

New York State Prevention Agenda

Promote Healthy Women, Infants, and Children Action Plan

Updated: April 27, 2021

Introduction

"Improving the well-being of mothers, infants, and children is an important public health goal for the United States. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the health care system." - Healthy People 2020

The health of women, infants, children, and their families is fundamental to population health. This Prevention Agenda priority aligns directly with the Maternal and Child Health Services Block Grant (Title V) Program, the core federal and state public health program for promoting the health and well-being of the nation's mothers, infants, and children, including children and youth with special health care needs, and their families.⁷ As part of Title V, states are required to develop a Maternal and Child Health (MCH) State Action Plan that includes state priorities, objectives, and strategies, which are established based on data and stakeholder input obtained through a comprehensive and ongoing needs assessment process.⁸

Addressing these priorities requires strong partnerships and collaboration at all levels. Such partnership and collaboration are at the heart of the Prevention Agenda, providing a natural opportunity to align the Prevention Agenda 2019-2024 with NY's Title V State Action Plan. The Prevention Agenda goals, objectives, and interventions for Healthy Women, Infants, and Children were drawn from the state's Title V plan, with special consideration for those areas that would benefit from enhanced local action and cross-sector collaboration, and for which local data are available to track progress across the state.

Mirroring NY's Title V action plan, the Prevention Agenda Healthy Women, Infants, and Children (HWIC) priority focuses on health outcomes in three focus areas:

1. Maternal and Women's Health,
2. Perinatal and Infant Health, and
3. Child and Adolescent Health, including children with special health care needs (CSHCN).

New York State Title V State Action Plan priorities (2016-2020)

- Reduce maternal mortality and morbidity.
- Reduce infant mortality and morbidity.
- Support and enhance children's and adolescents' social-emotional development and relationships.
- Increase supports to address the special needs of children and youth.
- Increase use of primary and preventive health care services across the life course.
- Promote oral health and reduce tooth decay across the life course.
- Promote supports and opportunities that foster healthy home and community environments.
- Reduce racial, ethnic, economic and geographic disparities and promote health equity.

In addition, the HWIC plan includes a fourth cross-cutting focus area on social determinants of health and health equity, intended to address the entire MCH life course.

It is important to view these focus areas in the context of a life course perspective. Promoting healthy development, behaviors, and relationships early in life and during critical periods lays the groundwork for health promotion and disease prevention throughout the lifespan. Supporting the health and wellness of all women is essential to their current and lifelong well-being, regardless of their age, sexual or gender identity, pregnancy history, or future reproductive plans. Moreover, it requires a deep commitment to promoting health equity and eliminating racial, ethnic, economic, and other disparities, as reflected in the fourth cross-cutting focus area.

Guided by a life course framework, interventions must focus on mitigating risk factors, strengthening support for individuals and families, building resiliency, and addressing the broad social, economic, and environmental determinants of health. Interventions need to focus on critical periods of development (such as fetal development and early childhood), as well as the cumulative impact of exposures and adverse experiences over the life course and across generations. Public health efforts must include strategies that engage and support individuals, families, and providers across different settings and sectors and over time.⁹

The health of women, infants, and children is integral to other priorities addressed by the Prevention Agenda. Thus, information presented for this priority should be viewed in conjunction with, not separately from, other sections of the Prevention Agenda.

For additional information about the importance of promoting healthy women, infants and children and the life course perspective/framework, see the: *NYS Health Assessment Contributing Causes of Health Challenges*: https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/sha/contributing_causes_of_health_challenges.pdf

Focus Area 1: Maternal and Women's Health

Goal 1.1: Increase use of primary and preventive health care services among women of all ages, with a focus on women of reproductive age.

Objective 1.1.1: By December 31, 2024, increase the percentage of women ages 18-44 years with a past year preventive medical visit by 10% to 80.6%. (*Baseline: 73.3%, Year: 2016; Source: Behavioral Risk Factor Surveillance System; Data availability: State (by race/ethnicity, income), County (selected years).*)

Objective 1.1.2: By December 31, 2024, increase the percentage of women ages 45 years and older with a past year preventive medical visit by 2% to 85.0%. (*Baseline: 18-44 years: 83.3%, Year 2016; Source: Behavioral Risk Factor Surveillance System; Data availability: State (by race/ethnicity, income), County (selected years).*)

Objective 1.1.3: By December 31, 2024, increase the percentage of women ages 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy by 10% to 38.1%. (*Baseline: 34.6%; Year 2014; Source: Behavioral Risk Factor Surveillance System; Data availability: State (by race/ethnicity, income, and region), County (selected years).*)

Intervention 1.1.1: Incorporate strategies to promote health insurance enrollment, well-woman visits, and age-appropriate preventive health care across public health programs serving women

Description: A well-woman visit provides a critical opportunity to receive recommended clinical preventive services, including age-appropriate screenings, counseling, and immunizations, to support women's health across the life span.¹⁰ The annual well-woman visit is endorsed by the American College of Obstetrics and Gynecologists (ACOG),¹¹ and is one of the preventive services required by the Affordable Care Act (ACA) to be covered by private insurance plans without cost sharing.¹² NYS survey data show that women without health insurance are significantly less likely to report having a preventive visit in the past year, highlighting the importance of continuing to promote enrollment in affordable health insurance for all women.¹³ For women of reproductive age (defined as ages 15-44 or 18-44 years, depending on the data source), well-woman visits provide a key opportunity for provision of reproductive health care (see Intervention 1.1.2 below). New York State survey data demonstrate that women ages 18-44 years are significantly less likely to receive annual preventive medical visits than older women. A recent review by the Women's and Children's Health Policy Center at Johns Hopkins University found strong evidence that patient reminders/invitations are effective in increasing use of preventive health care visits by women. Other interventions - including community-based group education, patient navigation supports, provider reminder/recall systems, provider education, designated clinics/extended hours, community-level media, and expansion of insurance coverage - also appear to be effective.¹⁴

Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 1: Well-Woman Visit:

- [Evidence Analysis Report. NPM 1: Well-Woman Visit, Johns Hopkins University](#)
- [Evidence Brief. Well Woman Visits. National Center for Education in Maternal and Child Health \(NCEMCH\), Georgetown University](#)
- [Title V Transformation Tools. Recommendations to support NPM1 – Well Woman Visit. MCH Navigator](#)
- [Title V National Performance Measure Resource Sheet. NPM 1: Well-Women Visit. Association of Maternal and Child Health Programs \(AMCHP\)](#)

[ACOG Committee Opinion on Well-Woman Visit. American College of Obstetricians and Gynecologists, Committee on Gynecologic Practice.](#)

[Maternal and Infant Community Health Collaboratives \(MICHC\) Initiative. New York State Department of Health.](#)

[New York State of Health: The Official Health Plan Marketplace. New York State Department of Health.](#)

[Technical Assistance Document: Implementing USPSTF Recommendations into Professional Education Programs. Agency for Healthcare Research and Quality \(AHRQ\).](#)

[Think Cultural Health. U.S. Department of Health & Human Services, Office of Minority Health.](#)

[Women’s Preventive Service Guidelines. U.S. Department of Health and Human Services, Health Resources and Services Administration \(HRSA\).](#)

Age groups impacted by this intervention: adolescents age 13-21 years; adults age 21-60 years; older adults age 60+ years

Social determinants of health addressed by this intervention: health care, *other:* social support, discrimination, health literacy

Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Employers, businesses, and unions; Insurers; Community-based organizations and human service agencies; Policymakers & elected officials;
- **Supporting:** Media; Colleges & universities; Community or neighborhood residents; Transportation agencies; Economic development agencies; Urban planning agencies.

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of strategies implemented by your organization to increase 1) women’s enrollment in health insurance 2) women’s use of preventive health care/ well woman visits.

Related interventions, focus areas, or goals from other Prevention Agenda priorities: Preventing Chronic Diseases – Preventive Care and Management

Intervention 1.1.2: Integrate discussion of reproductive goals, pregnancy planning, and pregnancy prevention in routine health care for all women of reproductive age.

Description: Both the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Family Physicians (AAFP) recommend that every health care visit should include a discussion of women’s reproductive life plan and pregnancy intentions. For women who desire pregnancy, discussion should address pregnancy risk factors including chronic disease management, how to prepare for a healthy pregnancy, and optimal birth spacing. For women, who wish to delay or prevent pregnancy, discussion should address contraceptive options, and effective contraception should be provided.^{15 16} Reproductive life planning discussions and care should include adolescents.

Nearly half of all pregnancies in the United States are unplanned (either mistimed or not wanted), which underscores the importance of raising discussions about pregnancy planning and promoting women’s health across the lifespan, regardless of pregnancy intentions.¹⁷ While over 70% of women ages 18-44 years report having a preventive medical visit in the past year, only 35% report that a health care provider had ever talked with them about ways to prepare for a healthy pregnancy.¹⁸

The NYS Partnership for Maternal Health (PMH), established in 2015, brings together key organizational partners committed to decreasing maternal mortality and morbidity (see Goal 1.2). The PMH has focused on preconception health as an initial priority, with several provider education projects, including a 2016 Commissioner's letter, completed to date.¹⁹

Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 1: Well-Woman Visit:

- [Evidence Analysis Report. NPM 1: Well-Woman Visit, Johns Hopkins University.](#)
- [Evidence Brief. Well Woman Visits. National Center for Education in Maternal and Child Health \(NCEMCH\), Georgetown University.](#)
- [Title V Transformation Tools. Recommendations to support NPM1 – Well Woman Visit.](#)
- [Title V National Performance Measure Resource Sheet. NPM 1: Well-Women Visit. Association of Maternal and Child Health Programs \(AMCHP\).](#)

[ACT for Youth. Act for Youth Center for Community Action \(2018\).](#)

[Action Plan for the National Initiative on Preconception health and Health Care \(2012-2014\). Centers for Disease Control and Prevention.](#)

[Bedsider and Bedsider Provider](#)

[Before, Between & Beyond pregnancy: Resource Guide for Clinicians \(2018\). Clinical Work Group of the National Preconception Health and Health Care Initiative.](#)

[IMPLICIT Interconception Toolkit. March of Dimes Foundation.](#)
[Know Your Options, Get the Facts. New York State.](#)

Preconception Care webinars for Health Home Providers. New York State Department of Health

- [Well Woman Care and Preconception Care: Webinar for Health Home Providers.](#)
- [Preconception, Contraception and Conception for Women Living with HIV \(WLWH\): How Health Home Care Managers Can Provide Support to Facilitate Improved Health Outcomes. \(July 2018\).](#)
- [Postpartum Care for Women Living with HIV \(WLWH\) and their Newborns: How Health Home Care Managers Can Provide Support to Facilitate Improved Health Outcomes. \(August 2018\)](#)

[Preconception Health and Health Care: The Clinical Content of Preconception Care. American Journal of Obstetrics and Gynecology.](#)

[Preconception Health is Essential Well Woman Care – Webinar. New York State Partnership for Maternal Health. \(August 2018\).](#)

[Show Your Love Campaign. Centers for Disease Control and Prevention National Preconception Health Consumer Workgroup \(2013\).](#)

Age groups impacted by this intervention: adolescents, adults age 21-60 years

Social determinants of health addressed by this intervention: health care, *other:* social support, health literacy, discrimination, reproductive rights and justice.

Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers.
- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials; Transportation agencies.

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of strategies developed to integrate discussion of reproductive goals, pregnancy planning, and pregnancy prevention in primary health care visits for women of reproductive age.

Related interventions, focus areas, or goals from other Prevention Agenda priorities: Preventing Chronic Diseases – Preventive Care and Management

Goal 1.2: Reduce Maternal Mortality and Morbidity

- **Objective 1.2.1:** By December 31, 2024, decrease the maternal mortality rate by 22% to 16.0 maternal deaths per 100,000 live births. (*Baseline: 20.4; Year 2014-2016; Source: NYS Vital Statistics; Data availability: State (by race/ethnicity and region), County.*)
- **Objective 1.2.2:** By December 31, 2024, decrease the racial disparity in maternal mortality rates (ratio of black maternal mortality rate to white maternal mortality rate) by 34% to 3.1. (*Baseline: 4.68; Year 2014-2016; Source: NYS Vital Statistics; Data availability: State.*)

- **Objective 1.2.3:** By December 31, 2024, decrease the rate of severe maternal morbidity by 6% to 202.0 per 10,000 delivery hospitalizations. (*Baseline: 214.9; Year 2014 (5-year average); Source: Healthcare Cost and Utilization Project – State Inpatient Database (HCUP-SID); Data availability: State (by race/ethnicity and region), County.*)
- **Objective 1.2.4:** By December 31, 2024, increase the percentage of women who report that a health care provider asked them about depression symptoms at a postpartum visit by 5% to 80.0%. (*Baseline: 76.1%; Year 2016; Source: PRAMS; Data availability: State (by race/ethnicity, income, and region)*)

Intervention 1.2.1: Systematically review maternal deaths and several maternal morbidities and use results to inform maternal mortality and morbidity prevention efforts.

Description: Maternal mortality – the death of a woman while pregnant or within six weeks of a pregnancy from causes related to her pregnancy – is a devastating outcome. While New York’s maternal mortality rate has been declining, it remains higher than many other states, with dramatic racial disparities. The most recent complete review of maternal deaths for New York State identified embolism, hemorrhage, infection, cardiomyopathy, and hypertensive disorders as the leading causes of maternal deaths. Severe Maternal Morbidity (SMM), also referred to as “near misses”, encompasses life threatening medical complications or the need for life-saving interventions during delivery-related hospitalizations. SMM is 50-100 times more common than maternal mortality, with similar racial and ethnic disparities. A study identifying and analyzing SMM cases in New York State was published in 2017 to expand knowledge of these events.²⁰

The New York State Department of Health (NYSDOH) conducts comprehensive maternal mortality surveillance activities. Linked birth and death records, hospital in-patient and emergency department data, and a hospital-based adverse event reporting system are used to identify maternal deaths. All identified deaths are reviewed using a standardized tool. Data are analyzed and aggregated for review, discussion, and action. A multidisciplinary committee reviews the findings and provides recommendations for prevention, improvements in medical care and management, and education. The NYS Partnership for Maternal Health, established in 2015, brings together key organizational partners committed to decreasing maternal mortality and morbidity through collaboration.

In 2018, as part of the state’s comprehensive maternal mortality initiative (see Intervention 1.2.2), NYSDOH is implementing an enhanced process for maternal death reviews, developed in collaboration with the state’s chapter of the American College of Obstetricians and Gynecologists (ACOG). A formal multidisciplinary Maternal Mortality Review Board will have an active role in reviewing maternal death cases to assess causes of death, factors leading to death, preventability, and opportunities for intervention. Findings will be translated into issue briefs, Grand Rounds, quality improvement projects, and reports.

Resources

[New York State Maternal Mortality Review Report, 2012-13. New York State Department of Health.](#)

[New York City, 2008-2012 Severe Maternal Morbidity. \(2016\) New York City Department of Health and Mental Hygiene, Bureau of Maternal, Infant and Reproductive Health.](#)

[Pregnancy-Associated Mortality: New York City, 2006-2010 New York City Department of Health and Mental Hygiene, Bureau of Maternal, Infant and Reproductive Health.](#)

[Proceedings of the 2018 New York Maternal Mortality Summit.](#)

[Severe Maternal Morbidity in the United States. Centers for Disease Control and Prevention](#)

[Severe maternal morbidity: A population-based study of an expanded measure and associated factors.](#)

[Severe Maternal Morbidity: Screening and Review. American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine.](#)

Age groups impacted by this intervention: adolescents, adults age 21-60 and their families

Social determinants of health addressed by this intervention: health care, community cohesion, *other:* social support, family support, discrimination, reproductive rights and justice.

Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system
- **Supporting:** Insurers; Media; Colleges & universities; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of prevention strategies implemented by your organization based on state and local data about maternal morbidity and mortality.

Related interventions, focus areas, or goals from other Prevention Agenda priorities: Preventing Chronic Diseases – Preventive Care and Management

Intervention 1.2.2: Collaborate with partners to advance a comprehensive maternal health agenda that includes policy, community prevention, and clinical quality improvement strategies, with a focus on reducing disparities in maternal mortality and morbidity.

Description: In April 2018, New York State launched a comprehensive initiative to target maternal mortality and reduce racial disparities in maternal health outcomes. Building on the state's established maternal mortality review process, this initiative encompasses a range of approaches to reducing maternal deaths and racial disparities, including:

- Creating a state Task Force on Maternal Mortality and Disparate Racial Outcomes
- Establishing a Maternal Mortality Review Board, building on the Department of Health's current maternal mortality review committee;
- Launching a Best Practice Summit with hospitals and obstetric providers;
- Piloting expansion of Medicaid coverage for doulas;
- Supporting *Centering Pregnancy* demonstration projects;
- Requiring Continuing Medical Education (CME) and curriculum development for health care practitioners and trainees;
- Expanding the New York State Perinatal Quality Collaborative (NYSPQC) clinical quality improvement activities; and,
- Convening a series of Commissioner listening sessions with women across the state.

These strategic activities should build on the rich array of existing clinical, community, and policy initiatives in the state. It is essential that a wide range of partners – including clinical providers and institutions, community-based organizations and leaders, and community members – be engaged in these efforts.

Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 2 (Low-Risk Cesarean Delivery)

- Evidence Analysis Report NPM 2: Low-Risk Cesarean Deliveries. Johns Hopkins University
- [Evidence Briefs. Cesarean Births among Low Risk First Births. National Center for Education in Maternal and Child Health \(NCEMCH\), Georgetown University.](#)
- [Title V Transformation Tools. Recommendations to support NPM 2 – Low-risk Cesarean Delivery](#)

[Alliance for Innovation on Maternal Health \(AIM\). Council on Patient Safety in Women's Health Care](#)

[Centering Pregnancy. Centering Healthcare Institute \(2018\).](#)

[Cochrane Systematic Review: Continuous Support for Women During Childbirth.](#)

[Home Visiting Evidence of Effectiveness \(HomVee\). U.S. Department of Health and Human Services and Administration for Children and Families.](#)

[Levels of Maternal Care. Obstetric Care Consensus. American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine \(2016\).](#)

[Maternal and Infant Community Health Collaboratives \(MICHC\) Initiative. New York State Department of Health.](#)

[New York State’s Home Visiting Programs: Support for Pregnant and Parenting Families. New York State Department of Health](#)

[New York State Perinatal Quality Collaborative \(NYSPQC\). New York State Department of Health.](#)

[New York State Taskforce on Maternal Mortality and Disparate Racial Outcomes.](#)

[Safe Motherhood Initiative \(SMI\). American College of Obstetricians and Gynecologists \(ACOG\) District II, New York State.](#)

[Training Modules for Community Health Workers.](#)

Age groups impacted by this intervention: adolescents, adults age 21-60 years and their families

Social determinants of health addressed by this intervention: community cohesion, economic stability, education, food security, health care, housing, transportation, *other:* family support, social support, health literacy, home environment, discrimination, reproductive rights and justice,

Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers; Media; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials;
- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Schools (K-12); Transportation agencies; Housing agencies; Economic development agencies; Urban planning agencies; *other:* Criminal justice system

Intermediate-level measure that can be used by organizations to track progress toward

implementation of the intervention in the short term: The number of strategies implemented in collaboration with partners to reduce disparities in maternal mortality and morbidity.

Related interventions, focus areas, or goals from other Prevention Agenda priorities: Preventing Chronic Diseases – Preventive Care and Management

Intervention 1.2.3: Increase use of effective contraceptives to prevent unintended pregnancy and support optimal birth spacing.

Description: Approximately 55% of pregnancies in New York State are unintended (not wanted or mistimed). Reducing unintended pregnancies is a fundamental public health approach to reducing maternal mortality and morbidity. Use of effective contraceptives is key to reducing unintended pregnancy. Long acting reversible contraceptives (LARC), which include Intrauterine Devices (IUDs) and subdermal hormonal implants, are the most effective reversible methods available. Patient and provider knowledge, contraceptive coverage, and acquisition costs and logistics are all important factors to address use of effective contraception.

Over the past several years, several national and New York State initiatives have focused on: provider reimbursement for postpartum LARC insertion and LARC acquisition costs; provider education and

training; integration of reproductive life planning in well-woman care; and, enhanced consumer outreach and pregnancy prevention education by Community Health Workers through the state's Maternal Infant Community Health Collaboratives (MICHC) program.

Resources

[6 | 18 Initiative: Prevent Unintended Pregnancy. Centers for Disease Control and Prevention \(CDC\).](#)

[Bedsider](#) and [Bedsider Provider](#)

[Increasing Access to Contraception. Association of State and Territorial Health Officials \(ASTHO\).](#)

[Know Your Options, Get the Facts. New York State](#)

Long-Acting Reversible Contraception (LARC) Program. American College of Obstetricians and Gynecologists (ACOG).

- [National ACOG LARC Program](#)
- [New York State \(ACOG District II\) LARC Program](#)
- [ACOG District II LARC Resource Summary](#)

Medicaid Coverage of Long-Acting Reversible Contraception (New York State)

- [Medicaid Update \(September 2016\)](#)
- [eMedNY reimbursement guidance for physicians \(May 2014\)](#)

[New York State Family Planning Training Center.](#)

Age groups impacted by this intervention: adolescents, adults age 21-60 years and their families

Social determinants of health addressed by this intervention: education, health care, other: family support, social support, health literacy, discrimination, reproductive rights and justice.

Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers; Media; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials;
- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Schools (K-12); Transportation agencies; Economic development agencies; Urban planning agencies; other: Criminal justice system

Intermediate-level measure that can be used by organizations to track progress toward

implementation of the intervention in the short term: The number of strategies implemented to discuss the use of effective contraception to prevent unwanted pregnancy and support optimal birth spacing as part of well care visits for women of reproductive age.

Related interventions, focus areas, or goals from other Prevention Agenda priorities: Preventing Chronic Diseases – Preventive Care and Management

Intervention 1.2.4: Screen all pregnant and postpartum women for depression, with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

Description: Depression is the most common morbidity among postpartum women, affecting 10-20% of women during or within 12 months of pregnancy. Depression has implications for the well-being of the entire family and the development of infants and children. Legislation enacted for NYS in 2014 requires hospitals to educate patients about maternal depression and requires insurers to cover postpartum depression screening regardless of which health care provider performs the screening, when depression screening is a covered benefit.

The United States Preventive Services Task Force recommends screening for depression in pregnant and postpartum women. For screening to be effective, systems must be in place to ensure accurate diagnosis and effective treatment and follow-up for women with positive screening results. The USPSTF review identified a range of systems to support screening follow-up, from having designated nurses to implement protocols for facilitated referrals to more intensive systems that include: staff and clinician training (1- or 2-day workshops); clinician manuals; monthly training lectures; academic detailing; materials for clinicians, staff, and patients; an initial visit with a nurse specialist for assessment, education, and discussion of patient preferences and goals; a visit with a trained nurse specialist for follow-up assessment and ongoing support for medication adherence; a visit with a trained therapist for cognitive behavioral therapy (CBT); and a reduced copayment for patients referred for psychotherapy. Multidisciplinary team-based primary care that includes self-management support and care coordination has been shown to be effective in management of depression, as detailed in recommendations from the Community Preventive Services Task Force (CPSTF).

In a multi-year prenatal care quality improvement project conducted by the NYSDOH with Medicaid prenatal care providers, documentation of depression screening increased from 63% to 85% at initial prenatal visit and from 51% to 84% at postpartum visits (2009 to 2014 data) - although use of standardized screening tools was much lower. PRAMS data, which are based on an annual survey of a representative sample of women giving birth in New York State, show that approximately 76% of women report being asked about depression symptoms at their postpartum visit (2016 survey). While these data are encouraging, more efforts are needed to increase screening and strengthen supports and services for women with postpartum depression. A variety of collaborative initiatives have been implemented and are in progress to address this key issue, including updates to Medicaid coverage and reimbursement, the First 1000 Days on Medicaid initiative, the Healthy Steps program led by NYS Office of Mental Health, and the Early Childhood Comprehensive Systems (ECCS) Impact initiative led by NYS Council on Children and Families.

Resources

[A Comprehensive Approach for Community-Based Programs to address Intimate Partner Violence and Perinatal Depression. Social Solutions International, Inc.](#)

[Depression in Adults: Screening. United States Preventive Services Task Force \(USPSTF\)](#)

Early Childhood Comprehensive Systems Collaborative Improvement and Innovation Network (ECCS CoIIN).

