Maternal and Child Health Services Title V Block Grant

New York

FY 2019 Application/ FY 2017 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

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

July 16, 2018

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

Dear Ms. Lawler:

With this letter, I transmit New York's FFY 2019 Maternal and Child Health Services Block Grant Application and FFY 2017 Annual Report.

I am confident that this application and report will demonstrate New York's continued commitment to the provision of high quality services to the Maternal and Child Health population. New York meets the requirement for a 30% set aside for children with special health care needs and for primary and preventive care for children and adolescents, and will not be requesting a waiver.

Sincerely,

Lauren J. Tobias
Director
Division of Family Health/
Title V Program

Empire State Plaza, Corning Tower, Albany, NY 12237 | health.ny.gov

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2018 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Section III.A. Executive Summary

IIIA1 Program Overview

The Title V Maternal and Child Health Services Block Grant (MCHSBG) is the Nation's oldest Federal-State partnership to ensure the health of mothers, children and youth - including children with special health care needs - and their families. This year's application from NYS reflects continued leadership and commitment to promote the health of the MCH community within the context of a changing health care landscape, the continued adoption of a life course perspective and a focus on data-driven, evidence-based public health interventions. The FY 2019 application reflects an in-depth analysis of State and National data, evidence-based and promising strategies to address the identified State Priorities and move towards achievement of the 2020 State Objectives. The information submitted in this application reflects significant work over the past three years to implement the strategies in the State Action Plan (SAP) as required for the eight core MCH priorities across six MCH population health domains: maternal and women's health, perinatal and infant health, child health, adolescent health, children with special health care needs and cross-cutting life course. NY's application reflects the ongoing commitment of NY's Title V program, DOH and key MCH partners as well as significant input from families, providers and other key stakeholders across NYS.

The eight priorities selected by NYS include:

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

Within the NYSDOH, Title V activities are led by the Division of Family Health (DFH). As the Title V program, DFH provides leadership on MCH, directly oversees many MCH programs and initiatives and collaborates with other key MCH-serving programs outside the DFH. A critical role of NY's Title V program is to ensure the needs of the MCH population are addressed through key State policy initiatives, including the significant efforts devoted to Medicaid Redesign in NYS, as reflected throughout the application.

Under Title V leadership, a comprehensive process was convened to refine NY's MCH needs assessment and action plan for previous years, building on extensive stakeholder engagement and needs assessment. Public input is sought throughout the year from consumers and other stakeholders to gain a more comprehensive understanding of those factors impacting the health of the community. This input is used to ensure that strategies and efforts reflect the needs, thoughts and priorities of these stakeholders. Cross-functional teams from across the DFH were maintained. To ensure that strategies and actions continued to be driven by evidence-based practice and data, the DFH strengthened the data (research) team by ensuring all DFH research scientists/data analysis staff are involved to ensure NY's Title V program continues to be data focused.

In keeping with a commitment to ensure the State supports and services align with the desires and needs of communities, the Title V program continues to obtain input to inform activities. Input was obtained from the MCHSBG Advisory Council, Parent to Parent of NY, Schuyler Center for Advocacy and Analysis (Schuyler Center), American Academy of Pediatrics (AAP); Association of Regional Perinatal Programs and Networks, MCH Committee of the New York State Association of County Health Officials, New York State Perinatal Association and other providers and key stakeholders.

Domain 1 – Maternal/Women's Health

Maternal mortality is a devastating event impacting women, families and communities. Addressing factors that lead to maternal mortality and morbidity is a priority of NY's Governor Cuomo. As stated in a press release by the Governor in April 2018, "Maternal mortality should not be a fear anyone in New York should have to face in the 21st century. We are taking aggressive action to break down barriers that prevent women from getting the prenatal care and information they need. This comprehensive initiative will work to correct unacceptable racial disparities in maternal mortality and help ensure a healthier and stronger New York for all." Title V staff will play a significant role to support these priority efforts which includes establishment of a Maternal Mortality Review Board (MMRB).

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

Title V leads efforts to improve the health of women in NYS with a key focus on women's ability to control their reproductive health. NYS has had a long-standing commitment to ensuring all women have access to comprehensive reproductive health care through programs such as the comprehensive system of family planning services and generous health benefits such as the Family Planning Benefit Program that includes presumptive eligibility. NY will continue to work to incorporate a social justice framework related to women's health including contraception to move towards achievement of health equity.

Domain 2 – Perinatal/Infant's Health

Infant mortality has been steadily declining, but striking disparities remain. Key accomplishments include the continued development of updated standards for a statewide system of regionalized perinatal care with accompanying metrics to assess outcomes, strong community-based services including evidence-based home visiting, clinical quality improvement initiatives with birthing hospitals, involvement with health care reform and strong partnerships to promote improved health outcomes. NY's SAP includes continuing work on improving the perinatal hospital system, especially ensuring the health and well-being of women are addressed by this system as well as newborns, and ensuring the system is developed in synergy with the changing health care landscape in NYS, increasing retention of families in evidence-based home visiting programs, and promoting safe sleep practices. An ongoing concern for infant health is increasing rates of neonatal abstinence syndrome resulting from opiate use and NY' s collaborative efforts continue to combat this growing public health crisis. Collaborative efforts will continue to be enhanced or developed to improve important perinatal practices, and to address new and emerging health issues such as maternal opioid use to improve perinatal outcomes.

Domain 3 – Child Health

The majority of NY's children are in good health, with declining mortality and hospitalization rates and high rates of health insurance coverage. A major priority of Title V is the social-emotional and behavioral health needs of children. Key accomplishments include partnerships with key stakeholders such as the Early Childhood Advisory Council and Early Intervention Coordinating Council, generous public health insurance options, rich networks of health care providers including one with the largest School Based Health Center (SBHC) program in the nation, and significant existing investments in child-serving MCH programs. To further strengthen capacity for supporting social-emotional development and relationships, NYS's SAP incorporates strategies to: expand analysis of population health data on social-emotional well-being and adverse childhood experiences (ACE); test and implement a tool for measuring positive assets across programs; enhance training for Title V staff and partners on social-emotional development and trauma-informed practice; and, integrate additional evidence-based practices for promoting social-emotional well-being across child-serving MCH programs. Efforts such as the First 1000 Days on Medicaid initiative provides an excellent opportunity to work with partners to improve the health and wellness of all NY's children.

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

Although most NY's children are insured, families of CSHCN continue to report lack of consistent, adequate health care coverage and lack of care coordination to meet special needs. In addition, adolescents with special needs remain challenged with navigating health care coverage and services as they transition to the adult care system. Key accomplishments to better support CSHCN include increasing health insurance options, comprehensive early intervention services for infants and toddlers with developmental delays and disabilities, engagement of Title V staff in developing and implementing Medicaid Health Home (MHH) for children including those with serious emotional disturbance and complex trauma, family representation on key advisory groups, and dedicated funding for local health department-based services to support families of CSHCN. Parents have reported that the myriad of services available to CSHCN are at times challenging to understand and access, with significant gaps in some services or in specific areas of NYS. NYS's SAP includes enhanced analysis of existing CSHCN data, continuation of a systems-mapping initiative to identify strengths, gaps and barriers to set future direction for Title V in this arena, continued efforts to improve reporting and follow-up of newborn screening, advancing focused improvement projects to enhance family support practices within Early Intervention including disseminating best practices to other Title V programs continued strong engagement with Medicaid to support successful implementation of Health Home (HH) for children, strengthening transition supports for young adults with Sickle Cell Disease, and seeking ways to enhance bi-directional communication with parents and adolescents with special needs. Contactors providing Sickle Cell Disease (SCD) transition services will work closely with the families in program adaptation to support successful transition to adult/self-care. Parent Training and Information centers in each contractor's region will be assessed to identify common activities and goals and to connect families of children with SCD with Parent Centers. In the coming year, continued efforts to talk directly with families and mining the data and information obtained through NY's CSHCNs will provide valuable insight into needed improvement to ensure CSHCN and their families are supported and well-integrated into the community.

Domain 5 – Adolescent Health

NY's Title V program is a national leader in building comprehensive systems for adolescents including access to confidential reproductive health services and delivery of evidence-based programming to improve adolescent health with a strong focus on positive youth development. NY's teen pregnancy rate has reached an all-time low, though disparities remain. The social-emotional well-being of NY's adolescents has been highlighted as a Title V priority, recognizing concerning rates of suicide in the adolescent population. Mental health, suicide, sexual violence and bullying are significant persistent challenges for adolescents. Key successes in NYS include strong networks of youth-serving providers including SBHCs and community-based programs, policies that support access to health insurance and confidential health care services, increased efforts on sexual violence prevention and strong technical support for evidence-based programming through state-academic partnerships/ Centers of Excellence. NYS's SAP includes adolescent-focused strategies mirroring those for Child Health (Domain 3) to build internal and external capacity for promoting social-emotional development and healthy relationships for NY's teens.

Domain 6 – Cross-Cutting/Life Course

Recognizing health equity is key to ensure all women, children and families can reach their maximum level of health and wellness. Throughout this application, racial, ethnic, economic and geographic disparities are highlighted for virtually all MCH outcomes and factors assessed. Disparities are not limited to race and ethnicity. Rather, economic status, geography, language, and other factors such as health literacy can have a significant impact on the health status of NY's MCH population. NY efforts to promote health equity will continue to improve and enhance Title V program staff knowledge and understanding of health equity to foster improved supports and services to decrease disparities in health outcomes.

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

NY's SAP outlines strategies for each of these cross-cutting priority areas. Strategies to address specific priority elements of preventive health care services across the life course, include preconception health care to improve women's health and birth outcomes for those women choosing to have children, promoting oral health, supporting First 1000 Days on Medicaid initiatives, community-based initiatives to improve health outcomes and promoting adolescent well care.

III.A.2. How Title V Funds Support State MCH Efforts

IIIA2 How Title V Funds Support State MCH Efforts

NYS is committed to ensuring the health and wellbeing of the MCH population. Due to generous Medicaid benefits, and insurance availability through the NYS of Health, and significant state appropriations for MCH, Title V funds support an infrastructure within the DOH that ensures the work of the Title V program and provides additional funding to support priority efforts to augment state investments. For example, Title V funds augment State investments to support a portion of family planning and adolescent health services. In addition, Title V funds support quality improvement efforts through grants to the Regional Perinatal Centers (RPC) for quality improvement activities to NY's 120 obstetrical hospitals to improve maternal and infant mortality and morbidity. Grants are provided to local health departments to support information and referral services for CSHCN. This application of NY's Title V program provides a picture of the extensive resources offered to NY's MCH population. NY's MCH programs and initiatives are complex. NY's Title V program provides an overview in this application that demonstrates NY's ongoing commitment to ensure the health and wellness of all NY's women, children and families.

III.A.3. MCH Success Story

IIIA3 Success Story

Access to data in a clear and digestible format is essential to making decisions on priorities, strategies and to assess outcomes. In ongoing conversation with partners, it is evident that organizations and community partners are often unable to access data due to lack of expertise in this arena. Over the past year, Title V staff worked with the DOH's Office of Public Health Practice (OPHP) to develop a MCH dashboard, mirroring the objectives and outcomes reflected in NY's SAP. The dashboard mirrors one that was developed for NY's Prevention Agenda (PA) as it provides clear and easy access to key data points and clearly show NY's progress in these priority outcomes and has been used extensively by community partners. In fact, in 2015, the DOH and Office of Information Technology Services received the **Best Data Analytics/ Business Intelligence Project** award for the PA dashboard from the Center for Digital Government for its promotion of civic engagement, transparency and government performance. NY's MCH dashboard reflects the same format and principles for ease in access and understanding while also allowing partners to identify and address priority MCH issues on the local level. Targets are being established and the expected release for MCH Dashboard 1.0 is Summer 2018. This success is clear evidence of the cross collaborative efforts within DOH and the commitment to work with partners in promotion of efforts for the MCH population.

III.B. Overview of the State

II.A. Overview of the State

As of 2017, New York State (NYS) has the fourth largest population after California, Texas and Florida, with a population of 19.8 million. NYS is a very diverse state with a substantial portion of its population being members of racial and ethnic minorities. Compared to the national population, in 2016, a larger percentage of NYS' population is Black (17.7% NYS; 13.3% US); Asian (8.9% NYS; 5.7% US); and Hispanic (19% NYS: 17.8% US). NYS also has a significantly higher foreign-born population (22.6% NYS: 13.2% US-2011-2015 data), and larger population speaking a language other than English at home (30.4% State: 21% US-2012-2016 data). NYS's cultural diversity is both a strength and challenge. Racial and ethnic minorities often have poorer health than white Americans, even when they are able to access insurance. A priority for NYS is to ensure that health care systems meet the needs of diverse populations at all levels to promote equity in health care and eliminate disparities in health access and outcomes.

In 2012-16, the percent of New Yorkers who graduated from high school is slightly below the national level (85.9% versus 87% US), while the percentage with a bachelor's degree or higher is 34.7% versus 30.3%. NY's per capita income in the past 12 months (2016 dollars – 2012-16) is higher than the national average ($34,212 versus $29,829 US), and NY's median household income for 2012-16 is also higher ($60,741 versus $55,322). However, the State's percentage of person's in poverty is higher than the national percentage (14.7% versus 12.7%). Educational attainment has a major impact on income and is a significant factor in access and quality of health care. Poverty is also associated with poor health outcomes, especially for women and children. Racial and ethnic minorities are significantly impacted by lower educational attainment and poverty in NYS.

NYS' population is dense; in 2010 there were 411 persons per square mile in NYS, compared to 87 in the US. New Yorkers are more likely to live in urban areas than residents of other states. 64 % of NYS's population live in the NY Metropolitan area; 43% in New York City (NYC) alone. NYC remains the most populous incorporated place in the US with 8.4 million people (2013). NYS is also geographically diverse; population density varies widely, from 69,467 persons per square mile in Manhattan to only three persons per square mile in Hamilton County in the Adirondack Mountain Range; NYC is 104 times more densely populated than the rest of the state. Population density often determines the number and types of health services in an area.

NYS has a rich system of health care. In 2016, NYS had the third-highest ratio of physicians to residents in the nation, with approximately 365 physicians per 100,000 residents, compared to a national average of 271 per 100,000. NYS also has 111 active primary care physicians per 100,000 residents, and 10 general surgeons per 100,000, both with rankings of the seventh highest ratio in the nation. NYS is home to more than 2,500 outpatient hospital and free-standing health clinics, including over 70 Federally Qualified Health Centers (FQHCs) with approximately 800 sites throughout NYS; 255 school-based health center clinics; 52 school-based health center-dental clinics with 1,848 sites across the state; and 172 family planning clinic sites. In addition, NY has over 220 hospitals including 120 perinatal hospitals and 3 free-standing birthing centers. Despite the substantial health care resources, many areas of the state lack access to needed services due to a maldistribution of resources. As of January, 2018, there were 178 primary care Health Professional Shortage Areas (HPSAs) in NYS, 137 dental HPSAs; and150 mental health HPSAs. Of the total HPSAs, about 38% of HPSAs are located in metropolitan areas; 62% are in rural or mostly rural (non-metropolitan) areas. More than 4 million New Yorkers live in a primary Care HPSA.

The redesign of NY's Medicaid program to improve health care outcomes while containing costs continues as a priority. At the inception of the Medicaid Redesign efforts, NYS's Medicaid (MA) Program, once the nation's largest, was spending nearly $59 billion to serve 6.3 million people, which is twice the national average when compared on a per recipient basis. There was increasing recognition that payment reform was necessary to shift the payment incentives from expensive facility-based care to keeping people healthy, including management of chronic diseases in ambulatory settings. To better serve patients in the right setting at the right price, NYS has invested in hospital programs, including outpatient clinics, ambulatory surgery, and emergency room; physicians' fees;

primary care; freestanding programs; and mental hygiene enhancements.

In 2011, Governor Cuomo launched the Medicaid Redesign Team (MRT), an innovative effort to collaborate with stakeholders and implement reform of NY's MA program to reduce costs while simultaneously improving quality of care. In doing so, NYS embraces the Institute for Healthcare Improvement's Triple Aim for delivery reform, improving the quality of care and reducing per capita costs. The MRT utilized an intensive stakeholder engagement process to develop a plan to reduce costs in NY's MA program while also focusing on improving quality and implementing reforms. The mission, scope and expertise of the Title V program well positions staff to provide leadership, subject matter expertise and engage key MCH stakeholders to ensure that the needs of NY's most vulnerable population including mothers, children and families are addressed through policy reforms.

Since the inception of Medicaid Redesign Team (MRT) in 2011, savings generated by the MRT reforms have led to an $8 billion reinvestment of federal money for NY's Delivery System Reform Incentive Payment program (DSRIP). In 2014, the Governor announced a Federal-state waiver that allowed NYS to reinvest $8 billion in federal savings generated by MRT reforms through DSRIP, which is currently in its fourth year. DSRIP has led to a network of Performing Provider Systems comprised of hospitals, individual providers, and community-based organizations, who collaborate to provide patients with community-based, higher quality, more coordinated care. Through community-level collaborations and a focus on system reform, the ultimate goal of these projects is to achieve a 25 percent reduction in avoidable hospital use over the 5 years of the program. As of the second quarter of year three, which marks the halfway mark for this five-year initiative, PPS have earned over $3 Billion in DSRIP funding with over 3 million patient engagements. PPS have also successfully met all state and/or PPS implementation requirements for a total number of 44 completed projects. These results show that PPS across NYS are performing as designed and patient outcomes are improving.

In July 2017, NY's former Medicaid Director Jason Helgerson announced a new focus for Medicaid Redesign in NY: The First 1000 Days on Medicaid initiative, recognizing that a child´s first three years are the most crucial years of their development. There is evidence that children on Medicaid have better health and life outcomes. This effort will ensure that NY's Medicaid program is working with health, education and other system stakeholders to maximize outcomes and deliver results for the children served.

The collaborative approach of the MRT serves as an example of how city and state agencies can partner with stakeholders to develop innovative solutions in the future. The efforts of the MRT benefit all Medicaid members, health care providers, other stakeholders, and all people in NYS, by improving quality and reducing costs. It is anticipated that savings from MRT reforms will continue to grow in future years as key structural reforms are implemented. In March 2018, NY's MRT was awarded this year's Public Service Innovation Award from the Citizens Budget Commission recognizing the MRT for transforming NYS's Medicaid program into a national model by cutting costs and putting patients first. NY's Title V program has a strong partnership with the Office of Health Insurance Program within DOH that oversees NY's Medicaid program. Further details regarding this collaborative effort to benefit NY's MCH population is described in Section E2biv Health Care Delivery System.

NY's Population Health Improvement Program (PHIP) complements DSRIP with regional PHIP contractors that identify, share, disseminate and help implement best practice and strategies to promote population health and advance the PA (discussed below) and the State Health Insurance Program (SHIP); and serve as a resource to DSRIP Performing Provider system (PPS). Priorities of this integration include integrating behavioral health into primary care as well as addressing broad social determinants of health. This planning and integration also includes Value Based Payments (VBP) - a method to directly tie payment to providers with quality of care and health outcomes to incentivize providers through shared savings and financial risk. By DSRIP Year 5 (2020) all Managed Care Organizations must employ VBP systems that reward value over volume for at least 80-90% of their provider payments. Broad representation is included in VBP workgroups to ensure the standards and guidelines for these payments reflect broad input. Title V

staff are involved in the Maternity Care workgroup as well as the Child Health workgroup in the development of the VBP system.

In addition to DSRIP, the federal waiver amendment allows for comprehensive reform through a tiered Advanced Primary Care (APC) model for primary care that includes behavioral and population health, and is complemented by a strong workforce and engaged consumers, with supportive payment and common metrics. The specific outcomes for this initiative includes:

- Instituting a state-wide program of regionally-based primary care practice transformation to help practices across NY adopt and use the APC model.
- Expand the use of value-based payments so that 80% of New Yorkers are receiving value-based care by 2020.
- Support performance improvement and capacity expansion in primary care by expanding NY's primary care workforce through innovations in professional education and training.
- Integrate APC with population health through Public Health Consultants funded to work with regional Population Health Improvement Program contractors (further discussed below).
- Develop a common scorecard, shared quality metrics and enhanced analytics to assure that delivery system and payment models support three-part aim objectives.
- Provide state-funded health information technology, including greatly enhanced capacities to exchange clinical data and an all-payer database.

NY's PA, was developed in conjunction with the Public Health Committee of the NYS Public Health and Health Planning Council (PHHPC), and in partnership with more than 140 organizations across the state. The PA focuses on eliminating the profound health disparities across all priority areas including: preventing chronic diseases; promoting a healthy and safe environment; promoting healthy women, infants and children; promoting mental health and preventing substance abuse; and, preventing HIV, sexually transmitted diseases, vaccine-preventable diseases, and healthcare-associated infections. Title V staff are directly involved in the process of updating the PA 2019 – 2024 related to Promoting Health Women, Infants and Children that directly aligns with NY's Title V State Action Plan.

Regardless of the efforts to improve NY's health care system, without health care coverage, New Yorkers are unable to access that system. Expanding access to health care by making affordable health insurance available is one of the critical accomplishments of the Governor's health care agenda. The NYS of Health (NYSOH), the state's official health plan marketplace, was created to assist New Yorkers to gain access to quality affordable health care coverage. As of January 2018, more than 4 million New Yorkers were enrolled in health care coverage, an increase of 700,000 people from 2016 and 92 % of those enrolled reported being uninsured at the time of application. Of those enrolled, 229,000 enrolled in private qualified health plans (QHPs); 716,000 enrolled in the state's new Essential Plan (described below); 364,000 enrolled in Child Health Plus (CHP); and, 2.9 million enrolled in Medicaid. NY's uninsured rate fell to 5% in 2016 - its lowest point in decades.

In 2016, NYSOH introduced another affordable health insurance option for New Yorkers. The Essential Plan is available to consumers under the age of 65, not eligible for Medicaid or CHIP, with income at or below 200 percent of the Federal Poverty Level (FPL) ($24,2800 for a household of one; $50,200 for a household of four in 2018). Consumers with income at or below 150 percent of the FPL ($18,210 for a household of one; $37,650 for a household of four in 2018) have no monthly premium. In accordance with Federal requirements, all plans cover essential health benefits including inpatient and outpatient care, physician services, diagnostic services and prescription drugs among others, with no annual deductible and low out of-pocket costs. Preventive care, such as routine office visits and recommended screenings, have no out-of-pocket cost to enrollees. This innovative Basic Health Program (BHP) is one of only two programs nationwide (Minnesota is the other) to receive federal approval under the ACA.

Individuals, families and small businesses can use the Marketplace to help them compare insurance options, calculate costs and select coverage online, in-person, over the phone or by mail and New Yorkers may obtain MA and CHP coverage through the Marketplace. NYSOH has certified almost 13,000 navigators, brokers and Certified Application Counselors to provide free, in-person enrollment assistance to apply for coverage in 27 languages. NYSOH features a state-of-the-art website where New Yorkers can shop and enroll in coverage and a customer service center to answer questions and enroll people into coverage. NYSOH has also continued to expand its outreach efforts to ensure that every New Yorker knows that affordable health care options are

available.

While QHP enrollment is only available year round to applicants who experience a qualifying event, Native Americans can enroll in QHPs year-round. Applicants who are eligible for the Essential Plan, Medicaid, or CHP can also enroll at any point in the year. Under federal ACA rules, a baby's birth triggers a qualifying event, but pregnancy does not. Legislation was enacted in NY in January 2016 that makes pregnancy a qualifying event through the state-run exchange, making NY the first state in the nation where the commencement of pregnancy allows a woman to enroll in a plan through the exchange.

NYS has benefitted from the receipt of ACA funding. Approximately $2.9 million in Personal Responsibility Education Program (PREP) funding has supported programs designed to educate adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted infections. NY previously received approximately $4 million in Abstinence Education Grant Program (AEGP) funds (renamed the State Sexual Avoidance Education grant) to implement mentoring, counseling and adult-supervised activities, designed to delay the initiation of sexual activity in young people ages 9-12 residing in high-need communities and is awaiting the release of the FOA to determine the potential for submission of future applications for this funding. Over $9.1million in Maternal, Infant and Early Childhood Home Visiting (MIECHV) funding is being used to implement evidence-based home visiting programs. Over $12 million in ACA funds have been used to support chronic disease prevention programs, including smoking cessation; evidence-based cancer screening and detection programs; implementation of comprehensive population-based strategies in community and health systems setting to prevent obesity, diabetes, heart disease and stroke, and to reduce health disparities among adults. Overall, ACA funding has provided NYS with tremendous opportunities to improve and enhance NY's MCH services and eliminate disparities. NY will continue to monitor the actions on the federal level to assess the impact on the health care of New Yorkers in general, and the MCH population in particular.

The Governor continues to support significant legal, economic and health efforts that will have a positive impact upon the MCH population. The Governor established the New York State Council on Women and Girls to recognize and advance women's rights within NYS. The Council provides a coordinated State response to issues that particularly impact the lives of women and girls, focusing on nine areas of impact. These include education, economic opportunity, workforce development, leadership, health care, child care, safety, Science, Technology and Math (STEM) and intersectionality. The Council issued a Status report in 2018 and the full document can be found at https://www.ny.gov/sites/ny.gov/files/atoms/files/StatusNYWomenGirls2018Outlook.pdf
Some of the advances already achieved in support of women and families in NYS include:

- Passed the Women's Equality Agenda in 2015, a series of new laws aimed at achieving pay equity, strengthening human trafficking laws, protecting domestic violence victims and ending pregnancy discrimination in the workplace.
- Set the highest minority-and-women-owned-enterprise contracting goal in the nation at 30 percent.
- Created the most comprehensive state Paid Family Leave program in the nation in 2016. Starting January 1, 2018, employees were eligible for eight weeks of paid family leave to bond with a child, take care of a family member with a serious health condition, or help relieve family pressures when a family member is called to active military service. When fully phased in, New Yorkers will be eligible for 12 weeks of paid time off.
- Launched the Enough is Enough initiative, the most aggressive policy in the nation to combat sexual assault on college campuses in 2016. Additionally, the Governor allocated a total of $6.4 million for Sexual Assault Prevention and Assistance providers across the State.
- Signed two executive orders ensuring pay equity by State employers and contractors, gathering data from State contractors about pay demographics and banning State employers from asking about prospective employees' previous salaries.
- Improved access to breast cancer screening by expanding screening hours at hospitals and clinics, removing insurance barriers, and offering paid leave for screenings to all public employees. Additionally, in 2017 Governor Cuomo passed legislation requiring health insurers in New York State to provide medically necessary coverage for 3-D mammograms without co-pays, coinsurance, or deductibles.

- Ended child marriage by raising the age of consent from 14 to 18 in 2017.
- Ensured that contraceptive drugs and devices and medically necessary abortions are covered by commercial health insurance policies without co-pays, coinsurance or deductibles.

In the coming year, the Governor continues to promote and support efforts in support of women and families. NY has always demonstrated a strong commitment to protect women's access to reproductive health options and the Governor is advancing an aggressive strategy to ensure that all new mothers have access to screening and treatment for maternal depression including review of insurance coverage for depression screening by both adult and pediatric primary care providers, launching an awareness campaign to provide life-saving information on symptoms and treatment options, and finally to advance cutting-edge specialty programs to treat maternal depression.

For nearly eight years, the DOH has conducted a Maternal Mortality Review (MMR) of all maternal deaths in NYS. While improvement has been seen, more work remains, particularly since African American New Yorkers remain almost four times more likely to die in childbirth than white women. Recognizing this significant health issue, the Governor recently announced a multi-pronged strategy to address these devastating events including, but not limited to:

- Creating a Governor's Task Force on Maternal Mortality and Disparate Racial Outcomes;
- Establishing a Maternal Mortality Review Board, enhancing the Title V Program's current MMR committee;
- Launching a Best Practice Summit with hospitals and OB/GYNs;
- Piloting Medicaid expansion for doulas;
- Supporting Centering Pregnancy demonstration projects;
- Requiring Medical Education and curriculum development;
- Expanding the NYS Perinatal Quality Collaborative (further addressed in the Annual report and application sections); and,
- Launching Commissioner Listening Sessions to hear from women and advocates across NYS and better understand those factors that impact maternal mortality and morbidity

Title V staff are working closely with the Governor's Office and other key stakeholders and partners to achieve these priorities to improve birth outcomes of all women, regardless of race, ethnicity and geographic location in NYS. Governor Cuomo remains strong in his support of New York's MCH population directly aligned with the purpose and mission of Title V.

Strong partnerships continue to bolster NY's efforts in MCH. The Title V program communicates regularly with the MCHSBG Advisory Council, the MCH committee of the New York State Association of County Health Officials, the NYC Department of Health and Mental Hygiene (NYCDHMH), Parent to Parent of NYS, with various stakeholders and MCH contractors, and through consumer surveys and forums. This communication has helped to identify global MCH priorities, as well as specific priorities at a regional level. These regular communication mechanisms have also been useful vehicles to convey important information to the MCH community.

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

The functions, powers and duties the Commissioner of Health and other DOH officers and employees are detailed in PHL Article 2. Some important powers granted by the legislature to DOH include: supervision and funding of local health activities; the ability to receive and expend funds for public health purposes; reporting and control of disease; control and supervision of abatement of nuisances affecting public health; and to serve as the single state agency for the federal Title XIX (MA) program. Article 2 also provides that DOH shall exercise all functions that, "…hereafter may be conferred and imposed on it by law."

Law governing the organization and operation of NY's local public health infrastructure, which includes the health departments of 57 counties and the City of NY, is contained in PHL Article 3, Local Health Organization. Local health departments are supported by millions of state local assistance dollars, which the DOH administers under the provisions of PHL Article VI, State Aid to Cities and Counties, providing further support for services targeting NY's MCH population.

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

health of the MCH population.

The comprehensive tobacco control capacities of DOH are specified in PHL Article 13-E, regulation of smoking in certain public areas, which enables DOH to reduce environmental exposure to tobacco smoke by prohibiting smoking in most indoor public places; PHL Article 13-F, regulation of tobacco products and herbal cigarettes; distribution to minors, which defines the State tobacco use prevention and control program, prohibits free distribution of promotional tobacco and herbal cigarette products, and which prohibits sale of such items to minors.
PHL Article 21, Control of Acute Communicable Diseases, details the role of local health officials in control efforts, and specifies reporting requirements and patient commitment procedures and provides control requirements for specific diseases, including HIV, rabies, typhoid fever, poliomyelitis and Hepatitis C. PHL Article 23, Control of Sexually Transmissible Diseases, outlines the roles of state and local health officials in the identification, care and treatment of persons with a sexually transmissible disease specified by the Commissioner, and provides for the injunction and abatement of houses of prostitution.

Direct reference to the duties of the Commissioner regarding the health needs for mothers, infants and children is made in PHL Article 25, Maternal and Child Health. Succeeding sections in PHL Article 25 authorize the Commissioner to, among other important activities, screen newborns for inherited metabolic diseases and critical congenital heart disease (§2500-a), HIV (§2500-f) and hearing problems (§2500-g). NY's Child Health Insurance Plan is detailed in PHL §2510 – 2511. The Commissioner's powers to affect prenatal care are enumerated in PHL §2522 – 2528-364-i and 365-k of Social Service Law. An important asset to DOH efforts to monitor, evaluate and improve patient care and outcomes is provided by PHL §2500-h, which authorizes development and maintenance of a statewide perinatal data system and sharing of information among perinatal centers.

DOH's Early Intervention (EI) Program, for children who may experience a developmental delay or disability is authorized by PHL §§2540 – 2559-b, while programming to provide medical services for the treatment and rehabilitation of children with physical disabilities is authorized by PHL §2580 – 2584.

Nutrition programming conducted on behalf of children in day care settings is authorized by PHL §2585 – 2589, while PHL §2595 – 2599 establishes the nutrition outreach and education program to promote utilization of nutrition education throughout the state. The operation of NY's Obesity Prevention Program is detailed in PHL§2599-a – 2599-d.

The ability of NYS to regulate hospitals, including ambulatory health facilities, is conferred by PHL Article 28, Hospitals, and is a prime determinant of DOH's capacity to promote and protect the health of mothers and children. Among the specific provisions relating to hospitals is the NYS Health Care Reform Act (HCRA), which is codified as PHL §2807-j – 2807-t. A major component of NYS Health Care financing laws, HCRA governs hospital reimbursement methodologies and targets funding for a multitude of health care initiatives. The law also requires that certain third-party payers and providers of health care services participate in the funding of these initiatives through the submission of authorized surcharges and assessments.
Similarly, DOH has been given broad powers to regulate home health care agencies and health maintenance organizations through PHL Article 36 and PHL Article 44, respectively. With increased interest in, and funding allocated to, maternal home visiting programs, the importance of DOH's home health agency regulation has grown considerably. Now that the majority of MA-eligible mothers and children are enrolled in MA managed care plans, DOH relies on its delegated powers to ensure the quality of care rendered to them.

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

III.C. Needs Assessment

FY 2019 Application/FY 2017 Annual Report Update

Over the past year, Title V staff continued their focus on the strategies in each priority area. Data is analyzed to identify priority issues and progress in each domain. An emphasis was also placed on stakeholder input to ensure NY's SAP and the PA was moving in synergy with issues and approaches identified by key partners. Input was sought to identify opportunities for collaboration and recommendations to strengthen the SAP and the PA from parents, professionals and other stakeholders including Parent to Parent of NYS, Schuyler Center, NYS Association of County Health Officials, Partnership for Maternal Health, Early Intervention Coordinating Council (EICC), NYS Perinatal Association, dental professionals, Maternal and Infant Community Health Collaboratives (MICHC) and others. NY's MCHSBG Advisory Council provided input to ensure the needs of NY's families were met. A summary of relevant feedback can be found in Section III.F. Public Input. Although NY addresses many aspects of MCH, the following Needs Assessment Summary specifically highlights data on major initiatives.

Domain 1: Maternal & Women's Health

Supporting the health of women before, during and beyond pregnancy continues to be a Title V priority in NYS. More than half (51.5%) of NYS residents are female, including more than 4 million women of reproductive age. BRFSS data reports that nearly 9 out of 10 women age 18-44 years report they are in good or better health, however these data also demonstrate that women in this age group report a variety of health conditions and high-risk behaviors. Approximately half of all pregnancies are unplanned, which underscores the importance of promoting women's health across the lifespan, regardless of pregnancy intentions.

Maternal mortality will continue to be a major focus in the coming year. With the completion of the 2012-2013 review of pregnancy-related deaths, the priority has shifted towards reviewing a new cohort of deaths occurring in 2014-15. The program also initiated data accuracy and consistency reviews of provisional death records for 2016-17 to assess the veracity of the pregnancy check box and cause of death. This became a priority in light of findings from the 2012-13 death reviews, where NY's maternal mortality rate based on data from the reviews was 11.7 in 2012 and 9.8 in 2013, in comparison with the rates of 18.8 in 2012 and 17.9 in 2013 based on death record information alone.

A priority for this domain is also a more complete analysis of factors impacting maternal mortality (MM) and morbidity. Leading causes of maternal deaths based on the review of 2012-13 cohort (N=59) included: embolism (not cerebral) (31%), hemorrhage (19%), infection (15%), cardiomyopathy (11%) and hypertensive disorders (11%). This shows a major change from the previous report when hypertensive disorders represented the top leading causes of death.

Racial disparities in maternal deaths are persistent; the statewide black to white mortality ratio varied between 4.8 to 1 in 2005-07 and 3.2 to 1 in 2011-13. The most recent data showed that geographic differences are minimal. In NYC, the black to white ratio decreased from 12.2 in 2007-09 to 3.4 in 2013-15. This decrease in the black to white ratio was due to a slight increase in the maternal mortality rate among white women while the rate remained stable among black women. Outside NYC, the black to white ratio peaked in 2013-15 at 3.9 to 1. Various key stakeholders, including the Partnership for Maternal Health, and others stressed the importance of addressing MM by ensuring women are healthy before they become pregnant, increasing inter-pregnancy spacing, and ensuring information regarding maternal deaths is shared to promote clinical learning and improvement efforts.

Title V also looked more closely at opioid use, a growing public health issue. Opioid use in pregnancy includes the use of heroin and the misuse of prescription opioid analgesic medications. During the last 5 years for which data are available on opioid use, misuse, morbidity, and mortality in NYS, both heroin and opioid analgesic-related deaths have increased. The age-adjusted rate of all opioid overdose deaths per 100,000 population in NYS doubled between 2010 (5.4) and 2015 (10.8). However, the age-adjusted rate of heroin deaths increased by over five times from 1.0/100,000 in 2010 to 5.4/100,000 in 2015, whereas the age-adjusted rate of

opioid pain reliever deaths per 100,000 increased 1.6 times between 2010 (4.3) and 2015 (6.9). During the same time period, the age-adjusted rates of overdose among women also increased reaching 5.7 per 100,000 population in 2015. The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations rose from 2.63 per 1,000 deliveries in 2008 to 5.84 in 2014, a relative increase of 122%.

Maternal depression remians the most common morbidity among postpartum women, affecting 10-20% of women during or within 12 months of pregnancy. It impacts the health of the woman, infant and the entire family. Addressing maternal depression is a Governor's priority and stakeholders strongly support addressing this issue, including increasing screening of pregnant and postpartum women for depression and identifying and expanding resources for treatment and support.

Domain 2: Perinatal and Infant Health

Maternal depression is the most common morbidity among postpartum women, affecting 10-20% of women during or within 12 months of pregnancy and impacts the entire family. Screening for maternal depression and referring to appropriate supports and services will continue to be a Title V priority.

Infant mortality is a critically important population indicator of maternal and child health and the overall health of a society. NY's infant mortality rate is below the HP2020 Goal and US rate, and has been improving over the last decade, driven primarily by reductions in NYC, where about half the births in the state occur. NYS's infant mortality rate was 4.6 per 1,000 live births in 2015, up slightly from 4.5 per 1,000 live births in 2014.

Despite improvements, striking disparities exist. The ratio of black-to-white low birth weight rates among Non-Hispanics was 1.9 in 2015, reflecting an increase in the rate of 1.8 in 2014. More than 100 infants die each year in NYS due to unsafe sleep practices and Sudden Unexpected Infant Death (SUID). Reducing infant mortality is a longstanding priority for NY's Title V Program, as evidenced by NY's ongoing support of community-based maternal and infant health initiatives such as evidence-based home visiting, and NY's CoIIN initiative, but there remains a need for ongoing targeted efforts. NY's efforts to update and enhance the system of perinatal regionalization in NYS will better ensure quality, appropriate levels of care.

Ensuring very low birth weight (VLBW) infants are delivered at a perinatal hospital (Level III or above) with capability to address their needs is paramount to decreasing infant mortality as well. NY has been a leader in the field related to a system of perinatal regionalized care and continues to exceed the HP2020 target of 83.7 with 94.9% of NY's VLBW infants born at a Level II or Regional Perinatal Center (RPC) facility. Efforts will continue to improve and enhance NY's system of regionalized care.

Domain 3: Child Health

NY's Title V Program continues to emphasize the importance of social emotional development to promote healthy, well-adjusted children. The NSCH 2016 report determined that only 15.1% of NY's children 10 months to five years received a standardized developmental screening as compared to 27.1% on the national level. The 2016 NSCH also found that 34.9% of NYS children age 3-17 had a problem getting needed mental health or counseling. Social supports are important part of ensuring the well-being of children. Both in NYS and nationally, one in five children age 6-17 had difficulty making or keeping friends. Likewise, 21% of NYS children age 6-17 were sometimes bullied, picked-on or excluded by other children.

As with each SP area, Title V staff are focusing on building the body of data and evidence to promote achievement of NY's objectives. Childhood experiences, both positive and negative, have a tremendous impact on future violence victimization and perpetration, and lifelong health and wellness, therefore, early experiences are a priority public health issue. In all stakeholder groups, the need to ensure all children receive comprehensive primary and preventive care including standardized developmental screening and appropriate assessment and supports for mental health and other developmental problems was underscored as a priority.

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

Assessment of this domain throughout the past year continues to reinforce the need for a more comprehensive approach to collecting and analyzing data for CSHCN in NYS. Title V staff review data from the NSCH, and data reported by NY's Title V Local Health Department (LHD)-based CSHCN and EI programs. Access to updated NSCH including state level data, released in 2017, has enabled NY to assess current functioning in this domain. The current CSHCNs program, overseen by LHDs, is focused on assessing the individual needs of CSHCN and their families. The majority of the assistance provided by the LHD are referrals to other programs and services such as EI or specialty services and insurance assistance.

Qualitative input from parents and other key stakeholders is essential to developing and promoting a comprehensive system of services for CSHCN and their families. Title V staff partnered with family organizations to obtain input from a wide range of parents, English and non-English speaking, to inform this needs assessment process. Input from parents of CSHCN, clinicians and other stakeholders continue to emphasize the fragmentation of the service system for CSHCN, complexity of accessing the myriad of services, and that some families receive services as needed while others go without, regardless of health insurance status. Parents express the need for information about their child's diagnosis as well as the systems of services that can assist them. The qualitative information will serve as framework for future Title V policy and program development.

Domain 5: Adolescent Health

Title V staff identified existing data sources as well as relevant research findings, and evidence-based program resources pertinent to adolescent health. Adolescents are particularly sensitive to environmental influences including family, peers, school and neighborhood environment that can either support or challenge their health and well-being. Supporting positive development of youth fosters healthy behaviors and helps to ensure a healthy and productive future adult population.

Much of the Title V staff work focused on understanding the complexities within this topic and to learn about the evidence-based strategies associated with this work including research and data for positive youth development strategies, Adverse Childhood Experiences (ACEs), trauma informed care, well-child definitions as well as reviewing state and national-level data on specific measures that are within the scope of social-emotional development for the adolescent health domain; including from the Youth Risk Behavior Surveillance (YRBS) System and the 2017 NSCH. In all stakeholder groups, the need to ensure adolescents receive comprehensive health care rather than sporadic care for health issues, as well as appropriate supports for mental health issues continued to be underscored as a priority.

Domain 6: Cross-Cutting & Life Course

Interwoven throughout all aspects of the NY's Title V work is a specific focus on identifying and addressing persistent health inequities in the MCH population. Data analysis in several of the Domains highlights significant disparities. Quantitative as well as qualitative data is essential to understanding those factors that result in health inequities and developing strategies and systems to promote equity.

Focus groups and listening forums conducted by Title V staff engaged community members to learn about their priorities and pressing issues facing their communities. Several topics were raised throughout NYS including many of the priorities in the SAP such as the need for safe and healthy communities, access to quality health care, among others. Underscoring this feedback is continued evidence of persistent disparities evidenced by Title V data analysis. A review of measures associated with strategies aimed at the life course, including preventive health care and oral health continue to demonstrate the need for a sustained focus on health equity.

In key indicators including early utilization of prenatal care within the last year, African American (AA) women remain overburdened by health inequities with only 68% AA women receiving early prenatal care compared to nearly 85% Non-Hispanic White. The 2015 NY PRAMS reported that 55.4% of non-Hispanic white pregnant women had their teeth cleaned during pregnancy while only 46.7% of non-Hispanic black, 49.3% Hispanic, and 45.6% non-Hispanic "other" did. The 2011-2012 National Health and

Nutrition Examination Survey found that 23% of children 2-5 years-old had dental caries and Hispanic and non-Hispanic black children 2-8 years-old were twice as likely to have untreated tooth decay as non-Hispanic white children.

Furthermore, access to dental care continues to be an issue especially for low income individuals. Over 2 million people in NY reside in a federally designated dental health professional shortage area (DHPSA). Twenty full counties are designated as Low Income or Medicaid-Eligible DHPSA with another 9 counties having a portion of the county designated. Additionally, 71.6% of people on public water systems (PWS) receive optimally fluoridated water; however, a disparity exists between NYC and the rest of the State (100% vs. 47.8%, respectively). NY's 3rd Grade Survey 2009-2011 indicates significant disparities between low- and high-income children with regards to caries experience, untreated caries and sealants.

All stakeholders emphasized the significance of improving oral health in NYS, and promoting healthy environments to promote the wellness of NY families. Through a review of evidence and input from the field, Title V recognizes the importance of addressing the social determinants of health through the lens of impacted communities to promote changes to improve health equity and access to healthy lifestyle choices.

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

II B. Five Year Needs Assessment (NA) Summary

2017 Five Year Needs Assessment Summary

II. B. 1. Process

As stated in the FY 2017 Application, NY's approach to the implementation of NY's SAP is through cross-functional teams comprised of professionals from across the DFH with varied background and expertise, representing the breadth of MCH. These teams were developed for each State Priority (SP) area, including Health Equity. As in previous years, all teams are comprised of a lead and staff with programmatic experience in the priority area, at least one with analytic skills and one from the Health Equity team to ensure an equity lens is brought to each area. Over the past year, teams continued their focus on the strategies in each priority area. As is evident in the Annual Report section, some priority areas, such as SP 1 – Reduce maternal mortality and morbidity – have a well-established body of work that continues to develop. In other areas, such a SP 3 – Support and enhance children's social-emotional development and relationships - teams devoted significant effort to gathering and assessing information and evidence to further develop the strategies within the SP area.

An emphasis was also placed on stakeholder input to ensure NY's SAP was moving in synergy with issues and approaches identified by key partners. Input was sought to identify further opportunities for collaboration and recommendations to strengthen the SAP from nearly 150 parents, professionals and other stakeholders including Parent to Parent of NYS, Schuyler Center, American Congress of Obstetricians and Gynecologists (ACOG), NYS Association of County Health Officials, Partnership for Maternal Health, Early Intervention Coordinating Council (EICC), NYS Perinatal Association, Regional Perinatal Centers, dental professionals, Maternal and Infant Community Collaborative Centers (MICHC) and others. NY's MCHSBG Advisory Council was engaged throughout the year to provide input to ensure the needs of NY's families were met. A summary of relevant feedback can be found in Section II.F.6. Public Input.

II.B.2 Findings

II.B.2.a MCH Population Needs

This section reflects any updates or enhanced analysis in support of NY's MCH priorities. Further details are outlined in the Annual Report section.

<u>Domain 1: Maternal & Women's Health</u>

Ensuring all New Yorkers are insured is essential to promote positive health outcomes. Through the NYSOH, NY's health plan Marketplace, NY continued efforts to enroll all New Yorkers into health care coverage. Over 2.8 million New Yorkers enrolled through the NYSOH, resulting in a reduction of 850,000 uninsured New Yorkers since the opening of the NYSOH. In 2015, 92% of women in NY had coverage with a continued emphasis on engaging women into health insurance coverage.

Maternal mortality and morbidity continues to be a priority area. To obtain a more comprehensive view of maternal birth outcomes, in addition to a review of maternal deaths, further analysis was done on factors contributing to maternal morbidity. Higher risk for maternal morbidity during delivery was linked to women who did not receive prenatal care, women hospitalized during pregnancy, preterm labor, vaginal deliveries for first time mothers, those with breech position or multiple infants, and cesarean deliveries in general.

Title V continued to assess other factors impacting women's health. Although maternal depression screening has increased in the Medicaid Prenatal Care Program (36% during the initial prenatal care visit and 51.4% in the postpartum visit in 2014 – to 84.9% and 84.4% respectively), there is much work to be done to promote screening as well as services for women who screen positive for depression. Effective in 2016 the NYS Medicaid program allows providers of infant healthcare to bill for postpartum maternal depression screening under the infant's Medicaid number. NY continues to address the opioid epidemic. As stated in the Annual

Report section, significant interagency efforts are underway to implement a coordinated effort to address this public health priority.

Over 50% of NY's births are unintended or mistimed. Various key stakeholders, including the Public Health Committee of the PHHPC, Partnership for Maternal Health, and MCHSBG Advisory Council continue to work with the Title V program, focusing on the importance of ensuring women are healthy before they become pregnant, increasing inter-pregnancy spacing, and ensuring the promotion of education, information and clinical improvement efforts.

Domain 2: Perinatal and Infant Health

Infant mortality is a critically important population indicator of maternal and child health and the overall health of a society. NY's infant mortality rate is below the HP2020 Goal and US rate, and has been improving over the last decade, driven primarily by reductions in NYC, where about half the births in the state occur. NYS's infant mortality rate was 4.5 per 1,000 live births in 2014, down slightly from 4.9 per 1,000 births in 2013.

Despite improvements, striking disparities exist. The ratio of black-to-white low birth weight rates was 1.6 in 2014, reflecting an improvement over the rates of 1.9 and 1.8 in 2010 and 2012, respectively. More than 90 infants die each year in NYS due to unsafe sleep practices and Sudden Infant Death Syndrome (SIDS). Reducing infant mortality is a longstanding, fundamental priority for NY's Title V Program, as evidenced by NY's ongoing support of community-based maternal and infant health initiatives such as evidence-based home visiting, and the work of NY's CoIIN initiative, but there remains a need for ongoing targeted efforts. NY's efforts to update and enhance the system of perinatal regionalization in NYS will better ensure quality, appropriate levels of care.

Domain 3: Child Health

NY's Title V Program continues to emphasize the importance of social emotional development to promote healthy, well adjusted children. The National Survey of Children's Health (NSCH) 2011-2012 report that 33.2% of NY's children four months to five years are determined to be at moderate or high risk for developmental or behavioral problems as compared with 26.2% on the National level. Of equal concern are findings from the same survey that determined that only 21.3% of NY's children 10 months to five years received a standardized developmental screening as compared to 30.8% on the national level and 64.4% of children age 2-27 with problems requiring counseling who received mental health care as compared to 61% on the national level. Access to updated NSCH including state level data, expected to be released later in 2017, is essential for States such as NY to assess current functioning in this and other Domains.

As with each SP area, Title V staff are focusing on building the body of data and evidence to promote achievement of NY's State Objectives. Childhood experiences, both positive and negative, have a tremendous impact on future violence victimization and perpetration, and lifelong health and wellness and therefore, early experiences are a priority public health issue. In all stakeholder groups, the need to ensure all children receive comprehensive primary and preventive care including standardized developmental screening as well as appropriate assessment and supports for mental health and other developmental problems was underscored as a priority for Title V.

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

Assessment of this domain throughout the past year continues to reinforce the need for a more comprehensive approach to collecting and analyzing data for CSHCN in NYS. Title V staff continue to review data from the 2009-2010 National Survey of Children's Health (NSCH), National Survey of Children with Special Health Care Needs (NSCSHCN) and data reported by NY's Title V Local Health Department-based CSHCN and EI programs. Access to updated NSCH including state level data, expected to be released later in 2017, is essential for States such as NY to assess current functioning in this and other Domains.

In addition to data, qualitative input from parents and other key stakeholders is essential to developing and promoting a comprehensive system of services for CSHCN and their families. Input from parents of CSHCN, clinicians and other stakeholders

continue to emphasize the fragmentation of the service system for CSHCN, complexity of accessing the myriad of services, and that some families receive services as needed while others go without, regardless of health insurance status. Parents also continue to stress the need to ensure a smooth transition into Health Home for Children (HH) and ongoing assessment of the comprehensiveness of case management that occurs through HH. In all stakeholder groups, an emphasis was placed on ensuring developmental screening for all children, ensuring children with autism are diagnosed early and receive appropriate services throughout their life span, and that adolescents with special needs receive support to transition to the adult health care system without negative impact on their well-being. The qualitative information will serve as framework for future Title V policy and program development.

Domain 5: Adolescent Health

As with the child health domain, Title V staff identified existing data sources as well as relevant research findings, and evidence-based program resources pertinent to adolescent health. Adolescents are particularly sensitive to environmental influences including family, peers, school and neighborhood environment that can either support or challenge their health and well-being. Supporting positive development of youth fosters healthy behaviors and helps to ensure a healthy and productive future adult population.

Much of the Title V staff work focused on understanding the complexities within this topic and to learn about the evidence-based strategies associated with this work. The focus for some of the formative work in this area includes research and data for positive youth development strategies, Adverse Childhood Experiences (ACEs), trauma informed care, well-child definitions as well as reviewing state and national-level data on specific measures that are considered to be within the scope of social-emotional development for the adolescent health domain; including from the Youth Risk Behavior Surveillance (YRBS) System and the NSCH, with updated date anticipated later in 2017.

In all stakeholder groups, the need to ensure adolescents receive comprehensive health care rather than sporadic care for health issues, as well as appropriate supports for mental health issues continued to be underscored as a priority for Title V.

Domain 6: Cross-Cutting & Life Course

Interwoven throughout all aspects of the NY's Title V work is a specific focus on identifying and addressing persistent health inequities in the MCH population. Data analysis in several of the Domains highlights significant disparities. Quantitative as well as qualitative data is essential to understanding those factors that result in health inequities and developing strategies and systems to promote equity.

Focus groups and listening forums conducted by Title V staff engaged community members to learn about their priorities and pressing issues facing their communities. Several topics were raised throughout NYS including many of the priorities in the SAP such as the need for safe and healthy communities, access to quality health care, among others. Underscoring this feedback is continued evidence of persistent disparities through Title V data analysis. A review of measures associated with strategies aimed at the life course, including preventive health care and oral health continue to demonstrate the need for a sustained focus on health equity.

In key indicators including early utilization of prenatal care within the last year, African American (AA) women remain overburdened by health inequities with only 68% AA women receiving early prenatal care compared to nearly 85% Non-Hispanic White. Furthermore, access to dental care continues to be an issue especially for low income individuals. Over 2 million people reside in a federally designated dental health professional shortage area (DHPSA) in NY. 21 full counties are designated as Low Income or Medicaid-Eligible DHPSA with another 9 counties having a portion of the county designated. Additionally, 71.7% of people on public water systems (PWS) receive optimally fluoridated water; however, a disparity exists between NYC and the rest of the State (100% vs. 47%, respectively). NY's 3 Grade Survey 2009-2012 indicates significant disparities between low and high income children with regards to caries experience, untreated caries and sealants.

All stakeholders emphasized the significance of improving oral health in NYS, and promoting healthy environments to promote the

wellness of NY families. Through a review of evidence and input from the field, Title V recognizes the importance of addressing the social determinants of health through the lens of impacted communities to promote changes to improve health equity and access to healthy lifestyle choices.

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

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

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

Organizational changes over the past year in the Office of Public Health (OPH) include: Nora Yates assumed the position of director of the Center for Community Health; Phillip Passero, the director of the DFH Bureau of Administration (BOA) retired. Susan Penn recently joined the DFH as Assistant Director of the BOA. See Attachment 2 for an organizational chart.

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

NY's commitment to ensuring the health of the MCH population is manifest in an extraordinary array of resources. An extensive list of partnerships is contained in Attachment 1. The following sections contain updates to NY's services by domain. Unless otherwise specified, the services contained in FFY 2017 application remain intact and are reported on in IIF Annual Report.

Domain 1: Women's & Maternal Health

No updates

Domain 2: Perinatal & Infant Health

No updates

Domain 3: Child Health

No updates

Domain 4: Children with Special Health Care Needs

No updates

Domain 5: Adolescent Health

No updates

Domain 6: Cross-cutting & Life Course

No updates

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

Included in Supporting Documents

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

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

II.B.1.

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

II.B.2

II.B.2.a

This section reflects any updates or enhanced analysis in support of NY's MCH priority issues (Refer to Needs Assessment Summary in Year 1 application).

Domain 1: Maternal & Women's Health

A priority for this domain was a complete analysis of factors impacting maternal mortality and morbidity. NYS Maternal Mortality (MM) Review Report - 2006-2008, comprised of a review of 125 maternal deaths, determined that Black women comprised 46% of the pregnancy-related deaths, followed by White (18%) and Asian (10%); 30% were obese (BMI of 30 or more); and, the leading causes of death were hemorrhage (23%), hypertension (23%), embolism (17%), and cardiovascular problems (10%).

Various key stakeholders, including the Partnership for Maternal Health, and others stressed the importance of addressing MM by ensuring women are healthy before they become pregnant, increasing inter-pregnancy spacing, and ensuring information regarding maternal deaths is shared on a timely basis and in a manner to promote improvement efforts.

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

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

Domain 2: Perinatal and Infant Health

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

Opioid use impacts infants and children as well as adults in NYS. Rates of drug-related discharges for newborns increased by 60% since 2008, with increases both upstate and in NYC and across all racial and ethnic groups, and higher rates outside NYC and among black infants. The rate of Neonatal Abstinence Syndrome has doubled outside of NYC since 2008 to 4.5 per 1000 delivery hospitalizations, primarily among white infants. Addressing the opioid epidemic has been emphasized as a NYS interagency priority

within and outside of DOH.

Universally, the continued development of evidence-based home visiting services has been stressed as essential to provide support to the MCH population by the MCHSBG Advisory Council, Schuyler Center for Analysis and Advocacy and other key stakeholders to continue to improve health outcomes in this population as well as children and families.

Domain 3: Child Health

A greater emphasis for this NA has been on social-emotional development. The National Survey of Children's Health 2011-2012 reports that 33.2% of NY's children 4 months to 5 years are at moderate or high risk for developmental or behavioral problems as compared with 26.2% on the national level. Of equal concern are findings from the same survey that found that only 21.3% of NY's children 10 months to 5 years received a standardized developmental screening as compared to 21.3% on the national level and 64.4% of individuals ages 2-27 with problems requiring counseling who received mental health care as compared to 61% on the national level.

Childhood experiences, both positive and negative, have a tremendous impact on future violence victimization and perpetration, and lifelong health and wellness and therefore, early experiences are a priority public health issue. Much foundational research has been done related to Adverse Childhood Experiences (ACEs). In the ACE module of the BRFSS, nationally 23.6% of all individuals experienced one ACE, 13.6% two, 8.1% three and 14.3% four or more ACE. NY's NA processes included reviewing the evidence to focus on the positive rather than negative behaviors of children, namely asset building processes.

In all stakeholder groups including the MCHSBG Advisory Council, parent representatives, Early Childhood Advisory Council, EICC among others, the need to ensure all children received comprehensive primary care including standardized developmental screening as well as appropriate assessment and supports for mental health and other developmental problems was underscored as a priority for Title V.

