested for lead 2 or more times by age 3 years. The application of strong policy and program efforts to enforce state regulations for lead testing at ages 1 and 2 has resulted in this improvement.
-Revisions to state regulations, effective 6/2009, authorized private physician office laboratories (POLs) and limited services registrant laboratories to conduct blood lead testing using point-of-care testing devices. Over 350 devices had been purchased in NYS as of the end of 2011, and over 200 laboratories were contacted and trained on how to report the results.
-Reporting mechanisms for POLs were streamlined in 2009 when Public Health Law was amended to authorize linkage of the NYSDOH childhood blood lead registry (LeadWeb) and the NYS Immunization Information System (NYSIIS). In 9/2010, the linkage was completed and a NYSIIS lead module was implemented to allow POLs to enter lead test results. As of the end of 2012, 1.6 million lead tests have been added and are available for POLs to view.
-In addition to allowing providers the ability to view a child's lead testing history in NYSIIS, a new feature allows reminder flags to be viewed on the child's immunization history and blood lead history screens to help reinforce compliance with PHL and regulations. These reminder flags cue the physician to assess a child's risk for exposure to lead at every well child visit, provide lead testing at 1 and again at 2 years of age and promote follow-up testing.
-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 retest.
-The release of provider Performance Reports related to lead testing was postponed due to technical issues in NYSIIS and a delay in extending the vendor's contract. The reports are scheduled to be released with the next changes the Immunization Program makes to the system. LHDs plan to use the reports to direct outreach to providers with low testing rates. Health care providers and health plans will also be able to access reports on their patients.
-The Office of Health Insurance Program 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.
-Transition of the administration of the LPPP from the Center for Community Health, Division of Family Health, BMCH, to the Bureau of Community Environmental Health and Food Protection, Center for Environmental Health (CEH) was completed by 12/31/11. This transition included 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 from HUD 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.
-The longstanding CDC funding for lead poisoning prevention has been eliminated, representing a loss of approximately $1 million to NYS and $1 million to the NYC Department of Health and Mental Hygiene. This funding reduction resulted in a loss of 9 staff directly working in the program.
-LHDs continued to receive grant funds to support statewide improvement of lead testing of children as part of a comprehensive LPPP, and to contract with 3 Regional Lead Resource Centers (RLRCs) in 5 teaching hospitals throughout NY to provide expert clinical support, education and outreach to LHDs and health care providers to improve lead testing and other preventive practices.
-The Childhood LPPP program 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. Implemented and monitored the Asthma Program through collaboration with a network of partners, to include an agency-wide, multi-disciplinary internal infrastructure to address asthma and the Asthma Partnership of NY.			X	X
2. Maintained the Comprehensive Asthma Surveillance System; disseminated asthma surveillance data; provided technical assistance and guidance around utilizing surveillance information.				X
3. Administered the Regional Asthma Coalition initiative, coalitions which bring together health care and community partners to plan, test, and implement population-based, system change interventions.			X	X
4. 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	
5. Implemented and monitored Eliminating Disparities in Asthma Care project			X	X
6. Expanded AE-C workforce, AE-C integration into clinical practice setting, and AE-C enrollment in NY MA program			X	X
7. Advanced MA Redesign Team recommendation to provide reimbursement for home-based asthma self-management education and assessment services.				X
8.				
9.				
10.				

b. Current Activities

-The LPPP provides funds to LHDs to improve lead testing of children and also contracts with 3 RLRCs in 5 hospitals to provide support, education and outreach to LHDs, health care providers, the general public and professional/community groups.
-The LPPP continues to work with the NYSIIS vendor to provide quality data for health care providers, LHDs and health plans regarding children's blood lead tests. Four short training videos were created for NYSIIS users and have been made available on the Health Commerce System. Two additional videos are in the planning stages.
-A project to promote "one-stick" blood lead and hemoglobin testing for children receiving services from the NYS WIC Program is being explored. NYS LPPP and Division of Nutrition staff met to begin discussing the requirements of both programs and how to develop standard/best practices for LHD LPPPs to pursue.
-The LPPP began a joint effort with the NYS Bureau of Occupational Health and Injury Prevention to notify LHDs of pregnant women with elevated blood lead levels residing in their jurisdiction in order to ensure other children in the family are tested, as well as the newborn upon delivery.
-As of the end of 2012, over 450 point-of-care devices have been purchased in NYS and over 300 laboratories were contacted and instructed about reporting requirements. During 2012, there were approximately 300,000 tests added to NYSIIS, approximately 51,000 from point of care devices, and 249,000 from laboratories.