- [National ECCS CoIIN Coordinating Center](#)
- [New York State ECCS Impact Initiative](#)

[First 1000 Days on Medicaid Initiative.](#)

Healthy Steps.

- [National Healthy Steps](#)
- [New York Office of Mental Health Implementation of Healthy Steps](#)

[Maternal Depression: Information for Health Care Providers. New York State Department of Health.](#)

[Medicaid Update: NYS Medicaid Coverage of Postpartum Maternal Depression Screening. New York State Department of Health.](#)

[Mental Health and Mental Illness: Collaborative Care for the Management of Depressive Disorders. The Guide to Community Preventive Services. Community Preventive Services Task Force \(CPSTF\). June 2010.](#)

[Postpartum Depression Toolkit. American Academy of Family Physicians National Research Network.](#)

[Postpartum Resource Center of New York.](#)

Age groups impacted by this intervention: adolescents, adults age 21-60 and their families

Social determinants of health addressed by this intervention: community cohesion, health care, other: family support, social support, health literacy, home environment.

Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers; Employers, businesses, and unions; Media; Community or neighborhood residents; Community-based organizations and human service agencies;
- **Supporting:** Insurers; Media; Colleges & universities; Schools (K-12); Policymakers & elected officials; Transportation agencies; Economic development agencies; Urban planning agencies; other: Child care, Criminal justice system

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of strategies implemented to effectively screen pregnant and postpartum women for depression and provide appropriate follow up.
Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote Well-Being and Prevent Mental & SU Disorders - Prevent Mental and SU Disorders

Focus Area 2: Perinatal & Infant Health

Goal 2.1: Reduce infant mortality and morbidity

- **Objective 2.1.1:** By December 31, 2024, decrease the infant mortality rate by 13% to 4.0 infant deaths per 1,000 live births.
(Baseline: 4.6; Year 2015; Source: National Vital Statistics System; Data availability: State (by race/ethnicity and region), County.)
- **Objective 2.1.2:** By December 31, 2024, decrease the percentage of births that are preterm by 5% to 8.3 percent of live births.
(Baseline: 8.7; Year 2015; Source: National Vital Statistics System; Data availability: State (by race/ethnicity and region), County.)
- **Objective 2.1.3:** By December 31, 2024, increase the percent of very low birthweight (VLBW) infants born in a Level III or higher hospital by 3% to 95.1%
(Baseline: 92.3; Year 2014; Source: National Vital Statistics System; Data availability: State (by race/ethnicity and region), County.)
- **Objective 2.1.4:** By December 31, 2024, decrease the rate of infants born with neonatal abstinence syndrome and/or affected by maternal use of drugs of addiction by 10% to 9.1 per 1,000 newborn discharges.
(Baseline: 10.1; Year 2016; Source: SPARCS; Data availability: State, Region, County.)
- **Objective 2.1.5:** By December 31, 2024, decrease the Sudden Unexpected Infant Death (SUID) mortality rate by 17% to 0.5 per 1,000 live births.
(Baseline: 0.6; Year 2015; Source: Vital Statistics; Data availability: State (by race/ethnicity and region), County.)

Intervention 2.1.1: Implement updated perinatal regionalization standards, designations, and structured clinical quality improvement initiatives in birthing hospitals and centers

Description: There is strong evidence that very high risk infants – such as those with very low birth weight (VLBW) or extreme prematurity – are significantly more likely to survive and thrive when born in facilities with Level III Neonatal Intensive Care Units equipped to handle high-risk newborns.²¹ For decades the American Academy of Pediatrics and others have recommended that VLBW and very preterm infants be delivered at hospitals with Level III/IV NICU facilities, designated based on uniform standards and organized within a statewide regionalized system of perinatal care.²² More recently, there has been renewed attention on the importance of standards and systems for regionalized maternal care to ensure that high risk women receive care in facilities prepared to provide the required level of care to reduce maternal morbidity and mortality.²³

The New York State Department of Health oversees a regionalized perinatal system in which every birthing hospital and birthing center in the state is designated at one of four levels based on the level of perinatal care it provides to women and newborns. Regional systems of Level I-III hospitals are led by Regional Perinatal Centers that provide or coordinate maternal-fetal and newborn transfers of high

risk patients from affiliate hospitals and birthing centers, and are responsible for support, education, consultation, and improvement in quality of care in their regional affiliates. A comprehensive process to update standards of care and designations, including incorporating midwife-led birthing centers in the system, is in progress. The New York State Perinatal Quality Collaborative (NYSPQC) initiative engages birthing hospitals and centers and other partners to translate evidence-based guidelines to clinical practice to improve outcomes for both mothers and infants.

A recent review by the Women’s and Children’s Health Policy Center at Johns Hopkins University found that population-based systems level approaches— such as statewide policies and guidelines – are an important component of interventions to increase risk-appropriate perinatal care. Adding a hospital component – such as ongoing education of hospital staff and clinical providers - to these systems interventions appears to increase their effectiveness.²⁴ New York's systems-building and quality improvement approaches are consistent with this evidence base and serve as a strong foundation for continued work in this area.

Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) NPM 3: Perinatal Regionalization:

- [Evidence Analysis Report. NPM 3: Risk-Appropriate Perinatal Care, Johns Hopkins University.](#)
- [Evidence Brief. Perinatal Regionalization. National Center for Education in Maternal and Child Health \(NCEMCH\), Georgetown University.](#)
- [Title V Transformation Tools. Recommendations to support NPM3 – Perinatal Regionalization.](#)

[Levels of Neonatal Care Policy Statement. American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine.](#)

[New York State Perinatal Quality Collaborative \(NYSPQC\).](#)

[Perinatal Regionalization. New York State Department of Health.](#)

[Toward Improving the Outcome of Pregnancy III: Enhancing Perinatal Health Through Quality, Safety and Performance Initiatives. March of Dimes Foundation.](#)

Age groups impacted by this intervention: adolescents, adults age 21-60 years, infants and their families

Social determinants of health addressed by this intervention: health care, family support

Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers
- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials; Transportation agencies;

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of local birthing hospitals that have been updated in accordance with perinatal designations.

Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote a Healthy and Safe Environment – Built and Indoor Environments

Intervention 2.1.2: Increase capacity and competencies of local maternal and infant home visiting programs

Description: Home visiting programs are a cornerstone of public health efforts to support pregnant and parenting families. An extensive body of research demonstrates that evidence-based home visiting programs improve numerous short- and long-term outcomes for mothers, infants, and families. As part of the national Maternal and Infant Early Childhood Home Visiting (MIECHV) program, the Home Visiting Evidence of Effectiveness (HomVee) project conducts ongoing in-depth analysis of research findings to identify evidence-based home visiting program models. In New York, MIECHV grant funds have supported the expansion of two specific evidence-based home visiting models: Nurse Family Partnership (NFP) and Healthy Families New York (HFNY). These complement other evidence-based programs operating in New York communities, including Early Head Start, Parents as Teachers, and Home Instruction for Parents of Preschool Youngers (HIPPY), as well as other traditional and emerging service models that include community outreach, home visit, and family support elements such as public health nursing, community health workers, and doulas.

Under New York State's MIECHV initiative, local home visiting programs have been engaged in a variety of efforts to build capacity and improve effectiveness in key areas, including: increasing referrals, client enrollment, and retention; extending the duration of breastfeeding; and increasing home visitors' knowledge and skills related to key topics such as intimate partner violence, substance use, mental health, smoking cessation, self-care, and post-partum/interconception care. Additionally, several local programs are working with the state to pilot the development of local coordinated intake and referral systems in communities with multiple home visiting programs.

Resources

[Community Health Workers Toolkit. NORC Walsh Center for Rural Health Analysis, University of Minnesota rural Health Resource Center, and Rural Health Information Hub.](#)

[First 1000 Days on Medicaid Initiative.](#)

[Home Visiting Evidence of Effectiveness \(HomVee\). U.S. Department of Health and Human Services and Administration for Children and Families.](#)

[Home Visiting Collaborative Improvement and Innovation Network \(CoIIN\).](#)

[Home Visiting – Your Partner in Helping Families. New York State Department of Health and University at Albany School of Public Health Center for Public Health Continuing Education. \(April 2018\).](#)

[Home is where the Start Is: Expanding Home Visiting to Strengthen All of New York’s Families. Schuyler Center for Analysis and Advocacy \(SCAA\).](#)

[New York State Home Visiting County Data Snapshots. Schuyler Center for Analysis and Advocacy \(SCAA\).](#)

[New York State’s Home Visiting Programs: Support for Pregnant and Parenting Families. New York State Department of Health. State](#)

[Training Modules for Community Health Workers.](#)

Age groups impacted by this intervention: adolescents, adults age 21-60, infants, children, and their families.

Social determinants of health addressed by this intervention: community cohesion, economic stability, education, food security, health care, housing, transportation, other: family support, social support, health literacy, learning environment, home environment, discrimination, reproductive rights and justice, incarceration, crime & violence

Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials.
- **Supporting:** Health care delivery system; Employers, businesses, and unions; Insurers; Media; Colleges & universities; Transportation agencies; Housing agencies; Economic development agencies; Urban planning agencies; other: Child care, Criminal justice system

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of strategies implemented to increase capacity and competencies of maternal and infant home visiting programs.

Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote Well-Being and Prevent Mental & SU Disorders - Promote Well-Being

Intervention 2.1.3: Engage in collaborative clinical and community-based strategies to reduce sleep-related infant deaths.

Description: Sudden Unexpected Infant Deaths (SUID) - a classification that includes Sudden Infant Death Syndrome (SIDS), accidental suffocation and strangulation in bed, and sleep-related deaths of unknown cause - are the leading cause of infant death after the first month of life and one of the leading causes of infant death overall. Because infants placed to sleep on their sides or stomachs (prone) are at increased risk of SIDS, the American Academy of Pediatrics and other public health organizations have long recommended that infants be placed to sleep on their backs. In 2011, these

recommendations were expanded to address other risk factors for sleep-related deaths by promoting safe sleep environments, breastfeeding, and avoiding smoke exposure.

A recent review by the Women’s and Children’s Health Policy Center at Johns Hopkins University found that national campaigns and interventions targeting caregivers, health care providers, and hospital levels appear to be effective at increasing exclusive back sleeping position in infants. There is less evidence to support interventions targeting only caregivers, health care providers, or child care providers alone. Researchers also noted substantial variation in following safe sleep recommendations by race and ethnicity, highlighting the need for interventions to consider these differences.²⁵ A variety of efforts to promote safe sleep and reduce sleep-related mortality have been completed or are underway in New York State, including community awareness campaigns and materials and several hospitals- and community-based quality improvement projects.

Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 4: Safe Sleep:

- [Evidence Analysis Report. NPM 4: Safe Sleep, Johns Hopkins University.](#)
- [Evidence Brief. Safe sleep. National Center for Education in Maternal and Child Health \(NCEMCH\), Georgetown University.](#)
- [Title V Transformation Tools – Safe Sleep](#)

[Building Integrated Systems for Address Sudden Unexpected Infant Death. National Center for Cultural Competence, Georgetown University](#)

[Caring for our Children – Safe Sleep Standards in Child Care Settings.](#)

[Collaborative Improvement and Innovation Network to Reduce Infant Mortality \(CoIIN\).](#)

[National Action Partnership to Promote Safe Sleep Improvement and Innovation Network \(NAPSS-IIN\) - Maternal and Child Health Bureau/ National Institute for Children's Health Quality \(NICHQ\).](#)

[New York State Perinatal Quality Collaborative \(NYSPQC\). New York State Department of Health.](#)

[Safe to Sleep Campaign®. Directed and managed by the National Institute of Child Health and Human Development.](#)

[SIDS and other sleep-related infant deaths: Expansion of recommendations for a safe infant sleeping environment. American Academy of Pediatrics](#)

[Sudden Unexpected Infant Death \(SUID\) and Sudden Infant Death Syndrome \(SIDS\) Gateway. National Center for Education in Maternal and Child Health, Georgetown University.](#)

[Toolkit for community health providers: Engaging ethnic media to inform communities about safe infant sleep. National Center for Cultural Competence, Georgetown University.](#)

Age groups impacted by this intervention: infants and their families.

Social determinants of health addressed by this intervention: community cohesion, health care, other: family support, social support, health literacy, home environment.

Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Media; Community or neighborhood residents; Community-based organizations and human service agencies; other: Child care.
- **Supporting:** Employers, businesses, and unions; Insurers; Colleges & universities; Schools (K-12); Policymakers & elected officials.

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of clinical or community-based strategies developed to reduce sleep related infant deaths.

Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote Well-Being and Prevent Mental & SU Disorders - Promote Well-Being

Intervention 2.1.4: Engage in collaborative strategies to respond to increasing use of opioids among women, including pregnant women, and impact on infants.

Description: Use of opioids among reproductive age women, including during pregnancy, has increased dramatically in recent years, paralleling the national and state opioid crisis. The rate of infants born with neonatal abstinence syndrome (withdrawal from opioids) increased by over 100% from 2008 to 2014, to nearly 6 infants per 1,000 delivery hospitalizations. Addressing the opioid epidemic is a public health priority in NYS. In 2014, the state established the Heroin and Opioid Task Force and enacted Combat Heroin legislation, establishing a multi-faceted response with a focus on prevention, harm reduction, treatment, recovery, and law enforcement. A collaborative approach is essential to addressing this complex issue. Several initiatives are in place and in process at the state level, including efforts focused specifically on pregnant women and families.

Resources

[A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders. Substance Abuse and Mental Health Service Administration \(SAMHSA\).](#)

[Combating the Heroin and Opioid Crisis: Heroin and Opioid Task Force Report \(June 2016\). Report of NYS Task Force](#)

[Institute for Research, Education and Training in Addictions \(IRETA\).](#)

[National Collaborative for Maternal Opioid Use Disorders. Alliance for Innovation on Maternal Health.](#)

[National Registry of Evidence-Based Programs and Practices \(NREPP\). Substance Abuse and Mental Health Services Administration \(SAMHSA\).](#)

[New York State Opioid Overdose Prevention Program. New York State Department of Health Opioid Addiction Prevention & Management Collaborative. Health Care Association of New York State \(HANYS\).](#)

[Opioid-related Data in New York State. New York State Department of Health \(2018\).](#)

[During Pregnancy. National Institutes of Health \(NIH\) National Institute on Drug Abuse \(NIDA\).](#)

[Preventing Opioid Misuse in Pregnant Women and New Moms Challenge. Maternal and Child Health Bureau.](#)

Age groups impacted by this intervention: infants, adolescents, adults age 21-60 and their families.

Social determinants of health addressed by this intervention: community cohesion, economic stability, education, health care, other: family support, social support, health literacy, discrimination, incarceration, crime & violence

Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials; Economic development agencies; Criminal justice system
- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Schools (K-12); Transportation agencies; Housing agencies; Urban planning agencies;

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of strategies implemented by local health organizations to address the increase in opioid use among women as well as its effect on infants.

Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote Well-Being and Prevent Mental & SU Disorders - Prevent Mental and SU Disorders

Goal 2.2: Increase breastfeeding

- **Objective 2.2.1:** By December 31, 2024, increase the percentage of infants who are exclusively breastfed in the hospital by 10%:
 - from 47.0% (2016) to 51.7% among all infants
 - from 34.0% (2016) to 37.4% among Hispanic infants
 - from 34.9% (2016) to 38.4% among Black, non-Hispanic infants
 - from 34.7% (2016) to 38.2% among infants insured by Medicaid
- (Data Source: Vital Statistics)*

- **Objective 2.2.2:** By December 31, 2024, decrease the percentage of breastfed infants supplemented with formula in the hospital by 10%:
 - from 46.6% (2016) to 41.9% among all infants
 - from 62.6% (2016) to 56.3% among Hispanic infants
 - from 59.4% (2016) to 53.5% among Black, non-Hispanic infants
 (Data Source: Vital Statistics)
- **Objective 2.2.3:** By December 31, 2024, increase the percentage of infants enrolled in WIC who are breastfed at 6 months by 10%:
 - from 41.4% (2016) to 45.5% among all WIC infants
 - from 37.7% (2016) to 41.5% among Black, non-Hispanic WIC infants
 - from 41.8% (2016) to 46.0% among Hispanic, WIC infants
 (Data Source: Pediatric Nutrition Surveillance System)

Intervention 2.2.1: Increase access to professional support, peer support, and formal education to change behavior and outcomes.

Description: Local health departments, hospitals, health centers, insurers (including Medicaid Managed Care), businesses, CBOs and other stakeholders should collaboratively work to ensure increased awareness, availability and accessibility of culturally competent lactation consultants, and breastfeeding support prenatally and postpartum. This includes ensuring that culturally competent, professional lactation consultants (e.g., IBCLCs); peer support (e.g., WIC); and formal breastfeeding education is available in the local area, and that information and resources on accessing support and contacts is up-to-date and accessible.

Resources

Cochrane Systematic Review (2016). [Interventions for Promoting the Initiation of Breastfeeding](#)

U.S. Preventive Services Task Force (2016). [Primary Care interventions to Support Breastfeeding Recommendation Statement](#) and [Breastfeeding: Primary Care interventions](#)

AHRQ: Breastfeeding Programs and Policies, Breastfeeding Uptake, and Maternal Health Outcomes in Developed Countries (2018). [Full Report](#) and [Evidence Summary](#)

U.S. Department of Agriculture (2018). [Partnering with WIC to Support Breastfeeding](#)

United States Breastfeeding Committee (2010). [Core Competencies in Breastfeeding Care and Services for All Health Professionals](#)

Centers for Disease Control and Prevention (2013). [Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies](#)

Atlanta: U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services (2011). [The Surgeon General's Call to Action to Support Breastfeeding](#) Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. (Actions 1, 2,3, 8 and 9: pgs. 38-40, 45-47).

Evans A, Marinelli KA, Taylor JS and The Academy of Breastfeeding Medicine (2014). [ABM Clinical Protocol #2: Guidelines for Hospital Discharge of the Breastfeeding Term Newborn and Mother: "The Going Home Protocol," Revised 2014](#) doi: 10.1089/bfm.2014.9996.
New York State Department of Health. [Women, Infants, and Children \(WIC\) Program Site Information Dataset](#)

New York State Department of Health. [Breastfeeding Friendly Practices by County](#)

Age range(s): Pregnant and Postpartum Women

Social Determinant of Health addressed: Health Care, Education, Community Cohesion

Sector(s) playing lead role: Healthcare Delivery System

Sector(s) playing contributing role: Insurers, Media, CBOs and Human Service Agencies

Intermediate-level measure: 1) Number of Supplemental Nutrition Program for Women, Infants and Children (WIC) local agencies or sites, hospitals, hospital-affiliated clinics, primary care practices) that provide professional support, peer support and formal education to change behavior and outcomes.

Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote evidence-based care to prevent and manage chronic diseases including obesity, reduce food insecurity, promote tobacco use cessation, eliminate exposure to secondhand smoke

Intervention 2.2.2: Promote and implement maternity care practices consistent with the Baby Friendly Hospital Initiative - Ten Steps to Successful Breastfeeding.

Description: Local health departments, health centers, insurers, businesses, CBOs and other stakeholders should work with hospitals to implement recommended maternity care practices and policies, and support hospitals in becoming certified as Baby Friendly. The goal is to increase the percent of mothers and newborns who are exposed to recommended maternity care practices, and the percent of infants born in Baby Friendly Hospitals.

Resources

World Health Organization (1998). [Evidence for the Ten Steps to Successful Breastfeeding](#)

World Health Organization (2018). Revised Baby-Friendly Hospital Initiative [Protecting, Promoting and Supporting Breastfeeding in Facilities Providing Maternity and Newborn Services](#)

Baby-Friendly USA, Inc. (2016). [The Baby-Friendly Initiative, Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation](#)

United States Lactation Consultant Association (2010). [International Board Certified Lactation Consultant Staffing Recommendations for the Inpatient Setting](#)

Nickel NC, Labbok MH, Hudgens MG, Daniels JL. [The Extent that Noncompliance with the Ten Steps to Successful Breastfeeding Influences Breastfeeding Duration](#)

J Hum Lact 2013;29(1): 59-70.

Baby-Friendly USA, Inc. (2016).

- [The Baby-Friendly Initiative, Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation](#)
- [Baby-Friendly Hospital Initiative: Facility Self-Appraisal Tool](#)
- [Designated Facilities by State](#)

Centers for Disease Control and Prevention (2015). [Maternity Practices in Infant Nutrition and Care \(mPINC\) Survey](#)

Age range(s): Pregnant and Postpartum Women

Social Determinant of Health addressed: Health Care, Education

Sector(s) playing lead role: Healthcare Delivery System

Sector(s) playing contributing role: Insurers, Media, CBOs and Human Service Agencies

Intermediate-level measure: 1) Number of hospitals that improve their maternity care practices towards consistency with the Ten Steps to Successful Breastfeeding.

Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote evidence-based care to prevent and manage chronic diseases including obesity, reduce food insecurity, promote tobacco use cessation, eliminate exposure to secondhand smoke

Intervention 2.2.3: Promote and implement early skin-to-skin contact in hospitals

Description: Local health departments, hospitals, health centers, insurers (including Medicaid Managed Care), businesses, CBOs and other stakeholders should work to promote early skin-to-skin contact by educating women and their families of the benefits of skin-to-skin contact. Hospitals and health centers can ensure that providers and staff are knowledgeable and informed, and their policies, practices, and staff support skin-to-skin contact between mother and newborn immediately following birth (until the first breastfeeding is completed), and the first six hours.

Resources:

Cochrane Systematic Review (2016). [Early Skin-to-Skin Contact for Mothers and Their Health Newborn Infants](#)

Hung KJ & Berg O. [Early Skin-To-Skin after Cesarean to Improve Breastfeeding](#) MCN 2011;36(5):318-324.

Feldman-Winter L, Goldsmith JP, Committee on Fetus and Newborn, Task Force on Sudden Infant Death Syndrome. American Academy of Pediatrics (AAP). [Safe Sleep and Skin-to-Skin Care in the Neonatal Period for Healthy Term Newborns](#) Pediatrics 2016;138(3):e1-e10.

Association of Women’s Health, Obstetric and Neonatal Nurses. [Immediate and Sustained Skin-to-Skin Contact for the Healthy Term Newborn After Birth](#)

AWHONN Practice Brief Number 5. JOGNN 2016;45:842-844.

United States Institute for Kangaroo Care. [Kangaroo Care Resources](#)

Rosen-Carole C, Hartman S and The Academy of Breastfeeding Medicine. [ABM Clinical Protocol #19: Breastfeeding Promotion in the Prenatal Setting, Revision 2015](#)

Baby-Friendly USA, Inc. (2016).

- [The Baby-Friendly Initiative, Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation](#)
- [Baby-Friendly Hospital Initiative: Facility Self-Appraisal Tool](#)
- [Designated Facilities by State](#)

Centers for Disease Control and Prevention (2015). [Maternity Practices in Infant Nutrition and Care \(mPINC\) Survey](#); questions A4, A5, A10, A11

Age range(s): Newborn infants up to 1 month; Pregnant and Postpartum Women

Social Determinant of Health addressed: Health Care, Education

Sector(s) playing lead role: Healthcare Delivery System, Governmental Public Health Agencies

Sector(s) playing contributing role: Healthcare Delivery System, Insurers, CBOs and Human Service Agencies

Intermediate-level measure: 1) Number of hospitals that improve their maternity care practices to promote and ensure early skin to skin contact 2) Number of staff (nurses, lactation consultant or other professionals, doulas, and/or WIC nutrition educators) trained in Kangaroo Care, who provide prenatal education and/or maternal support on early skin-to-skin contact after delivery.

Related interventions, focus areas and goals from other priorities: Promote evidence-based care to prevent and manage chronic diseases including obesity, reduce food insecurity, promote tobacco use cessation, eliminate exposure to secondhand smoke

Intervention 2.2.4: Increase access to primary care practices that are supportive of breastfeeding.