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

Assessment of this domain throughout the past year has reinforced the need for a more comprehensive approach to collecting and analyzing data for CSHCN in NYS. In addition, input from Parent to Parent of NYS, key stakeholders and others, also emphasized the fragmentation of the service system for CSHCN, complexity of accessing the myriad of available services, and the fact that some families receive supports and services as needed while others go without regardless of health insurance status. As stated in the annual report section of this application, Title V staff are directly involved in the development of Health Home for Children (HH). Parents stressed the importance of ensuring a smooth transition into HH and ongoing assessment of the comprehensiveness of case management that occurs through HH. In addition, Parent to Parent also stressed the need to focus on those CSHCN who are not eligible for HH but nonetheless require supports and services. Parents also emphasized the need for bi-directional information to ensure they were aware of changes and updates in the service system and Title V continues to hear their voices. In all stakeholder groups, an emphasis was placed on ensuring developmental screening for all children, ensuring children with autism are diagnosed early and receive appropriate supports and services throughout their life span, and that adolescents with special needs receive comprehensive information and supports to transition to the adult health care system without negative impact on their well-being. Ensuring statewide services for CSHCN including in rural areas as well as neighborhoods in poverty where there may be safety concerns for the family and/or provider was also emphasized in conversations with parents. The qualitative information obtained throughout the past year has clarified and strengthened NY's Title V State Action Plan related to CSHCN and will serve as framework for future Title V policy and program development.

Domain 5: Adolescent Health

As with the child domain, an emphasis was placed on the social-emotional wellness of NY's adolescents over the past year. The rate (per 100,000) of suicide deaths among youth aged 15-19 increased from 4.2 in 2013 to 5.1 in 2014. In NYS, vital statistics data demonstrate that suicide is the leading cause of injury death for children ages 10 to 14 years and the fourth leading cause for children ages 15 to 19 years. Young males are less likely to seek help or talk about their feelings.

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

In all stakeholder groups, the need to ensure adolescents receive comprehensive health care rather than sporadic care for health issues, as well as appropriate supports for mental health issues was underscored as a priority for Title V.

Domain 6: Cross-Cutting & Life Course

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

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

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

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

II.B.2.b. Program Capacity

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

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

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

NY's commitment to ensuring the health of the MCH population is manifest in an extraordinary array of resources. The extensive list of partnerships is contained in Attachment 1. The following sections contain updates to NY's supports and services by domain. Unless otherwise specified, the services contained in FFY 2016 application remain intact and are reported on in IIF Annual Report.

Domain 1: Women's & Maternal Health No updates to this section.

Domain 2: Perinatal & Infant Health CDC's 6/18 Initiative – Title V staff and OHIP are participating in this initiative related to the high-burden health condition of unintended pregnancy focusing on administrative systems, supports and financing to increase access to LARC and prevent unintended pregnancies.

Domain 3: Child Health No updates to this section.

Domain 4: Children with Special Health Care Needs No updates to this section.

Domain 5: Adolescent Health Enough is Enough is a Governor's initiative to address and prevent sexual violence on college campuses using strategies to help college faculty, staff and students learn to identify sexual assault and safely intervene in the prevention of relationship violence and stalking.

Domain 6: Cross-cutting & Life Course Place-based Initiative Workgroup is a Governor's initiative to determine promising practices for current and future place-based efforts.

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

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

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

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

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

Five-Year Needs Assessment Summary
(as submitted with the FY 2016 Application/FY 2014 Annual Report)

II.B.1. Process

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

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

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

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

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

II.B.2. Findings

II.B.2.a. MCH Population Needs

Domain 1: Maternal & Women's Health

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

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

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

Maternal Mortality is a devastating outcome with dramatic impact on families and communities. NYS maternal mortality peaked at 29.2 deaths/100,000 live births in 2008 and declined to 18.8 in 2012, with rates four times higher among Black women and 1.5 times higher among NYC women [4]. Both mortality rates and racial disparities for NYS are notably higher than national rates. Leading causes include cardiac disorders, hemorrhage, hypertension and embolism. **Severe or "near miss" maternal morbidity** increased in NYS from 2008-10 then declined, with significant racial, ethnic and economic disparities [7]. Risk factors identified in NYS analyses include: greater maternal age; obesity and chronic medical conditions; multiple pregnancies; delayed or inadequate prenatal care; depression; and, Cesarean delivery. **Maternal depression** is the most common morbidity among postpartum women, affecting 10-20% of women during or within 12 months of pregnancy. Risk increases with low social support, personal or family mental illness, substance abuse and pregnancy or birth complications.

Key successes to build on in NYS include:

- **Robust surveillance and data systems** including SPDS, PRAMS, Family Planning and Home Visiting data systems and Maternal Mortality Review systems. A new partnership with BRFSS provides data on women's preconception

health and family planning practices.

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

"The family planning learning collaborative provided a platform

to engage in an educated discussion about how to improve

performance regarding contraceptives and LARC"

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

Domain 2: Perinatal and Infant Health

Infant mortality is a fundamental indicator of the health of a nation, state or community. NY's infant mortality rate declined from 5.8/1,000 in 2005 to 5/1,000 in 2012 [4]. Leading causes include preterm birth, birth defects, sudden unexpected infant death (SUID), accidents and homicide. Important risk factors include lack of prenatal care, short birth intervals, maternal chronic disease or tobacco, alcohol and drug use, chronic stress, interpersonal violence, and injury prevention practices. **Neonatal mortality** (within first month of life), accounting for 70% of all infant deaths, peaked at 4.2 in 2004 and declined to 3.3 in 2012, mirroring a decline in **preterm-related mortality** [4]. Since 2009, 90% of **VLBW infants were delivered in hospitals with Level III-IV NICUs**, with a corresponding decline in VLBW mortality rates [4]. **Post neonatal mortality** has been fairly steady over the last decade at ~1.6/1,000 in 2012, while **sleep-related SUID-related mortality rates** have improved [4]. For all these measures there striking disparities with rates for black infants 2-2.5 times higher than white. Rates are generally lower in NYC, although **fetal death** rates are higher in NYC [7].

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

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

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

"Mothers need support to be healthy and to keep their babies healthy; services like home visiting help families"

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

"We need to employ more people in front line positions to reflect the communities we serve"

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

Domain 3: Child Health

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

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

Parent and provider stakeholders in NYS voiced concerns about children's physical and behavioral health and barriers to healthy lifestyles including **affordable healthy food**, **opportunities for physical activity** and **positive social-emotional relationships** [3] (*see also Domain 6*). NYS data find that nearly one in five school-age children, and one in seven WIC-enrolled younger children are **obese**, and less than 25% of children age 6-11 are **physically active** for at least 20 minutes daily [14-16]. While most parents indicate that their child is **"flourishing"**, this decreases as children age and there are notable racial/ethnic and economic disparities [11]; stakeholders voiced deep concerns about the impact of toxic stress on early brain development [3]. One in five NYS children live in poverty and 4.5 per 1,000 are in foster care [17]. Nearly 18% of children age 0-18 have had two or more **adverse childhood experiences**, and preliminary data show that about 7 per 100,000 children are hospitalized annually related to **child maltreatment**, with highest rates among infants, black and low income children [7]. One-third of young children age 0-5 years are at moderate or high **risk for developmental or behavioral problems** based on parents' concerns, 7.4% of children 2-17 are taking **medication for ADHD. emotional or behavioral concerns** and 4.9% of children 6-11 have current **behavioral or conduct problems** [11]. Both parents and providers articulated needs for universal education and enhanced social support to help parents better understand normal child development and strengthen parenting skills [3].

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

They have more important things to deal with"

Key NYS successes to build on include:

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

strong history of developing innovative asset-based public health programming for children and youth.

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

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

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

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

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

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

Support for families is a key cross-cutting need identified by stakeholders [3]. In 2009-10, 17.6% of CYSHCN families indicated their child's health needs created **financial problems** for the family, 14.4% spent **11+ hours/week providing or coordinating their child's health care** and 26.7% **cut back or stopped working** due to their child's health condition, while 43.1% reported their child does not receive **family-centered health care** [18].

Increasing support for families is a central priority for the state's Early Intervention (IDEA Part C) program, for which the proportion of **families reporting positive family outcomes** decreased from 2008 to 2012.

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

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

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

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

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

Domain 5: Adolescent Health

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

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

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

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

"Get us involved. The minute I feel like my word matters, I

will stay involved…I will think and I will make better choices"

Key successes to build on in NYS include:

- strong and longstanding **networks of youth-serving community and clinical providers** across the state;
- widespread implementation of **evidence-based sexual health education** through community-based adolescent programs, with strong training and technical support to ensure **fidelity;**
- long history of innovative **asset-based youth development strategies** across programs for both younger and older teens;
- **access to confidential health care services** for teens in a variety of settings including community family planning and school-based clinics; and
- mature and productive **state-academic partnerships** to support development, implementation and evaluation of

evidence- and theory-based youth programming.

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

Domain 6: Cross-Cutting & Life Course

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

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

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

Across all MCH stakeholder groups, **home, neighborhood and community environments** were noted as key factors influencing cross-cutting health risks and issues including nutrition, physical activity, social supports and relationships, violence, injury prevention, asthma and lead poisoning [3]. Parents report that 79% of children and youth age 0-17 live in **supportive/cohesive neighborhoods** and 80% feel that their child is usually or always **safe in their community or neighborhood**, with disparities for non-white and lower income young people [11]. About 58% of young people live in a **neighborhood that has a park. recreation center, sidewalks and library**; 85% live in neighborhoods with at least three of these resources [11]. In contrast, about 17% of young people live in

neighborhoods with two or more **detracting elements (vandalism, rundown housing, litter)**, with notable racial and ethnic disparities [11]. In 2011, USDA identified **food deserts** in more than half of NYS counties, with about 2.5% of low-income NYS residents living > 1 mile (urban) or > 10 miles (rural) from a supermarket or grocery store that provides affordable fruits and vegetables [22]. About 19% of young people age 0-17 live in a **household in which someone smokes**, which is declining [11]. Common **home environmental hazards** identified by the DOH Healthy Neighborhoods Program include: second-hand smoke, lack of carbon monoxide and smoke detectors, lead paint hazards, rodent and insect pests, mold and structural disrepairs [23].

"My kids would be healthier if they could

go out to play instead of watching TV"

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

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

- Strong **evidence base for action to improve oral health** through **community water fluoridation**, **school-based programs** and other prevention practices, combined with diverse partnerships and new funding support;
- Infrastructure to conduct **in-home assessments and interventions** for environmental health hazards in targeted neighborhoods through the state's **Healthy Neighborhoods Program**, with significant improvements in tobacco control, fire safety, lead poisoning risks, indoor air quality and asthma triggers on follow-up visits.
- A strong cross-sector commitment to investing in **proven community-based programs to improve physical activity and nutrition and reduce tobacco use**, with particular focus on **policy and environmental** change strategies.
- **Statewide nutrition programs** that provide resources for healthy food as well as family and community nutrition education in a number of settings.
- An array of strategies to **reduce disparities and promote health equity** across MCH programs and initiatives, with a shared commitment to advancing further evidence-based approaches.

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

II.B.2.b Title V Program Capacity

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

NY's state government is comprised of executive, legislative and judicial branches. The bicameral Legislature includes a 62 member Senate and 150 member Assembly. The judicial branch, comprised of courts with jurisdictions from village/town to the State Court of Appeals, functions under a Unified Court System to resolve civil, family, and criminal matters and provide

legal protection for children, mentally ill persons and others entitled to special protections. The Governor heads the executive branch, including 20 departments; department and agency heads are appointed by the Governor, with the exception of the Commissioner of the State Education Department who is appointed by the State Board of Regents.

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

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

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

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

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

Domain 1: Women's & Maternal Health

Family Planning Program – community-based outreach and clinical services with 49 agencies in 177 sites serving 340,000

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

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

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

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

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

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

Domain 2: Perinatal & Infant Health

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

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

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

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

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

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

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

Domain 3: Child Health

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

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

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

Public Health Nutrition Programs – statewide programs provide access to healthy food for MCH and other populations: **Special Supplemental Nutrition Program for Women, Infants and Children (WIC**), the third largest in the country, offers nutrition education, breastfeeding support, referrals and nutritious foods to 500,000 participants per month through 93 WIC local agencies via a network of 500 service sites; **Child and Adult Care Food Program (CACFP)** ensures that nutritious meals and snacks are available in eligible child care and after school programs, with 1,400 sponsoring organizations representing 14,000 participating care sites serving 340,000 meals daily; **Hunger Prevention and Nutrition Assistance Program (HPNAP)** funds 47 contractors and their 2,400 emergency food programs to provide nutritious food to those in need throughout NYS. *See Domain 6 for additional related capacity.*

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

Domain 4: Children with Special Health Care Needs

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

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

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

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

Domain 5: Adolescent Health

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

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

OMH's Suicide Prevention Office (SPO) - established in May 2014 to coordinate a comprehensive approach to suicide prevention in NYS; aligned with **National Action Alliance for Suicide Prevention** guidelines and the **Zero Suicide** approach in health and behavioral care; key collaborations with the **Center for Practice Innovation** to advance implementation of evidence based practices, the **Suicide Prevention Center of New York** to coordinate and provide - training and the **DOH Injury Prevention program** to develop research opportunities.

Domain 6: Cross-cutting & Life Course

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

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

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

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

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

As noted, New York's Title V Program, based in the NYSDOH Division of Family Health, supports and collaborates with MCH-serving programs and partners spanning multiple organizational units outside the Division and within other state agencies and organizations to achieve MCH goals. **Systems-building**, **integration and coordination of services**, **community engagement** and **family support and empowerment** are hallmarks of this work across all domains and focus areas. See *II.A* and *II.B.2.c* for additional information on Title V coordination and collaboration with other state and local agencies, non-governmental partners, health services and systems, including current major national and state health systems reform efforts.

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

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

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

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

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

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

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

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

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

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

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

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

Rachel Gaul, MBA, Director, Bureau of Administration

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

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

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

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

III.D. Financial Narrative

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$38,909,810	$38,909,810	$38,909,810	$38,909,810
State Funds	$29,200,000	$58,908,173	$29,226,355	$65,501,510
Local Funds	$22,198,393	$317,759,172	$25,254,603	$85,526,375
Other Funds	$0	$0	$0	$0
Program Funds	$12,794,604	$274,679,941	$34,368,556	$26,095,730
SubTotal	$103,102,807	$690,257,096	$127,759,324	$216,033,425
Other Federal Funds	$54,870,832	$41,545,988	$72,809,819	$65,158,879
Total	$157,973,639	$731,803,084	$200,569,143	$281,192,304

	2017		2018	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$38,909,810	$37,671,624	$38,909,810	
State Funds	$12,147,081	$29,285,355	$29,226,355	
Local Funds	$102,765,310	$64,999,454	$64,591,358	
Other Funds	$0	$0	$0	
Program Funds	$34,368,556	$78,393,470	$26,851,106	
SubTotal	$188,190,757	$210,349,903	$159,578,629	
Other Federal Funds	$57,096,314	$46,962,126	$68,845,166	
Total	$245,287,071	$257,312,029	$228,423,795	

	2019	
	Budgeted	Expended
Federal Allocation	$37,671,810	
State Funds	$29,285,356	
Local Funds	$122,324,435	
Other Funds	$0	
Program Funds	$30,303,017	
SubTotal	$219,584,618	
Other Federal Funds	$47,470,052	
Total	$267,054,670	

D. Financial Narrative

1. Expenditures

FY 17 Expenditures including Title V, State appropriations and other grant funding demonstrates NY's commitment to providing supports and services to NY's women, children and families. The State Allocation Plan is described in Section 504, Use of Allotment of Funds, and Section 505, Application for Block Grant Funds.

Expenditures reflected in Form 2, confirm that NY has continued to comply with the 30%-30%-10% requirements, as specified in Section 504(d) and Section 505(a)(3). In addition, actual FY 17 expenditures exceeded the budgeted values by more than $22M, further demonstrating our commitment to allocating resources which complement the MCHS Block Grant funding ensuring that the needs of the NYS MCH population is being met. The scope and comprehensiveness of services for NY's MCH population are fully outlined and described in the FY 2017 report and FY 2019 application.

Title V funds supported primary and preventive health care services and infrastructure to continue to achieve the objectives for each State Priority in NY's Title V State Action Plan. Initiatives including the Comprehensive Adolescent Pregnancy Prevention and Center for Community Action on Adolescent Health and Family Planning and Reproductive Health Care Program promote primary and preventive health care, preconception and interconception health, and social-emotional health and wellness for all individuals served. Programs such as the School Based Health Center Program ensures access to health care for all NY's children and adolescents, also focusing on reproductive and behavioral health. The Lead Poisoning Prevention Program provides identification and follow-up for children at risk for, or with high blood lead levels. Title V funding is provided to NY's Regional Perinatal Centers to ensure all pregnant women and newborns have access to high quality, appropriate level of perinatal care to improve birth outcomes. The School-Based Dental Sealant Program and the NYS Oral Health Center of Excellence promote improved oral health for NY's highest risk population. Program targeting specific populations such as the American Indian Health - Community Health Worker Program and Migrant and Seasonal Farmworker Health engage very hard-to-reach populations into health care across the life course. Title V funds supported monitoring of family planning, school based health center and school based dental sealant programs to ensure services are provided in accordance with State and Federal requirements where applicable. Title V funds also support efforts to update NY's standards for perinatal regionalization and efforts to identify and address those factors that result in maternal mortality and morbidity.

Title V funds, in conjunction with state and other federal funds, supports a rich tapestry of programs and initiatives developed to support NY's Title V State Action Plan and assists NYS to address the needs of NY's women, children and families including the overarching priority to promote health equity. NY's Part C of the Individuals with Disabilities Education Action funding supports the administration of the largest Early Intervention Program in the nation. Grants such as MIECHV to support evidence-based home visiting and efforts to engage women and families into health insurance, interconception health, breastfeeding, parenting support and a range of other supports and services. Funding provided through PREP and Pathways allows an expansion of adolescent programming to support the growth and development of children and adolescents. The Universal Newborn Hearing Screening and Early Hearing Detection and Tracking Surveillance and Intervention grant augments the statewide newborn hearing screening program and supports enhanced efforts to track newborns lost to follow-up services. NY's Title V program oversees several federal grants related to oral health NYS Oral Disease Prevention Program, Grants to Support State Oral Health Workforce Activities and NYS Oral Health and Chronic Disease Collaboration that assist NY to build a system to promote oral health across the life course through efforts such as promoting community water fluoridation and promoting an understanding of the importance of oral health by professionals and families. NY leverages the Perinatal Quality Collaborative grant to support efforts to improve the quality of care provided to women

and newborns in NY's perinatal hospitals. Efforts supported in NY's Rape Prevention and Education program are targeted at decreasing sexual violence and promoting healthy relationships among NY's adolescents and young adults.

Supports and services to NY's Children with Special Health Care Needs CSHCN and their families is an essential component of NY's Title V services. Through the Physically Handicapped Children's Program - Diagnosis & Evaluation (PHCP-D&E), funding is provided for medical assessment of children with suspected health issues where there is no other source of financial support. Although all primary and preventive health care programs provide services to CSHCN, NY's Title V program also oversees services specifically designed to serve CSHCN. For example, Title V funds support forty-nine Local Health Departments (LHDs) to provide information and referral services to families of CSHCN. This funding supports staff in LHDs to respond to inquiries by families related to issues such as insurance coverage, assistance with services, family support and needed items for their CSHCN. Support is provided to NY's Wadsworth Center Laboratory that administers the statewide Newborn Metabolic Screening Program as well as specialty centers for individuals with genetic diseases and disabilities. NY's Lead Poisoning Prevention Program focuses on environmental changes as well as identifying and supporting potentially lead poisoned children and their families. Programs such as NY's SBHC provide services to children, including CSHCN that can result in decreased absenteeism. As stated in NY's application, NY's Title V program continues to focus improving supports and services for CSHCN and their families. Information obtained from CSHCN and their families will assist NY's Title V Program to improve and enhance supports and services for CSHCN in the coming years.

To calculate data on population served by group (pregnant women, infants under 1 year of age, children ages 1-22 years, CSHCNs and others) and level of the MCH pyramid (direct health care services, enabling services, and population and infrastructure services), program managers provide information on population served based on actual data collected from each program, or provide an estimation for each of these categories and the data are compiled for Forms 3a and 3b. Expenditure reports are generated for the appropriate period and distributions by population and pyramid level are then calculated. NYS does not provide direct health care services using Title V funding except for limited funding through the Physically Handicapped Children's Program Diagnosis and Evaluation (PHCP D&E) services. A rich health care coverage and service system in NYS results in very limited expenditures through PHCP D&E as NY's direct care expenses remain less than 1%.

NY's commitment to the MCH population is evidenced by the substantial State appropriation that is devoted to supports and services for NY's women, children, including CSHCN and families. Differences in state and local contributions from prior years are evident as NYS continues to promote enrollment into health insurance coverage for all New Yorkers, as well as maximize the use of other state and federal fund sources to enhance services for the MCH population.

Overall the actual expenditures for FY 17 exceeded budgeted values by more than $22M (increase 11.11%). Of particular note, is the amount of program income generated for the reporting period was 128% of the anticipated income. This is likely related to the timing of the reporting rather than an actual increase in expenditures.

NY's FY 16 application reflected a budget of over $29 million in State MCH funds and over $25 million for Local funds. Expenditures in both categories far exceeded the budgeted figures from an increase in local public health policies and reformulated expenditure categories. This also applies to the Total State match and State Federal Partnership. Expenditures for State MCH funds exceeded the budgeted figures in the program areas of Child Lead Poisoning Prevention, Comprehensive Adolescent Pregnancy Prevention, Family Planning, and American Indian Health. Expenditures for Local funds increased significantly in the areas of provision of primary and preventive care to uninsured children (<21 years) in a clinic setting, maternal and infant health, provision of prenatal/postpartum care in a home visiting setting, and reproductive health. NYS appropriates significantly more funding to services for the MCH population. NY's Title V program uses additional State funds to leverage other resources such as to obtain Federal Medicaid Assistance Program (FMAP) funding when possible.

The actual FY 17 expenditures for the Federal Allocation C. Title V Administrative Costs exceeded projected administrative costs due to a substantial organization change at the State level. All Information and Technology Services (ITS) services were centralized across NYS. This reorganization allowed NYS to better understand that costs incurred by all State Agencies for ITS and develop a fair share methodology that is then applied to each major grant. These expenditures for Title V are reflected in this budget.

NY continues to be committed to identifying additional resources to serve NY's MCH population. NY's Title V program has been very successful in accessing additional funding to develop the comprehensive system that currently exists in NYS. and a myriad of other grants support NYS's efforts to improve outcomes of all women, children, including CSHCN and families across NYS.

2. Budget

This FY 2018 budget reflects NYS's commitment to Title V programs and services. NYS will continue to use FY 2018 Title V funds to fully support the implementation of NY's Title V State Action Plan. Title V funds, in addition to State appropriation, FMAP, and federal grant funds will continue to support programs and initiatives across all domains as described in the application section. This includes the development of substantial data analyses and reports to guide NY's services for the MCH population. Support for efforts such as maternal and infant mortality and morbidity surveillance and quality improvement efforts to avoid these devastating outcomes is a priority. Enhancing NY's efforts to identify those factors that result in maternal mortality and morbidity and addressing those factors will continue to be of importance in NY's Title V program. Title V will continue interagency efforts to address maternal depression. Efforts will continue to update and improve NY's system of perinatal regionalization. NY will continue to move towards a greater understanding of social emotional development in children and adolescents and promote and support efforts to ensure all NY's children have the opportunity for healthy development. Information obtained through systems mapping will assist NY's Title V program to improve and enhance supports and services for CSHCN and their families.

Overall efforts will continue to provide supports and services for children and adolescents, with a significant focus on social-emotional development, school based health centers and school based-dental programs, evidence-based home visiting services, community health workers including CHWs serving Native Americans, oral health services, services for CSHCN and many other supports and services discussed throughout NY's application. And paramount to the plan across the life course is the promotion of health equity for all.

Financially, the Title V Administrative budget of $3.2 million increased slightly from prior years to account for the ITS cost and remains below the 10% limit for these costs. As in prior years, the NYS share for MCH services will continue to be considerable, and will more than meet the requirements for state match. Expenditures for FY18 are expected to utilize the full allocation of $37,671,810. NYS continues to be fully committed to the health and wellness of all New Yorkers and will move forward in the comprehensive work as outlines in the Title V State Action Plan.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: New York

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

Section III.E.2. State Action Plan Narrative Overview

a. State Title V Program Purpose and Design

NY's Title V program builds on years of MCH leadership and public health investments. Unlike many smaller states, states such as NY address the needs of the MCH population through intra-and interagency partnerships internally and externally, using Title V funding to provide internal infrastructure and support gaps in supports and services that are not otherwise provided through State or other federal fund sources for maximum benefit to improve MCH outcomes. Similar to other large states, NY does not provide direct services, rather works to improve supports and services through contracts and community partnerships to better address the extremely diverse MCH population.

NY's State Action Plan (SAP) is driven by data, evidence and input from stakeholders including families and directly flows from the Needs Assessment (NA), State Priorities and National Performance Measures. NY's SAP established quantitative 2020 targets for objectives, refined strategies, and established state performance measures (SPM) and Evidence-Based/Informed Strategy Measures (ESM) and has evolved annually as needs, strategies and outcomes have evolved. Much of this work continues to be led by cross-programmatic Title V Staff Action Planning Teams in areas where there is not one 'home" for this work such as health equity and child and adolescent social-emotional development. Targets were set based on analysis of data trends and projected impact of strategies and continue to be assessed. As will be evident in the Annual Report and Application section, the Title V program continues to make progress in the defined strategies and enhance staffs' ability to continue to move forward through education, valuable internal and external partnerships and a strong commitment to improving the health and well-being of all NY's women, children and families.

III.E.2.b. Supportive Administrative Systems and Processes

III.E.2.b.i. MCH Workforce Development

Section III.E.2.b.i MCH Workforce Development

A strong and diverse MCH workforce is needed to meet the needs of NY's MCH population. As stated previously, at the community level, the majority of services and programs are implemented by local partners including LHDs, universities and academic medical centers, hospitals and clinics, and community based organizations.

To best meet the training and technical assistance needs of these partners, Centers of Excellence (COEs) have been established that provide information and education to major Title V provider groups, including COEs for adolescent health, family planning, and reproductive health. This allows the Title V program to provide maximum support to this MCH workforce including facilitating access to experts in the field, research, updates on new and emerging evidence to guide practice, and technical assistance to improve practice. The family planning and reproductive health COE is also facilitating performance improvement efforts within the network of family planning providers. The COEs not only provide opportunities for current practice improvement efforts, but serves to provide MCH program staff with expertise in the science of improvement to lead quality efforts in the future.

MCH providers also use funds provided by the Title V program to access qualified and competent staff, participate in training and conferences and other activities to improve the quality of the workforce providing services. Title V advocates for staff to attend national conferences whenever possible to continue to build expertise in the MCH arena and make connections on the federal level as well as develop partnerships across states to continue to improve NY's approach to improving the health and wellness of the MCH population. Information is shared within the Title V program and with DOH partners through efforts such as Info for Action bulletins on MCH topics such as smoking in pregnancy, oral health, safe sleep and other priority MCH topics. A quarterly newsletter created by Title V program's social and emotional wellness team (Social Emotional Wellness SEW), provides staff with information and learning opportunities to improve knowledge on the tenets of social and emotional wellness as it relates to Title V work.

As previously discussed, NY's Title V program also leads various efforts with health care providers, hospitals and other professionals throughout NYS to enhance practice. These include, but are not limited to, the improvement initiatives through New York State Perinatal Quality Collaborative (NYSPQC), training and information provided to and through professional organizations such as the identification of children with Autism Spectrum Disorder (ASD), the identification and treatment of hypertension during pregnancy, screening and referral of children for oral health services, application of fluoride varnish by pediatricians and other health professionals to improve oral health, addressing maternal hemorrhage and a range of other topics. Title V staff in collaboration with other partners are leading efforts to update standards for the system of perinatal hospital care in NYS. The development of the NYS Partnership for Maternal Health as discussed in the Annual Report and Application section further supports efforts to promote public awareness and clinical quality improvement efforts to improve maternal and infant mortality and morbidity through women's health and preconception health.

Title V staff within DOH are the core of the Title V program and responsible to ensure the scope and mission of Title V is carried out in NYS. To ensure a strong focus on the needs of the Title V programs, strong connections and linkages are maintained with resources supported through HRSA. NYS Title V staff continued to receive technical assistance and coaching from the University of North Carolina's Workforce Development Center (WDC) regarding the planning and implementation of a state systems mapping initiative regarding the systems of care for CSHCN and their families. A strong relationship has been built through these efforts as a member of NY's Title V Health Equity team is now a member of UNC's Health Equity Committee. Title V staff also consulted with UNC for information that formed the basis for NYS' CSHCN systems mapping initiative. In April 2017, Title V staff participated in a webinar in which UNC faculty provided instruction on group map facilitation to Title V staff. With the solid understanding of the theory and practice of systems mapping techniques, developed with the assistance of the UNC Workforce Development Center, Title V staff were able to tailor the technique to better fit program needs, conduct independently facilitated stakeholder group discussion, gather systems level data, and begin the analytical phase. The value of this technical assistance and coaching goes beyond completion of the immediate systems mapping initiative by helping to provide professional development opportunities for several Title V staff.

Title V continues to foster the growth of the MCH workforce by encouraging staff to access the Association of Maternal and Child Health Programs' (AMCHP) educational opportunities to network and grow in the field of MCH. An AMCHP representative regularly presents at the NYS MCHSBG Advisory Council meetings to ensure NYS has the most current information from the federal level. DOH is a membership organization of AMCHP and Title V staff participate in the periodic AMCHP policy and informational calls.

NY's Title V program is committed to improving health equity for all New Yorkers. In order to further this agenda, Title V staff

require an in-depth understanding of those factors and actions leading to disparities and share a common understanding of the issues. The Title V Health Equity team identified four courses focused on various aspects of health equity. These have been packaged into a comprehensive health equity curriculum with pre- and post-evaluation modules. All existing and incoming staff regardless of role and responsibilities (from support staff through upper management), will be required to complete the series in 2018. Through this workforce development initiative, leadership aims to sensitize and inform staff on the issues of health equity, which impacts all aspects of Title V work.

Title V leadership also promotes and supports staff development on an ongoing basis at periodic DFH-wide meetings. To further enhance staff skills in health equity, and to continue to promote an environment of continuous learning, the Title V program hosted a DFH-wide full day training led by a nationally recognized expert on issues related to poverty, entitled "Bridges Out of Poverty-Bridges to Health Care". The focus of the training was to develop a greater understanding of the challenges and barriers people in poverty face so as to better develop program strategies to address the needs of people in poverty. Leadership underscored the importance of this training by strongly encouraging all staff to attend and enabled this by arranging back-up administrative coverage for essential staff so that they could attend. Over 100 staff attended the training including partners across the Center for Community Health and Office of Public Health. In order to further solidify the concepts presented at the training, the Health Equity team is hosting four "lunch and learn" discussions of the material covered in the training that can be attended by any interested staff participant. By gaining a greater understanding, NY's Title V program will have the ability to foster and promote programs and practices that support the movement to complete health equity for all in NYS.

In addition, staff benefit from presentations on initiatives in other areas within the DOH. Staff from the Title V program as well as OHIP, other Divisions within the CCH and other DOH staff focusing on the MCH population have provided and/or participated in training on such topics as social determinants of health projects, reproductive health in a social justice framework and DSRIP. In collaboration with OHIP, Title V staff also developed and provided training for care managers in Health Homes on topics such as the impact of chronic health issues on birth outcomes and the importance of preconception health. Bureaus within the DFH are equally committed to workforce development. Professional development has become a component of regularly held bureau staff meetings such as a recently help session on evidence-based practice by a COE. This provide staff an opportunity to learn about the work of their peers, and an opportunity to develop and polish their personal presentation skills to enhance staff's ability to network and partner with internal and external stakeholders and partners.

An innovative staffing structure that has become incorporated into the fabric of the Title V program and described earlier, is the creation of cross functional teams designed around the SAP priority areas. These teams, originally established in year one of this grant cycle, not only help to develop and monitor the implementation of strategies, but also provide members with valuable workforce development opportunities. Staff work outside their specific position descriptions to take a more global approach to the overall priority area. Ongoing opportunities for leadership and public presentation are embedded in the actions of the teams. Furthermore, there was a specific effort to strengthen the data team that was expanded to include all research scientists/data analysts within the DFH to foster information sharing, knowledge transfer and collaboration.

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

professional care across the lifespan of people from diverse communities and cultures. The Title V program hosts up to two dental residents annually.

As an outgrowth of the partnership between the SPH and DOH, a HRSA MCH Catalyst Program grant was awarded to develop an increased focus on MCH and prepare students for MCH careers. Rachel de Long, M.D., M.P.H., the former Title V director, is continuing her work as co-director of the MCH Catalyst Program at the SPH. The Catalyst program offers academic coursework in MCH, funds MCH-related internships for SPH students in local community-based partner organizations that may not otherwise have the funds to support student interns, supports student and faculty travel to MCH conferences, and facilitates a wide array of professional development opportunities for both students and MCH practitioners. The partnership with NY's State Title V program is a distinguishing strength of the Catalyst Program.

In tangible recognition of the state's commitment to ensure a highly qualified state workforce, enhance staff retention and recruitment and support staff development, the NY Governor's Office of Employee Relations offers tuition reimbursement for all staff who are interested in furthering their education at the undergraduate and graduate level. This employee benefit helps to ensure that NY's workforce remains competitive and up-to-date in this complex and ever changing economic landscape.

Title V will continue to make workforce development a priority and promote internal and external efforts to address these needs. See Attachments for the DOH organizational chart and description of core Title V leadership.

III.E.2.b.ii. Family Partnership

As stated previously, at the community level, most services and programs are implemented by local partners. When procuring services, efforts are made to locate services within communities provided by individuals from the community or reflective of the diversity of the community. Contractors are required to obtain consumer input from the MCH population served whether it is membership on a board to guide services, workgroups to provide input regarding education materials or outreach strategies, or direct input from families served. In a state the size and complexity of NY, obtaining input through provider organizations or other organizations representative of the population is the most practical, meaningful way to obtain input from the broad population that is MCH in NY. For example, family engagement is the essence in the Early Intervention Program's (EIP) State Systemic Improvement Plan quality improvement initiative that aims to improve family outcomes in EI service delivery. (Refer to the Annual Report and Application section for further detail.)

NY's Title V's commitment to families is evidenced by efforts such as the long-standing Family Initiatives Coordination Services Project that coordinates the development and implementation of a variety of family initiatives including training and support for parents involved in the EIP to become advocates for special needs children at local, state and national levels continues. Parents are also members of the EI Coordinating Council as well as the MCHSBG Advisory Council and provide valuable input to guide policy and practice. Michele Juda, executive director of Parent to Parent of NYS has been designated as a member of NY's MCHSBG Advisory Council and NY's family representation to AMCHP.

NYS has a long history of partnering with families and family organizations to achieve positive outcomes throughout the life course. The CSHSN Program requires contractors to provide program outreach and awareness regarding the local CSHCN Program, gap-filling programs and community resources. The goal of these activities is to empower families of CSHCN and youth/young adults with special health care needs to navigate the systems of care.

Families and family-led organizations are participating in the CSHCN Program's systems mapping initiative. Parent to Parent of NYS is contracted to host five regional meetings with parents of children with special health care needs. At these meetings, Parent to Parent staff and Title V staff worked collaboratively to facilitate discussion and obtain parental feedback for group charts itemizing needs, services and barriers. At least one session was conducted in two languages. Families Together of NYS, a family-led support organization for those children affected by mental illness, worked with Title V to host a group information gathering session for family feedback. This feedback contributed to the needs assessment for CSHCN and their families and will continue to inform the Title V work going forward.

The Title V CSHCN Program collects family satisfaction survey results directly from those families served. More information is provided about the survey results in the CSHCN domain report. The CSHCN Program is working to provide staff development opportunities for local CSHCN Programs through statewide discussions with local contractors regarding activities that support families of CSHCN. The first session was held in March 2018.

NYS has a large network of 255 SBHC sites. New School Based Health Center sites are required to convene a Community Advisory Board for the first three years in operation. At least one family representative serves on the SBHC Advisory Board.

Finally, efforts are being made to connect with the community to ensure all supports and services meet the expectations and the need of the community. This is evidenced by the MCH Listening forums that were held last year and discussed in the Annual Application and Report section. This model will be used as the Title V program and others work to plan and implement the Listening Forums on Maternal Mortality, a Governors' priority, that will be conducted over the next few months. NY's Title V program has a strong commitment to strengthen these connections to the community to promote health equity and improve health outcomes going into the future as well.

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

III.E.2.b.iii State Systems Development Initiative (SSDI) and Other MCH Data Capacity Efforts

One of the main objectives of the SSDI is to build and expand NYS MCH data capacity to support Title V program activities and contribute to data-driven decision making, including assessment, planning, implementation and evaluation. Improving data integration and utilization allows for greater ability to assess trends in outcomes, including health disparities. With the changing landscape of NYS' population, services and resources, coupled with health reform changes that seek to improve outcomes while not increasing costs, there is an increased demand for quality data that is available to MCH decision makers, program administrators and staff who are monitoring and evaluating programs.

The Title V program and SSDI staff guide the collection and analysis of the data that form the basis for the Needs Assessment Summary and the SAP which describe NY's priority needs, key strategies and activities and National Health Status/Outcome Measures (NHS/OMS), NPMs and SPMs and structural and process measures (S & PMS). Staff continue to partner with stakeholders to review and discuss relevant MCH data, and recommend structural and process measures used to monitor progress in all maternal and child health population domains.

In 2018 staff will continue to guide the development, selection, refinement and/or tracking of data and performance measures that are associated with the Title V MCHSBG priorities for the purpose of ascertaining progress towards achieving reported goals. Staff will also continue to participate on teams to support the MCHSBG Application/Annual Report by assisting with the coordination of data collection for reporting minimum and core data set elements (M/CDS), NPMs and SPMs both within and outside the DFH; contribute to ad hoc data analyses and write summaries of data analyses relevant to the MCH population for the MCHSBG Application/Annual Report. These activities prepare Title V to submit the NPMs and related structural/process objectives as part of the MCHSBG Application/Annual Report.

Staff are also assisting with the development of a plan to improve data linkages across the five-year funding cycle, particularly focusing on indicators from the M/CDS for Title V MCHSBG programs, and in FFY 2018 through FFY 2022, SSDI staff will implement the plan for overcoming identified barriers. NYS is currently reporting seven of the Core/National Dataset elements and six of the Core/State Dataset elements as part of the MCHSBG. In 2019, staff will continue to perform a gap analysis based on amended or added CDS elements. Staff will review the CDS gap analysis with Title V and Public Health Information Group (PHIG) staff to discuss strategies to improve NYS capacity to report additional CDS elements.

NYS has a strong commitment to data systems development, and invests in infrastructure to promote data linkages and timely reporting to assess, monitor, and evaluate Title V programming in NYS including: Newborn Screening Program data; Vital Records (births, deaths); NYC Vital Records (births, deaths); SPDS; CSHCN Database; EIP Data; Behavioral Risk Factor Surveillance System; CDC Pregnancy Risk Assessment Monitoring System; Immunization Information System; Medicaid; Quality Assurance Reporting; Statewide Planning and Research Cooperative System; National Survey of Children's Health; Early Hearing Detection Intervention; CDC Breastfeeding Report Card; National Immunization Survey; Sexually Transmitted Disease Surveillance; United States Current Population Survey; National Pediatric Nutrition Surveillance System; National Survey of Children with Special Healthcare Needs, and United States Census data.

As reflected in the Executive Summary of this application, Title V staff worked with the DOH's OPHP to develop a MCH dashboard, mirroring the objectives and outcomes reflected in NY's SAP. The dashboard mirrors one that was developed for NY's PA as it provides clear and easy access to key data points and clearly show NY's progress in these priority outcomes. In 2015, the DOH and Office of Information Technology Services received the **Best Data Analytics/ Business Intelligence Project** award for the PA dashboard from the Center for Digital Government for its promotion of civic engagement, transparency and government

performance. NY's MCH dashboard reflects the same format and principles for ease in access and understanding while also allowing partners to identify and address priority MCH issues on the local level. The MCH dashboard is organized by Title V domains and includes metrics that align with NY's SAP including metrics focusing on MCH outcomes such as pregnancy planning, maternal mortality and morbidity, non-medically indicated elective deliveries, neonatal abstinence syndrome, breastfeeding, very low birth weight births at Level III or above perinatal hospital, newborn hearing screening follow-up, infant, neonatal and post-neonatal mortality, child and adolescent obesity and social emotional wellness, CSHCN supports, oral health measures and many others reflecting the status of NY's MCH population. Disparity measures are included as well. The dashboard also includes a county breakdown for those measures that can be reported as such to allow local assessment and intervention. Targets are being established and the expected release for MCH Dashboard 1.0 is Summer 2018. This dashboard will enable LHDs and community partners to assess the status of the MCH population and prioritize efforts to improve the health and wellness of NY's MCH population.

In addition, the Title V program has initiated several efforts to increase data capacity and advance the development and utilization of linked information systems between key MCH datasets in NYS to improve access to electronic MCH health data. Updates on these various data linkage projects are as follows:

- NYS and NYC Linked Birth and Infant Death Data: Linked birth and infant death data sets are currently available for use by the Title V program for infant deaths occurring between the years 2002 and 2015. In this statewide linked data set, information from the death certificate is linked to information from the birth certificate for each infant under 1 year of age who was born and died as a NYS resident. The linked files include information from both the birth and death certificates. The linked birth and infant death data are used to meet Title V's need to identify mortality patterns during the neonatal and post neonatal time periods and risk factors present at birth needed for prevention planning to lower the burden of and decrease disparities in infant mortality (IM) rates. Title V staff has requested the 2016 NYS and NYC linked birth and infant death data from internal partners in the OQPS that will be used for maternal and infant morbidity/mortality surveillance and Title V monitoring and reporting.
- Statewide Perinatal Data System (SPDS): The SPDS is an electronic maternal and newborn data collection system which was established and is currently maintained by the DOH with the purpose of improving prenatal, obstetric and newborn care for mothers and infants in NYS. The SPDS was developed to make data available for the DOH and hospitals for monitoring and quality improvement. Web-based and modular in design, the Core module comprises the electronic birth certificate (EBC) that captures birth data in hospitals outside of NYC, and an additional module (NICU module) that captures data on high risk newborns admitted to neonatal intensive care units across NYS. EBC data for births in NYC hospitals are captured in a separate by coordinated system. The SPDS links individual-level data elements related to clinical measures and interventions, participation in public programs, demographics, and psychosocial and socioeconomic characteristics from various data sources including the NYS/ NYC live birth certificate and other sources specific to maternal and newborn health and care in hospitals and birthing centers. The SPDS has been used to conduct public health surveillance of birth outcomes and develop and implement an expanded plan for analysis and reporting of infant mortality and selected morbidity data, and issue initial data reports. The NICU Module of the SPDS is currently being used by the NYS Perinatal Quality Collaborative (NYSPQC) for the Enteral Nutrition Project.

- NYS and NYC Linked Birth, Death and Hospital Discharge Data for Maternal Mortality and Morbidity: Linked Files for Maternal Morbidity/Mortality: The NYS Maternal Mortality Review (MMR) aims to identify female deaths that were pregnancy-related (either directly caused or exacerbated by the pregnancy) and to conduct a comprehensive review of factors leading to these deaths, and provide information to develop strategies and interventions to decrease their risk. This is achieved through complex linkages between NYS death records of women ages 10-55 years old, NYS and NYC birth records, and SPARCS records. The Title V program uses the statewide linked file to compile a complete view of the factors leading to maternal deaths with the goal to inform interventions to reduce the risk of these deaths. Title V staff works closely with the OQPS with a common goal of improving data quality and completeness on administrative state databases. During the reporting period, Title V staff obtained access to preliminary 2017 death records for deaths occurring outside NYC. Title V staff obtained permission to work with provisional NYC death records for 2016 for the same purpose. Quarterly linkages between statewide death records and hospital inpatient discharges provide additional sources of data for our maternal and infant mortality and morbidity efforts.
- Linked NYS Early Intervention Program (EIP) and with Special Health Care Needs: To strengthen coordination and collaboration between EIP and CSHCN programs on the local level, Title V staff have facilitated ongoing discussions and webinars between staff of both programs to ensure coordination of services for families of CSHCN, including supports and services after the child has aged out of EIP. During the Fall of 2017, Title V staff updated the CSHCN database to enable the collection of more detailed information on the NYS CSHCN population.
- Pregnancy Risk Assessment Monitoring System (PRAMS) Data Linked to NYS Birth Data: In the winter of 2018, PHIG staff developed the statewide 2015 PRAMS indicator sets that will be used by Title V staff for tracking programmatic activities, including oral health care during pregnancy, infant sleep positioning and breastfeeding practices.
- Early Hearing Detection and Integration EHDI-IS 2.0: A new version of the front-end web EHDI-IS application has been developed and integrated with the New York State Immunization Information System (NYSIIS). Functionality of the new EHDI application has been tested and Title V staff is preparing to merge 1.3 million Vital Records with newborn hearing screening records by July 2018.

In addition to the above-mentioned data linkage projects, during the reporting period Title V staff participated in a training webinar on the use of the 2016 National Survey of Children's Health data, and has begun using the Data Resource Center for Child and Adolescent Health Interactive Data Query Tool for a variety of Title V monitoring, including tracking CSHCN.

The OQPS within DOH is continuing to develop the All Payor Database (APD), a comprehensive health claims and clinical database aimed at improving quality of care, efficiency, cost of care and patient satisfaction available in a self-sustainable, non-duplicative, interactive and interoperable manner that ensures safeguards for privacy, confidentiality and security. The vision of the APD is "to provide policymakers, researchers and consumers with the most comprehensive health database in NYS to achieve the triple aim of improving patient experience; improving population health; and reducing the costs of health care." NYS is among a handful of states in the implementation phase. At present NYS's APD includes 10 years of hospital discharge (SPARCS) and Vital Records (VR) death data, plus 5 years of Medicaid claims and encounter data, and ultimately will integrate VR birth data and commercial claims data as well as other public health registries and electronic health records. This tool will be an invaluable source of comprehensive and longitudinal MCH data for the Title V program, and will allow for more direct access to vital statistics, hospital discharge and Medicaid data.

III.E.2.b.iv Health Care Delivery System

As stated in the State Overview section of this application, NY's Title V program has a strong collaborative partnership with OHIP, the organizational unit within DOH that oversees NY's Medicaid program. Other sections of the application address the strong collaborative ongoing work that benefits NY's MCH population. This section will specifically address a new focus for Medicaid Redesign in NYS with strong implications for improvements for the MCH population. In July 2017, the First 1000 Days on Medicaid initiative was unveiled. This initiative recognizes that a child´s first three years are the most crucial years of their development and about 59% of NY's Children are currently covered by Medicaid. Since there is evidence that children on Medicaid have better health and life outcomes, NY´s Medicaid program is leading efforts to work with health, education and other systems and stakeholders to maximize outcomes and deliver results for the children NY serves.

The First 1000 Days is a collaborative effort, bringing together stakeholders that provided input into actionable activities to improve outcomes for children in their first 1,000 days of life. After extensive input, the following initiatives were identified including:

- Create a preventive pediatric care clinical advisory group framework model for how best to organize well–child visits/pediatric care in order to implement the *Bright Futures* Guidelines.
- Promote early literacy through local strategies that involves Medicaid launching three–year pilots to expand the use of Reach Out and Read (ROR) in pediatric primary care and foster local cross–sector collaboration focused on improving early language development skills in children ages 0 – 3.
- Expand centering pregnancy that involves Medicaid supporting a pilot project in the communities of poorest birth outcomes to encourage obstetrical providers serving Medicaid patients to adopt this model.
- NYS developmental inventory upon kindergarten entry that involves the SED, Medicaid, and other partners to agree upon a measurement tool to assess child development upon Kindergarten entry
- Statewide home visiting that requires Medicaid to take steps to ensure the sustainability of home visiting in New York so every child and pregnant woman who is eligible and desiring of the services receives them
- Require the DOH to have a two-year kids quality agenda to improve managed care plan performance on children and perinatal health care quality measures.
- Data system development for cross-sector referrals requires Medicaid to direct competitive grant funds to at least 3 communities for the purchasing of a Medicaid–determined hub–and–spoke data system that enables screening and referrals across clinical and community settings.
- Braided funding for early childhood mental health consultations involves OHIP convening a design committee with colleagues in the OMH, OPWD, OASAS, OCFS, and potentially SED to explore a braided funding approach for paying for mental health consultation services to early childhood professionals in early care and education settings
- Parent/caregiver diagnosis as eligibility criteria for dyadic therapy involves Medicaid allowing providers to bill for the provision of evidence–based parent/caregiver–child therapy based solely on the parent/caregiver being diagnosed with a mood, anxiety, or substance use disorder.
- Pilot and evaluate nine pilot peer navigators in multiple settings that would provide peer family navigator services.

Title V program staff have provided leadership and guidance in the development of the 1000 days initiatives and are participating in its implementation. Title V staff participate in weekly planning calls with OHIP and serve on several of the project workgroups. The goals of several Title V's current programs are consistent with the goals for this initiative and will contribute to improved outcomes.

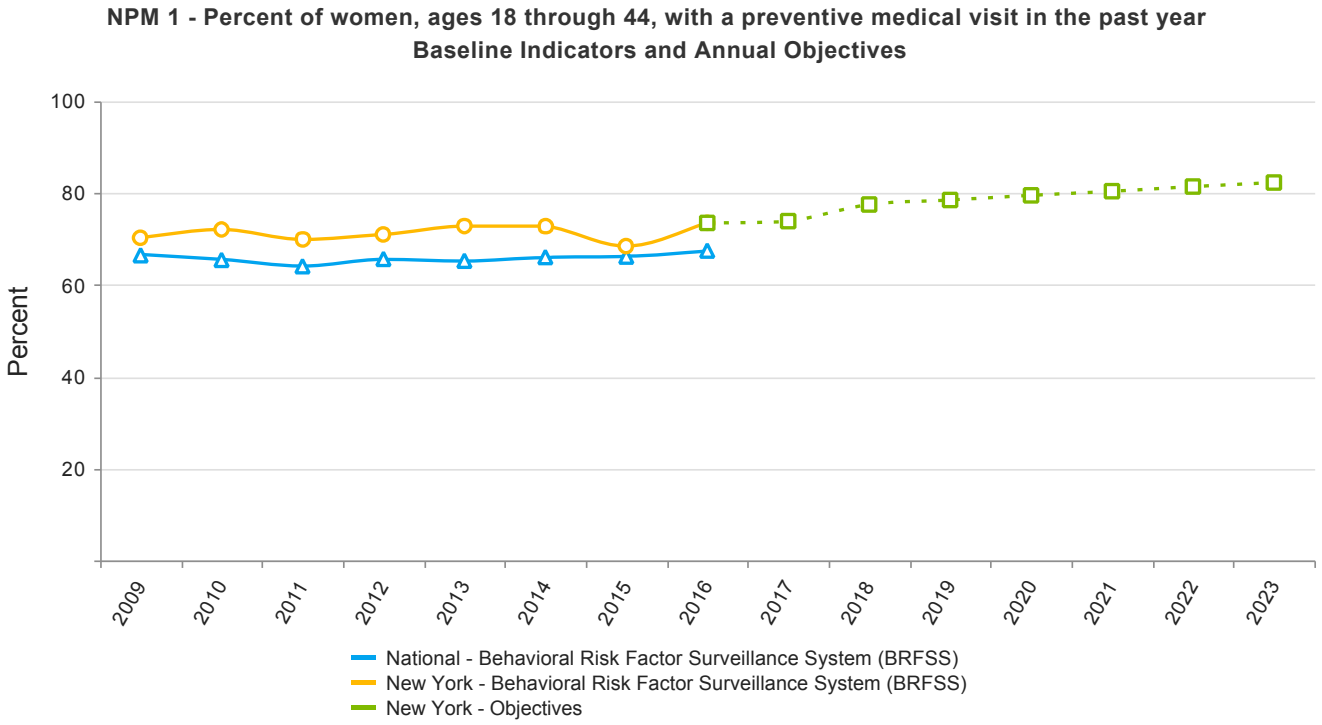
III.E.2.c State Action Plan Narrative by Domain

Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2015	214.3	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2012_2016	19.2	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2016	7.9 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2016	9.0 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2016	23.5 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2015	5.2	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	4.6	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2015	3.2	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	1.5	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2015	168.2	NPM 1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS-2015	8.3 %	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2015	4.2	NPM 1
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2016	8.4 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	89.3 %	NPM 13.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	13.2	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2015	12.2 %	NPM 1

National Performance Measures



Federally Available Data		
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)		
	2016	**2017**
Annual Objective	73.4	73.8
Annual Indicator	68.4	73.3
Numerator	2,471,455	2,653,864
Denominator	3,612,104	3,619,067
Data Source	BRFSS	BRFSS
Data Source Year	2015	2016

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	77.4	78.4	79.4	80.3	81.3	82.2

Evidence-Based or –Informed Strategy Measures

ESM 1.3 - Percentage of DFH procurements that complete community listening forums as part of concept development process.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		40
Annual Indicator	5	5.3
Numerator		1
Denominator		19
Data Source	Title V Program Records	Title V Program Records
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	5.0	5.0	11.0	16.0	21.0	26.0

ESM 1.7 - The number of relevant Title V programs that demonstrate incorporation of strategies to reinforce well-woman and preconception health care services.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	11	7
Numerator		
Denominator		
Data Source	NYS Title V Program Records	NYS Title V Program Records
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

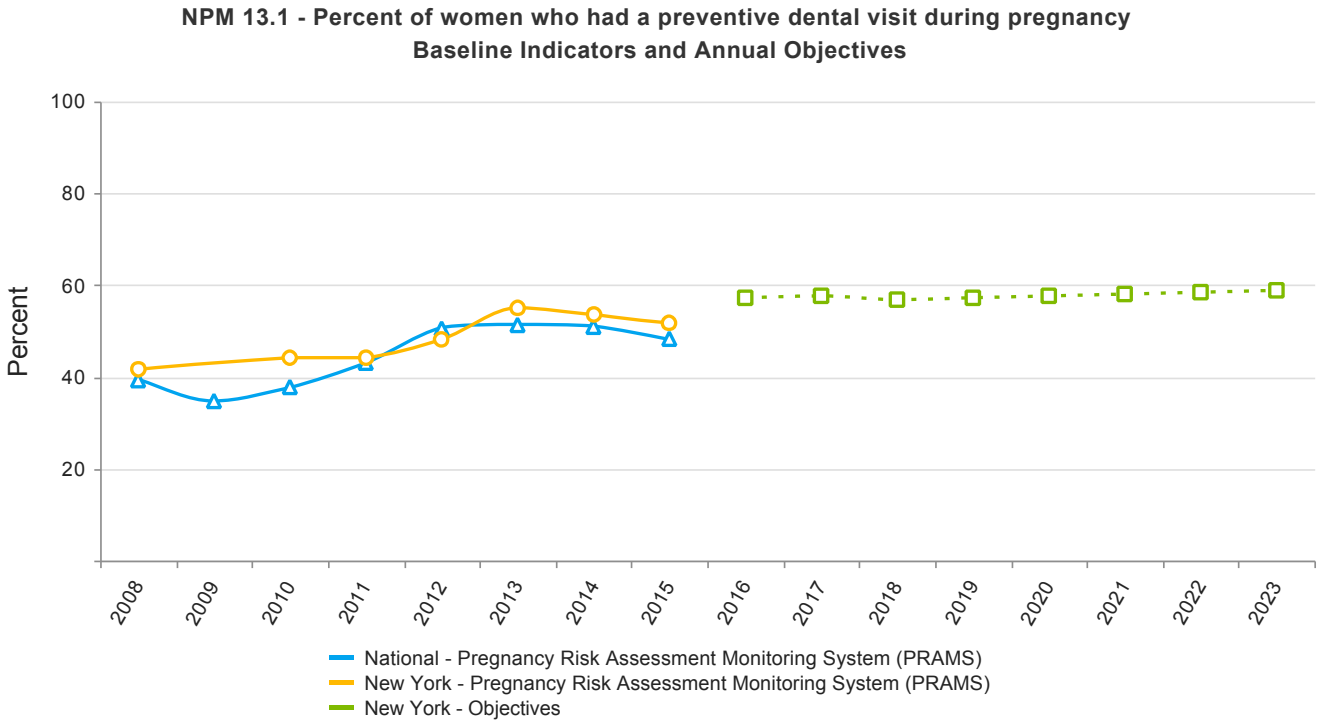
Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	7.0	7.0	7.0	8.0	8.0	8.0

ESM 1.14 - Percentage of women enrolled in Medicaid who are screened for maternal depression during postpartum care.

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	87
Annual Indicator	6.2
Numerator	
Denominator	
Data Source	Medicaid claims
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	6.4	6.6	6.8	7.0	7.2	7.4



Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2016	**2017**
Annual Objective	57.2	57.6
Annual Indicator	54.9	51.7
Numerator	117,570	110,325
Denominator	214,301	213,585
Data Source	PRAMS	PRAMS
Data Source Year	2013	2015

State Provided Data		
	2016	2017
Annual Objective	57.2	57.6
Annual Indicator	53.5	51.7
Numerator		
Denominator		
Data Source	PRAMS NYS	PRAMS NYS
Data Source Year	2014	2015
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	56.8	57.2	57.6	58.0	58.4	58.8

Evidence-Based or –Informed Strategy Measures

ESM 13.1.1 - Percentage of pregnant women served by Title V community health workers that have a documented screening or referral for dental services.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		10
Annual Indicator	36.7	45.3
Numerator		
Denominator		
Data Source	MICHC reports	MICHC reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	50.0	50.0	50.0	50.0	50.0	55.0

State Performance Measures

SPM 1 - The percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		45
Annual Indicator	36.4	35.2
Numerator		
Denominator		
Data Source	BRFSS	BRFSS
Data Source Year	2014	2016
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	36.4	36.4	38.2	38.2	40.1	40.1

SPM 2 - The percentage of women aged 15 to 44 years that adopt or continue use of the most effective or moderately effective methods of contraception.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		8
Annual Indicator	27	24.5
Numerator		
Denominator		
Data Source	Medicaid Claims	Medicaid Claims
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	25.0	25.0	26.3	26.3	27.6	27.6

SPM 5 - The percentage of NYS residents served by community water systems that have optimally fluoridated water

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		72
Annual Indicator	71.7	71.6
Numerator		
Denominator		
Data Source	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	73.0	75.0	77.0	78.5	78.5	78.5

State Action Plan Table

State Action Plan Table (New York) - Women/Maternal Health - Entry 1

Priority Need

Reduce maternal mortality and morbidity

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

Objective MWH-1: Reduce the maternal mortality rate in NYS by 22%, to 16.1 maternal deaths per 100,000 live births in 2020.