c. Plan for the Coming Year

-Partnerships established within the Childhood LPPP, Healthy Neighborhood and the LPPP will be reviewed, consolidated, streamlined, and expanded upon to allow for a comprehensive HH Program. For example, CEH will continue to explore the collaboration of the RLRCs and NY Occupational Health Centers to expand the services provided to consumers and health care providers to include the HH concept.
-Contracts with LHDs and RLRCs for the prevention, identification and follow up of lead exposure in children will be continued.
-In partnership with the American Congress of Obstetricians and Gynecologist, the Guidelines for the Prevention, Identification and Management of Lead Poisoning in Pregnant and Postpartum Women will be distributed to its members via newsletter and web posting.
-LPPP staff will begin work with NYSIIS staff and the vendor to develop the capacity to accept electronic blood lead test results along with immunizations in a file submitted by a health care provider (replacing manual data entry) and additional quality improvement enhancements.
-CEH staff will continue to collaborate with internal partners in the Medicaid Redesign Team (MRT): Lead Inspection Reimbursement initiative. Staff is developing a cost saving proposal to pay for the environmental lead investigations for Medicaid eligible children who meet the criteria for such investigations.
-The design of a program evaluation for the Lead poisoning primary prevention program is being developed. The evaluation would measure the health outcomes of housing based lead poisoning efforts in targeted high risk communities.
-It is unclear at this time how activities in the LPPP and HH programs will be maintained at their current levels after March 1, 2013 when resources for the HH and lead poisoning surveillance programs will be exhausted.

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	2008	2009	2010	2011	2012

Performance Data					
Annual Performance Objective				31	26.5
Annual Indicator	28.4	31.1	26.7	26.5	26.5
Numerator	12509	13781	11552	11341	11341
Denominator	4408016	4424083	4324929	4286008	4286008
Data Source	SPARCS	SPARCS	SPARCS	SPARCS	SPARCS
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	26.4	26.3	26.2	26	25.7

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.

Notes - 2010
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

a. Last Year's Accomplishments
-The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than 18 years of age decreased from 27.1/10,000 to 26.2/10,000. Using 2011 data as a proxy for 2012, the annual performance objective for this measure was met. The program attributes this decrease to the strategic targeting of resources, policy initiatives, and interventions to address geographic areas and populations who experience a disproportionate share of the burden of asthma, such as children and low-income, minority populations. -
-DOH implemented and monitored the Asthma Program through collaboration with a network of partners, to include an agency-wide, multi-disciplinary internal infrastructure to address asthma and the Asthma Partnership of NY, an external public/private collaboration.
-Funding for Regional Asthma Coalitions (RACs) was awarded to areas of high need across NY, as defined by county-level asthma-related hospital discharge and emergency department (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. Current NY asthma surveillance data was made available to the coalitions 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 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 NY 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. Over 6,000 hard copies of the asthma guideline tool were distributed to health care providers, health plans, asthma educators and community-based partners across NY.
-Guided by the findings of a Certified Asthma Educator (AE-C) workforce analysis, the DOH Asthma Program and OHIP provided education about the Asthma Self-Management Training services benefit and certification. The RACs were awarded additional funding to support efforts to expand the AE-C workforce and its integration into clinical practice settings serving individuals with asthma who are enrolled in Medicaid (MA).

-The Eliminating Disparities in Asthma Care 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.-A proposal was drafted in response to the NY MA Redesign Team's recommendation to provide reimbursement for home-based asthma education and assessment services which included a waiver request to the Center for Medicaid 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. Implemented and monitored the Asthma Program through collaboration with a network of partners, to include an agency-wide, multi-disciplinary internal infrastructure to address asthma and the Asthma Partnership of NY.			X	X
2. Maintained the Comprehensive Asthma Surveillance System; disseminated asthma surveillance data; provided technical assistance and guidance around utilizing surveillance information.				X
3. Administered the Regional Asthma Coalition initiative, coalitions which bring together health care and community partners to plan, test, and implement population-based, system change interventions.			X	X
4. 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
5. Implemented and monitored Eliminating Disparities in Asthma Care project			X	X
6. Expanded AE-C workforce, AE-C integration into clinical practice setting, and AE-C enrollment in NY MA program			X	X
7. Advanced MA Redesign Team recommendation to provide reimbursement for home-based asthma self-management education and assessment services.				X
8.				
9.				
10.				

b. Current Activities

-The RACs are implementing action plans with their health care and community partners focusing on high risk populations.

-The 2012 Asthma Outcomes Learning Network is being led by DOH and the coalitions. AOLN's 26 teams, representing primary care, hospitals, schools, pharmacy, and human service agencies, are planning, testing and implementing system changes to improve asthma care processes and health outcomes. Performance across a core set of measures is monitored.

-The 2013 NYS Asthma Surveillance Summary Report is being finalized and data on the DOH public website is updated. A series of asthma information briefs are being produced, the first of which, "Asthma Data to Action: Asthma Self-Management Education and Support" was released October 2012.