Description: Local health departments, hospitals, health centers, insurers, businesses, CBOs and other stakeholders should work with primary care practices to support staff education and training, provide guidance in developing policies and procedures that are consistent with recommended guidelines, and that practices meet the criteria to become designated as a NYS Breastfeeding Friendly Practice. The goal is to increase the number of designated practices, and the number of patients who are supported and receive primary care in a Breastfeeding Friendly Practice.

Resources

AHRQ: Breastfeeding Programs and Policies, Breastfeeding Uptake, and Maternal Health Outcomes in Developed Countries (2018). [Full Report](#) and [Evidence Summary](#)

The Academy of Breastfeeding Medicine Protocol Committee. ABM Clinical Protocol #14: [Breastfeeding Friendly Physician's Office](#), Part 1: Optimizing care for infants and children, Revised 2013. *Breastfeeding Med* 2006;1(2):115-119.

Shariff F, Levitt C, Kaczorowski J, et al. Workshop to implement the [Baby Friendly Office](#) initiative. Effect on community physicians' offices. *Can Fam Physician* 2000;46:1090-1097.

The American Academy of Pediatrics, Breastfeeding Initiatives. [How to Have a Breastfeeding Friendly Practice](#)

American College of Obstetricians and Gynecologists (ACOG). Optimizing Support for Breastfeeding as Part of Obstetric Practice. Committee Opinion. No. 756. *Obstet Gynecol* 2018;132:e187-196.

New York State Department of Health.

- [Breastfeeding Friendly Practice Designation](#)
- [NYS Breastfeeding Friendly Practice Designation Assessment Survey](#)
- [Breastfeeding Friendly Practices by County](#)

Age range(s): Infants and Young Children (0 - 3 years), Prenatal and Postpartum Women

Social Determinant of Health addressed: Health Care, Community Cohesion, Education

Sector(s) playing lead role: Healthcare Delivery System

Sector(s) playing contributing role: Insurers, Community or Neighborhood Residents, Governmental Public Health Agencies

Intermediate-level measure: 1) Number of health care practices that improve their policies and practices to support breastfeeding mothers and families. 2) Number of practices (pediatric, obstetric or family medicine) with breastfeeding office policies. 3) Number of practices that become designated as a NYS Breastfeeding Friendly Practice.

Related interventions, focus areas and goals from other priorities: Promote evidence-based care to prevent and manage chronic diseases including obesity, reduce food insecurity, promote tobacco use cessation, eliminate exposure to secondhand smoke

Intervention 2.2.5: Increase access to community-based interventions that provide mothers with peer support via home visits in the prenatal and early postpartum period.

Description: Local health departments, hospitals, health centers, insurers (including Medicaid Managed Care), businesses, and other stakeholders should establish partnerships with community-based organizations (i.e., trained community health workers, doulas and other peer support) to provide prenatal breastfeeding education, assistance, support, and facilitate coordination to community resources, and continuity of care post-discharge.

Resources

AHRQ: Breastfeeding Programs and Policies, Breastfeeding Uptake, and Maternal Health Outcomes in Developed Countries (2018). [Full Report](#) and [Evidence Summary](#)

Cochrane Systematic Review (2017). [Schedules for Home Visits in the Early Postpartum Period](#)

U.S. Department of Health and Human Services. [Home Visiting Evidence of Effectiveness](#)

Centers for Disease Control and Prevention (2005). Shealy KR, Li R, Benton-Davis S, Grummer-Strawn LM. The CDC Guide to Breastfeeding interventions Atlanta: U.S. Department of Health and Human Services.

Centers for Disease Control and Prevention (2013). [Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies](#) Atlanta: U.S. Department of Health and Human Services.

New York State Department of Health. [Find a Home Visiting Program](#) and [List of Home Visiting Programs in NYS](#)

Age range(s): Infants, Prenatal and Postpartum Women

Social Determinant of Health addressed: Health Care, Community Cohesion, Education

Sector(s) playing lead role: Governmental Public Health Agencies, Healthcare Delivery System

Sector(s) playing contributing role: Insurers, Community or neighborhood residents, CBOs and Human service agencies, Policy makers and other elected officials

Intermediate-level measure: 1) Number of community-based organizations that provide information, support and referrals to promote and support breastfeeding via home visits 2) Number of mothers that receive information, support and referrals to promote support breastfeeding via home visits.

Related interventions, focus areas and goals from other priorities: Promote evidence-based care to prevent and manage chronic diseases including obesity, reduce food insecurity, promote tobacco use cessation, eliminate exposure to secondhand smoke

Intervention 2.2.6: Increase support for breastfeeding in the workplace.

Description: Local health departments, hospitals, health centers, insurers, businesses, CBOs and other stakeholders should ensure their worksite has fully implemented the NY Nursing Mothers in the Workplace Act (NY Labor Law 206-c) and can work to assist other worksites to implement this Labor Law and adopt and implement policies and recommended multi-component worksite breastfeeding support programs. At the county or regional level, several health departments are working together to develop interventions to support local worksites, including educational materials, assessment tools, and guidelines to designate worksites as Breastfeeding Friendly.

Resources

Dinour L, Szaro J. Employer-Based Programs to Support Breastfeeding Among Working Mothers: A Systematic Review. *Breastfeeding Medicine* 2017;12(3).

New York State Department of Labor. [NYS Nursing Mothers in the Workplace Act](#)

Centers for Disease Control and Prevention (2013). [Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies](#)
Atlanta: U.S. Department of Health and Human Services (Strategy 5: Support for Breastfeeding in the Workplace pg. 23 - 28)

U.S. Department of Health and Human Services (2011). [The Surgeon General's Call to Action to Support Breastfeeding](#) Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. (Action 13: pg. 50).
[Making It Work Toolkit](#)

U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau (2008). [Business Case for Breastfeeding](#)

New York City Department of Health, Center for Health Equity (2018). [Breastfeeding Toolkit for Business Owners](#)

Niagara County Breastfeeding Friendly Employer Initiative
<http://www.niagaracounty.com/health/Services/Lactation-and-Breastfeeding>

Centers for Disease Control and Prevention (2014). [The CDC Worksite Health Score Card: An Assessment Tool for Employers to Prevent Heart Disease, Stroke, & Related Health Conditions](#)
Lactation Support Module (6 questions); page 21

Niagara County Department of Health. [Breastfeeding Friendly Workplace Assessment](#)

Age range(s): All Infants (0-3yrs), Women of Child-Bearing Age, Prenatal and Postpartum Women

Social Determinant of Health addressed: Economic Stability

Sector(s) playing lead role: Governmental Public Health Agencies; Policy Makers and Elected Officials

Sector(s) playing contributing role: Media; Insurers; Healthcare Delivery Systems

Intermediate-level measure: 1) Number of worksites that improve their policies and practices to support breastfeeding mothers and families.

Related interventions, focus areas and goals from other priorities: Healthy Eating and Food Security

Intervention 2.2.7: Increase access to Early Care and Education programs that support breastfeeding families.

Description: Local health departments, hospitals, health centers, insurers, businesses, CBOs and other stakeholders should work to assist child care providers support breastfeeding families. This includes encouraging and supporting child care providers to receive training and education to support breastfeeding families, helping facilities develop breastfeeding friendly policies and working with day care centers and homes to meet the criteria to become designated as breastfeeding friendly.

Resources

Batan M, Li R, Scanlon K. [Association of child care providers breastfeeding support with breastfeeding duration at 6 months](#). *Matern Child Health J.* 2012 doi: 10.1007/s10995-012-1050-7. Centers for Disease Control and Prevention (2013). [Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies](#) Atlanta: U.S. Department of Health and Human Services. (Strategy 6: Support for Breastfeeding in the Early Care and Education pg. 29 – 32)

American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. 2011. *Caring for our children: National health and safety performance standards; Guidelines for early care and education programs*. 3rd Edition. Also available at <http://nrckids.org>

[Chapter 4: Nutrition and Food Service, 4.3 Requirements for Specials Groups or Ages of Children, 4.3.1 Nutrition for Infant](#)

[Breastfeeding and Early Care and Education – Centers for Disease Control and Prevention](#)

New York State Department of Health - [CACFP Breastfeeding Friendly Child Care Designation Program](#)

- [Child Care Center Breastfeeding Friendly Self-Assessment](#)

- [Day Care Home Breastfeeding Friendly Self-Assessment](#)
- [Day Care Home Breastfeeding Friendly Self-Assessment Spanish](#)
- [Breastfeeding Friendly Child Care Centers by County](#)
- [Breastfeeding Friendly Child Care Homes by County](#)

Age range(s): Infants and young children (6 weeks – 3 years), Women of Child-Bearing Age, Prenatal and Postpartum Women

Social Determinant of Health addressed: Economic Stability, Food Security, Community Cohesion

Sector(s) playing lead role: Governmental Public Health Agencies; Employers, Businesses and Unions; Policy Makers and Elected Officials

Sector(s) playing contributing role: Media; Insurers; Healthcare Delivery Systems

Intermediate-level measure: 1) Number of child care programs that improve their practices to support breastfeeding mothers and families.

Related interventions, focus areas and goals from other priorities: Healthy Eating and Food Security

Intervention 2.2.8: Increase access to peer and professional breastfeeding support by creating drop-in centers (e.g., Baby Cafés®) in faith-based, community-based or health care organizations in communities.

Description: Local health departments, hospitals, health centers, insurers, businesses, CBOs and other stakeholders should work together to support and establish breastfeeding support groups in faith-based, community-based or health care organizations in communities. Support groups should provide access to lactation consultants (IBCLCs), other lactation professionals and peer support (pregnant and/or breastfeeding), their families, and other support persons).

Resources

Fox, Rebekah & McMullen, Sarah & Newburn, Mary. (2015). [UK women’s experiences of breastfeeding and additional breastfeeding support: a qualitative study of Baby Café services.](#) BMC Pregnancy and Childbirth. 15:147. DOI 10.1186/s12884-015-0581-5.

Evans, Marinelli, Taylor, Academy of Breastfeeding Medicine (2014). [ABM Clinical Protocol #2: Guidelines for Hospital Discharge of the Breastfeeding Term Newborn and Mother: “The Going Home Protocol,” Revised 2014](#) Breastfeeding Med 2014; 9(1). DOI: 10.1089/bfm.2014.9996

U.S. Department of Health and Human Services (2011). [The Surgeon General’s Call to Action to Support Breastfeeding.](#) Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. (Actions 3 and 11: pgs. 40 and 48).

Centers for Disease Control and Prevention (2013). [Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies](#) Atlanta: U.S. Department of Health and Human Services.

Baby Café USA: <http://www.babycafeusa.org/> and [List of Baby Cafés in your state](#)

Age range(s): Infants and Young Children (0-3 years), Women of Child-Bearing Age, Prenatal and Postpartum Women

Social Determinant of Health addressed: Economic Stability, Food Security, Community Cohesion, Health Care

Sector(s) playing lead role: CBOs and Human Service Agencies, Community or Neighborhood Residents

Sector(s) playing contributing role: Media; Insurers; Healthcare Delivery Systems; Policy Makers and Elected Officials; Governmental Public Health Agencies

Intermediate-level measure: 1) Number of faith-based, community-based or health care organizations that provide peer and professional breastfeeding support by creating drop-in centers/Baby Cafés® 2) Number of mothers who received peer- and professional support at drop-in centers/Baby Cafés®.

Related interventions, focus areas and goals from other priorities: Healthy Eating and Food Security

Focus Area 3: Child and Adolescent Health

Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships

- **Objective 3.1.1:** By December 31, 2024, increase the percentage of children ages 9-35 months who received a developmental screening using a parent-completed screening tool in the past year by 20% to 21.0%. (*Baseline: 17.5%; Year: 2016; Source: National Survey of Children's Health; Data availability: State*).
- **Objective 3.1.2:** By December 31, 2024, increase the percentage of children and adolescents, age 3-17 years, with a mental/behavioral health condition who received treatment or counseling by 10% to 49.8%. (*Baseline: 45.3%; Year: 2016; Source: National Survey of Children's Health; Data availability: State*).
- **Objective 3.1.3:** By December 31, 2024, decrease the percentage of adolescents in grades 9-12 who felt sad or hopeless for two or more weeks in a row in the past year by 25% to 21.5% (*Baseline: 28.6%; Year: 2015; Source: Youth Risk Behavior Survey; Data availability: State (by race, grade, sex, sexual identity)*).
- **Objective 3.1.4:** By December 31, 2024, decrease the suicide mortality rate for youth ages 15-19 years by 6% to 4.7 per 100,000. (*Baseline: 5.0 deaths per 100,000 population ages 15-19 years; Year: 2014-16; Source: Vital Statistics; Data availability: State (by race), County*).

Intervention 3.1.1: Increase awareness, knowledge, and skills of providers serving children, youth, and families related to social-emotional development, adverse childhood experiences (ACEs), and trauma-informed care.

Description: Supporting the healthy social-emotional development of children has emerged as a public health priority. Social-emotional development is foundational to children's development in other domains, school readiness and success, and lifelong health and well-being.²⁶ Adverse childhood experiences (ACEs) including abuse and neglect, parental mental illness and addiction, family separation, and other traumatic experiences can have profound impact on children's development. ACEs are associated with significantly increased risk for a wide range of chronic health conditions and risk factors later in life – as well as adverse pregnancy outcomes such as preterm birth.^{27 28 29}

Strategies to increase individual foundational knowledge and skills for those working with children and families are a key element of building an effective capacity and response. A variety of state projects and national resources are available for individual practitioners and organizations to support this aspect of workforce development. Additional resources will be added as this emerging area of practice continues to grow.

Resources

[Docs for Tots.](#)

[National Center of Trauma Informed Care \(NCTIC\). Supported by the federal Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#)

[The Pyramid Model.](#)

[Trauma Informed Care: Perspectives and Resources. Developed by the National Technical Assistance Center for Children’s Mental Health at Georgetown University Center for Child and Human Development.](#)

[The Trauma Informed Care Project \(TCIP\).](#)

Age groups impacted by this intervention: infants, children, adolescents and their families

Social determinants of health addressed by this intervention: education, community cohesion, health care, family support, social support, incarceration, discrimination.

Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Colleges & universities; Schools (K-12); Community-based organizations and human service agencies; Media; Other: Child care, Criminal justice
- **Supporting:** Insurers; Policymakers & elected officials; Economic development agencies; Housing agencies

Intermediate-level measure that can be used by organizations to track progress toward

implementation of the intervention in the short term: The number of providers who have received training/professional development to improve knowledge and skills related to social emotional development, adverse childhood experiences, or trauma informed care.

Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote Well-Being and Prevent Mental & SU Disorders - Promote Well-Being

Intervention 3.1.2: Identify and integrate evidence-based and evidence-informed strategies to promote social-emotional wellness through public health programs serving children, youth, and families.

Description: As noted for Intervention 3.1.2, social-emotional development is foundational to children’s development in other domains, school readiness and success, and lifelong health and well-being.³⁰ Adverse childhood experiences (ACEs) including abuse and neglect, parental mental illness and addiction, family separation, and other traumatic experiences can have profound impact on children’s development and are associated with significantly increased risk for a wide range of chronic health conditions and risk factors later in life – as well as adverse pregnancy outcomes such as preterm birth.^{31 32 33}

Collaborative strategies to promote positive development, build resiliency, and support safe, stable, and nurturing relationships and environments throughout childhood and adolescence have the potential to improve health outcomes across the life course.³⁴ Integrating basic trauma-informed approaches and practices can help recognize and respond to the impact of trauma on individuals and communities. While intensive behavioral health and trauma-informed care interventions are beyond the scope of some service settings and programs, strategies to promote positive social-emotional development and fundamental trauma-informed approaches should be integrated across all programs serving children, youth, and families. (See also Intervention 3.1.1)

Resources

[Essentials for Childhood Framework: Creating Safe, Stable, Nurturing Relationships and Environments for All Children. Centers for Disease Control and Prevention \(CDC\). First 1000 Days on Medicaid Initiative.](#)

Healthy Steps.

- [National Healthy Steps](#)
- [New York Office of Mental Health Implementation of Healthy Steps](#)

Help Me Grow.

- [Help Me Grow National Center](#)
- [Help Me Grow New York](#)

[Meeting the Social-Emotional Development Needs of Infants and Toddlers: Guidance for Early Intervention and Other Early Childhood Professionals \(2017\). Joint Task Force on Social-Emotional Development: New York State Department of Health Early Intervention Coordinating Council and New York State Early Childhood Advisory Council.](#)

[The National Center for Pyramid Model Interventions \(NCPMI\).](#)

[The Resilience Project. American Academy of Pediatrics.](#)

[The Search Institute.](#)

[Supporting Social-Emotional Learning with Evidence-Based Programs. Annie E. Casey Foundation.](#)

[Teaching Students to Prevent Bullying: Curriculum and Resources. National Education Association.](#)

Age groups impacted by this intervention: infants, children, adolescents and their families

Social determinants of health addressed by this intervention: education, community cohesion, health care, family support, social support, incarceration, discrimination.

Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers; Schools (K-12); Community-based organizations and human service agencies; Other: Child care, Criminal justice system
- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Community residents; Policymakers & elected officials; Housing agencies; Economic development agencies; Natural environment agencies; Urban planning agencies

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of strategies implemented that promote social-emotional wellness among children, youth, and families through public health programs.

Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote Well-Being and Prevent Mental & SU Disorders - Promote Well-Being

Intervention 3.1.3: Engage in collaborative strategies to increase developmental screening of young children in accordance with professional medical guidelines.

Description: Early identification of developmental delays and disabilities is critical to the well-being of children and their families. Routine developmental screening at specified intervals, combined with ongoing developmental surveillance, is an integral component of children’s health care. The American Academy of Pediatrics recommends that developmental screening using standardized tools be completed at the 9, 18, and 30 (or 24) month well-child visits, but screening rates have remained low. Based on the 2016 National Survey of Children’s Health (NSCH), only 30.4% of children ages 9 to 35 months nationally, and 17.5% in New York State, received a parent-completed standardized developmental screening in the previous year. National data also reveal disparities in screening rates, with lower rates among black and Asian children, children living in poverty, and children whose parents have lower education.³⁵ A study published in *Pediatrics* found that disparities in age at diagnosis for autism spectrum disorders (ASD) between white and Latino children may be due in part to lack of language-appropriate screenings, culturally appropriate materials for families, and access to developmental specialists.³⁶

A recent review by the Women’s and Children’s Health Policy Center at Johns Hopkins University found evidence that structured quality improvement activities (e.g., Plan-Do-Study-Act cycles) in health care settings appear to be effective. Quality improvement initiatives that include additional systems-level approaches - such as collaboration with health departments, insurance coding or payment changes, or involvement in larger systems-change initiatives or improvement partnerships - also appear to be effective. Other interventions, including health care provider training and home visiting programs may be effective, but because the number of published studies is limited, further evidence is needed to fully assess these.³⁷

Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 6: Developmental Screening:

- [Evidence Analysis Report. NPM 6: Developmental Screening, Johns Hopkins University.](#)
- [Evidence Brief. Developmental Screening. National Center for Education in Maternal and Child Health \(NCEMCH\), Georgetown University.](#)
- [Title V Transformation Tools.](#)

American Academy of Pediatrics - clinical guidelines:

- [Recommendations for preventive pediatric health care \(periodicity schedule\)](#)
- [Policy statement: Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening.](#)
- [Bright Futures Tool and Resource Kit.](#)

[Birth to Five: Watch me Thrive.](#)

Early Childhood Comprehensive Systems Collaborative Improvement and Innovation Network (ECCS CoIIN).

- [National ECCS CoIIN Coordinating Center](#)
- [New York State ECCS Impact Initiative](#)

[First 1000 Days on Medicaid Initiative.](#)

Healthy Steps.

- [National Healthy Steps](#)
- [New York Office of Mental Health Implementation of Healthy Steps](#)

Help Me Grow.

- [Help Me Grow National Center](#)
- [Help Me Grow New York](#)

[Learn the Signs, Act Early. Centers for Disease Control and Prevention](#)

Age groups impacted by this intervention: infants, children

Social determinants of health addressed by this intervention: economic stability, education, health care

Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials; Other: Child care
- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Schools (K-12); Policymakers & elected officials; Economic development agencies; Urban planning agencies.

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: Number of strategies implemented to increase developmental screening in young children.

Related interventions, focus areas, or goals from other Prevention Agenda priorities: Chronic Disease - Preventive Care & Management

Goal 3.2: Increase supports for children and youth with special health care needs

- **Objective 3.2.1:** By December 31, 2024, increase the percentage of infants who fail their initial hearing screening who have a documented follow-up by 60% to 50.0% (*Baseline: 31.0%; Year 2015; Source: Early Hearing Detection and Intervention Program; Data availability: State, County*).
- **Objective 3.2.2:** By December 31, 2024, increase the percentage of children ages 9-35 months who received a developmental screening using a parent-completed screening tool in the past year by 20% to 21.0%. (*Baseline: 17.5%; Year: 2016; Source: National Survey of Children's Health; Data availability: State (by race, income, insurance, other child & family factors)*). [same as Objective 3.1.1]
- **Objective 3.2.3:** By December 31, 2024, increase the percentage of families participating in the Early Intervention Program who meet the state's standard for the NY Impact on Family Scale by 20% to 73.9% (*Baseline: 61.6; Year 2015-16; Source: Early Intervention Program Data; Data availability: State, County*).
- **Objective 3.2.4:** By December 31, 2024, increase the percentage of children with special health care needs (CSHCN) ages 0-17 years whose families report that they receive care in a well-functioning system by 20% to 13.2%. (*Baseline: 11.0; Year 2016; Source: National Survey of Children's Health; Data availability: State*).
- **Objective 3.2.5:** By December 31, 2024, increase the percentage of adolescents with special health care needs (CSHCN) ages 12-17 years whose families report that they received services necessary to make transitions to adult health care by 20% to 18.4%. (*Baseline: 15.3; Year 2016; Source: National Survey of Children's Health; Data availability: State*).

Intervention 3.2.1: Engage families in planning and systems work to improve family centered services and effective practices for supporting CSHCN and their families.

Description: Children with special health care needs (CSHCN) are those who have chronic physical, developmental, behavioral, or emotional conditions and require health and related services beyond that which generally is required by most children – nearly one in five children ages birth to 17 years in New York State. Families of children with special health care needs (CSHCN) face unique challenges and bring tremendous knowledge, experience, and strengths to the care of their children that is an asset to both individual and population-based public health efforts. Systems must be designed and implemented to meet the needs of families, and to engage them in meaningful roles as their children's most important caregivers.

The New York State Department of Health Children with Special Health Care Needs (CSHCN) Program recently completed a Systems Mapping project to engage families from across the state in identifying successes, gaps, and barriers to services for CSHCN, using tools and technical support from the Maternal Child Health Workforce Development Center at the University of North Carolina (UNC). Through this process, over 130 family members of CSHCN from all regions of the state and diverse demographics participated in facilitated discussions. The resulting qualitative data (system maps) will inform the future practices of the CSHCN Program.

Throughout this systems mapping process and other ongoing needs assessments, parents and providers of CSHCN in New York State have emphasized the fragmentation of services for CSHCN, the complexity of finding providers and accessing the myriad of services needed, and disparities in care – with some families getting what they need for their children and others “going without”.³⁸ Parents are seeking better information about their child’s diagnosis and service systems, and they want more connections to other families who have had similar experiences. Partnering with and supporting families who reflect the diversity of our communities is essential to improving these service systems and experiences.

Family engagement may help to improve the quality and efficiency of the health care and public health systems at all levels, from direct care to organizational design to policy.³⁹ There are opportunities for parents to receive leadership training and participate in state and local advisory and workgroups through several core programs.

Resources

[Children and Youth with Special Health Care Needs \(CYSCHN\) Program Early Intervention Program.](#)

Early Intervention Family Outcomes Project.

- [Child and Family Outcomes Survey](#)
- [Early Intervention Family Outcomes & the State Systemic Improvement Plan](#)
- [Improving Family Centeredness Together](#)
- [Early Intervention Partners Training Project.](#)

[Families Together in New York State.](#)

Hands and Voices.

- National organization: <http://www.handsandvoices.org>
- New York State chapter: <http://www.handsandvoicesny.org/>

[Parent to Parent of New York State.](#)

[National Center for Family/ Professional Partnerships \(NCFPP\).](#)

Age groups impacted by this intervention: infants, children, adolescents and their families

Social determinants of health addressed by this intervention: community cohesion, economic stability, education, health care, family support, social support

Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Schools (K-12); Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials; Child care; Criminal justice
- **Supporting:** Employers, businesses, and unions; Insurers; Media; Colleges & universities; Transportation agencies; Housing agencies; Economic development agencies; Urban planning agencies.