Objective MWH-2: Increase the percentage of women enrolled in Medicaid who are screened for maternal depression during postpartum care by 5% to 6.8%.

Strategies

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

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

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

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

Strategy MWH-5: Collaborate with partners to increase screening and follow-up support for maternal depression.

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

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

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

Strategy LC-3: Incorporate performance measures and strategies to reinforce use of well-woman care including pregnancy planning and prevention across core Title V programs serving women of reproductive age, including: Family Planning Program, Maternal & Infant Community Heath Collaboratives, Maternal, Infant & Early Childhood Home Visiting, Perinatal Regionalization and School-Based Health Centers.

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

Strategy LC-14: Build internal capacity within the Division of Family Health (DFH)/ Title V Program to advance health equity through all Title V programs, including: creation of a cross-program DFH Equity Action Team; completion of an organizational assessment of equity practices, and facilitation of staff training and professional development through Equity Learning Labs.

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

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

Note: Life Course Strategies and associated ESMs are fully described in the Life Course Domain, and repeat across multiple relevant domains/ priorities consistent with their cross-cutting design.

ESMs	Status
ESM 1.1 - Number of Title V programs for which health equity analyses are completed	Inactive
ESM 1.2 - a) Number of Equity Action Team meetings held; b) Number of DFH staff who have completed one or more Equity Learning Labs	Inactive
ESM 1.3 - Percentage of DFH procurements that complete community listening forums as part of concept development process.	Active
ESM 1.4 - Percentage of DFH procurements that demonstrate inclusion of evidence-based/-informed communityengagement and collective impact strategies.	Inactive
ESM 1.5 - The number of Title V programs with health insurance elements incorporated in program requirements.	Inactive
ESM 1.6 - The number of analytic reports developed and shared.	Inactive
ESM 1.7 - The number of relevant Title V programs that demonstrate incorporation of strategies to reinforce well-woman and preconception health care services.	Active
ESM 1.8 - Maternal mortality report issued at least annually.	Inactive
ESM 1.9 - Severe maternal morbidity surveillance initiated and operationalized by program.	Inactive
ESM 1.10 - Number of policy, community prevention or clinical quality improvement strategies implemented in past year as a result of the Partnership collaboration.	Inactive
ESM 1.11 - Percentage of managed care organizations that provide reimbursement for postpartum LARC insertion.	Inactive
ESM 1.12 - Percentage of women enrolled in Medicaid Managed Care who are screened for maternal depression during a) prenatal care; b) postpartum care.	Inactive
ESM 1.13 - Title V staff participate in intra-and inter-agency groups developing response to opioid use.	Inactive
ESM 1.14 - Percentage of women enrolled in Medicaid who are screened for maternal depression during postpartum care.	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

State Action Plan Table (New York) - Women/Maternal Health - Entry 2

Priority Need

Increase the use of preventive health care services across the life course.

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

Objective LC-1: Increase the percentage of women 18-44 years old with a past year preventive medical visit by 10% to 79.4%.

Objective LC-2 (same as CH-2): Increase the percentage of children 9-35 months who received a developmental screening using a parent-completed screening tool by 5%, to 18.4%.

Objective LC-3 (same as AH-3): Increase the percentage of adolescents ages 12-17 who received a preventive health care visit in the last year by 5% to 83.2%.

Strategies

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

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

Strategy LC-3: Incorporate performance measures and strategies to reinforce use of well-woman care including pregnancy planning and prevention across core Title V programs serving women of reproductive age, including: • Family Planning Program • Maternal & Infant Community Heath Collaboratives • Maternal, Infant & Early Childhood Home Visiting • Perinatal Regionalization • School-Based Health Centers

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

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

ESMs	Status
ESM 1.1 - Number of Title V programs for which health equity analyses are completed	Inactive
ESM 1.2 - a) Number of Equity Action Team meetings held; b) Number of DFH staff who have completed one or more Equity Learning Labs	Inactive
ESM 1.3 - Percentage of DFH procurements that complete community listening forums as part of concept development process.	Active
ESM 1.4 - Percentage of DFH procurements that demonstrate inclusion of evidence-based/-informed communityengagement and collective impact strategies.	Inactive
ESM 1.5 - The number of Title V programs with health insurance elements incorporated in program requirements.	Inactive
ESM 1.6 - The number of analytic reports developed and shared.	Inactive
ESM 1.7 - The number of relevant Title V programs that demonstrate incorporation of strategies to reinforce well-woman and preconception health care services.	Active
ESM 1.8 - Maternal mortality report issued at least annually.	Inactive
ESM 1.9 - Severe maternal morbidity surveillance initiated and operationalized by program.	Inactive
ESM 1.10 - Number of policy, community prevention or clinical quality improvement strategies implemented in past year as a result of the Partnership collaboration.	Inactive
ESM 1.11 - Percentage of managed care organizations that provide reimbursement for postpartum LARC insertion.	Inactive
ESM 1.12 - Percentage of women enrolled in Medicaid Managed Care who are screened for maternal depression during a) prenatal care; b) postpartum care.	Inactive
ESM 1.13 - Title V staff participate in intra-and inter-agency groups developing response to opioid use.	Inactive
ESM 1.14 - Percentage of women enrolled in Medicaid who are screened for maternal depression during postpartum care.	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

State Action Plan Table (New York) - Women/Maternal Health - Entry 3

Priority Need

Promote oral health and reduce tooth decay across the life course

NPM

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Objectives

Objective LC-4: Increase the percentage of NYS residents served by community water systems that have optimally fluoridated water by 8% to 77%

Objective LC-5: Reduce the prevalence of dental caries among children and adolescents ages 1-17 by 5%, to 8%.

Objective LC-6: Increase the percentage of children and adolescents age 1-17 years who had a preventive dental visit in the past year by 5% to 81%

• Objective LC-7: Increase the percentage of pregnant women who had a dental visit during pregnancy by 5% to 57.6%.

Strategies

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

Strategy LC-7: Increase the delivery of evidence-based preventive dental services across key settings: • school-based clinics • primary care practices • public health nutrition programs.

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

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

ESMs	Status
ESM 13.1.1 - Percentage of pregnant women served by Title V community health workers that have a documentedscreening or referral for dental services.	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (New York) - Women/Maternal Health - Entry 4

Priority Need

Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population(cross-cutting).

NPM

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Objectives

Objective LC-11: Increase the percentage of Title V staff that improve their knowledge of health equity concepts by 20% from baseline (baseline to be established in conjunction with Strategy LC-15).

Objective LC-12: Increase the percentage of DFH procurements that demonstrate application of health equity strategies listed by 20% from baseline (to be established in Year 2-3).

Objective LC-13: Reduce disparities for all selected national and state performance measures by 5% from baseline (targets vary by measure).

Strategies

ESM LC-13: # of Title V programs for which health equity analyses completed

ESM LC-14: a) # of Equity Action Team meetings held; b) # of DFH staff who have completed one or more Equity Learning Labs

ESM LC-15: Percentage of DFH procurements that complete community listening forums as part of concept development process

ESM LC-16: Percentage of DFH procurements that demonstrate inclusion of evidence-based/-informed community engagement and collective impact strategies

ESMs	Status
ESM 13.1.1 - Percentage of pregnant women served by Title V community health workers that have a documentedscreening or referral for dental services.	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (New York) - Women/Maternal Health - Entry 5

Priority Need

Reduce maternal mortality and morbidity

SPM

SPM 1 - The percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy

Objectives

Objective MWH-1: Reduce the maternal mortality rate in NYS by 22%, to 16.1 maternal deaths per 100,000 live births in 2020.

Objective MWH-2: Increase the percentage of women enrolled in Medicaid who are screened for maternal depression during postpartum care by 5%, to 6.8%.

Strategies

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

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

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

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

Strategy MWH-5: Collaborate with partners to increase screening and follow-up support for maternal depression.

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

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

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

Strategy LC-3: Incorporate performance measures and strategies to reinforce use of well-woman care including pregnancy planning and prevention across core Title V programs serving women of reproductive age, including: Family Planning Program, Maternal & Infant Community Heath Collaboratives, Maternal, Infant & Early Childhood Home Visiting, Perinatal Regionalization and School-Based Health Centers.

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

Strategy LC-14: Build internal capacity within the Division of Family Health (DFH)/ Title V Program to advance health equity through all Title V programs, including: creation of a cross-program DFH Equity Action Team; completion of an organizational assessment of equity practices, and facilitation of staff training and professional development through Equity Learning Labs.

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

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

Note: Life Course Strategies and associated ESMs are fully described in the Life Course Domain, and repeat across multiple relevant domains/ priorities consistent with their cross-cutting design.

State Action Plan Table (New York) - Women/Maternal Health - Entry 6

Priority Need

Reduce maternal mortality and morbidity

SPM

SPM 2 - The percentage of women aged 15 to 44 years that adopt or continue use of the most effective or moderately effective methods of contraception.

Objectives

Objective MWH-1: Reduce the maternal mortality rate in NYS by 22%, to 16.1 maternal deaths per 100,000 live births in 2020. Objective MWH-2: Increase the percentage of women enrolled in Medicaid who are screened for maternal depression during postpartum care by 5% to 6.8%.

Strategies

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

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

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

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

Strategy MWH-5: Collaborate with partners to increase screening and follow-up support for maternal depression.

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

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

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

Strategy LC-3: Incorporate performance measures and strategies to reinforce use of well-woman care including pregnancy planning and prevention across core Title V programs serving women of reproductive age, including: Family Planning Program, Maternal & Infant Community Heath Collaboratives, Maternal, Infant & Early Childhood Home Visiting, Perinatal Regionalization and School-Based Health Centers.

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

Strategy LC-14: Build internal capacity within the Division of Family Health (DFH)/ Title V Program to advance health equity through all Title V programs, including: creation of a cross-program DFH Equity Action Team; completion of an organizational assessment of equity practices, and facilitation of staff training and professional development through Equity Learning Labs

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

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

Note: Life Course Strategies and associated ESMs are fully described in the Life Course Domain, and repeat across multiple relevant domains/ priorities consistent with their cross-cutting design.

State Action Plan Table (New York) - Women/Maternal Health - Entry 7

Priority Need

Increase the use of preventive health care services across the life course.

SPM

SPM 1 - The percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy

Objectives

Objective MWH-1: Reduce the maternal mortality rate in NYS by 22%, to 16.1 maternal deaths per 100,000 live births in 2020.

Objective MWH-2: Increase the percentage of women enrolled in Medicaid who are screened for maternal depression during postpartum care by 5%, to 6.8%.

Strategies

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

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

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

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State Action Plan Table (New York) - Women/Maternal Health - Entry 8

Priority Need

Increase the use of preventive health care services across the life course.

SPM

SPM 2 - The percentage of women aged 15 to 44 years that adopt or continue use of the most effective or moderately effective methods of contraception.

Objectives

Objective MWH-1: Reduce the maternal mortality rate in NYS by 22%, to 16.1 maternal deaths per 100,000 live births in 2020. Objective MWH-2: Increase the percentage of women enrolled in Medicaid who are screened for maternal depression during postpartum care by 5%, to 6.8%.

Strategies

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

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

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

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

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

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

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FY 2017 Annual Report

Women's /Maternal Health – State Priority #1: Reduce maternal mortality and morbidity.

The factors impacting women's health are complex and varied, ranging from social-emotional issues, environmental impact, health insurance status, access to health care, to birth spacing and any number of other factors including the social determinants of health in which individuals are born, grow, live, work and age. Improving women's health throughout the lifespan is an essential component to improving the health and wellness of NY's women. NY's Title V program promotes and supports a myriad of efforts to improve the health of all women. Over the past year pursuant to NYs SAP, the Title V program continued to focus on improving access to health care, including access to the most effective forms of contraceptives; preconception health to promote women's health prior to pregnancy; and improving screening and treatment for maternal depression and substance use. All-encompassing is the goal to promote health equity for all New Yorkers, which is emphasized throughout all domains, and reflected in the Life Course section of this application.

As stated previously, access to comprehensive health care coverage is a significant factor in ensuring health care is accessible and available to women. Through the NYSOH, NY continued its efforts to enroll all New Yorkers into comprehensive health care coverage. There are now over 4.1 million New Yorkers with health insurance coverage through the NYSOH. The rate of uninsured New Yorkers has decreased from 10% to 5% since the opening of the NYSOH. In 2016, 92.9% of women in NY had coverage. Rates differed by race and ethnicity, with whites having the highest coverage rate (93.6%) and Hispanic or Latino having the lowest (83.5%). Education also influenced rates. Those who had less than a high school education had much lower rates of insurance (81.7%) than those with a Bachelor's degree or higher (94.6%). To address this, NY's Marketplace launched a statewide media campaign across TV, radio, print, digital, social media and out-of-home media to show how easy it is to get a health plan. Additionally, the Marketplace offered easier access to information including a NYSOH customer service center that responded to nearly two million calls in 2017 in over 108 different languages. Consumer educational materials are produced in 27 different languages. All Title V programs prioritize engaging families into health care coverage and, for many programs overseen by the Title V program, enrollment into health insurance is a required performance measure, to promote outreach and engagement for all uninsured women, children and families.

Maternal mortality and morbidity are critical indictors for maternal and women's health in NYS and therefore a priority in NY's Title V SAP. Understanding those factors associated with maternal mortality and morbidity is essential for improving maternal health outcomes. Therefore, a strategy for this domain continues to be a more complete analysis of factors impacting maternal mortality and morbidity. As stated in previous Title V applications, NYS has a history of more than a decade in assessing factors leading to maternal deaths and developing strategies to reduce the risk of maternal mortalities. NY's Title V program led the effort to establish the MMR Initiative in 2010, which is a comprehensive review of all maternal deaths. In the MMR Initiative, the DOH conducts comprehensive surveillance activities based on linked birth and death record data, hospital in-patient and emergency department data and a hospital-based adverse event reporting system to identify maternal deaths. The report summarizing findings from the surveillance of 2012-2013 cohort was released last year. The report is available at the link below:
https://www.health.ny.gov/community/adults/women/docs/maternal_mortality_review_2012-2013.pdf

Leading causes of maternal deaths (N=59) included: embolism (not cerebral) (31%), hemorrhage (19%), infection (15%), cardiomyopathy (11%) and hypertensive disorders (11%). This is a change from the previous report when hypertensive disorders represented the top leading cause of death. Another change from the previous report is that Black and White mothers contribute equally to the pregnancy-related cohort. In addition, the majority of pregnancy-related deaths were covered by Medicaid.

Racial disparities in maternal deaths are persistent; the statewide Black to White mortality ratio varied between 4.8 to 1 in 2005-2007 and 3.2 to 1 in 2011-2013. The most recent data showed that geographic differences are minimal. In New York City, the Black to White ratio decreased from 12.2 in 2007-2009 to 3.4 in 2013-2015. This decrease in the Black to White ratio was due to a slight increase in the maternal mortality rate among White women while the rate remained stable among Black women. Outside New York City, the Black to White ratio peaked in 2013-2015 at 3.9 to 1.

Recent data from NYS Vital Statistics showed that maternal deaths increased to 20.7 per 100,000 live births in 2013-2015 but remained lower than the Prevention Agenda (PA) 2013-2017: New York State's Health Improvement Plan goal to reduce maternal mortality (MM) to fewer than 21 maternal deaths for every 100,000 live births by 2018. By continuing the comprehensive review of factors leading to maternal deaths through the MMR Initiative and designing strategies to address those factors, Title V aims to continue to improve outcomes for mothers and babies.

The Title V staff is currently implementing an enhanced process for maternal death reviews developed in collaboration with the American Congress of Obstetricians and Gynecologists (ACOG-NY). The goal of these planning efforts is to develop a process that will not only address the population health approach, which includes surveillance and planning on a statewide level, but also enrich the process for providing health care providers and others with information needed to improve and enhance health care standards and practices. The process is being strengthened by instituting a formal multidisciplinary Maternal Mortality Review Board (MMRB) that will have an active role in each review. The MMRB will conduct a complete assessment of the causes of death, factors leading to death, preventability, and opportunities for intervention. The MMR findings on recent trends and issues will be translated into action through collaboration with ACOG-NY and other key stakeholders to develop Issue Briefs, Grand Rounds, and quality improvement projects through the New York State Perinatal Quality Collaborative (NYSPQC) with partners (e.g., hospital associations, professional associations, regional perinatal centers and affiliate obstetrical hospitals, among others). A maternal mortality report will also be issued to provide data and information that can be broadly used to improve maternal outcomes.

The reviews of the new cohort are underway. For 2014 a total of 119 cases were identified and 51% are completed. 2015 maternal death cases are not currently fully assessed or identified. 15 maternal deaths reported to the New York Patient Occurrence Reporting Tracking System (NYPORTS) are under review with 5 of them completed. NYPORTS is a mandatory adverse events system required by all hospitals pursuant to Public Health Law. One of the required adverse events for reporting is maternal death. Using provisional death records for deaths occurring outside NYC, deaths were identified for review for 2016 (112) and 2017 (59); out of these 21% are completed for 2016 and 46% for 2017. Since 2016 and 2017 data are not final, these numbers may change as data are updated.

In addition to maternal deaths, those women who experience Severe Maternal Morbidity (SMM) or "near misses", defined as experiencing life threatening medical complications (e.g., sepsis, embolism, etc.) and/or the need for life saving interventions (e.g., assisted ventilation) during delivery-related hospitalizations, are 50 – 100 times more common than maternal mortality. To fully understand those factors that influence both outcomes, Title V staff have focused on identifying cases of SMM through linked birth and hospital discharge data to conduct an analysis to define the major causes of maternal morbidity. A manuscript summarizing the findings of SMM surveillance in NY was published last year in PLOS-ONE. The study showed that perinatal regionalization in NY was effective in routing high risk pregnancies to higher levels of perinatal care birthing facilities. The race/ethnic disparities in severe maternal morbidity mirrored known disparities in maternal mortality and morbidity with White Non-Hispanic women experiencing the lowest odds for severe maternal morbidity at delivery. The one exception was that Black and White Non-Hispanic mothers with vaginal deliveries had similar experiences.

In general, women who deliver vaginally were less likely to experience severe maternal morbidity than women with cesarean deliveries. In addition, the odds of severe maternal morbidity among women who delivered vaginally decreased since 2010, yet the rate remained stable for cesarean deliveries. The risk factors for severe maternal morbidity depend on delivery mode: there is a lower risk of SMM associated with cesarean deliveries for deliveries of multiple infants or for pregnancies with hospital admissions before delivery. The Title V program is continuing to develop further analyses to understand these factors and work with key stakeholders and partners to disseminate and translate findings into action to improve maternal birth outcomes.

An outgrowth of the focus on maternal mortality and the work of the Public Health Committee of the NYS PHHPC discussed in NY's FY 2018 application, is the Partnership for Maternal Health (PMH) that was formed in 2015. The PMH is comprised of various key stakeholders including Title V staff, ACOG-NY, NY's hospital associations, New York City Department of Health and Mental Hygiene (NYCDHMH) and others with a common interest of identifying collaborative opportunities to decrease maternal mortality and morbidity. Recognizing that to improve maternal health outcomes, it is imperative for women to enter pregnancy in a healthy state, and that approximately 55% of the pregnancies in NYS are unintended, an initial priority of the PMH is preconception health.

Over the past year, to better address the breadth of this issue, the PMH invited additional health care providers and key stakeholders that intersect with women throughout the life course, to join the PMH. New invitees included NYS Association of Licensed Midwives, NYS Psychological Association, Nurse Practitioner Association of NYS, Emergency Medicine, the NYS Society of Physician's Assistants, among others. As part of the invitation, organizations could commit to varying levels of participation, from simply receiving updates on the work to actively participating in the PMH.

During the last year, a subcommittee of the PMH developed an instructional webinar on the importance of preconception care. The webinar is intended for healthcare providers caring for women of reproductive age, such as obstetricians, adolescent medicine specialists, internists, physician assistants, midwives, nurse practitioners, nurses and behavioral health providers. Its purpose is to increase the healthcare provider's understanding of the impact a woman's health care can have on pregnancy outcomes. Currently, continuing medical education credits are being sought for the webinar, which is slated for release in early summer 2018.

Internal partnerships are also contributing to this work. Meetings between Title V and DOH Division of Chronic Disease Prevention (DCDP) staff led to a collaboration on webinars for Medicaid Health Home staff. Office of Health Insurance Programs (OHIP) provides regular webinars for their Health Home providers and invites subject matter experts in the DOH to present on a variety of topics. To increase awareness among Health Home care managers about the importance of preconception health, Title V and DCDP staff co-presented webinars on management of hypertension and diabetes. Both webinars included a section on addressing pregnancy intendedness, the impact of chronic disease on pregnancy outcomes and the necessity for well woman care. An additional webinar was provided by Title V staff for Health Home staff on the broader aspects of well woman care and possible provider responses to patients' needs based on their pregnancy intention: yes, no, not sure.

As stated previously, approximately 55% of pregnancies in NYS are unintended or mistimed. One strategy for improving maternal health is decreasing unplanned pregnancies through increasing access to and use of effective and highly effective contraceptives. Since one of the most effective means of birth control is long acting reversible contraception (LARC), Title V staff have been collaborating with OHIP to: reimburse providers for the full range of contraceptive services; reimburse providers or health systems for the actual cost of LARC or other contraceptive devices to provide the full range of contraceptive methods; reimburse for immediate postpartum LARC by unbundling payment for LARC insertion; and remove administrative and logistical barriers to LARC. The DOH obtained approval from the Center for Medicare and Medicaid Services (CMS) to allow the cost of LARC to be paid to FQHCs separately from the Prospective Payment System (PPS) rate. This is significant as the acquisition cost of LARC can be prohibitive in many settings. Reimbursement for actual acquisition cost of LARC is available retroactively to April

1, 2016.

Title V staff and OHIP concluded participation in CDC's 6|18 Initiative. Lessons learned are being incorporated into other LARC initiatives. OHIP and Title V program widely distributed the changes in postpartum LARC reimbursement through the monthly Medicaid Update as well as to programs serving the MCH population and external partners such as ACOG. Additionally, NYSDOH participated in the Association of State and Territorial Health Officials (ASTHO) *Increasing Access to Contraception Learning Community* through the summer of 2017. The learning community focused on removing administrative and logistical barriers to LARC and included partners from around the state such as ACOG, the NYCDOHMH and Community Healthcare Association of NYS (CHCANYS). While the work in 6|18 and the ASTHO learning community have ended, the Title V program continues to work with a number of partners including ACOG, NYCDOHMH, and CHCANYS on the following activities: educate primary care providers on full range of FDA-approved contraceptive methods, including LARC; educate, train and support family planning providers and providers interested in providing family planning services to the full range of contraceptive methods, including LARC.

Promoting LARC was also a strategy through the Infant Mortality Collaborative Improvement and Innovation Network (IM CoIIN) initiative which ended in the fall of 2017. NY's Title V program specifically focused on promoting the use of LARC in the postpartum setting and increasing the number of providers integrating a question regarding pregnancy intention into delivery of primary care services. The IM CoIIN work was implemented through three strategies: community health worker (CHW) promotion (as discussed below) of effective contraception and the importance of the postpartum visit; promotion of integration of pre/interconception messages into routine preventive care services; and improved life course care for women related to pre- and interconception care in the following FQHC settings: walk-in pregnancy testing, pediatric clinic and primary care settings.

Title V in NYS also continued to support and promote direct outreach to engage women into health care, promote health insurance enrollment and entry into prenatal care. Through the Maternal and Infant Community Health Collaboratives (MICHC), CHWs focused on educating women on improved birth spacing, adherence to the postpartum visit, and use of an effective contraceptive method.

Through CHW efforts, from 2015 to 2017, there was an increase from 76.2% to 84.2% in providing information to prenatal clients about the importance of the postpartum visit and an increase from 76.2% to 78.9% in providing information to clients about effective contraception methods. The percent of clients selecting an effective contraception method in the prenatal period to use in the postpartum period increased from 38.9% to 64.3%. For postpartum clients, both adherence of the postpartum visit (PPV) and use of an effective contraception (EC) method in the postpartum period improved: adherence to the PPV increased from 45.5% to 85.3%, and EC use increased from 31.8% to 70.6%.

The FQHC CoIIN project discussed above demonstrated successes as well between 2015 and 2017: 100% of clients were asked about pregnancy intention, up from 75.2%; the use of an effective or highly effective contraceptive method/LARC rates increased from 44% to 59%; and the rates for client referrals for a highly effective/LARC method increased from 3% to 8%.

In addition to addressing women's physical health, NY's Title V program is addressing women's social-emotional health. Maternal depression has a significant impact not only on mothers themselves but also on the social-emotional stability of their children. NY's Title V program is committed to addressing the comprehensive needs of women. In 2014, legislation was enacted requiring hospitals to educate patients about maternal depression, maternal depression screening and referral. The Title V program in collaboration with the Office of Primary Care and Health Systems Management (OPCHSM) notified all obstetric hospitals of this requirement. Staff also researched and updated resources on the DOH web site, an activity that is done regularly to keep resources current. In addition, the Title V program initiated discussions with the Office of Mental Health (OMH) and other key stakeholders to discuss strategies to improve maternal depression screening and enhance resources for those women experiencing

depression. Finally, legislation was passed mandating that, to the extent depression screening is already a covered benefit, insurers must pay regardless of which health care provider performs the screening.

For the past few years, Title V staff have participated in a Prenatal Care workgroup with the Office of Quality and Patient Safety (OQPS) to promote collaboration and maximize resources. Title V staff provided input into the development and implementation of a study on the quality of prenatal care provided through the Medicaid Prenatal Care Program.
Selected medical records from provider agencies were reviewed to determine compliance with comprehensive care requirements such as required education, laboratory testing and screening, including screening for maternal depression. NYS specific data from the 2013 Medicaid Prenatal Care Study showed that 63% of women were assessed for depression during the initial prenatal visit, and 51.4% at postpartum visits, but among these only 7% of records documented using standardized screening tools. Medicaid Managed Care quality data from 2014 reviews suggest that depression assessment practices are improving for both prenatal (84.9%) and postpartum (84.4%) visits. Of the 5.3% of women who screened positive for depression during prenatal care visits, 90.2% were addressed in the practice or referred for care. During postpartum visits, 4.2% of women screened positive and 88% of those women who screened positive were addressed in the practice or referred for follow-up. (**ESM MWH-5: Percentage of women enrolled in Medicaid who are screened for maternal depression during postpartum care.)** While the screening rates have been improving, there is insufficient evidence to show that there has been an increase in the use of standardized screening tools and practitioners often identified a lack of treatment services as an issue for women who screen positive. Please note that the annual objective for this ESM has been adjusted going forward as the MMC study has concluded and data will now be obtained through Medicaid claims data.

Recognizing that women are more likely to seek health care for their infants than themselves in the postpartum period, OHIP released guidance in 2015 clarifying that pediatric providers could bill a mother's insurance if they screen her for depression and in 2016, released guidance that this can alternatively be billed to the child's insurance. OHIP provided two codes – one for a positive screen and referral and one for a negative screen. Pediatric providers began using the new screening codes in October 2016. The Title V program is collaborating with OHIP to obtain data reflective of this guidance implementation. Meanwhile, maternal depression screening practices among maternal providers will be used for program implementation and monitoring.

NY's Title V program is committed to continued work to address this significant health issue for mothers and children. In addition to the programs and initiatives already discussed, several new strategies were initiated in the past year to address maternal depression. The NYS Early Childhood Advisory Council (ECAC) identified early identification, prevention and intervention for maternal depression as a current priority, and convened a workgroup to develop and help advance relevant strategies. ECAC group members were active in NYS's First 1000 Days on Medicaid initiative (described elsewhere in this application), advocating for efforts to improve screening and treatment for maternal depression. Title V staff participate in this ongoing workgroup.

Two of the initiatives in the 10-point plan selected under the First 1000 Days on Medicaid initiative could positively affect maternal depression: Medicaid to allow providers to bill for the provision of evidence–based parent/caregiver–child therapy (also called dyadic therapy) based solely on the parent/caregiver being diagnosed with a mood, anxiety, or substance use disorder; and statewide home visiting, which would include a pilot in three communities and an identification of common programmatic elements that could be paid for through Medicaid funding. The first would allow for treatment of mothers identified as depressed and the second would help identify women through maternal depression screening conducted by home visitors.

Addressing the complex needs of NY's women requires interagency partnerships and collaboration among key stakeholders. The NYS OMH supports 17 HealthySteps programs in pediatric medical practices across the state. The HealthySteps model is an evidence-based pediatric primary care program focused on early child development and effective parenting. A child development professional (HealthySteps Specialist) connects with families during pediatric well child visits as part of the primary care team. The

NYS initiative provides full-time HealthySteps Specialists in medical practices to provide screening, including maternal depression, parental protective and risk factors, and social determinants of health.

The 17 HealthySteps sites have successfully completed the three-day National HealthySteps training from Zero to Three and received year-long technical assistance to support implementation. The 17 providers are fully operational and are engaging new parents to enroll their infants in the HealthySteps program by 4 months of age. Over 1300 children and their families were enrolled as of September 30, 2017; they are on track to reach target enrollment of nearly 6,000 families by end of year three.

OMH is conducting an independent evaluation of the HealthySteps practices. Sites are tracking the maternal depression screening tools used, referrals made and/or approaches to care and report challenges to accessing services when making linkages/referrals to supports and services. The Title V program continues to collaborate with OMH on improving efforts for maternal depression screening and referral for appropriate services.

To further enhance supports and services, the Title V program successfully collaborated on the development of an Early Childhood Comprehensive Systems Impact grant with the Council on Children and Families (CCF). The grant supports collaborative quality improvement projects in three high need counties (Erie, Niagara and Nassau) to improve maternal depression screening and follow-up as well as developmental screening and follow-up for young children. CCF is working closely with DOH on this grant which was initiated in 2016. With leadership from Dr. Kuo, Associate Professor and Division Chief for General Pediatrics at the University at Buffalo, the Erie/Niagara team organized a learning collaborative and designed a referral algorithm in 2017 for families with young children. At the other end of the state, under the leadership of Dr. Isaacson, the Nassau team hosted a kickoff on January 16, 2018 of Help Me Grow Long Island, with the goal of improving developmental health promotion, detection and linkages for families with young children on Long Island.

Addressing the opioid epidemic is a public health priority in NYS, mirroring the national experience. In 2014, Governor Cuomo established the Heroin and Opioid Task Force and signed the Combat Heroin Legislation which established a multi-faceted response to the opioid epidemic, with a focus on prevention, harm reduction, treatment, recovery and law enforcement. In response to the Task Force and legislation, NYSDOH developed an interagency opioid surveillance workgroup that consists of various state agencies and stakeholders with an interest in addressing this public health priority. The workgroup developed a comprehensive website for opioid-related data in NYS (http://www.health.ny.gov/statistics/opioid). This site provides the most recent data (NYS Opioid Annual Report 2017) and trends over time on opioid prevalence, healthcare utilization (emergency department visits, hospitalizations) and mortality at state, regional and county (County Opioid Quarterly Report for NYS) level, where available. Access to these data allows agencies and stakeholders to more easily identify priority areas to target in order to address the opioid epidemic in NYS.

NY's Title V Program is also working collaboratively with state agencies and stakeholders to increase understanding of, and develop strategies to address NY's growing opioid epidemic. Since spring 2016, Title V staff have been participating on an interagency work group, led by the NYS Office of Alcoholism and Substance Abuse Services (OASAS), to address pregnant and parenting women with opioid use disorders. OASAS received an in-depth technical assistance grant from the National Center for Substance Abuse and Child Welfare, focused on women with substance use disorders and their substance exposed infants in Onondaga, Warren and Washington counties. This is a two-year pilot (6/2016 – 9/2018) and the core team, which includes Title V staff and agencies in the three pilot counties, is working to establish universal screening, increase treatment access, develop peer services, and address the Comprehensive Addiction and Recovery Act amendment to the Child Abuse Prevention and Treatment Act. Lessons learned will be disseminated across the state. The core team meets monthly.

In collaboration with several DOH sister programs, Title V and OHIP staff have been co-leading an analytic project to conduct two studies of maternal opioid use and NAS.

The workgroup meets biweekly to develop consistent methodology on study inclusion and exclusion criteria, exposure definition and categorization, morphine milligram equivalent (MME) calculation and other analytic points. The data analysis planning team, comprised of Title V staff and other state agency representatives, has been addressing questions and concerns that arise throughout the study period.

In addition, DOH's Growing Up Healthy Hotline (GUHH), NY's Title V 24/7 phone line provides information and referral in English and Spanish and in other languages via the AT&T language line. Any New Yorker can call the GUHH for information on a wide range of programs and services and is used in public health media campaigns. In 2017 GUHH responded to 10,376 calls including 1,263 calls requesting referral and information related to prenatal care, health insurance and Medicaid, and perinatal depression, among other priority MCH needs.

This NYS priority is tracked through NPM #1: Percent of women with a past year preventive medical visit obtained through BRFSS**.** In 2014, 72.6% of the women interviewed had a past year preventive visit as compared to 68.4% in 2015. While this represents a slight decline, NY still exceeds the national measure of 66.1% in 2015. **SPM 1**: **The percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy** which is also reported from BRFSS data showed a slight drop from 37.3% in 2014 to 35.1% in 2016, however, this could be attributed to a larger sample size in 2016. Finally, **SPM 2**: **The percentage of women age 15-44 years and enrolled in Medicaid using the most effective, or moderately effective methods of contraception** which is assessed from Medicaid claims data was down from 27% in 2015 to 24.5% in 2016.

NY has selected several NOMs to target this priority. **NOM #2 Percent of delivery or postpartum hospitalizations with an indication of SMM**. NYS far exceeds the national measure of 171.4 incidents of SMM per 10,000 delivery hospitalizations as reported in Healthcare Cost and Utilization Project (HCUP) data in 2015. For the same time period, NYS is reported to have 214.2 per 10,000 delivery hospitalizations. NY fares slightly better than the national average for **NOM #3 Maternal mortality rate per 100,000 live births** at 20.6 vs. 21.9**.** NYS also demonstrates significant success in **NOM #7 Percent of non-medically indicated deliveries at 37, 38 weeks gestation among singleton deliveries without pre-existing condition** with 2.0 in 2015-2016 (mirroring the national average) down from 5.0 in 2013-2014. Finally, although NYS is far below the national average (5.8 NYS vs. 10.7 national average for 2014) for **NOM #11 The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations,** NYS mirrors the national trend of this significant public health issue as the NYS rate was 5.5 in 2013.

The application continues to reflect ongoing efforts to address these priority public health issues to achieve selected targets.

FY2019 Application
Maternal/Women's Health

State Priority #1: Reduce maternal mortality and morbidity

2020 State Objectives:
Objective MWH-1: Reduce the maternal mortality rate in NYS by 22% to 16.1 maternal deaths per 100,000 live births in 2020.
Objective MWH-2: Increase the percentage of women enrolled in Medicaid who are screened for maternal depression during postpartum care by 5% to 6.8%.

Maternal mortality and morbidity are critical indictors for maternal and women's health in NYS. In 2016, NYS ranked 30th among

50 states in maternal mortality. NYS's maternal mortality rate of 19.3 in 2014 and 22.3 in 2015 (with a three-year average of 20.7 for 2013-2015) maternal deaths per 100,000 live births remains almost two times higher than the Healthy People 2020 objective of 11.4. Racial disparities in maternal deaths are persistent; the statewide Black to White mortality ratio varied between 4.8 to 1 in 2005-2007 and 3.2 to 1 in 2011-2013. The most recent data showed that geographic differences are minimal. In NYC, the Black to White ratio
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hospital standards in NYS. Details regarding this process are contained in the Perinatal and Infant Health Domain. Through these efforts, the DOH will ensure high quality care to improve health and birth outcomes for women and newborns throughout NYS.

Through the updates to NYS's perinatal regionalization system and standards of care (see Priority #2) and the Title V Program's emerging collaboration with the PMH (See Strategy MWH-3), NY's Title V Program will continue to explore opportunities to streamline data analysis processes, and share lessons learned to improve maternity care practices.

Strategy MWH-2: Expand surveillance and reporting activities to include severe maternal morbidity. Studying SMM is critical both to preventing maternal morbidity and to strengthening Title V understanding of maternal death. Because SMM captures the most serious cases of maternal morbidity, analysis of SMM improves the opportunity to identify factors that are relevant to preventing future cases from progressing to the most serious stages of illness, disability or death. Building on the initial SMM data analysis work described above and in the 2016 annual report, Title V is working toward incorporating SMM case identification and analysis in annual surveillance reports to inform clinical and community prevention activities led by both Title V and partners.

NY's Title V program recognizes the importance of data access for all key partners and stakeholders. To that end, Title V staff are working with the NYSDOH's OPHP to develop a MCH dashboard, mirroring the objectives and outcomes reflected in NY's SAP. The MCH dashboard, mirrored on the dashboard for NY's Prevention Agenda (PA) will provide easy access to key data points reflected in NY's SAP and clearly show NY's progress in these priority outcomes, while also allowing partners to identify and address priority MCH issues on the local level. Targets are being established and the expected release for MCH Dashboard 1.0 is Summer 2018.
https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard&p=sh

Strategy MWH-3: In collaboration with key partners, continue to co-convene the NYS PMH to advance a comprehensive maternal health agenda that includes policy, community prevention and clinical quality improvement strategies. In NYS, heightened attention to the public health priority of maternal mortality – in particular the striking racial and economic disparities – has prompted significant work across several key organizations and settings, including the DOH Title V Program, ACOG-NY, state hospital associations including both the Health Care Association of New York State (HANYS) and Greater New York Hospital Association (GNYHA), the NYCDHMH, the New York Academy of Medicine (NYAM) and March of Dimes. The PMH seeks to advance a comprehensive and collaborative agenda for improving maternal health across the life course and ensuring the quality and safety of maternity care in NYS, with a particular focus on health equity. As discussed in the annual report section of this application, building on the Public Health Committee discussions and an initial review of shared goals resources and data, the partnership identified pre/interconception health as a starting point for collaboration and an initial focus of improving preconception care for women.

Currently, the partnership is focused on increasing awareness and action among health care providers of women of reproductive age regarding well woman and preconception health. The webinar on the importance of preconception health that was developed over the last year will be delivered in the late early summer of 2018 and will be archived for subsequent viewing. CME credits will be offered to those who complete the webinar. Partner organizations have committed to promoting the webinar. PMH members have expressed interest in materials that would facilitate the discussion with women of childbearing age about pregnancy intendedness. As a follow up to the webinar, the partners are discussing the development of materials, such as a poster or check list of topics to address at an encounter.

Title V staff have also been meeting with DOH DCDP staff to connect their prevention and treatment efforts with Title V initiatives to improve pre/interconception health. The DCDP implements evidence-based, evidenced-informed, and innovative public health strategies in high need areas of the state to support New Yorkers to live healthier lives and eliminate health disparities by reducing

the incidence and burden of chronic diseases and conditions (e.g., heart disease, stroke, cancer, obesity, diabetes, asthma, arthritis) and their associated risk factors (poor nutrition, tobacco use, and lack of physical activity). There is a tremendous overlap between the priorities and areas served by DCDP and the Title V program. This cross-division relationship allows greater reach of these efforts by increasing awareness of and collaboration around both divisions' priorities among local-level Title V and chronic disease prevention partners working in the same communities.

Title V will also continue its efforts through the NYSPQC, a partnership with the NICHQ, RPCs and affiliate obstetrical hospitals to improve birth outcomes. The NYSPQC, ACOG-NY, GNYHA and the HANYS, will continue to work collaboratively to leverage skills and expertise to reduce maternal morbidity and mortality, specifically on issues identified by the NYS MMR. Together, the aforementioned organizations have developed the NYS Obstetric Hemorrhage Project to assist birthing hospitals across NYS with translating evidence-based guidelines into clinical practice to improve the assessment and management of maternal hemorrhage, one of the leading causes of maternal morbidity and mortality in NYS. This is being accomplished through: the implementation of a learning collaborative among NYS birthing hospitals to share and learn from one another; implementation of the Safe Motherhood Initiative (SMI) obstetric hemorrhage bundle; tailored clinical and quality improvement education (in-person and virtual, webinars, grand rounds, etc.) and technical assistance; and ongoing data collection, analysis and feedback to track relevant measures. As stated previously, the expansion of NYSPQC is an important aspect of the Governor's priority actions to address maternal mortality in NYS.

This initiative will align with the national ACOG Alliance for Innovation on Maternal Health (AIM). The purpose of the AIM program is to equip, empower and embolden every state, perinatal quality collaborative, hospital network/system, birth facility and maternity care provider in the U.S to significantly reduce severe maternal morbidity and maternal mortality through proven implementation of consistent maternity care practices that are outlined in maternal safety bundles. The AIM Program is designed to complement current maternal safety initiatives in progress, as well as drive continuous quality improvement on a state and birth facility level. Currently, Title V staff and ACOG are in the planning stages of a hospital-based initiatives on pregnant women with opioid use disorders and infants with neonatal abstinence syndrome.

Strategy MWH-4: Collaborate with Medicaid to institute reimbursement for immediate postpartum insertion of LARC. As stated previously, over half of pregnancies in NYS are unintended. Pregnancy planning and prevention are greatly influenced by use of effective contraception. Despite the effectiveness of LARC, it is not widely used by most women due to concerns regarding safety, misunderstanding that devices may cause sexually transmitted diseases, and a general lack of knowledge regarding LARC. Additionally, because of the decreasing popularity of Intrauterine Devices (IUDs) in the past, health care providers may not have had been trained on placing IUDs. In addition, the high acquisition cost, lack of insurance reimbursement and inadequate supplies of LARCs in provider offices may pose challenges for the use of LARC in cost-effective and time-efficient ways.

Building on the extensive work summarized in the 2017 Annual Report, including NY's IM CoIIN initiative and CDC-led 6|18 initiative, NY's Title V Program will continue to collaborate with NY's State Medicaid Program and other partners to educate providers on the policy change that provides reimbursement for immediate postpartum insertion of LARC and to address misconceptions about LARC among providers and women of reproductive age.

Strategy MWH-5: Collaborate with partners to increase screening and follow-up support for maternal depression. As highlighted in the NA, maternal depression is the most common morbidity among postpartum women, affecting 10-20% of women during or within 12 months of pregnancy. Maternal depression is a priority concern of many stakeholder groups and organizations in NYS. The Title V Program is uniquely positioned to provide leadership in facilitating connections among partners and advancing collaborative strategies that span health insurance, health care and community-based settings.

There is solid evidence that maternal depression can be accurately identified using brief validated depression screening instruments,

and that treatment improves the prognosis for the woman and her family. Screening can be incorporated in routine prenatal, postpartum and well-baby visits, and must be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. Despite widespread acknowledgement of the prevalence and impact of maternal depression, previous studies suggest that screening for maternal depression is not standard practice, and especially that few providers use validated screening tools.

For the past few years, Title V staff have participated in a Prenatal Care workgroup with the OQPS to support implementation of Medicaid Prenatal Care standards and other related collaborative efforts. Part of the focus of this workgroup has been the development and implementation of a focused study on the quality of prenatal care provided through the Medicaid Prenatal Care Program. Title V staff will continue to work with OQPS focusing on the initiatives discussed below.

The 2017 – 2018 Perinatal Care Performance Improvement Project (PIP) is a two-year initiative with 15 NYS Medicaid Managed Care Plans. This PIP includes four priority areas of focus:

- Improving Access to 17-alpha hydroxyprogesterone caproate (17P) to reduce the risk of recurrent preterm birth
- Behavioral Health risk assessment and follow-up – depression
- Behavioral Health risk assessment and follow-up – tobacco use
- Improving utilization of LARC to support birth spacing that is optimal for maternal-fetal outcomes and patient choice.

As measured in MWH-2, NYS specific data from the 2013 Medicaid Prenatal Care Study showed that 63% of women were assessed for depression during the initial prenatal visit, and 51.4% at postpartum visits, but among these only 7% of records documented using standardized screening tools. Medicaid quality data from 2014 reviews suggest that depression assessment practices are improving for both prenatal (84.9%) and postpartum (84.4%) visits. Of the 5.3% of women who screened positive for depression during prenatal care visits, 90.2% were addressed in the practice or referred for care. During postpartum visits, 4.2% of women screened positive and 88% of those women who screened positive were addressed in the practice or referred for follow-up.

The Medicaid Prenatal Care Quality Improvement Project is the statewide practice-based quality improvement initiative which monitors the quality of perinatal care delivered to Medicaid-eligible pregnant women. Prenatal care providers in each Cohort are asked to report prenatal and post-partum care data, based on documentation in medical records for a Department-selected, random sample of patients of Medicaid-enrolled women. Work will continue in this area to continue to ensure NY's women receive comprehensive prenatal care in accordance with current standard of care and established guidelines.

Title V staff will continue to participate in monthly Prenatal Care Workgroup meetings to provide input into quality improvement activities. and provide updates on the NYSPQC (http://www.albany.edu/sph/cphce/mch_nyspqc.shtml).

Several new initiatives began in 2016 and continued into 2017 that include a focus on maternal depression. Title V staff partner with the CCF on the implementation of a community-led project through the Early Childhood Comprehensive Systems (ECCS) Impact grant to improve maternal depression screening and follow-up as well as developmental screening and follow-up for young children through building partnerships and collaborative efforts. To support this initiative, Title V staff participate on a workgroup charged with implementation of developmental health promotion by increasing monitoring, screening, and follow up. The ECCS Impact grant is a community-led program that identifies community leaders to participate in local teams to identify ways to improve services including screening and services. As discussed in the annual report, both projects have made progress in convening partners and starting work on improving screening and referrals into services. Title V staff will continue to participate in the leadership team and support engagement of DOH-funded partners in the communities. Relevant lessons learned will also be shared with partners working in these areas.

Schuyler Center for Analysis and Advocacy is holding a statewide summit on the issue of Maternal Depression in June 2018, bringing

stakeholders from many disciplines together to discuss this complex public health issue. Title V staff provided input in the planning stages of this summit and will be in attendance to continue to build Title V's knowledge base in this area.

Similar to the ECCS Impact initiative, Title V staff working in the Home Visiting Unit are supporting a community-led Coordinated Intake and Referral System pilot designed to increase referrals into home visiting programs. This project complements NYS OMH's funding of the expansion of HealthySteps model to 17 additional pediatric health care practice settings as discussed in the annual report. Title V staff participate on a workgroup to support the HealthySteps initiative to engage both the child and family during routine early-life doctor visits and provide screening services for the entire family, including screenings for maternal depression. These enhanced early-life visits offer an opportunity for families to find support in an accessible and non-stigmatizing environment.

Additionally, the state's ECAC identified early identification, prevention and intervention for maternal depression as a current priority, and has convened a workgroup to develop and help advance relevant strategies. As mentioned in the annual report, members of the ECAC subgroup working on this issue were active in the development of priorities in NYS's First 1000 Days on Medicaid initiative. Members will help with implementation and spread, as they are able, of the initiatives that address maternal depression: allowing providers to bill for the provision of evidence–based parent/caregiver–child therapy (also called dyadic therapy) based solely on the parent/caregiver being diagnosed with a mood, anxiety, or substance use disorder; and piloting home visiting in three communities and an identification of common programmatic elements that could be paid for through Medicaid funding.

NY's Title V program will continue to partner with OHIP regarding tracking screening codes to learn about current billing practices. The Title V program will continue to collaborate and provide relevant data on maternal depression screenings conducted for clients receiving home visiting services. Other areas discussed for possible attention are screening tools, referral practices and follow-up care. The Title V Program will continue to collaborate with partners including OHIP, OQPS, DFS, OMH, CCF and the ECAC to advance this work. Implementation of this strategy will be tracked by **ESM MWH-5**: **Percentage of women enrolled in Medicaid who are screened for maternal depression during postpartum care,** revised this year to include women enrolled in Medicaid.

Strategy MWH-6: Participate in intra- and interagency groups developing response to increased opioid use to ensure maternal and child health perspectives and populations are addressed. The increase of opioid use among MCH population is a key concern of many stakeholders in NY. The age-adjusted rate of all opioid overdose deaths per 100,000 population in NYS doubled between 2010 (5.4) and 2015 (10.8). However, the age-adjusted rate of heroin deaths increased by over five times from 1.0/100,000 in 2010 to 5.4/100,000 in 2015, whereas the age-adjusted rate of opioid pain reliever deaths per 100,000 increased 1.6 times between 2010 (4.3) and 2015 (6.9). During the same time period, the age-adjusted rates of overdose among women also increased reaching 5.7 per 100,000 population in 2015.

For the MCH population specifically, the impact of this crisis is visible in the dramatic increase in rates of drug-related discharges for newborns over the last several years. While rates have increased across the state and among all racial/ethnic groups, the trend is especially pronounced outside of New York City, where the rate of NAS has doubled since 2008. In response to this rapidly emerging issue, Title V staff have been engaging with several key partners to assess needs, identify existing resources and participate in the development of additional strategies. Title V staff have been participating on an interagency work group, led by the NYS OASAS, with support from an in-depth technical assistance grant from the National Center for Substance Abuse and Child Welfare to address women with substance use disorders and their substance exposed infants in Onondaga, Warren and Washington counties. There is a core team of state and local agency partners and four workgroups, each addressing a priority (screening, peer services, access to treatment, and NY's response to the CARA amendment to CAPTA). Tools have been developed in three out of four workgroups that will be piloted and refined in the next eight months. Lessons learned will be disseminated across the state.

Title V staff are engaged in several efforts to contribute to and benefit from work related to surveillance and data for opioid use. The Title V Program will continue its collaboration across NYSDOH sister programs on a study of maternal opioid use and NAS. Study questions to be addressed for 2010 - 2015:

- Among women in the Medicaid program who delivered an infant, how many filled prescriptions for opioids or received opioid dependence treatment during pregnancy?
- Did patterns vary by geographical area, provider or type of drug?
- Among infants born with NAS in NYS, how many had mothers who filled prescriptions for opioids or received opioid dependence treatment?
- How did this impact the infant's length of stay and inpatient costs?

The data analyses will continue to determine the counties or regions with the highest burden. A clearer understanding of the epidemic will help determine the most effective intervention tactics. The data analysis planning team, comprised of Title V staff and other state agency representatives, will continue biweekly meetings to address questions or concerns that arise throughout the study period.

The opioid surveillance workgroup will continue to monitor opioid overdose deaths in the state and will report these deaths to counties. They will also continue to update the DOH website with the most recent data and trends on opioid prevalence, healthcare utilization and mortality in NYS.

As more information about this significant public health issue becomes available, the Title V Program will incorporate the information within relevant community-based prevention programs. Governor Cuomo's statewide task force to combat heroin and opioid abuse, comprised of experts in health care, drug policy, advocacy, education, parents and New Yorkers in recovery, will continue to build on the state's previous efforts and use members' expertise and experience to develop a comprehensive action plan. Title V staff will continue to identify opportunities to assure the needs of NYS's MCH population are included in statewide efforts to address this issue and make recommendations regarding opportunities to intervene.

FY2019 Application
Maternal/Women's Health

State Priority #1: Reduce maternal mortality and morbidity

2020 State Objectives:
Objective MWH-1: Reduce the maternal mortality rate in NYS by 22% to 16.1 maternal deaths per 100,000 live births in 2020.
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Title V plans to continue this review process while aiming to release data reports annually to support prevention and clinical improvement strategies with partners.

NYS has demonstrated a long-standing commitment to a regionalized system of perinatal care. The DOH oversees a perinatal regionalized system in which every birthing hospital in NYS is designated at a specific level based upon its ability to provide perinatal care to women and newborns. Hospitals are designated as one of four levels of perinatal care based upon the types of patients that are treated, sub-specialty consultation available, qualifications of staff, types of equipment available and volume of high risk perinatal patients treated. Basic or Level I hospitals provide care to normal or low-risk pregnant women and newborns, and they do not operate neonatal intensive care units (NICUs). Level II hospitals provide care to women and newborns at moderate risk, and Level III hospitals care for patients requiring increasingly complex care. Level II and III hospitals must operate NICUs. The highest level hospital, the Regional Perinatal Center (RPC), is either a tertiary care hospital or a combination of tertiary care hospitals, capable of providing all the services and expertise required by the most acutely sick or at-risk pregnant women and newborns. The concentration of high risk patients makes it possible to maintain the substantial expertise and expense required for the care of high risk women and newborns and attending level sub-specialty consultation in maternal-fetal medicine and neonatology. Due to the changing landscape of the health care system as well as standards of perinatal care, the DOH is fully supporting efforts to update perinatal hospital standards in NYS. Details regarding this process are contained in the Perinatal and Infant Health Domain. Through these efforts, the DOH will ensure high quality care to improve health and birth outcomes for women and newborns throughout NYS.

Through the updates to NYS's perinatal regionalization system and standards of care (see Priority #2) and the Title V Program's emerging collaboration with the PMH (See Strategy MWH-3), NY's Title V Program will continue to explore opportunities to streamline data analysis processes, and share lessons learned to improve maternity care practices.

Strategy MWH-2: Expand surveillance and reporting activities to include severe maternal morbidity. Studying SMM is critical both to preventing maternal morbidity and to strengthening Title V understanding of maternal death. Because SMM captures the most serious cases of maternal morbidity, analysis of SMM improves the opportunity to identify factors that are relevant to preventing future cases from progressing to the most serious stages of illness, disability or death. Building on the initial SMM data analysis work described above and in the 2016 annual report, Title V is working toward incorporating SMM case identification and analysis in annual surveillance reports to inform clinical and community prevention activities led by both Title V and partners.

NY's Title V program recognizes the importance of data access for all key partners and stakeholders. To that end, Title V staff are working with the NYSDOH's OPHP to develop a MCH dashboard, mirroring the objectives and outcomes reflected in NY's SAP. The MCH dashboard, mirrored on the dashboard for NY's Prevention Agenda (PA) will provide easy access to key data points reflected in NY's SAP and clearly show NY's progress in these priority outcomes, while also allowing partners to identify and address priority MCH issues on the local level. Targets are being established and the expected release for MCH Dashboard 1.0 is Summer 2018.
https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard&p=sh

Strategy MWH-3: In collaboration with key partners, continue to co-convene the NYS PMH to advance a comprehensive maternal health agenda that includes policy, community prevention and clinical quality improvement strategies. In NYS, heightened attention to the public health priority of maternal mortality – in particular the striking racial and economic disparities – has prompted significant work across several key organizations and settings, including the DOH Title V Program, ACOG-NY, state hospital associations including both the Health Care Association of New York State (HANYS) and Greater New York Hospital Association (GNYHA), the NYCDHMH, the New York Academy of Medicine (NYAM) and March of Dimes. The PMH seeks to advance a comprehensive and collaborative agenda for improving maternal health across the life course and ensuring the quality and safety of maternity care in NYS, with a particular focus on health equity. As discussed in the annual report section of this application, building on the Public Health Committee discussions and an initial review of shared goals resources and data, the

partnership identified pre/interconception health as a starting point for collaboration and an initial focus of improving preconception care for women.

Currently, the partnership is focused on increasing awareness and action among health care providers of women of reproductive age regarding well woman and preconception health. The webinar on the importance of preconception health that was developed over the last year will be delivered in the late early summer of 2018 and will be archived for subsequent viewing. CME credits will be offered to those who complete the webinar. Partner organizations have committed to promoting the webinar. PMH members have expressed interest in materials that would facilitate the discussion with women of childbearing age about pregnancy intendedness. As a follow up to the webinar, the partners are discussing the development of materials, such as a poster or check list of topics to address at an encounter.

Title V staff have also been meeting with DOH DCDP staff to connect their prevention and treatment efforts with Title V initiatives to improve pre/interconception health. The DCDP implements evidence-based, evidenced-informed, and innovative public health strategies in high need areas of the state to support New Yorkers to live healthier lives and eliminate health disparities by reducing the incidence and burden of chronic diseases and conditions (e.g., heart disease, stroke, cancer, obesity, diabetes, asthma, arthritis) and their associated risk factors (poor nutrition, tobacco use, and lack of physical activity). There is a tremendous overlap between the priorities and areas served by DCDP and the Title V program. This cross-division relationship allows greater reach of these efforts by increasing awareness of and collaboration around both divisions' priorities among local-level Title V and chronic disease prevention partners working in the same communities.

Title V will also continue its efforts through the NYSPQC, a partnership with the NICHQ, RPCs and affiliate obstetrical hospitals to improve birth outcomes. The NYSPQC, ACOG-NY, GNYHA and the HANYS, will continue to work collaboratively to leverage skills and expertise to reduce maternal morbidity and mortality, specifically on issues identified by the NYS MMR. Together, the aforementioned organizations have developed the NYS Obstetric Hemorrhage Project to assist birthing hospitals across NYS with translating evidence-based guidelines into clinical practice to improve the assessment and management of maternal hemorrhage, one of the leading causes of maternal morbidity and mortality in NYS. This is being accomplished through: the implementation of a learning collaborative among NYS birthing hospitals to share and learn from one another; implementation of the Safe Motherhood Initiative (SMI) obstetric hemorrhage bundle; tailored clinical and quality improvement education (in-person and virtual, webinars, grand rounds, etc.) and technical assistance; and ongoing data collection, analysis and feedback to track relevant measures. As stated previously, the expansion of NYSPQC is an important aspect of the Governor's priority actions to address maternal mortality in NYS.