-Final data collection for the Eliminating Disparities in Asthma Care project is underway. An

evaluation will be conducted and findings widely disseminated to inform best practices for improving asthma care and health outcomes for high risk populations with asthma.
-The NY consensus asthma guideline support tool and the Asthma in the Primary Care Setting course continue to be available at no cost.
-Improving outdoor air quality, reducing indoor asthma triggers, reducing tobacco use and second hand smoke exposure, promoting the use of evidence-based care management and culturally relevant chronic disease self-management education for asthma and other chronic diseases are all priority goals for the 2012-17 Prevention Agenda.

c. Plan for the Coming Year
-The RAC initiative will continue to be administered and monitored by the DOH. As the RACs expand their efforts to include new systems and larger populations, they will continue to implement an approach based on translating the national guidelines for asthma care into practice utilizing an evidence based improvement methods. RAC performance across a core set of measures will be monitored on a monthly basis.
-The Clinical Guideline for the Diagnosis, Evaluation and Management of Adults and Children with Asthma, a NY 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.
-Successes from the 2012 Asthma Outcomes Learning Network (AOLN) will be spread to additional systems of care and broader populations. The 2013 AOLN will be convened, to include the provision of training and technical assistance to a new cohort of project teams. A minimum of 12 new AOLN projects, aimed at improving asthma care processes and health outcomes, will be implemented and monitored in collaboration with the RACs.
-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 number of clinically licensed AE-Cs who are enrolled in the NY Asthma Self-Management Training Services MA program and are providing services to high risk patients with asthma. If approval is received from the Center of MA Services, the DOH will implement a demonstration project for home-based asthma education and assessment services for low-income individuals with poorly controlled asthma. Without public insurance funding provided through the waiver process, other strategies for increasing access to home-based asthma services will be pursued. Hard copy asthma self-management support tools will continue to be provided in to the public, and conversion of self-management tools into mobile applications will be explored.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				43.1	43.6
Annual Indicator	42.0	42.7	43.5	39.8	39.8
Numerator	95496	96080	95511	86126	86126
Denominator	227604	224903	219503	216625	216625
Data Source	Statewide	Statewide	Statewide	Statewide	Statewide

	Perinatal Data System	Perinatal Data System	Perinatal Data System	Perinatal Data System	Perinatal Data System
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	44	44.4	44.8	45.4	45.4

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.

Notes - 2010
The denominator includes all live born infants, excluding infants who were admitted to the NICU or transferred in or out of the hospital. Method 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.
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

a. Last Year's Accomplishments
-DOH completed the pilot of the NYS Breastfeeding Quality Improvement in Hospitals (BQIH) Learning Collaborative with 12 hospitals outside of NYC. Hospitals learned fundamentals of quality improvement and used the IHI Breakthrough Series Methodology to improve maternity care practices. Eleven of 12 hospitals eliminated the distribution of formula samples, formula coupons, and educational materials provided by formula companies to breastfeeding mothers at the time of discharge. The average prevalence of infants who were exclusively fed breast milk across all hospitals in the project was 41.4% in November 2011, up from a June 2010 baseline of 33.8%. Over the 18 month collaborative, there was a mean increase of 22% in exclusive breastfeeding and significant increases in breastfeeding initiation and rooming-in > 18 hours/day. NYS BQIH is the foundation for the CDC's Best Fed Beginnings Initiative. In addition, the New York City Department of Health and Mental Hygiene (NYCDOHMH) engaged 9 hospitals in a Baby Friendly Hospital Learning Collaborative. DOH staff supports this collaborative through provision of faculty and coaching to hospital improvement teams.
-The BQIH Change Package and Data Measurement Plan have been posted to the DOH public

webpage.
-Successes from the Communities Putting Prevention to Work (CPPW) Breastfeeding Initiatives have been showcased nationally and through scholarly publication.
-Ten Steps to Successful BF: An Online Course was offered to staff in 92 hospitals (exclusive of NYC) providing maternity care services in NYS. Staff from all 92 hospitals completed the course which meets the staff education requirement for Baby Friendly Hospital (BFH) Designation. There was an 84% completion rate among 3348 distributed course codes. (2195 accessed and 1855 completed).
-Hospital BF policies were codified and compared with a 2009 review. Hospitals were notified of inclusion of required components. Hospitals that did not include all required components were asked to revise their policies and resubmit to DOH. Eight of 132 hospitals had all 28 required components in their written policy.
-DOH endorsed Latch On NYC an initiative to support mothers choosing to breastfeed. The goal of Latch On NYC is to improve the health of mothers and children by increasing breastfeeding initiation and duration, and exclusive BF. Twenty-eight of 40 NYC hospitals have signed on to participate in this initiative.
-WIC sponsored a graduate public health student to conduct a study on national and statewide best practices to improve exclusive breastfeeding (BF).
-WIC developed and conducted training for all staff on breastfeeding competencies. Specialized training was provided to staff on building milk supply to support exclusive breastfeeding.
-The USDA Food and Nutrition Service (FNS) Loving Support through Peer Counseling: A Journey Together was implemented in the WIC program. All state and local staff were trained on managing the program and using the new curriculum platform. Through this training, agencies and peer counselors were encouraged to work with hospitals to establish peer counselor visiting privileges.
-Infant feeding data from hospitals (excluding NYC) was analyzed using the Statewide Perinatal Data System (SPDS). Hospitals were ranked using three indicators (percentages of infants fed exclusively breast milk, fed any breast milk, and breastfed infants also fed formula in the hospital). Each hospital was informed of its performance relative to other hospitals and this information was posted on the DOH public webpage.
-CPPSNs and home visiting programs such as NFP and CHWP provided education and support to promote exclusive breastfeeding. DOH developed a RFA 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 and support evidence-based home visiting. One of the priority areas of focus is the promotion of breastfeeding.
-The standards for Medicaid Prenatal Care requires providers to counsel women on the benefits of exclusive breastfeeding. In addition, the MRT MA redesign proposal to reimburse for lactation consultation was approved.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Using SPDS data, hospitals were ranked based on 3 BF indicators (newborn infants fed exclusively breast milk, fed any breast milk, and breastfed infants supplemented with formula) and informed of their relative performance.				X
2. DOH continued offering the Ten Steps to Successful Breastfeeding: An Online Course to staff at 92 hospitals (exclusive of NYC) providing maternity care services across the state.		X	X	
3. DOH completed the pilot of the NYS BQIH Learning Collaborative with 12 hospitals to improve policies, systems, and practices consistent with the recommended Ten Steps to			X	X