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: Number of families of CSHCN participating in the development or improvement of family centered services for CSHCN.

Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote Well-Being and Prevent Mental & SU Disorders - Promote Well-Being

Intervention 3.2.2.: Engage health care providers and other partners in efforts to improve newborn hearing screening and follow up, including reporting of results into the New York Early Hearing Detection and Intervention Information System (NYEHDI-IS).

Description: NYS Public Health Law requires all maternity hospitals and birthing centers to administer newborn hearing screening programs, which is consistent with national public health goals and guidelines for early detection of hearing loss. Infants are screened shortly after birth in the hospital or birthing facility. Infants that do not pass their initial screenings are referred for follow up, which may include a second screening and, when needed, a full diagnostic hearing assessment. Infants with hearing loss are referred to the NYS Early Intervention Program for appropriate intervention services. Providers at each step in this process are required to report screening and follow-up test results in the state's Early Hearing Detection and Intervention Information System (NYEHDI-IS). Timely follow up of infants with hearing loss is critical to optimizing their development. Documentation of follow up in NYEHDI-IS is essential to tracking progress and informing public health improvement efforts.

Over 97% of infants born in New York State in 2016, had a documented initial hearing screening after birth. Of those infants who failed this initial screening, only 37.5% had follow-up test results documented in the NYEHDI-IS system. Although this percentage has improved significantly from the baseline of 9% in 2014, there is still substantial need for improvement. For the past several years, the New York State Department of Health has been engaged in a variety of efforts to improve newborn hearing screening and follow up, including enhancements to the data system to make it more useful for providers, dissemination of data to hospitals and other partners to reinforce the need for reporting, and convening structured quality improvement collaboratives with health care providers and families to improve follow up services, including linkage to the Early Intervention Program. There is a need to build on these efforts and engage more partners to ensure that all babies who fail their initial hearing screening receive timely and appropriate follow up.

Resources

[Early Hearing Detection and Intervention Program \(EHDI\). New York State Department of Health.](#)

Hands and Voices.

- National organization: <http://www.handsandvoices.org>
- New York State chapter: <http://www.handsandvoicesny.org/>

[Joint Committee on Infant Hearing.](#)

[National Center on Birth Defects and Developmental Disabilities \(NCBDD\). \(2018\). Centers for Disease Control and Prevention.](#)

[National Center for Hearing Assessment and Management \(NCHAM\).](#)

[Program to Enhance the Health & Development of Infants and Children \(PEHDIC\): Early Hearing Detection & Intervention \(2018\). American Academy of Pediatrics \(AAP\).](#)

Age groups impacted by this intervention: Infants, children and their families

Social determinants of health addressed by this intervention: education, health care, family support, social support

Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers; Policymakers & elected officials;
- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Community or neighborhood residents; Community-based organizations and human service agencies;

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: Number of health care providers that are consistently reporting results of newborn hearing screening and follow up.

Related interventions, focus areas, or goals from other Prevention Agenda priorities: Chronic Disease - Preventive Care & Management

Intervention 3.2.3: Enhance care coordination and transition support services for eligible children and youth with special health care needs.

Description: Care coordination is the purposeful organization of care activities and information sharing among patients and those involved in their care to improve efficiency, quality of care, health outcomes, and patient satisfaction. The Institute of Medicine has identified care coordination as a key strategy with the potential to improve the effectiveness, safety, and efficiency of the U.S. health care system, improving outcomes for patients, providers, and payers.⁴⁰

Children with special health care needs (CSHCN) may require specialty medical services across multiple providers and service settings. They may experience multiple transitions as they develop and “age out” of specific programs or services (e.g., from Early Intervention to Special Education, elementary to

secondary school, pediatric to adult health care) and move across service and community settings (e.g., hospital to community, home to school).

Both formal care coordination/ care management services and more informal transition supports can be critical for CSHCN and their families to manage their health and family needs during key periods of change and overtime. The 2016 National Survey of Children’s Health found that about 73% of children age birth to 17 years in New York State who needed care coordination services received effective services, while about 15% of youth with special health care needs received services necessary to transition to adult health care.⁴¹

Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 12: Transition to Adulthood:

- [Evidence Analysis Report. NPM 12: Transition, Johns Hopkins University.](#)
- [Evidence Brief. Transition to Adulthood. National Center for Education in Maternal and Child Health \(NCEMCH\), Georgetown University.](#)
- [Title V Transformation Tools - Transition.](#)

[Care Coordination for CSHCN Challenge. Maternal and Child Health Bureau](#)

[Coordinating Care and Supporting Transition for Children, Adolescents and Young Adults with Sickle Cell Disease. New York State Department of Health](#)

[Got Transition. Maternal and Child Health Bureau/ National Alliance to Advance Adolescent Health](#)

Medicaid Health Homes Serving Children. New York State Department of Health.

- [New York State Health Homes Serving Children Website](#)
- [Find a Health Home](#)

[National Technical Assistance Center on Transition \(NTACT\). U.S. Department of Education’s Office of Special Education Programs \(OSEP\)/ Rehabilitation Services Administration \(RSA\).](#)

[State Department of Health Early Intervention Program to the State Education Department Preschool Special Education Program or Other Early Childhood Services.](#)

Age groups impacted by this intervention: infants, children, adolescents and their families

Social determinants of health addressed by this intervention: community cohesion, economic stability, education, food security, health care, housing, transportation, family support, social support

Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers; Schools (K-12); Community or neighborhood residents; Community-based organizations and human service agencies; Economic development agencies; Policymakers & elected officials; other: child care

- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Transportation agencies; Housing agencies; Urban planning agencies; other: Criminal justice system

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of strategies implemented to enhance care coordination or transition services.

Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote Well-Being and Prevent Mental & SU Disorders - Promote Well-Being

Goal 3.3: Reduce dental caries among children

- **Objective 3.3.1:** By December 31, 2024, increase the percentage of New York State residents served by community water systems that have optimally fluoridated water by 9% to 77.5% (*Baseline: 71.1; Year 2016; Source: Safe Drinking Water Information System (SDWIS); Data availability: State, County*).
- **Objective 3.3.2:** By December 31, 2024, decrease the percentage of children ages 1-17 years who had decayed teeth or cavities in the past year by 20% to 6.7%. (*Baseline: 8.4; Year 2016; Source: National Survey of Children’s Health; Data availability: State*).
- **Objective 3.3.3:** By December 31, 2024, increase the percentage of children ages 1-17 years who had one or more preventive dental visits in the past year by 10% to 85.4%. (*Baseline: 77.6; Year 2016; Source: National Survey of Children’s Health; Data availability: State*).

Intervention 3.3.1: Maintain and expand community water fluoridation.

Description: The US Surgeon General’s Reports have emphasized oral health as a critical aspect of overall individual and population health. Research demonstrates the large number of lost school and work hours attributed to oral health problems. Dental cavities (also called dental caries or tooth decay) are one of the most common chronic diseases of childhood.

Drinking fluoridated water keeps teeth strong and reduces cavities by about 25% in children and adults. By preventing cavities, community water fluoridation has been shown to save money for families and for the US health care system. Community water fluoridation is the most cost-effective way to deliver fluoride to people of all ages, education levels, and income levels who live in a community. Most water has some natural levels of fluoride, but usually not enough to prevent cavities. Community water systems can add the right amount of fluoride to the local drinking water to prevent cavities. Community water fluoridation is recommended by nearly all public health, medical, and dental organizations. It is recommended by the American Dental Association, American Academy of Pediatrics, US Public Health Service, World Health Organization, and the Community Preventive Services Task Force. Grant funds are available from the New York State Department of Health to support implementation and maintenance of fluoridation systems in communities.

Resources

[Best Practice Approach Reports - Use of Fluoride: Community Water Fluoridation. Association for State and Territorial Dental Directors.](#)
[Community Water Fluoridation. Centers for Disease Control and Prevention.](#)

[Community Water Fluoridation. National Association of County and City Health Officials.](#)
[Dental Caries \(Cavities\): Community Water Fluoridation. Community Preventive Services Task Force.](#)

[Drinking Water Fluoridation Grant Program. New York State Department of Health.](#)

[Patient Engagement About Fluoride and Fluoridation. New York State Department of Health, University at Albany School of Public Health, and New York State Dental Foundation.](#)

Age groups impacted by this intervention: infants, children, adolescents, adults age 21-60 years, older adults

Social determinants of health addressed by this intervention: economic stability, education, food security, health care, built environment

Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Media; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials; Urban planning agencies; other: Community water systems
- **Supporting:** Health care delivery system; Employers, businesses, and unions; Insurers; Colleges & universities; Schools (K-12); Economic development agencies.

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: Number of strategies implemented to expand or maintain community water fluoridation.

Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote a Healthy and Safe Environment - Water Quality

Intervention 3.3.2: Increase delivery of evidence-based preventive dental services across key settings, including school-based and community-based primary care clinics.

Description: Access to oral (dental) health care is critical to maintain oral health throughout the life course. Early dental visits teach children that oral health is important and improve children's positive attitudes about oral health professionals and dental visits. Pregnant women who receive dental care are more likely to take their children to get oral health care, and untreated maternal dental caries may increase the odds of her children developing cavities.^{42 43} Children should be taught proper oral hygiene, including daily teeth brushing, at an early age.

Preventive dentistry encompasses several practices to keep teeth healthy and prevent cavities, gum disease, enamel wear, and tooth loss. It includes personal oral hygiene practices (including daily tooth brushing), dental cleanings, the application of sealants, and fluoride supplementation. To maintain optimal oral health, the American Dental Association (ADA) recommends visits to the dentist at regular intervals determined by a dentist. The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride, and that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption. The Community Preventive Services Task Force (CPSTF) recommends school-based programs to deliver dental sealants and prevent tooth decay among children (see also Intervention 3.3.1).

A recent review by the Women’s and Children’s Health Policy Center at Johns Hopkins University found evidence that school-based oral health services, preschool interventions (participation in Head Start), enrollment in public health insurance programs (Medicaid or CHIP/Child Health Plus), and Medicaid reforms (e.g., increased provider reimbursements, enhanced benefits, administrative changes, and health plan incentives) appear to be effective. Caregiver education/counseling, home visits, and outreach to recruit dental practices to provide care may be effective but there is currently insufficient evidence to assess their effectiveness.⁴⁴ There is also insufficient evidence currently to assess the effectiveness of interventions to increase dental visits of women during pregnancy.⁴⁵ Of note, this particular review did not look at other promising strategies to increase use of preventive oral health services such as integration of oral health in primary medical care settings, co-location of dental and medical services, enhanced patient outreach and reminder systems (which have been found effective in increasing use of other preventive health services), or delivery of oral health services through other community-based programs.

Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 13: Oral Health:

- Evidence Analysis Reports (2017) Johns Hopkins University. Reports include detailed tables of interventions reviewed with citations for individual studies.
 - [NPM 13A – Oral Health in Pregnancy](#)
 - [NPM 13B – Oral Health in Childhood.](#)
- [Evidence Brief. Oral Health. National Center for Education in Maternal and Child Health \(NCEMCH\), Georgetown University.](#)
- [Title V Transformation Tools – Oral Health.](#)

Best Practice Approach Reports. Association for State and Territorial Dental Directors.

- [School-Based Dental Sealant Programs \(2017\)](#)
- [Use of Fluorides in Schools. \(2018\)](#)
- [Prevention and Control of Early Childhood Tooth Decay \(2011\).](#)

[Dental Sealants. Centers for Disease Control and Prevention.](#)

[Dental Caries \(Cavities\): School-Based Dental Sealant Delivery Programs. Community Preventive Services Task Force.](#)

[Medical-Dental Integration New York State Department of Health and University at Albany School of Public Health.](#)

[Patient Engagement About Fluoride and Fluoridation. New York State Department of Health, University at Albany School of Public Health, and New York State Dental Foundation.](#)

[Smiles for Life: A National Oral Health Curriculum, Third Edition.](#)

Age groups impacted by this intervention: all ages (focus on infants, children, adolescents)

Social determinants of health addressed by this intervention: community cohesion, economic stability, education, food security, health care, housing, transportation, natural environment, build environment, family support, social support

Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; Employers, businesses, and unions; Health care delivery system; Insurers; Schools (K-12); Community-based organizations and human service agencies; other: Child care
- **Supporting:** Media; Colleges & universities; Community or neighborhood residents; Policymakers & elected officials; Transportation agencies; Economic development agencies; Urban planning agencies

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of schools or community centers providing preventive dental care in the community.

Related interventions, focus areas, or goals from other Prevention Agenda priorities: Chronic Disease - Preventive Care & Management

Intervention 3.3.3: Integrate oral health messages and evidence-based prevention strategies within community-based programs serving women, infants, and children.

Description: Integrating oral health messages and prevention strategies in other public health programs has the potential to increase awareness, knowledge, and preventive oral hygiene practices among children and their families. Home visiting programs, nutrition programs, child care, and other early care and education programs are examples of community-based programs that may have opportunities to reinforce oral health promotion.

Resources

Best Practice Approach Reports. Association for State and Territorial Dental Directors.

- [Improving Children’s Oral Health through the Whole School, Whole Community, Whole Child \(WSCC\) Model. \(March 2017\)](#)
- [Oral Health of Children, Adolescents and Adults with Special Health Care Needs. \(August 2007\)](#)

- [Perinatal Oral Health. \(October 2012\).](#)

Caring for Our Children: National Health and Safety Performance Standards for Early Care and Education Programs – Oral Health

- [Routine Oral Hygiene Activities](#)
- [Toothbrushes and toothpaste](#)
- [Oral Health Education](#)
- [Oral Health Policy](#)

[Cavity Free Kids.](#)

[Oral Health Educational Resources for Home Visitors and Families: Environmental Scan. \(2018 update\). Association of State and Territorial Dental Directors, Early Childhood Committee.](#)

Age groups impacted by this intervention: infants, children age 2-12, adolescents age 13-21 years; pregnant women.

Social determinants of health addressed by this intervention: community cohesion, economic stability, education, health care, other: family support, social support, health literacy, learning environment.

Sectors that can play lead and contributing roles in implementing this intervention:

- **Lead:** Governmental public health agencies; employers, businesses, and unions; Schools (K-12); Community or neighborhood residents; Community-based organizations and human service agencies; other: Child care.
- **Supporting:** Health care delivery system; Insurers; Media; Colleges & universities; Policymakers & elected officials; Economic development agencies.

Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term: The number of community-based programs serving women, infants, and children, that incorporate oral health promotion messages.

Related interventions, focus areas, or goals from other Prevention Agenda priorities: Promote Well-Being and Prevent Mental & SU Disorders - Promote Well-Being

Focus Area 4: Cross Cutting Healthy Women, Infants, & Children (applicable to all HWIC focus areas and goals)

Goal: *Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations.*

Intervention 4.1: Enhance collaboration with other programs, providers, agencies, and community members to address key social determinants of health that impact the health of women, infants, children, and families across the life course.

Description: The focus within public health increasingly is on addressing social determinants of health: the conditions in which people are born, grow, live, work, and age. Social factors such as food insecurity, homelessness, employment conditions, poverty, adverse neighborhood environments, inadequate health care, lack of educational opportunities, social exclusion, racism and discrimination, lack of social support, and gender-based inequities are important forces that influence MCH outcomes, both directly and through their impact on other individual risk factors. These social determinants help explain why rates of key indicators – such as infant mortality and maternal mortality – are worse in the United States compared to other countries. They also help to explain the persistent racial, economic, and other disparities we see across virtually all key indicators of maternal and child health.

A dedicated focus on social determinants of health across the life course is consistent with input received from youth, families, and service providers as part of New York's needs assessment activities over the past three years. Stakeholders repeatedly identified factors that influence their use of health care services: health insurance coverage, accessibility of health care, provider diversity and cultural competence, transportation, stigma and confidentiality concerns, language barriers, cost, inability to take time off from work, and competing life responsibilities (cite: Title V applications for 2017 and 2019). Additionally, stakeholders noted lack of social support, unsafe neighborhoods, lack of affordable housing, limited access to affordable, healthy food, and lack of opportunities for physical activity as key barriers to good health.

While these factors may be addressed in the context of other topic-specific interventions described throughout this plan, it is essential that public health organizations and practitioners partner with other sectors to address them directly as foundational influences on all aspects of health and well-being. For this reason, the stakeholder group contributing to this action plan endorsed the inclusion of this cross-cutting goal and intervention to underpin other sections of the plan.

Healthy People 2020 has emphasized the need to address social determinants of health by including a new goal to “create social and physical environments that promote good health for all” as one of the four overarching goals for the decade.⁴⁶ Achieving this goal in New York State will require new approaches, partnerships, and collaborations across a wide range of sectors, at both the community and state level.

Resources:

[Essentials for Childhood Framework: Creating Safe, Stable, Nurturing Relationships and Environments for All Children. Centers for Disease Control and Prevention \(CDC\).](#)

[The EveryONE Project™. American Academy of Family Physicians.](#)

[The Guide to Community Preventive Services: Health Equity Reviews. Community Preventive Services Task Force.](#)

[Health Impact in 5 Years \(HI-5\). Centers for Disease Control and Prevention.](#)

[Healthy People 2020: Social Determinants of Health Interventions & Resources. Office of Disease Prevention and Health Promotion](#)

[National Center for Cultural Competence \(NCCC\). Georgetown University Center for Child and Human Development.](#)

[Paid Family Leave – New York State.](#)

[Policy Resources to Support Social Determinants of Health. Centers for Disease Control and Prevention](#)

[Sources for Data on Social Determinants of Health. Centers for Disease Control and Prevention](#)

[Technical Packages for Violence Prevention. Centers for Disease Control and Prevention.](#)

[Think Cultural Health. U.S. Department of Health & Human Services, Office of Minority Health.](#)

Tools for Putting Social Determinants of Health into Action. Centers for Disease Control and Prevention:

- [At-a-Glance: 10 Essential Public Health Services and How They Can Include Addressing Social Determinants of Health Inequities.](#)
- [Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health.](#)

Age groups impacted by this intervention: All

Social determinants of health addressed by this intervention: All

Sectors that can play lead and contributing roles in implementing this intervention: All

Intermediate-level measure that can be used by organizations to track progress toward

implementation of the intervention in the short term: The number of collaborations with partners that address social determinants of health impacting women, infants, children, and families.

Related interventions, focus areas, or goals from other Prevention Agenda priorities: All

Healthy Women, Infants, and Children Action Plan Appendix

This appendix provides additional detail on resources to support the evidence base and implementation for each intervention in the Healthy Women, Infants, and Children Action Plan for the 2019-2024 New York State Prevention Agenda.

Focus Area 1: Maternal and Women’s Health

Goal 1.1: Increase use of primary and preventative health care services among women of all ages, with a focus on women of reproductive age.

Intervention 1.1.1: Incorporate strategies to promote health insurance enrollment, well-woman visits, and age-appropriate preventive health care across public health programs serving women

Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 1: Well-Woman Visit:

- **Evidence Analysis Report. NPM 1: Well-Woman Visit**, Johns Hopkins University. https://www.mchevidence.org/documents/reviews/npm_1_well_woman_visit_evidence_review_brief_june_2017.pdf
- **Evidence Brief. Well Woman Visits**. National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University. <https://www.ncemch.org/evidence/NPM-1-well-woman.php>
- **Title V Transformation Tools**. Recommendations to support NPM1 – Well Woman Visit. <https://www.mchnavigator.org/transformation/npm-1.php>
- **Title V National Performance Measure Resource Sheet. NPM 1: Well-Women Visit**. Association of Maternal and Child Health Programs (AMCHP). Summary bulletin highlights specific promising practices from the AMCHP Innovation Station related to well woman visits. <http://www.amchp.org/Calendar/Webinars/Documents/NPM%20State%20Action%20Plan%201.pdf>.

ACOG Committee Opinion on Well-Woman Visit. American College of Obstetricians and Gynecologists, Committee on Gynecologic Practice. (2014). Describes the importance of the annual health assessment for women and provides clinical guidelines related to important elements of the annual examination at defined ages. <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Well-Woman-Visit>

Care Women Deserve. Information and resources on preventive health services for women of all ages. Developed by a coalition dedicated to educating people about the women’s preventive services available at no out-of-pocket costs under the Affordable Care Act. <http://carewomensdeserve.org/>

Health Care Innovations Exchange. [Agency for Healthcare Research and Quality \(AHRQ\)](https://www.ahrq.gov/). (2016) A resource for health professionals and researchers on evidence-based and promising innovations and tools for health care delivery. Includes searchable databases of innovations and quality tools and other resources. <https://innovations.ahrq.gov/>

Health Communication and Social marketing: Campaigns that Include Mass Media and Health-Related Product Distribution. The Guide to Community Preventive Services. Community Preventive

Services Task Force (CPSTF). December 2010. <https://www.thecommunityguide.org/findings/health-communication-and-social-marketing-campaigns-include-mass-media-and-health-related>

Maternal and Infant Community Health Collaboratives (MICHC) Initiative. New York State Department of Health. The MICHC initiative addresses outcomes for women of reproductive age, infants, and families through a combination of individual, family, community, and organizational strategies, including Community Health Workers (CHWs). Site provides an overview of the MICHC initiative, link to on-line CHW training, and list of current projects.
https://www.health.ny.gov/community/adults/women/maternal_and_infant_comm_health_collaboratives.htm

New York State of Health: The Official Health Plan Marketplace. NYS' marketplace to help people shop for and enroll in health insurance coverage. Individuals, families, and small businesses can use the Marketplace to compare insurance options, calculate costs, and select coverage. The Marketplace uses a single application that helps people to check eligibility and enroll in health care programs like [Medicaid](#), [Child Health Plus](#), and the [Essential Plan](#), and provides information on [financial assistance](#). Options for [online](#), [in-person](#), [over the phone](#) or mail applications.
<https://info.nystateofhealth.ny.gov/what-ny-state-health>

Technical Assistance Document: Implementing USPSTF Recommendations into Professional Education Programs (2010). Developed as part of an Agency for Healthcare Research and Quality (AHRQ) initiative. Includes examples of lesson plans and activities from academic institutions that have integrated the USPSTF recommendations in their curricula.
<https://www.ahrq.gov/sites/default/files/wysiwyg/cpi/centers/ockt/kt/tools/impuspstf/impuspstf.pdf>

Think Cultural Health. U.S. Department of Health & Human Services, Office of Minority Health. Dedicated to advancing health equity, site features information, continuing education opportunities, and resources for health professionals to learn about culturally and linguistically appropriate services (CLAS). Includes link to CLAS standards and resources for implementation.
<https://www.thinkculturalhealth.hhs.gov/>

Women's Preventive Service Guidelines. U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). Updated December 2016.
<https://www.hrsa.gov/womens-guidelines-2016/index.html>

Focus Area 1: Maternal and Women’s Health

Intervention 1.1.2: Integrate discussion of reproductive goals, pregnancy planning, and pregnancy prevention in routine health care for all women of reproductive age.

Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 1: Well-Woman Visit:

- **Evidence Analysis Report. NPM 1: Well-Woman Visit**, Johns Hopkins University. https://www.mchevidence.org/documents/reviews/npm_1_well_woman_visit_evidence_review_brief_june_2017.pdf
- **Evidence Brief. Well Woman Visits**. National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University. <https://www.ncemch.org/evidence/NPM-1-well-woman.php>
- **Title V Transformation Tools**. Recommendations to support NPM1 – Well Woman Visit. <https://www.mchnavigator.org/transformation/npm-1.php>
- **Title V National Performance Measure Resource Sheet. NPM 1: Well-Women Visit**. Association of Maternal and Child Health Programs (AMCHP). <http://www.amchp.org/Calendar/Webinars/Documents/NPM%20State%20Action%20Plan%201.pdf>. This is a 2-page summary bulletin. It highlights specific promising practices from the AMCHP Innovation Station related to well woman visits.

ACT for Youth. Act for Youth Center for Community Action (2018). NYSDOH-funded center to support evidence-based practice for youth-serving programs in NYS. Comprehensive website for positive youth development initiatives and resources focuses on connecting research to practice and youth engagement. Includes resources on adolescent sexual health and development.