This initiative will align with the national ACOG Alliance for Innovation on Maternal Health (AIM). The purpose of the AIM program is to equip, empower and embolden every state, perinatal quality collaborative, hospital network/system, birth facility and maternity care provider in the U.S to significantly reduce severe maternal morbidity and maternal mortality through proven implementation of consistent maternity care practices that are outlined in maternal safety bundles. The AIM Program is designed to complement current maternal safety initiatives in progress, as well as drive continuous quality improvement on a state and birth facility level. Currently, Title V staff and ACOG are in the planning stages of a hospital-based initiatives on pregnant women with opioid use disorders and infants with neonatal abstinence syndrome.

Strategy MWH-4: Collaborate with Medicaid to institute reimbursement for immediate postpartum insertion of LARC. As stated previously, over half of pregnancies in NYS are unintended. Pregnancy planning and prevention are greatly influenced by use of effective contraception. Despite the effectiveness of LARC, it is not widely used by most women due to concerns regarding safety, misunderstanding that devices may cause sexually transmitted diseases, and a general lack of knowledge regarding LARC. Additionally, because of the decreasing popularity of Intrauterine Devices (IUDs) in the past, health care providers may not have

had been trained on placing IUDs. In addition, the high acquisition cost, lack of insurance reimbursement and inadequate supplies of LARCs in provider offices may pose challenges for the use of LARC in cost-effective and time-efficient ways.

Building on the extensive work summarized in the 2017 Annual Report, including NY's IM CoIIN initiative and CDC-led 6|18 initiative, NY's Title V Program will continue to collaborate with NY's State Medicaid Program and other partners to educate providers on the policy change that provides reimbursement for immediate postpartum insertion of LARC and to address misconceptions about LARC among providers and women of reproductive age.

Strategy MWH-5: Collaborate with partners to increase screening and follow-up support for maternal depression. As highlighted in the NA, maternal depression is the most common morbidity among postpartum women, affecting 10-20% of women during or within 12 months of pregnancy. Maternal depression is a priority concern of many stakeholder groups and organizations in NYS. The Title V Program is uniquely positioned to provide leadership in facilitating connections among partners and advancing collaborative strategies that span health insurance, health care and community-based settings.

There is solid evidence that maternal depression can be accurately identified using brief validated depression screening instruments, and that treatment improves the prognosis for the woman and her family. Screening can be incorporated in routine prenatal, postpartum and well-baby visits, and must be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. Despite widespread acknowledgement of the prevalence and impact of maternal depression, previous studies suggest that screening for maternal depression is not standard practice, and especially that few providers use validated screening tools.

For the past few years, Title V staff have participated in a Prenatal Care workgroup with the OQPS to support implementation of Medicaid Prenatal Care standards and other related collaborative efforts. Part of the focus of this workgroup has been the development and implementation of a focused study on the quality of prenatal care provided through the Medicaid Prenatal Care Program. Title V staff will continue to work with OQPS focusing on the initiatives discussed below.

The 2017 – 2018 Perinatal Care Performance Improvement Project (PIP) is a two-year initiative with 15 NYS Medicaid Managed Care Plans. This PIP includes four priority areas of focus:

- Improving Access to 17-alpha hydroxyprogesterone caproate (17P) to reduce the risk of recurrent preterm birth
- Behavioral Health risk assessment and follow-up – depression
- Behavioral Health risk assessment and follow-up – tobacco use
- Improving utilization of LARC to support birth spacing that is optimal for maternal-fetal outcomes and patient choice.

As measured in MWH-2, NYS specific data from the 2013 Medicaid Prenatal Care Study showed that 63% of women were assessed for depression during the initial prenatal visit, and 51.4% at postpartum visits, but among these only 7% of records documented using standardized screening tools. Medicaid quality data from 2014 reviews suggest that depression assessment practices are improving for both prenatal (84.9%) and postpartum (84.4%) visits. Of the 5.3% of women who screened positive for depression during prenatal care visits, 90.2% were addressed in the practice or referred for care. During postpartum visits, 4.2% of women screened positive and 88% of those women who screened positive were addressed in the practice or referred for follow-up.

The Medicaid Prenatal Care Quality Improvement Project is the statewide practice-based quality improvement initiative which monitors the quality of perinatal care delivered to Medicaid-eligible pregnant women. Prenatal care providers in each Cohort are asked to report prenatal and post-partum care data, based on documentation in medical records for a Department-selected, random sample of patients of Medicaid-enrolled women. Work will continue in this area to continue to ensure NY's women receive comprehensive prenatal care in accordance with current standard of care and established guidelines.

Title V staff will continue to participate in monthly Prenatal Care Workgroup meetings to provide input into quality improvement activities. and provide updates on the NYSPQC (http://www.albany.edu/sph/cphce/mch_nyspqc.shtml).

Several new initiatives began in 2016 and continued into 2017 that include a focus on maternal depression. Title V staff partner with the CCF on the implementation of a community-led project through the Early Childhood Comprehensive Systems (ECCS) Impact grant to improve maternal depression screening and follow-up as well as developmental screening and follow-up for young children through building partnerships and collaborative efforts. To support this initiative, Title V staff participate on a workgroup charged with implementation of developmental health promotion by increasing monitoring, screening, and follow up. The ECCS Impact grant is a community-led program that identifies community leaders to participate in local teams to identify ways to improve services including screening and services. As discussed in the annual report, both projects have made progress in convening partners and starting work on improving screening and referrals into services. Title V staff will continue to participate in the leadership team and support engagement of DOH-funded partners in the communities. Relevant lessons learned will also be shared with partners working in these areas.

Schuyler Center for Analysis and Advocacy is holding a statewide summit on the issue of Maternal Depression in June 2018, bringing stakeholders from many disciplines together to discuss this complex public health issue. Title V staff provided input in the planning stages of this summit and will be in attendance to continue to build Title V's knowledge base in this area.

Similar to the ECCS Impact initiative, Title V staff working in the Home Visiting Unit are supporting a community-led Coordinated Intake and Referral System pilot designed to increase referrals into home visiting programs. This project complements NYS OMH's funding of the expansion of HealthySteps model to 17 additional pediatric health care practice settings as discussed in the annual report. Title V staff participate on a workgroup to support the HealthySteps initiative to engage both the child and family during routine early-life doctor visits and provide screening services for the entire family, including screenings for maternal depression. These enhanced early-life visits offer an opportunity for families to find support in an accessible and non-stigmatizing environment.

Additionally, the state's ECAC identified early identification, prevention and intervention for maternal depression as a current priority, and has convened a workgroup to develop and help advance relevant strategies. As mentioned in the annual report, members of the ECAC subgroup working on this issue were active in the development of priorities in NYS's First 1000 Days on Medicaid initiative. Members will help with implementation and spread, as they are able, of the initiatives that address maternal depression: allowing providers to bill for the provision of evidence–based parent/caregiver–child therapy (also called dyadic therapy) based solely on the parent/caregiver being diagnosed with a mood, anxiety, or substance use disorder; and piloting home visiting in three communities and an identification of common programmatic elements that could be paid for through Medicaid funding.

NY's Title V program will continue to partner with OHIP regarding tracking screening codes to learn about current billing practices. The Title V program will continue to collaborate and provide relevant data on maternal depression screenings conducted for clients receiving home visiting services. Other areas discussed for possible attention are screening tools, referral practices and follow-up care. The Title V Program will continue to collaborate with partners including OHIP, OQPS, DFS, OMH, CCF and the ECAC to advance this work. Implementation of this strategy will be tracked by **ESM MWH-5**: **Percentage of women enrolled in Medicaid who are screened for maternal depression during postpartum care,** revised this year to include women enrolled in Medicaid.

Strategy MWH-6: Participate in intra- and interagency groups developing response to increased opioid use to ensure maternal and child health perspectives and populations are addressed. The increase of opioid use among MCH population is a key concern of many stakeholders in NY. The age-adjusted rate of all opioid overdose deaths per 100,000 population in NYS doubled between 2010 (5.4) and 2015 (10.8). However, the age-adjusted rate of heroin deaths increased by over five times from

1.0/100,000 in 2010 to 5.4/100,000 in 2015, whereas the age-adjusted rate of opioid pain reliever deaths per 100,000 increased 1.6 times between 2010 (4.3) and 2015 (6.9). During the same time period, the age-adjusted rates of overdose among women also increased reaching 5.7 per 100,000 population in 2015.

For the MCH population specifically, the impact of this crisis is visible in the dramatic increase in rates of drug-related discharges for newborns over the last several years. While rates have increased across the state and among all racial/ethnic groups, the trend is especially pronounced outside of New York City, where the rate of NAS has doubled since 2008. In response to this rapidly emerging issue, Title V staff have been engaging with several key partners to assess needs, identify existing resources and participate in the development of additional strategies. Title V staff have been participating on an interagency work group, led by the NYS OASAS, with support from an in-depth technical assistance grant from the National Center for Substance Abuse and Child Welfare to address women with substance use disorders and their substance exposed infants in Onondaga, Warren and Washington counties. There is a core team of state and local agency partners and four workgroups, each addressing a priority (screening, peer services, access to treatment, and NY's response to the CARA amendment to CAPTA). Tools have been developed in three out of four workgroups that will be piloted and refined in the next eight months. Lessons learned will be disseminated across the state.

Title V staff are engaged in several efforts to contribute to and benefit from work related to surveillance and data for opioid use. The Title V Program will continue its collaboration across NYSDOH sister programs on a study of maternal opioid use and NAS. Study questions to be addressed for 2010 - 2015:

- Among women in the Medicaid program who delivered an infant, how many filled prescriptions for opioids or received opioid dependence treatment during pregnancy?
- Did patterns vary by geographical area, provider or type of drug?
- Among infants born with NAS in NYS, how many had mothers who filled prescriptions for opioids or received opioid dependence treatment?
- How did this impact the infant's length of stay and inpatient costs?

The data analyses will continue to determine the counties or regions with the highest burden. A clearer understanding of the epidemic will help determine the most effective intervention tactics. The data analysis planning team, comprised of Title V staff and other state agency representatives, will continue biweekly meetings to address questions or concerns that arise throughout the study period.

The opioid surveillance workgroup will continue to monitor opioid overdose deaths in the state and will report these deaths to counties. They will also continue to update the DOH website with the most recent data and trends on opioid prevalence, healthcare utilization and mortality in NYS.

As more information about this significant public health issue becomes available, the Title V Program will incorporate the information within relevant community-based prevention programs. Governor Cuomo's statewide task force to combat heroin and opioid abuse, comprised of experts in health care, drug policy, advocacy, education, parents and New Yorkers in recovery, will continue to build on the state's previous efforts and use members' expertise and experience to develop a comprehensive action plan. Title V staff will continue to identify opportunities to assure the needs of NYS's MCH population are included in statewide efforts to address this issue and make recommendations regarding opportunities to intervene.

Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2015	5.2	NPM 3
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	4.6	NPM 3 NPM 5
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2015	3.2	NPM 3
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	1.5	NPM 5
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2015	168.2	NPM 3
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2015	56.5	NPM 5

National Performance Measures

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

FAD for this measure is not available for the State.

State Provided Data		
	2016	2017
Annual Objective	91	91
Annual Indicator	92.3	92.7
Numerator		
Denominator		
Data Source	NYS VS	NYS VS
Data Source Year	2014	2015
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	93.4	93.7	94.0	94.3	94.6	94.8

Evidence-Based or –Informed Strategy Measures

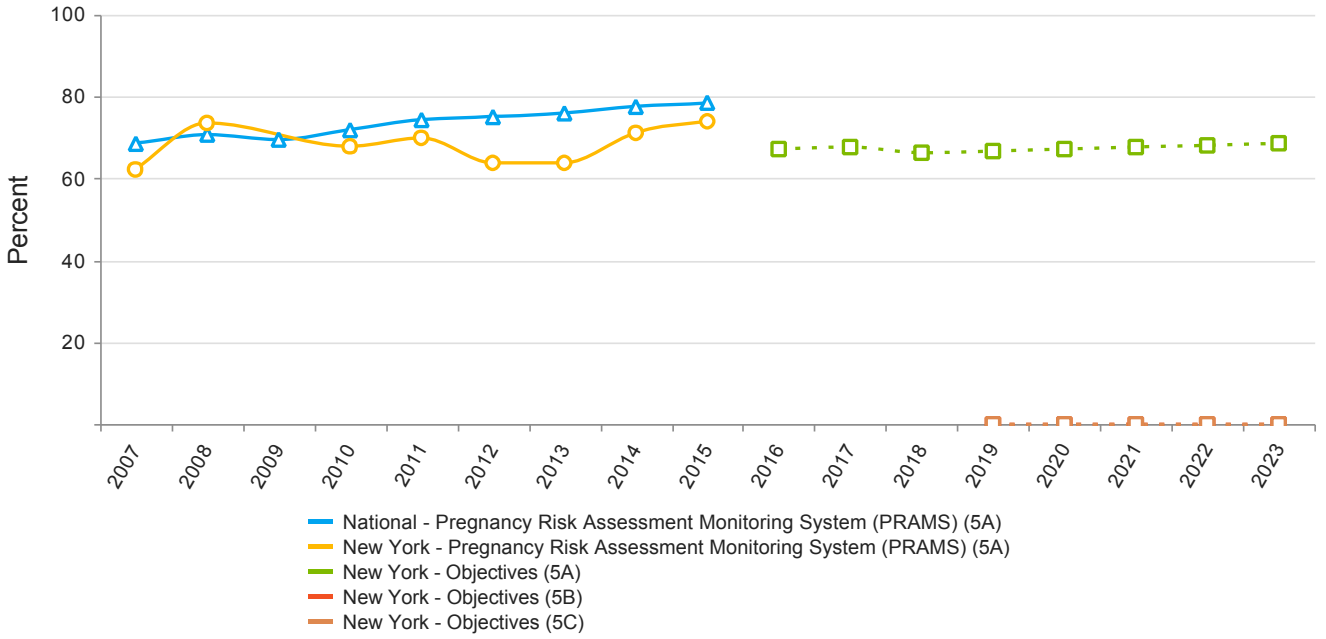
ESM 3.1 - Percentage of birthing hospitals re-designated with updated standards.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		0
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	NYS Title V Program records	NYS Title V Program records
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	0.0	0.0	100.0	100.0	100.0	100.0

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding
Baseline Indicators and Annual Objectives



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

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2016	**2017**
Annual Objective	67.1	67.6
Annual Indicator	63.9	73.9
Numerator	135,686	155,836
Denominator	212,507	210,880
Data Source	PRAMS	PRAMS
Data Source Year	2013	2015

State Provided Data		
	2016	2017
Annual Objective	67.1	67.6
Annual Indicator	71.3	73.9
Numerator		
Denominator		
Data Source	PRAMS NYS	PRAMS NYS
Data Source Year	2014	2015
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	66.2	66.6	67.1	67.6	68.0	68.5

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

FAD for this measure is not available for the State.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	100
Data Source	NYS PRAMS
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	0.0	0.0	0.0	0.0	0.0

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

FAD for this measure is not available for the State.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	100
Data Source	2016
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	0.0	0.0	0.0	0.0	0.0

Evidence-Based or –Informed Strategy Measures

ESM 5.5 - Percent of infants, sleeping or awake-and-unattended in crib, in a safe sleep environment

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	90
Annual Indicator	91.7
Numerator	
Denominator	
Data Source	NYS sampled Birthing Hospitals
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	90.0	90.0	90.0	92.0	92.0	92.0

State Performance Measures

SPM 5 - The percentage of NYS residents served by community water systems that have optimally fluoridated water

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		72
Annual Indicator	71.7	71.6
Numerator		
Denominator		
Data Source	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	73.0	75.0	77.0	78.5	78.5	78.5

State Action Plan Table

State Action Plan Table (New York) - Perinatal/Infant Health - Entry 1

Priority Need

Reduce infant mortality & morbidity

NPM

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

Objectives

Objective PIH-1: Decrease the infant mortality rate by 18%, to 4.0 per 1,000 live births

Objective PIH-2: Decrease the preterm birth rate by 5%, to 8.4% of live births

Objective PIH-3: Increase the percent of very low birthweight (VLBW) infants born in a hospital with a Level III or higher Neonatal Intensive Care Unit (NICU) by 2%, to 94% of eligible infants.

Objective PIH-4: Decrease the SUID rate by 50%, to 0.3 per 1,000 live births

Strategies
Strategy PIH-1: Develop and implement an expanded plan for analysis and reporting of infant mortality and selected morbidity data, and issue initial data report.
Strategy PIH-2: Update NYS perinatal regionalization standards and designations and implement updated performance measures for Regional Perinatal Centers and affiliate birthing hospitals.
Strategy PIH-3: Continue to convene and lead structured statewide clinical quality improvement initiatives in birthing hospitals through the NYS Perinatal Quality Collaborative (NYSPQC).
Strategy PIH-4: Work with local home visiting grantees to increase capacity of established programs through improvements in outreach, enrollment and retention of eligible families.
Strategy PIH-5: Provide training and technical assistance to local MIECHV and MICHC grantees to enhance competencies of home visitors and community health workers related to pre- and interconception health, smoking cessation, substance abuse, safe sleep and breastfeeding promotion
Strategy PIH-6: Lead collaborative strategies to reduce sleep-related infant death.
Strategy LC-1: Integrate performance standards, measures and improvement strategies related to health insurance enrollment across all Title V/ MCH programs.
Strategy LC-13: Develop and implement a data analysis plan to assess distribution of DFH/Title V resources and services through a health equity lens
Strategy LC-14: Build internal capacity within the Division of Family Health (DFH)/ Title V Program to advance health equity through all Title V programs, including: creation of a cross-program DFH Equity Action Team; completion of an organizational assessment of equity practices, and facilitation of staff training and professional development through Equity Learning Labs.
Strategy LC-15: Integrate an equity framework into the development of all DFH/Title V procurements through community listening forums conducted as part of the concept development process.
Strategy LC-16: Incorporate evidence-based/-informed community engagement and collective impact strategies in all relevant DFH/Title V programs.
Note: Life Course Strategies and associated ESMs are fully described in the Life Course Domain, and repeat across multiple relevant domains/ priorities consistent with their cross-cutting design.

ESMs	Status
ESM 3.1 - Percentage of birthing hospitals re-designated with updated standards.	Active
ESM 3.2 - Number of home visiting and community health worker staff trained in the identified competencies.	Inactive

NOMs

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

State Action Plan Table (New York) - Perinatal/Infant Health - Entry 2

Priority Need

Reduce infant mortality & morbidity

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

Objective PIH-1: Decrease the infant mortality rate by 18%, to 4.0 per 1,000 live births

Objective PIH-2: Decrease the preterm birth rate by 5%, to 8.4% of live births

Objective PIH-3: Increase the percent of very low birthweight (VLBW) infants born in a hospital with a Level III or higher Neonatal Intensive Care Unit (NICU) by 2%, to 94% of eligible infants.

Objective PIH-4: Decrease the SUID rate by 50%, to 0.3 per 1,000 live births

Strategies
Strategy PIH-1: Develop and implement an expanded plan for analysis and reporting of infant mortality and selected morbidity data, and issue initial data report.
Strategy PIH-2: Update NYS perinatal regionalization standards and designations and implement updated performance measures for Regional Perinatal Centers and affiliate birthing hospitals.
Strategy PIH-3: Continue to convene and lead structured statewide clinical quality improvement initiatives in birthing hospitals through the NYS Perinatal Quality Collaborative (NYSPQC).
Strategy PIH-4: Work with local home visiting grantees to increase capacity of established programs through improvements in outreach, enrollment and retention of eligible families.
Strategy PIH-5: Provide training and technical assistance to local MIECHV and MICHC grantees to enhance competencies of home visitors and community health workers related to pre- and interconception health, smoking cessation, substance abuse, safe sleep and breastfeeding promotion
Strategy PIH-6: Lead collaborative strategies to reduce sleep-related infant death.
Strategy LC-1: Integrate performance standards, measures and improvement strategies related to health insurance enrollment across all Title V/ MCH programs.
Strategy LC-14: Build internal capacity within the Division of Family Health (DFH)/ Title V Program to advance health equity through all Title V programs, including: creation of a cross-program DFH Equity Action Team; completion of an organizational assessment of equity practices, and facilitation of staff training and professional development through Equity Learning Labs.
Strategy LC-15: Integrate an equity framework into the development of all DFH/Title V procurements through community listening forums conducted as part of the concept development process.
Strategy LC-16: Incorporate evidence-based/-informed community engagement and collective impact strategies in all relevant DFH/Title V programs.
Note: Life Course Strategies and associated ESMs are fully described in the Life Course Domain, and repeat across multiple relevant domains/ priorities consistent with their cross-cutting design.

ESMs	Status
ESM 5.1 - Initial infant mortality and morbidity data report published.	Inactive
ESM 5.2 - Percentage of eligible birthing hospitals participating in a current QI activity.	Inactive
ESM 5.3 - Capacity rates of local home visiting grantee projects (to be aligned with new MIEHCV performance measure, currently pending from HRSA MCHB).	Inactive
ESM 5.4 - Number of collaborative strategies implemented to reduce sleep-related infant death.	Inactive
ESM 5.5 - Percent of infants, sleeping or awake-and-unattended in crib, in a safe sleep environment	Active

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (New York) - Perinatal/Infant Health - Entry 3

Priority Need

Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population(cross-cutting).

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

Objective LC-11: Increase the percentage of Title V staff that improve their knowledge of health equity concepts by 20% from baseline (baseline to be established in conjunction with Strategy LC-15).

Objective LC-12: Increase the percentage of DFH procurements that demonstrate application of health equity strategies listed by 20% from baseline (to be established in Year 2-3).

Objective LC-13: Reduce disparities for all selected national and state performance measures by 5% from baseline (targets vary by measure).

Strategies

ESM LC-13: # of Title V programs for which health equity analyses completed

ESM LC-14: a) # of Equity Action Team meetings held; b) # of DFH staff who have completed one or more Equity Learning Labs

ESM LC-15: Percentage of DFH procurements that complete community listening forums as part of concept development process

ESM LC-16: Percentage of DFH procurements that demonstrate inclusion of evidence-based/-informed community engagement and collective impact strategies

ESMs	Status
ESM 5.1 - Initial infant mortality and morbidity data report published.	Inactive
ESM 5.2 - Percentage of eligible birthing hospitals participating in a current QI activity.	Inactive
ESM 5.3 - Capacity rates of local home visiting grantee projects (to be aligned with new MIEHCV performance measure, currently pending from HRSA MCHB).	Inactive
ESM 5.4 - Number of collaborative strategies implemented to reduce sleep-related infant death.	Inactive
ESM 5.5 - Percent of infants, sleeping or awake-and-unattended in crib, in a safe sleep environment	Active

NOMs
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (New York) - Perinatal/Infant Health - Entry 4

Priority Need

Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population(cross-cutting).

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

Objective PIH-1: Decrease the infant mortality rate by 18%, to 4.0 per 1,000 live births

Objective PIH-3: Increase the percent of very low birthweight (VLBW) infants born in a hospital with a Level III or higher Neonatal Intensive Care Unit (NICU) by 2%, to 94% of eligible infants.

Objective PIH-4: Decrease the SUID rate by 50%, to 0.3 per 1,000 live births

Strategies
Strategy PIH-1: Develop and implement an expanded plan for analysis and reporting of infant mortality and selected morbidity data, and issue initial data report.
Strategy PIH-2: Update NYS perinatal regionalization standards and designations and implement updated performance measures for Regional Perinatal Centers and affiliate birthing hospitals.
Strategy PIH-3: Continue to convene and lead structured statewide clinical quality improvement initiatives in birthing hospitals through the NYS Perinatal Quality Collaborative (NYSPQC).
Strategy PIH-4: Work with local home visiting grantees to increase capacity of established programs through improvements in outreach, enrollment and retention of eligible families.
Strategy PIH-5: Provide training and technical assistance to local MIECHV and MICHC grantees to enhance competencies of home visitors and community health workers related to pre- and interconception health, smoking cessation, substance abuse, safe sleep and breastfeeding promotion
Strategy PIH-6: Lead collaborative strategies to reduce sleep-related infant death.
Strategy LC-1: Integrate performance standards, measures and improvement strategies related to health insurance enrollment across all Title V/ MCH programs.
Strategy LC-14: Build internal capacity within the Division of Family Health (DFH)/ Title V Program to advance health equity through all Title V programs, including: creation of a cross-program DFH Equity Action Team; completion of an organizational assessment of equity practices, and facilitation of staff training and professional development through Equity Learning Labs.
Strategy LC-15: Integrate an equity framework into the development of all DFH/Title V procurements through community listening forums conducted as part of the concept development process.
Strategy LC-16: Incorporate evidence-based/-informed community engagement and collective impact strategies in all relevant DFH/Title V programs.
Note: Life Course Strategies and associated ESMs are fully described in the Life Course Domain, and repeat across multiple relevant domains/ priorities consistent with their cross-cutting design.

ESMs	Status
ESM 5.1 - Initial infant mortality and morbidity data report published.	Inactive
ESM 5.2 - Percentage of eligible birthing hospitals participating in a current QI activity.	Inactive
ESM 5.3 - Capacity rates of local home visiting grantee projects (to be aligned with new MIEHCV performance measure, currently pending from HRSA MCHB).	Inactive
ESM 5.4 - Number of collaborative strategies implemented to reduce sleep-related infant death.	Inactive
ESM 5.5 - Percent of infants, sleeping or awake-and-unattended in crib, in a safe sleep environment	Active

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (New York) - Perinatal/Infant Health - Entry 5

Priority Need

Promote oral health and reduce tooth decay across the life course

SPM

SPM 5 - The percentage of NYS residents served by community water systems that have optimally fluoridated water

Objectives

Objective LC-4: Increase the percentage of NYS residents served by community water systems that have optimally fluoridated water by 8%, to 77%.

Objective LC-5: Reduce the prevalence of dental caries among NYS children by 5%, to 8%.

Objective LC-6: Increase the percentage of children and adolescents age 1-17 years who had a preventive dental visit in the past year by 5% to 81%

Objective LC-7: Increase the percentage of pregnant women who had a dental visit during pregnancy by 5% to 57.6%.

Strategies

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

Strategy LC-7: Increase the delivery of evidence-based preventive dental services across key settings: • school-based clinics • primary care practices • public health nutrition programs.

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

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

FY 2017 Annual Report

Perinatal and Infant Health – State Priority #2: Reduce infant mortality and morbidity.

Addressing factors that lead to infant mortality (IM) continues to be at the forefront of all NY's maternal and child health initiatives. Overall, infant and neonatal mortality rates are declining in NY and are below the HP 2020 thresholds. NYS's infant mortality rate was 4.6 per 1,000 live births in 2015, up slightly from 4.5 per 1,000 births in 2014. The number of infant deaths was 1,079 in 2015, 280 fewer than in 2008. From 2008 to 2015, the IM rate declined 11% for non-Hispanic Whites to 3.40 per 1,000 live births; 22% for non-Hispanic Blacks to 8.5 per 1,000 live births; and 10% for Hispanics to 4.2 per 1,000 live births. Non-Hispanic Asian and Pacific Islanders had the lowest rate in 2015 at 2.8 per 1,000 live births, representing a 15% decrease since 2002 for this group. From 2008 to 2015, the neonatal mortality rate declined by 16% to 3.1 per 1,000 live births, while the post-neonatal mortality rate declined 17% to 1.5 per 1,000 live births.

Despite improvements, striking disparities exist. The ratio of non-Hispanic Black-to-White low birth weight rates was 1.9 in 2015, reflecting an increase in the rate of 1.8 in 2014. In 2015, the mortality rate for early term infants (37-38 weeks gestation) was nearly twice the rate of full term infants (39-40 weeks gestation): 2.32 and 1.31 per 1,000 live births, respectively. The three leading causes of infant death in 2015 were prematurity, congenital malformation and sudden unexpected infant death (SUID). Title V is leading statewide efforts with key stakeholders, agencies, partners, and providers to reduce infant deaths and decrease economic and racial/ethnic disparities in IM rates across NY. Through a variety of focused and collective evidence-based interventions, NY's Title V program is improving the ability of new parents to raise healthy infants through several strategies. This State Priority is measured through **NOM #8 Perinatal mortality rate per 1,000 live births plus fetal deaths.** NYS is below the national average at 5.5 per 1,000 live births in 2014 vs. 6.0 on the national level. NY also fares better than the national average based on National Vital Statistics Data for 2014 for **NOM #9.1 Infant mortality rate per 1,000 live births** at 4.6 vs. 5.8. NY is also lower than the national average for **NOM #9.2 Neonatal mortality rate per 1,000 live births** (3.2 vs. 4.0) and **NOM #9.3 Post-neonatal mortality rate per 1,000 live births** (1.4 vs. 1.9).and **NOM #9.4 Preterm-related mortality rate per 100,000 live births** (175.9 vs. 211.4).

In order to address priorities such as infant mortality on a state, regional or local level, it is imperative to access comprehensive data for identification, implementation and evaluation of public health initiatives. Over the past year, NY's Title V program developed and began implementation of an expanded plan for analysis and reporting of infant mortality and selected morbidity data and developed an initial data report, *Infant Mortality in New York State: Surveillance, Goals and Strategies for Reduction*, that highlights collaborations and describes trends in NYS's IM rates between 2002 and 2015, the DOH's plan to reduce IM, and identified further efforts needed to reduce IM.

To monitor progress of improving the health of woman, infants, and children and reducing health disparities, Title V staff are collaborating with the DOH's Office of Public Health Practice to develop a MCH dashboard (previously discussed in the Women Maternal Health section of the Annual Report), that will be comprised of National Performance and Outcome Measures as well as State Performance Measures and Objectives. The dashboard will serve as an interactive visual presentation of available national, state and county data (where available) that can be used by a wide group of public and private partners to identify trends and issues and develop strategies for improvement. The most current data are compared to previous year data to monitor performance. Multiple partners within the NYSDOH are collaborating to support the data presentation and content of the dashboard for Phase I release. Title V staff have finalized the list of indicators, determined state specific targets for the measures, and determined an outline of supporting documentation for the indicators.

An important factor in improving birth outcomes and reducing infant morbidity and mortality is ensuring access to comprehensive prenatal care. NYS has long supported access to comprehensive prenatal care for all women. Title V staff continued its collaborative efforts with the NY OHIP to ensure quality prenatal care services are available to NY's MA population. Services are available to women up to 223% of the Federal poverty level (FPL) and undocumented women, using State only funding. Supports are also provided to women to promote healthy behaviors and foster infant development. NY's Title V program is home to the MIECHV initiative that strives to improve the health and well-being of high risk families and reduce racial/ethnic disparities through 19 evidence-based home visiting programs including eight Nurse-Family Partnership (NFP) and 11 Healthy Families New York (HFNY) in ten high-risk counties. NY MIECHV grantees provided services to over 3,015 families in the FY16 (10/1/2016 to 9/30/2017) reporting period. New benchmark measures were reported for the first time in FY16, making the metrics incomparable to previous reporting periods. Below are examples of how NY performed in some of the new benchmark measures related to infant mortality:

- 10.7% of children served, born during the reporting period, were born preterm.
- 41.2% of children served reaching 6 months of age during the reporting period were being fed breastmilk at 6 months of age.

Recognizing the need to promote systems change on the local level to improve community-wide MCH outcomes, Title V has continued to fund 23 MICHC projects in 32 NY counties. The MICHC projects are community organizations funded to improve maternal and infant health (MIH) outcomes for high-need MA-eligible women and their families. The MICHC projects work with community partners to assess community needs and strengths and foster the development and coordination of services within the larger community system including, but not limited to, identifying and engaging high-need women and their families in health insurance and needed supports and services, ensuring coordinated follow-up to address their risks and needs, and through education and support, facilitating healthy behaviors across the lifespan for men, women, children, and families.

Improving birth outcomes requires greater coordination of referrals and services on the local level. Home visiting grantees expressed some concerns and confusion about where to enroll women into home visiting, when different home visiting programs are operating in close proximity. In addition, the length of enrollment as well as the number of home visits otherwise known as "dosage" has an impact on outcomes. Therefore, in October 2016 NY's Title V program invited all MICHC grantees to participate in the development of a coordinated intake and referral system pilot project in each MICHC community. Nine of the 23 MICHCs expressed interest in participating in this pilot project that aims to improve coordination and collaboration among home visiting programs, and ultimately improve community-level maternal and child health outcomes. Cohort one included four teams and began in January 2017; the teams made strides in developing local coordinated systems by developing partnerships with the other home visiting programs in their community, building trust among programs, completing several tools necessary for the planning of a coordinated system, and having a plan for implementation of a piece of their coordinated system. Cohort two includes five teams and began in January 2018. Title V staff provide programmatic support through in-person meetings, monthly coaching calls, sample tools, webinars, and ongoing technical assistance. Lessons learned from cohort one improved the process for the cohort two teams; the lessons include focusing more time up-front on building trust among home visiting programs, getting to know each other's programs, and maintaining a regular meeting schedule. Additional lessons will be learned as cohort one begins to implement pieces of their coordinated system and as cohort two begins to plan their coordinated systems. These lessons will help inform the development of standards of practice for community-led coordinated intake and referral systems in home visiting throughout NYS communities. Title V staff received federal TA through HRSA's TA provider, HV-ImpACT, for the coordinated intake and referral system pilot project between November 2016 and February 2018. HV-ImpACT provided one-on-one technical assistance to Title V staff to assist in researching coordinated intake systems from around the country, developing a pilot process, designing tools and activities that help the coordinated intake pilot teams build their coordinated systems, and developing monthly coaching calls.

Addressing a public health issue such as infant mortality requires coordination of all available resources to address the complex factors leading to infant deaths. MICHC initiatives are located in areas of the NYS also served by federal Healthy Start (HS) grantees, namely in Queens, Brooklyn, Staten Island, Harlem, Bronx, Syracuse, and Rochester; five of the seven NY HS grantees are also MICHC grantees. Title V staff meet semi-annually with the HS grantees to discuss communication, collaboration, and

coordination between the HS and MICHC programs to maximize existing resources, and improve community infrastructure. All NYS HS programs have been invited to trainings provided by the MIH COE (described in the next paragraph) and attend the annual provider meeting to foster ongoing communication and collaborative efforts. Quarterly calls with the NY HS grantees and Title V staff began in October 2017. The calls increased involvement of the HS grantees in NYSDOH initiatives, for example Medicaid's First 1000 Days and the Infant Mortality CoIIN. They also help Title V staff connect local grantees to HS efforts in their communities, such as the coordinated intake project that the Brooklyn HS program was launching.

NY's Title V program continues to enhance local systems building efforts through training, technical assistance, data collection and analysis, and quality improvement for NY's Title V community-based MIH programs, including the MICHC and MIECHV. The Title V program held the second annual meeting of the MIH and Title V staff in May 2017 and provided training on a variety of topics (e.g., substance abuse, sexually transmitted diseases, maternal depression). Evaluations show that home visitors gained new information and feel able to apply what they learned. Title V staff began monthly MICHC calls in December 2017 with a discussion about CHW data and quarterly MIECHV calls began in January 2018 with a discussion about increasing referrals into home visiting programs. Topics for both MICHC and MIECHV calls include family engagement, referrals made by the program, and breastfeeding.

Title V began the 2016-2017 MIECHV Continuous Quality Improvement (CQI) plan which used two strategies to improve recruitment and retention of families in home visiting services – proactive communication with families and securing multiple contact numbers to connect with families. Early results suggest a small improvement in retention; a full report will be completed in May 2018. Work on the next CQI cycle is in its early stages with a focus on improving referrals to the program and breastfeeding duration. NYS DOH is receiving federal TA from HRSA to build competencies for CQI strategies. The support from the practicum will help establish a strong CQI framework for NYS, which will foster replication in future years.

Title V staff continued to lead efforts to improve the health and well-being of young people and their newborns. Through the Pathways to Success initiative, Title V continued to provide support for three high schools and community colleges in Erie and Monroe counties and the Bronx (for the period 6/30/16-7/31/17) to create and sustain supportive systems that assist pregnant and parenting teens/young adults to succeed through health, education, self-sufficiency, and building strong families. The funded projects collaborate with Title V programs such as MICHC and MIECHV for home visiting supports, and other programs to strengthen support networks and referral systems for pregnant and parenting teens/young adults in these communities. Students enrolled in the projects receive healthcare referrals for prenatal, interconception, and postpartum care, social service referrals to the Supplemental Nutrition Assistance and Women, Infants and Children's program, local Department of Social Services (DSS), and educational supports to better ensure academic success. From 6/30/16-7/31/17, the program served 699 students (133 high school and 566 community college) and 96 children, with a total of 2,812 direct services received by program participants. All six pilots developed sustainability and action plans that included clearly defined timelines outlining the responsibilities of key personnel, including: carrying out the mission of the Pathways Program; transitioning core components of programs, including beginning to leverage shared positions and resources; and cross training of other school personnel, social workers and guidance counselors. In addition, all six pilots were able to incorporate Pathways to Success program staff into the existing infrastructure in order to maintain services.

A new Pathways to Success project was funded beginning 7/1/17-6/30/18 focused in NYC based on 2014 NYS Vital Statistics data showing Kings, Bronx and Queens counties with the highest birth rates among 15 - 24-year-old females. Funding supports three community colleges, a community-based organization and a high-school based program to develop, expand and sustain supportive communities to help expectant and parenting teens/young adults succeed. This will be accomplished by strengthening linkages and existing NYC infrastructure to create sustainable systems of tightly integrated health, education, and social service supports-while leveraging existing resources within DOH's Title V programs. In late 2017, a new funding announcement was released. DOH applied for additional funding. If awarded, the project will continue in the three community colleges and the community-based organization.

In addition to strong community supports and services, improving birth outcomes necessitates a strong system of perinatal hospital services, ensuring pregnant and postpartum women and newborns receive a comprehensive level of care to meet their needs. Perinatal regionalization is essential to improving the health of pregnant and postpartum women and infants. NY has achieved long-standing leadership in the field of perinatal regionalization by ensuring pregnant and postpartum women and their newborns receive care from, and deliver at, a perinatal hospital with the appropriate level of expertise. In 2015, 92.7% of VLBW infants were delivered at facilities for high risk deliveries and neonates, well above the HP 2020 target of 82.5%. NY's system of regionalized perinatal services includes a hierarchy of four levels of perinatal care provided by the hospitals within a region and led by a RPC. The regional systems are led by RPCs capable of providing all services and expertise required by the most acutely sick or at-risk pregnant women and newborns. RPCs provide or coordinate maternal-fetal and newborn transfers of high-risk patients from their affiliate hospitals, and are responsible for support, education, consultation and improvements in the quality of care in the affiliate hospitals within their regions.

Due to the changing landscape of the health care system as well as standards of perinatal care, the DOH is fully supporting efforts to update perinatal hospital standards in NYS. NY's Title V program developed a process to re-designate all obstetrical hospitals, and develop standard metrics to assess maternal and neonatal outcomes to identify opportunities for quality improvement. The project started with researching current standards of care including ACOG/AAP Guidelines for Perinatal Care and review of literature. Title V staff worked with key stakeholders to identify an expert panel consisting of clinicians, hospital associations, health plans and others to work with the DOH to recommend standards for the perinatal system of care. Three in-person meetings of the expert panel were held to discuss recommendations for updated standards. Due to the complexity of the system, subcommittees were developed on specific topics requiring more in-depth discussion including topics such as the role of the RPC, subspecialty requirements for level of care, behavioral health and finance. The subcommittees were comprised of expert panelists and experts in the field and met between meetings of the full expert panel to refine recommendations. The final meeting of the expert panel on May 10, 2018 was an opportunity to review and discuss the proposed recommendations made by the expert panel through the first two in-person meetings and the multiple subcommittees. In 2016, legislation was passed allowing mid-wife led birthing centers in NYS. The new standards will include birthing centers as the first level of care followed by Levels 1 through 3 and RPCs as the highest level of perinatal care. (**ESM PIH-2: Percentage of birthing hospitals re-designated with updated standards.**) The goal of this important initiative is to strengthen the perinatal regionalized system in NYS to ensure all birthing centers and obstetrical hospitals in NY meet current standards of care, and are affiliated with a strong RPC, in order for all pregnant and postpartum women and newborns to receive the best care possible at an appropriate level perinatal hospital.

To build on NY's rich system of perinatal care and aim to provide the best and safest care for pregnant and postpartum women and infants, Title V staff lead the NYSPQC initiative through collaboration with RPCs, RPC affiliate birthing hospitals, perinatal care providers, community-based organizations, NY's hospital associations, the National Institute for Children's Health Quality (NICHQ), and other key stakeholders. The initiative aims to prevent and minimize harm through the translation of evidence-based guidelines to clinical practice. Several initiatives under the scope of the NYSPQC focused on reducing infant mortality and morbidity including: the, IM-CoIIN Safe Sleep Hospital-based and Community-based Safe Sleep Projects, NYSPQC Enteral Nutrition Improvement Project, NYSPQC/March of Dimes (MOD) Big 5 State Prematurity Collaborative Antenatal Corticosteroid Treatment (ACT) Project, and NYS Opioid Use Disorder (OUD)/Neonatal Abstinence Syndrome (NAS) Project

The NYSPQC Hospital-based Safe Sleep Project began in September 2015 and focused on improving safe sleep practices to reduce IM in NY. The project aligned with national and NY efforts pertaining to the IM-CoIIN. NY's Title V program worked with 81 NY birthing hospitals, that had 183,605 (77.2%) statewide births in 2014, to improve infant safe sleep practices. Participating facilities collaborated across hospital teams to share and learn, implemented hospital policies to support/facilitate safe sleep practices, educated health care professionals, endorsed and modeled safe sleep practices, and provided infant caregivers education opportunities on safe sleep. All NY birthing hospitals assessed practices and variation across facilities in relation to infant safe sleep.

During the reporting period, Title V staff held one in-person Learning Session, and five Coaching Call webinars. Project participants reported a 9% increase in medical records with documentation of safe sleep education; 38% increase in the percent of infants, sleeping or awake-and-unattended in crib in a safe sleep environment; 10% increase in the percent of caregivers who reported they received information on how to put their baby to sleep safely; and 22% increase in the percent of primary caregivers indicating they understood safe sleep practices, between September 2015 and July 2017. As of July 2017, the project entered sustain mode. Currently, 70 birthing hospitals continue to submit data to the NYSDOH regarding the percent of infants, sleeping or awake-and-unattended in a crib, in a safe sleep environment, during the birth hospitalization.

An *Information for Action* document was developed to provide basic information and action steps on IM related to an unsafe sleep environment. The bulletin includes data for NYS including racial and ethnic differences related to IM due to unsafe sleep and key measures from PRAMS (e.g., placing a baby on its back to sleep, co-sleeping). It also includes action steps including "do's and don'ts" for safe sleep, what parents, healthcare providers, community-based organization and local health departments can do, and resources for additional action. *Information for Action* bulletins are developed by Title V staff in collaboration with the DOH OPHP that provide basic data and information on public health priorities as well as strategies to address the issue. Over the past year, Title V released bulletins on Prematurity, Smoking Relapse Postpartum and Unsafe Sleep.

Also through the NYSPQC Safe Sleep Project, the Title V program engaged MICHC grantees in three communities (Orange, Onondaga, and Suffolk Counties) to develop and implement safe sleep practices by providing safe sleep education to caregivers, 98% of whom are mothers. Surveys were administered 30-60 days later to assess the effectiveness of safe sleep education on caregivers' safe sleep practices in the home setting. This project began in September 2015 and continued through July of 2017. Best practices will be distributed to MICHC projects across NY.

Additionally, under the HRSA-led national IM-CoIIN, Title V focused on increasing awareness and collaboration for stakeholders on one of the leading causes of IM in NY, Sudden Unexpected Infant Death (SUID). The NY IM-CoIIN develops key projects in partnership with the child welfare system including the NY OCFS, NY OASAS, the Division of Nutrition's (DON) Women, Infants and Children (WIC) clinics, and NY Department of Motor Vehicles. In partnership with OCFS, patient education materials highlighting the ABCs of safe sleep (Alone, Back, Crib) were developed in 2015, and distributed to all NY birthing hospitals in 2015 and 2016. These safe sleep materials included a brochure available in the seven most commonly spoken languages in NY, mirror clings, magnets, posters in English and Spanish, crib cards, and a one-minute video in English and Spanish made available on the NYSDOH YouTube channel. To ensure the safe sleep video was accessible and usable for all birthing hospitals and stakeholders, it was closed captioned into additional languages, and made available to birthing hospitals on both flash drives and DVDs. The DOH also adapted an anatomical diagram originally created by National Institutes of Health (NIH) to provide patient education on the importance of putting a baby to sleep on his/her back while addressing the concern parents have regarding the potential for babies choking while they are on their backs. The anatomical diagram was also translated into multiple languages, laminated, and made available to all NYS birthing hospitals and stakeholder organizations. NY's efforts related to safe sleep are measured by **NOM #9.5 Sleep related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births.** NY is far below the national average as reported in 2014 of 56.5 vs. 87.2 which demonstrates the efforts NY has made to reduce the incidence of SUID.

The NYSPQC initiative also focused on an Enteral Nutrition Improvement Project that aims to reduce the percentage of newborns <31 weeks' gestational age discharged from a NICU below the 10^{th} percentile on the Fenton growth scales. Outcome, process, and balancing measures are calculated for infants born prior to 31 weeks' gestation and admitted within 48 hours of birth to a NICU and discharged alive. Key measures are the percentage below the 10^{th} percentile for discharge weight on the Fenton Growth Scale, difference in Z-scores for birth and discharge weights, percentage below the 10^{th} percentile for head circumference on the Fenton Growth Scale, difference in Z-scores for birth and discharge head circumferences, post menstrual age at discharge (days), and

median initial length of stay (days). All NY RPCs began participation in 2010 and the initiative was expanded in 2016 to include 20 Level III facilities. All facilities share efforts and results through monthly Coaching Calls and quarterly performance measure data reports. The initiative has continued to significantly increase the use of breast milk at all feeding junctures, increases in weight and head circumference percentages below the 10th percentile at discharge have been noted. These seeming reversals of previous gains in growth improvement are consistent with the apparent breast milk paradox where breast milk-fed infants experience slower growth (Roze´ J-C, Darmaun D, Boquien C-Y, et al. BMJ Open 2012;2:e000834. doi:10.1136/bmjopen-2012-000834). No increase in the incidences of nosocomial sepsis or NEC, nor an increase in the babies discharged more than the 75th percentile for either growth measure indicate the interventions are safe. A manuscript entitled, "*Variation in Enteral Feeding Practices and Growth Outcomes among Very Premature Infants: A Report from the NYS Perinatal Quality Collaborative,*" was published in the *American Journal of Perinatology* in January 2016; a second manuscript entitled, "*Statewide Initiative to Reduce Postnatal Growth Restriction among Infants <31 Weeks' Gestation* " was accepted in January 2018 for publication in *The Journal of Pediatrics*, and seven abstracts have been published and presented at national meetings based on this project.

To reduce neonatal morbidity and mortality, the NYSPQC/MOD Big 5 State Prematurity Collaborative ACT Project worked toward improving hospital obstetric practices so all pregnant women at risk for delivery between 23 0/7 and 34 0/7 weeks' gestation receive appropriate ACT. According to 2014 NY birth data, only 36% of mothers with infants born between 23 0/7and 34 0/7 weeks' gestation received ACT. Participating NY RPCs, recruited by the NYSPQC, collaborated with hospitals from other Big 5 states regarding ACT to align goals and resources to bring more attention and energy to this effort. The joint project addressed the understanding and timing of ACT administration and standardization of assessment of imminent delivery. National and NY specific ACT Coaching Call webinars gave NY RPCs the opportunity to learn from national experts and hospital teams. Data collected through the Big 5 State Prematurity Collaborative showed that among participating hospitals, the percent of births between 23 0/7 and 34 0/7 weeks' gestation receiving any ACT increased from 90% in January 2016, to 93% in October 2017. Participating hospitals also reported an increase in the percent of births receiving ACT in the optimal period, 24 hours to seven days prior to delivery, from 51% of births in January 2016 to 60% in October 2017.

NY's Title V program has also been involved in discussions and plans related to DSRIP which include at least one project focusing on increasing the use of evidence-informed policies and evidence-based programs pertaining to the healthy development of children, youth, and adults. DSRIP providers are encouraged to collaborate with the community and other providers to address statewide public health priorities pursuant to NY's PA, namely Prevention of Chronic Diseases, Promoting a Healthy and Safe Environment, Promoting Healthy Women, Infants, and Children through the prevention of prematurity, Promoting Mental Health and Preventing Substance Abuse, Prevention of HIV/STDs, Vaccine-Preventable Disease and Healthcare-Associated Infections. Some of these projects are focused on increasing support for maternal and child health through expansion of NFP projects or the use of CHWs for community outreach and engaging women in prenatal care. Through Medicaid Redesign, Health Information Technology (HIT) projects were established in four high need areas (Monroe, Onondaga, Westchester, and Kings counties) to demonstrate the effectiveness of HIT to coordinate perinatal services, reduce costs by streamlining fragmented and redundant systems, increase on-time patient access to medical records, and improve quality of care. In 2017, one of the HIT projects (i.e. Westchester) stepped down, as they were not able to meet the planned objectives. The other three projects completed the development and are at varying stages of implementation. The HIT systems are designed to identify the medical, pregnancy, and psycho-social risks of pregnancy women, and make and track referrals to the needed services. During development of the HIT systems, national guidance and state legal counsel addressed system issues related to confidentiality. In 2018, data extract templates are being developed for the pilot projects to submit de-identified aggregate data. Based on gathered data extracts, analysis will be conducted and reported to the state and Medicaid Redesign Team, presenting the efficacy of the HIT projects in the targeted communities.

Title V remains ready to address any public health issue impacting the maternal and child health population including new and

emerging public health priorities such as the Zika virus and opioid epidemic. (Refer to the annual report and application section for Maternal and Women's Health for information related to NY's Title V role in the opioid epidemic.)

FY 2019 Application

State Priority #2: Reduce infant mortality and morbidity

2020 State Objectives:

- **Objective PIH-1: Decrease the infant mortality rate by 18%, to 4.0 per 1,000 live births**
- **Objective PIH-2: Decrease the preterm birth rate by 5%, to 8.4% of live births**
- **Objective PIH-3: Increase the percent of very low birthweight (VLBW) infants born in a hospital with a Level III or higher Neonatal Intensive Care Unit (NICU) by 0.2%, to 94% of eligible infants.**
- **Objective PIH-4: Decrease the SUID rate by 20%, to 0.5 per 1,000 live births**

IM, or the death of children under one year of age, is a fundamental indicator of the health of a population. In addition to being used as a measure of infant death, IM also serves as a proxy measure for the overall health and wellbeing of a community. In 2015, the United States (US) IM rate of 5.9 deaths per 1,000 live births lagged far behind other industrialized nations. In order to address this significant public health priority, the Title V program is promoting efforts to reduce infant deaths and decrease economic and racial/ethnic disparities in IM rates across NY through a variety of focused and collective evidence-based interventions.

Reducing IM is a longstanding, fundamental priority for NY's Title V Program. NY's IM rate is better than the HP2020 Goal and US rate, and has been improving over the last decade, driven primarily by reductions in NYC, where about half the births in NYS occur. As measured by **PIH-1**, NY's infant mortality rate was 4.6 per 1,000 births in 2015, up slightly from 4.5 in 2014. There are, however, persistent and marked racial, ethnic, and economic disparities in IM rates across NY. This priority is closely linked to other state priorities, including Priority #1: Reduce maternal mortality and morbidity, and all four life course priorities (#5-8). As noted for Priority #1 above, strategies to address IM are largely inextricable from those to address maternal mortality and morbidity, thus, the strategies and performance measures described above for Domain 1 should be considered part of the continuum of public health activities to address Priority #2.

Progress toward achievement of objectives and outcomes associated with Priority #2 are being tracked through **NPM #3: Percent of Very Low Birth Weight (VLBW) infants born in a hospital with a Level III or higher Neonatal Intensive Care Unit (NICU).** In 2015, 92.7% of VLBW infants in NYS were delivered at hospitals with a Level III or higher NICU, well above the HP 2020 target of 82.5%. and **NPM 5**: Percent of infants placed to sleep on their backs. **NPM #5 Percent of infants placed to sleep on their backs** is viewed as a proxy for both sleep positioning and other safe sleep practices that are the focus of prevention strategies. PRAMS data shows that NYS increased the percent of infants from 63.8 in 2014 to 75.8 in 2015. While not selected for reporting purposes due to MCHB's limit on the number of NPMs per state, NY will also follow and focus on improving NPM 4: Percent of infants ever breastfed and exclusively breastfed for 6 months. In 2015, 87.6% of NY infants initiated breastfeeding, yet only 44.8% were fed exclusively breast milk in the hospital. Using separate survey data for infants born in 2013, 55.8% of babies were breastfeeding at age 6 months, but only 19.7% were exclusively breastfed. The Title V program continues to collaborate with BCDP in efforts to increase exclusive breastfeeding in NY's hospitals and promote and support breastfeeding in community efforts such as home visiting and supports provided by the MICHC's community health workers. This is also one of the priorities of NY's PA and will continue to remain a priority in hospital and community efforts.

Strategy PIH-1: Develop and implement an expanded plan for analysis and reporting of infant mortality and selected morbidity data, and issue initial data report.

As noted above, inclusion of strategies to enhance public health surveillance and data analysis activities in each population health

domain is a cross-cutting priority for NY's SAP, as an essential public health function to inform ongoing program and policy development, implementation, and evaluation. While IM data from NY's Statewide Perinatal Data System (SPDS), including birth certificate and NICU module data, are reviewed annually by Title V staff, more focused analyses need to be accomplished to develop a complete picture of this priority.

To combat the national crisis of IM, Title V leads a statewide collaboration of key stakeholders, agencies, partners, and providers to reduce infant deaths and decrease economic and racial/ethnic disparities in IM across NY through a variety of focused and collective evidence-based interventions. Title V continues to develop the *Infant Mortality in New York State: Surveillance, Goals and Strategies for Reduction* report, a document that describes trends in IM rates in NY between 2002 and 2015 and the action plan to reduce the number of infants who do not survive their first year of life. Title V plans to revise and update the document periodically as new data become available to provide the most up-to-date information for the key stakeholders, partners, and providers.

As stated in the annual report section of this domain, Title V staff are collaborating with the Department's OPHP to develop a MCH dashboard. Title V staff have identified those measures that will be included in Phase 1 of this dashboard and determine state specific targets for the measures as well as a process to increase awareness and the existence and use of the dashboard among key stakeholders as it is developed. The expected launch for the MCH dashboard is summer 2018.

Strategy PIH-2: Update NY perinatal regionalization standards and designations and implement updated performance measures for Regional Perinatal Centers and affiliate birthing hospitals.

NY has been a leader and national model for the development and oversight of a regionalized system of perinatal care. NY's system includes a hierarchy of four levels of perinatal care, led by RPCs capable of providing all the services and expertise required by the most acutely sick or at-risk pregnant and postpartum women and newborns. RPCs provide or coordinate maternal-fetal and newborn transfers of high-risk patients from their affiliate hospitals, and are responsible for support, education, consultation, and improvements in the quality of care in the affiliate hospitals within their regions.

Although NY exceeds the HP 2020 goals for delivery of VLBW infants in Level 3 or 4 perinatal hospitals, standards of perinatal care have evolved and the landscape of the perinatal hospital system, as well as health care coverage and systems, has changed. As measured by **PIH-3**, in 2015, 92.7% of VLBW infants in NYS were delivered at hospitals with a Level III or higher NICU, well above the HP 2020 target of 82.5%. NY will ensure all perinatal hospitals and birthing centers are functioning in accordance with current standards of care for both maternal and infant outcomes by continuing to lead efforts to update standards for perinatal regionalization in NYS, re-designate all birthing hospitals and birthing centers in the state, and engage RPCs and their affiliates in quality assurance and improvement activities to implement the updated standards, and monitor and improve performance and outcomes. This work began in 2017 and is jointly led by the DOH OPCHSM, which is responsible for regulatory oversight of hospitals, and is being accomplished in close partnership with key partners including birthing hospitals, clinicians, hospital associations, professional organizations and other key stakeholders.

To ensure standards for NY's system of regionalized care aligned with current standard of practice, Title V staff began this initiative by researching standards of care for perinatal levels of regionalized care as well as conducting an extensive review of research and literature for evidence-based and promising practice. An expert panel, co-chaired by the Executive Director of ACOG-NY and the Associate Commissioner, Western Region, DOH, was then established that consisted of maternal fetal medicine specialists, obstetricians and nurses for RPCs, Level III and Level II perinatal hospitals across NYS. In addition, the panel consisted of representatives from the NYS Association of Licensed Midwives, Healthcare Association of NYS, Greater NY Hospital Association, Community Healthcare Association of NYS, March of Dimes, NYS Academy of Family Physicians, NYS Nurses Association, and representatives from health plans and NY's Department of Financial Services. To gain a national perspective, the panel also included a representative from the Association of Women's Health, Obstetric and Neonatal Nurses and a representative

from the ACOG Maternal Care Consensus Panel from the University of North Carolina.

Over the past year, three meetings of the expert panel were held where the panel reviewed standards of care and made recommendations to the DOH regarding standards for care for birthing centers, Level I, II, III perinatal hospitals and RPCs. The standards included recommendations for requirements and qualifications of clinical and ancillary staffing, facility requirements and equipment, and laboratory requirements among others. Due to the complexity of the process, subcommittees of the panel were formed to address the topics of: role of the RPC; neonatal and maternal subspecialists requirements; behavioral health; transports; volume and acuity standards as well as finance. A majority of the recommendations have been finalized with subcommittee discussions remaining to address final recommendations regarding subspecialists, volume and acuity standards and finance. Once the panel finalizes recommendations, DOH will consider all recommendations and finalize standards for levels of care in NYS. Once final, the standards and process will be presented via webinars to ensure all are informed of the updated requirements. Subsequent to this, a survey process will be conducted among all NY birthing centers and obstetrical hospitals. The surveys will be used to assign appropriate levels to all maternity hospitals in the state and identify RPCs as the hubs for networks of lower level facilities. Due to the complexity of the undertaking, this has been a multi-year process with final re-designations occurring in 2020.