Successful BF.				
4. WIC implemented the Loving Support through Peer Counseling: A Journey Together Curriculum and encouraged agencies and Peer Counselors to work with hospitals to establish Peer Counselor visiting privileges.		X		
5. WIC developed and conducting training for all staff on breastfeeding competencies.		X		
6. DOH endorsed Latch On NYC to support mothers choosing to breastfeed. 28 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. Hospital BF policies were codified. 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
9.				
10.				

b. Current Activities

-DOH will survey 132 hospitals providing maternity care to collect information regarding patient education and support, staff education, training & BF policies.
-Hospital BF rates are updated yearly & posted to the DOH webpage.
-An additional 27 hospitals will be recruited to engage in a 15 month learning collaborative to improve practices.
-DOH is designing & implementing a BF Friendly Practice Designation for OB/GYN, Pediatricians, & Family Practice Physicians. Practices in Erie Co. will be participating in a virtual learning network to inform the designation process.
-WIC will implement a new initiative to improve exclusive BF. Two trainings will be conducted on recognizing feeding cues & exclusive breastfeeding. Participant publications will be developed that support exclusive BF.
-DOH is implementing Great Beginnings NY an initiative complementary to Latch On NYC. Hospitals will be implementing Steps 6 & 10 of the Ten Steps to Successful BF & limiting supplementation of breastfed infants to medical necessity.
-DOH will continue to offer the Ten Steps to Successful BF: Online Course to 92 hospitals providing maternity care in NYS.
-Effective 4/1/13, Medicaid will provide reimbursement for evidence-based breastfeeding education & lactation counseling consistent with the USPSTF recommendation.
-The Prevention Agenda 2013-2017 was developed that includes the goal to increase the proportion of NYS babies who are breastfed.

c. Plan for the Coming Year

-WIC will revise and implement breastfeeding policies to support exclusive breastfeeding as the norm and public health strategy.
-Training to improve competencies of WIC staff in breastfeeding assessment, support, and counseling will continue.
-The expansion of the Peer Counselor Programs to include hospital, health care provider, and community visits will continue.
-Collaboration will continue among Title V staff, Divisions of Nutrition and Chronic Disease and NYCDOHMH to educate providers, assist hospitals with the implementation of baby friendly policies and practice, and to link women with home visiting programs to educate and assist with support for BF.
-Staff will continue to develop details and specifications of the Medicaid breastfeeding education

and lactation counseling benefit by specifically trained lactation consultants, consistent with USPTF recommendations for interventions during pregnancy and after birth to promote and support BF.
-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 initiate contracts in support of the new 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 and support evidence-based home visiting.
-Work will continue on the Prevention Agenda, NY's State Improvement Plan.

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	2008	2009	2010	2011	2012
Annual Indicator	8.2	8.2	8.2	8.1	8.1
Numerator	20471	20226	19910	19417	19417
Denominator	249655	246360	242693	239498	239498
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 - 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

Notes - 2010
Source: NYS DOH Vital Records
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

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%. There was a slight decrease in 2011 to 8.1%. NY's experience mirrors the national trend; in 2011, preliminary data suggests that 8.1% of births nationally were LBW. NY is making progress in this area related to disparities. However, 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 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 year Title V redesigned NY's perinatal initiatives and developed the Maternal and Infant Health RFA to establish MIH Community 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.