<http://actforyouth.net/>

Action Plan for the National Initiative on Preconception health and Health Care (2012-2014). CDC report outlines objectives, strategies and action steps to improve preconception care with a renewed vision for achieving change in maternal and child health. <https://stacks.cdc.gov/view/cdc/31755>

Bedsider. A non-profit organization and web-based resource providing in-depth information, decision and reminder tools, and other resources related to contraception for consumers.

<https://www.bedsider.org>. Companion site for providers <https://providers.bedsider.org> provides contraception information and tools for health care providers.

Before, Between & Beyond Pregnancy: Resource Guide for Clinicians (2018). Designed to help primary care providers meet their patient’s needs based on the response to the “vital sign” key question “Would you like to become pregnant in the next year?” Developed by the Clinical Work Group of the National Preconception Health and Health Care Initiative, recommendations in the guide are evidence-based and reflect national and professional recommendations for routine preventive care. Site also includes a link to a new “At Your Fingertips” Mobile app for clinicians.

<https://beforeandbeyond.org/toolkit/about-this-toolkit/>

Before Pregnancy. Centers for Disease Control and Prevention (CDC). Site provides information on preconception health and health care for women and men, including a pregnancy planning checklist <https://www.cdc.gov/preconception/index.html>

Health Communication and Social marketing: Campaigns that Include mass Media and Health-Related Product Distribution. The Guide to Community Preventive Services. Community Preventive Services Task Force (CPSTF). December 2010. <https://www.thecommunityguide.org/findings/health-communication-and-social-marketing-campaigns-include-mass-media-and-health-related>

IMPLICIT Interconception Toolkit. March of Dimes Foundation. The IMPLICIT (Interventions to Minimize Preterm and Low birth weight Infants using Continuous Improvement Techniques) Network is a family medicine maternal child health learning collaborative focused on improving care for women, infants and families through faculty, resident, and student development and quality improvement. The toolkit provides the background, evidence, and resources to implement the IMPLICIT ICC model in the context of well-child visits, tailored to the needs of individual clinic sites, practice settings, and populations. <https://www.prematurityprevention.org/Toolkits-Reports/IMPLICIT-interconception-care-toolkit>

Know Your Options, Get the Facts. New York State initiative to connect women with comprehensive family planning services delivered by quality health care providers licensed in NYS and meeting high standards of care for the NYS Family Planning Program. Information and links for consumers on contraception, preconception care, infertility services, and pregnancy options including prenatal care, adoption, and abortion services. <https://www.ny.gov/programs/pregnancy-know-your-options-get-facts>

One Key Question®. A strategic initiative developed by the [Power to Decide](#) to transform women’s health care experience with a routine question: “would you like to become pregnant in the next year?” Site offers information about consulting services, training, and technical assistance for provider networks and community organizations interested in becoming certified as One Key Question® providers or institutions. <https://powertodecide.org/select360-consulting>

Power to Decide (formerly the National Campaign to Prevent Teen and Unplanned Pregnancy). A public, nonprofit and nonpartisan organization and national campaign to prevent unplanned pregnancy. Website offers variety of information, resources, and services for health care providers, organizations, and consumers related to pregnancy prevention methods, programs, and policies. <https://powertodecide.org/>

Preconception Health and Health Care: The Clinical Content of Preconception Care. 2008 supplement to the *American Journal of Obstetrics and Gynecology*. Documents the evidence base for preconception care, with recommendations across 14 areas of clinical services. [https://www.ajog.org/issue/S0002-9378\(08\)X0011-0](https://www.ajog.org/issue/S0002-9378(08)X0011-0)

[Preconception interventions.](#) 2014 supplement to *Reproductive Health* journal that includes a series of systematic reviews regarding the impact of public health interventions during the preconception

period on maternal and child health. <https://reproductive-health-journal.biomedcentral.com/articles/supplements/volume-11-supplement-3>

Recommendations to Improve Preconception Health and Health Care – United States. A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. Includes 10 recommendations with key action steps.

<https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5506a1.htm>

Technical Assistance Document: Implementing USPSTF Recommendations into Professional Education Programs (2010). Developed as part of an Agency for Healthcare Research and Quality (AHRQ) initiative. Includes examples of lesson plans and activities from academic institutions that have integrated the USPSTF recommendations in their curricula.

<https://www.ahrq.gov/sites/default/files/wysiwyg/cpi/centers/ockt/kt/tools/impuspstf/impuspstf.pdf>

Toward Improving the Outcome of Pregnancy III: Enhancing Perinatal Health Through Quality, Safety and Performance Initiatives. March of Dimes Foundation. 2010 report explores the elements that are essential to improving quality, safety and performance across the continuum of perinatal care. Includes chapter on preconception and interconception care (must create free registration to download report).

<https://www.prematurityprevention.org/>

Preconception Care webinars for Health Home Providers. New York State Department of Health. A series of webinars developed to address aspects of preconception health for Health Home providers working with women with multiple chronic medical and behavioral health conditions and care coordination needs. Includes a set of webinars specifically for women living with HIV.

- *Well Woman Care and Preconception Care: Webinar for Health Home Providers.* New York State Department of Health (October 2017). Addresses the importance of well woman and preconception care to prevent unintended pregnancy and improve pregnancy outcomes for women, including women with chronic medical issues.
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/webinars/docs/2017/2017-10-11_preconception_care_for_hhcm.pdf
- *Preconception, Contraception and Conception for Women Living with HIV (WLWH): How Health Home Care Managers Can Provide Support to Facilitate Improved Health Outcomes.* (July 2018).
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/webinars/docs/2018/preconception_contraception_conception_for_wlwh_7_16_2018.pdf
- *Postpartum Care for Women Living with HIV (WLWH) and their Newborns: How Health Home Care Managers Can Provide Support to Facilitate Improved Health Outcomes.* (August 2018)
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/webinars/docs/2018/hh_webinar_pp_nb_bf_retention_8_15_2018.pdf

Preconception Health is Essential Well Woman Care - Webinar. New York State Partnership for Maternal Health. (August 2018). Addresses preconception health as key component of preventing maternal morbidity and mortality. Health practitioners serving women of reproductive age will learn how to incorporate “every woman, every time” into their practice to improve women’s health and

birth outcomes. Link to archived webinar from this page (users will need to register first):

<https://www.health.ny.gov/community/adults/women/>

Show Your Love Campaign. Developed by the CDC’s National Preconception Health Consumer Workgroup. National campaign designed to improve the health of women and babies by promoting preconception health and healthcare. This evidence-based social marketing campaign is seeking to elevate preconception health to same level of awareness and significance as prenatal health. Includes links to an implementation tool kit and other resources.

[http://www.nationalhealthystart.org/what we do/show your love preconception social marketing campaign](http://www.nationalhealthystart.org/what_we_do/show_your_love_preconception_social_marketing_campaign)

Focus Area 1: Maternal and Women’s Health

Goal 1.2: Reduce maternal mortality and morbidity

Intervention 1.2.1: Systematically review maternal deaths and severe maternal morbidities and use results to inform maternal mortality and morbidity prevention efforts.

Resources

New York State Maternal Mortality Review Report, 2012-13. New York State Department of Health.

https://www.health.ny.gov/community/adults/women/docs/maternal_mortality_review_2012-2013.pdf

New York City, 2008-2012 Severe Maternal Morbidity. (2016) New York City Department of Health and Mental Hygiene, Bureau of Maternal, Infant and Reproductive Health. Report focuses on severe maternal morbidity in New York City from 2008-2012. Report provides background information on SMM, highlights summary and detailed findings, and provides recommendations.

<https://www1.nyc.gov/assets/doh/downloads/pdf/data/maternal-morbidity-report-08-12.pdf>

Pregnancy-Associated Mortality: New York City, 2006-2010. New York City Department of Health and Mental Hygiene, Bureau of Maternal, Infant and Reproductive Health. Report provides estimates and examines characteristics and causes of death for women within one year of pregnancy in New York City from 2006-2010. <https://www1.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report.pdf>

Proceedings of the 2018 New York Maternal Mortality Summit. February 14, 2018. This 2018 Summit convened stakeholders from New York State to: assess statewide progress in addressing maternal mortality; understand the factors in maternal health inequity; and discuss outstanding challenges to reducing maternal mortality, disparities, and strategies to address them. Convened by the New York Academy of Medicine with funding from Merck and Company and in collaboration with the New York State Department of Health, New York City Department of Health and Mental Hygiene, American College of Obstetricians and Gynecologists District II, Greater New York Hospital Association, and the

Healthcare Association of New York State. https://nyam.org/media/filer_public/f3/be/f3beda7e-44d0-4a59-b403-80c980f33454/mm_summit_proceedings_final_062118.pdf

Severe Maternal Morbidity in the United States. Centers for Disease Control and Prevention. Includes an overview of the issue, summary national data trends, and links to lists of indicators and corresponding ICD codes used to identify SMM.

<https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html>

Severe maternal morbidity: A population-based study of an expanded measure and associated factors. 2017 study by Lazariu et al discusses identification and analysis of severe maternal morbidity cases in New York State. Identifying and analyzing SMM cases in New York State

<https://doi.org/10.1371/journal.pone.0182343>

Severe Maternal Morbidity: Screening and Review. American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine. Obstetric Care Consensus. Outlines a two-step screen and review process intended to efficiently detect severe maternal morbidity in women and to ensure that each case undergoes a review to determine whether there were opportunities for improvement in care. <https://www.acog.org/Clinical-Guidance-and-Publications/Obstetric-Care-Consensus-Series/Severe-Maternal-Morbidity-Screening-and-Review>

Focus Area 1: Maternal and Women’s Health

Goal 1.2: Reduce maternal mortality and morbidity

Intervention 1.2.2: Collaborate with partners to advance a comprehensive maternal health agenda that includes policy, community prevention, and clinical quality improvement strategies, with a focus on reducing disparities in maternal mortality and morbidity.

Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 2 (Low-Risk Cesarean Delivery) and NPM 3 (Perinatal Regionalization):

- **Evidence Analysis Reports.** Johns Hopkins University:
 - **NPM 2: Low-Risk Cesarean Deliveries** https://www.mchevidence.org/documents/reviews/npm_2_low_risk_cesarean_delivery_evidence_review_brief_feb_2017.pdf
 - **NPM 3: Risk-Appropriate Perinatal Care,** https://www.mchevidence.org/documents/reviews/npm_3_riskappropriate_perinatal_care_brief_feb_2017.pdf
- **Evidence Briefs.** National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University.
 - **Cesarean Births among Low Risk First Births** <https://www.ncemch.org/evidence/NPM-2-cesarean.php>
 - **Perinatal Regionalization** <https://www.ncemch.org/evidence/NPM-3-VLBW.php>

- **Title V Transformation Tools.**
 - **Recommendations to support NPM 2 – Low-risk Cesarean Delivery**
<https://www.mchnavigator.org/transformation/npm-2.php>
 - **NPM3 – Perinatal Regionalization.** <https://www.mchnavigator.org/transformation/npm-3.php>

Alliance for Innovation on Maternal Health (AIM). Council on Patient Safety in Women's Health Care. AIM is a national alliance to promote consistent and safe maternity care to reduce maternal mortality and severe maternal morbidity funded through the federal Maternal and Child Health Bureau, AIM is a data-driven improvement initiative focusing on the use of best practice safety bundles for maternity care. <https://safehealthcareforeverywoman.org/aim-program/>

Centering Pregnancy. Centering Healthcare Institute (2018). Site provides information on the evidence-based Centering group prenatal care model, with a variety of implementation resources including an organizational readiness assessment tool, facilitator certification, technical assistance and implementation grants. <https://www.centeringhealthcare.org/what-we-do/centering-pregnancy>.

Community Health Workers Toolkit. Toolkit created by the NORC Walsh Center for Rural Health Analysis, University of Minnesota rural Health Resource Center, and Rural Health Information Hub. Designed to help rural communities evaluate opportunities for developing a CHW program and provide resources and best practices developed by successful CHW programs. Modules focus on different aspects of CHW programs, with resources for developing local CHW programs. <https://www.ruralhealthinfo.org/toolkits/community-health-workers>

Cochrane Systematic Review: Continuous Support for Women During Childbirth. Doulas are individuals who provide continuous physical, emotional, and informational support to women during pregnancy, childbirth, and/or postpartum periods. There are a number of organizations offering training, certification, and continuing education for doulas. A pilot of Medicaid coverage for doulas is an element of the New York State's maternal mortality reduction initiative. A 2017 review of 26 studies from 17 countries published in the Cochrane Database of Systemic Reviews concluded that women who received continuous labor during labor may be less likely to have cesarean births, use pain medications, have low Apgar scores at birth, and have negative feelings about childbirth, and more likely to have spontaneous vaginal deliveries. <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD003766.pub6/full?highlightAbstract=doul&highlightAbstract=doula>

Home Visiting Evidence of Effectiveness (HomVee). U.S. Department of Health and Human Services and Administration for Children and Families. Review of the home visiting research literature assessing the evidence of effectiveness for home visiting program models that serve families with pregnant women and children from birth to age 5. Provides information about which home visiting program models have evidence of effectiveness, as well as detailed information about the samples of families who participated in the research, the outcomes measured in each study, and the implementation guidelines for each model. <https://homvee.acf.hhs.gov/>.

Institute for the Advancement of Family Support Professionals. Funded in part through a federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Innovation Grant, the Institute offers Family Support Professionals everywhere the opportunity to learn new skills and grow their careers. Through engaging, online modules and a personalized learning map feature, professionals take charge of their growth and advancement. <https://institutefsp.org/modules>

Levels of Maternal Care. Obstetric Care Consensus. American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine (2016). Calls for standards and regionalized systems of maternal hospital care to reduce maternal morbidity and mortality. <https://www.acog.org/-/media/Obstetric-Care-Consensus-series/oc002.pdf?dmc=1&ts=20180802T1643258695>

Maternal and Infant Community Health Collaboratives (MICHC) Initiative. New York State Department of Health. The MICHC initiative addresses outcomes for women of reproductive age, infants, and families through a combination of individual, family, community, and organizational strategies, including Community Health Workers (CHWs). Site provides an overview of the MICHC initiative, link to on-line CHW training, and list of current projects. https://www.health.ny.gov/community/adults/women/maternal_and_infant_comm_health_collaboratives.htm

New York State Home Visiting County Data Snapshots. Schuyler Center for Analysis and Advocacy (SCAA). Snapshots for each county in New York State designed to illustrate current home visiting services and community needs that could be addressed through expansion of home visiting programs. <http://www.scaany.org/policy-areas/maternal-infant-and-early-childhood/numbers-tell-a-story-new-york-state-home-visiting-data-snapshots/>

New York State's Home Visiting Programs: Support for Pregnant and Parenting Families. New York State Department of Health. State website includes information for providers and families, including a searchable list of home visiting programs in New York State by county. https://www.health.ny.gov/community/pregnancy/home_visiting_programs/

New York State Perinatal Quality Collaborative (NYSPQC). New York State Department of Health. Site includes materials, reports, archived presentations, and other resources from multiple NYSPQC quality improvement projects related to improving pregnancy outcomes for women and infants. https://www.albany.edu/sph/cphce/mch_nyspqc.shtml.

Remote Pregnancy Monitoring Challenge. Sponsored by the federal Maternal and Child Health Bureau, this challenge will support the development and testing of low-cost, scalable, technology-based innovations to help prenatal care providers remotely monitor the health and well-being of pregnant women, and to place health data into the hands of pregnant women as a tool to monitor their own health and make informed decisions about care. The design phase for this challenge will launch in September 2018, with subsequent development, small-scale testing, and scaling phases through Winter 2019. <https://mchbgrandchallenges.hrsa.gov/challenges/remote-pregnancy-monitoring>

Safe Motherhood Initiative (SMI). American College of Obstetricians and Gynecologists (ACOG) District II, New York State. Collaborative initiative to develop and implement standard approaches for handling obstetric emergencies associated with maternal mortality and morbidity. Focuses on the three leading causes of maternal death – obstetric hemorrhage (severe bleeding), venous thromboembolism (blood clots), and severe hypertension in pregnancy (high blood pressure). Site includes information, patient materials, clinician tools, and other resources. <https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Safe-Motherhood-Initiative>

Toward Improving the Outcome of Pregnancy III: Enhancing Perinatal Health Through Quality, Safety and Performance Initiatives. March of Dimes Foundation. 2010 report explores the elements that are essential to improving quality, safety and performance across the continuum of perinatal care (must create free registration to download report). <https://www.prematurityprevention.org/>

Training Modules for Community Health Workers. Six modules provide introductory training for community health workers on maternal and child health information, resources and strategies. Four webinars are also available for supervising community health workers. https://www.health.ny.gov/community/adults/women/chw_training/

Focus Area 1: Maternal and Women’s Health

Goal 1.2: Reduce maternal mortality and morbidity

Intervention 1.2.3: Increase use of effective contraceptives to prevent unintended pregnancy and support optimal birth spacing.

Resources

6 | 18 Initiative: Prevent Unintended Pregnancy. Centers for Disease Control and Prevention (CDC). Information on national initiative led by CDC to target unintended pregnancies as one of six common and costly health conditions through the expansion of 18 initial evidence-based interventions to engage purchasers, payers, and providers in improving health outcomes and controlling health costs. Includes information and resource links for three specific evidence-based interventions related to reimbursement for contraceptives, including LARC. <https://www.cdc.gov/sixteen/pregnancy/index.htm>

Bedsider. A non-profit organization and web-based resource providing in-depth information, decision and reminder tools, and other resources related to contraception for consumers. <https://www.bedsider.org>. Companion site for providers <https://providers.bedsider.org> provides contraception information and tools for health care providers.

Increasing Access to Contraception. Association of State and Territorial Health Officials (ASTHO). Information, tools, and resources to drive the work of states and territories to increase access to contraception. Includes links to ROI calculation and monitoring tools, fact sheets, recorded

presentations, and publications. <http://www.astho.org/Maternal-and-Child-Health/Increasing-Access-to-Contraception-Resources-from-States-Partners-and-ASTHO/>

Know Your Options, Get the Facts. New York State initiative to connect women with comprehensive family planning services delivered by quality health care providers licensed to practice in NYS and meeting high standards of care for the NYS Family Planning Program. Information and links for consumers on contraception, preconception care, infertility services, and pregnancy options including prenatal care, adoption, and abortion services. <https://www.ny.gov/programs/pregnancy-know-your-options-get-facts>

Long-Acting Reversible Contraception (LARC) Program. American College of Obstetricians and Gynecologists (ACOG). ACOG's LARC Program works to lower the unintended pregnancy rate in the US by connecting providers, patients, and the public with the most up-to-date information and resources on LARC methods and increasing access to the full range of contraceptive methods.

- **National ACOG LARC Program:** Comprehensive site includes clinical guidelines, education, and training resources; billing, coding, and reimbursement guidance; a technical assistance “help desk”; patient resources; and more. <https://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception>
- **New York State (ACOG District II) LARC Program:** Site includes information on LARC methods, clinical practice considerations, insertion considerations, and system and reimbursement barriers, along with complex case studies to test providers' knowledge. Links to patient education materials and waiting room posters, fact sheets, quick guides, and other practical resources for providers. <https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Long-Acting-Reversible-Contraception-LARC>
- **ACOG District II LARC Resource Summary:** 2-page resource document includes links to multiple ACOG and other organizational resources and sites for LARC. https://www.acog.org/-/media/Districts/District-II/Public/PDFs/FINAL_LARC_RESOURCE_SUMMARY_Web_2Updated_July_2018.pdf?dmc=1&ts=20180909T1118306705

Medicaid Coverage of Long-Acting Reversible Contraception. Key resources for Medicaid providers related to coverage and reimbursement for LARC, including updates to carve-out LARC from FQHC prospective payment system (PPS) rates and unbundle payment for post-partum LARC from inpatient delivery rates.

- **Medicaid Update** (September 2016): https://www.health.ny.gov/health_care/medicaid/program/update/2016/2016-09.htm#larc_coverage
- **eMedNY reimbursement guidance for physicians** (May 2014): https://www.emedny.org/listserv/physician/physician_reimbursement_for_larc_provided_as_a

[n_inpatient_post-partum_service_05-28-14.pdf](#)

New York State Family Planning Training Center. JSI Research and Training Institute, Inc. (2018). New York State Department of Health-funded training center to support family planning providers to deliver quality reproductive health services across New York State. Website includes training, events, and wide array of provider resources. <https://nysfptraining.org>

One Key Question®. A strategic initiative developed by the [Power to Decide](#) to transform women's health care experience with a routine question: *"would you like to become pregnant in the next year?"* Site offers information about consulting services, training, and technical assistance for provider networks and community organizations interested in becoming certified as One Key Question® providers or institutions. <https://powertodecide.org/select360-consulting>

Power to Decide (formerly the National Campaign to Prevent Teen and Unplanned Pregnancy). A public, nonprofit and nonpartisan organization and national campaign to prevent unplanned pregnancy. Website offers variety of information, resources, and services for health care providers, organizations, and consumers related to pregnancy prevention methods, programs, and policies. <https://powertodecide.org/>

Focus Area 1: Maternal and Women's Health

Goal 1.2: Reduce maternal mortality and morbidity

Intervention 1.2.4: Screen all pregnant and postpartum women for depression, with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

Resources

A Comprehensive Approach for Community-Based Programs to address Intimate Partner Violence and Perinatal Depression. This toolkit was produced for the U.S. Department of Health and Human Services Health Resources and Services Administration by Social Solutions International, Inc. The goal of the toolkit is to highlight innovative state and community-based strategies and provide a resource that assists community-based organizations with addressing the intersection of intimate partner violence and perinatal depression. The target audience is community-based organizations working with women, children and families.

https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthTopics/maternal-womens-health/A_COMPREHENSIVE_APPROACH_FOR_COMMUNITY-BASED_PROGRAMS_TO_ADDRESS_INTIMATE_PARTNER_VIOLENCE_AND_PERINATAL_DEPRESSION_JANUARY_2013_%281%29.pdf

Depression in Adults: Screening. United States Preventive Services Task Force (USPSTF) (January 2016). Summarizes USPSTF evidence-based recommendation for depression screening in the general adult population, including pregnant and postpartum women, with adequate systems in place to

ensure accurate diagnosis, effective treatment, and appropriate follow up.

<https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-adults-screening1>

Early Childhood Comprehensive Systems Collaborative Improvement and Innovation Network (ECCS CoIIN). Multiyear initiative funded by federal Maternal and Child Health Bureau to improve early childhood service systems in 12 states, including New York State, to increase age-appropriate developmental skills and reduce developmental disparities among 3-year old children. *See also **Help Me Grow** resource.*

- **National ECCS CoIIN Coordinating Center** led by National Institute for Children’s Health Quality (NICHQ) supports state teams through quality improvement and innovation. Site includes information about the initiative, approach, and resources. <https://www.nichq.org/project/early-childhood-comprehensive-systems-collaborative-improvement-and-innovation-network-eccs>
- **New York State ECCS Impact Initiative** led by the NYS Council on Children and Families is working with community teams in Nassau County and Western New York. Site includes an overview of the NYS initiative and resources related to project implementation. <http://ccf.ny.gov/council-initiatives/early-childhood-comprehensive-systems-impact-initiative-eccs-impact/>

Emergency Resources for Women in Crisis. New York State Office of Mental Health. Includes suicide prevention and parental stress hot lines and a crisis text line. <https://omh.ny.gov/omhweb/maternal-depression/>

First 1000 Days on Medicaid Initiative. Launched in 2017 as a new focus for Medicaid Redesign in New York State, the First 1,000 Days on Medicaid Initiative recognizes the crucial importance of a child’s first three years of development, and seeks to ensure that New York’s Medicaid program is working with health, education and other system stakeholders to maximize outcomes and deliver results for the children we serve. A stakeholder workgroup was charged with developing a ten-point agenda to focus on enhancing access to services and improving outcomes for children on Medicaid in their first 1,000 days of life. Website includes information on the initiative and materials from workgroup and advisory group meetings to date. https://health.ny.gov/health_care/medicaid/redesign/first_1000.htm

Healthy Steps. Evidence-based primary care program model that integrates child development professional (“specialist”) to primary care practice teams to enhance screening, family engagement and communication, and coordination of family support and follow up services.