Implementation of this strategy will be tracked by **ESM PIH-2**: **Percentage of birthing hospitals re-designated with updated standards.** The annual objective for this ESM to reflect 0 in 2019 as the process continues. It is anticipated that perinatal designations will be made in 2020 based on the revised standards.

Strategy PIH 3:

Convene and lead structured statewide clinical quality improvement initiatives in birthing hospitals through the NY Perinatal Quality Collaborative (NYSPQC).

NY's Title V Program leads the NYSPQC, a robust initiative comprising multiple structured projects to improve the quality of care and maternal and infant health outcomes in birthing hospitals. Building on the previously-completed projects to reduce early elective deliveries, improve clinical practices related to assessment and education for maternal hemorrhage and hypertension, reduce Central Line Associated Blood Stream Infections (CLABSIs) in the NICU, and improve infant safe sleep practices to reduce infant mortality, there are several NYSPQC projects currently underway related to IM reduction.

NYSPQC, which is convened and led by the Title V program, continues to focus on providing the best and safest care for women and infants in NY by collaborating with birthing hospitals, perinatal care providers, and other key stakeholders to prevent and minimize harm through the translation of evidence-based guidelines to clinical practice. The intervention projects of the NYSPQC for the coming year are:

- Reducing maternal morbidity and mortality by improving the assessment, identification and management of obstetric hemorrhage. The NYSDOH NYSPQC is leading this project in collaboration with ACOG District II, GNYHA and HANYS;
- Preventing, identifying and managing women with opioid use disorder during pregnancy, and improving the identification, standardization of therapy and coordination of aftercare of infants with neonatal abstinence syndrome. This project is being undertaken as a collaboration of the NYSDOH NYSPQC and ACOG District II, as part of the national Alliance for Innovation in Maternal Health (AIM);
- Reducing infant mortality by improving safe sleep practices; and
- Optimizing early enteral nutrition in newborns of <31 weeks gestational age to minimize discharge from a neonatal intensive care unit (NICU) below the 10th percentile on the Fenton growth scale.

Approximately 80 birthing hospitals across NY are collaborating with the DOH on one or more of these projects.

Data gathered through the Maternal Mortality Review Initiative will continue to be used by NY's Title V program to incorporate efforts into the NYSPQC to identify areas where QI activities can improve outcomes. The NYSPQC has implemented a new obstetric focus area on maternal hemorrhage, the leading cause of maternal morbidity and mortality in NY. This was previously discussed under Priority 1 regarding maternal morbidity and mortality.

The NYSPQC is developing an initiative focused on preventing, identifying and managing women with opioid use disorder (OUD) during pregnancy, and improving the identification, standardization of therapy and coordination of aftercare of infants with neonatal abstinence syndrome (NAS). The OUD/NAS project is being undertaken as a collaboration of the NYSDOH and ACOG District II, as part of the national Alliance for Innovation in Maternal Health (AIM). The NYS specific project is in early development, and is anticipated to run similarly to other NYSPQC quality improvement learning collaborative projects, for a 12-18-month period. The NYSDOH expect to recruit ~10 – 15 NYS birthing hospitals at all levels, on both the OB and pediatrics/neonatal side, to begin piloting targeted interventions.

NY's Title V program continuously considers focus areas for future initiatives through the NYSPQC. Potential projects that may be explored include: unplanned extubation in NICU patients; antibiotic stewardship among patients in the NICU; and management of the obese obstetric patient.

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

As the designated lead agency for NY's MIECHV initiative, NY's Title V program plays a key leadership role in overseeing the implementation of both federal and state funds for evidence-based home visiting programs, specifically NFP projects and coordinated closely with partner agencies that implement other home visiting programs, including the HFNY led by the NY OCFS. See the Annual Report section of this Domain for further information.

As a key focal point for strengthening and increasing the impact of home visiting on MCH outcomes that aligns closely with federal MIECHV priorities, NY's Title V program will continue to provide training, technical assistance, and CQI cycles. Title V staff have been working with NFP and HFNY home visiting programs funded by the federal MIECHV grant to improve client retention through CQI in 2016-2017. Two strategies were used – proactive communication with families and securing multiple contact numbers to improve the ability to contact families. While early results suggest an improvement in retention, Title V staff will complete analysis of the results of the CQI retention evaluation in the coming year (as discussed in the Annual Report section of this Domain).

The FY 2017/18 MIECHV CQI cycle includes two new projects, addressing the following topics: referrals into programs and breastfeeding duration. These topics were chosen by the MIECHV programs through surveys. Additionally, these topic areas closely align with the MIECHV state and federal priorities. The focus on referrals into the program is to increase referral into programs for increased enrollment by September 30, 2018, in order to increase the MIECHV capacity utilization to 85% from 75.8%. The focus on breastfeeding duration is to increase the proportion of infants who were breastfed any amount at 6 months of age (among mothers who enrolled in home visiting prenatally) by 10%, from 42% to 46.2% by September 30, 2018. Based on lessons learned in the previous cycle, DOH began the new cycle working with MIECHV programs to create process maps for their respective topics. The next step will be to support MIECHV programs as they implement Plan, Do, Study, Act (PDSA) cycles. Data will be collected by the NYSDOH and reviewed monthly to determine if impact of change has occurred.

As stated in the Annual Report section of this Domain, NY's Title V program embarked on the development of a community coordinated intake and referral system for home visiting services. The aim of the pilot is to improve coordination and collaboration among maternal, infant, and early childhood home visiting programs in communities and link families to programs most appropriate to their needs and preferences using a locally-developed coordinated intake and referral system. The long-range goal of this pilot is

community-level improvement in pregnancy outcomes and children's health and development, and strengthening of family function over the life course.

The Title V program will continue to provide programmatic support and technical assistance to nine pilot communities, including the four in cohort one that began in January 2017 and the five that began in January 2018. The pilot communities are provided with technical assistance through webinars, in-person meetings and discussions and sample processes and tools to facilitate the development of the central intake system. The Title V program also facilitates a learning collaborative to build systems that work for the target community and families served. Pilot programs are provided with sample triage tools/decision trees to adapt to their community's needs. Lessons learned from this pilot will help inform the development of standards of practice for coordinated intake and referral systems for home visiting in communities across NYS.

Strategy PIH-5:

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

Ensuring supports are available in the community to improve maternal and infant health outcomes and to reduce racial, ethnic and economic disparities in those outcomes is a priority of NY's Title V program. As described elsewhere in this application, in addition to MIECHV, the Title V program supports a MICHC initiative; community-based organizations that strive to improve maternal and infant health outcomes for Medicaid-eligible high-need low-income women and their families while reducing persistent racial, ethnic and economic disparities in those outcomes. MICHC projects use a combination of individual/family strategies, implemented primarily through the engagement of CHWs, and organizational/community level strategies to improve environmental factors and systems. The Title V program will continue to oversee the local implementation of both MICHC and MIECHV projects as a central component of NY's SAP for both maternal and infant health.

Both MICHC and MIECHV are part of NY's core Title V infrastructure for reaching, engaging and supporting MCH populations, high-need women, infants and families. MICHC and MIECHV home visitors have been receiving training on a variety of topics, including intimate partner violence, substance use, mental health, smoking cessation, self-care, and interconception care. Evaluations show that home visitors gained new information and feel able to apply what they learned. Title V staff continuously support MICHC and MIECHV grantees on training of these priority areas (mentioned above) and other topics based on feedback from grantees through in-person meetings, regular webinars/calls with Title V staff, and webinar trainings available through other Maternal and Child Health sources. Title V staff hold quarterly MIECHV webinars/calls and monthly MICHC webinars/calls. Introductory training is provided for new MICHC home visitors, which includes core competencies. Quarterly reports and data analysis will continue to serve to evaluate progress and success in meeting training needs and provide guidance, training, and technical support to grantees concerning data collection and reporting.

Strategy PIH-6:

Lead collaborative strategies to reduce sleep-related infant death.

As described in the Annual Report for this Domain and other relevant NY SAP strategies, NY's Title V Program has been leading the state's work under the HRSA-led national IM-CoIIN since 2015. A major focus of this work in NY has been to promote safe sleep practices. SUID is among the leading causes of IM in the state, and a focus has been on increasing awareness and collaboration for stakeholders and including partners working in the child welfare system. The NY IM-CoIIN team focuses on improving infant safe sleep, and included partners from the NY OCFS, NY OASAS, and the DON's Supplemental Nutrition for WIC programs.

Title V staff continue to work with the national IM-CoIIN, and specifically NICHQ, to improve safe sleep education and practices through collaboration with community-based organizations. NY's Title V program through NYSPQC is currently recruiting organizations to continue to improve safe sleep practices, with an emphasis on reducing disparities. Organizations being targeted for participation include MICHCs, Healthy Starts and HFNY. This project is in early stages of development.

The NYSPQC Hospital-based Safe Sleep Project entered sustain mode in July 2017. Currently, 70 birthing hospitals continue to submit data to the NYSDOH regarding the percent of infants, sleeping or awake-and-unattended in a crib, in a safe sleep environment, during the birth hospitalization.

Finally, staff from the Title V are collaborating with the National Action Partnership to Promote Safe Sleep – Innovation and Improvement Network (NAPPSS-IIN). Specifically, NAPPSS 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, which is funded by HRSA's MCHB, engaged five pilot site hospitals in five states, including NYS. NYS's representative hospital is New York Presbyterian (NYP) Lawrence (Westchester). Title V staff are working as part of the larger national project, and in support of NYP Lawrence.

As an outgrowth of this work, Title V will continue to collaborate with NY's WIC program to disseminate safe sleep messages to parents. Infant safe sleep posters in English and Spanish will continue to be provided and posted in all of NY's 400 WIC clinics. These, along with supplies of the infant safe sleep brochure, will continue to reinforce the safe sleep message that new parents receive during the birth of their infants.

FY 2019 Application

State Priority #2: Reduce infant mortality and morbidity

2020 State Objectives:

- **Objective PIH-1: Decrease the infant mortality rate by 18%, to 4.0 per 1,000 live births**
- **Objective PIH-2: Decrease the preterm birth rate by 5%, to 8.4% of live births**
- **Objective PIH-3: Increase the percent of very low birthweight (VLBW) infants born in a hospital with a Level III or higher Neonatal Intensive Care Unit (NICU) by 0.2%, to 94% of eligible infants.**
- **Objective PIH-4: Decrease the SUID rate by 20%, to 0.5 per 1,000 live births**

IM, or the death of children under one year of age, is a fundamental indicator of the health of a population. In addition to being used as a measure of infant death, IM also serves as a proxy measure for the overall health and wellbeing of a community. In 2015, the United States (US) IM rate of 5.9 deaths per 1,000 live births lagged far behind other industrialized nations. In order to address this significant public health priority, the Title V program is promoting efforts to reduce infant deaths and decrease economic and racial/ethnic disparities in IM rates across NY through a variety of focused and collective evidence-based interventions.

Reducing IM is a longstanding, fundamental priority for NY's Title V Program. NY's IM rate is better than the HP2020 Goal and US rate, and has been improving over the last decade, driven primarily by reductions in NYC, where about half the births in NYS occur. As measured by **PIH-1**, NY's infant mortality rate was 4.6 per 1,000 births in 2015, up slightly from 4.5 in 2014. There are, however, persistent and marked racial, ethnic, and economic disparities in IM rates across NY. This priority is closely linked to other state priorities, including Priority #1: Reduce maternal mortality and morbidity, and all four life course priorities (#5-8). As noted for Priority #1 above, strategies to address IM are largely inextricable from those to address maternal mortality and morbidity, thus, the strategies and performance measures described above for Domain 1 should be considered part of the continuum of public health activities to address Priority #2.

Progress toward achievement of objectives and outcomes associated with Priority #2 are being tracked through **NPM #3: Percent of Very Low Birth Weight (VLBW) infants born in a hospital with a Level III or higher Neonatal Intensive Care Unit (NICU).** In 2015, 92.7% of VLBW infants in NYS were delivered at hospitals with a Level III or higher NICU, well above the HP 2020 target of 82.5%. and **NPM 5**: Percent of infants placed to sleep on their backs. **NPM #5 Percent of infants placed to sleep on their backs** is viewed as a proxy for both sleep positioning and other safe sleep practices that are the focus of prevention strategies. PRAMS data shows that NYS increased the percent of infants from 63.8 in 2014 to 75.8 in 2015. While not selected for reporting purposes due to MCHB's limit on the number of NPMs per state, NY will also follow and focus on improving NPM 4: Percent of infants ever breastfed and exclusively breastfed for 6 months. In 2015, 87.6% of NY infants initiated breastfeeding, yet only 44.8% were fed exclusively breast milk in the hospital. Using separate survey data for infants born in 2013, 55.8% of babies were breastfeeding at age 6 months, but only 19.7% were exclusively breastfed. The Title V program continues to collaborate with BCDP in efforts to increase exclusive breastfeeding in NY's hospitals and promote and support breastfeeding in community efforts such as home visiting and supports provided by the MICHC's community health workers. This is also one of the priorities of NY's PA and will continue to remain a priority in hospital and community efforts.

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development, implementation, and evaluation. While IM data from NY's Statewide Perinatal Data System (SPDS), including birth certificate and NICU module data, are reviewed annually by Title V staff, more focused analyses need to be accomplished to develop a complete picture of this priority.

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Strategy PIH-2: Update NY perinatal regionalization standards and designations and implement updated performance measures for Regional Perinatal Centers and affiliate birthing hospitals.

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

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As a key focal point for strengthening and increasing the impact of home visiting on MCH outcomes that aligns closely with federal MIECHV priorities, NY's Title V program will continue to provide training, technical assistance, and CQI cycles. Title V staff have been working with NFP and HFNY home visiting programs funded by the federal MIECHV grant to improve client retention through CQI in 2016-2017. Two strategies were used – proactive communication with families and securing multiple contact numbers to improve the ability to contact families. While early results suggest an improvement in retention, Title V staff will complete analysis of the results of the CQI retention evaluation in the coming year (as discussed in the Annual Report section of this Domain).

The FY 2017/18 MIECHV CQI cycle includes two new projects, addressing the following topics: referrals into programs and breastfeeding duration. These topics were chosen by the MIECHV programs through surveys. Additionally, these topic areas closely align with the MIECHV state and federal priorities. The focus on referrals into the program is to increase referral into programs for increased enrollment by September 30, 2018, in order to increase the MIECHV capacity utilization to 85% from 75.8%. The focus on breastfeeding duration is to increase the proportion of infants who were breastfed any amount at 6 months of age (among mothers who enrolled in home visiting prenatally) by 10%, from 42% to 46.2% by September 30, 2018. Based on lessons learned in the previous cycle, DOH began the new cycle working with MIECHV programs to create process maps for their respective topics. The next step will be to support MIECHV programs as they implement Plan, Do, Study, Act (PDSA) cycles. Data will be collected by the NYSDOH and reviewed monthly to determine if impact of change has occurred.

As stated in the Annual Report section of this Domain, NY's Title V program embarked on the development of a community coordinated intake and referral system for home visiting services. The aim of the pilot is to improve coordination and collaboration among maternal, infant, and early childhood home visiting programs in communities and link families to programs most appropriate to their needs and preferences using a locally-developed coordinated intake and referral system. The long-range goal of this pilot is community-level improvement in pregnancy outcomes and children's health and development, and strengthening of family function

over the life course.

The Title V program will continue to provide programmatic support and technical assistance to nine pilot communities, including the four in cohort one that began in January 2017 and the five that began in January 2018. The pilot communities are provided with technical assistance through webinars, in-person meetings and discussions and sample processes and tools to facilitate the development of the central intake system. The Title V program also facilitates a learning collaborative to build systems that work for the target community and families served. Pilot programs are provided with sample triage tools/decision trees to adapt to their community's needs. Lessons learned from this pilot will help inform the development of standards of practice for coordinated intake and referral systems for home visiting in communities across NYS.

Strategy PIH-5:

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

Ensuring supports are available in the community to improve maternal and infant health outcomes and to reduce racial, ethnic and economic disparities in those outcomes is a priority of NY's Title V program. As described elsewhere in this application, in addition to MIECHV, the Title V program supports a MICHC initiative; community-based organizations that strive to improve maternal and infant health outcomes for Medicaid-eligible high-need low-income women and their families while reducing persistent racial, ethnic and economic disparities in those outcomes. MICHC projects use a combination of individual/family strategies, implemented primarily through the engagement of CHWs, and organizational/community level strategies to improve environmental factors and systems. The Title V program will continue to oversee the local implementation of both MICHC and MIECHV projects as a central component of NY's SAP for both maternal and infant health.

Both MICHC and MIECHV are part of NY's core Title V infrastructure for reaching, engaging and supporting MCH populations, high-need women, infants and families. MICHC and MIECHV home visitors have been receiving training on a variety of topics, including intimate partner violence, substance use, mental health, smoking cessation, self-care, and interconception care. Evaluations show that home visitors gained new information and feel able to apply what they learned. Title V staff continuously support MICHC and MIECHV grantees on training of these priority areas (mentioned above) and other topics based on feedback from grantees through in-person meetings, regular webinars/calls with Title V staff, and webinar trainings available through other Maternal and Child Health sources. Title V staff hold quarterly MIECHV webinars/calls and monthly MICHC webinars/calls. Introductory training is provided for new MICHC home visitors, which includes core competencies. Quarterly reports and data analysis will continue to serve to evaluate progress and success in meeting training needs and provide guidance, training, and technical support to grantees concerning data collection and reporting.

Strategy PIH-6:

Lead collaborative strategies to reduce sleep-related infant death.

As described in the Annual Report for this Domain and other relevant NY SAP strategies, NY's Title V Program has been leading the state's work under the HRSA-led national IM-CoIIN since 2015. A major focus of this work in NY has been to promote safe sleep practices. SUID is among the leading causes of IM in the state, and a focus has been on increasing awareness and collaboration for stakeholders and including partners working in the child welfare system. The NY IM-CoIIN team focuses on improving infant safe sleep, and included partners from the NY OCFS, NY OASAS, and the DON's Supplemental Nutrition for WIC programs.

Title V staff continue to work with the national IM-CoIIN, and specifically NICHQ, to improve safe sleep education and practices

through collaboration with community-based organizations. NY's Title V program through NYSPQC is currently recruiting organizations to continue to improve safe sleep practices, with an emphasis on reducing disparities. Organizations being targeted for participation include MICHCs, Healthy Starts and HFNY. This project is in early stages of development.

The NYSPQC Hospital-based Safe Sleep Project entered sustain mode in July 2017. Currently, 70 birthing hospitals continue to submit data to the NYSDOH regarding the percent of infants, sleeping or awake-and-unattended in a crib, in a safe sleep environment, during the birth hospitalization.

Finally, staff from the Title V are collaborating with the National Action Partnership to Promote Safe Sleep – Innovation and Improvement Network (NAPPSS-IIN). Specifically, NAPPSS 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, which is funded by HRSA's MCHB, engaged five pilot site hospitals in five states, including NYS. NYS's representative hospital is New York Presbyterian (NYP) Lawrence (Westchester). Title V staff are working as part of the larger national project, and in support of NYP Lawrence.

As an outgrowth of this work, Title V will continue to collaborate with NY's WIC program to disseminate safe sleep messages to parents. Infant safe sleep posters in English and Spanish will continue to be provided and posted in all of NY's 400 WIC clinics. These, along with supplies of the infant safe sleep brochure, will continue to reinforce the safe sleep message that new parents receive during the birth of their infants.

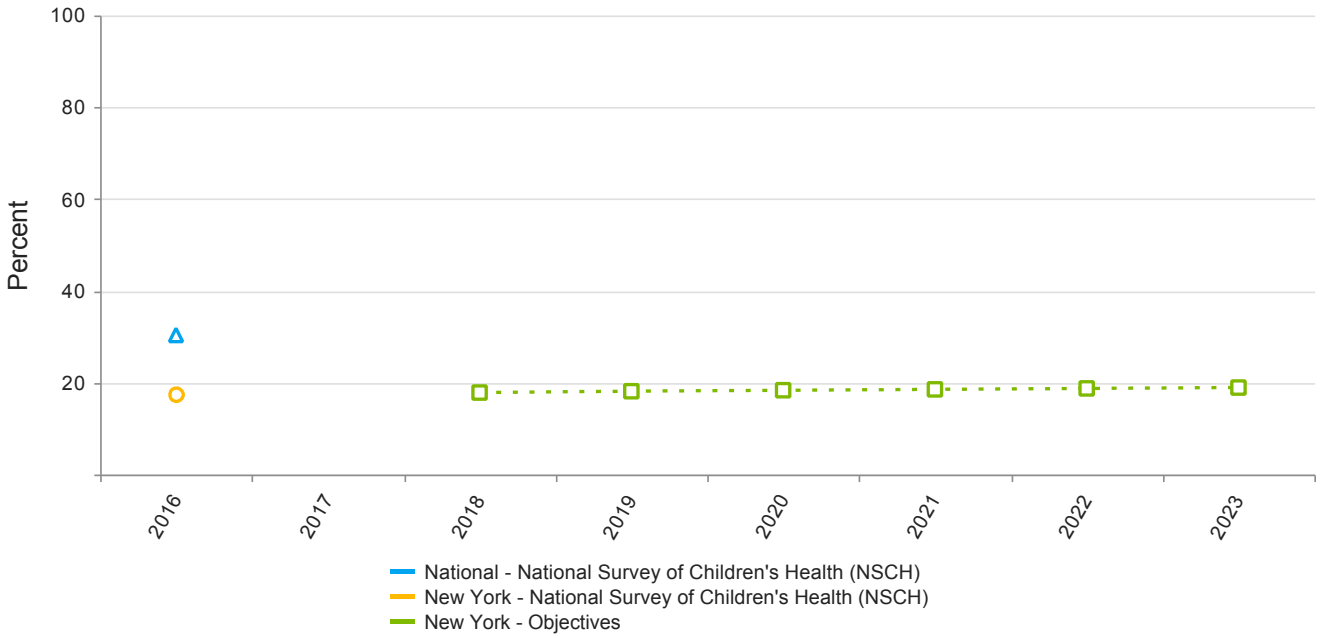
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2016	8.4 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	89.3 %	NPM 6 NPM 13.2

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Baseline Indicators and Annual Objectives



Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		17.5
Numerator		101,178
Denominator		578,216
Data Source		NSCH
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	17.9	18.2	18.4	18.6	18.8	19.0

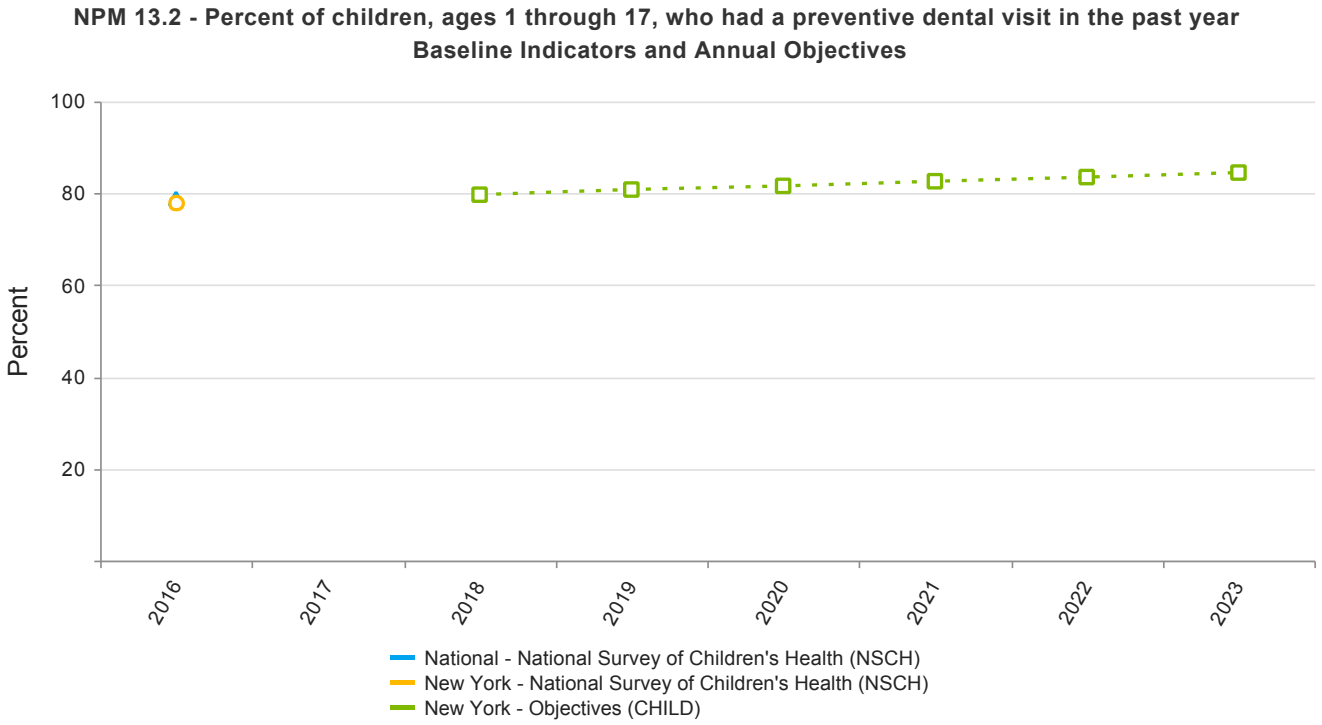
Evidence-Based or –Informed Strategy Measures

ESM 6.5 - Number of children with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		0
Annual Indicator	0	1,694
Numerator		
Denominator		
Data Source	NYS Medicaid Health Home Data	NYS Medicaid Health Home Data
Data Source Year	2016-17	2017-18
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	1,600.0	1,680.0	1,764.0	1,852.0	1,889.0	1,927.0



NPM 13.2 - Child Health

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		77.6
Numerator		2,955,156
Denominator		3,810,186
Data Source		NSCH
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	79.6	80.7	81.5	82.5	83.4	84.4

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Number of public water systems that receive financial and/or technical support from NYSDOH to maintain or initiate community water fluoridation.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		20
Annual Indicator	58	60
Numerator		
Denominator		
Data Source	NYS Title V Program records	NYS Title V Program records
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	60.0	61.0	61.0	62.0	62.0	63.0

ESM 13.2.2 - Percentage of 2nd and 3rd graders served by School-Based Dental Programs who receive sealants.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		40
Annual Indicator	61.2	50.5
Numerator		
Denominator		
Data Source	SEALS (CDC Data)	SEALS (CDC Data)
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	41.0	44.0	47.0	50.0	53.0	56.0

State Performance Measures

SPM 3 - The percentage of children and adolescents survey who demonstrate 20 or more developmental assets

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		50
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	To Be Developed	Developmental Assessment Tool
Data Source Year	2017-2018	2017-2018
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	50.0	50.0	50.0	50.0	50.0	50.0

SPM 5 - The percentage of NYS residents served by community water systems that have optimally fluoridated water

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		72
Annual Indicator	71.7	71.6
Numerator		
Denominator		
Data Source	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	73.0	75.0	77.0	78.5	78.5	78.5

State Action Plan Table

State Action Plan Table (New York) - Child Health - Entry 1

Priority Need

Support and enhance social-emotional development and relationships for children and adolescents

NPM

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Objectives

Objective CH-1: Increase the percentage of children surveyed who demonstrate 20 or more developmental assets by 10% from baseline.

Objective CH-2 (Same as LC-2): Increase the percentage of children 9-35 months who whose parents report they have had a developmental screening using a parent-completed screening tool by 5% to 18.4%.

Strategies

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

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

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

Strategy CH-4: Identify, support and integrate evidence-based/-informed strategies to promote children's social-emotional wellness and positive developmental assets through established Title V programs, including: Maternal and Infant Community Health Collaboratives (MICHC), Home Visiting, Infant/Child Mortality initiative, Early Intervention, Successfully Transitioning Youth to Adolescence (STYA) and School-Based Health Centers.

Strategy CH-5: Continue to provide subject matter and technical support to NY's Medicaid Health Home Program to implement enhanced care coordination for eligible children with serious emotional disturbance and complex trauma.
Strategy LC-1: Integrate performance standards, measures and improvement strategies related to health insurance enrollment across all Title V/ MCH programs.

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

Strategy LC-10: Continue and increase Title V staff leadership and participation in the DOH Place-Based Initiative (PBI) work group to: Adopt a shared definition and set of indicators to measure healthy communities; Review place-based initiatives to identify best practices for community environmental change; Develop a toolkit of data and evidence-based/-

informed practices for community change; and Incorporate requirements for healthy community practices within relevant MCH funding procurements.

Strategy LC-11: Enhance collaboration with key partners to advance changes in community environments that promote maternal & child health: increase access to healthy affordable foods & opportunities for physical activity in high-need communities through the Creating Healthy Schools & Communities program(with DOH Division of Chronic Disease Prevention)strengthen linkages between Title V programs and the Healthy Neighborhoods Program(with DOH Center for Environmental Health)support the Regional Centers for Sexual Violence Prevention to implement primary prevention environmental change strategies at the community and individual levels(with DOH Bureau of Injury Prevention) & incorporate selected health-related quality indicators in new quality improvement initiative for regulated child care programs(with Office of Children & Family Services)incorporate health promotion information & linkages within Community Schools initiative (State Education Department and Council on Children & Families

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

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

Strategy LC-14: Build internal capacity within the Division of Family Health (DFH)/ Title V Program to advance health equity through all Title V programs, including: creation of a cross-program DFH Equity Action Team; completion of an organizational assessment of equity practices, and facilitation of staff training and professional development through Equity Learning Labs.

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

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

Note: Life Course Strategies and associated ESMs are fully described in the Life Course Domain, and repeat across multiple relevant domains/ priorities consistent with their cross-cutting design.

ESMs	Status
ESM 6.1 - Initial data report is issued.	Inactive
ESM 6.2 - Number of child-serving MCH programs implementing the asset profile tool.	Inactive
ESM 6.3 - Number of DOH MCH staff and external partners trained on:a) social-emotional wellness and b) trauma-informed care practices.	Inactive
ESM 6.4 - Number of child-serving MCH programs identified with an evidence-based social-emotional component.	Inactive
ESM 6.5 - Number of children with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home.	Active
ESM 6.6 - Number of strategies implemented to improve developmental screening.	Inactive

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (New York) - Child Health - Entry 2

Priority Need

Increase the use of preventive health care services across the life course.

NPM

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Objectives

Objective CH-1: Increase the percentage of children surveyed who demonstrate 20 or more developmental assets by 10% from baseline (to be established in Years 2-3)

Objective CH-2 (Same as LC-2): Increase the percentage of children 9-35 months who received a developmental screening using a parent-completed screening tool by 5%, to 18.4%.

Strategies

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

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

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

Strategy CH-4: Identify, support and integrate evidence-based/-informed strategies to promote children's social-emotional wellness and positive developmental assets through established Title V programs, including: Maternal and Infant Community Health Collaboratives (MICHC), Home Visiting, Infant/Child Mortality initiative, Early Intervention, Successfully Transitioning Youth to Adolescence (STYA) and School-Based Health Centers.

Strategy CH-5: Continue to provide subject matter and technical support to NY's Medicaid Health Home Program to implement enhanced care coordination for eligible children with serious emotional disturbance and complex trauma.
Strategy LC-1: Integrate performance standards, measures and improvement strategies related to health insurance enrollment across all Title V/ MCH programs.

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

Strategy LC-10: Continue and increase Title V staff leadership and participation in the DOH Place-Based Initiative (PBI) work group to: Adopt a shared definition and set of indicators to measure healthy communities; Review place-based initiatives to identify best practices for community environmental change; Develop a toolkit of data and evidence-based/-informed practices for community change; and Incorporate requirements for healthy community practices within relevant MCH funding procurements.

Strategy LC-11: Enhance collaboration with key partners to advance changes in community environments that promote maternal & child health: increase access to healthy affordable foods & opportunities for physical activity in high-need communities through the Creating Healthy Schools & Communities program(with DOH Division of Chronic Disease Prevention)strengthen linkages between Title V programs and the Healthy Neighborhoods Program(with DOH Center for Environmental Health)support the Regional Centers for Sexual Violence Prevention to implement primary prevention environmental change strategies at the community and individual levels(with DOH Bureau of Injury Prevention) & incorporate selected health-related quality indicators in new quality improvement initiative for regulated child care programs(with Office of Children & Family Services)incorporate health promotion information & linkages within Community Schools initiative (State Education Department and Council on Children & Families

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

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

Strategy LC-14: Build internal capacity within the Division of Family Health (DFH)/ Title V Program to advance health equity through all Title V programs, including: creation of a cross-program DFH Equity Action Team; completion of an organizational assessment of equity practices, and facilitation of staff training and professional development through Equity Learning Labs.

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

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

Note: Life Course Strategies and associated ESMs are fully described in the Life Course Domain, and repeat across multiple relevant domains/ priorities consistent with their cross-cutting design.

ESMs	Status
ESM 6.1 - Initial data report is issued.	Inactive
ESM 6.2 - Number of child-serving MCH programs implementing the asset profile tool.	Inactive
ESM 6.3 - Number of DOH MCH staff and external partners trained on:a) social-emotional wellness and b) trauma-informed care practices.	Inactive
ESM 6.4 - Number of child-serving MCH programs identified with an evidence-based social-emotional component.	Inactive
ESM 6.5 - Number of children with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home.	Active
ESM 6.6 - Number of strategies implemented to improve developmental screening.	Inactive

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (New York) - Child Health - Entry 3

Priority Need

Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population(cross-cutting).

NPM

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives

Objective LC-11: Increase the percentage of Title V staff that improve their knowledge of health equity concepts by 20% from baseline (baseline to be established in conjunction with Strategy LC-15).

Objective LC-12: Increase the percentage of DFH procurements that demonstrate application of health equity strategies listed by 20% from baseline (to be established in Year 2-3).

Objective LC-13: Reduce disparities for all selected national and state performance measures by 5% from baseline (targets vary by measure).

Strategies

ESM LC-13: # of Title V programs for which health equity analyses completed

ESM LC-14: a) # of Equity Action Team meetings held; b) # of DFH staff who have completed one or more Equity Learning Labs

ESM LC-15: Percentage of DFH procurements that complete community listening forums as part of concept development process

ESM LC-16: Percentage of DFH procurements that demonstrate inclusion of evidence-based/-informed community engagement and collective impact strategies

ESMs	Status
ESM 13.2.1 - Number of public water systems that receive financial and/or technical support from NYSDOH to maintainor initiate community water fluoridation.	Active
ESM 13.2.2 - Percentage of 2nd and 3rd graders served by School-Based Dental Programs who receive sealants.	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (New York) - Child Health - Entry 4

Priority Need

Support and enhance social-emotional development and relationships for children and adolescents

SPM

SPM 3 - The percentage of children and adolescents survey who demonstrate 20 or more developmental assets

Objectives

Objective CH-1: Increase the percentage of children surveyed who demonstrate 20 or more developmental assets by 10% from baseline (to be established in Years 2-3)

Objective CH-2 (Same as LC-2): Increase the percentage of children 9-35 months who received a developmental screening using a parent-completed screening tool by 5%, to 18.4%.

Strategies

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

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

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

Strategy CH-4: Identify, support and integrate evidence-based/-informed strategies to promote children's social-emotional wellness and positive developmental assets through established Title V programs, including: Maternal and Infant Community Health Collaboratives (MICHC), Home Visiting, Infant/Child Mortality initiative, Early Intervention, Successfully Transitioning Youth to Adolescence (STYA) and School-Based Health Centers.

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

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

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

Strategy LC-10: Continue and increase Title V staff leadership and participation in the DOH Place-Based Initiative (PBI) work group to: Adopt a shared definition and set of indicators to measure healthy communities; Review place-based initiatives to identify best practices for community environmental change; Develop a toolkit of data and evidence-based/-informed practices for community change; and Incorporate requirements for healthy community practices within relevant MCH funding procurements.

Strategy LC-11: Enhance collaboration with key partners to advance changes in community environments that promote maternal & child health: increase access to healthy affordable foods & opportunities for physical activity in high-need communities through the Creating Healthy Schools & Communities program(with DOH Division of Chronic Disease Prevention)strengthen linkages between Title V programs and the Healthy Neighborhoods Program(with DOH Center for Environmental Health)support the Regional Centers for Sexual Violence Prevention to implement primary prevention environmental change strategies at the community and individual levels(with DOH Bureau of Injury Prevention) & incorporate selected health-related quality indicators in new quality improvement initiative for regulated child care programs(with Office of Children & Family Services)incorporate health promotion information & linkages within Community Schools initiative (State Education Department and Council on Children & Families

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

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

Strategy LC-14: Build internal capacity within the Division of Family Health (DFH)/ Title V Program to advance health equity through all Title V programs, including: creation of a cross-program DFH Equity Action Team; completion of an organizational assessment of equity practices, and facilitation of staff training and professional development through Equity Learning Labs.

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

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

Note: Life Course Strategies and associated ESMs are fully described in the Life Course Domain, and repeat across multiple relevant domains/ priorities consistent with their cross-cutting design.

State Action Plan Table (New York) - Child Health - Entry 5

Priority Need

Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population(cross-cutting).

SPM

SPM 5 - The percentage of NYS residents served by community water systems that have optimally fluoridated water

Objectives

Objective LC-4: Increase the percentage of NYS residents served by community water systems that have optimally fluoridated water by 8% to 77%

Objective LC-5: Reduce the prevalence of dental caries among NYS children by 5% to 8%.

Objective LC-6: Increase the percentage of children and adolescents age 1-17 years who had a preventive dental visit in the past year by 5% to 81%

Objective LC-7: Increase the percentage of pregnant women who had a dental visit during pregnancy by 5% to 57.6%.

Strategies

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

Strategy LC-7: Increase the delivery of evidence-based preventive dental services across key settings: • school-based clinics • primary care practices • public health nutrition programs.

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

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

FY 2017 Annual Report

Child Health – State Priority #3: Support and enhance children's social-emotional development and relationships.

Social-emotional development is defined as a child's capacity for self-confidence, trust, and empathy and is a strong predictor of later academic, social and emotional success throughout life. Social-emotional development is impacted by a wide range of factors including but not limited to genetics, relationships, and the environment, all interacting and changing through life. Due to the strong influence social-emotional development can have on children and adolescents throughout the lifespan, NY's Title V program selected the *Social-Emotional Development and Relationships for Children and Adolescents* as state priorities. Although work on these domains is closely intertwined, it will be reported separately for children and adolescents.

One of the challenges identified for this priority focus is that the National Outcome Measures (NOMs) and National Performance Measures (NPMs) for the child health domain do not appear to comprehensively reflect social-emotional wellness for children. While the NOMs and NPMs are included for the Annual Report, the Title V program established specific state measures to better reflect the work being done on this topic in NY's Title V program. The aim of these strategies is to increase Title V staff's awareness of the factors influencing social-emotional wellness, promote evidence-based and informed strategies throughout community-based programs supported by Title V and to decrease disparities related to social-emotional wellness.

As with all NY's SAP priorities, each priority includes a strategy related to data analysis to ensure a clear understanding of the scope of the public health issue. Over the past year, staff identified several existing data sources, as well as relevant research findings, and evidence-based program resources, and made them available and accessible to all Title V staff by posting them on an internally shared website, as an important step in analyzing and reporting available data on children's social-emotional well-being. This includes current research, national and state-level statistics and indicators, registries of programs effective in reducing youth risk behaviors and resources for evidence-based programs. On a periodic basis, staff reviews the materials and discusses the information during unit and Division wide-meetings.

Staff also created an information publication, titled "Social Emotional Wellness Update". This quarterly publication was created to help highlight and disseminate information with internal partners regarding social emotional development and relationships in children and adolescents by exploring relevant data, discussing available resources and addressing the importance of using these strategies while allowing for an opportunity to take an in-depth view on specific aspects related to the priority.

As stated in NY's FY 2018 application, supporting children and adolescents' social-emotional development is an emerging area for NY's Title V program and, as such, work on this priority for NY's Title V program continues to evolve. Over the past year, Title V staff have worked to increase their understanding of the complexities within this topic and to identify and embrace the evidence-based strategies associated with this work. Foundational work was conducted to develop a framework within which to address social-emotional development in the children and families that Title V programs serve. The focus for some of the formative work in this area includes research and data for positive youth development strategies, impact of ACEs, trauma informed care, well-child definitions and early intervention strategies as well as reviewing state and national-level data on specific measures that are considered to be within the scope of social-emotional development and relationships for the child health domain; including from the YRBS and the NSCH.

As stated previously, for Title V staff to address this priority area, it is essential that staff are well-informed regarding the issues and strategies to support social-emotional development and trauma-informed care. Over the past year, Title V staff continued to identify relevant local, statewide and national trainings offered to Title V staff, community providers and other external partners. Specifically,

eighteen training opportunities were offered between September 2017 and January 2018. Staff determined that the majority of Title V staff and their respective program providers participated in at least one related training, while many staff have attended three or more trainings. Information on training attendance was collected with the assistance of various community partners and contracted providers. Examples of trainings shared with Title V staff include: Supporting Young Children Suffering from Trauma, Supporting Young Children who have Experienced Trauma, Implementing Trauma-Informed Care into Organizational Culture and Practice, and the NYS Kids Count Data Book. Many of these trainings were attended by both staff and providers.

Over the past year, work was initiated on identifying, testing and implementing a validated tool for measuring positive developmental social-emotional assets among children. During the reporting period, Title V staff identified programs that are suitable for a pilot and have continued to work with key partners, who have identified three validated tools to measure self-efficacy, healthy decision making and youth/adult connectedness. The three constructs will be used together incorporating pre-post surveys and measuring specific aspects related to social-emotional assets in children and adolescents. The first program that implemented the tool is the Comprehensive Adolescent Pregnancy Prevention (CAPP) initiative. There are two components of the CAPP initiative. The first component focuses on the implementation of comprehensive sexual health evidence-based programs (EBPs) that have been proven based on scientific research to change behavior, such as delaying sexual activity, increasing condom or contraceptive use for sexually active youth, or reducing pregnancy among youth. The second component, (which is optional) strives to support and enhance adolescents' social emotional development and relationships, as well as promote home and community environments that support their health and safety. The selected CAPP program providers are all implementing the second CAPP component.

The constructs encompass youth developmental assets as identified by the Search Institute. The Search Institute is a public health research and policy organization that specializes in tools concentrating on social-emotional wellness and positive development for youth. The Search Institute developed the 40 developmental assets for specific age-ranges throughout childhood and adolescence; from newborns through adolescence, which is the framework for positive social-emotional development that has become a primary focus for this priority group. The validated surveys will be used within priority populations focusing on children and adolescents currently enrolled in Title V programs that use positive youth development approaches.
Title V staff built on previous work completed that assessed the capacity of existing Title V programs with a social-emotional component, by assessing the effectiveness of the strategies used. Programs using evidence-based strategies or evidence informed strategies were considered to be the most effective by Title V staff since these practices use the best available research and practice knowledge to guide program design and implementation.

A chart was developed identifying the practices used and how the programs focused on aspects of social-emotional wellness. Of the 21 previously identified Title V programs, Title V staff identified ten programs that utilize evidence-based or evidence informed strategies, and five programs that use best practices. Staff need to further review these programs to ensure that evidence that has been identified by these programs directly impact the developmental assets as defined by the Search Institute.

NY's Title V program is also able to build on experiences learned from Title V programs and initiatives that address social and emotional wellness. The Early Intervention Program (EIP) provides services to infants and toddlers 0-3 with developmental delay or disability and their families. Developmental delay means that a child has not attained developmental milestones expected for the child's chronological age adjusted for prematurity in one or more of the following areas of development: cognitive, physical (including vision, hearing, oral-motor feeding and swallowing disorders), communication, social/emotional, or adaptive development. Disability means a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. Eligible children and their families receive a range of therapeutic and supportive services at no cost pursuant to an Individualized Family Services Plan. Services include family education, counseling, parent support groups, occupational and physical therapy, speech pathology and audiology, nursing, nutrition, social work, vision, psychological and service coordination services. The EIP provides over eight million service interactions to approximately 69,000 children every year. The EIP collects data on a sample of children's social-emotional development and uses the information to evaluate the program. EIP has held three trainings regarding

Child Outcomes for county staff. The trainings focused on updates and changes to the child outcomes summary form and the data collection process. It also helped provide additional support and information regarding how the forms should be completed, and how the counties can help providers and families understand the process, including the importance of social-emotional wellness.

Title V programs serving school-age children also include core strategies that address positive development and behavioral health. School Based Health Centers (SBHCs) are required to provide behavioral health screening for all patients (elementary, middle and high school age) as part of ongoing primary care, and most provide additional mental health services on-site within SBHC clinics. Mental health services are also provided by referral in sites that do not have in-clinic resources. NY has over 255 SBHCs which provide services including mental health assessments, crisis intervention, counseling, and referrals to a continuum of services including emergency psychiatric care, community support programs, and inpatient care and outpatient programs. Research has shown SBHCs improve attendance in school and decrease emergency room visits. In the past year SBHCs enrolled 186,566 students and provided 692,607 visits for health and supportive services.
NY's innovative Successfully Transitioning Youth to Adolescence (STYA) program, funded through the federal Abstinence Education Grant Program, supports 16 community-based organizations across the state to implement strategies to build protective factors for young people ages 9-12 living in high risk communities, including youth in foster care, youth with physical disabilities, and homeless and disconnected youth, to promote a transition to a healthy, productive, connected adolescence. Mentors provide youth with support and information on a wide range of topics framed in a youth development philosophy, focusing on the needs of youth and building on and nurturing the youth's individual strengths and needs. They provide adult-supervised activities to stimulate cognitive, social, physical and emotional growth. Group discussions occur to share information regarding topics of interest to pre-teen youth. Caring adults are available for more in-depth support and discussions. These programs also provide parent education to parents, guardians and adult caregivers to create a more nurturing environment for these youths. Over the past year, the STYA program reached 2,100 participants. Title V staff will continue to work with these providers to promote social emotional development of NY's pre-teen population.

In a state as large and diverse as NYS, it is imperative to develop community partnerships to connect with families on the local level. The MICHC initiative aims to improve health outcomes for high need women and infants, by working with community partners and utilizing CHW to assess women and their families and connect them with needed resources. There are currently 23 MICHC projects in priority communities across NYS. The MICHC initiative touches upon developmental assets in the following areas: support, empowerment, positive values, social competencies, and positive identity**.**

In addition, NY supports and promotes evidence-based home visiting services. Extensive research of evidence-based home visiting has shown to improve: pregnancy and maternal health, child health and development, home and child safety, school readiness, family safety, family self-sufficiency; and, coordination and referrals to community resources and supports. It also helps to reduce smoking during pregnancy, pregnancy-induced hypertension, pre-term births, low-birth weight deliveries, pregnancies spaced less than 18 months apart, child abuse; and, juvenile crime. NY's Title V program oversees the MIECHV program that targets families of infants up to two years old to promote healthy behaviors and provide support for mothers. The MIECHV Initiative supports the NFP and the HFNY program; both evidence-based home visiting initiatives. NFP pairs first-time, low-income mothers with a nurse home visitor. The nurse helps to engage the mother in preventive health practices (e.g. prenatal care, healthier diet), empower parents to provide the best care for their children, and to become economically self-sufficient. Home visits occur from pregnancy through two years of age. The program served 3,454 pregnant women and caregivers of 2,702 young children between the ages of 0-5 in the past year.

HFNY pairs under-resourced families with home visitors from their own community (Family Support Workers) during the pregnancy or shortly after birth. Weekly visits occur until the child is six months old and occur less frequently until the child is enrolled in Head Start, kindergarten, or turns five years old. Visits are individualized to suit the family's needs. Programs aim to aid families struggling with homelessness, mental health issues, substance abuse, domestic violence, teen pregnancy, unemployment and underemployment,

child abuse and neglect, poverty, among other issues. HFNY is currently offered in 31 NYS counties. Both NFP and HFNY support the social-emotional development of infants and toddlers through support, positive values, social competencies and positive identity.

Title V staff continued to collaborate with OHIP and other key partners on Health Home (HH) for Children initiative that launched in December 2016. There are sixteen HHs designated to serve children in NYS. Fourteen have initiated outreach and enrollment. As of October 31, 2017, there were 48,881 enrolled and additional 14,074 children are working with a Health Home manager but have not yet enrolled. The number of Health Homes Serving Children enrolled by primary chronic conditions is as follows: 4964 with Asthma; 413 with Cardiovascular Disease; 2988 with Depression; 1086 with Diabetes; 198 with HIV AIDS; 208 with Hypertension; 7833 with other mental health and 6478 with Schizophrenia.

A number of webinar presentations have been jointly delivered to key stakeholders: the NYS Association of Counties (NYSAC) on November 3, 2016; the NYSACHO on November 3, 2016; the State's EIP on November 16, 2016; the HH and their Case Management Agencies (CMAs) on December 13, 2016; and the State's EICC, which is authorized in federal and state statute to advise the Department on the EIP, on December 3, 2015, September 17, 2016, and September 15, 2016. On January 24, 2017, a webinar presentation on Complex Trauma was delivered. Presentations were recorded and are available on the NYSDOH website: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/health_homes_and_children
Children who are in the EIP and who meet the HH eligibility criteria will transition to the HH in March/April 2017.

In the first quarter of 2018, Title V and OHIP staff participated in site visits to four designated CHH agencies: OISHEI, formerly known as Kaleida (Buffalo); Children's Health Homes of Upstate NY (Rochester); ENCOMPASS (Broome) and Collaborative Children and Families (NYC). Title V staff participate in case/chart review, development of a score card, site visit auditing process and developing a process to increase provider expertise and expand populations served to build capacity.

Staff are working to obtain data on the number of children enrolled in HH by age distribution based on the Association of American Pediatrics definitions of Infancy, Early Childhood, Middle Childhood and Adolescence; the number of enrolled children by condition type, and the number of children in foster care. Staff is interested in these data for several analyses: serious emotional disturbance (SED) is a qualifying condition which can co-occur with other medical conditions, making the individual eligible for HH; children in foster care may also have co-occurring medical and SED, such as social communication disorder, asthma, diabetes and autism.

In an effort to enhance the connection between HH and CSHCN, a HH webinar was held with LHD CSHCN program to provide information on the referral process to HH. Local Health Department (LHD) staff will be added as users to the Health Home Tracking System to better inform them of client status. Bureau of Child Health (BCH) staff attended NYSACHO meeting to promote the CSHCN HH webinar for LHD.

The Leadership Education in Neurodevelopmental and related Disabilities (LEND) learning day was held April 27, 2017 at the SUNY School of Public Health. This annual meeting provided an opportunity for LEND trainees to meet with NYS Title V program directors, staff and other state agencies to learn about team research projects that impact children with disabilities and their families. The Title V Medical Director described how NYS uses HH to provide more coordinated care for CSHCNs.

On July 20,2017 the First 1,000 Days on Medicaid Initiative was announced. This initiative recognized that a child's first three years are the most crucial years of their development, including social-emotional development. The initiative is designed to ensure that NY's Medicaid program works with health, education and other system stakeholders to maximize outcomes and deliver results for the children served through a collaborative effort. This initiative identified 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. Title V staff worked on several specific proposals for this initiative which include social-emotional development related subject matter. The Create a Preventive Pediatric Care Clinical

Advisory Group was convened to develop a framework model for how to best organize well-child visits and pediatric care to implement the Bright Futures guidelines. The group is charged with identifying barriers, incentives and new system approaches. The group will make recommendations to the NY Medicaid program on how to work with managed care organizations and providers to turn its implementation guidance into routine practice. The Promote Early Literacy through Local Strategies project is focusing efforts for Medicaid to launch one or more three-year pilots to expand the use of Reach Out and Read (ROR) in pediatric primary care and foster local cross-sector collaboration focused on improving early language development skills in the first 1,000 days. The Statewide Home Visiting proposal is for NY Medicaid to take several significant steps to ensure the sustainability of home visiting in NY so every child and pregnant woman who is eligible and desiring the services, receives them.

NY is committed to continued support and promotion of the social-emotional wellness of children and families. This is demonstrated through a joint effort of two NY Governor-appointed bodies – the EICC and the ECAC. The EICC is established in PHL and is a thirty-member Governor appointed body, charged with advising and assisting the NYSDOH as Lead Agency for the EIP Part C of the IDEA. IDEA requires that states establish an advisory group which must include parents of children with disabilities, public and private providers of early intervention services, an individual engaged in personnel preparation, a Head Start representative, state governmental agencies and insurance provider representatives. The ECAC was established in 2009 to provide advice to the Governor and the Commissioners of the state, health, education, and human service agencies on the development of a comprehensive system of supports and services for young children and their families. ECAC members include people with expertise in such areas as early childhood education, health and mental health care, child welfare services, home visiting, and parenting education and supports the state by monitoring and guiding the implementation of a range of strategies to achieve its vision -"All young children are healthy, learning, and thriving in families that are supported by a full complement of services and resources essential for successful development."

The two Councils collaborated on the development of a guidance document on social-emotional development, entitled; *Meeting the Social-Emotional Development Needs of Infants and Toddlers: Guidance for Early Intervention and Other Early Childhood Professionals*, due to the importance of the issue and the shared concerns for the large numbers of children and families who are struggling with social-emotional development issues and the need to strengthen the current system of services. This document contains guidance for early childhood professionals who deliver services to infants and toddlers and their families across a broad array of early childhood programs and services including the EIP, early education, child welfare, health and mental health care, home visiting, and supportive services. There are four objectives for the guidance document: 1) ensure that the general population of young children receive routine and ongoing screening of children's development, including social emotional development; 2) identify children at risk of experiencing social emotional development delay or disability and ensure their families receive assistance from a wide array of early childhood programs and services; 3) improve the early identification of children who may already be experiencing developmental delays in social-emotional development; and, 4) ensure that evaluations. and assessments for all children in the EIP adequately address the area of social emotional development. The guidance was approved by both Councils and published in June 2017.

In the Fall of 2017, the EICC created a workgroup that is focused on the dissemination and training of the document. The workgroup has three priorities that they are currently focused on completing by the Fall of 2018. The first priority is to create companion materials and quick reference documents based on the full guidance document. These documents will be directed towards providers and families to have vital information in a condensed format. The second priority is to create a webpage that will be hosted on the NYSDOH website that will be focused on social-emotional development for children birth-three. The webpage will include FAQs, a family friendly video explaining the importance of social-emotional development, as well as links to resources for further information. The third priority is to create a web-based training on the document that would be available to both professionals and families to help understand the document and how the guidance should be implemented. This work will further advance NY's Title V strategic efforts to increase the number of child-serving MCH programs with evidence-based social-emotional components.

Title V staff is also involved in an interagency workgroup focused on identifying the prevalence of ACEs in New Yorkers as well as best practices for preventing, reducing and addressing ACES. Partners include representatives from through DOH as well as the Offices of Mental Health and Alcoholism and Substance Abuse Services. The workgroup submitted a proposal to Robert Wood Johnson Foundation called *Facilitating Resilient Communities, Integrating ACEs Science* Initiative that focuses on community revitalization efforts as a strategy to promote resilience and wellbeing using a trauma-informed lens in at least five communities in NYS. Interventions will include leveraging the potential of anchor institutions, worker cooperatives, and processes such as procurement policies as drivers of community revitalization, using a trauma-informed lens.

For the first time, in 2016, New York State Department of Health (DOH) collected data about ACEs from over 9,000 adults through the Behavioral Risk Factor Surveillance System (BRFSS). Findings show six out of 10 adults (59.3%) reported having experienced at least one ACE, and 13.1% reported four or more ACEs. ACE scores of three or more were higher among those who identified as Lesbian-Gay-Bisexual-Transgender Questioning (LGBTQ); people with household incomes less than $15,000; adults in households with children; women; and Hispanics and multiracial groups. Surveillance data on resilience are not available. There are ongoing efforts in the state to integrate a trauma-informed lens in health care and school-based settings. This effort would focus on workplace and community settings.

From May through August 2018, New York State (NYS) Department of Health (DOH), the NYS Office of Mental Health (OMH) and NYS Office of Alcoholism and Substance Abuse Services (OASAS) will work with stakeholders to develop an action plan that will include: goals, objectives, best practice policy and program interventions, measures, an equity readiness assessment, and a theory of change. Specific communities interested in partnering on these efforts, and matching funds to launch Equity Action Labs will be identified.

Taken together these actions and strategies are critical assets that can be effectively leveraged to further support social-emotional development and relationships for children and their families through the integration of additional evidence-based/-informed practices and strategies.

FY 2019 Application

Child Health: State Priority #3: Support and enhance children's social-emotional development and relationships.

2020 State Objectives:

- **Objective CH-1: Increase the percentage of children surveyed who demonstrate 20 or more developmental assets by 10% from baseline.**
- **Objective CH-2: Increase the percentage of children 9-35 months who received a developmental screening using a parent-completed screening tool by 5%, to 18.4%.**

Due to the strong influence social-emotional development can have on children and adolescents throughout the lifespan, NY's Title V program selected the *Social-Emotional Development and Relationships for Children and Adolescents* as state priorities. Although work on these domains is closely intertwined, plans will be addressed separately for children and adolescents.

In the upcoming year, NY's Title V program will continue to focus efforts on the priority to support and enhance social-emotional development and relationships for both the child health and adolescent health domains. There is no specific data to report on State Objectives listed above (CH-1 and CH-2) as the past year has been devoted to foundational work necessary for strategy implementation. These data are from the NSCH report which was recently released in fall 2017.