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 will support NY's effort to improve low birth weight, including impacting disparities. Major PA Goals related to this area include:
•Reduce premature births in NYS by 12% to 10.2% and to reduce disparities in this area by 10%.
•Reduce the rate of adolescent and unplanned pregnancies by 10% to 25.6 per 1,000 females, and reduce disparities by 10%.
•Increase the use of preventive health services among women of reproductive age to improve wellness, pregnancy outcome sand reduce recurrence of adverse birth outcomes through increasing health care coverage to women 18-64 years to 100%.
•Reduce the percentage of all live births that occur within 24 months of a previous pregnancy by 10% to 17%.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	6.3	6.2	6.2	6.1	6.1
Numerator	15081	14587	14489	14118	14118
Denominator	240075	236463	233203	230108	230108
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 - 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

Notes - 2010
Source: NYS DOH Vital Records
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

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 2011 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 2011 the rate was 3.9%. The singleton LBW rate of 6.1 percent in 2011 represents a slight decrease from 2010 (6.2 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 HRSA-funded First Time Motherhood/New Parents Initiative, DOH supported 6 CPPSN programs to convene key stakeholders to increase awareness of CDC's Recommendations to Improve Preconception Health and Health Care. Programs will develop community action plans to increase consumer awareness of preconception health. DOH also entered into an agreement with the National Healthy Mothers-Healthy Baby Coalition and implemented the national Text4baby initiative in NY. The DOH is working with providers in 6 high-risk communities (Erie, Monroe, Onondaga, Albany, Westchester and Bronx counties) to develop local action plans to identify existing preconception health resources and supports, gaps in services and strategies to increase community awareness of preconception health, and utilization of local resources to promote preconception health/care. These communities represent areas 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	2008	2009	2010	2011	2012
Annual Indicator	1.5	1.5	1.5	1.5	1.5
Numerator	3733	3763	3683	3526	3526
Denominator	249655	246360	242693	239498	239498

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 - 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

Notes - 2010
Source: NYS DOH Vital Records
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

Narrative:
The percent of very low birthweight births (<1500 grams) in New York State was 1.5% in 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 Programs 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). 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. 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%.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	1.1	1.1	1.1	1.1	1.1
Numerator	2706	2611	2670	2548	2548
Denominator	240075	236463	233203	230108	230108
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 - 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

Notes - 2010
Source: NYS DOH Vital Records
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	4.3	3.4	3.8	3.0	3.0
Numerator	155	123	135	107	107
Denominator	3604140	3633448	3531233	3515032	3515032
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 - 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

Notes - 2010
Source: NYS DOH Vital Records
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

Narrative:
The death rate for unintentional injuries among children aged 14 years and younger has decreased from 3.8 per 100,000 in 2010 to 3.0 in 2011. DOH's Bureau of Occupational Health and Injury Prevention (BOHIP) devotes significant efforts to decrease these injuries. BOHIP is a lead member of the NY Child Passenger Safety Advisory Board. The Communications/Public Outreach Committee of this advisory board developed and coordinated a statewide "Sit, Click, Ride-Always Buckle Up" child passenger safety campaign targeting children ages 8-12 and their parents that was conducted during National Child Passenger Safety Week.

During the past year, BOHIP also hosted an Injury Community Planning Group meeting for traffic safety stakeholders to enhance NY's injury infrastructure. The Child Injury Prevention Policy Subgroup focuses on the education of decision makers/public health professionals about safety benefits for children ages 12 and under to ride properly restrained in the back seat of a motor vehicle.

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 such as the CHWP 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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	1.2	1.0	1.3	0.8	0.8
Numerator	43	37	47	29	29
Denominator	3604140	3633448	3531233	3515032	3515032
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 - 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

Notes - 2010
Source: NYS DOH Vital Records
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

Narrative:
The death rate for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes continues to decrease. In 2008, the rate was 1.2 per 100,000, in 2010 1.3 per 100,000 and 0.8 in 2011. 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 provided the Governors Traffic Safety Committee (GTSC) with fact sheets for all NY counties that demonstrate the injury burden for unrestrained motor vehicle passengers. The fact sheets will be distributed to law enforcement in the counties and posted on the NY State Police Intranet. 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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	8.6	9.5	9.2	7.8	7.8
Numerator	240	258	255	216	216
Denominator	2802996	2714522	2777213	2756593	2756593
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 - 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

Notes - 2010
Source: NYS DOH Vital Records
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

Narrative:
The death rates for unintentional injuries due to motor vehicle crashed among youth aged 15 through 24 years has decreased significantly in the past year from 9.2 per 100,000 in 2010 to 7.8 per 100,00 in 2011.

As stated previously, the Bureau of Occupational Health and Injury Prevention (BOHIP) identifies and monitors where and why injuries occur across the state and develops programs to prevent them. It consists of unintentional injury prevention, violence prevention and injury surveillance programs. Over the past year, the BOHIP represented DOH on the Hempstead Turnpike Pedestrian Safety Team that was convened by the NYS Department of Transportation in response to the increased number of pedestrian crashes that occurred on the 16 mile stretch of roadway in Nassau County between 2008 and 2011 (232 crashes between, resulting in 17 pedestrian fatalities). The Team worked together to develop solutions for the Hempstead Turnpike utilizing a variety of engineering, education and enforcement strategies to improve pedestrian safety. Staff assisted in the identification of educational strategies and materials appropriate for this initiative. Both short and long term measures were considered and the BOHIP will continue to assist with the development and implementation of a pedestrian safety initiative that will complement the Hempstead effort. A press event was held in Nassau County and was attended by representatives from federal, state and local partner agencies who discussed the measures that have been implemented to improve pedestrian safety on and around the Turnpike, per the recommendations of the team. A press release was also issued and included information about the formation of the team and its member agencies. It also provided background data and a description of the safety strategies that have been implemented and further plans to expand those efforts to a broader geographic region.