- **National Healthy Steps** site includes an overview of the model and evidence base, materials for families, and resources for providers, including information on how to become a HealthySteps site. <https://www.healthysteps.org/>
- **New York Office of Mental Health Implementation of Healthy Steps** includes 2016 Request for Proposals to support implementation of Healthy Steps in primary care medical care practices across New York State. <https://omh.ny.gov/omhweb/rfp/2016/healthy-steps/>

Help Me Grow. A system model that works to promote cross-sector collaboration to build early childhood systems that mitigate the impact of adversity and support protective factors among families, so that all children can grow, develop, and thrive to their full potential. Help Me Grow is not a stand-alone program, but a system model that leverages and builds on programs and resources already in place to develop and enhance early childhood system building in any given community. Core components of the model include Centralized Access Point, Family & Community Outreach, Child Health Care Provider Outreach, and Data Collection.

- **Help Me Grow National Center** site includes information on the model and the role of the national center to support local programs, links to its affiliate network of local programs, and other resources. <https://helpmegrownational.org/>
- **Help Me Grow New York** includes information on Western New York and Long Island Help Me Grow networks, partners, events, and other resources. <http://helpmegrownny.org/> See also *ECCS Impact Initiative resource*.

Maternal Depression: Information for Health Care Providers. New York State Department of Health. Includes information on maternal depression, overview and links to screening recommendations and tools, treatment guidelines, links to implementation toolkits, and additional national and state resources for providers and families. https://www.health.ny.gov/community/pregnancy/health_care/perinatal/maternal_depression/providers/

Medicaid Update: NYS Medicaid Coverage of Postpartum Maternal Depression Screening. New York State Department of Health. (July 2015). Provides guidance on billing for postpartum screening reimbursement effective August 2015. https://www.health.ny.gov/health_care/medicaid/program/update/2015/2015-07.htm#pmd

Mental Health and Mental Illness: Collaborative Care for the Management of Depressive Disorders. The Guide to Community Preventive Services. Community Preventive Services Task Force (CPSTF). June 2010. <https://www.thecommunityguide.org/findings/mental-health-and-mental-illness-collaborative-care-management-depressive-disorders>

Mom's Mental Health Matters. National Child & Maternal Health Education Program, *Eunice Kennedy Shriver* National Institute of Child Health and Human Development. Information for women and their partners, family, and friends related to depression and anxiety around pregnancy. <https://www1.nichd.nih.gov/ncmhep/initiatives/moms-mental-health-matters/moms/Pages/default.aspx>

Paid Family Leave. Research studies have shown that new mothers who take paid leave have fewer postpartum depression symptoms, higher rates of breastfeeding, less stress, and stronger parent-child bonding. Website includes information on New York State's Paid Family Leave law and benefits to support bonding with a new child. <https://paidfamilyleave.ny.gov/>

Postpartum Depression Toolkit. American Academy of Family Physicians National Research Network. Site includes documents, slide sets, clinical tools for screening and follow up, and other resources used as part of the Translating Screening and Management of Postpartum Depression (TRIPPD) study. The TRIPPD study (2005-2010) was designed to assess the impact of a universal postpartum depression (PPD) screening and follow-up management program on patient-oriented outcomes and practice-based process measures associated with PPD, and to explore the impact of practice characteristics on the translation of research regarding a PPD screening and follow-up management program. <https://www.aafp.org/patient-care/nrn/studies/all/trippd/ppd-toolkit.html>

Postpartum Resource Center of New York. The Postpartum Resource Center of New York offers support and education around perinatal mood and anxiety disorders for individuals and health care providers. Site includes a searchable statewide resource directory. <https://postpartumny.org/>

Focus area 2: Perinatal & Infant Health

Goal 2.1: Reduce infant mortality and morbidity

Intervention 2.1.1: Implement updated perinatal regionalization standards, designations, and structured clinical quality improvement initiatives in birthing hospitals

Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) NPM 3: Perinatal Regionalization:

- **Evidence Analysis Report. NPM 3: Risk-Appropriate Perinatal Care**, Johns Hopkins University. https://www.mchevidence.org/documents/reviews/npm_3_riskappropriate_perinatal_care_brief_feb_2017.pdf
- **Evidence Brief. Perinatal Regionalization.** National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University. <https://www.ncemch.org/evidence/NPM-3-VLBW.php>
- **Title V Transformation Tools.** Recommendations to support NPM3 – Perinatal Regionalization. <https://www.mchnavigator.org/transformation/npm-3.php>

Levels of Maternal Care. Obstetric Care Consensus. American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine. Statement adopted in 2015 and reaffirmed in 2016 calling for standards and regionalized systems of maternal hospital care to reduce maternal morbidity and mortality. <https://www.acog.org/-/media/Obstetric-Care-Consensus-series/oc002.pdf?dmc=1&ts=20180802T1643258695>

Levels of Neonatal Care Policy Statement. American Academy of Pediatrics Committee on Fetus and Newborn. (2012). Update policy statement summarizing review of data supporting evidence for a

tiered provision of care and reaffirming the need for uniform definitions and standards of care and designation of facilities that provide hospital care for newborns on the basis of functional capabilities, organized within a regionalized system of perinatal care.

<http://pediatrics.aappublications.org/content/130/3/587.full>

New York State Perinatal Quality Collaborative (NYSPQC). New York State Department of Health. Site includes materials, reports, archived presentations, and other resources from multiple NYSPQC quality improvement projects related to improving pregnancy outcomes for women and infants.

https://www.albany.edu/sph/cphce/mch_nyspgc.shtml.

Perinatal Regionalization. New York State Department of Health. Site includes overview of the state’s regionalized perinatal system and materials related to process launched in 2017 review and update the standards for perinatal hospital level requirements, conduct site visits, assign new designations, and development of performance measures for perinatal hospitals and birthing centers in New York State.

https://www.health.ny.gov/community/pregnancy/health_care/perinatal/regionalization_descrip.htm

Toward Improving the Outcome of Pregnancy III: Enhancing Perinatal Health Through Quality, Safety and Performance Initiatives. March of Dimes Foundation. 2010 report explores the elements that are essential to improving quality, safety and performance across the continuum of perinatal care (must create free registration to download report). <https://www.prematurityprevention.org/>

Focus Area 2: Perinatal & Infant Health

Goal 2.1: Reduce infant mortality and morbidity

Intervention 2.1.2: Increase capacity and competencies of local maternal and infant home visiting programs

Resources

Community Health Workers Toolkit. NORC Walsh Center for Rural Health Analysis, University of Minnesota rural Health Resource Center, and Rural Health Information Hub. Designed to help rural communities evaluate opportunities for developing a CHW program and provide resources and best practices developed by successful CHW programs. Modules focus on different aspects of CHW programs and include resources for developing local CHW programs.

<https://www.ruralhealthinfo.org/toolkits/community-health-workers>

Doula Support. Doulas are individuals who provide continuous physical, emotional, and informational support to women during pregnancy, childbirth, and/or postpartum periods. There are a number of organizations offering training, certification, and continuing education for doulas. A pilot of Medicaid coverage for doulas is an element of the state’s maternal mortality reduction initiative. A 2017 review of 26 studies from 17 countries published in the Cochrane Database of Systemic Reviews concluded

that women who received continuous labor during labor may be less likely to have cesarean births, use pain medications, have low Apgar scores at birth, and have negative feelings about childbirth, and more likely to have spontaneous vaginal deliveries.

<https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD003766.pub6/full#CD003766-sec1-0001>

First 1000 Days on Medicaid Initiative. Launched in 2017 as a new focus for Medicaid Redesign in New York State, the First 1,000 Days on Medicaid Initiative recognizes the crucial importance of a child's first three years of development and seeks to ensure that New York's Medicaid program is working with health, education and other system stakeholders to maximize outcomes and deliver results for the children we serve. A stakeholder workgroup was charged with developing a ten-point agenda to focus on enhancing access to services and improving outcomes for children on Medicaid in their first 1,000 days of life. Website includes information on the initiative and materials from workgroup and advisory group meetings to date. https://health.ny.gov/health_care/medicaid/redesign/first_1000.htm

Home Visiting Evidence of Effectiveness (HomVee). *U.S. Department of Health and Human Services and Administration for Children and Families.* Review of the home visiting research literature assessing the evidence of effectiveness for home visiting program models that serve families with pregnant women and children from birth to age 5. Provides information about which home visiting program models have evidence of effectiveness, as well as detailed information about the samples of families who participated in the research, the outcomes measured in each study, and the implementation guidelines for each model. <https://homvee.acf.hhs.gov/>.

Home Visiting Collaborative Improvement and Innovation Network (CoIIN). A national quality improvement initiative launched in 2013 to support the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. Specific areas for improvement include breastfeeding, developmental assessments and interventions, screening and follow up for maternal depression, and retention of enrolled families. Site includes links to toolkits developed for each area. <http://hv-coiin.edc.org/>

Home Visiting – Your Partner in Helping Families. New York State Department of Health and University at Albany School of Public Health Center for Public Health Continuing Education. (April 2018). Webcast for health care providers, local public health professionals, and local community-based agencies working with families discusses the benefits of home visiting to the clients and to referring agencies, including improved adherence to immunization schedules, reinforcement of health messages delivered during pregnancy and early childhood, and screening for maternal depression and child developmental delays. Archived at: https://www.albany.edu/sph/cphce/phl_0418.shtml

Home is where the Start Is: Expanding Home Visiting to Strengthen All of New York's Families. Schuyler Center for Analysis and Advocacy (SCAA). 2016 report describes the benefits of home visiting, evidence-based and evidence-informed programs currently operating in New York State, and recommendations for expanding maternal, infant and early childhood home visiting in the state. http://www.scaany.org/wp-content/uploads/2016/08/Home_Is_Where_the_Start_Is-Expanding_HV-06-2016.pdf

Institute for the Advancement of Family Support Professionals. The Institute offers Family Support Professionals everywhere the opportunity to learn new skills and grow their careers. Through engaging, online modules and a personalized learning map feature, professionals take charge of their growth and advancement. <https://institutefsp.org/modules>

New York State Home Visiting County Data Snapshots. Schuyler Center for Analysis and Advocacy (SCAA). Snapshots for each county in New York State designed to illustrate current home visiting services and community needs that could be addressed through expansion of home visiting programs. <http://www.scaany.org/policy-areas/maternal-infant-and-early-childhood/numbers-tell-a-story-new-york-state-home-visiting-data-snapshots/>

New York State’s Home Visiting Programs: Support for Pregnant and Parenting Families. New York State Department of Health. State website includes information for providers and families, including a searchable list of home visiting programs in New York State by county. https://www.health.ny.gov/community/pregnancy/home_visiting_programs/

Training Modules for Community Health Workers. Six modules provide introductory training for community health workers on maternal and child health information, resources and strategies. Four webinars are also available for supervising community health workers. https://www.health.ny.gov/community/adults/women/chw_training/

Focus Area 2: Perinatal & Infant Health

Goal 2.1: Reduce infant mortality and morbidity

Intervention 2.1.3: Engage in collaborative clinical and community-based strategies to reduce sleep-related infant deaths.

Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 4: Safe Sleep:

- **Evidence Analysis Report. NPM 4: Safe Sleep,** Johns Hopkins University. https://www.mchevidence.org/documents/reviews/npm_5_safe_sleep_evidence_review_brief_feb_2017.pdf
- **Evidence Brief. Safe sleep.** National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University. <https://www.ncemch.org/evidence/NPM-5-safe-sleep.php>
- **Title V Transformation Tools.** Skills and knowledge recommendations for the MCH workforce to support NPM5 – Safe Sleep. <https://www.mchnavigator.org/transformation/npm-5.php>

Building Integrated Systems for Address Sudden Unexpected Infant Death. National Center for Cultural Competence, Georgetown University https://nccc.georgetown.edu/documents/MI_BL.pdf

Caring for our Children - National Health and Safety Performance Standards for Early Care and Education Programs – Safe Sleep. Health and safety standards on sleep safety in out of home child care settings developed by the American Academy of Pediatrics, American Public Health Association, and National Resource Center for Health and Safety in Child Care and Early Education, in consultation with panels of experts. <http://nrckids.org/CFOC/Database/3.1.4.1>

Collaborative Improvement and Innovation Network to Reduce Infant Mortality (CoIIN). A public-private partnership developed by the Maternal and Child Health Bureau to reduce infant mortality and improve birth outcomes. Participants learn from one another and national experts, share best practices and lessons learned, and track progress toward shared benchmarks. Site includes information on Infant Mortality CoIIN and link to an interactive [infant mortality prevention toolkit](#). Promoting infant safe sleep practices is one of five priorities selected by CoIIN participants.

<https://mchb.hrsa.gov/maternal-child-health-initiatives/collaborative-improvement-innovation-networks-coiins>

National Action Partnership to Promote Safe Sleep Improvement and Innovation Network (NAPPSS-IIN). Funded by the federal Maternal and Child Health Bureau and based at the National Institute for Children's Health Quality (NICHQ). (2017-2022). NAPPSS-IIN is an initiative to make infant safe sleep and breastfeeding the national norm by aligning stakeholders to test safety bundles in multiple care settings to improve the likelihood that infant caregivers and families receive consistent, evidence-based instruction about safe sleep and breastfeeding. The project is currently working with five pilot hospitals in five states, including New York Presbyterian Lawrence Hospital in Westchester County representing New York State. Site includes information and tools related to the project.

<https://www.nichq.org/project/national-action-partnership-promote-safe-sleep-improvement-and-innovation-network-nappss>

New York State Perinatal Quality Collaborative (NYSPQC). New York State Department of Health. Site includes materials, reports, archived presentations, and other resources from multiple NYPQC quality improvement projects related to improving pregnancy outcomes for women and infants.

https://www.albany.edu/sph/cphce/mch_nyspqc.shtml.

Psychosocial interventions for supporting women to stop smoking in pregnancy (2017). Systematic review of interventions from Cochrane Database. <http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD001055.pub5/full>

Safe to Sleep Campaign®. Directed and managed by the National Institute of Child Health and Human Development. National campaign aimed at health professionals, child care providers, and families about ways to reduce the risk for SIDS and other sleep-related causes of infant death. Includes outreach materials in English and Spanish and online curricula for nurses and pharmacists. Includes

information about outreach activities in specific communities informed by research and experience.
<https://www1.nichd.nih.gov/sts/Pages/default.aspx>

SIDS and other sleep-related infant deaths: Expansion of recommendations for a safe infant sleeping environment. American Academy of Pediatrics, Task Force on Sudden Infant Death Syndrome 2011 policy statement on safe sleep.
<http://pediatrics.aappublications.org/content/early/2011/10/12/peds.2011-2284>

Sudden Unexpected Infant Death (SUID) and Sudden Infant Death Syndrome (SIDS) Gateway. National Center for Education in Maternal and Child Health, Georgetown University. Resources for states, communities, health and social services professionals, child care providers, and families to reduce SUID and SIDS, promote healthy outcomes, and cope with grief when losses occur. Resources related to infant sleep environments include a resource page, training toolkit, infant safe sleep campaigns and materials, resources to support AAP's policy statement on SIDS and other sleep-related infant deaths, and other implementation support materials. <https://www.ncemch.org/suid-sids/index.php>

Toolkit for community health providers: Engaging ethnic media to inform communities about safe infant sleep. National Center for Cultural Competence, Georgetown University.
<https://nccc.georgetown.edu/engaging-ethnic-media/Engaging-Ethnic-Media.pdf>

Focus Area 2: Perinatal & Infant Health

Goal 2.1: Reduce infant mortality and morbidity

Intervention 2.1.4: Engage in collaborative strategies to respond to increasing use of opioids among women, including pregnant women, and impact on infants.

Resources

A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders. Substance Abuse and Mental Health Service Administration (SAMHSA). 2016. Manual offers best practices to states, tribes, and local communities on collaborative treatment approaches for pregnant women living with opioid use disorders, and the risks and benefits associated with medication-assisted treatment. https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf

Combating the Heroin and Opioid Crisis: Heroin and Opioid Task Force Report (June 2016). Report of NYS Task Force, informed by series of statewide listening sessions and other public input. Provides recommendations in four areas: Prevention, Treatment, Recovery, and Enforcement.
https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/HeroinTaskForceReport_3.pdf.

Institute for Research, Education and Training in Addictions (IRETA). Non-profit organization that works with national, state, and local partners to improve recognition, prevention, treatment, research,

and policy related to addiction and recovery. Includes evidence-based and best practice resources for the substance abuse field including descriptions of intervention implementation, technical assistance resources, information on fidelity measurement and staff training, and evidence-based practice references. <https://ireta.org/>

National Collaborative for Maternal Opioid Use Disorders. Alliance for Innovation on Maternal Health. As part of the larger AIM initiative (see Intervention 1.2.3), this collaborative seeks to optimize the care of mothers with opioid use disorder and their infants during the prenatal and postpartum periods through improvements to care in hospitals, outpatient settings, and in the community. Includes a number of clinical and quality improvement resources.

<https://safehealthcareforeverywoman.org/national-collaborative-on-maternal-oud/>

National Registry of Evidence-Based Programs and Practices (NREPP). Substance Abuse and Mental Health Services Administration (SAMHSA). Developed to increase awareness and promote the adoption of scientifically established behavioral health interventions. Site includes a searchable database of interventions and a learning center with resources to support the selection, adoption, implementation, and evaluation of evidence-based programs and practices.

<https://www.samhsa.gov/nrepp>

New York State Opioid Overdose Prevention Program. New York State Department of Health to support community programs for administration of Naloxone to prevent opioid overdose fatalities. Includes information on registration, resources for providers and the public, program locator, and calendar of training events. <https://www.nyoverdose.org/>

Opioid Addiction Prevention & Management Collaborative. Health Care Association of New York State (HANYS). Statewide collaborative launched by HANYS to help members prevent opioid addiction and manage the care of patients in crisis. Includes education, networking opportunities, and resources for health care providers and to advance community dialogue around opioid addiction.

https://www.hanys.org/quality/collaboratives_and_learning_networks/opioids/

Opioid-related Data in New York State. New York State Department of Health (2018). website designed to provide comprehensive and useful data and information regarding opioid use and misuse to support statewide prevention efforts. Site provides the most up-to-date summary opioid summary reports as well as prescription monitoring program, overdose death, hospital and emergency department visits, and other data at state, regional, and county level where available.

<https://www.health.ny.gov/statistics/opioid/>

Preventing Opioid Misuse in Pregnant Women and New Moms Challenge. Sponsored by the federal Maternal and Child Health Bureau, this challenge will support the development and testing of low-cost, scalable, technology-based innovations to improve access to quality health care, including substance use disorder (SUD) treatment, recovery, and support services for pregnant women with opioid use disorders (OUD), their infants, and families, especially those in rural and geographically isolated areas. The design phase for this challenge will launch in September 2018, with subsequent development, small-scale testing, and scaling phases through Winter 2019.

<https://mchbgrandchallenges.hrsa.gov/challenges/addressing-opioid-use-disorder-pregnant-women-and-new-moms>

Treating Opioid Use Disorder During Pregnancy. National Institutes of Health (NIH) National Institute on Drug Abuse (NIDA). July 2017. Brief provides overview of risk of opioid use during pregnancy, evidence-based treatment options including considerations for breastfeeding, and considerations for improving engagement in treatment, with links to additional citations and resources.

<https://www.drugabuse.gov/publications/treating-opioid-use-disorder-during-pregnancy/treating-opioid-use-disorder-during-pregnancy>

Focus Area 2: Perinatal & Infant Health

Goal 2.2: Increase breastfeeding

Intervention 2.2.1: Increase access to professional support, peer support, and formal education to change behavior and outcomes.

Resources

Evidence base:

Cochrane Systematic Review (2016). [Interventions for Promoting the Initiation of Breastfeeding](#)

U.S. Preventive Services Task Force (2008). [Primary Care Interventions to Promote Breastfeeding](#)

U.S. Preventive Services Task Force (2016). [Primary Care interventions to Support Breastfeeding Recommendation Statement](#) and [Breastfeeding: Primary Care interventions](#)

AHRQ (2007). [Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries](#)

AHRQ: Breastfeeding Programs and Policies, Breastfeeding Uptake, and Maternal Health Outcomes in Developed Countries (2018). [Full Report](#) and [Evidence Summary](#)

Implementation Resources:

U.S. Department of Agriculture (2018). [Partnering with WIC to Support Breastfeeding](#)

United States Breastfeeding Committee (2010). [Core Competencies in Breastfeeding Care and Services for All Health Professionals](#)

Centers for Disease Control and Prevention (2013). [Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies](#) Atlanta: U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services (2011). [The Surgeon General’s Call to Action to Support Breastfeeding](#) Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. (Actions 1, 2,3, 8 and 9: pgs. 38-40, 45-47).

Hannula L, Kaunonen M, Tarkka MT. [A Systematic Review of Professional Support Interventions for Breastfeeding](#). *J Clin Nurs*. 2008;17(9):1132-1143.

Evans A, Marinelli KA, Taylor JS and The Academy of Breastfeeding Medicine (2014). [ABM Clinical Protocol #2: Guidelines for Hospital Discharge of the Breastfeeding Term Newborn and Mother: “The Going Home Protocol,” Revised 2014](#) doi: 10.1089/bfm.2014.9996.

Evaluation Resources:

New York State Department of Health. [Women, Infants, and Children \(WIC\) Program Site Information Dataset](#)

New York State Department of Health. [Breastfeeding Friendly Practices by County](#)

Baby-Friendly USA. [Designated Facilities by State](#)

Focus Area 2: Perinatal & Infant Health

Goal 2.2: Increase breastfeeding

Intervention 2.2.2: Promote and implement maternity care practices consistent with the Baby Friendly Hospital Initiative - Ten Steps to Successful Breastfeeding.

Resources

Evidence base:

World Health Organization (1998). [Evidence for the Ten Steps to Successful Breastfeeding](#)

World Health Organization (2018). Revised Baby-Friendly Hospital Initiative [Protecting, Promoting and Supporting Breastfeeding in Facilities Providing Maternity and Newborn Services](#)

Implementation Resources:

Baby-Friendly USA, Inc. (2016). [The Baby-Friendly Initiative, Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation](#)

Baby-Friendly USA, Inc. Final Report (2004). [Overcoming Barriers to Implementing The Ten Steps to Successful Breastfeeding](#)

Centers for Disease Control and Prevention (2013). [Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies](#). Atlanta: U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services (2011). [The Surgeon General's Call to Action to Support Breastfeeding](#). Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. (Action 7: pg. 44).

United States Lactation Consultant Association (2010). [International Board Certified Lactation Consultant Staffing Recommendations for the Inpatient Setting](#)

Nickel NC, Labbok MH, Hudgens MG, Daniels JL. [The Extent that Noncompliance with the Ten Steps to Successful Breastfeeding Influences Breastfeeding Duration](#)

J Hum Lact 2013;29(1): 59-70.

Evaluation Resources:

Baby-Friendly USA, Inc. (2016).

- [The Baby-Friendly Initiative, Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation](#)
- [Baby-Friendly Hospital Initiative: Facility Self-Appraisal Tool](#)
- [Designated Facilities by State](#)

Centers for Disease Control and Prevention (2015). [Maternity Practices in Infant Nutrition and Care \(mPINC\) Survey](#)

Focus Area 2: Perinatal & Infant Health

Goal 2.2: Increase breastfeeding

Intervention 2.2.3: Promote and implement early skin-to-skin contact in hospitals

Resources

Evidence base:

Cochrane Systematic Review (2016). [Early Skin-to-Skin Contact for Mothers and Their Health Newborn Infants](#)

Implementation Resources:

Hung KJ & Berg O. [Early Skin-To-Skin after Cesarean to Improve Breastfeeding](#) MCN 2011;36(5):318-324.

Feldman-Winter L, Goldsmith JP, Committee on Fetus and Newborn, Task Force on Sudden Infant Death Syndrome. American Academy of Pediatrics (AAP). [Safe Sleep and Skin-to-Skin Care in the Neonatal Period for Healthy Term Newborns](#) Pediatrics 2016;138(3):e1-e10.

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). [Immediate and Sustained Skin-to-Skin Contact for the Healthy Term Newborn After Birth](#)

AWHONN Practice Brief Number 5. JOGNN 2016;45:842-844.