Specific to child health, Title V will continue the work throughout the Title V program as described in the Annual Report. These programs are strong public health initiatives that impact social-emotional development and relationships for children. Staff will continue to refine strategy areas, plan and further develop work that is already underway. Staff will focus on assessing progress, successes, barriers and challenges while evaluating progress on measures and reviewing further developments for this priority. A commitment to strengthen aspects of social-emotional developmental assets will continue to have positive effects across the life course. As new procurements are released to provide funding for organizations that work with children and adolescents throughout NY communities, language supporting evidence-based /evidence-informed strategies will be incorporated to include building social-emotional wellness for these population domains.

Title V staff will also continue to be involved in the ACES interagency workgroup as discussed in the annual report section of this domain in collaboration with representatives across DOH as well as the Offices of Mental Health and Alcoholism and Substance Abuse Services. Focused efforts will continue on the *Facilitating Resilient Communities, Integrating ACEs Science Initiative* to promote resilience and wellbeing using a trauma-informed lens in at least five communities in NYS. In addition, specific action steps have been identified by the workgroup including:

- Facilitate cross-sector engagement in developing, implementing and evaluating the ACES action plan;
- Offer technical support on best practice to prevent, reduce and respond to ACES;
- Support alignment of actions to address ACES;
- Strengthen capacity for training and communication; and
- Collect data and information on ACES and resilience periodically.

Additional specific actions based on the five strategies for this priority are listed below.

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

During the upcoming period, the Title V program will seek to increase collaborative efforts with other NYSDOH initiatives, including continuing efforts to use evidence-based and evidence informed models that focus on the promotion of social, emotional and behavioral developmental strategies for children, and incorporate a trauma-informed perspective into Title V work. The workgroup will also focus on fostering partnerships with other state agencies, including the Council on Children and Families (CCF) and the Office of Mental Health (OMH) to continue to enhance the catalogue of emerging data and information as well as disseminate relevant information to staff and providers. The quarterly social-emotional wellness update created by the Social and Emotional Wellness (SEW) team provides an efficient way to regularly provide information on current work focusing on social-emotional wellness efforts, emerging trends and relevant data, resources, and materials to Title V staff. The Title V program will develop a plan for wider dissemination to a broader audience throughout DOH as well as external providers and partners. The priority team will remain as a source of content expertise within the Title V program to specifically address and incorporate social-emotional evidence based /evidence-informed strategies into funding procurements. Next steps for this strategy measure include the sharing of dialogue and information with key staff members assigned to these collaborative efforts to identify opportunities for collaboration. Title V staff will continue to highlight these efforts through site sharing and will identify opportunities to place a social-emotional wellness lens to ongoing Title V work.

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

During the upcoming reporting period, NY's Title V program will oversee the administration of the developmental assets combined survey constructs tool with the CAPP and will determine if it can be used with other programs within Title V. Title V staff will determine if the use of these constructs can be adapted for different age groups and will assess the viability of implementing in additional Title V programs, including child-focused programs identified by the Bureau of Early Intervention (BEI) and BCH. Many of these programs have a direct and specific impact on social-emotional wellbeing, in addition to focusing on different age groups which should provide rich data for the Title V program: EI focuses on children aged 0-3, BCH focuses on children, adolescents and children with special health care needs and CAPP works with adolescents between the ages of 13-21.

This tool will be used with a representative sample of the populations that Title V serves to provide a baseline of NYS children's developmental assets. Title V staff will work with program contractors to approve the tool before it is implemented in their respective programs. The Assets Coming Together for Youth Center for Community Action (ACT CCA). The ACT CCA, a NYSDOH contractor that brings research to practice in areas of positive youth development and adolescent health, will also gather data using the tool.

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

NY's Title V program will continue to track the number of Title V staff who have participated in at least one training on social-emotional development or trauma-informed care practices. Efforts will continue to track the number of trainings, the intended audience and the actual audience for each training conducted within the Title V program as well as those presented by our external partners. Feedback will be provided to Title V staff and recommendations will be made for specific trainings that could benefit staff and community providers that focus on aspects specific to their programs and initiatives. Additionally, staff will continue to identify trainings within the realm of social-emotional wellness and trauma-informed care and notify Title V staff and/or providers of these training opportunities on a monthly basis.

The SEW team has identified the next steps for Title V to be integrated with a trauma-informed care (TIC) approach and during the

upcoming grant period will focus on the following:
Leadership Engagement: The SEW team will continue to take on a leadership role in expanding engagement on this topic throughout the Title V program. Information Provision: SEW team will continue to ensure that data, information and training sessions are sent regularly to Title V staff.
Coordinated Alliances: The SEW team will work regularly with other state agencies and divisions that are engaging in TIC efforts. Updates on collaborative efforts will be highlighted in future newsletters. Training: A student intern will review and recommend relevant training modules to train staff to become TIC trainers. TIC trainers will then provide additional small group training sessions to interested Title V staff. Policy Review: A trauma informed workforce will assess if outgoing procurements and policy initiatives incorporate trauma informed principles. Resource Dissemination: The SEW team will provide/develop TIC resources to our youth-serving organizations, partners and the public. Evaluation: The team will develop criteria to evaluate the TIC initiative.

Strategy CH-4 – Identify, support and integrate evidence-based/informed strategies to promote children's social-emotional wellness and positive developmental assets through established Title V programs, including: Maternal and Infant Community Health Collaboratives (MICHC), Home Visiting, Infant/Child Mortality Initiative, Early Intervention, Successfully Transitioning Youth to Adolescence (STYA) and, School-Based Health Centers.

During the upcoming reporting period, Title V staff will contact previously identified programs within Title V and gather additional information on how/if health equities and disparities are being addressed. The identified strategies will be separated into groups based on the strength of the research behind the practice as well as inclusion of how they are implemented by the programs. Staff will continue to explore how socio-economic and other areas of potential health disparities impact overall social-emotional health and wellness for youth and the communities in which they reside. Staff will highlight programs that are using sound methodology to incorporate social-emotional relationships and development while offering recommendations to the programs that can benefit from incorporating these methodologies. Programs that are excelling in using these strategies will be highlighted in the quarterly Social Emotional Wellness Update.

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

Title V staff will continue to provide subject matter and technical support to NY'S Medicaid HH program to implement enhanced care coordination for eligible children with serious emotional disturbance and complex trauma. Title V staff will work with colleagues in the OHIP to monitor enrollment and ensure children receive coordinated care across all NY's systems of care. Staff are involved in case/chart review, development of a score card, site visit auditing process and developing a process for providers to increase expertise and expand populations served, to build capacity. Staff will complete training on the Child and Adolescent Needs and Strengths (CANS) - a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes.

Implementation of this strategy is being measured through **ESM CH-5**: Number of children with documented serious emotional disturbances and/or complex trauma who are enrolled in Medicaid Health Home.

Adolescent Health

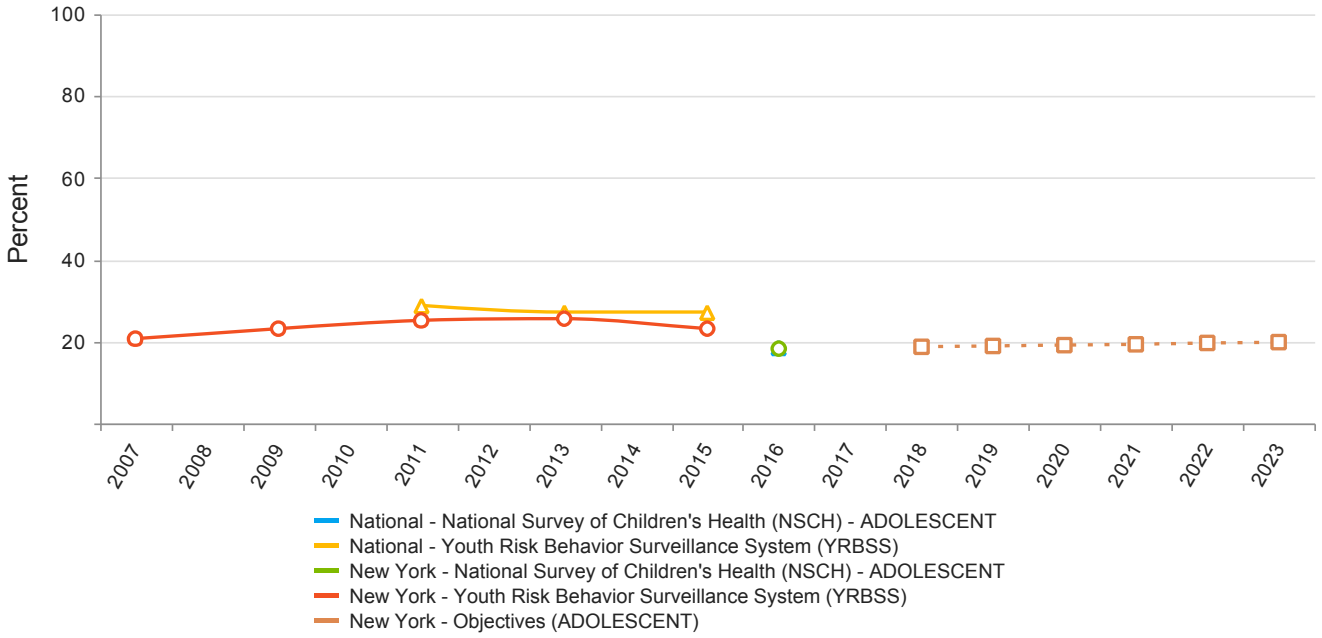
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2016	8.4 %	NPM 13.2
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2016	22.8	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2014_2016	5.0	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2014_2016	5.0	NPM 10
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2016	11.0 %	NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016	45.3 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	89.3 %	NPM 8.2 NPM 10 NPM 13.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2016	14.8 %	NPM 8.2 NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2014	14.3 %	NPM 8.2 NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2015	13.1 %	NPM 8.2 NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2016_2017	65.9 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2016	75.0 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2016	68.2 %	NPM 10

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2016	91.2 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2016	89.2 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	13.2	NPM 10

National Performance Measures

NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day
Baseline Indicators and Annual Objectives



Federally Available Data		
Data Source: Youth Risk Behavior Surveillance System (YRBSS)		
	2016	**2017**
Annual Objective	27.1	27.5
Annual Indicator	23.3	23.3
Numerator	161,704	161,704
Denominator	694,960	694,960
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2015	2015

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT		
	2016	**2017**
Annual Objective		
Annual Indicator		18.3
Numerator		246,053
Denominator		1,346,787
Data Source		NSCH-ADOLESCENT
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	18.8	19.0	19.2	19.4	19.7	19.9

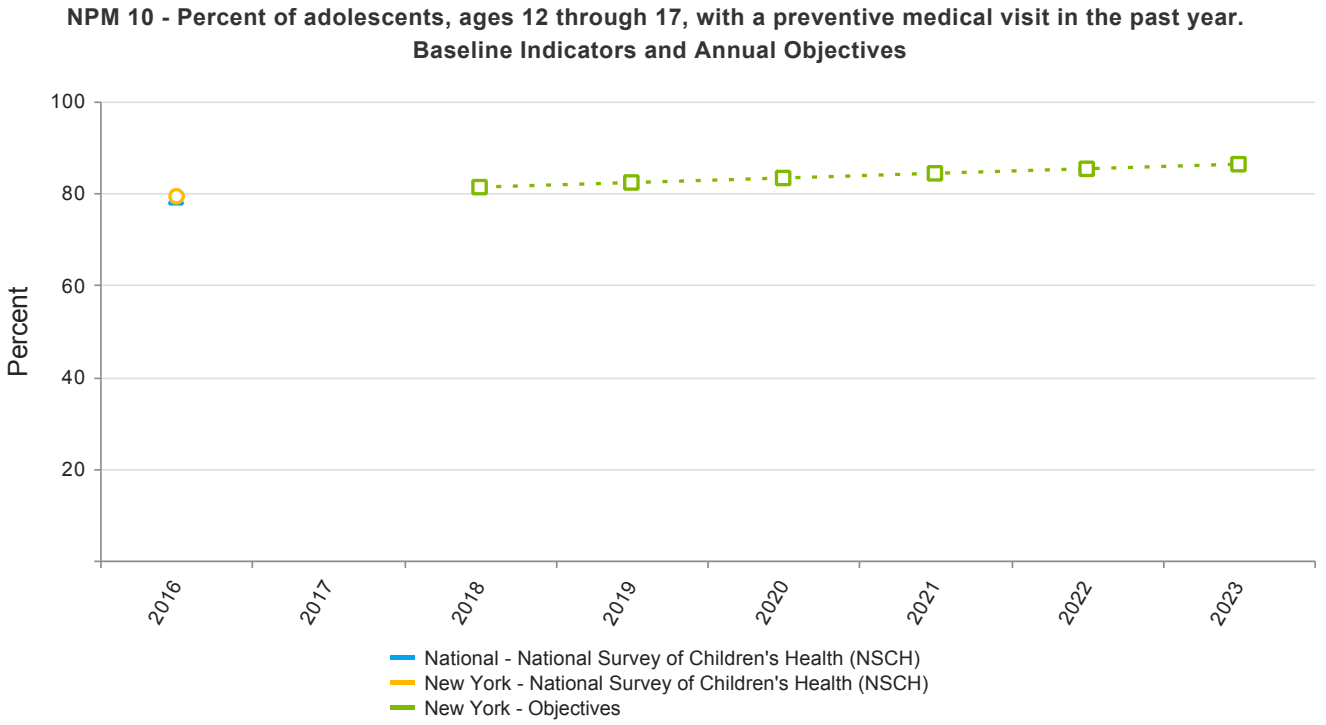
Evidence-Based or –Informed Strategy Measures

ESM 8.2.1 - Number of community environmental changes demonstrated as a result of enhanced collaborations.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	1	6
Numerator		
Denominator		
Data Source	Title V Program data	Title V Program data
Data Source Year	7/16-6/17	16-18
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	6.0	7.0	8.0	9.0	10.0	11.0



Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		79.2
Numerator		1,103,856
Denominator		1,393,274
Data Source		NSCH
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	81.2	82.2	83.2	84.2	85.2	86.2

Evidence-Based or –Informed Strategy Measures

ESM 10.3 - Number of adolescents with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home.

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	1,000
Annual Indicator	1,060
Numerator	
Denominator	
Data Source	NYS Medicaid Health Home Data
Data Source Year	2017-18
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	1,000.0	1,050.0	1,103.0	1,125.0	1,147.0	1,170.0

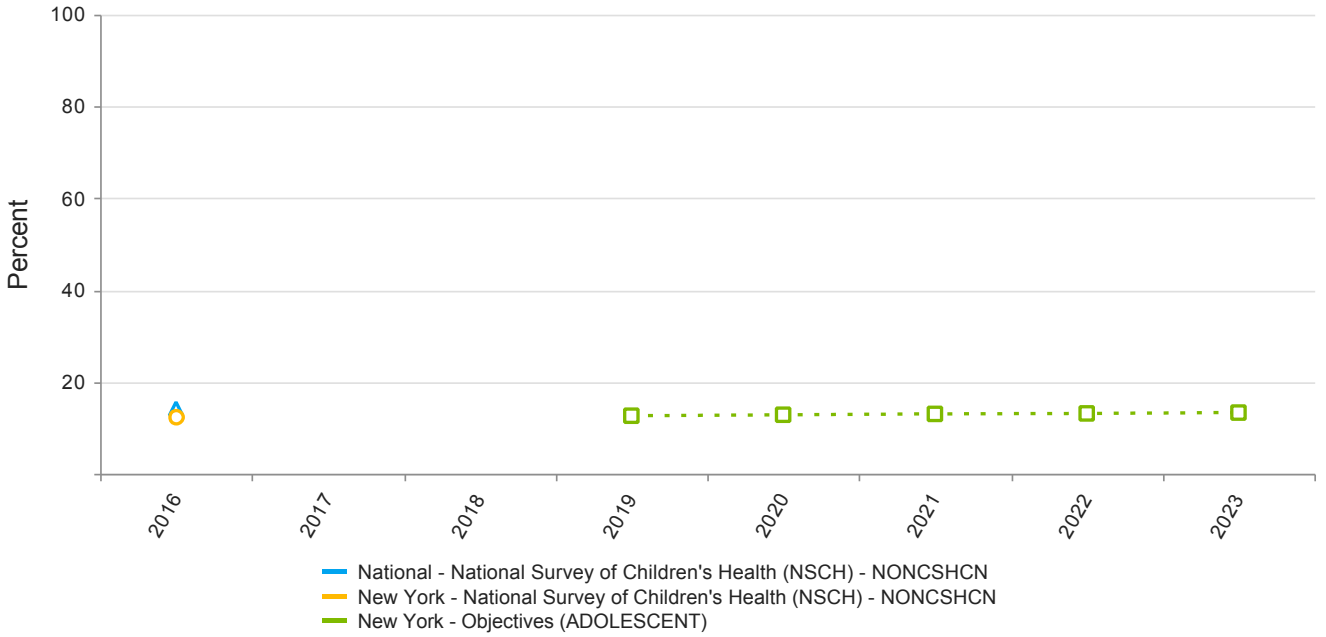
ESM 10.4 - Number of strategies implemented to improve adolescent use of preventive health care services.

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	1
Annual Indicator	1
Numerator	
Denominator	
Data Source	NYS Title V Program Records
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care
Baseline Indicators and Annual Objectives



NPM 12 - Adolescent Health - NONCSHCN

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - NONCSHCN	
	2017
Annual Objective	
Annual Indicator	12.3
Numerator	130,919
Denominator	1,062,218
Data Source	NSCH-NONCSHCN
Data Source Year	2016

Annual Objectives					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	12.7	12.9	13.1	13.2	13.4

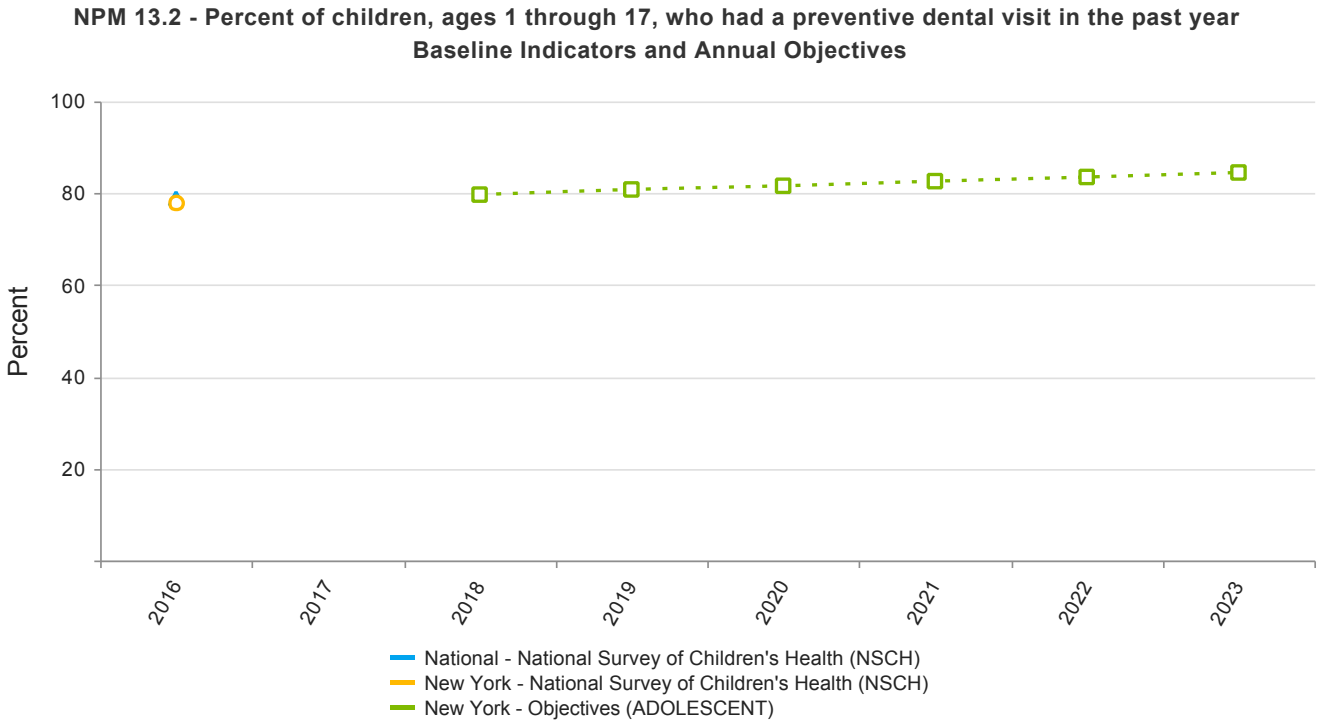
Evidence-Based or –Informed Strategy Measures

ESM 12.7 - Percentage of infants with initial abnormal hearing screening results for whom follow-up is documented in NYEHDI-IS.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		45
Annual Indicator	63.9	66.9
Numerator	4,275	5,244
Denominator	6,688	7,843
Data Source	NYEHDI	NYEHDI
Data Source Year	CY2016	CY2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	60.0	67.0	70.0	72.0	75.0	77.0



NPM 13.2 - Adolescent Health

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		77.6
Numerator		2,955,156
Denominator		3,810,186
Data Source		NSCH
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	79.6	80.7	81.5	82.5	83.4	84.4

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Number of public water systems that receive financial and/or technical support from NYSDOH to maintain or initiate community water fluoridation.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		20
Annual Indicator	58	60
Numerator		
Denominator		
Data Source	NYS Title V Program records	NYS Title V Program records
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	60.0	61.0	61.0	62.0	62.0	63.0

ESM 13.2.2 - Percentage of 2nd and 3rd graders served by School-Based Dental Programs who receive sealants.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		40
Annual Indicator	61.2	50.5
Numerator		
Denominator		
Data Source	SEALS (CDC Data)	SEALS (CDC Data)
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	41.0	44.0	47.0	50.0	53.0	56.0

State Performance Measures

SPM 3 - The percentage of children and adolescents survey who demonstrate 20 or more developmental assets

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		50
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	To Be Developed	Developmental Assessment Tool
Data Source Year	2017-2018	2017-2018
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	50.0	50.0	50.0	50.0	50.0	50.0

SPM 5 - The percentage of NYS residents served by community water systems that have optimally fluoridated water

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		72
Annual Indicator	71.7	71.6
Numerator		
Denominator		
Data Source	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	73.0	75.0	77.0	78.5	78.5	78.5

State Action Plan Table

State Action Plan Table (New York) - Adolescent Health - Entry 1

Priority Need

Promote home and community environments that support health, safety, physical activity and healthy food choices across the life course.

NPM

NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Objectives

Objective AH-1: Increase the percentage of adolescents surveyed who demonstrate 20 or more developmental assets by 10% from baseline.

Objective AH-2: Reduce the percentage of adolescents who feel sad or hopeless for two weeks or longer in the past year by 10%, to 21.6%.

Objective AH-3 (Same as LC-3): Increase the percentage of adolescents who receive a preventive health care visit in the last year by 5% to 83.2%.

Strategies
Strategy AH-1: Develop and implement a plan for analysis and reporting of available data on adolescent's social-emotional well-being and adverse childhood experiences (ACES), including Youth Risk Behavior Survey (YRBS) and forthcoming revised National Survey of Children's Health data.
Strategy AH-2: Identify, pilot test and implement a framework and validated tool for measuring developmental social-emotional assets among children and adolescents that can be used across MCH programs.
Strategy AH-3: Provide training for Title V staff and external partners, including local adolescent-serving grantees, to increase awareness, knowledge, and skills to support: 1) adolescents' social emotional development and 2) trauma-informed care practices.
Strategy AH-4: Identify, support and integrate evidence-based/-informed strategies to promote adolescents' social-emotional wellness and positive developmental assets through established Title V programs, including: • Comprehensive Adolescent Pregnancy Prevention (CAPP) • Family Planning • Pathways to Success • Personal Responsibility Education Program (PREP) • School-Based Health Centers and • Sexual Violence Prevention.
Strategy AH-5: Continue to provide subject matter and technical support to NY's Medicaid Health Home Program to implement enhanced care coordination and transition supports for eligible youth and young adults with serious emotional disturbance and complex trauma.
Strategy LC-1: Integrate performance standards, measures and improvement strategies related to health insurance enrollment across all Title V/ MCH programs.
Strategy LC-5: In conjunction with ACT For Youth Center of Excellence, Convene focus groups and review literature to identify contributing factors and effective strategies for improving preventive health care service delivery to adolescents, with a focus on reducing disparities.
Strategy LC-13: Develop and implement a data analysis plan to assess distribution of DFH/Title V resources and services through a health equity lens
Strategy LC-14: Build internal capacity within the Division of Family Health (DFH)/ Title V Program to advance health equity through all Title V programs, including: • creation of a cross-program DFH Equity Action Team; • completion of an organizational assessment of equity practices, and • facilitation of staff training and professional development through Equity Learning Labs.
Strategy LC-15: Integrate an equity framework into the development of all DFH/Title V procurements through community listening forums conducted as part of the concept development process.
Strategy LC-16: Incorporate evidence-based/-informed community engagement and collective impact strategies in all relevant DFH/Title V programs.
Note: Life Course Strategies and associated ESMs are fully described in the Life Course Domain, and repeat across multiple relevant domains/ priorities consistent with their cross-cutting design.

ESMs	Status
ESM 8.2.1 - Number of community environmental changes demonstrated as a result of enhanced collaborations.	Active

NOMs

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

State Action Plan Table (New York) - Adolescent Health - Entry 2

Priority Need

Support and enhance social-emotional development and relationships for children and adolescents

NPM

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

Objectives

Objective AH-1: Increase the percentage of adolescents surveyed who demonstrate 20 or more developmental assets by 10% from baseline.

Objective AH-2: Reduce the percentage of adolescents who feel sad or hopeless for two weeks or longer in the past year by 10%, to 21.6%.

Objective AH-3 (Same as LC-3): Increase the percentage of adolescents who receive a preventive health care visit in the last year by 5% to 83.2%.

Strategies

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

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

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

Strategy AH-4: Identify, support and integrate evidence-based/-informed strategies to promote adolescents' social-emotional wellness and positive developmental assets through established Title V programs, including: • Comprehensive Adolescent Pregnancy Prevention (CAPP) • Family Planning • Pathways to Success • Personal Responsibility Education Program (PREP) • School-Based Health Centers and • Sexual Violence Prevention.

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

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

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

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

Strategy LC-14: Build internal capacity within the Division of Family Health (DFH)/ Title V Program to advance health equity through all Title V programs, including: • creation of a cross-program DFH Equity Action Team; • completion of an organizational assessment of equity practices, and • facilitation of staff training and professional development through Equity Learning Labs.

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

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

Note: Life Course Strategies and associated ESMs are fully described in the Life Course Domain, and repeat across multiple relevant domains/ priorities consistent with their cross-cutting design.

ESMs	Status
ESM 10.1 - Initial data report is issued.	Inactive
ESM 10.2 - The number of focus groups conducted.	Inactive
ESM 10.3 - Number of adolescents with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home.	Active
ESM 10.4 - Number of strategies implemented to improve adolescent use of preventive health care services.	Active

NOMs
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

State Action Plan Table (New York) - Adolescent Health - Entry 3

Priority Need

Increase the use of preventive health care services across the life course.

NPM

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

Objectives

Objective AH-1: Increase the percentage of adolescents surveyed who demonstrate 20 or more developmental assets by 10% from baseline (to be established in Years 2-3)

Objective AH-2: Reduce the percentage of adolescents who feel sad or hopeless for two weeks or longer in the past year by 10%, to 21.6%.

Objective AH-3 (Same as LC-3): Increase the percentage of adolescents who receive a preventive health care visit in the last year by 6.5% to 97.7%.

Strategies

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

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

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

Strategy AH-4: Identify, support and integrate evidence-based/-informed strategies to promote adolescents' social-emotional wellness and positive developmental assets through established Title V programs, including: • Comprehensive Adolescent Pregnancy Prevention (CAPP) • Family Planning • Pathways to Success • Personal Responsibility Education Program (PREP) • School-Based Health Centers and • Sexual Violence Prevention.

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

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

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

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

Strategy LC-14: Build internal capacity within the Division of Family Health (DFH)/ Title V Program to advance health equity through all Title V programs, including: • creation of a cross-program DFH Equity Action Team; • completion of an organizational assessment of equity practices, and • facilitation of staff training and professional development through Equity Learning Labs.

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

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

Note: Life Course Strategies and associated ESMs are fully described in the Life Course Domain, and repeat across multiple relevant domains/ priorities consistent with their cross-cutting design.

ESMs	Status
ESM 10.1 - Initial data report is issued.	Inactive
ESM 10.2 - The number of focus groups conducted.	Inactive
ESM 10.3 - Number of adolescents with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home.	Active
ESM 10.4 - Number of strategies implemented to improve adolescent use of preventive health care services.	Active

NOMs
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

State Action Plan Table (New York) - Adolescent Health - Entry 4

Priority Need

Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population(cross-cutting).

NPM

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives

Objective LC-11: Increase the percentage of Title V staff that improve their knowledge of health equity concepts by 20% from baseline (baseline to be established in conjunction with Strategy LC-15).

Objective LC-12: Increase the percentage of DFH procurements that demonstrate application of health equity strategies listed by 20% from baseline (to be established in Year 2-3).

Objective LC-13: Reduce disparities for all selected national and state performance measures by 5% from baseline (targets vary by measure).

Strategies

ESM LC-13: # of Title V programs for which health equity analyses completed

ESM LC-14: a) # of Equity Action Team meetings held; b) # of DFH staff who have completed one or more Equity Learning Labs

ESM LC-15: Percentage of DFH procurements that complete community listening forums as part of concept development process

ESM LC-16: Percentage of DFH procurements that demonstrate inclusion of evidence-based/-informed community engagement and collective impact strategies

ESMs	Status
ESM 13.2.1 - Number of public water systems that receive financial and/or technical support from NYSDOH to maintainor initiate community water fluoridation.	Active
ESM 13.2.2 - Percentage of 2nd and 3rd graders served by School-Based Dental Programs who receive sealants.	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (New York) - Adolescent Health - Entry 5

Priority Need

Support and enhance social-emotional development and relationships for children and adolescents

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Objectives

Objective CSHCN-1: Increase the percentage of adolescents with special health care needs ages 12-17 who received services necessary to make to transitions to adult health care by 5% to 16.1%.

Objective CSHCN-2:• Objective CSHCN-2: Increase the percentage of families participating in the Early Intervention Program who meet the state's standard for the NY Impact on Family Scale (> 576) by 16% to 71.5%.

Objective CSHCN-3: Increase the percentage of CSHCN who need and receive care coordination services that meet their needs by 10% to 44%.

Objective CSHCN-4: Increase the percentage of infants who receive a follow-up hearing screenings after failing initial hearing screening by 60% to 50%

Strategies

Strategy CSHCN-1: Develop and implement a plan for analysis and reporting of CSCHN data for NYS, including forthcoming data from revised National Survey of Children's Health, and issue initial data report.

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

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

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

Strategy CSHCN-5: In collaboration University Centers for Excellence in Developmental Disabilities Education, Research, & Service (UCEDD) and other stakeholders implement NY's IDEA Part C State Systemic Improvement Plan (SSIP) to: • create a repository of evidence-based practices for family centered services; • convene statewide learning collaboratives to improve family outcomes for children served in the state's Early Intervention Program; and, • evaluate projects to identify resources and best practices that can be extended to other CSHCN populations.

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

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

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

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

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

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

Strategy LC-14: Build internal capacity within the Division of Family Health (DFH)/ Title V Program to advance health equity through all Title V programs, including: • creation of a cross-program DFH Equity Action Team; • completion of an organizational assessment of equity practices, and • facilitation of staff training and professional development through Equity Learning Labs.

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

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

Note: Life Course Strategies and associated ESMs are fully described in the Life Course Domain, and repeat across multiple relevant domains/ priorities consistent with their cross-cutting design.

ESMs	Status
ESM 12.1 - Initial data report published.	Inactive
ESM 12.2 - Number of partners engaged in system mapping.	Inactive
ESM 12.3 - Number of CSHCN enrolled in Health Homes designated to serve children.	Inactive
ESM 12.4 - Percent of Adolescents/ Young Adults with SCD age 12-21 years in the funded projects who have a transition readiness assessment completed and documented.	Inactive
ESM 12.5 - Number of best practice strategies for improving family outcomes that are documented through review and learning collaboratives.	Inactive
ESM 12.6 - Percent of children transitioning from EIP to Special Education services who have a documented referral to LHD-based CSHCN Program.	Inactive
ESM 12.7 - Percentage of infants with initial abnormal hearing screening results for whom follow-up is documented in NYEHDI-IS.	Active
ESM 12.8 - Number of adolescent-serving MCH programs implementing the asset profile tool.	Inactive
ESM 12.9 - Number of DOH MCH staff and external partners trained on: a)social-emotional wellness b)trauma-informed care practices.	Inactive
ESM 12.10 - Number of adolescent-serving MCH programs identified with an evidence-based social-emotional component.	Inactive
ESM 12.11 - Number of adolescents with documented serious emotional disturbance and/or complex trauma whoare: a) enrolled in Medicaid Health Home; b)transitioned to adult-serving Health Homes.	Inactive

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (New York) - Adolescent Health - Entry 6

Priority Need

Support and enhance social-emotional development and relationships for children and adolescents

SPM

SPM 3 - The percentage of children and adolescents survey who demonstrate 20 or more developmental assets

Objectives

Objective AH-1: Increase the percentage of adolescents surveyed who demonstrate 20 or more developmental assets by 10% from baseline (to be established in Years 2-3)

Objective AH-2: Reduce the percentage of adolescents who feel sad or hopeless for two weeks or longer in the past year by 10%, to 21.6%.

Objective AH-3 (Same as LC-3): Increase the percentage of adolescents who receive a preventive health care visit in the last year by 6.5% to 97.7%.

Strategies

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

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

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

Strategy AH-4: Identify, support and integrate evidence-based/-informed strategies to promote adolescents' social-emotional wellness and positive developmental assets through established Title V programs, including: • Comprehensive Adolescent Pregnancy Prevention (CAPP) • Family Planning • Pathways to Success • Personal Responsibility Education Program (PREP) • School-Based Health Centers and • Sexual Violence Prevention.

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

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

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

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

Strategy LC-14: Build internal capacity within the Division of Family Health (DFH)/ Title V Program to advance health equity through all Title V programs, including: • creation of a cross-program DFH Equity Action Team; • completion of an organizational assessment of equity practices, and • facilitation of staff training and professional development through Equity Learning Labs.

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

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

FY 2017 Annual Report

Adolescent Health – State Priority #3: Support and enhance adolescent's social-emotional development and relationships.

As stated in the Child Health Domain of this report, a priority for NY's SAP is: *Social-Emotional Development and Relationships for Children and Adolescents*. Work on this priority is focused in both the Child Health and Adolescent Health domains and although there is a tremendous overlap of the strategies and activities, they will be reported separately in this report.

Over the past year, Title V staff identified many existing data sources as well as relevant research findings, and evidence-based program resources, and made them available and accessible to all Title V staff by posting them on the Title V internally shared website, as an important step in analyzing and reporting available data on adolescent's social-emotional well-being. This includes current research, national and state-level statistics and indicators, registries of programs effective in reducing youth risk behaviors and resources for evidence-based programs. On a periodic basis, Title V staff reviews the materials and discusses the information during team and Division wide-meetings. Staff also created a preliminary information publication distributed throughout the Title V program, titled "Social Emotional Wellness Update". This publication was created to help highlight and disseminate information regarding social emotional development and relationships in children and adolescents by exploring relevant data, discussing available resources and addressing the importance of using these strategies while allowing for an opportunity to take an in-depth view on specific aspects related to the priority. Staff will continue to publish the Social Emotional Wellness Update on a quarterly basis.

As with the Child Health domain, in order to provide a meaningful contribution, a priority of the past year was to increase Title V staff's understanding of the complexities within this topic and to learn about the evidence-based strategies associated with this work. During the past year, foundational work was conducted to develop a framework within which to address social-emotional development. The focus for some of the formative work in this area includes research and data for positive youth development strategies, ACEs, trauma informed care, well-child definitions as well as reviewing state and national-level data on specific measures that are within the scope of social-emotional development and relationships for the adolescent health domain.

In 2017, New York State data from nationally recognized surveys that included questions on ACEs and trauma were reviewed by Title V staff. The survey data were gleaned from the 2016 NSCH, the 2015 YRBS and the 2016 BRFSS. Key findings include: Six out of 10 adults (59.3 %) reported having experienced at least one ACE, and 13.1% reported 4 or more ACEs. Most reported ACEs are: emotional abuse (24.6%), parental separation (23%) and substance abuse in the home (22.2%). The surveys all indicated that there is a significant presence of trauma being faced by today's youth therefore it is advisable to proceed with a trauma-informed approach with vulnerable MCH populations.

Title V staff have worked on collaborative efforts on social-emotional wellness subject-matter. In addition to the ECAC and EICC, the ACEs workgroup partnered with several DOH bureaus as well as the NYS OASAS. Objectives included discussing the prevalence of ACEs in NYS and demographics of those affected and best practices to prevent, reduce and address ACEs. The Youth Development Team includes Title V staff, OASAS, OMH and the Office of Temporary Disability Assistance (OTDA) and OCFS and meets on a quarterly basis to address many topics facing today's teenagers.

As discussed in the Annual Report for the Child Health Domain, during the reporting period, Title V staff evaluated programs suitable for a pilot and have worked with key partners in identifying a proper validated tool that can measure social-emotional assets in children and adolescents. As of 1/1/2018, these surveys are being used/piloted in CAPP and it is expected that validated surveys will be used within priority populations focusing on children and adolescents currently enrolled in additional Title V programs that use

positive youth development approaches.

Title V staff identified local, statewide and national trainings offered to Title V staff, community providers and other external partners. Specifically, the group identified eighteen different training opportunities that were offered between September 2017 and January 2018. Staff determined that the majority of Title V staff and their respective program providers have participated in at least one related training, while many staff have attended three or more trainings. Information on training attendance was collected with the assistance of various community partners and contracted providers. Examples of trainings offered to Title V staff include: Supporting Young Children from Suffering from Trauma, Supporting Young Children who have Experienced Trauma, Implementing Trauma-Informed Care into Organizational Culture and Practice, and the NYS Kids Count Data Book. Many of these trainings were attended by both staff and providers.

Title V staff also reviewed the list of programs that were identified as having a social emotional component through a process of interviews, data synthesis and feedback for further revisions. Within the Title V program, twenty-one community-based programs were identified and reviewed. Of these, seventeen programs were identified as addressing some aspect of their programs focusing on social-emotional wellness, based on the previously identified internal and external developmental asset categories defined by The Search Institute. A table was developed identifying the Title V programs and developmental asset categories. Members reached out to the programs and are compiling a list of the evidence-based, evidence-informed and promising strategies that each program uses to monitor their social emotional component. Priority group members have also reviewed the list to identify programs that may include an equity component within the social emotional aspect since many Title V programs are focused on socio economic hardship, disadvantaged communities and populations.

Title V staff is also involved in an interagency workgroup focused on identifying the prevalence of ACEs in NYS as well as best practices for preventing, reducing and addressing ACES. Partners include representatives from throughout DOH as well as the Offices of Mental Health and Alcoholism and Substance Abuse Services. The workgroup submitted a proposal to Robert Wood Johnson Foundation called *Facilitating Resilient Communities, Integrating ACEs Science Initiative* that focuses on community revitalization efforts as a strategy to promote resilience and wellbeing using a trauma-informed lens in at least five communities in NYS. Interventions will include leveraging the potential of anchor institutions, worker cooperatives, and processes such as procurement policies as drivers of community revitalization, using a trauma-informed lens.

NY's Title V program has a long history of addressing social and emotional wellness in many programs that serve youth and adolescents, in fact, social and emotional wellness is at the heart of these programs. Programs focusing on both children and adolescents have been included in the Child Health Domain of the Annual Report. An additional Title V program focusing on adolescents and adults is the Rape Prevention and Education program, which has a central focus on social-emotional development and relationships. Programs are supported with Rape Prevention and Education (RPE) funds from the Centers for Disease Control and Prevention (CDC). Regional Centers for Sexual Violence Prevention implement interventions that focus on adolescents aged 10 to 24 years old and include community mobilization, coalition building, development or improvement of sexual violence prevention organizational policies, changing social norms, policy education, building social capital and additional educational sessions.

The Rape Crisis and Sexual Violence Prevention Program (RCSVPP), which was housed within the Bureau of Women, Infant and Adolescent Health (BWIAH) until October 1, 2017 provided 24-hour crisis hotlines and intervention services, counseling, medical, forensic, and support services (e.g. accompaniment, advocacy, information, and referrals) to rape and sexual assault victims and survivors. The funding for this program has since been transferred to the NYS Department of Criminal Justice Services (DCJS), however, the BWIAH is still responsible for approving rape crisis programs throughout the state for rape crisis counselor certification. These programs also build community support systems to improve prevention and response, provide community education and trainings for professionals who respond to victims, provide direct services to victims/survivors and provide outreach. Rape crisis program touch upon the developmental assets in the following areas: support, empowerment, boundaries and expectations, positive

values, social competencies, and positive identity.

The Rape Prevention and Education Program (RPE) consists of six Regional Centers for Sexual Violence Prevention and the Statewide Center for Sexual Violence Prevention Training and Technical Assistance. These centers are funded by the CDC to implement evidence-based/evidence-informed primary prevention strategies and community change strategies in 17 counties throughout the state that have the highest reported forcible rapes in New York. In 2017, the six RPE regional centers conducted 312 community mobilization events, 131 coalition building events and 45 individual evidence-based educational curricula course sessions.

The Enough is Enough (EIE) law was signed by Governor Cuomo in July 2015 to address sexual assault, dating violence, stalking, and domestic violence on college and university campuses. This program is housed within the BWIAH, Campus Sexual Assault Unit. In the 2017-2018 contract year, funding was distributed to 54 rape crisis and sexual violence programs throughout the state, to partner with colleges and universities to assist them in implementing uniform prevention and response policies and procedures to prevent and respond to sexual assault, dating violence, domestic violence and stalking on their campuses. Some activities offered through this initiative are faculty, staff, and student training to prevent sexual violence and domestic violence, provision of victim services, referrals, and medical services. The social-emotional components of this program include the provision of crisis counseling and victim services provided to sexual assault survivors, in addition to education training on prevention of sexual and domestic violence throughout campus communities. Trainings included a webinar on bystander intervention through an intersectional lens, and an in-person full-day training for all three of the Alliance TA regions on engaging men on campus for the EIE program. There was also an annual statewide EIE provider meeting, October 24-25, 2017, where various topics were discussed, including understanding and implementing evidence-based programs, measuring program impact, and campus engagement strategies. To date, the EIE program has provided 27,680 direct services to campus sexual assault victims and rape crisis programs have reached 159,457 individuals through awareness events, 18,864 through training and 81,557 through educational campaigns. These numbers include college/university students, faculty, staff and some parents and are expected to continue to increase.

From June through August 2017, Title V staff assisted in a statewide compliance audit/review of the EIE requirements for all higher education learning institutions in NY. The results of the audit were published and the EIE program focused on increasing compliance with underperforming institutions.

SBHCs are required to provide behavioral health screening for all patients (elementary, middle and high school age) as part of ongoing primary care, and most provide additional mental health services on-site within SBHC clinics; mental health services are provided by referral in sites that do not have in-clinic resources. Currently, in NYS there are over 255 SBHCs which provide services including mental health assessments, crisis intervention, counseling, and referrals to a treatment continuum of services including emergency psychiatric care, community support programs, and inpatient care and outpatient programs. Research has shown SBHCs improve attendance in school and decrease emergency room visits. In the past year SBHCs enrolled 186,566 students and provided 692,607 visits for health and supportive services.

The Pathways to Success program creates and sustains supportive systems that help pregnant and parenting teens and young adults travel pathways to success through health, education, self-sufficiency, and strong families with their infants and children. The partners in the Pathways to Success program are working towards strengthening community systems serving pregnant and parenting teens and young adults; improving the health, development, and well-being of young parents and their children; improving young parents' self-sufficiency through educational attainment; and increasing awareness of resources available to expectant and parenting teens and young adults in each community statewide. Pathways to Success utilizes an Asset and Risk Assessment Tool that assesses the student's financial, social, and educational support, as well as mental health, employment status, housing, food, clothing, health care, transportation, and parenting skills and touches upon developmental assets in all eight categories.

Pathways to Success began a new one-year initiative on 7/1/2017. The initiative will develop, expand and sustain supportive communities to help expectant and parenting teens/young adults succeed by strengthening linkages and existing infrastructure to create sustainable systems of tightly integrated health, education, and social service supports-while leveraging existing resources within NYSDOH's Title V programs. The goals of this program align with the SAP priorities including: support and enhance adolescent social-emotional development and relationships; increase use of primary and preventive health care services; early identification and support for children's special health care needs; and promote supports and opportunities that foster healthy and safe home and community environment.

Adolescent Health initiatives, including the CAPP, PREP and STYA all aim to promote healthy development, parent-child communication, relationship skills and healthy life skills through youth focused activities. The CAPP program continues to support providers specifically focusing on a multi-dimensional approach to adolescent health to support social-emotional well-being and strengthen community relationships to increase positive youth development and build developmental assets in youth. These programs reach approximately 31,000 adolescents aged 9-21 on an annual basis. Due to a change in the requirements for funding, the STYA initiative will be ending on 9/30/2018, however NY's Title V program is committed to exploring additional funding opportunities that provide positive social-emotional development and relationship initiatives to pre-adolescents in underserved populations/communities.

FY 2019 Application

Adolescent Health: State Priority #3: Support and enhance adolescents' social-emotional development and relationships

2020 State Objectives:

- **Objective AH-1: Increase the percentage of adolescents surveyed who demonstrate 20 or more developmental assets by 10% from baseline.**
- **Objective AH-2: Reduce the percentage of adolescents who feel sad or hopeless for two weeks or longer in the past year by 10%, to 21.6%.**
- **Objective AH-3: Increase the percentage of adolescents ages 12-17 who receive a preventive health care visit in the last year by 5% to 83.2%.**

As noted in the Child Health Domain, due to the strong influence social-emotional development can have on children and adolescents throughout the lifespan, NY's Title V program selected the *Social-Emotional Development and Relationships for Children and Adolescents* as state priorities. There is no specific data to report on State Objectives listed above (AH-1 and AH-3) since the past year has been devoted to the developmental work needed to prepare to implement the strategies needed to support these objectives. These data are also from the NSCH report that was released in 2017. Objective AH-2 reporting awaits release of current BRFSS data. Although work on these domains is closely intertwined, plans will be addressed separately for children and adolescents.

For the upcoming Title V MCHSBG period, the Title V program will continue to focus efforts for the priority to support and enhance social-emotional development and relationships for the adolescent health domain and continue to support existing work as described in the Annual Report section of this Domain. This is also a priority throughout DOH and other State agencies. Title V staff are involved in an interagency workgroup consisting of partners within DOH and other state partners such as OMH, Office of Alcoholism and Substance Abuse Services (OASAS) and the Council on Children and Families to develop a multi-pronged strategy to develop supports and services to address the needs of children and adolescents who have experienced ACES, to promote health and development throughout the life course. These programs are strong public health initiatives that impact social-emotional development and relationships for adolescents. Staff will continue to discuss strategy areas, plan and further develop the work that is already underway. Staff will review progress, successes, barriers and challenges while evaluating progress on measures and reviewing further developments for this priority. A commitment to strengthen aspects of social-emotional development assets will continue to have positive effects beyond adolescents. As new procurements are released to provide funding for organizations that work with adolescents throughout NYS communities, it is anticipated that language supporting evidence-based/evidence-informed strategies will be adopted to include building social-emotional wellness for these domains.

Title V staff will also continue to be involved in the ACES interagency workgroup as discussed in the annual report section of this domain in collaboration with representatives across DOH as well as the Offices of Mental Health and Alcoholism and Substance Abuse Services. Focused efforts will continue on the *Facilitating Resilient Communities, Integrating ACEs Science Initiative* to promote resilience and wellbeing using a trauma-informed lens in at least five communities in NYS. In addition, specific action steps have been identified by the workgroup including:

- Facilitate cross-sector engagement in developing, implementing and evaluating the ACES action plan;
- Offer technical support on best practice to prevent, reduce and respond to ACES;
- Support alignment of actions to address ACES;
- Strengthen capacity for training and communication; and
- Collect data and information on ACES and resilience periodically.

Additional specific actions based on the five strategies for this priority are listed below.

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

During the upcoming period, the Title V program will use the information collected from the YRBS, the NCHS and the BRFSS about ACEs and trauma to help inform policy and program interventions with the intent to prevent, reduce and otherwise address ACEs in New York. The team will also work on maintaining an accessible database with relevant materials and data collected on ACEs, and the impact of trauma that can be readily shared within DFH. The team will seek to increase collaborative efforts with other NYSDOH initiatives. The SEW team will also foster and strengthen established partnerships with groups from other state agencies, including CCF and the OMH to continue to enhance the catalogue of emerging data and information as well as disseminate relevant information to staff and providers. Title V staff will continue to distribute the quarterly Social-Emotional Wellness Update to Title V staff and remain a source of content expertise within the Title V program to specifically address and incorporate social-emotional evidence based /evidence-informed strategies into funding procurements. Next steps for this strategy include the sharing of dialogue and information with key staff members assigned to these collaborative efforts to enhance opportunities for collaboration. Staff will highlight these efforts through site sharing and will determine if there are additional opportunities to bring these efforts into the work being done through the Title V program on social-emotional wellness initiatives.

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

During the upcoming reporting period, NY's Title V program will oversee the administration of the developmental assets combined survey constructs tool with the CAPP and will determine if it can be used with other programs within NY's Title V program. Title V staff will determine if the use of these constructs can be adapted for different age populations and will be implemented in additional Title V programs, including child-focused programs identified by BCH. Many of these programs have a direct and specific impact on social-emotional wellbeing, in addition to focusing on different age groups which should provide rich data for the Title V program: BCH focuses on CYSHCNs and CAPP works with adolescents between the ages of 13-21. This tool will be used with a representative sample of the populations that Title V serves to provide a baseline of NYS children's developmental assets. Title V staff will work with stakeholders to approve the tool before it is implemented in their respective programs. Stakeholders include program contractors and the Assets Coming Together for Youth Center for Community Action (ACT CCA). The ACT CCA is a NYSDOH contractor that brings research to practice in areas of positive youth development and adolescent health

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

NY's Title V program will continue to track the number of Title V staff who have participated in at least one related training. Efforts will continue to track the number of trainings, the intended audience and the actual audience for each training conducted within the Title V program as well as those presented by our external partners. Feedback will be provided to Title V staff and recommendations will be made for specific trainings that could benefit staff and community providers that focus on aspects specific to their programs and initiatives. Additionally, staff will continue to identify trainings within the realm of social-emotional wellness and trauma-informed care and notify Title V staff and/or providers of these training opportunities on a monthly basis.
The priority group have identified the next steps for Title V to be integrated with a trauma-informed care (TIC) approach and during the upcoming grant period will focus on the following:
Leadership Engagement: The team will continue to take on a leadership role in expanding engagement on this topic throughout the

Division. Information Provision: SEW team will continue to ensure that data, information and training sessions are sent regularly to Title V staff.
Coordinated Alliances: The SEW team will work regularly with our other state agencies and divisions that are engaging in TIC efforts. This will include updates on collaborative efforts in future newsletters. Training: A student intern will review and recommend relevant training modules to be used to train Title V staff to become TIC trainers. TIC trainers will provide small group training sessions to other interested the Title V staff. Policy Review: A trauma informed workforce will assess if outgoing procurements and policy initiatives include trauma informed principles. Resource Dissemination: The SEW team will provide/develop TIC resources to youth-serving organizations, partners and the public. Evaluation The team will develop criteria to evaluate the TIC initiative.

Strategy AH-4 – Identify, support and integrate evidence-based/informed strategies to promote adolescent's social-emotional wellness and positive developmental assets through established Title V programs, including: Maternal and Infant Community Health Collaboratives (MICHCs), Home Visiting, Infant/Child Mortality Initiative, Early Intervention, Successfully Transitioning Youth to Adolescence (STYA) and, School-Based Health Centers.

During the upcoming reporting period, staff will contact previously identified programs within the Title V program and gather additional information on how/if health equities and disparities are addressed. Through research review, staff will analyze the responses and determine if the strategies are evidence-based, evidence-informed, promising practices or best practices or if the initiatives need to incorporate these strategies into their program. Staff will explore how social-economic and other health disparities impacted overall social-emotional health and wellness for youth residing in communities throughout NY. The Title V program will highlight programs that are using sound methodology to incorporate social-emotional development while offering recommendations to the programs that can benefit from incorporating these methodologies. Programs that are excelling in using these strategies will be highlighted in the quarterly Social Emotional Wellness Update that is distributed throughout NY's Title V program.

Strategy AH-5 – Continue to provide subject matter and technical support to NY's Medicaid Health Home Program to implement enhanced care coordination for eligible youth and young adults with serious emotional disturbance and complex trauma.

NY's Title V program will continue to provide subject matter and technical support to NY'S Medicaid HH to implement enhanced care coordination for eligible adolescents with serious emotional disturbance and complex trauma. The HH for Children will be implemented statewide during this period. Title V staff will work with colleagues in the OHIP to monitor enrollment and ensure adolescents receive coordinated care across all the State's systems of care. Staff are involved in the policy making aspect of Title V such as case/chart review, development of a score card, site visit auditing process and developing a process on how providers can add expertise and expand populations served to build capacity. Staff will complete training on the Child and Adolescent Needs and Strengths (CANS) - a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

This strategy is being measured through **ESM AH-5**: Number of adolescents with documented serious emotional disturbances and/or complex trauma who are enrolled in Medicaid Health Home. These data are just being collected. For the 2017-18 year, 1,060 adolescents with serious emotional disturbances and/or complex trauma were enrolled in NY's Medicaid Health Home Program.

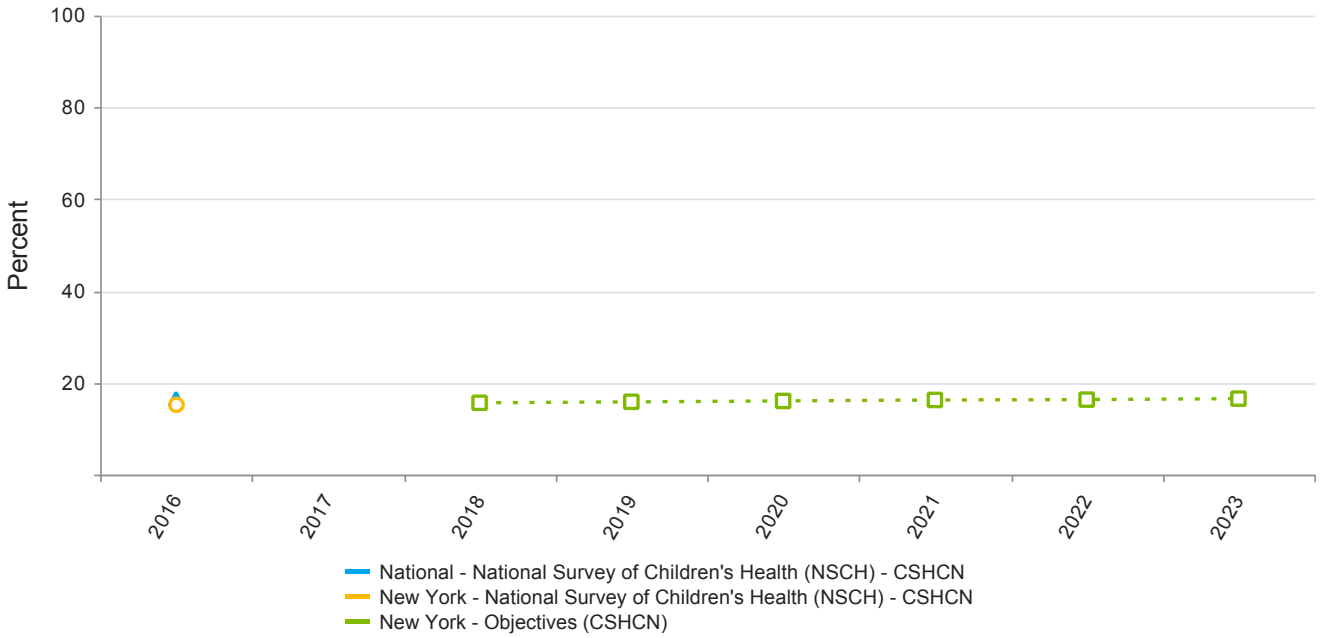
Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2016	11.0 %	NPM 12

National Performance Measures

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care
Baseline Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	**2017**
Annual Objective		
Annual Indicator		15.3
Numerator		48,081
Denominator		314,730
Data Source		NSCH-CSHCN
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	15.7	15.9	16.1	16.3	16.4	16.6

Evidence-Based or –Informed Strategy Measures

ESM 12.7 - Percentage of infants with initial abnormal hearing screening results for whom follow-up is documented in NYEHDI-IS.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		45
Annual Indicator	63.9	66.9
Numerator	4,275	5,244
Denominator	6,688	7,843
Data Source	NYEHDI	NYEHDI
Data Source Year	CY2016	CY2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	60.0	67.0	70.0	72.0	75.0	77.0

State Performance Measures

SPM 3 - The percentage of children and adolescents survey who demonstrate 20 or more developmental assets

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		50
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	To Be Developed	Developmental Assessment Tool
Data Source Year	2017-2018	2017-2018
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	50.0	50.0	50.0	50.0	50.0	50.0

SPM 4 - The percent of families participating in the Early Intervention Program who meet or exceed the state's standard for the New York Impact on Family Scale

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		65
Annual Indicator	61.6	70.1
Numerator	673	1,021
Denominator	1,092	1,456
Data Source	New York Family Survey	New York Family Survey
Data Source Year	2015-2016	2016-2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	65.5	71.0	71.5	72.0	72.5	73.0

State Action Plan Table

State Action Plan Table (New York) - Children with Special Health Care Needs - Entry 1

Priority Need

Increase supports to address the special health care needs of children and youth

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Objectives

Objective CSHCN-1: Increase the percentage of adolescents with special health care needs who receive services necessary to make to transitions to adult services by 10%, to 44%.