New York has also speared headed policies and programs such as New York's Graduated Driver's License program that has specific restrictions for drivers under 18 years of age and the school based education programs that promote awareness and driver safety.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	253.0	244.7	246.1	231.7	231.7
Numerator	9118	8892	8691	8145	8145
Denominator	3604140	3633448	3531233	3515032	3515032
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 - 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)

Notes - 2010
Source: Statewide Planning & Research Cooperative System (SPARCS - Hospital Discharge Data)
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

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 and 231.7 per 100,000 in 2011. 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 Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	25.8	23.0	22.7	20.6	20.6
Numerator	929	835	802	725	725
Denominator	3604140	3633448	3531233	3515032	3515032
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 - 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)

Notes - 2010
Non-fatal MV related injuries include pedestrians and cyclists Statewide Planning & Research Cooperative System (SPARCS - Hospital Discharge Data)

2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	103.4	103.0	96.1	92.9	92.9
Numerator	2898	2796	2670	2561	2561
Denominator	2802996	2714522	2777213	2756593	2756593
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 - 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)

Notes - 2010
Non-fatal MV related injuries include pedestrians and cyclists. Source: Statewide Planning & Research Cooperative System (SPARCS - Hospital Discharge Data)
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

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 and 92.9 in 2011. 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	2008	2009	2010	2011	2012
Annual Indicator	33.7	36.1	38.0	39.2	39.2
Numerator	23104	24085	25326	25366	25366
Denominator	686495	667979	666730	646710	646710
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 - 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.

Notes - 2010
.Source: NYS Bureau os Sexually Transmitted Disease Prevention.
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

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. In 2010 the rate was 38.0 and in 2011 increased to 39.2 per 10,000. In 2011, 102,460 cases of Chlamydia were reported for this group in NYS, making it the most commonly reported communicable disease. 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 2012, the Family Planning Program served more than 344, 916 women and men including 59.8% minority and 81.3% under 150% of the Federal Poverty Level. 182,537 individuals were tested in family planning clinics including 164,646 females and 17,891 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. DOH was awarded funding for the Personal Responsibility Education Program initiative that 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 is a new initiative that will fund Successfully Transitioning Youth to Adolescence (STYA), a 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. Specifically, NYS seeks to reduce the chlamydia rate among females ages 15-44 years by 10% to no more than 1,458 cases per 100,000.

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	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	10.6	11.1	11.9	12.3	12.3
Numerator	35910	37183	40244	41715	41715
Denominator	3389687	3354554	3381217	3385604	3385604
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 - 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.

Notes - 2010
Source: NYS Bureau of Sexually Transmitted Disease Prevention
2010 data have been updated and finalized since NYS's previous MCH block grant application submission.

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 100,000, increasing to 11.9 in 2010 and 12.3 in 2011. In 2012, 102,460 cases of Chlamydia were reported in New York State, making it the most commonly reported communicable disease. 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	242280	159695	58142	3846	20597	0	0	0
Children 1 through 4	921300	634010	197886	14089	75315	0	0	0
Children 5 through 9	1154819	802460	242649	16983	92727	0	0	0
Children 10 through 14	1196633	830450	257991	16863	91329	0	0	0
Children 15 through 19	1324252	916614	289184	18401	100053	0	0	0
Children 20 through 24	1432341	980600	302526	19438	129777	0	0	0
Children 0 through 24	6271625	4323829	1348378	89620	509798	0	0	0

Notes - 2014

Narrative:
According to the 2010 Census estimates, 19,378,102 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.

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 21.8% of its total population being foreign born in 2011. 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 32% or 6,271,625 of NY's population is 0--24 years of age. 1% is under age 1, 4.7%1-4 years of age, 5.9% 5-9 years of age, 6.2% 10-14 years of age, 6.8% 15-19 years of age, and 7.4% 20-24 years of age. Out of this age group, 22.5% are Hispanic, while 77.5% are non-Hispanic. NY has a higher percentage of children living in immigrant families (33% as compared to 23% nationally). There are over 160 languages spoken by children in NY public schools receiving limited English proficient services. One in five children in NYS live in poverty. Hispanic (33%) and African American (31%) children are more likely to live in poverty than White non-Hispanic (11%) or Asian (19%) children. (Kids Count Data Book 2011: NYS Touchstones.)

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	177246	65034	0
Children 1 through 4	692770	228530	0
Children 5 through 9	887815	267004	0
Children 10 through 14	938421	258212	0
Children 15 through 19	1039854	284398	0
Children 20 through 24	1123981	308360	0
Children 0 through 24	4860087	1411538	0

Notes - 2014

Narrative:
Please refer to Health Status Indicator 06A for information.