United States Institute for Kangaroo Care. [Kangaroo Care Resources](#)

Centers for Disease Control and Prevention (CDC), Division of Nutrition, Physical Activity, and Obesity (2015). [Maternity Practices in Infant Nutrition & Care \(mPINC\) Survey](#)

American Congress of Obstetricians and Gynecologists (ACOG). [Optimizing Support for Breastfeeding as Part of Obstetric Practice](#) Committee Opinion No. 658. Obstet Gynecol 2016;127:e86-92.

Baby-Friendly USA, Inc. [The Baby-Friendly Initiative, Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation](#) 2016 Edition, Updated 06/30/16.

Rosen-Carole C, Hartman S and The Academy of Breastfeeding Medicine. [ABM Clinical Protocol #19: Breastfeeding Promotion in the Prenatal Setting, Revision 2015](#)

Evaluation Resources:

Baby-Friendly USA, Inc. (2016).

- [The Baby-Friendly Initiative, Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation](#)
- [Baby-Friendly Hospital Initiative: Facility Self-Appraisal Tool](#)
- [Designated Facilities by State](#)

Centers for Disease Control and Prevention (2015). [Maternity Practices in Infant Nutrition and Care \(mPINC\) Survey](#); questions A4, A5, A10, A11

Focus Area 2: Perinatal & Infant Health

Goal 2.2: Increase breastfeeding

Intervention 2.2.4: Increase access to primary care practices that are supportive of breastfeeding.

Resources

Evidence base:

AHRQ: Breastfeeding Programs and Policies, Breastfeeding Uptake, and Maternal Health Outcomes in Developed Countries (2018). [Full Report](#) and [Evidence Summary](#)

Implementation Resources:

The Academy of Breastfeeding Medicine Protocol Committee. ABM Clinical Protocol #14: [Breastfeeding Friendly Physician's Office](#), Part 1: Optimizing care for infants and children, Revised 2013. *Breastfeeding Med* 2006;1(2):115-119.

Shariff F, Levitt C, Kaczorowski J, et al. Workshop to implement the [Baby Friendly Office](#) initiative. Effect on community physicians' offices. *Can Fam Physician* 2000;46:1090-1097.

The American Academy of Pediatrics, Breastfeeding Initiatives. [How to Have a Breastfeeding Friendly Practice](#)

New York State Department of Health. [Breastfeeding Friendly Practice Designation](#)

Evaluation Resources:

New York State Department of Health.

- [NYS Breastfeeding Friendly Practice Designation Assessment Survey](#)
- [Breastfeeding Friendly Practices by County](#)

Focus Area 2: Perinatal & Infant Health

Goal 2.2: Increase breastfeeding

Intervention 2.2.5: Increase access to community-based interventions that provide mothers with peer support via home visits in the prenatal and early postpartum period.

Resources

Evidence base:

AHRQ: Breastfeeding Programs and Policies, Breastfeeding Uptake, and Maternal Health Outcomes in Developed Countries (2018). [Full Report](#) and [Evidence Summary](#)

Cochrane Systematic Review (2017). [Schedules for Home Visits in the Early Postpartum Period](#)

U.S. Department of Health and Human Services. [Home Visiting Evidence of Effectiveness](#)

Implementation Resources:

Centers for Disease Control and Prevention (2005). Shealy KR, Li R, Benton-Davis S, Grummer-Strawn LM. The CDC Guide to Breastfeeding interventions Atlanta: U.S. Department of Health and Human Services.

Centers for Disease Control and Prevention (2013). [Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies](#) Atlanta: U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services (2011). [The Surgeon General's Call to Action to Support Breastfeeding](#) Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. (Actions 4 and 8: pgs. 41 and 45).

New York State Department of Health. [Find a Home Visiting Program](#)

Evaluation Resources:

New York State Department of Health. [List of Home Visiting Programs in NYS](#)

Focus Area 2: Perinatal & Infant Health

Goal 2.2: Increase breastfeeding

Intervention 2.2.6: Increase support for breastfeeding in the workplace.

Resources

Evidence base:

Dinour L, Szaro J. Employer-Based Programs to Support Breastfeeding Among Working Mothers: A Systematic Review. *Breastfeeding Medicine* 2017;12(3).

Implementation Resources:

New York State Department of Labor. [NYS Nursing Mothers in the Workplace Act](#)

Centers for Disease Control and Prevention (2013). [Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies](#) Atlanta: U.S. Department of Health and Human Services (Strategy 5: Support for Breastfeeding in the Workplace pg. 23 - 28)

U.S. Department of Health and Human Services (2011). [The Surgeon General's Call to Action to Support Breastfeeding](#) Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. (Action 13: pg. 50).
[Making It Work Toolkit](#)

U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau (2008). [Business Case for Breastfeeding](#)

New York City Department of Health, Center for Health Equity (2018). [Breastfeeding Toolkit for Business Owners](#)

Niagara County Breastfeeding Friendly Employer Initiative
<http://www.niagaracounty.com/health/Services/Lactation-and-Breastfeeding>

Evaluation Resources:

Centers for Disease Control and Prevention (2014). [The CDC Worksite Health Score Card: An Assessment Tool for Employers to Prevent Heart Disease, Stroke, & Related Health Conditions](#) Lactation Support Module (6 questions); page 21

Niagara County Department of Health. [Breastfeeding Friendly Workplace Assessment](#)

New York State Department of Health. Contact promotebreastfeeding@health.ny.gov for an additional worksite assessment tool

Focus Area 2: Perinatal & Infant Health

Goal 2.2: Increase breastfeeding

Intervention 2.2.7: Increase access to Early Care and Education programs that support breastfeeding families.

Resources

Evidence base:

Batan M, Li R, Scanlon K. [Association of child care providers breastfeeding support with breastfeeding duration at 6 months](#). Maternal Child Health J. 2012 doi: 10.1007/s10995-012-1050-7.

Implementation Resources:

Centers for Disease Control and Prevention (2013). [Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies](#) Atlanta: U.S. Department of Health and Human Services. (Strategy 6: Support for Breastfeeding in the Early Care and Education pg. 29 – 32)

American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. 2011. *Caring for our children: National health and safety performance standards; Guidelines for early care and education programs*. 3rd Edition. Also available at <http://nrckids.org>

U.S. Department of Health and Human Services (2011). [The Surgeon General’s Call to Action to Support Breastfeeding](#). Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. (Action 16: pg. 53).

[Caring for our children: National health and safety performance standards; Guidelines for early care and education programs](#). Chapter 4: Nutrition and Food Service, 4.3.1 Nutrition for Infant (pp. 162-173).

New York State Department of Health. [CACFP Breastfeeding Friendly Child Care Designation Program](#)

Evaluation Resources:

New York State Department of Health.

- [Child Care Center Breastfeeding Friendly Self-Assessment](#)
- [Day Care Home Breastfeeding Friendly Self-Assessment](#)
- [Day Care Home Breastfeeding Friendly Self-Assessment Spanish](#)
- [Breastfeeding Friendly Child Care Centers by County](#)
- [Breastfeeding Friendly Child Care Homes by County](#)

Focus Area 2: Perinatal & Infant Health

Goal 2.2: Increase breastfeeding

Intervention 2.2.8: Increase access to peer and professional breastfeeding support by creating drop-in centers (e.g., Baby Cafés®) in faith-based, community-based or health care organizations in communities.

Resources

Evidence base:

Fox, Rebekah & McMullen, Sarah & Newburn, Mary. (2015). [UK women’s experiences of breastfeeding and additional breastfeeding support: a qualitative study of Baby Café services](#). BMC Pregnancy and Childbirth. 15:147. DOI 10.1186/s12884-015-0581-5.

Implementation Resources:

Evans, Marinelli, Taylor, Academy of Breastfeeding Medicine (2014). [ABM Clinical Protocol #2: Guidelines for Hospital Discharge of the Breastfeeding Term Newborn and Mother: “The Going Home Protocol,” Revised 2014](#) Breastfeeding Med 2014; 9(1). DOI: 10.1089/bfm.2014.9996

U.S. Department of Health and Human Services (2011). [The Surgeon General’s Call to Action to Support Breastfeeding](#). Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. (Actions 3 and 11: pgs. 40 and 48).

Centers for Disease Control and Prevention (2013). [Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies](#) Atlanta: U.S. Department of Health and Human Services.

Baby Café USA: <http://www.babycafeusa.org/>

Evaluation Resources:

Baby Café USA. [List of Baby Cafés in your state](#)

Focus Area 3: Child and Adolescent Health

Goal 3.1: Support and enhance children and adolescents’ social-emotional development and relationships

Intervention 3.1.1: Increase awareness, knowledge, and skills of providers serving children, youth, and families related to social-emotional development, adverse childhood experiences (ACEs), and trauma-informed care.

Resources

Docs for Tots. A non-profit, non-partisan organization led by pediatricians to promote practices, policies, and investments that will enable young children to thrive. Docs for Tots offers resources, tools, technical assistance and training to ensure that social-emotional health is addressed by doctors and in all early childhood settings. Site includes resources related to social-emotional health and other related topics, organized for doctors, early childhood providers, families, and advocates.

<http://docsfortots.org/>

National Center of Trauma Informed Care (NCTIC). Supported by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), NCTIC supports interest in developing approaches to eliminate the use of seclusion, restraints, and other coercive practices and to further advance the knowledge base related to implementation of trauma-informed approaches. NCTIC offers consultation and technical assistance, education and outreach, and resources to support a broad range of service systems, including systems providing mental health and substance abuse services, housing and homelessness services, HIV services, peer and family organizations, child welfare, criminal justice, and education. <https://www.samhsa.gov/nctic>

The Pyramid Model. The Pyramid Model is an evidence-based framework for implementing a multi-level system of support for children ages birth to six years and their families in diverse settings. It is a relationship-based, child and family-centered professional development model that addresses the drivers outlined in implementation science research: competency, leadership, and organization. In New York State, the *New York State Pyramid Model Partnership* was established to promote statewide use of the Pyramid Model to build social and emotional competence in early care and education programs.

<http://www.nysecac.org/ecac-initiatives/pyramid-model/>

Trauma Informed Care: Perspectives and Resources. Developed by the National Technical Assistance Center for Children’s Mental Health at Georgetown University Center for Child and Human Development. A comprehensive web-based, video-enhanced resource tool to support leaders and decision makers at all levels (national, state, tribal, territorial, and local) in becoming “trauma informed”. <https://gucchdtacenter.georgetown.edu/TraumaInformedCare/>

The Trauma Informed Care Project (TCIP). Trauma Informed Care (TIC) is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. It emphasizes physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment. The Trauma Informed

Care Project (TIC), based at Orchard Place/Child Guidance Center in Iowa, provides a variety of resource links to publications, trainings, and other tools for practitioners.

<http://traumainformedcareproject.org/index.php>

Focus Area 3: Child and Adolescent Health

Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships

Intervention 3.1.2: Identify and integrate evidence-based and evidence-informed strategies to promote social-emotional wellness through public health programs serving children, youth, and families.

Resources

Bright Futures Tool and Resource Kit. American Academy of Pediatrics. This kit provides forms and tools for health care professionals, patients, and families to complete before, during, or after well-child visits. These items help pediatricians and other health care professionals support and implement the guidance provided in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition*. Providers can use or adapt these materials to meet the needs of their practices and ensure they are following the recommendations presented in the *Guidelines* when delivering care to patients. An update to the kit is anticipated in the near future.

<https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/default.aspx>

Center for Integrated Health Solutions - Children and Youth. The CIHS, supported by the Health Resources and Services Administration (HRSA) and Substance Abuse and Mental Health Services Administration (SAMHSA), reviews the latest resources and research related to integrated care for children and youth, and compiles links to useful resources for providers.

<https://www.integration.samhsa.gov/integrated-care-models/children-and-youth>

Essentials for Childhood Framework: Creating Safe, Stable, Nurturing Relationships and Environments for All Children. Centers for Disease Control and Prevention (CDC). This framework outlines strategies communities can consider to promote relationships and environments that help children grow up to be healthy and productive citizens. The framework is intended for communities committed to the positive development of children and families, and specifically to the prevention of child abuse and neglect. The framework has four goal areas and suggests strategies based on best available evidence to achieve each goal. Site includes link to full framework and a number of related resources. <https://www.cdc.gov/violenceprevention/childabuseandneglect/essentials.html>.

Evidence-based Bullying Programs, Curricula and Practices. Oklahoma State Department of Education. Provides a list of evidence-based bullying prevention programs examined and approved by federal agencies to assist schools in prevention efforts, with links to additional resources for each program.

<http://sde.ok.gov/sde/bullying-prevention-curriculum>

First 1000 Days on Medicaid Initiative. Launched in 2017 as a new focus for Medicaid Redesign in New York State, the First 1,000 Days on Medicaid Initiative recognizes the crucial importance of a child's first three years of development and seeks to ensure that New York's Medicaid program is working with health, education and other system stakeholders to maximize outcomes and deliver results for the children we serve. A stakeholder workgroup was charged with developing a ten-point agenda to focus on enhancing access to services and improving outcomes for children on Medicaid in their first 1,000 days of life. Website includes information on the initiative and materials from workgroup and advisory group meetings to date. https://health.ny.gov/health_care/medicaid/redesign/first_1000.htm

Fostering Cultural Competence: Using Children's Literature to Talk about Difficult Issues in K-12 Classrooms. Center for Safe Schools. 2015 Webinar focuses on strategies for broaching sensitive topics with students and for examining one's own assumptions about others. <http://www.safeschools.info/bullying-prevention/professional-development/429>

Healthy Steps. Evidence-based primary care program model that integrates child development professional ("specialist") to primary care practice teams to enhance screening, family engagement and communication, and coordination of family support and follow up services.

- **National Healthy Steps** site includes an overview of the model and evidence base, materials for families, and resources for providers, including information on how to become a HealthySteps site. <https://www.healthysteps.org/>
- **New York Office of Mental Health Implementation of Healthy Steps** includes 2016 Request for Proposals to support implementation of Healthy Steps in primary care medical care practices across New York State. <https://omh.ny.gov/omhweb/rfp/2016/healthy-steps/>

Help Me Grow. A system model that works to promote cross-sector collaboration to build early childhood systems that mitigate the impact of adversity and support protective factors among families, so that all children can grow, develop, and thrive to their full potential. Help Me Grow is not a stand-alone program, but a system model that leverages and builds on programs and resources already in place to develop and enhance early childhood system building in any given community. Core components of the model include Centralized Access Point, Family & Community Outreach, Child Health Care Provider Outreach, and Data Collection.

- **Help Me Grow National Center** site includes information on the model and the role of the national center to support local programs, links to its affiliate network of local programs, and other resources. <https://helpmegrownational.org/>
- **Help Me Grow New York** includes information on Western New York and Long Island Help Me Grow networks, partners, events, and other resources. <http://helpmegrownny.org/> See also **ECCS Impact Initiative** resource.

Meeting the Social-Emotional Development Needs of Infants and Toddlers: Guidance for Early Intervention and Other Early Childhood Professionals (2017). Joint Task Force on Social-Emotional

Development: New York State Department of Health Early Intervention Coordinating Council and New York State Early Childhood Advisory Council. This guidance document is geared towards early childhood health, development specialists, and early care and learning professionals to partner with families to promote and support healthy social emotional development in infants and toddlers, including those in the State's Early Intervention Program.

<https://www.health.ny.gov/publications/4226.pdf>

The National Center for Pyramid Model Interventions (NCPMI). The NCPMI aims to assist states and programs in their implementation of sustainable systems for the implementation of the Pyramid Model for Supporting Social Emotional Competence in Infants and Young Children (Pyramid Model) within early intervention and early education programs. The focus is on promoting the social, emotional, and behavioral outcomes of young children birth to five, reducing the use of inappropriate discipline practices, promoting family engagement, using data for decision-making, integrating early childhood and infant mental health consultation and fostering inclusion. <http://challengingbehavior.cbcs.usf.edu/>

The Resilience Project. American Academy of Pediatrics. Website clearinghouse for resources developed for pediatricians and medical home teams to more effectively identify and care for children and youth exposed to violence. Includes links to a variety of resources including websites, toolkits, and practice guides. <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Prevention.aspx>

The Search Institute. The Search Institute bridges research and practice to help young people be and become their best selves. The Institute supports a wide range of research-based resources including its Developmental Assets®, one of the foundational frameworks in positive youth development that has become among the most frequently cited and widely utilized frameworks in the world. Site includes a wide array of resources and tools for schools, youth and family serving programs, and community coalitions. www.search-institute.org

Supporting Social-Emotional Learning with Evidence-Based Programs. Annie E. Casey Foundation. This brief shares nine strategies for implementing and sustaining evidence-based programs to support students' social and emotional health. Situated within a four-stage framework, these strategies consider the costs, resource allocations, funding streams, infrastructure and partnerships that are necessary for effective implementation. Input from administrators in seven school districts — each with a track record of delivering and sustaining social-emotional learning (SEL) programs — helped shape the strategies identified. <https://www.aecf.org/resources/supporting-social-emotional-learning-with-evidence-based-programs/>

Teaching Students to Prevent Bullying: Curriculum and Resources. National Education Association. Curriculum resources to prevent, identify, and confront bullying. Site includes lesson plans, activities, games, and other resources for elementary through high school grade levels. <http://www.nea.org/tools/lessons/teaching-students-to-prevent-bullying.html>

Focus Area 3: Child and Adolescent Health

Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships

Intervention 3.1.3: Engage in collaborative strategies to increase developmental screening of young children in accordance with professional medical guidelines.

Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 6: Developmental Screening:

- **Evidence Analysis Report. NPM 6: Developmental Screening**, Johns Hopkins University. Report includes detailed tables of interventions reviewed with citations for individual studies. https://www.mchevidence.org/documents/reviews/npm_6_developmental_screening_evidence_review_april_2018.pdf
- **Evidence Brief. Developmental Screening**. National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University. <https://www.ncemch.org/evidence/NPM-6-developmental-screening.php>
- **Title V Transformation Tools**. Recommendations to support NPM6 – Developmental Screening. <https://www.mchnavigator.org/transformation/npm-6.php>

American Academy of Pediatrics. Clinical guidelines for pediatric health care providers:

- **Recommendations for preventive pediatric health care** (periodicity schedule) - https://www.aap.org/en-us/Documents/periodicity_schedule.pdf
- **Policy statement: Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening.** <http://pediatrics.aappublications.org/content/118/1/405.long>
- **Bright Futures Tool and Resource Kit.** <https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/default.aspx>

Birth to Five: Watch me Thrive. This initiative of the Early Childhood Development office of the Administration for Children and Families is a coordinated federal effort to encourage healthy child development, universal developmental and behavioral screening for children, and support for the families and providers who care for them. The website includes a list of research-based [developmental screening tools](#) for use across a wide range of settings. Its [Families page](#) offers resources families can use to track their child's development and know how to take action when needed. <https://www.acf.hhs.gov/ecd/child-health-development/watch-me-thrive>

Early Childhood Comprehensive Systems Collaborative Improvement and Innovation Network (ECCS CoIIN). Multiyear initiative funded by federal Maternal and Child Health Bureau to improve early childhood service systems in 12 states, including New York State, to increase age-appropriate developmental skills and reduce developmental disparities among 3-year old children. *See also **Help Me Grow** resource.*

- **National ECCS CoIIN Coordinating Center** led by National Institute for Children’s Health Quality (NICHQ) supports state teams through quality improvement and innovation. Site includes information about the initiative, approach, and resources. <https://www.nichq.org/project/early-childhood-comprehensive-systems-collaborative-improvement-and-innovation-network-eccs>
- **New York State ECCS Impact Initiative** led by the NYS Council on Children and Families is working with community teams in Nassau County and Western New York. Site includes an overview of the NYS initiative and resources related to project implementation. <http://ccf.ny.gov/council-initiatives/early-childhood-comprehensive-systems-impact-initiative-eccs-impact/> *See also **Help Me Grow** resource.*

First 1000 Days on Medicaid Initiative. Launched in 2017 as a new focus for Medicaid Redesign in New York State, the First 1,000 Days on Medicaid Initiative recognizes the crucial importance of a child’s first three years of development and seeks to ensure that New York’s Medicaid program is working with health, education and other system stakeholders to maximize outcomes and deliver results for the children we serve. A stakeholder workgroup was charged with developing a ten-point agenda to focus on enhancing access to services and improving outcomes for children on Medicaid in their first 1,000 days of life. Website includes information on the initiative and materials from workgroup and advisory group meetings to date. https://health.ny.gov/health_care/medicaid/redesign/first_1000.htm

Healthy Steps. Evidence-based primary care program model that integrates child development professional (“specialist”) to primary care practice teams to enhance screening, family engagement and communication, and coordination of family support and follow up services.

- **National Healthy Steps** site includes an overview of the model and evidence base, materials for families, and resources for providers, including information on how to become a HealthySteps site. <https://www.healthysteps.org/>
- **New York Office of Mental Health Implementation of Healthy Steps** includes 2016 Request for Proposals to support implementation of Healthy Steps in primary care medical care practices across New York State. <https://omh.ny.gov/omhweb/rfp/2016/healthy-steps/>

Help Me Grow. A system model that works to promote cross-sector collaboration to build early childhood systems that mitigate the impact of adversity and support protective factors among families, so that all children can grow, develop, and thrive to their full potential. Help Me Grow is not a stand-alone program, but a system model that leverages and builds on programs and resources already in place to develop and enhance early childhood system building in any given community. Core

components of the model include Centralized Access Point, Family & Community Outreach, Child Health Care Provider Outreach, and Data Collection.

- **Help Me Grow National Center** site includes information on the model and the role of the national center to support local programs, links to its affiliate network of local programs, and other resources. <https://helpmegrownational.org/>
- **Help Me Grow New York** includes information on Western New York and Long Island Help Me Grow networks, partners, events, and other resources. <http://helpmegrownny.org/> See also **ECCS Impact Initiative** resource.

Learn the Signs, Act Early. This resource for parents from the Centers for Disease Control and Prevention provides information on milestones children should reach from birth to age 5 in how they play, learn, speak, act, and move. The website includes materials, training for early care and education providers, how to get involved, what to do about concerns with a child's development, autism case training, and multimedia and tools. It also provides a link to standardized, validated [developmental screening tools](https://www.cdc.gov/ncbddd/actearly/index.html) for parents and providers from AAP. <https://www.cdc.gov/ncbddd/actearly/index.html>

Think Cultural Health. U.S. Department of Health & Human Services, Office of Minority Health. Dedicated to advancing health equity, website features information, continuing education opportunities, resources, and more for health and health care professionals to learn about culturally and linguistically appropriate services, or CLAS. Includes link to CLAS standards and resources for implementation. <https://www.thinkculturalhealth.hhs.gov/>

Focus Area 3: Child and Adolescent Health

Goal 3.2: Increase supports for children and youth with special health care needs.

Intervention 3.2.1: Engage families in planning and systems work to improve family centered services and effective practices for supporting CSHCN and their families.

Resources

Children and Youth with Special Health Care Needs (CYSCHN) Program. The New York State CYSCHN Program seeks to improve the system of care for children with special health care needs from birth to 21 years of age and their families. The Program helps to shape public policy so families can get the best health care for their children. Programs in most counties in NYS help families of CSHCN by giving them information on health insurance and connecting them with health care providers. These programs will also work with families to help them meet the medical and non-medical needs of their children. State website includes link to contact information for local CYSCHN programs, materials, and other resources. https://www.health.ny.gov/community/special_needs/

Early Intervention Program. The New York State Early Intervention Program (EIP) is part of the national Early Intervention Program for infants and toddlers with disabilities and their families. First created by Congress in 1986 under the Individuals with Disabilities Education Act (IDEA), the EIP is administered by the New York State Department of Health through the Bureau of Early Intervention. To be eligible for services, children must be under 3 years of age and have a confirmed disability or established developmental delay in one or more areas of development. The EIP offers a variety of therapeutic and support services to eligible infants and toddlers with disabilities and their families, including family education and counseling, home visits, and parent support groups. The EIP Website includes wide array of resources for localities, providers, and families, multiple trainings for providers on working with families, https://www.health.ny.gov/community/infants_children/early_intervention/index.htm

Early Intervention Family Outcomes Project. New York's Early Intervention Program (EIP) has prioritized family and engagement and support as an area for improvement. Approximately 62% of families participating in the state's EIP met the state's standard for family impact scale in 2015-16. Improving performance in family outcomes is a core focus of the EIP State Systemic Improvement Plan (SSIP), which seeks to identify, implement, and evaluate evidence-based and promising practices to improve family centered services and family outcomes for children served in the state's Early Intervention Program.