Objective CSHCN-2: Increase the percentage of families participating in the Early Intervention Program who meet the state's standard for the NY Impact on Family Scale (> 576) by .50% to 66.5% (in 2018).

Objective CSHCN-3: Increase the percentage of CSHCN who need and receive care coordination services that meet their needs by 10% to 44%.

Objective CSHCN-4: Increase the percentage of infants who receive a follow-up hearing screenings after failing initial hearing screening by 45% to 50%

Strategies

Strategy CSHCN-1: Develop and implement a plan for analysis and reporting of CSCHN data for NYS, including forthcoming data from revised National Survey of Children's Health, and issue initial data report.

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

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

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

Strategy CSHCN-5: In collaboration University Centers for Excellence in Developmental Disabilities Education, Research, & Service (UCEDD) and other stakeholders implement NY's IDEA Part C State Systemic Improvement Plan (SSIP) to: • create a repository of evidence-based practices for family centered services; • convene statewide learning collaboratives to improve family outcomes for children served in the state's Early Intervention Program; and, • evaluate projects to identify resources and best practices that can be extended to other CSHCN populations.

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

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

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

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

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

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

Strategy LC-14: Build internal capacity within the Division of Family Health (DFH)/ Title V Program to advance health equity through all Title V programs, including: • creation of a cross-program DFH Equity Action Team; • completion of an organizational assessment of equity practices, and • facilitation of staff training and professional development through Equity Learning Labs.

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

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

Note: Life Course Strategies and associated ESMs are fully described in the Life Course Domain, and repeat across multiple relevant domains/ priorities consistent with their cross-cutting design.

ESMs	Status
ESM 12.1 - Initial data report published.	Inactive
ESM 12.2 - Number of partners engaged in system mapping.	Inactive
ESM 12.3 - Number of CSHCN enrolled in Health Homes designated to serve children.	Inactive
ESM 12.4 - Percent of Adolescents/ Young Adults with SCD age 12-21 years in the funded projects who have a transition readiness assessment completed and documented.	Inactive
ESM 12.5 - Number of best practice strategies for improving family outcomes that are documented through review and learning collaboratives.	Inactive
ESM 12.6 - Percent of children transitioning from EIP to Special Education services who have a documented referral to LHD-based CSHCN Program.	Inactive
ESM 12.7 - Percentage of infants with initial abnormal hearing screening results for whom follow-up is documented in NYEHDI-IS.	Active
ESM 12.8 - Number of adolescent-serving MCH programs implementing the asset profile tool.	Inactive
ESM 12.9 - Number of DOH MCH staff and external partners trained on: a)social-emotional wellness b)trauma-informed care practices.	Inactive
ESM 12.10 - Number of adolescent-serving MCH programs identified with an evidence-based social-emotional component.	Inactive
ESM 12.11 - Number of adolescents with documented serious emotional disturbance and/or complex trauma whoare: a) enrolled in Medicaid Health Home; b)transitioned to adult-serving Health Homes.	Inactive

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (New York) - Children with Special Health Care Needs - Entry 2

Priority Need

Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population(cross-cutting).

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Objectives

Objective CSHCN-1: Increase the percentage of adolescents with special health care needs who receive services necessary to make to transitions to adult services by 10% to 44%.

Objective CSHCN-2: Increase the percentage of families participating in the Early Intervention Program who meet the state's standard for the NY Impact on Family Scale (> 576) by .50% to 66.5% (in 2018).

Objective CSHCN-3: Increase the percentage of CSHCN who need and receive care coordination services that meet their needs by 10% to 44%.

Objective CSHCN-4: Increase the percentage of infants who receive a follow-up hearing screenings after failing initial hearing screening by 45% to 50%

Strategies

Strategy CSHCN-1: Develop and implement a plan for analysis and reporting of CSCHN data for NYS, including forthcoming data from revised National Survey of Children's Health, and issue initial data report.

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

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

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

Strategy CSHCN-5: In collaboration University Centers for Excellence in Developmental Disabilities Education, Research, & Service (UCEDD) and other stakeholders implement NY's IDEA Part C State Systemic Improvement Plan (SSIP) to: • create a repository of evidence-based practices for family centered services; • convene statewide learning collaboratives to improve family outcomes for children served in the state's Early Intervention Program; and, • evaluate projects to identify resources and best practices that can be extended to other CSHCN populations.

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

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

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

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

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

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

Strategy LC-14: Build internal capacity within the Division of Family Health (DFH)/ Title V Program to advance health equity through all Title V programs, including: • creation of a cross-program DFH Equity Action Team; • completion of an organizational assessment of equity practices, and • facilitation of staff training and professional development through Equity Learning Labs.

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

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

Note: Life Course Strategies and associated ESMs are fully described in the Life Course Domain, and repeat across multiple relevant domains/ priorities consistent with their cross-cutting design.

ESMs	Status
ESM 12.1 - Initial data report published.	Inactive
ESM 12.2 - Number of partners engaged in system mapping.	Inactive
ESM 12.3 - Number of CSHCN enrolled in Health Homes designated to serve children.	Inactive
ESM 12.4 - Percent of Adolescents/ Young Adults with SCD age 12-21 years in the funded projects who have a transition readiness assessment completed and documented.	Inactive
ESM 12.5 - Number of best practice strategies for improving family outcomes that are documented through review and learning collaboratives.	Inactive
ESM 12.6 - Percent of children transitioning from EIP to Special Education services who have a documented referral to LHD-based CSHCN Program.	Inactive
ESM 12.7 - Percentage of infants with initial abnormal hearing screening results for whom follow-up is documented in NYEHDI-IS.	Active
ESM 12.8 - Number of adolescent-serving MCH programs implementing the asset profile tool.	Inactive
ESM 12.9 - Number of DOH MCH staff and external partners trained on: a)social-emotional wellness b)trauma-informed care practices.	Inactive
ESM 12.10 - Number of adolescent-serving MCH programs identified with an evidence-based social-emotional component.	Inactive
ESM 12.11 - Number of adolescents with documented serious emotional disturbance and/or complex trauma whoare: a) enrolled in Medicaid Health Home; b)transitioned to adult-serving Health Homes.	Inactive

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (New York) - Children with Special Health Care Needs - Entry 3

Priority Need

Increase supports to address the special health care needs of children and youth

SPM

SPM 4 - The percent of families participating in the Early Intervention Program who meet or exceed the state's standard for the New York Impact on Family Scale

Objectives

Objective CSHCN-1: Increase the percentage of adolescents with special health care needs who received services necessary to make to transitions to adult services by 5% to 16.1%.

Objective CSHCN-2: Increase the percentage of families participating in the Early Intervention Program who meet the state's standard for the NY Impact on Family Scale (> 576) by 16% to 71.5%.

Objective CSHCN-3: Increase the percentage of CSHCN who need and receive care coordination services that meet their needs by 10% to 44%.

Objective CSHCN-4: Increase the percentage of infants who receive a follow-up hearing screenings after failing initial hearing screening by 60% to 50%

Strategies

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FY 2017 Annual Report

Children with Special Health Care Needs (CSHCN) – State Priority #4: Increase supports to address the special health care needs of children and youth.

Population and program data are needed to help drive and evaluate work across all areas of MCH, including CSHCN. Title V staff continue to review data from the 2009-2010 National Survey of Children with Special Health Care Needs (NSCSHCN), the NSCH, and data reported by NY's Title V LHD-based CSHCN and EI programs. Access to the 2017 release of NSCH including state level data, provides essential information for states such as NY to assess current functioning in this and other Domains.

NY LHD CSHCN Program preliminary 2016-2017 data shows that 54.3% of children have Medicaid; 21.3% have commercial insurance; 11.7% have CHP; and 2.6% have Social Security Income (SSI). Data shows that 56.1% are White, 8.9% are African American, 4.7% are Asian or Pacific Islander, .3% are American Indian or Alaska Native and 9.5% are Hispanic. The percent of children with a primary care provider is 73.6%. The percentage of children who report needing assistance for aspects of care are as follows: 59.3% need help paying for items that are not covered; 17.7% exceeds benefit amount; 10.1% premium; 3.5% deductible and 9.5% copays.

Review and analysis of data are essential elements of MCH work. To expand and formalize this process, a data analysis plan was developed that includes regular NYS summary reports of national survey data. Data from the last national survey of CSHCN 2009-2010, were analyzed following the analysis plan. Frequencies were run to evaluate data quality and identify prevalence of conditions within the NY CSHCN population. Title V staff implemented a data plan involving a process of stratifying conditions by age and developed a methodology to identify frequency of groups of conditions. These exploratory exercises allowed for a better understanding of the population and helped to identify associations most appropriate to run for data analysis in future years. Title V staff seek to increase understanding of the impact of having a child with special needs on the child and family and the factors associated with the impact (i.e. presence of having insurance, medical home). The 2009-2010 national survey data indicate that having a medical home as well as private insurance were both mitigating factors for NY families of CSHCNs impacting number of days missed from school, family members' stopping work, financial problems and coordinating their child's care.

Title V created a new state CSHCN Program database to capture data about those children served by LHDs. Title V staff had received feedback from the LHDs about what data is necessary for their work with families of CSHCN and what reports would be useful. Title V staff met several times with data specialists to discuss data elements and database design, incorporating some data elements that align with the NSCH. Six LHDs pilot tested the new database design. Incorporating LHD and Title V input, the database was finalized and launched October 1, 2017. The new database enables LHDs to generate their own county-specific reports. New data elements include an assessment of dental insurance, in addition to medical insurance, and referrals to Health Homes.

In November 2017, Title V staff held a webinar to provide technical assistance and respond to questions from the LHDs regarding the new CSHCN Program database. During this webinar, Title V staff reviewed the grant narrative reporting tool and the electronic reporting submission process for the LHDs' quarterly reports to the state. Title V staff are closely monitoring uptake of database utilization, data quality, and quarterly report submission.

In developing NY's SAP, Title V staff recognized the challenges in NYS related to fragmentation of services and the need to more fully understand the needs of NY's CSHCN and their families as well as their perception as to what is currently effective and where there are significant gaps and barriers to ensuring CSHCN and their families are fully supported and integrated into society. NY is estimated to be home to over 750,000 CSHCN. Families with CSHCN require health and supportive services from a complex and potentially fragmented network of public and private programs in health care, social service, and education systems in NY. Caring for CSHCN can be challenging for families, particularly with respect to meeting the complex and varied medical needs of these children. Consistent access to comprehensive health care and supportive community services is essential to ensuring positive health and developmental outcomes for CSHCN. Several NY agencies, including the NYSDOH, OCFS, OMH and Office of Persons with Developmental Disabilities (OPWDD), support programs and services to aid CSHCN and their families. The Title V program recognizes that the current systems in place in the state vary tremendously, all with potentially differing eligibility criteria, processes, and their own technical language (i.e., acronyms) that can be confusing to fully understand and access.

Over the past 18 months, Title V staff embarked on the development of a process to systemically assess how agencies and programs relate to each other and to the CSHCN and families served and to identify gaps in services. While systems and programs are in place for CSHCN, they may not be available in all locations, easy for families to understand or navigate, or are less than optimally coordinated. The same challenge may exist for professionals seeking to support the CSHCN and families they serve and support. System support maps offer a guided approach to help families and other stakeholders think about and document a system from their perspective. The map is a tool that will allow families/stakeholders to visually express their personal ongoing journey or "story" as they support the child(ren) for whom they are responsible. The process of creating a map will help families and stakeholders clarify, demonstrate and document the complex web of responsibilities, needs, resources, services and wish lists involved in supporting their CSHCN. The information NY staff receives from these maps will help to answer questions, such as, "What supports and services are needed to help providers, local DOH staff and others support families of CSHCN?"; "What can providers, local DOH staff and others do to support families?"; "What do families need to care for their CSHCN?"; "What is currently working that supports families?"; and, "What are the gaps and barriers to supports and services for CSHCN and their families?".

NY's Title V program, with assistance of the National MCH Workforce Development Center (WDC) initiated a systems mapping initiative to identify the connections/relationships that exist among programs and services and to identify specific issues, gaps and barriers in the system of public health programs and services for CSHCN and their families. This initiative included engaging a variety of members representing different stakeholders involved with CSHCN, including parents, advocacy groups, health care systems and community based providers, academia, county officials and state agency staff to complete systems maps.

Parents are essential partners in this mapping exercise. NY staff continues to work with local parent agencies to ensure that a diverse group of parents are engaged on a state-wide basis to provide their input. Parent feedback is collected via a tool known as a "map". Instructions on how to complete a systems map for an individual child or family were presented to a pilot cohort of twelve parents of CSHCN in December 2016 at an Early Intervention parent training session. The pilot cohort showed interest in participating in systems mapping and a desire to be involved in planning of future supports but only one parent of the twelve completed their map. According to the WDC, more parents made attempts to start a map but only one was successfully completed. In March 2017, an email and instructions on how to access and complete a family systems support map was sent to 350 graduates of the EI Parents in Partners Training Program, which is an initiative of the EIP. Parents of children receiving EI services apply and are selected to participate in this training to enhance their leadership skills, network with each other, and learn how to become better advocates for the care of their special needs child at the local, state and national levels. A follow-up reminder was forwarded to the same parent group in April 2017. Despite the initial contact and reminder, fewer than 30 maps were completed.

In addition to requests for individual parents to complete maps on their own via the WDC online mapping tool, several parent groups were engaged in group mapping sessions. On April 3, 2017, UNC WDC held a web-based training for NY Title V Program staff on how to facilitate map development in a group setting. Group mapping sessions allow parents to have their voices heard, while working together to come up with a map that reflects the most common systems challenges experienced by the group. In 2017 several groups participated in group map creation. These included: participants of the Westchester Institute for Human Development's (WIHD) LEND fellowship program, Families Together in New York s Family Advocacy group, and parents and providers at the NYC CSHCN Program's Quarterly Health Forum.

Nearly 20 additional organizations and agencies were contacted regarding helping Title V engage parents in the systems mapping project, including but not limited to: Autism Speaks, Help Me Grow of Western New York, Spina Bifida Association, ECCS, Docs for Tots, Family Ties of Westchester, and the NYS Council on Children and Families. The anonymous nature of the maps makes it difficult to identify if completion of a map was related to a specific organization's outreach, however, one map was received from a parent working with ECCS and the organization's name was entered in the map.

Additionally, NY staff introduced the system mapping tool to local County EI managers in December 2016 during a call with all counties. A statewide webinar for local Title V CSHCN staff took place in March 2017 to introduce the system mapping tool and request that local Title V CSHCN and EI staff create their own individual maps using the WDC's online mapping tool. In April 2017, local Title V staff reported difficulty accessing the mapping tool due to county firewalls and technical difficulties. Some staff experienced difficulty downloading their completed maps or saving a map and retrieving it at a later time.

In total, 32 parent/caregiver maps and 21 provider maps were completed using the online mapping tool or at group mapping sessions during the first phase of data collection, through November 2017. Many maps were initiated but not completed and could not be used for evaluation. Common themes identified by parents from the completed maps included the wish for their child's independence and success, more family and peer support, opportunities and equipment for community involvement and physical activeness, and a desire for greater care coordination. One parent expressed a wish that their "friends would take my kid, the way I take theirs, to events." Many parents did express success in using resources to meet their needs. The most helpful resources included: special education and school supports (7), having a flexible job that allows fluid hours (5), coordination services or case managers (4), health insurance and waivers (4), a strong support network among family and friends (4), and transportation (4). Resources that parent reported being not helpful included various prompts and reminder systems (3), transition services (1), and support for supervision and socialization (1).

Common themes among service providers included the desire for more guidance and training for local CSHCN staff, more local organizations and services for children and families, and more qualified healthcare providers. One provider expressed the need for "more cohesive administration between DOH and SED for children under five." Another common response from providers was the need for a better CSHCN data collection system, electronic forms, and less cumbersome paperwork (5). The need for a better data collection system was addressed in the fall of 2017 with the release of a new, more user-friendly CSHCN Program data reporting system for local Title V staff. (described earlier). The new data system will assist in CSHCN contractor reporting and program evaluation.

It is essential to obtain demographic information such as participant's race and ethnicity so that analysis can be conducted using a health equity lens. The WDC's online mapping tool could not accommodate this need. This limitation, coupled with repeated feedback from parents and providers that the mapping tool was difficult to use, leading to few maps actually being completed, caused Title V staff to decide, in late 2017, to abandon the online mapping tool as a means of collecting these data.

In order to continue the systemic collection of family and provider data, Title V staff developed a structured and more tabular paper-based tool, developed new instructions, and included a demographic form to use in Phase 2 of data collection. NYS has maintained the UNC concepts of the systems mapping project by continuing to focus on responsibilities, needs, resources, and wishes of caregivers and providers. Title V has utilized the same concepts that were used with the systems mapping tool to help focus stakeholder group discussions and lead families through a standard method of providing feedback at meetings throughout the state.

The Title V Program expects to gain a greater understanding of the strengths as well as gaps and barriers to care to improve access to appropriate and necessary services for families of CSHCN. The Title V program will share the results of the information gathering with partners to help develop a more integrated, comprehensive, family centered and consistent system of care for families of CSHCN in NY.

Based on the experience with the systems-mapping tool and process as discussed above, Title V staff developed a simplified tool and process to obtain input from parents and providers. Title V staff initiated a process that consisted of specific questions and a facilitated discussion that has proven to be more successful in ascertaining input and responses. Contact was made with the three University Centers of Excellence in Developmental Disabilities (UCEDDs) to engage their expertise in the mapping process. The UCEDDs work with people with disabilities, members of their families, state and local government agencies and community providers that focus on building the capacity of communities to sustain all their citizens. UCEDDs have played key roles in major disability initiatives involving issues such as early intervention, healthcare, community-based services, inclusive education, transition from school to work, employment, housing, assistive technology and transportation. In January and early February 2018, Title V staff facilitated an abridged, 45-minute mapping activity with participants of three EI Improving Family Centeredness Together (IFaCT) in-person learning sessions hosted by the UCEDDs. Participants worked as groups, with at least one parent in each group, to work through a shortened systems map from the parent's perspective. A total of 22 parent maps were collected.

Title V staff collaborated with Parent to Parent of NY to identify parents with CSHCN who will help develop aggregate system maps in five regions of NY. Five regional mapping sessions took place in February 2018. Each session took place with a small group of 5-12 parents, with facilitation by state staff to complete an aggregate map over 2-3 hours. A total of 45 parents participated in the regional mapping sessions. One of the regional meetings was conducted with Spanish-speaking parents with the aid of an interpreter. In addition to group maps, Title V staff took notes about themes that might have been raised during the group discussion but not

captured in the group map. During this reporting period a total of 99 parent maps and 21 provider maps were received. By analyzing the data from these "maps", the Title V Program expects to gain a greater understanding of the strengths as well as gaps and barriers in the state system of care for CSHCN and their families. The Title V program will share the systems mapping results with internal and external partners to help strengthen and ensure an integrated, comprehensive, family centered and effective system of care for families of CSHCN in NY.

Another Title V policy and program focus for CSHCN is the implementation of Children's Health Homes (CHH). The enrollment of children in CHH began in October 2016. In order to be eligible for CHH a child must be Medicaid eligible and have two or more chronic conditions including; alcohol or substance abuse, mental health condition, cardiovascular disease, metabolic disease, respiratory disease, BMI at or above 85% or other chronic conditions; or one single qualifying condition such as HIV/AIDS or serious mental illness, serious emotional disturbance or trauma and at risk for another chronic condition.

Title V staff participated in ongoing plans and efforts to develop and implement CHH. In November 2016, Title V and OHIP staff participated in site visits to three designated CHH agencies prior to the program launch in December 2016. The three site visits included Kaleida (Buffalo), Collaborative Children and Families (NYC) and Children's Health Homes of Upstate NY (Rochester). The purpose of the visits was to assess each of the agency's organizational structure, governance model, readiness criteria, relations and connection to adult HH, planning for transitional youth, provider connection and training/knowledge of special populations (Medically Fragile, Early Intervention, specific geographical needs, among others) and their role in behavioral health. During February and March 2018, Title V participated with OHIP staff in site visits to four designated CHH agencies. These CHH agencies are OISHEI, formerly known as Kaleida (Buffalo), Children's Health Homes of Upstate NY (Rochester) ENCOMPASS (Broome) and Collaborative Children and Families (NYC). Title V staff are involved with the development of the site visit auditing process, as well the onsite case/chart review, site visit auditing process and how providers can add expertise and build capacity to expand the populations they can serve. OHIP has developed several reports concerning the number of children in the outreach and enrollment phases of CHH. Title V has requested consideration of additional reports, such as the number of children enrolled by specific condition type, such as sickle cell disease, asthma, diabetes and autism.

In January 2018, Title V staff attended New York State Association of Counties meeting to promote a training opportunity for local CSHCN Programs about CHHs. In February 2018, the Title V Program held a webinar for LHD CSHCN Program staff to provide information on Health Home eligibility criteria for children and the LHD role in the referral process to CHHs. The Title V Program has gained access for LHDs CSHCN Program staff to the OHIP's electronic referral portal for HHs. This access allows LHD CSHCN Programs the ability to make referrals of children to Health Homes and to see which care management agency the child was connected to. The state CSHCN Program will be monitoring the number of children referred to HHs by the local CSHCN Programs. With the new CSHCN Program database that was created, these referral types to CHHs can be captured.

Title V staff, as part of the CHH team, also collaborated to define policy elements related to comprehensive assessment of children enrolled in CHH. Title V staff contributed to the development of CHH indicators designed to assess process and outcomes related to children receiving care management. Title V staff co-presented at three webinars for CHH and EI provider agencies to obtain input on supports and barriers to the CHH referral process for EI eligible children. On February 14, 2018, the CSHCN Program held a one-hour webinar with contracted CSHCN Programs to provide technical assistance and answer questions about referral of children to HH. The webinar also provided specific information regarding the responsibilities of CHH care managers for children who are receiving EI services. OHIP reports that as of December 31, 2017, a total of 48,881children were enrolled in CHH up from 2,889 in December 2016. An additional 14,074 children are receiving CHH outreach. This strategy is measured by the number of CSHCN children enrolled in Health Homes designated to serve children. Additionally, a readiness survey was developed and distributed to EI providers, municipalities, HH care management agencies, and CHHs to gain feedback on readiness and needs for additional training to receive referrals of EI eligible children. The survey returned 148 responses and determined that more than 50% of responders were interested in more training and establishing business agreements to work with CHHs and EI eligible children. It is anticipated that more EI children will be referred when additional training and EI approval of providers has been accomplished. The anticipated date for referral of EI children to CHH was September 2017.

The LEND learning day was held April 27, 2017 at the School of Public Health. Since 2005, LEND trainees have met annually with NYSDOH Title V and other state agency staff to share their team research projects regarding children with disabilities and their families. This year the Department shared information with the LEND fellows about CHHs.

Transition to adult services can be a challenge for youth with special health care needs. Local CSHCN programs provide adolescents with information about transitions to adult services and CHH can strengthen transition supports for eligible adolescents enrolled in Medicaid. Youth with sickle cell disease (SCD) are particularly vulnerable during this transition and require coordinated consistent support to develop the independent skills and knowledge they need to become healthy and productive adults. Research shows that adolescents and young adults (AYA) with SCD have a higher morbidity and mortality than their younger and older cohorts in the five years after transition. As individuals with SCD enter adolescence, they are faced with the same options and challenges as their peers, but with the extra burden of SCD. They may experience challenges such as finding health care providers who are available and experienced in working with adults with SCD. Young adults with SCD can experience significant health problems and incur a higher use of emergency and inpatient medical care as compared to their younger and older cohorts.

For close to three decades, NY provided funding to qualified hemoglobinopathy centers to support transition navigation services. When contracts ended on December 31, 2016. NYS had already implemented CHH. CHH were identified as strong partners in supporting transition activities. Title V released a Request for Applications in July 2017 to fund Article 28 facilities to provide transition services for children to age 21 years with SCD and to connect hemoglobinopathy centers to CHH so transitioning youth insured by Medicaid have access to care managers as adults. There were eight applications. Three applicants were recommended for funding. The new contract year begins July 2018 with a five-year term ending in June 2023. The new contract focuses on transition navigation from pediatric to adult health care, completion of transition readiness assessments and referrals to Health Homes for individuals insured by Medicaid who are transitioning to adult health care providers. Health Homes can provide an ongoing source of care management for individuals with Medicaid avoiding the loss to follow up that sometimes occurs with young adults who have transitioned to adult medical care.

NY has established supports and services for CSHCNs and their families across the life course. Beginning at birth, NY's Newborn Screening Program (NBSP) performs blood testing for over 275,000 specimens annually for 49 diseases and conditions. Families and primary care providers are notified of any positive results. In addition, all birthing facilities in NY are required to conduct hearing screening on all newborns. If the result of a hearing screening test is abnormal, a referral is made to an appropriate specialized care center for hearing evaluation.

NY also supports several programs and initiatives to provide support for CSHCN and their families (CSHCN is further discussed later in this report). One of these programs is the EIP, one of the largest EIPs in the nation. Annually, there are over 68,000 children enrolled in the EIP, of which over 12,000 are potentially eligible for SED Preschool Program for children 3-5 years of age who qualify for these educationally-oriented services. NY also supports 50 CSHCN programs in LHDs to provide information and referral services for families of CSHCN. These CSHCN programs worked to ensure that each child had a primary health care provider and appropriate health insurance. CSHCN contractors link families with facilitated enrollers, the NY Health Exchange and other community gap-filling programs. Title V program staff analyzed data from the EI survey to better understand the needs of families exiting the EIP so that patterns of insufficiency within a community can be identified that may be negatively impacting this transition process. One of the challenges for smooth transition from EIP to CSHCNs is that the EIP program provides families with a service coordinator, but SED Preschool Special Education Program does not. To fill this gap, CSHCN program staff and/or CHH (for children who are Medicaid eligible) provided brief or more systematic care coordination to manage this transition.

An important component of finalizing NY's SAP was addressing improved coordination and maximizing existing efforts to improve supports and services for CSHCN. A prime example of this is NY's State Systemic Improvement Plan (SSIP), which is a comprehensive multi-year plan for improving results for infants and toddlers with special needs. The SSIP is a federal requirement,

focused on improving family outcomes and is reported to the federal Office of Special Education Programs. The NY Family Survey is distributed annually to a representative sample of families as they transition out of the EIP. This survey captured feedback about outcomes for the family and child and the quality of EI services. In 2016-2017, 70.1% of families met or exceeded the state-established standard for the NY Impact on Family Scale, an improvement from 61.6% in 2015-16.

NY's SSIP, which is called Improving Family Centeredness Together (IFaCT), is using a quality improvement methodology developed by the Institute for Healthcare Improvement (IHI). This quality improvement methodology uses a Learning Collaborative (LC) model, which is a short term (6-15 months) system that uses Plan-Do-Study-Act (PDSA) cycles to implement small changes resulting in improvement in a focused topic area. Local teams focus on areas of improvement, small changes are made in a short period of time, data are measured, and, based on the results of the changes, the plan is adopted, adapted and abandoned. Ongoing coaching support is provided over 6-15 months until successes are achieved and sustained. These successes are shared, or spread statewide. The NY IFaCT teams are comprised of families, EI Officials, Designees or Managers, service coordinators and EI providers. Each team has a Champion, who is a well-respected leader willing to devote time, who understands EI well and has a desire to drive system improvements. Each team also has a Key Contact who drives the project and cycles of change, coordinates communication and oversees data collection. All the team members participate in the change cycles and data collection. The goal of NY's IFaCT LC is to make small changes to ensure family-centered practices are part of daily interactions with families enrolled in the state's Part C Early Intervention Program.

A Statewide Advisory Group has been convened, and consists of parents, EI providers, EI Officials, EICC members, ECAC members and members representing other NYS agencies. The Statewide Advisory Group provides advice and expertise to support to the learning collaborative efforts. This strategy will be measured by the number of best practice strategies for improving family outcomes that are documented through review and utilized in the Learning Collaborative work at the local level.

The Advisory Group has been convened via WebEx six times. The group has provided guidance on the development of brochures to recruit parents/caregivers, EI providers, service coordinators, and Early Intervention Officials, as well as an application to be completed by parents/caregivers and EI providers. The group has provided guidance on recruitment, and assisted with recruitment by reaching out to statewide professional associations, parent groups, and colleagues, as well as through social media, including Facebook and Twitter. A seventh webinar with the Statewide Advisory Group is scheduled for April 20, 2018 to provide an update on progress.

To support the SSIP, the Department has executed contracts with the state's three Universities of Excellence in Developmental Disabilities (UCEDDs). The UCEDDs were selected as contractors based on their experience and work in the field of children with disabilities, as well as their locations in the state. All three UCEDDs have LEND programs. The Rose F. Kennedy University Center for Excellence in Developmental Disabilities is in Bronx, New York. The WIHD is in Valhalla, NY. The Strong Center for Developmental Disabilities (SCDD) at the University of Rochester Medical Center is in Rochester, NY.

Each UCEDD has designated staff to work with counties and stakeholders to improve family outcomes. Learning Collaboratives are using the IHI Breakthrough series model, and have recruited local teams to implement changes. The teams are comprised of parents/caregivers, Early Intervention providers (such as occupational therapists, physical therapists, speech language pathologists and teachers of special education), service coordinators, and local Early Intervention Officials or their designees. Each region will ultimately have two cohorts. The UCEDDs began recruitment in the Fall of 2017, and the three in-person, kick-off Learning Sessions held on January 18, 2018 in NYC, January 22, 2018 in Kingston, NY and February 2, 2018 in Fayetteville, NY for their respective regions of the State. The local teams will work together for one year and will receive coaching and support from the UCEDDs. Teams are collecting data monthly, submitting the data to UCEDDs, and participating in monthly webinars/calls to review their work the previous month and to give and receive feedback from other teams (peer-to-peer) and from the experts at the UCEDDs.

As described earlier, the systems mapping initiative also collaborates with the UCEDDS to obtain systems maps created from the parent perspective for the county teams involved in the SSIP.

The Title V staff reviewed the EIP Family Survey outcomes to identify areas that are the most difficult to meet through EI services. The survey was sent out to about 1/3 of families of children (approximately 10,000 of 30,000) aging out of the EIP. By responding to the EIP Family Survey, parents have a voice in helping to improve the services for their children. Some of the items parents identified as the most difficult for the EIP to help them/their child with include: 1) Connecting with parents of children with similar needs, 2) Taking part in typical activities for children and families in the community, 3) Coping with stressful situations, 4) Supporting the needs of other children in the family, 5) Feeling welcome in the community, and 6) Involving the child's doctor in EI services. The Title V CSHCN Program staff selected two areas from the Family Survey results on which to focus. These areas were: 1) Helping parents/families connect with parent of children with similar needs; and 2) Supporting families of children with special healthcare needs to participate in typical activities in their community. The same needs have been identified by parents of CSHCN through the system mapping initiative. LHD CSHCN program quarterly reports were reviewed for 2016-2017 to identify counties with promising practices addressing these two needs. A series of webinars are being planned during which LHDs will share their work with other local CSHCN Programs in the hopes of spurring new ideas and activities to support CSHCN and their families.

In order to more fully understand the needs of NY's CSHCN and their families, CSHCN information and referral programs have been required to distribute Family Satisfaction Surveys to all families served by the program the local level. Since the number of families served by this program is limited (1459), the number of completed Family Satisfaction Surveys statewide is low (247 or 17%) as well. This satisfaction tool provides data from the families served and assists with program planning to meet identified needs of families. Families of CSHCN were asked, as an example, "how easy is it to get information and help from staff?"; 86% of responses stated always easy, 13% stated sometimes easy and 1 % stated never easy. Ninety-seven percent of families were either very satisfied (85%) or satisfied (12%) with the help provided by local CSHCN Program staff. Respondents noted that local CSHCN staff were there when they were needed and were efficient and forthcoming about how to navigate the system. Several comments were made about improving the program by obtaining an interpreter or "bilingual person." Although not all counties have in-person interpreters available, telephonic interpretation is available to all programs. To help local CSHCN Programs support limited English- speaking families, the Title V staff sent out a NYS Language Identification Tool to all local CSHCN Programs in December 2017. This 8.5" X 11" card helps LHDs identify the language a person speaks so the correct interpreter can be called. The state Title V CSHCN staff participated in in-person training to assist callers with limited English proficiency. Staff were trained about how to use the NYS Language Line.

It has been recognized that on the local level, EIP staff in LHDs were not always aware of the LHD's CSHCN services even when they were in the same agency. The Title V CSHCN Program has been working to make local Early Intervention and CSHCN staff aware that as children age out of the EIP their families can be informed about the CSHCN Program. One Family Survey respondent commented about losing touch with what was out there for ages 4-21 after leaving the EIP and suggested more outreach to this age group. The CSHCN Program staff conducted a webinar for local EIP and CSHCN staff in January 2017 about establishing improved linkages between these programs at the local level and providing families with information about the CSHCN Program at the time of transition out of the EIP. This strategy will be measured by the percent of children transitioning from EIP to Special Education services who have a documented referral to LHD-based CSHCN program. Data for the 2016-2017 year, indicates that the number of children referred from the EIP to the CSHCN Program has more than doubled, to 187 from 82 in 2015-2016.

While the majority of NY's children are insured, there still appears to be some gaps for CSHCN and their families. The Physically Handicapped Children's Program (PHCP) provided gap-filling services for those underinsured. In 2017, 45 children received an evaluation and 207 received treatment services. Service categories were orthodontia, medications, physician office visits, enteral formula and specialty foods, and medical equipment/supplies. The race of participants was reported as follows: 159 White, 4 African

American, 2 Asian, 0 Pacific Islander,10 Other and 25 Unknown and ethnicity was: 6 Spanish, Hispanic or Latino, 38 considered themselves Other and 38 were Unknown.

The NY Early Hearing Detection Intervention Information System (NYEHDI-IS), an online information system, is utilized to capture inpatient hearing screening and allows for data entry of subsequent hearing screening and follow-up diagnostic testing that occurs after birth. Data generated from this system helps to ensure that newborns with positive screenings receive appropriate follow-up supports and services and helps to identify those infants who did not pass a hearing screening and require follow-up, but the follow-up tests are not documented (loss to documentation) or did not occur (loss to follow-up).

This is measured through **ESM CSHCN-7 Percentage of infants with initial abnormal hearing screening results for whom follow-up is documented in NYEHDI-IS.** Grant funding from HRSA was received for the period, April 1, 2017 through March 31, 2020 to support work to improve documentation of screening and follow-up test results. The state has made improvements over the past three years. For infants born in 2014, 90.4% had a documented initial hearing screening compared to 96.8% in 2015 and 97.1% in 2016. For documentation of follow-up, the state's baseline performance was established for infants born in 2014. The state has also made improvements in the documentation of follow-up. For infants born in 2014, 9% of infants who failed the initial hearing screening had documented follow-up test results compared to 31% in 2015 and 37.5% in 2016.

The Early Hearing Detection and Intervention (EHDI) Program relies heavily on data, which are collected initially through the state's two vital records system, and integrated in the state's online health portal in the EHDI application. Follow-up hearing test results are manually entered by audiologists. Grant funding was received from the CDC to provide support for the programs' online information system for the period of July 1, 2017 through June 30, 2020. Funding from this grant was used to develop enhancements to the NYEHDI-IS based on user feedback and available resources. Bi-weekly meetings were held with Title V staff to review system requirements, system enhancements and system modifications.

FY 2019 Application
CSHCN Application

2020 State Objectives:

- **Objective CSHCN-1: Increase the percentage of adolescents with special health care needs ages 12-17 who received services necessary to make to transitions to adult health care by 5% to 16.1%.**
- **Objective CSHCN-2: Increase the percentage of families participating in the Early Intervention Program who meet the state's standard for the NY Impact on Family Scale (≥ 576) by 16% to 71.5% (in 2018).**
- **Objective CSHCN-3: Increase the percentage of CSHCN who need and receive care coordination services that meet their needs by 10% to 44%.**
- **Objective CSHCN-4: Increase the percentage of infants who receive a follow-up hearing screening after failing initial hearing screening by 60%, to 50%**

A priority for NY's Title V Program is to promote and support a more coordinated, comprehensive system of supports and services for CSHCN and their families. The results of the system mapping initiative will assist Title V to have a more comprehensive understanding of the complex needs of families across NYS. The systems mapping initiative has been implemented based on a solid collaborative relationship between NYS' EIP and CSHCN Programs. Parent organizations have been key to engaging family caregivers in this initiative. Building on this information, NY's Title V Program can promote partnerships, demonstrate leadership in policy and program development and engage in ongoing dialogue with parents and key stakeholders to improve outcomes for CSHCN.

Strategy CSHCN-1: Develop and Implement a Plan for analysis and reporting of Children with Special Health Care Needs (CSHCN) data for NY, including data from revised National Survey of Children's Health, and issue initial data report.

Title V staff has developed a formal plan for analyzing and reporting available data to provide staff with a better understanding of the CSHCN population and their needs and to inform program planning within NY's Title V CSHCN Program and with external partners. While this essential public health and MCH function has always been an essential element of the NY's Title V work, through this strategy the goal is to expand and formalize this process to include a data analysis plan and regular summary reports. With the release of the 2016 NSCH data, including state level data, the Title V staff has developed a state level analysis plan related to CSHCN. The NSCH is a foundational component of this strategy. State CSHCN Program data provided by local CSHCN Programs will be reviewed along with national survey data to look for areas of similarities and differences. Staff have completed the review of 2009-2010 NY data and a report of the data analysis has been completed. Even though the data is almost 10 years old, it does show alignment with what families are expressing during the systems mapping meetings.

Title V staff will utilize all these sources of data, i.e. state specific national survey data, state CSHCN Program data, and family/caregiver data, to inform CSHCN program planning. NY's Title V program will continue to develop strategies to improve and enhance supports and services. Title V staff will share data results with partners, including the OHIP and other State agencies and stakeholders. Title V staff will continue to review state level data to see if implementation of CHH improves results for care coordination. As stated earlier, further work needs to be done to understand the needs of CSHCN and their families and to develop supports and services to address those needs. This strategy is measured by Title V program reports for annual local CSHCN Program data, quantitative and qualitative data of systems mapping and state analysis of NSCH.

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

Title V staff will continue to elicit parent maps from families of CSHCN and providers, professionals and clinicians who work with and support CSHCN and their families through December 2018. Critical to the success of using systems mapping, is the engagement of families who represent the state's diversity. Family recruitment efforts targeted several groups that work with families of children who have physical issues, behavioral health issues, genetic conditions, as well as families from different socio-economic, racial, ethnic,

and geographic backgrounds. Demographic data will be analyzed to determine if we have been successful in gathering feedback from a diverse population. Further targeted outreach and engagement will occur, if necessary, to obtain a diverse sample of families for systems mapping.

Collaboration with Parent to Parent of NYS will continue to enable gathering input from parents throughout the state and completion of group maps. Collaboration with UCEDDS will continue through another round of IFaCT meetings in the fall of 2018, with a focus on Chinese and Spanish-speaking agencies in NYC. Title V staff intend to include the systems mapping activity at these meetings. Systems mapping materials will be translated for these meetings.

Evaluation of feedback gathered from parents at group mapping sessions with UCEDDs and Parent to Parent of NYS will take place in the Spring 2018 with an update to take place in the winter of 2018 following the second round of IFaCT meetings. This evaluation of individual/group maps will include a descriptive analysis of needs and wishes expressed by parents, Title V staff and providers. Qualitative data obtained from discussion during mapping sessions will also be reviewed for successful and challenging themes.

The Title V Program intends to share this expertise and the information with all Title V partners to collaborate and improve the systems of care for families with CSHCN across the State. Title V staff will review and analyze the data generated from the system maps provided by parents and providers to identify enhancements to further support families of CSHCN.

Strategy CSHCN-3: Provide subject matter and technical support to NY Medicaid Program to implement enhanced care coordination and transition support services for CSHCN through Children's Health Home (CHH).

Title V will continue to provide subject matter technical support to NY's Medicaid Program to implement enhanced care coordination and transition support services for CSHCN through CHH. Staff will participate in weekly conference calls and provide technical support to increase the number of EI eligible children who are referred to CHH. According to EIP data for 2015-2016, there are 38,649 Medicaid and EI eligible children that may be eligible for CHH, based on their EIP diagnosis. NY staff have worked with OHIP to develop a survey of EI providers to solicit readiness, capacity, linkages and identify training that may need to take place prior to dually enrolling children who would meet eligibility for both EIP and CHH Care Management services. The survey was issued to EIP providers in January 2017. As previously noted, 148 responses were received that reported interest in making connections with CHH agencies, becoming an approved EI provider and interested in training regarding EI Service Coordinator responsibilities and requirements for EI eligible children when they are referred to CHH. Documents regarding Notice of Interest forms and EI provider applications have been distributed via state wide email distribution list. Work is being done to secure training for those providers interested in learning more about the responsibilities for providing EI service coordination through a recently procured Statewide Training Contract and extension of the previous contract to provide this mandated training.

Title V staff will continue to participate in site visits to CHHs with OHIP and other state agency staff. Title V staff will continue to promote workforce capacity of local CSHCN Programs by providing technical assistance and additional training, if necessary, regarding CHHs. A webinar presentation is currently in the approval process to provide Health Home Case Managers an overview of the CSHCN program. This presentation will help strengthen the collaboration and referral activities of both HH and CSHCN programs. Local CSHCN Programs will be encouraged to obtain electronic access to the OHIP referral portal for CSHCN so they can determine whether their referrals to CHH resulted in enrollment.

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

Providing assistance and preparing AYA/SCD for transition to adult care has been shown to reduce emergency room usage, avoid pain crisis occurrence, and mortality. A transition readiness assessment and plan can help these children successfully move to adult care and improve their quality of life. Title V staff released a Request for Applications (RFA) to seek providers who will provide supports and services for young adults with sickle cell disease and other hemoglobinopathies as they transition to adult medical care is in the approval process. Eight applications were reviewed and three recommended for funding. The new contract year begins July 2018 with a five-year term ending in June 2023. After a contract has been established, the Department will collaborate with

contractors regarding their plans to implement transition services within their organization. The providers serve as "transition navigators," to assist adolescents to make a successful transition to an adult hematologist or other adult medical care provider and will also focus on providing adolescents with the skills they need to successfully transition to adult care. This will be assessed by evaluation of readiness and post transition for satisfaction with care. These transition services will have new emphasis on transition planning based on evidence based practices such as the "Got Transition" program and partnership with CHH. Many AYA/SCD are likely to be eligible for CCH based on Medicaid coverage in the AYA/SCD population and likelihood of two or more serious health conditions due to SCD.

Title V staff will also work to identify a SCD professional within each funded project to provide information to HH care managers about SCD when working on transition plans. Children and AYA/SCD who do not meet the requirements for HHs will have transition services provided by the funded project. Several areas identified as in need of continuing focus include strengthening patient independence, making and keeping appointments, preparing questions for patient to ask their doctor, fear of the adult emergency room/adult admission and education about changes in healthcare privacy at age 18. Many AYA/SCD lack the skill and, financial independence to transition to adult care without assistance from subject experts. Many patients have developed a strong emotional bond with their physician. Some patients are mature enough to transition and manage their own healthcare and do not wish to leave their doctor. The contracted experts will develop best practices and educational materials for replication of services by non-funded centers. Materials are to include transition readiness forms for use through the entire period of care, pre-transition evaluation and post transition survey to assess success of services.

This strategy will be measured by percent of AYA with SCD age 14-21 years in the funded projects who have transition readiness assessment completed and documented. Program changed the measurement for the age of adolescents needing transition readiness assessments in accordance with the age specified in the "Got Transition" tools for transition readiness. The goal of the NYS SCD grant is to improve the quality of life/health outcomes for children and adolescent young adults (AYA) with Sickle Cell Disease transitioning to self-care management and adult medical care providers. Progress in achieving the work plan objectives will be captured through monitoring of grantees' quarterly narrative and data reports. The three grant objectives are: 1) develop and implement a transition and care management services model using health care professionals or community health workers/paraprofessionals under the supervision of professionals; 2) identify and develop relationships with available Medicaid Health Homes to enable AYA/SCD and their families to use the appropriate services of care managers; and 3) involve individuals and families in all phases of program development, evaluation and the provision of supports to children and AYA with SCD and their families. The grant's performance measures for transition readiness assessment completion aligns with the national performance measure of adolescents who receive services necessary to make transitions to adult health care. Other performance measures relate to the involvement of AYA/SCD and their families in the development of grant program and quality improvement activities, peer to peer information and outreach/education to these AYA/SCD and their families.

Strategy CSHCN-5: In Collaboration with UCEDDs and other stakeholders, implement NY's IDEA Part C State Systemic Improvement Plan (SSIP) to: create a repository of evidence-based practices for family centered services; convene statewide learning collaboratives to improve family outcomes for children served in NY's Early Intervention Program (EIP); and evaluate best practices that can be extended to other CSHCN populations.

The UCEDDs will work with NY and other EI stakeholders, including county EI staff, EI providers and parents to implement a second cohort of learning collaboratives in regions of NY utilizing the Institute for Healthcare Improvement's (IHI) Breakthrough Series. The learning collaboratives will be implemented for one year and are expected to begin in the summer and early fall and will provide technical assistance, training, mentorship and monthly coaching support to improve performance and collaboration with families within the community. Learning collaboratives are comprised of three to six members, including EI service coordinators, EI providers, local EI officials, and parents of children currently enrolled in the NYS EIP or who were enrolled within the past two years. This work will enhance training opportunities in the EIP and improve the quality of EI service provision to children and families enrolled in the EIP. In addition to conducting learning collaboratives throughout NY, the UCEDDs will update a resource guide with

evidence-based strategies and best practices for providing family-centered services in the EIP and improving family outcomes as a result of participating in the EIP. The Theory of Action underlying the SSIP is that problem identification and utilization of small Plan, Do, Study, Act (PDSA) cycles will lead to improvements in family outcomes, as reported by families on the annual NYS Family Survey.

The UCEDDs will convene the teams in their region in an in-person, kick-off meeting in Fall 2018, and will continue their support through webinars each month to discuss progress on PDSA small tests of change, data collected in the previous month, and barriers and challenges. The monthly webinars provide opportunities for peer-to-peer feedback as well as guidance from experts at the UCEDDs. Recruitment of teams for the second cohort will begin in summer 2018 with the goal of having the in-person, kick-off meeting in fall 2018, followed by coaching webinars each month for an additional eleven months. The second cohort will include agencies in NYC and counties outside of NYC that did not participate in the first cohort, which began in January 2018.

The statewide Advisory Group will continue to meet to review and refine the list of evidence based practices for EI services; review data collected and data collection tools; and support the Learning Collaborative effort by participating in coaching calls, review ongoing data collected, provide support for teams especially with engaging families through increased participation in the annual family survey.

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

The transitioning of children out of the EIP is an opportune time for the LHD programs to consider referring the child and family to the local CSHCN Program if the child/family are in need of supports to navigate the systems of care. The number of local programs making improvements in referrals from EIP to CSHCN will be monitored. The Title V Program will continue to stress to local programs the importance of documenting referrals between both programs. According to the 2016-2017 CSHCN data, 187 children, ages 1-5, were referred to CSHCN Program. Title V and local efforts for strengthening these connections between programs has resulted in an increase in the number of EI children referred to the CSHCN Program. The Title V Program will continue to monitor the data for the number of children that were referred from EIP to CSHCN in in 2017-2018.

The Title V CSHCN staff plans to host webinars every four months to have peer to peer dialogue among the local CSHCN Program staff statewide to share promising work being accomplished in the area of improving support to children and youth with special needs and their families. These webinars will align with CSHCN Program work plan deliverables related to outreach and education to families and providers, and offering information, support and linkages for families, CSHCN and youth that are transitioning to adult health care. Local CSHCN Programs will be featured as the guest speakers with Title V staff facilitating discussion.

Coinciding with the beginning of a new five-year contract cycle for local CSHCN Programs that began October 1, 2017, an updated CSHCN data collection tool and database has been released. Local CSHCN Programs have begun to utilize the tool and database to record the information and referral services provided to families of CSHCN. Title V staff are monitoring uptake of the database utilization, identifying any malfunctions that need to be addressed by technology staff and providing technical assistance to contractors. Title V will continue to measure this strategy by the percentage of children transitioning from EIP to Special Education services who have a documented referral to the LHD-based CSHCN program.

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

This year, staff are working on enhancements to the NYEHDI-IS based on user feedback and available resources. The Division was awarded grant funding from the CDC for the time period from July 1, 2017 to June 30, 2020 to further expand the NYEHDI-IS. The goal of the grant funding is to ensure that the state's online information system, NYEHDI-IS, has all fields required for the annual report to the CDC on the Hearing Screening and Follow-up Survey (HSFS).

In particular, new data elements are being added to NYEHDI-IS to capture infants who transfer from the birth facility, referral

providers, and referral to early intervention. Tracking infants after they leave the birth facility has been problematic since the information system does not currently have this functionality. The additional data fields will make it possible to direct inquiries for missing results to the appropriate hospital/provider reducing the time to obtain this information.

In addition, the EHDI Program is working with the state's Office of Information Technology Services (ITS) to develop reporting functionality to allow users to generate and download reports aggregated at their organization or facility level.

The EHDI Program has implemented and is supporting one state-based Learning Community for healthcare professionals and families during each year of the three-year grant period, and has embedded evidence-based quality improvement methodology to improve hearing screening, follow-up for infants who fail their hearing screening, and referral to the state's Early Intervention Program for infants with confirmed or suspected hearing loss. The EHDI Program has supported a Learning Community in Western New York. During the upcoming period, the program will implement and support a Learning Community in the Capital District and Eastern NY.

For infants born in 2014, 90.4% had a documented initial hearing screening compared to 96.8% in 2015 and 97.1% in 2016. For documentation of follow-up, the state's baseline performance was established for infants born in 2014. The state has also made improvements in the documentation of follow-up. For infants born in 2014, 9% of infants who failed the initial hearing screening had documented follow-up test results compared to 31% in 2015 and 37.5% in 2016. This strategy is measured by **ESM-CSHCN-7**: Percentage of infants with initial hearing screening results for whom follow-up is documented in NYEHDI-IS.

FFY 2017 Annual Report

Cross Cutting and Life Course

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

A life course approach to preventive health care is essential to ensuring healthy families and healthy communities. Increases in chronic disease such as heart disease, diabetes and obesity impacts longevity and health outcomes. Racial and ethnic minority communities experience higher rates of obesity, cancer, diabetes and HIV/AIDS. Children are becoming increasingly vulnerable as an increase in overweight or obesity predisposes them to chronic disease and the numbers are even higher in African American and Hispanic communities. NY's Title V program selected this as a state priority since focusing on preventing disease and illness before they occur will create healthier homes, workplaces, schools and communities, so that New Yorkers can live long and productive lives and reduce healthcare costs.

An essential component of any effort to improve birth outcomes must be a specific focus on improving access and utilization of preventive health care services. With 50% of all pregnancies in NY unplanned, impacting the overall health of all women in NY is a key step in improving pregnancy and birth outcomes. To that end, improving access to health insurance and preventive health care is a major priority across the life course. By improving the overall health of NY women before pregnancy and concurrently working to improve the intendedness of pregnancies, Title V can be assured that this work will improve the health status and birth outcomes for all women.

Preventive health care services encompass well-woman, preconception, prenatal, postpartum, interconception, well-baby, well-child and well-teen care. Based on analysis of available data and stakeholder input, Title V staff identified access to health insurance as a necessary element to the increased use of preventive services. NY's Title V program continued to rely on key external resources to further develop this scope of work that included: the USPSTF recommendation for preventive care, the AAP *Bright Futures* Guidelines for Health Supervision of Infants, Children and Adolescents, and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines for state Medicaid programs.

Last year, Title V staff assessed all current Title V programs to determine if individual programs included any requirements to increase access to well woman care and/or health insurance enrollment. Measured by **ESM LC3 – The number of relevant Title V programs that demonstrate incorporation of strategies to reinforce well-woman and preconception health care services.** At that time, 58% (16) of all Title V programs included some requirement to promote well woman care and 65% (7) of programs included a focus on increasing health insurance enrollment. This year, Title V staff focused their efforts on better understanding the substance of those requirements with a goal toward recommending universal language and metrics to be used across all Title V programs. Staff believe that by implementing standard language and tracking measures to promote well woman care and health insurance enrollment, programs will be able to increase promotion of preventive care, and improve collaboration with partners.

All programs within Title V were asked to submit specific performance measures, standards, and activities related to preventive care. Next steps include analysis of all information submitted and work to merge concepts and language into more streamlined and universal measures. Through an initial review of current language, it is apparent that "well-woman care" is not currently clearly defined and that there are many components of well-woman care. Moving forward staff will identify the most pertinent components currently identified in Title V programs and propose more specific measures to track these components.

The review of current program standards will serve to compliment other Title V activities aimed at increasing staff understanding of how and when NY women access preventive care services. By continuing efforts to promote the inclusion of the full reproductive health module in the upcoming BRFSS, Title V staff has made it a priority to capture data on the availability of preventive health care services essential to improved reproductive health outcomes.

Improving developmental screening for all children is also an important priority in NYS. Currently Title V staff from across the DFH are participating in or leading six major initiatives aimed at improving developmental screenings in NYS. These initiatives include the following collaborations/projects: supporting the inclusion of developmental screening in Title V's maternal and infant health initiatives and regulated child care; ongoing steps to promote early identification of potential developmental delays and referrals to EI; participation in the ECAC; ongoing work with the ECCS grant with the CCF; participating in the Albany Promise Project; collaborating on several statewide First 1000 Days in Medicaid Initiative workgroups and the development of a NYS Early Childhood Services for Children and Families Prenatal Through Age Five infographic.

NY's Title V program remains committed to ongoing efforts to support the integration of improved developmental screenings in both Title V work and within the EIP. Title V staff working in MICHC and MIECHV programs, have continued to make the inclusion of developmental screenings, either directly by program staff or via referrals to appropriate providers, a priority of their work. Current MIECHV activities include facilitation of a parent-completed developmental screening which is reviewed by home visitors and used to determine whether a referral to EI is necessary. In order to determine if improvements could be made with the MIECHV grantees, EI and the EHDI, Title V staff in the MIECHV and EI programs collaborated to develop and implement a plan to survey the MIECHV programs to determine the quality of the relationship between the MIECHV program and EIP in their community. Since procedures differ amongst home visiting programs, the MIECHV programs were also surveyed to determine if home visitors ask about an infant's hearing test (not required by the two evidence-based home visiting models in NYS) and where they make referrals regarding a newborn's hearing, if needed. To ensure that the home visitors were knowledgeable regarding follow-up for newborns who did not pass their hearing screening in the birthing hospital, a MIECHV quarterly technical assistance call included information about referrals to EI and the EHDI program.

EI staff continue to focus on increasing developmental screening for all children they serve. The Child Find component of the EIP, which coordinates efforts made by other agencies and community programs that serve infants and toddlers to identify, locate, and track at-risk children using available resources, will also increase emphasis on developmental screening.

An important element of these strategies has been the Title V's long standing commitment to the NYS ECAC workgroup. Convened by the NYS Governor's Office, this council is comprised of dozens of partners from all sectors of the early childhood community. ECAC has a priority interest in promoting children's development, and a specific focus on increasing rates of developmental screening. To further that goal, ECAC convened a workgroup to advance developmental screening and follow-up, with a focus on policy-oriented interventions. Title V staff are members of this group and will remain in this capacity throughout the upcoming program year.

Yet another way in which the NYS Title V program works to support improved developmental screening across NYS is through the work of the ECCS. Working in two communities, Nassau County (Docs for Tots) and Erie and Niagara Counties (Help Me Grown Western NY & CCRN of Western NY), the ECCS has begun work as part of a larger cohort to promote developmental health in these projects. Through a place-based approach focusing on an "intentional effort to build, sustain and operationalize community capacity in improving systems around children's developmental health and family well-being," the project specifically aims to demonstrate a 25% increase from baseline in age appropriate developmental skills among 3-year-old children in selected NYS communities.

The grant supports collaborative quality improvement projects in the three high need counties (Erie, Niagara and Nassau) to improve maternal depression screening and follow-up as well as developmental screening and follow-up for young children. CCF is working closely with DOH on this grant which was initiated in 2016. With leadership from Dr. Kuo, Associate Professor and Division Chief for General Pediatrics at the University at Buffalo, the Erie/Niagara team organized a learning collaborative and designed a referral algorithm in 2017 for families with young children. At the other end of the state, under Dr. Isaacson, the Nassau team hosted a kickoff on January 16, 2018 of Help Me Grow Long Island, with the goal of improving developmental health promotion, detection and linkages for families with young children on Long Island.

Another unique collaborative opportunity to promote developmental screenings can be seen through the DOH support of the Albany Promise Project which is a regional cross sector partnership where community leaders in Albany, NY come together to support a shared cradle to career education vision. Focused on increasing school readiness among young children in the city of Albany, the Promise Program targets children under the age of five with a range of cross-sector multi-dimensional interventions. The DOH is partnering with Albany Promise, Medicaid managed care plans, and pediatricians to create a pilot program in Albany County that incentivizes pediatricians and health plans to help ensure all children enter school ready to learn. Title V staff participate on the Early Childhood Success Team that has focused on increasing enrollment in quality early childcare programs and increasing the proportion of Albany children performing at or above benchmark when they enter pre-kindergarten. Concurrently, the NYS Medicaid Redesign Team is conducting a pilot program that is assessing a wide range of benchmarks associated with access and quality of developmental screenings available. This included: number of child well visits, number of children screened above, close to, or below cut-off, the number of children who screened in need that were referred to either EI or CPSE, as well as longer-term outcomes including the number of children screened and number referred who then received services and did or did not show improvement.