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	180	67	72	1	0	0	0	40
Women 15 through 17	3811	1775	1168	31	50	0	0	787
Women 18 through 19	9868	5111	2820	64	178	0	0	1695
Women 20 through 34	177889	108843	31074	619	18169	0	0	19184
Women 35 or older	47979	30732	7500	108	5688	0	0	3951
Women of all ages	239727	146528	42634	823	24085	0	0	25657

Notes - 2014

Narrative:
There were 239,727 births in NYS in 2011. 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 New York City residents. In 2011, births to white mothers accounted for 61 percent of all births and births to Black mothers represented 18 percent of the total. Twenty-one percent 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 percent 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 and 18-19 year olds accounted for 12,171 live births. In 2001, births for those age groups dropped to 180, 3,811 and 9,868 respectively. The majority of births occurred to women between the ages of 20 and 39 (89.8%). 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 and the Title V program. Adolescents are less likely to seek early prenatal care, therefore risking poor birth outcomes, and are also more likely to live in poverty. NY's adolescent health initiatives and comprehensive family planning program as discussed, in this application, strive to address this issue. New York State's perinatal programs employ a comprehensive, multi-level strategy, which integrates broad based systems approaches, involving county and local planning efforts, with one-on-one outreach through home visiting programs to assess, intervene and address the perinatal health needs of residents in high risk communities.

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 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.

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 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	180	84	96
Women 15 through 17	3811	1722	2089
Women 18 through 19	9868	3639	6229
Women 20 through 34	177889	42879	135010
Women 35 or older	47979	8704	39275
Women of all ages	239727	57028	182699

Notes - 2014

Narrative:
Please 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	1202	651	378	4	57	4	23	85
Children 1 through 4	181	108	44	0	14	0	2	13
Children 5 through 9	126	76	36	1	4	0	1	8
Children 10 through 14	140	92	40	0	1	1	0	6
Children 15 through 19	491	324	118	2	16	2	5	24
Children 20 through 24	927	609	246	4	23	0	5	40
Children 0 through 24	3067	1860	862	11	115	7	36	176

Notes - 2014

Narrative:
The infant mortality rate has been slowly declining in NYS. The 2011 infant mortality rate was 5.0/1,000 live births as compared to 5.1 in 2010 and 5.4 in 2008. The infant mortality rate declined most dramatically during the early 90's and at a slower pace in recent years. NYS has exceeded the HP 2020 goal for infant mortality (6.0) and is working toward meeting NYS's 2013 Prevention Agenda Objective of no more than 4.5 infant deaths/100,000 live births.

Hispanic and 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 9.6 in 2011. In 2011, the white non-Hispanic infant mortality rate was unchanged from the 2008 rate of 4.2/1,000 live births. Asian/Pacific Islander non-Hispanic infants experienced the lowest rate of infant mortality in 2011, at 2.5/1,000 live births. Infant mortality among Hispanic infants was 4.2 in 2011, down from 4.5/1,000 in 2009. 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 and 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 and Whites and Hispanics that were seen in both infant and neonatal mortality rates are also seen in postneonatal mortality.

Within the Title V Program, there are specific projects to monitor and analyze mortality data, including infant mortality data to guide the development of priorities and interventions. Based on 2011 vital statistics data, the top causes of infant death included conditions originating in the perinatal period, congenital anomalies/birth defects, sudden infant death syndrome, unintentional

injuries and diseases of the heart. Driven by these data, in addition to enhanced perinatal activities, efforts to reduce infant mortality have focused on promotion of safe sleep and reduction of SIDS, including extensive risk reduction education for SIDS and other sleep related deaths, and work with local child fatality review and data collection activities to better understand the contributing factors to sleep related, other accidental deaths and homicides. In addition, the Title V program collaborates with other partner programs including WIC, Injury Prevention and 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 and 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 and the development of local public health risk reduction and 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	962	237	3
Children 1 through 4	138	43	0
Children 5 through 9	105	21	0
Children 10 through 14	118	21	1
Children 15 through 19	400	90	1
Children 20 through 24	764	161	2
Children 0 through 24	2487	573	7

Notes - 2014

Narrative:
Please 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	4839284	3343229	1045852	70182	380021	0	0	0	2011
Percent in household headed by single parent	36.0	21.0	66.0	0.0	15.0	0.0	0.0	0.0	2011
Percent in	4.2	0.0	0.0	0.0	0.0	0.0	0.0	4.2	2012

TANF (Grant) families									
Number enrolled in Medicaid	2280280	0	0	0	0	0	0	2280280	2012
Number enrolled in SCHIP	401054	0	0	0	0	0	0	401054	2012
Number living in foster home care	20940	0	0	0	0	0	0	20940	2011
Number enrolled in food stamp program	1179082	0	0	0	0	0	0	1179082	2011
Number enrolled in WIC	603090	273201	164040	82020	54278	9046	20505	0	2012
Rate (per 100,000) of juvenile crime arrests	2511.0	0.0	0.0	0.0	0.0	0.0	0.0	2511.0	2011
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 - 2014
Zero (0) indicates data is not available.

Zero (0) indicates data was not available.

Zero (0) indicates data is not available.