- ***Child and Family Outcomes Survey*** – provides links to information about the Family & Child Outcomes surveys used in the EIP.
https://www.health.ny.gov/community/infants_children/early_intervention/outcomes_survey/
- ***Early Intervention Family Outcomes & the State Systemic Improvement Plan*** - presentation on the SSIP Family Outcomes project to New York State Association of County Health Officials (NYSACHO) membership (May 2016).
<http://www.nysacho.org/files/Family%20Outcomes%20and%20SSIP%20Presentation%20for%20NYSACHO%20May%206%202016.pdf>
- ***Improving Family Centeredness Together*** - presentation/ update on SSIP to York State Association of County Health Officials (NYSACHO) membership (April 2018).
http://www.nysacho.org/files/EICC%20Handouts/1_%20SSIP%20All%20County%20Meeting%20April%2025%202018%20.pdf

Early Intervention Partners Training Project. This training is for parents of infants and toddlers with disabilities currently receiving services through New York's Early Intervention Program. These training sessions provide information, resources, and skill-building activities designed to increase parent advocacy and leadership skills. Families interested in this training apply for admittance to the Family Initiative Coordination Services Project. Additional information on the PTP is available on the eiFamilies website: <https://www.eifamilies.com/ei-training-you-ei-partners-training-project>

Families Together in New York State. Families Together in New York State is a family-run, nonprofit organization that strives to establish a unified voice for children and youth with emotional, behavioral and social challenges. It provides training, education, support, referrals, and several workforce

development initiatives including a Parent Empowerment Program and Family Peer Advocate Credential. <https://www.ftnys.org/>

Hands and Voices. Parent-to-parent support for families of children with hearing loss, with a focus on providing unbiased information and interventions that best meet child and family needs.

- **National organization:** <http://www.handsandvoices.org>
- **New York State chapter:** <http://www.handsandvoicesny.org/>

Parent to Parent of New York State. Parent to Parent of New York State builds a supportive network of families to reduce isolation and empower those who care for people with developmental disabilities or special healthcare needs to navigate and influence service systems and make informed decisions. Parent to Parent also serves as New York's Family Voices state affiliate organization. Site includes information on parent-to-parent matching program, Family to Family (F2F) Health Information Center, parent trainings, and other resources. <http://parenttoparentnys.org/site/>

National Center for Family/ Professional Partnerships (NCFPP). Funded by the federal Maternal and Child Health Bureau, the NCFPP is a project of Family Voices, a national family-led organization of families and friends of CSHCN. NCFPP supports state and local Family-to-Family Information Centers (F2F), Family Voices state affiliate organizations, and other family organizations and initiatives. <http://familyvoices.org/ncfpp/>

Focus Area 3: Child and Adolescent Health

Goal 3.2: Increase supports for children and youth with special health care needs

Intervention 3.2.2.: Engage health care providers and other partners in efforts to improve newborn hearing screening and follow up, including reporting of results into the New York Early Hearing Detection and Intervention Information System (NYEHDI-IS).

Resources

Early Hearing Detection and Intervention Program (EHDI). New York State Department of Health. Web page includes overview of newborn hearing screening and follow up requirements and a variety of resources for parents and providers including educational materials and links to state and national trainings.

https://www.health.ny.gov/community/infants_children/early_intervention/newborn_hearing_screening/

Hands and Voices. Parent-to-parent support for families of children with hearing loss, with a focus on providing unbiased information and interventions that best meet child and family needs.

- **National organization:** <http://www.handsandvoices.org>
- **New York State chapter:** <http://www.handsandvoicesny.org/>

Joint Committee on Infant Hearing. Committee comprised of representatives from the American Academy of Pediatrics, the American Academy of Otolaryngology-Head and Neck Surgery, American Speech-Language-Hearing Association, Council of Education of the Deaf, and Directors of Speech and Hearing Programs in State Health and Welfare Agencies. The primary activity is the publication of position statements summarizing the state of the science and art in infant hearing and recommending the preferred practice in early identification and appropriate intervention of newborns and infants at risk for or with hearing loss. <http://www.jcih.org/>

National Center on Birth Defects and Developmental Disabilities (NCBDD). (2018). Centers for Disease Control and Prevention. Provides research, basic information and statistics regarding hearing loss, screening, and diagnosis, as well as current articles and educational materials for clinicians and families. <https://www.cdc.gov/ncbddd/hearingloss/index.html>

National Center for Hearing Assessment and Management (NCHAM). Serves as the national resource center for the implementation and improvement of comprehensive and effective Early Hearing Detection and Intervention (EHDl) systems. Comprehensive website includes wide array of resources and links to other partner organizations. <http://www.infanthearing.org/index.html>

Program to Enhance the Health & Development of Infants and Children (PEHDIC): Early Hearing Detection & Intervention (2018). American Academy of Pediatrics (AAP). Comprehensive website outlines national AAP goals, innovative and promising practices, links to partner organizations, and a variety of resources and tools for primary care clinicians, including specific “lost to follow-up” resources. <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/PEHDIC/Pages/Early-Hearing-Detection-and-Intervention.aspx>

Focus Area 3: Child and Adolescent Health

Goal 3.2: Increase supports for children and youth with special health care needs

Intervention 3.2.3: Enhance care coordination and transition support services for eligible children and youth with special health care needs.

Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 12: Transition to Adulthood:

- **Evidence Analysis Report. NPM 12: Transition,** Johns Hopkins University. Under development. Link to be posted at: <https://www.mchevidence.org/tools/>
- **Evidence Brief. Transition to Adulthood.** National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University. <https://www.ncemch.org/evidence/NPM-12->

[transition.php](#)

- **Title V Transformation Tools.** Recommendations to support NPM12 – Transition.
<https://www.mchnavigator.org/transformation/npm-12.php>

Care Coordination for CSHCN Challenge. Sponsored by the federal Maternal and Child Health Bureau, this challenge will support the development and testing of low-cost, scalable, technology-based innovations to meet the needs of CSHCN and their families. Innovations should improve the quality of care, enhance family engagement, and positively impact health care outcomes with the potential of saving costs to families, society, and to the health care system. CSHCN and their families are the primary stakeholders for all solutions proposed and must be involved in the development. The design phase for this challenge will launch August 30, 2018, with subsequent development, small-scale testing, and scaling phases through Fall 2019. <https://mchbgrandchallenges.hrsa.gov/challenges/care-coordination-cshcn>

Coordinating Care and Supporting Transition for Children, Adolescents and Young Adults with Sickle Cell Disease. Funded and administered by the New York State Department of Health, this program contracts with three certified hemoglobinopathy centers to improve transition of care services for adolescents and young adults (AYA) with Sickle Cell disease. The program began in July 2018 and uses the “Got Transition” six core elements for successful transition to adult and self-care services. Linkage to Health Homes is a key aspect in this program, with relevant webinars delivered to the hemoglobinopathy centers and Health Home Case Managers, respectively.
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/webinars/docs/2017/2017-08-16_sickle_cell_and_transitional_care.pdf

Got Transition. Got Transition/Center for Health Care Transition Improvement is a cooperative agreement between the Maternal and Child Health Bureau and The National Alliance to Advance Adolescent Health. Our aim is to improve transition from pediatric to adult health care through the use of new and innovative strategies for health professionals and youth and families. Partners are working to: expand the use of six core elements of health care transition; partner with professional training programs; develop youth and parent leadership; promote health system measurement, performance and policies; and, serve as a clearinghouse for transition tools and resources. Site includes resources, including sample tools, for health care providers, youth and families, researchers, and policymakers.
<https://www.gottransition.org/>

Medicaid Health Homes Serving Children. New York State Department of Health. Medicaid Health Homes is a care management service to help eligible individuals get the care and services they need to stay healthy. To be eligible for Health Home services, the individual must: be enrolled in Medicaid; have an eligible condition (two or more chronic conditions, HIV/AIDS, or Serious Mental Illness, Serious Emotional Disturbance, or Complex Trauma); and satisfy the appropriateness criteria for need of intensive case management. The Health Home Serving Children’s (HHSC) program was launched in December 2016, with 16 Health Homes designated to serve children.

- **New York State Health Homes Serving Children Website** includes wide range of resources

including important information, guidance and presentation/webinars developed by the State (The New York State Department of Health, the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services, and the Office of Children and Family Services) in consultation with Health Homes, Managed Care Plans, children’s advocates and other stakeholders to tailor the Health Home model to better serve children.

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/index.htm

- **Find a Health Home** page helps providers and families locate and contact Health Homes by county. https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_map/index.htm

National Technical Assistance Center on Transition (NTACT). NTACT is a Technical Assistance and Dissemination project, funded by the U.S. Department of Education’s Office of Special Education Programs (OSEP) and the Rehabilitation Services Administration (RSA). NTACT’s purpose is to assist State Education Agencies, Local Education Agencies, State VR agencies, and VR service providers in implementing evidence-based and promising practices ensuring students with disabilities, including those with significant disabilities, graduate prepared for success in postsecondary education and employment. Site includes evidence-based practices, capacity-building tools, lesson plan starters, publications, and other resources to help state agencies, educators, students, and families improve transition planning, services, and outcomes for youth with disabilities. <https://transitionta.org/>

The Transition of Children from the New York State Department of Health Early Intervention Program to the State Education Department Preschool Special Education Program or Other Early Childhood Services. This document provides guidance on the transition of children from the Early Intervention Program (EIP) to preschool special education programs and services, other state service delivery systems, or other early childhood services available to support children and their families. To ensure the transition process is successful for families, it is important that parents and professionals understand the requirements for transition and the services available in their communities for young children with, and without, disabilities. https://www.health.ny.gov/community/infants_children/early_intervention/transition/purpose.htm

Focus Area 3: Child and Adolescent Health

Goal 3.3: Reduce dental caries among children

Intervention 3.3.1: Maintain and expand community water fluoridation.

Resources

Best Practice Approach Reports - Use of Fluoride: Community Water Fluoridation. Association for State and Territorial Dental Directors. May 2016. ASTDD Best Practice Reports capture key information

that describes specific public health strategies, assesses the strength of supporting evidence, and illustrates implementation with current practice examples. They are intended as resources to share ideas and promote best practices for state and community oral health programs.

<https://www.astdd.org/use-of-fluoride-community-water-fluoridation/>

Community Water Fluoridation. Centers for Disease Control and Prevention. February 2018. Available at: <https://www.cdc.gov/fluoridation/index.html>

Community Water Fluoridation. National Association of County and City Health Officials. 2018. Available at: <https://www.naccho.org/programs/community-health/community-water-fluoridation>

Dental Caries (Cavities): Community Water Fluoridation. Community Preventive Services Task Force. April 2013. Available at: <https://www.thecommunityguide.org/findings/dental-caries-cavities-community-water-fluoridation>

Drinking Water Fluoridation Grant Program. New York State Department of Health. August 2017. Applications are being accepted on the New York State Grants Gateway, <https://grantsgateway.ny.gov/>. (Drinking Water Fluoridation – Round 4 Component 1: Planning and Feasibility Projects (Grant Opportunity ID: DOH01-DWFR41-2017); Drinking Water Fluoridation – Round 4 Component 2: Implementation and Maintenance Projects (Grant Opportunity ID: DOH01-DWFR42-2017))

Patient Engagement About Fluoride and Fluoridation. Continuing education webinar produced by the New York State Department of Health, University at Albany School of Public Health, and New York State Dental Foundation. August 2018. Available at https://www.albany.edu/sph/cphce/fluoridation_webinars_aug2018.shtml.

Focus Area 3: Child and Adolescent Health

Goal 3.3: Reduce dental caries among children

Intervention 3.3.2: Increase delivery of evidence-based preventive dental services across key settings, including school-based and community-based primary care clinics.

Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 13: Oral Health:

- **Evidence Analysis Reports** (2017) Johns Hopkins University. Reports include detailed tables of interventions reviewed with citations for individual studies.
 - **NPM 13A – Oral Health in Pregnancy**

https://www.mchevidence.org/documents/reviews/npm_13a_oral_health_in_pregnancy_evidence_review_june_2017.pdf

○ **NPM 13B – Oral Health in Childhood.**

https://www.mchevidence.org/documents/reviews/npm_13b_childrens_oral_health_evidence_review_august_2017.pdf

- **Evidence Brief. Oral Health.** National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University. <https://www.ncemch.org/evidence/NPM-13-oralhealth.php>
- **Title V Transformation Tools.** Recommendations to support NPM13 – Oral Health. <https://www.mchnavigator.org/transformation/npm-13.php>

Best Practice Approach Reports. Association for State and Territorial Dental Directors. Reports capture key information that describes specific public health strategies, assesses the strength of supporting evidence, and illustrates implementation with current practice examples. They are intended as resources to share ideas and promote best practices for state and community oral health programs.

- **School-Based Dental Sealant Programs** (2017). <https://www.astdd.org/school-based-dental-sealant-programs/>
- **Use of Fluorides in Schools.** (2018) <https://www.astdd.org/use-of-fluoride-in-schools/>
- **Prevention and Control of Early Childhood Tooth Decay** (2011). <https://www.astdd.org/docs/BPAEarlyChildhood.pdf>

Dental Sealants. Centers for Disease Control and Prevention. March 2018. Available at: https://www.cdc.gov/oralhealth/dental_sealant_program/index.htm

Dental Caries (Cavities): School-Based Dental Sealant Delivery Programs. Community Preventive Services Task Force. April 2013. Available at: <https://www.thecommunityguide.org/findings/dental-caries-cavities-school-based-dental-sealant-delivery-programs>

Medical-Dental Integration Learning Session 1 continuing education webinar produced by New York State Department of Health and University at Albany School of Public Health. March 2018. https://www.albany.edu/sph/cphce/fluoridation_march2018.shtml

Patient Engagement About Fluoride and Fluoridation. Continuing education webinar produced by the New York State Department of Health, University at Albany School of Public Health, and New York State Dental Foundation. August 2018. https://www.albany.edu/sph/cphce/fluoridation_webinars_aug2018.shtml.

Smiles for Life: A National Oral Health Curriculum, Third Edition.

<https://www.smilesforlifeoralhealth.org/buildcontent.aspx?pagekey=101553&lastpagekey=101554&userkey=14079114&sessionkey=4355764&tut=555&customerkey=84&custsitegroupkey=0>

Focus Area 3: Child and Adolescent Health

Goal 3.3: Reduce dental caries among children

Intervention 3.3.3: Integrate oral health messages and evidence-based prevention strategies within community-based programs serving women, infants, and children.

Resources

Best Practice Approach Reports. Association for State and Territorial Dental Directors. Reports capture key information that describes specific public health strategies, assesses the strength of supporting evidence, and illustrates implementation with current practice examples. They are intended as resources to share ideas and promote best practices for state and community oral health programs.

- **Improving Children’s Oral Health through the Whole School, Whole Community, Whole Child (WSCC) Model.** (March 2017): [https://www.astdd.org/improving-childrens-oral-health-through-the-whole-school-whole-community-whole-child-\(wsc\)-model/](https://www.astdd.org/improving-childrens-oral-health-through-the-whole-school-whole-community-whole-child-(wsc)-model/)
- **Oral Health of Children, Adolescents and Adults with Special Health Care Needs.** (August 2007) <https://www.astdd.org/special-health-care-needs/>
- **Perinatal Oral Health.** (October 2012). Available at: <https://www.astdd.org/perinatal-oral-health/>

Cavity Free Kids. Cavity Free Kids is an oral health education initiative for young children ages from birth through five years and their families, developed by the Arcora Foundation, a non-profit foundation funded by Delta Dental. It is designed for use in Head Start and Early Head Start, child care, preschool, home visiting, and other programs. Cavity Free Kids includes a rich collection of lessons, activities, stories, songs and other resources that actively engage young children in fun-filled, play-based learning and help parents practice good oral health habits at home. Activities on the website are available for open use while the complete curricula, updates, and other training resources are available for download after attending a Cavity Free Kids training. <http://cavityfreekids.org/>

Oral Health Educational Resources for Home Visitors and Families: Environmental Scan. (2018 update). Association of State and Territorial Dental Directors, Early Childhood Committee. Update to previous 2014 report identifies oral health educational resources for home visitors and the families they serve and addresses gaps in existing oral health resources. <https://www.astdd.org/docs/home-visiting-environmental-scan-2018.pdf>

Focus Area 4: Cross Cutting Health Women, Infants & Children (applicable to all HWIC focus areas & goals)

Goal: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations.

Intervention 4.1: Enhance collaboration with other programs, providers, agencies, and community members to address key social determinants of health that impact the health of women, infants, children, and families across the life course.

Resources

Essentials for Childhood Framework: Creating Safe, Stable, Nurturing Relationships and Environments for All Children. Centers for Disease Control and Prevention (CDC). This framework outlines strategies communities can consider to promote relationships and environments that help children grow up to be healthy and productive citizens. The framework is intended for communities committed to the positive development of children and families, and specifically to the prevention of child abuse and neglect. It has four goal areas and suggests strategies based on best available evidence to achieve each goal. Site includes link to full framework and a number of related resources.
<https://www.cdc.gov/violenceprevention/childabuseandneglect/essentials.html>.

The EveryONE Project™. American Academy of Family Physicians. Designed to help family physicians and their practice teams take action and confront health disparities. The EveryONE Project Toolkit provides clinicians with education, resources, and practical tools to address social determinants of health. <https://www.aafp.org/patient-care/social-determinants-of-health/everyone-project.html>

The Guide to Community Preventive Services: Health Equity Reviews. A collection of evidence-based findings of the Community Preventive Services Task Force. Health Equity reviews focus on interventions to reduce health inequities among racial and ethnic minorities and low-income populations. Recommended interventions included in this set of reviews include: Center-Based Early Childhood Education, Full-Day Kindergarten Programs, School-Based Health Centers, High School Completion Programs, Out-of-School-Time Academic Programs, and Tenant-Based Rental Assistance Programs. Includes summaries and links to full reviews.
<https://www.thecommunityguide.org/topic/health-equity>

Health Impact in 5 Years (HI-5). Centers for Disease Control and Prevention. The Health Impact in 5 Years (HI-5) initiative highlights 14 non-clinical, community-wide approaches that have evidence reporting 1) positive health impacts, 2) results within five years, and 3) cost effectiveness and/or cost savings over the lifetime of the population or earlier. Examples of HI-5 interventions that address SDOH include public transportation system expansion, home improvement loans and grants, community water fluoridation, safe routes to school, and more. Site includes links to HI-5 implementation stories, slide sets, and detailed information and implementation resources for each of the 14 interventions.
<https://www.cdc.gov/policy/hst/hi5/>

Healthy People 2020: Social Determinants of Health Interventions & Resources. Office of Disease Prevention and Health Promotion (last updated 2018). Summarizes information around five key domains: (1) Economic Stability, (2) Education, (3) Health and Health Care, (4) Neighborhood and Built

Environment, and (5) Social and Community Context. Site includes link to a variety of resources for communities to work collaboratively across sectors, organized by domain, including literature reviews; national, state, and local resources; and relevant HP2020 objectives and indicators.

<https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources>

Maternal and Infant Community Health Collaboratives (MICHC) Initiative. New York State Department of Health. The MICHC initiative supports improved outcomes for women, infants, and families through a combination of individual, family, community, and organizational strategies, including Community Health Workers (CHWs). Web page provides an overview of the MICHC initiative, link to on-line CHW training, and list of current projects across the state.

https://www.health.ny.gov/community/adults/women/maternal_and_infant_comm_health_collaboratives.htm

National Center for Cultural Competence (NCCC). Georgetown University Center for Child and Human Development. The NCCC is recognized as a national and international leader in the design, implementation, and evaluation of cultural and linguistic competence in a broad array of systems and organizations. The site provides a variety of publications, tools and other information and resources to promote health equity. <https://nccc.georgetown.edu/>

New York State's Home Visiting Programs: Support for Pregnant and Parenting Families. New York State Department of Health. State website includes information for providers and families, including a searchable list of home visiting programs in New York State by county.

https://www.health.ny.gov/community/pregnancy/home_visiting_programs/

Paid Family Leave. NY.gov (last updated 2018). Research studies have shown that new mothers who take paid leave have fewer postpartum depression symptoms, higher rates of breastfeeding, less stress, and stronger parent-child bonding. Website includes information on New York State's Paid Family Leave law and benefits to support bonding with a new child. <https://paidfamilyleave.ny.gov/>

Parent to Parent of New York State. Parent to Parent of New York State builds a supportive network of families to reduce isolation and empower those who care for people with developmental disabilities or special healthcare needs to navigate and influence service systems and make informed decisions. Parent to Parent also serves as New York's Family Voices state affiliate organization. Site includes information on parent-to-parent matching program, Family to Family (F2F) Health Information Center, parent trainings, and other resources. <http://parenttoparentnys.org/site/>

Policy Resources to Support Social Determinants of Health. Centers for Disease Control and Prevention (last updated 2017). CDC Web page includes resources on policies that support a multi-sector approach to improving health. Includes summaries and links to resources to help identify and describe policy opportunities and involve other sectors to improve health and well-being.

<https://www.cdc.gov/socialdeterminants/policy/index.htm>

The Search Institute. The Search Institute bridges research and practice to help young people be and become their best selves. The Institute supports a wide range of research-based resources including its Developmental Assets®, one of the foundational frameworks in positive youth development that has become among the most frequently cited and widely utilized frameworks in the world. Site includes a wide array of resources and tools for schools, youth and family serving programs, and community coalitions. www.search-institute.org

Sources for Data on Social Determinants of Health. Centers for Disease Control and Prevention (last updated 2018). Data can be a catalyst for improving community health and well-being. Understanding data on social determinants of health, such as income, educational level, and employment, can help focus efforts to improve community health. Page lists and links to tools supported by CDC resources and to data sources outside of CDC. <https://www.cdc.gov/socialdeterminants/data/index.htm>

Technical Packages for Violence Prevention. Centers for Disease Control and Prevention. Technical packages help states and communities take advantage of the best available evidence to prevent violence using multi-level, multi-sector engagement. Each package is intended as a resource to guide and inform prevention decision-making in communities and states. The strategies and approaches in the technical package represent different levels of the social ecology with efforts intended to impact individual behaviors as well as the relationship, family, school, community, and societal factors that influence risk and protective factors for violence. Includes links to infographics that provide visual representations of technical package contents.

<https://www.cdc.gov/violenceprevention/pub/technical-packages.html>

Think Cultural Health. U.S. Department of Health & Human Services, Office of Minority Health. Dedicated to advancing health equity, website features information, continuing education opportunities, resources, and more for health and health care professionals to learn about culturally and linguistically appropriate services, or CLAS. Includes link to CLAS standards and resources for implementation. <https://www.thinkculturalhealth.hhs.gov/>

Tools for Putting Social Determinants of Health into Action. Centers for Disease Control and Prevention (last reviewed February 2018). Collection of resources developed by CDC to help practitioners take action to address social determinants of health. Selected resources of particular relevance within this site include:

- ***At-a-Glance: 10 Essential Public Health Services and How They Can Include Addressing Social Determinants of Health Inequities.*** brief document to help public health agencies embed social determinants of health efforts as part of their portfolio in protecting the health of communities that they serve, with links to relevant examples of SDOH resources and tools. https://www.cdc.gov/stltpublichealth/publichealthservices/pdf/ten_essential_services_and_sdo.pdf
- ***Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health.*** Workbook with tools to develop, implement, and evaluate interventions that target social determinants of health. <https://www.cdc.gov/socialdeterminants/tools/index.htm>

Use of Fluoride: Community Water Fluoridation – Best Practice Reports. Association for State and Territorial Dental Directors. May 2016. ASTDD Best Practice Reports capture key information that describes specific public health strategies, assesses the strength of supporting evidence, and illustrates implementation with current practice examples. They are intended as resources to share ideas and promote best practices for state and community oral health programs. <https://www.astdd.org/use-of-fluoride-community-water-fluoridation/>

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- ¹³ New York State Department of Health. Maternal and Child Health Dashboard (under development). To be available at: <https://www.health.ny.gov>
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