Zero (0) indicates data is not available

Zero (0) indicates data is not available

Zero (0) indicates data is not available

Zero (0) indicates data is not available

Zero (0) indicates data is not available

Zero (0) indicates data is not available.

Zero (0) indicates data is not available

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, 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 relate directly to improving the health of NY's children including, but not limited to:
•Reduce the percentage of children and adolescents who are obese by 5% so that the percentage of public school children in NYS outside of NYC who are obese is reduced from 17.6% to 16.7%, and percentage in NYC is reduced from 20.7% to 19.7%.
•Reduce the asthma emergency department visit rate for 0-4 year olds by 10% from 218,3 per 10,000 to 196,5 per 10,000.
•Increase the rates of 19-35 month olds with appropriate vaccine series by 23% to 80% or higher.
•Increase the percentage of NYS residents served by community water systems that receive optimally fluoridated water by 10% from 71.4% to 78.5%.

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	3736106	1103178	0	2011
Percent in household headed by single parent	24.4	37.7	37.9	2011
Percent in TANF (Grant) families	0.0	0.0	4.2	2012
Number enrolled in Medicaid	0	0	2280280	2012
Number enrolled in SCHIP	0	0	401054	2012
Number living in foster home care	0	0	20940	2011
Number enrolled in food stamp program	0	0	1179082	2011
Number enrolled in WIC	381756	221334	0	2012
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	2511.0	2011
Percentage of high school drop-outs (grade 9 through 12)	0.0	0.0	2.7	2011

Notes - 2014

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	4452141
Living in urban areas	4452141
Living in rural areas	387143
Living in frontier areas	0
Total - all children 0 through 19	4839284

Notes - 2014
Urban/Metropolitan areas are combined. 2011 Data are being used as a proxy for 2012

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. 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	19329000
Percent Below: 50% of poverty	7
100% of poverty	16
200% of poverty	33.6

Notes - 2014

Narrative:
These data highlight NY's challenge of addressing supports and services for individuals at or below 200% of fpl. According to the 2012 Current Population Survey, 33.6% of New Yorkers are at 200% of the fpl and below. 16% of these individuals are at 100% of the fpl or below, and 50% 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 6.6% in 2011. 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 through one application that can be used to apply for Child Health Plus, Family Health Plus, MA and the Family Planning Benefit Program. The application is available electronically on NY's website in English and Spanish. A screening tool on this site informs individuals which program they are eligible for based upon the information they have provided. Facilitated enrollers are available in local neighborhoods to help individuals apply.

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. Works continues on ensuring NY implements the provision of the ACA to better ensure access to health care for all New Yorkers.

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	4770000
Percent Below: 50% of poverty	9.9
100% of poverty	22.3
200% of poverty	42.4

Notes - 2014
Source: US Census Bureau, Current Population Survey, 2012 Annual Social and Economic Supplement (CPS Data collected in 2012)

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 2012 Current Population Survey, 42.4% of NY's children ages 0-19 years were below the fpl. Of these, 22.3% were below 100% and 9.9% 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 2012		FY 2013		FY 2014	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	41036806	40036911	40033023		37919712	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	144502296	153566602	62208171		62208171	
4. Local MCH Funds *(Line4, Form 2)*	301048616	272432651	271491225		271646100	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	404365207	305333730	314762086		236737888	
7. Subtotal	890952925	771369894	688494505		608511871	
8. Other Federal Funds *(Line10, Form 2)*	63259202	55450663	57643011		62905602	
9. Total *(Line11, Form 2)*	954212127	826820557	746137516		671417473	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2012		FY 2013		FY 2014	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	47653244	47402457	37033896		36745187	
b. Infants < 1 year old	35366730	42613258	17701104		44527916	

c. Children 1 to 22 years old	127701617	162245544	93767071		125809244	
d. Children with Special Healthcare Needs	612613715	434299598	503301337		367279334	
e. Others	64329713	81251555	34804474		32206795	
f. Administration	3287906	3557482	1886623		1943395	
g. SUBTOTAL	890952925	771369894	688494505		608511871	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		270000		0	
b. SSDI	101303		85000		74835	
c. CISS	0		0		0	
d. Abstinence Education	2991440		2841809		2802179	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	900000		806338		808146	
j. Education	23765113		23867174		23178502	
k. Home Visiting	0		5604010		11208020	
k. Other						
DHHS ACF			3102520		3061535	
DHHS PHS Title X	11644517		10290042		11088112	
DHHS SAMSA	850000		850000		850000	
HRSA					800005	
Medicaid Match	8646452		9081530		9034268	
DHHS HRSA	6624047		844588			
DHHS ACF TANF	4500000					
DHHS ACF	3236330					

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2012		**FY 2013**		**FY 2014**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	633765886	503328135	491943772		386244310	
II. Enabling Services	49755348	58853435	36683291		53993385	
III. Population-Based Services	85056641	95803170	72912918		85630526	
IV. Infrastructure Building	122375050	113385154	86954524		82643650	

Services						
V. Federal-State Title V Block Grant Partnership Total	890952925	771369894	688494505		608511871	

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//

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//

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.