Early in the process, partners identified a key area of concern – the late identification of developmental delays in many school-aged children. Finding that many children were beginning school with delays that could have been identified earlier, partners began an intensive process to better understand the system of child health care and how improved developmental screenings could improve subsequent outcomes for youth. Screening children at ages 0-4 and then addressing any needs that are present at that point in the child's life can significantly improve a child's outcomes as he/she grows.

Beginning with a process map of the current screening, referral, and treatment systems with the community, the Albany Promise Program worked through a collective impact framework. This work included development of mutually reinforcing activities to improve the identification of developmental delays, referral, and service provision systems. While this kind of collaboration is not without its challenges, this dynamic opportunity is working to better inform the Title V support for developmental screenings in ways that could be applicable in other communities across NYS.

Title V is also continuing work to support the First 1,000 Days initiative a multi-disciplinary effort to maximize access to services for children and families within the first 1,000 days of life. NY's Title V program has been selected to partner on several activities as part of this initiative, chief among them working to expand access to Centering Pregnancy and evidence-based home visiting programs. Work to expand access to Centering Pregnancy, a group prenatal care model shown to improve birth outcomes, has focused on developing a protocol to pilot test program expansion. Focusing on increasing access to Centering Pregnancy in geographic areas across NYS shown to have high rates of poor birth outcomes, this work has allowed Title V to collaborate with colleagues from OHIP, OQPS, NYCDHMH, and external experts in the Centering Pregnancy Model.

To build on these efforts, Title V staff led efforts to develop two NYS Early Childhood Services for Children and Families Prenatal Through Age 5 infographics. This work began with a focus on researching and identifying activities and initiatives supported by state agencies focusing on developmental screenings in NYS in order to identify commonalities and gaps in these systems. The result is a pair of infographics, based on a guide developed by the Kentucky Partnership for Families and Children, Inc., to help service providers and families to connect young children to appropriate programs and community services that are designed to support

families with children from the prenatal stage through age five. The infographics outline NYS's prenatal and early childhood support systems and directs families and/or providers to various resources to learn more about maternal and child health programs and how to locate supports and services in their area. They also give a visual and color guide to help understand the system, and the interconnectedness of the various maternal and child health programs in NYS. Infographics have been developed and are being reviewed internally with a goal of eventual dissemination to providers and the public.

Recognizing the unique barriers impacting the ability of adolescents to obtain preventive health care services and the need to identify strategies that address barriers, staff initially sought to collaborate with adolescent health experts from Cornell University ACT for Youth Center of Excellence (ACT for Youth) to facilitate focus groups with diverse adolescent populations to obtain this information. However, ACT for Youth recommended that, in the absence of specific interventions, a focus group approach would not be the most effective way to obtain adolescent feedback.

Therefore, over the past year, ACT for Youth conducted a literature review to obtain information on two questions; What does recent research (2013-2017) identify as the barriers adolescents face in accessing preventive health care services to improve sexual and reproductive health? And outside traditional (curricular) sex education strategies, what strategies have been recently identified to overcome these barriers? Thirteen studies were reviewed that focused on adolescents in general, homeless and runaway youth, rural teens, boys and girls involved in the justice system. Some common barriers identified were: fear of breaching confidentiality, sense of general discomfort, limited access due to transportation, lack of knowledge, perceived costs, and lack of convenience, poor quality of care, and other personal factors such as fear of police involvement. In addition, some common strategies found to improve access to care included changes in policy with respect to confidentiality, staff professional development, changes to clinic environment to signal youth friendliness and respect, involving youth as messengers, use of technology, and offering sexual health services at every opportunity.

From the literature review, ACT for Youth found that research on preventative health care services, not focused on sexual and reproductive health, was limited. Preventative health care services are not well defined and incorporate a variety of activities (e.g. vaccinations, screenings, counseling, and well-visits). Staff continues to develop a better understanding of the overall health of adolescents and their needs for preventive care. Title V staff met with staff from the DCDP to discuss resources and data related to this area. Staff continue to gather information and will be collaborating with an MPH intern to develop a comprehensive analysis of the overall status of adolescent health and wellbeing across NYS. This analysis will include health outcome data (shared through a collaboration with the DCDP) and include information on various social determinant factors known to impact health outcomes including race, ethnic, geographic region, and socioeconomic status. Measured by **ESM LC-5 Number of strategies implemented to improve adolescent use of preventive health care services.** This represents a modification of the previous ESM as the Title V program is developing one comprehensive strategy to increase the use of preventive health care that will be developed based on the literature as well as input from adolescents.

Beyond ensuring preventive care is emphasized in Title V programs, staff also recognized the importance of assessing whether women of reproductive age receive preconception health care. In order to measure the actual implementation of preconception health during routine visits, Title V staff have been working to support the inclusion of a "preconception health" module in the NYS BRFSS sampling. This survey, which broadly represents the non-institutionalized civilian 18 years and older population of NYS, will be used to help Title V staff understand if women are getting these important health care services. The 2013-2014 BRFSS contains seven questions on pre-conception health as part of the family planning module, and these data have been analyzed and reports issued.

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

Oral health remains a key health indicator for women, infants, children and families throughout their lives. Poor oral health can impact learning, social-emotional wellness and overall health. While tooth decay remains the most common chronic disease for children, oral

health disease is largely preventable and entirely treatable. NY's Title V Program is committed to promoting oral health through education, community-based interventions and programming that benefits all NYS residents.

Over the past year, progress has been made in improving the oral health of NY's residents. The prevention of tooth decay remains a high priority area for the Title V program not only because of the effects of this disease but also because of the associated social and financial costs. According to the 2009-2011 DOH Oral Health Survey of Third Grade Children, 44.1% of third grade children have had a history of tooth decay and 22.1% had untreated tooth decay. The Guide to Community Preventive Services, re-released in April 2013 by the Community Preventive Services Task Force, recommends only two interventions as evidence-based practices to prevent dental caries: school-based dental sealant delivery programs and Community Water Fluoridation (CWF). CWF is an important intervention that communities can undertake to significantly address the problem of tooth decay. It has consistently been shown to reduce tooth decay by 25% across the lifespan regardless of age, race, income, and insurance status. CWF is considered by the CDC to be one of the 10 great public health achievements of the 20th century because of its role in the decline of tooth decay in children and tooth loss in adults.

In NY, more than 13 million people on PWS receive fluoridated water, representing 71.6% of residents served by community water systems. A priority of NY's Title V Program is to increase the percentage of NYS residents served by community water systems that have optimally fluoridated water by 10% to 78.5%. To achieve this, DOH must maintain its existing fluoridating PWS and several new communities (collective population size >1.23 million people) must support CWF. A primary strategy to accomplish this is to provide support, both financial and technical, directly to communities to maintain and expand CWF. Over the course of the 18-month reporting period, 60 different PWS received technical and/or financial support, up from 58 in the prior reporting year, with 11 PWS receiving both types of support Measured by **ESM LC-6: Number of public water systems that receive financial and/or technical support from NYSDOH to maintain or initiate community water fluoridation.** DOH has partnered with the NY Rural Water Association (NYRWA) since 2003 to provide technical assistance to PWS. The goal of DOH's contract with NYRWA is to provide technical assistance and guidance, in addition to raising operators' knowledge on CWF, to help ensure fluoridated PWS across NY are maintained and operated in compliance with all state laws, rules and regulations. Activities include conducting onsite visits at water treatment plants to provide guidance on operating issues; ensuring PWS are fluoridating at the optimal level; and organizing and holding continuing education trainings for water operators on the CWF-related topics, including public health, regulations, additives, equipment, laboratory analysis, personnel safety, operations, and management of CWF. During the 18-month reporting period, NYRWA completed 35 onsite technical assistance visits (30 unique PWS) and held 8 CWF trainings (training 146 water operators).

Financial assistance was provided to PWS through the Drinking Water Fluoridation (DWF) Grant Program, which was developed and authorized under the NY 2015-16 Enacted Budget. Two different types of projects are supported under the Program: 1) Planning & Feasibility Projects – support the development of an Engineering Report for feasibility, design or update purposes; and 2) Implementation & Maintenance Projects – support the upgrade, replacement, repair or purchase of equipment to maintain or initiate CWF. A total of 45 awards (benefitting 41 PWS), for a total of $7.15 million were made to support the maintenance of CWF. Because of this support, these PWS will be able to upgrade their equipment and infrastructure to ensure that the communities they serve will have continuous access to optimally fluoridated water for many years to come. To date, 36 contracts supporting CWF have been executed. Measures by **SPM #5 Percentage of NYS residents served by community water systems that have optimally fluoridated water.** 71.6% of NYS residents are reported by CDC Water Fluoridated System data as served by community water systems with optimally fluoridated water in this current reporting year as compared to 71.7% last year.

The work outlined above was informed by and conducted in parallel with a DOH quality improvement initiative on CWF reporting. Title V staff collaborated with the DOH Bureau of Water Supply Protection (BWSP) to address consistent and timely access to CWF operation data from PWS; and consistent delivery of optimally fluoridated water from PWS to residents. Two performance measures were created and monitored by Title V staff for this initiative. In addition, PDSA cycles were conducted. This work

remains ongoing, as is the collaboration between Title V and BWSP staff. In April 2017, the DOH collaborated with the Association of State and Territorial Dental Directors (ASTDD) for their "Adopting Performance Management Strategies to Improve Oral Health in Your State" webinar that provided an overview on performance management and quality improvement in state oral health programs. The DOH was one of only two states invited to present on how it has implemented performance management within its oral health program. DOH's presentation focused on CWF and its alignment within the priorities of NYS.

In November 2017, staff of the BWSP and BCH issued a Request for Proposal (RFP) to obtain technical assistance services for providing support to small PWS and Fluoridating Water Systems. The scope of work involves TA visits, services and trainings to water plant operators, superintendents and local officials of PWSs. The application review process has been completed and an applicant has been recommended for approval. A contract is anticipated to be in place by summer 2018.

To build on the evidence-based work to improve oral health in NYS, the Title V program integrated the promotion of dental sealants into its ongoing program work. The SBHC-D Program targets high-risk children from pre-kindergarten to high school who have limited access to a dental home or services. DOH continues to work across NY to provide preventive oral health services, including sealant application on first year molars, to school age children. Use of dental sealants is an evidence based approach to combatting tooth decay. Currently, 50.5% of 2nd and 3rd graders served by SBHC-D programs receive sealants, which is a decrease of 10% from last year. The decrease is likely a data recording issue rather than an actual decrease and may be attributed to provider errors in handwritten forms, which will be addressed via a CDC on-line database that will require providers to data enter their own information. In July 2017, 25 SBHC-D providers were awarded $50,000 a year for 5 years to participate in the SBSP for the purpose of increasing the use of sealants with high need 2nd and 3rd graders. The sealant work is captured on the Sealant Efficiency Assessment for Locals and States (SEALS), a CDC software that captures data used to evaluate the effectiveness and efficiency of the school dental sealant programs. As of November 2017, all grantees were required to enter their sealant data directly into the SEALS database. In December 2017, DOH released a SBHC-D Quarterly Report for SBHC-D providers (funded and nonfunded) and in January 2018, hosted a WebEx training on the Report. This report captures both preventative dental and restorative provided by all SBHC-D sponsors regardless of funding to children participating in their dental program. The training was well attended with 33 out of 52 SBHC-D providers participating. During the training, the new report template was reviewed, including the required performance measures, and, it also provided an opportunity to review expectations with funded providers regarding the SEALS online database. The webinar was recorded and the archived link was sent to all SBHC-D providers. A Questions and Answers document was released in March 2018 to provide further technical support to providers based on questions generated from the training. Measured by **ESM LC-7: Percentage of 2nd and 3rd graders served by School Based Dental Programs (SBSP) who receive sealants**. 50.5% of these children received sealants by SBHC-D programs this reporting year as compared to 61.2% last year. The apparent decrease may be related to data cleaning as validity issues were identified over the past year and have been corrected.

While the SBSP grant work addresses dental caries in school age children, NY's Medical-Dental Integration Learning Collaborative (MDIL) Initiative, launching in March 2018, addresses tooth decay in children under the age of six. MDIL was designed to accelerate improvement in priority strategy areas through collaborative learning, quality improvement and innovation. It specifically focuses on improving access to preventive oral health care services by adopting procedures to ensure integration of routine oral examinations/screenings, oral health education/counseling, and fluoride varnish application within medical wellness visits. Under MDIL, Community Health Centers (CHC) will meet monthly for shared learning, facilitated discussions, and coaching to improve the oral health status of young children in their communities. Over the course of this reporting period, DOH worked with medical, dental and quality improvement experts to build the MDIL infrastructure including: the Driver Diagram, measurement strategy, and Recruitment and Pre-Work Package. DOH presented the MDIL Initiative on the December 2017, on the CHCANYS Oral Health Subcommittee call followed by a second informational call to promote the MDIL Learning Collaborative in January 2018. Between April 1, 2016 and March 31, 2017, the NYS Medicaid program received a total of 11,409 claims from primary care providers for

the application of fluoride varnish in children ages birth -5 years, with approximately 93% of these claims being submitted by MMC organizations. The remaining 7% of claims were submitted on a fee-for-service basis. This represents a 21% increase in the total number of fluoride varnish claims in the Medicaid program since the previous application year, in which 9,447 claims were received.

The Title V Program also partnered with the NYSACHO on a public health detailing webinar series for LHDs. NYSACHO staff organized and facilitated Fluoride Varnish Technical Assistance Calls to discuss strategies for public health detailing in primary care practices regarding the application of fluoride varnish. The dental director participates in coaching calls and assists with addressing challenges that providers have with providing fluoride varnish to children 0-6 years old. According to the 2017 State Aid Survey, 17 LHDs conduct or facilitate training for primary health care providers and dental professionals on specific evidence-based clinical preventive dental practices, primarily implementing caries risk assessments and application of fluoride varnish.

Title V staff assembled a collaborative team of oral health and chronic disease experts to develop and implement a plan to reduce sugar sweetened beverage (SSB) consumption in adolescent males of color. In addition to SSB consumption reduction, a primary objective of the project was to integrate oral health into other chronic disease prevention program. The grant was awarded by the CDC in September 1, 2016 and its goal is to create messages that resonate with this population, educating them on behavior changes necessary to reduce the risk of chronic diseases like obesity and dental decay by making good choices in beverage consumption. In the past year, Title V program hosted three face-to-face, expert work group meetings. Topics included a parallel project in the BCDP called "the Healthy Beverage Campaign" (geared to an older demographic 18-35), a review of the NYSDOH Prevention Agenda related priority areas, public health surveillance on SSB consumption, existing policies and programs for potential message integration, and media strategic communication theories and practice. In July and November 2017, the first-round of focus groups were held with 41 participants. The SSB work will provide a foundation for social media messaging that can be used in a nutrition education initiative.

The Perinatal and Infant Oral Health Quality Improvement (PIOHQI) Project has continued its work with the MICHC Program to integrate oral health strategies into community-based maternal and infant health programs through care coordination, and public health detailing which entails training providers on best practices to promote preventive health interventions. Healthy Baby Network (HBN), the PIOHQI pilot program in Rochester, NY, partnered with Eastman Institute for Oral Health (EIOH) to develop the training materials and Oral Health Manual/Toolkit, recruit providers from the community for the trainings and solicit feedback. A total of 126 participants, ranging from dental care providers, perinatal care providers, and CHWs were trained via webinars and in-person meetings on the use of the Toolkit and offered continuing education credits.

HBN has successfully piloted this initiative and fully integrated oral health into their program workflow. The Title V program has expanded the PIOHQI Program statewide by integrating oral health into the workflow of CHWs at all 23 MICHC sites to ensure that the oral health needs of high risk pregnant women are addressed. Successful strategies include: incorporation of two standardized dental screening questions used by the pilot project; routine data collection through quarterly CHW encounter reports to capture the number of oral health screenings and referrals made; and use of the Oral Health Manual/Toolkit and training materials developed by the pilot site to assist MICHC staff and pre/perinatal health care providers in incorporating greater oral health integration.

October-December 2017, 89.2% of the targeted population at the pilot site (prenatal and postpartum women) received an oral health screening compared to 44.5% at baseline (April-June 2015) representing a marked improvement in the number of women screened, but also a higher number of high-need women receiving oral healthcare. Measured by **ESM LC-8 Percentage of pregnant women served by Title V community health workers that have a documented screening or referral for dental services.** A reported 45.3% of pregnant women served by community health workers had a documented screening or referral, up from 36.7 in the last reporting year. NYSDOH has facilitated trainings for all MICHC providers starting with an introductory webinar in April 2017, and four in-person regional "train the trainer" events beginning in July 2017 through January 2018. The trainings incorporated successful strategies from the pilot site, contained a prepared presentation that can be used by MICHCs to

train their staff and prenatal care/dental providers, and provided a platform for MICHCs to meet in-person, learn from each other and share ideas and promising practices for implementing oral health strategies into their programs. Tools and lessons learned from the NY PIOHQI Project were shared with the other HRSA-funded states through a PIOHQI National Learning Collaborative to develop best practice models for integrating oral health care into existing community-based pre/perinatal services. Title V staff conducted a capacity assessment survey of MICHCs before the trainings commenced to identify current practices, resources and technical assistance needs. Feedback from the survey provided information on MICHCs oral health capacity. The survey results informed the content of the MICHC oral health trainings. An abstract/poster of the survey process and outcomes was accepted and presented at the Association of Maternal and Child Health Programs conference in Arlington, VA on February 10-13, 2018.

In 2017, among all 23 MICHC programs state-wide, the percentage of pregnant/post-partum women served by MICHC that received an oral health screening was 42.6%, a marked improvement from the baseline of 16.6% in 2015. (**ESM LC-8: Percentage of pregnant women served by Title V community health workers that have a documented screening or referral for dental services.)**

In conjunction with the PIOHQI Project, the Pathways to Success initiative is also working to integrate oral health strategies into community-based maternal and infant health programs. Pathways to Success works to develop and implement programs to improve educational, health and social outcomes for expectant and parenting teens, women, fathers and their families. The current project is based in NYC, with three community colleges, a community-based organization and a high-school based program. These projects focus on building collaborations both internally within their organizations and externally with community providers and with other DOH maternal and child health programs to strengthen support networks and referral systems to core services, including personal health, child health, education, employment, concrete supports (e.g. housing, transportation, etc.) and parenting supports (e.g. parenting education, healthy relationships, etc.). The goal is to establish solid and sustainable collaborations to ensure that young parents and their families are identified early on and receive referrals to needed resources and supports. The Pathways to Success program will share the resources developed by the PIOHQI Project with these organizations and incorporate oral health resources with the other resources that are provided to expectant and parenting teens.

The NYS Dental Public Health Residency Program (NYSDPHRP) is designed to support and build capacity for all MCH oral health programs through the utilization of dental residents' subject matter expertise in clinical dentistry and public health. The curriculum, based upon the core competencies as recognized by the American Association of Public Health Dentistry, focuses on MCH goals and objectives. Through collaboration and engagement with Title V staff on various MCH programs, the dental residents have a unique opportunity to apply concepts and tools in real public health settings, preparing them to assume critical roles in the practice of dental public health for improving health outcomes. Specifically, NY's strategy is to strengthen Title V internal capacity by developing core dental public health competencies in residents. During their residency, the residents contribute to oral health surveillance activities and analysis of evidence-based interventions implemented by Title V. Between 1998 and 2016, NYSDPHRP had 42 graduates, the majority of whom are working as public health dentists in state government and academic and hospital settings.

Since joining the NYSDPHRP in the fall of 2016, DOH's current dental resident has completed 10 projects and activities and is scheduled to complete the residency program by 2018. The resident has analyzed the 2014-16 SBHC-D data to evaluate performance and impact with support from DOH research scientists. Findings include an increase in sealant application and dental caries reduction among 2nd and 3rd graders served by the program. The resident has also been conducting critical assessment of the school-based dental sealant program and developing data management tool such as the Quarterly Report and strategies in efforts to ensure best practices in all NY MCH oral health programs. An additional resident joined the NYSDRHRP in the fall of 2017. This resident has been focused on reviewing community water fluoridation grant applications, developing research projects based on interest in cultural and linguistic consideration when accessing dental care.

This State Priority is measured by **NPM #13.1: Percent of women who had a dental visit during pregnancy and NPM #13.2:**

children age 1-17 who had a preventive dental visit in the past year. For 2015 as reported in PRAMs, 51.7 % of women surveyed had a dental visit during pregnancy as compared to the national average of 51.9%. For children with a preventive dental visit, the NSCH reports NY at 77, in close alignment to the national average of 77.2 For **NOM #14 Percent of children ages 1-17 who had decayed teeth or cavities in the past 12 months,** the NSCH reports NYS at 8.4% as compared to 11.7 on the national level for 2016 which demonstrates to commitment NYS has made to promoting and improving oral health.

Healthy Communities – State Priority #7: Promote supports and opportunities that foster healthy homes and community environments.

The objectives and measures in this priority area address a variety of subjects, reflecting the broad scope of factors impacting MCH. This priority area aims to impact physical activity, obesity, wellness, safety, and community social cohesion. Title V programs cannot impact these areas alone, making collaboration a critical focus of this priority area's strategies. The sources of these metrics are national surveys including the NSCH, YRBS, using the most recent data available. Measured by **NPM #8 Percent of children ages 6-11 and adolescents age 12-17 who are physically active at least 60 minutes per day.** For adolescents in grades 9-12, slightly fewer achieve at least 60 minutes of physical activity daily, after years of increasing rates—a decrease from 25.7% in 2013 to 23.3% in 2015. This mirrors the increase in adolescent obesity which had followed a former steady downward trend—from 24.4% in 2013 to 27% in 2015. For children ages 6-11, daily physical activity decreased in 2011/12 to 30% from 33.7% in 2007. Changes to the NSCH survey have made 2016 data incomparable to previous years—in 2016, 22.9% of children ages 6-11 participated in at least 60 minutes of physical activity daily.

In the 2016 NSCH survey, 50.1% of NY parents reported that their child lives in a supportive/cohesive neighborhood, which is slightly lower than the national level (54%). This includes parents' responses about whether people in the neighborhood help each other out and watch out for each other's children, and whether they know where to go for help in their community. Fewer NYS parents reported they definitely agree their child is safe in their neighborhood compared to all parents nationally (57.2% compared to 63.8%, respectively).

Stakeholder input obtained in the preparation for this application identified factors including access to healthy affordable food, safe places to engage in physical activity, and social support as important elements of a desirable community in which to live and are believed to have significant impact on families' health and wellbeing. These perceptions are consistent with broader and longstanding public health approaches aimed at supporting healthy communities, including strong commitments to community-driven change, fostering policy and environmental change strategies, and a focus on addressing social determinants of health. Taking on these broad policy-level issues cannot be achieved by the health sector alone--strong collaborations with social services and other non-traditional partners is needed to have a positive impact in NY’s communities.

As stated in previous reports, the Title V program prioritized a focus on Placed-Based Initiatives (PBI) as a multidisciplinary team-based approach to achieve significant changes in a physical location. The PBI works to improve health equity by improving access to healthy lifestyle options, affordable and comprehensive healthcare, social services, and quality housing. In September 2015, the NYSDOH Commissioner established a workgroup to review all the PBIs sponsored by the DOH over the last ten years to 1) determine promising practices and strategies for current and future place-based efforts; 2) identify duplicative efforts and opportunity for synergy; and 3) develop collaborative efforts to address health inequities. The PBI workgroup meets quarterly and is comprised of staff from the Title V program, the DCDP, DON, CEH, Office of Minority Health, the AIDS Institute and the OPHP. Previous accomplishments of the PBI workgroup include: the successful development and adoption of a shared definition for what a PBI is; a descriptive analysis of PBI health indicators; and the initiation of an online survey of PBI community contractors to identify best practices, challenges, and strategies that resulted in sustained, environmental changes. During the reporting period, two PBI workgroup meetings were held and both were attended by Title V staff. Title V staff serve as liaisons between both programs, providing the work group with the family health perspective and sharing reports of progress from the PBI meetings with relevant

MCH staff. During the November 2017 meeting it was decided that a sub-committee should be formed to determine future directions for the larger workgroup, plan ways to engage community survey respondents for discussion and identify discussion topics, and incorporate results of the surveys and discussions into procurement development and training for contractors.

In addition to PBIs, Title V staff have initiated and/or enhanced collaborative relationships with other key partners to advance changes in community environments that improve health outcomes for women, children, and families. The broad scope of environmental-level issues impacting communities' health—physical activity, obesity, wellness, safety, and community social cohesion—require cross-sectorial involvement. During this reporting period, Title V staff continued engagement with several initiatives that are ongoing in other areas of the DOH and other state agencies that are potential partners for meaningful collaboration with Title V program. Staff met to identify continued opportunities for collaborative efforts with the following programs: Creating Healthy Schools and Communities, Healthy Neighborhoods Program, Regional Centers for Sexual Violence Prevention, Community Schools, Health Related Quality Indicators in New Quality Improvement for Regulated Child Care Programs, and Building Resistance Against Climate Effects. Enhanced collaborations will offer opportunities to impact health outcomes of significance to MCH. Staff monitor the accomplishments of Title V partnerships by tracking programs with activities focused on collaboration or partnerships and outcomes at the community, environmental, or policy levels. Measured by **ESM LC-11: Number of community environmental changes demonstrated as a result of enhanced collaborations**. During the past reporting period, of 10 programs meeting those criteria, 6 met their community, environmental, or policy level changes as a result of their enhanced collaborative efforts.

During the reporting period, Title V staff tracked instances of established or strengthened linkages with program contacts, and overlapping service areas and opportunities for collaboration. The Healthy Neighborhoods Program (HNP) in the DOH CEH seeks to reduce the burden of housing-related illness and injury through a healthy homes approach in selected high-risk areas. After initial meetings and cross-walking programs at the county level, HNP and Title V sent their respective programs contact information for the other, encouraging collaboration. HNP's local grantees generate reports of referrals quarterly which include referrals to and from Title V home visiting programs and EI. Nine of the 19 HNPs established referral relationships with MCH programs, including home visiting, EI, and county health department nurse visits, in their counties. Two programs now coordinate home visits between the HNP and MCH programs.

Environmental change continues through enhanced collaboration with partnerships and coalitions from activities of the Title V's six Regional Centers for the Prevention of Sexual Violence (Regional Centers). These Regional Centers are implementing innovative primary prevention community-level (coalition-building, community mobilization, social norms and policy change) and individual-level sexual violence prevention strategies with youth and young adults, ages 10-24, from six high-risk regions across NYS. During this reporting period, several Regional Centers participated in coalitions for specific populations who are at increased risk for sexual violence perpetration or victimization based on data and/or sound theory. For instance, Region 5 (Onondaga and Broome Counties) maintains coalitions including the LGBTQ Coalition, Alliance for Sexual Assault Prevention-Upstate Coalition, and Sexual Violence Prevention Coalition; and Region 6 (Erie, Monroe, and Niagara Counties) has an established sexual violence primary prevention coalition with local college campuses and community members. In this reporting period, the Sexual Violence Prevention Program (SVPP) Unit joined the State University of New York Impact Team for Transgender and Non-Gender Conforming students. This team identified that community-based organizations lacked sufficient knowledge to create programs, written guidance, and policies that are non-gender conforming. A webinar is being developed for Title V staff to help them become proficient at identifying and utilizing LGBTQ-specific language and terms, and create written guidance and policies that are non-gender conforming.

The Regional Centers and community partners have invested considerable time and effort this past year in the development and/or implementation of healthy community-level strategies including healthy nightlife (an initiative aimed to promote a healthy community by engaging bar owners, bar staff, and community patrons to create and build safe nightlife establishments) and healthy schools (an initiative aimed to promote a healthy school community by providing sexual violence prevention education and establishing policies).

In the Spring of 2017, a Coalition Assessment Tool (CAT) was disseminated to the six Regional Centers and partners to evaluate the effectiveness of each Region's established coalitions. There were 64 responses to the survey, representing approximately 20 coalitions and committees. About 95% of the coalitions/committees represented by the survey results are working on sexual violence prevention directly and the small minority are principally crisis service providers. Over 70% of respondents could agree that their coalition had a clearly defined purpose and goals, regular meetings and communication, and the support of community leaders and key stakeholders. The area identified for improvement was to expand diversity and representation of underserved populations on the committees and coalitions.

The work of the Regional Centers is informed by data collection and evaluation activities. There is an ongoing effort to increase the tracking and analysis of state-level indicators of sexual violence outcomes to support this work. This effort includes: assessing data systems and sources for tracking sexual violence, engaging partners and involving stakeholders in the tracking and analysis process, ongoing data management, and the of creation maps, summaries and assessments for program communication. During this reporting period, the Regional Centers and partners conducted over 450 sexual violence prevention community-level and individual-level activities and events with youth, young adults and/or influential adults who work with youth and young adults from six high-need areas across the state.

Because of increased collaboration across DOH, a new initiative was successfully identified for inclusion in this strategy: Building Resistance Against Climate Effects (BRACE). One of the strategies of the BRACE initiative, in CEH, focuses on efforts to support and protect pregnant women and other vulnerable populations during periods of extreme heat exposure. BRACE staff created and maintains an application on the Department's website which identifies cooling center locations across the state that individuals may seek out during periods of extreme heat. Title V staff created a spreadsheet to indicate where centers are co-located within Title V-funded communities at the county level. Title V programs serving pregnant and parenting women were notified of the existence of these cooling stations, and were also given brochures about safely coping with extreme heat to distribute to community members. The partnership connected the BRACE program to Title V's Text4Baby initiative and facilitated customized messages about extreme heat and cooling station locations sent to pregnant and parenting women across NYS during July 2017 (2,700 English messages and 157 Spanish messages were sent).

Title V staff met with the Creating Healthy Schools and Communities Program in DCDP in November 2017. The aim of this program is to increase demand for healthy, affordable foods and opportunities for daily physical activity in high-need communities by implementing policy and environmental changes in schools and communities. During the meeting, opportunities for collaboration were identified by sharing information about: geographic areas served, priority populations served, useful tools and resources, and overlaps in technical assistance and trainings, particularly about serving the LGBTQ population and people with disabilities. The first opportunity for collaboration is to build capacity on topics concerning the LGBTQ population. The first webinar for the Title V staff will be May 8, 2018 and will be presented by the NYC Anti-Violence Project (AVP). AVP will present on language and terms specific to the LGBTQ community and offer Title V guidance on how to use these terms and language when interacting with the LGBTQ population, build connectivity and collaboration and write/produce state-level guidance for providers that is inclusive.

Although strong collaborations are required to achieve community environmental change that result in positive outcomes, collaboration is often loosely structured or undefined. To provide support and evaluate enhanced collaborative efforts, Title V staff have developed an evidence-informed collaboration plan template for structuring, measuring, and monitoring collaboration at both the state and community levels. This strategy was a new area of work for Title V program. To begin, a graduate student intern from the SUNY Albany School of Public Health conducted a literature review in Summer 2017 to identify elements of or best practices for collaboration to inform development of a new framework. This information was used by Title V staff to create a draft collaboration plan template, which was then circulated among select Title V staff for comment. Components of the template include establishing a shared purpose, outlining the team's ground rules, defining team members and how they will work together (e.g., communication,

decision making, meeting schedule), and defining milestones or objectives, a work plan, and measures of progress. The Regional Centers for Sexual Violence Prevention have been selected to pilot the collaboration plan template with their local-level partners throughout 2018. Based on the results of that pilot, the template will be disseminated to Title V staff to establish future state-level partnerships and to Title V programs for local-level use.

This State Priority is also measured by: **NOM #15 Rate of death in children aged 1 through 9 per 100,000.** NY is far below the national average at 13.3 as compared with the national average of 17.5 in 2015. **NOM 16.1 Rate of deaths in adolescents age 10-19 per 100,000.** NY is again below the national average at 21.5 vs. 31.6. Finally, **NOM #20 Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile).** NY again is below the national average of 29.9 at 27 as reported in 2015 YRBS data.

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

While numerous interventions have positively impacted MCH health outcomes over the years, persistent health inequities, especially racial, ethnic and geographic, have continued to manifest. As stated in NY's FY 2018 application, NY's Title V program includes health equity as a life course priority to ensure a stronger concentration on improving access to quality, comprehensive health and supportive services across all domains.

To fully meet the needs of all New Yorkers, NY's Title V program has made a concerted effort to incorporate a Health Equity framework into all aspects of NY's Title V program. Since Fall 2016, Title V initiated the development and implementation of a series of strategies aimed at improving health equity in NYS as it relates to MCH.

As with all State Priorities (SP) across Domains, Title V staff focused on improving data collection and measurement of Title V initiatives to identify health disparities. Coordination expanded among the Title V staff and research groups within the DOH Bureau of Chronic Disease Research and Evaluation, Bureau of Injury and Occupational Health, Office of Minority Health and Health Disparities Prevention (OMH-HDP), OHIP and PHIG, to provide performance and outcome measures for each SP area.

For several years, DOH has had a PA dashboard which tracks many public health elements at the county level. The PA dashboard enables partners to use these data to tailor their efforts and track impact. Title V program decided to pattern the MCH dashboard on the DOH PA dashboard. Plans for the MCH dashboard were developed and Title V staff worked with OPHP to identify pertinent data elements that could be tracked at the county level. The ability to view county-level data that mirror national and state metrics in NY's SAP that include race and ethnicity will allow partners to address Title V priorities on the local level, and strengthen NY's efforts to promote health equity and improve the health and wellness of the MCH population. Targets were established by the Title V data committee for each of the measures and the programming of the system is nearly complete.

Social determinants impact health equity, and therefore it is imperative that staff develop an understanding of the complex interconnection of various social, environmental, and systemic issues that often manifest in health inequity. Additionally, NY's Title V program recognizes that all staff members bring with them their own experiences, history, and bias which can make proactively addressing health equity even more challenging. To improve Title V staff's understanding of health equity, additional training and support beyond the typical onboarding process and education is being planned.

Title V staff worked to improve the internal capacity of Title V staff to promote and support health equity in all aspects of work. Promotion of health equity requires a unique, often tailored, approach. As noted in earlier applications, DFH established a cross functional health equity team for this purpose. To ensure each SP focused on health equity, each member of the health equity team serves as a subject matter expert (SME) for the other SP areas. That team member ensures that a health equity lens is placed on

each SP area, with at least one strategy or initiative focused on improving health equity. Title V staff investigated the disparities that exist, strategies and mechanisms that Title V programs are currently using to address disparities and/or health equity, possible additional areas for intervention and committed to at least one health equity area on which to focus for each SP. Increasingly, health equity team members are called upon by Title V to lend their expertise in program discussions and new initiatives to ensure that they include ways to improve equity.

Over the past year, Title V staff investigated the options for providing staff training through the DOH Learning Management System (LMS). The LMS platform provides tracking of training module completion and can also generate Certificates of Completion for each individual course and for the full curriculum. Staff catalogued existing modules and content for focus areas including health literacy, health equity, eliminating health disparities, and social determinants of health. Title V staff accessed resources from the HRSA-funded Region 2 Public Health Training Center (PHTC), a partnership of three Council on Education for Public Health accredited schools of public health, including Columbia University Mailman School of Public Health, Rutgers School of Public Health, and the University of Puerto Rico Graduate School of Public Health, along with the University of the Virgin Islands Community Engagement and Lifelong Learning Center, and NYSACHO. The Center's mission is to enhance the current and future public health workforce's ability to effectively deliver the Essential Public Health Services (EPHS) to the populations of NY, New Jersey, Puerto Rico, and the U.S. Virgin Islands. Using the "Training Program Evaluation Criteria" tool, developed by PHTC, the team evaluated courses and determined which merited inclusion in the curriculum. From this exercise the four courses to be included are: 1) From Concept to Practice: Health Equity, Health Inequities, Health Disparities & Social Determinants of Health, 2) Health Literacy for Public Health Professionals, Center for Community Health Lecture Series: 3) Bridges out of Poverty and 4) Health Equity Data to Action. All staff working in the Title V program will be required to complete the training over a four-month period. Objectives from the four courses were collected to form the basis for an evaluation plan for the curriculum.

The NYS 2017 Health Equity Reports were issued by OMH-HDP during this reporting period. These represent data on health outcomes, demographics and other community characteristics for 21 select cities and towns that have a Minority Area, defined as having 40% or greater non-White population. Each report contains data associated with the priority areas of the PA and includes social determinant indicators such as housing, educational levels and insurance coverage. This information is useful in assessing health disparities in "Minority Areas" and focusing efforts to increase capacity to address SPs in all domains. These data can also inform program and policy development, support targeted community engagement, capacity building and mobilization efforts; increase provider and community awareness; refine scopes of work and support statements of need for grant applications.

Title V staff also identified several opportunities for professional development aimed at improving health equity competence of Title V staff. These included events, webinars, meetings and book clubs. The Epidemiology and Biostatistics Community of Practice (EBCoP), the Affirmative Action Advisory Committee, and the OMH-HDP collaborated to present a series of events, from September 2016 to March 2018, to provide staff with learning opportunities to increase understanding of the factors that lead to disparities. The events included the screening of the acclaimed documentary series, "UNNATURAL CAUSES: Is Inequality Making Us Sick?" Monthly screening events were held featuring different episodes in the series including "In Sickness & In Wealth," "When the Bough Breaks," "Becoming American," "Bad Sugar" and "Collateral Damage" followed by a 30-minute discussion period for all participants. The screening series was promoted to all Title V staff and staff served as moderators for three of these sessions. These collaborative efforts continued with the screening of "Raising of America: Early Childhood and the Future of Our Nation" offered in the same monthly format.

Title V staff also worked with the EBCoP to develop a health equity-focused book club that is held during hours outside of the normal work day, for any staff who choose to participate. The purpose of the book club is to offer a non-threatening venue in which issues related to health disparities can be discussed by a diverse group of interested members to increase awareness and understanding. As of March 2018, the book club has read and discussed two books: The Immortal Life of Henrietta Lacks by Rebecca Skloot and The Hillbilly Elegy: A memoir of a Family and Culture in Crisis by J.D Vance. The current selection being

discussed is My Beloved World by Sonia Sotomayor.

Title V and CCH had the opportunity to learn about incorporating health equity into MCH through a "Reproductive Justice" framework. Presented by the NYCDOHMH. This interactive presentation allowed Title V staff to explore how this theoretical framework can be operationalized to improve women's health. With its emphasis on involvement of members of key priority populations, the necessity of shared decision making, and focus on engaging nontraditional partners in promoting health equity, much of this work aligned with key concepts embraced by the Title V's life course approach outlined in NY's SAP.

An important component of health equity is ensuring a connection and understanding of the priorities, needs and opinions of the communities served. Title V staff focused on the development and piloting of a Community Listening Forum (CLF) protocol for use in all Title V procurement development and program implementation and evaluation. Title V staff adapted the CLF resources provided by the OMH-HDP for use in Title V programs. Staff obtained training materials, resources, marketing information, and findings from a series of large scale CLFs conducted across NYS.

The first Title V procurement selected to pilot this process was the MICHC program. **ESM LC-15: Percentage of DFH procurements that complete community listening forums as part of concept development process**. Three forums with 25-40 participants each, were conducted and participants shared ideas, and suggestions for improvement on key MCH topics areas.

Information gathered during each event was provided to the Title V for qualitative data analysis and summarized in reports outlining key themes for each of the CLF sites. Among the major themes reported across the state were: increased desire for social supports, more opportunities for father engagement, frustrations with the health care system and health providers (including provider bias, lack of communication, limited time interacting with physicians), and opportunities for participants to be collaborative partners in improving the physical environments in which they live (e.g. creating more space for play, walkable communities, and improving safety). Following the completion of the analysis, information gathered from forums was distributed to Title V staff working on the development of a new MICHC procurement so opportunities could be identified to incorporate insights gleaned into the next MICHC procurement. While reprocuring the MICHC program has been delayed, this feedback will be incorporated into this and other Title V activities.

The Title V program recognizes the challenges presented with evaluating a program for health equity when the evaluation methodology and outcomes were not clearly established during project development. In order to develop an internal culture that includes health equity work as a priority in every program, staff members worked to identify key community engagement strategies best suited to support the health equity priorities of Title V. Through this review, staff determined that evidence based or best practice was a necessary component of any effort to promote health equity and must be included in all Title V programs and procurements moving forward. Title V staff is working to increase their knowledge of these practices and infuse them into procurements moving forward.

As a first step to creating uniform community engagement standards, all Title V programs were surveyed on the current requirements and their potential capacity to include elements of community engagement. Results were used to establish a baseline for compliance. Currently, 47% (9/19) of current Title V programs require some element of community engagement activities. It is important to note that elements of community engagement can vary widely among the included programs. Building on this baseline, NY's Title V program plans to increase the number of programs including community engagement elements and work to ensure community engagement activities are implemented consistently and in accordance with best practices.

Finally, conducting a Culturally and Linguistically Appropriate Services (CLAS) assessment is an effective way to determine the NYSDOH cultural competence and collective impact towards addressing health disparities which are key components of the DOH's

National Accreditation, Strategic Plan, and PA. DOH Executive Staff guided a CLAS Steering Committee comprised of staff from divisions within OPH including Title V. Title V staff participated on the OPH CLAS assessment project to support an internal DOH assessment of CLAS compliance. Utilizing the CLAS Standards, an internal assessment was piloted within the OPH. Results were analyzed, and division specific recommendations and best practices were shared to correct for gaps and deficiencies identified by the assessment. Steering Committee members supported distribution and completion of the assessment, and development and implementation of action plans to address deficiencies and share best practices.

FY 2019 Application
Cross Cutting and Life Course

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

2020 State Objectives:

- **Objective LC-1: Increase the percentage of women 18-44 years old with a past year preventive medical visit by 10% to 79.4%.**
- **Objective LC-2: Increase the percentage of children 9-35 months who received a developmental screening using a parent-completed screening tool by 5%, to 18.4%.**
- **Objective LC-3*:* Increase the percentage of adolescents ages 12-17 who received a preventive health care visit in the last year by 5% to 83.2%.**

Building on the established baseline of 11 of 19 Title V programs with health insurance requirements and an additional 11 of 17 programs with well-woman visit promotion requirements, staff will focus efforts during the upcoming year on increasing the number of Title V programs with preventive care components. Staff will continue to increase the number of Title V programs which include a focus on preventive health care. Further, work will begin to ensure that all strategies and activities promoting increased use of preventive care align with evidence based or informed best practices. In the coming year, Title V staff will analyze information gathered on current program standards, measures, and strategies being used across Title V programs to promote preventive health care.

A key focus of this work continues to be the development of Title V program measures for the promotion of preventive health care services for all populations, especially those with disparate outcomes. To better compare the successes and challenges of Title V programs in promoting preventive health care, adoption of universal standards and measures will enable more accurate assessment among different programs. To that end, Title V staff will work to determine which current measures can best be applied across all Title V programs and advocate for their adoption. Moving forward, performance goals and measures will be aligned and assessed.

As part of improving use of preventive health care services, Title V staff will continue to support implementation of the preconception module in BRFSS and subsequent analysis of the results to inform program work. This will include analysis of the most recent BRFSS data, where available, based on four questions from the preconception module. Health measures from BRFSS will be reported in the MCH Dashboard (discussed elsewhere in this application). This year Title V staff will collaborate with internal DOH partners to ensure that that the Family Planning/Preconception Health module of questions is fully implemented. Following implementation, Title V research scientists will review the most current data and produce recommendations for program staff about how these results should inform Title V programs. Additional analysis will be conducted to identify relationships between variables (e.g., is there any relation between women who say a doctor talked to them about planning a health pregnancy and women who report having particular chronic diseases?).

As with previous years, Title V staff will continue to support the improvement of developmental screenings rates for youth across NYS. This will include ongoing participation in the ECAC, support for the Albany Promise Initiative, collaboration on the Early Childhood Comprehensive Systems (ECCS) initiative, regular internal efforts to improve developmental screening rates and continuing the efforts to complete development of a NYS Early Childhood Services for Children and Families Prenatal through Age 5 infographic (as mentioned in the Annual Report).

In the upcoming year, the NYSDOH MIECHV program will further emphasize developmental screenings among evidence-based home visiting programs. Through the inclusion of two performance indicators defined by HRSA for the MIECHV program and implemented in October 2016, all home visiting programs receiving MIECHV funds must provide additional information and support for developmental screening rates of all enrolled children. New MIECHV areas of focus include reporting on the following measures: the percent of children enrolled in home visiting programs with a timely screen for developmental delays using a validated parent completed tool; the percent of children enrolled in home visiting with positive screens for developmental delays (measured using a validated tool) who receive services in a timely manner; and the number of completed referrals which include a) individuals receiving developmental support from a home visitor; or b) individuals who were referred to EI services and received an evaluation within 45 days; or c) individuals who were connected to other community services and received those services within 30 days. These metrics will continue to be tracked at least bi-annually and used to inform technical assistance needs.

Finally, staff will continue to focus on addressing the unique needs of adolescents. As a result of the literature review completed by ACT for Youth, staff at Cornell recommended joining efforts with the BWIAH by adding questions to their focus group project on sex, pregnancy, and STDs.

In the upcoming year, Title V staff will gather resources and data from the Division of Chronic Disease Prevention (DCDP) to develop a needs assessment on the current state of adolescent's health in NYS based on race, ethnicity, and socioeconomic status. The results of the needs assessment will determine what preventative health care services need the most attention for future research on barriers and strategies for improvement. Staff will then develop questions to add to the BWIAH focus group project. All strategies have the goal of incorporating best practice strategies and implementing interventions designed to increase adolescent use of preventive health care services in all Title V programs serving adolescents. Title V staff will continue to work with ACT for Youth to develop strategies to improve preventive health care service delivery to adolescents, with a focus on reducing disparities.

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

2020 State Objectives:

- **Objective LC-4: Increase the percentage of NYS residents served by community water systems that have optimally fluoridated water by 8% to 77%**
- **Objective LC-5: Reduce the prevalence of dental caries among children and adolescents ages 1-17 by 5% to 8%.**
- **Objective LC-6: Increase the percentage of children and adolescents age 1-17 years who had a preventive dental visit in the past year by 5% to 81.5%**
- **Objective LC-7: Increase the percentage of pregnant women who had a dental visit during pregnancy by 5% to 57.6%.**

Promoting oral health across the life span is an important priority for NY's Title V Program. Among children, tooth decay is the most common chronic disease, and receiving appropriate dental care is the greatest unmet service need. Access to dental care remains a challenge for many, especially low-income individuals of all ages. In June 2014, there were 127 federally-designated dental health professional shortage areas in NY. As of January 1, 2017, this increased by over 9% to 139, impacting almost 2.2 million New Yorkers. Expanding access to evidence-based interventions, specifically CWF and dental sealants; delivery of preventative dental services across diverse settings including school-based clinics, primary care settings, and nutrition programs; and integrating oral health messaging and education within maternal and infant health programs, are core strategies of the Title V Program and SAP.

Strategy LC-6: Provide financial and technical support for maintenance and expansion of community water fluoridation. NY's Title V program will continue to focus on activities to maintain and expand CWF which include providing financial and technical assistance to PWS. In the NY's 2018-19 Enacted Budget, $10 million was appropriated to support the CWF Grant Program. The CWF RFA accepts and reviews applications on a rolling basis until funds are exhausted. With the appropriation of new funds in the

2018-19 budget, DOH will continue to accept, review and make new awards in the upcoming year. Title V partners will work together to promote the CWF Grant Program, specifically in non-fluoridated communities, to increase the percent of NY communities on PWS receiving optimally fluoridated water. This includes working with LHDs across NYS and DOH District Offices to promote the RFA and provide direct outreach to municipalities to discuss eligibility, raising the level of awareness and empowering local CWF champions to work with their elected officials and PWS to submit applications, and provide a greater level of technical assistance to potential applicants. In addition to promoting CWF, Title V staff will continue to work with the grantees previously awarded funding under CWF grant to ensure completion of the projects and will continue to provide technical assistance needed.

Pursuant to a RFP, the Title V program will contract with a vendor to provide technical CWF to PWS through direct onsite visits and water operator trainings. The goal of this contract is to identify and address CWF operation issues and ensure a knowledgeable PWS workforce on CWF. The vendor is expected to conduct 25 site visits in 2018-19 selected based on specific criteria such as: variation in fluoride level trends or an interest in initiating CWF. This strategy will be measured by **ESM LC-6:** Number of public water systems that receive financial and/or technical support from NYSDOH to maintain or initiate community water fluoridation.

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

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

At the 2017 annual meeting of the New York School-Based Health Alliance (Alliance), staff presented "Site Visit Review and Update" to the 52 hospital or diagnostic and treatment center sponsors that provide SBHC services at 255 schools throughout NYS. Staff surveyed attendees as to their interest in participating in an in-person regional training session on SBHC and SBHC-D topics and the response was overwhelmingly positive. Four regional trainings are planned for the spring of 2018 in Western, Central, Capital and Metropolitan regions of NYS. Topics being considered include: showcasing successful strategies on increasing student enrollment, practices to increase provider credentialing and provider reimbursement, successful participation in Medicaid Managed Care, encouraging SBHC/D providers to engage with their community partners to expand access to medical, dental, behavioral and reproductive health care models. The agenda will be adapted to meet regional needs and the availability of speakers.

Activities to promote the evidence-based practice of fluoride varnish application to young children by medical providers will continue throughout the upcoming grant year. The DOH and NYSACHO will continue to collaborate to promote and provide technical assistance to LHDs on public health detailing for fluoride varnish. Title V staff will participate in monthly calls and provide additional support to counties developing plans to engage in this activity. DOH will continue to conduct in-person trainings at CHCs on fluoride varnish. Title V staff and consultants will provide technical assistance and expertise on the MDIL and fluoride varnish to CHCs throughout the performance period.

These efforts will be measured through number of Medicaid claims submitted by primary care providers for application of fluoride varnish for children 0-5 enrolled in Medicaid that receive fluoride varnish applications from their primary care providers.

Title V staff will complete the work on SSB grant in the summer of 2018 and will work with the DCDP and the DON to incorporate the messaging into established programs to educate on good nutritional habits and the health risks of SSBs.

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

NY's Title V program continued to integrate oral health services into the MICHC program infrastructure by facilitating oral health trainings and providing oral health resources to MICHC providers and their community partners. Title V will continue to provide

guidance and technical assistance to MICHC programs on the oral health integration process including: assisting MICHC sites to engage and train dental providers and CHW staff, conducting periodic coaching calls with MICHCs to monitor progress/barriers and provide technical assistance, analyzing data from quarterly reports to measure progress and provide feedback, and drafting a final report. Between 2015-2017, program saw improvements in oral health services provided for women enrolled in MICHC programs. We anticipate continued improvements in oral health services among MICHC programs as more staff and community partners are trained, and Title V staff continue to provide technical assistance and collect/analyze data. Funding for the PIOHQI grant ends 9/29/18. This is being measured through **ESM LC-8: Percentage of pregnant women served by Title V CHWs that have a documented screening or referral for dental services.**

The Pathways to Success initiative will work with PIOHQI program staff to develop an implementation plan for incorporating oral health into the Pathways to Success initiative. If feasible, the Pathway to Success initiative will work with PIOHQI program staff to hold a Train the Trainer event so that the Pathways to Success partners can incorporate oral health services into the resources and services that are currently being provided. Pathways to Success staff will explore the possibility of adding oral health screening questions to the Pathways to Success Asset and Risk Assessment tool, which is used to track program participants and determine which services and resources they need most.

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

The dental resident will continue to work collaboratively with Title V staff to provide support for MCH oral health programs. The resident has initiated activities to meet competencies as required and is developing an evaluation plan to update the NYS Basic Screening Survey Data or 3rd Grade Survey. This will include providing continued support for the ongoing analysis of SBHC-D quarterly reports and recommend revisions to measures for more accurate evaluation of performance; assessment of EC3, including lessons learned, to develop performance measures and an evaluation plan for the MDIL. The dental resident will also conduct an assessment of evidence-based interventions and best practices, particularly in nutrition, to help MCH promote integration of oral health strategies in at least one public health nutrition program.

Healthy Communities – State Priority #7: Promote supports and opportunities that foster healthy homes and community environments.

2020 State Objectives:

- **Objective LC-8: Increase the percentage of children ages 6-11 and adolescents ages 12-17 who are physically active at least 60 minutes daily by 5%, from 22.9% to 24% and from 18.3% 19.2% respectively.**
- **Objective LC-9: Increase the percentage of children and adolescents who live in supportive neighborhoods by 5%, from 50.1% in 2016 to 52.6%.**
- **Objective LC-10: Increase the percentage of children and adolescents who live in a safe neighborhood by 5%, from 57.2% in 2016 to 60.1%.**

Safe and healthy environments including, but not limited to, safe places for families to walk and children to play, access to fruits and vegetables and other healthy food options, and housing free from hazards, all impact health and well-being throughout the life course. The identified State objectives for this priority area listed above have been updated since the last report. The National Survey of Children's Health was updated for 2016, making the data incomparable to previous years. To address this, the baseline has been updated with 2016 data and targets have been adjusted accordingly.

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

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

During the upcoming year, Title V leadership will continue to participate in the quarterly meetings of the DOH PBI workgroup. Best practices, challenges, and strategies for effecting community-level change identified from the PBI community contractor survey will be analyzed and presented during the upcoming year. Title V staff will share these results with all appropriate Title V programs to maintain alignment with partners and incorporate requirements for healthy community practices within relevant MCH procurements. In the 2016 State of the State, Governor Cuomo introduced the Empire State Poverty Reduction Initiative (ESPRI) which aims to combat extreme poverty and reduce inequality in 16 cities with the highest poverty rates in the state. ESPRI is modeled after NY's successful Rochester Anti-Poverty Task Force, part of a broad coalition of state and local government, business, and nonprofit representatives working together to redesign and coordinate efforts to address extreme poverty. ESPRI will replicate this model to provide planning and implementation grants for the identification of specific, measurable objectives to improve residents' well-being and quality of life; to better align public and private resources with community-based interventions that are successful in improving outcomes for residents; to develop strategies that match promising practices to the challenges of each community; and to build partnerships among public and private, municipal and nonprofit organizations to provide a continuum of solutions. The workgroup is exploring using the procurement process to require providers to engage in community collaboration and potentially using the collaboration toolkit we are developing as a report card to measure how well collaborations are working.

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

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

Health equity will continue to be an overarching priority across all Domain and State Priorities. Collaborative efforts to increase awareness of and access to health-related resources at the local level will continue with key program partners: Creating Healthy Schools and Communities, Healthy Neighborhoods Program, the Regional Centers for Sexual Violence Prevention, Community Schools, Health Related Quality Indicators in New Quality Improvement for Regulated Child Care Programs, BRACE and the AIDS Institute's Faith Communities Project Program. Title V staff will meet at regular intervals with the DCDP, Bureau of CEH and Food Protection, Bureau of Occupational Health and Injury Prevention and the AIDS Institute to ensure connection of local-level programs and coordination of state-level efforts, especially around reducing disparities. This strategy will be measured by **ESM LC-11**: Number of community environmental changes demonstrated as a result of enhanced collaboration.

As previously discussed, the Regional Centers collaborate with community partners/community-based organizations to implement community and individual-level change strategies to improve health equity for all. The Sexual Violence Prevention Statewide Training and Technical Assistance Center, Cicatelli Associates, Inc., provides the six Regional Centers with guidance, training, and technical

assistance on community-level sexual violence prevention activities through needs assessments, online resources, conference calls, webinars, and in-person meetings. The Sexual Violence Prevention Statewide Training and Technical Assistance Center will continue to support the six Regional Centers in these and their individual and community-level change strategies. To pilot test the evidence-informed framework to evaluate collaboration, the Regional Centers under Title V will utilize the Collaborative Work Plan (as described in LC-12) to assess how the Regional Centers establish community partnerships, work together to implement primary prevention community-level activities and communicate within organizations to produce outcomes that create healthy environments free from sexual violence.

Title V staff coordinated a webinar for DFH and other DOH partners on terms and language usage for the LGBTQ community scheduled for May 8, 2018. Staff selected the NYC AVP to deliver this training. AVP is a progressive agency in NYC with programming specific to the LGBTQ and non-gender conforming community and has presented varying LGBTQ topics to the DOH, the Office for the Prevention of Domestic Violence (OPDV) and other state agencies.

To further enhance LGBTQ inclusivity, the SVPP Unit will work with the One Circle Foundation, creators of the Council for Boys and Young Men and the Girls' Circle programs, to adapt these curricula to reflect inclusivity of the LGBTQ community. These updated curricula will be used for Title V community-based providers that engage with LGBTQ youth between 9 – 12 years old.

NYS' approach to supporting the Community Schools initiative continues to evolve. NY's enacted budget increases support for Community Schools through the provision of $150 million to support the continued transformation of high-need schools into community hubs. This funding supports services that are unique to each school's and communities' individual needs, which may include before-and-after school programs, summer learning activities, social services, and medical and dental care through school-based health centers. Title V staff will continue to serve as a resource for information regarding SBHC services as a key component of the larger Community Schools model.

Following further internal DOH review, the 14 recommendations for new health-related quality indicators for child care programs developed by the workgroup of several DOH units and the OMH were presented to OCFS in June of 2017 for feedback, review, and to determine next steps to support adoption and implementation. This project represents significant collaboration and has the potential for substantial impact on health-promoting environments in child care including promoting safe sleep practices, providing age-appropriate physical activity, encouraging healthy food choices and breastfeeding, and providing supports for child development and CSHCNs. Title V staff will continue to collaborate with OCFS on this initiative and provide technical assistance.

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

As described in the report section, strong collaboration is required to achieve community environmental change that results in positive outcomes including achieving health equity and reducing disparities, however, collaboration is often loosely structured or undefined. Many work plans include strategies to collaborate with partners, but the parameters or anticipated outcomes of that collaboration are not specified, making it difficult to identify the impact of the collaborative efforts. Title V staff created a draft collaboration plan template to be pilot tested. Components of the template include establishing a shared purpose, outlining the team's ground rules, defining team members and how they will work together (e.g., communication, decision making, meeting schedule), and defining milestones or objectives, a work plan, and measures of progress. The Regional Centers for Sexual Violence Prevention have been selected to pilot the collaboration plan template with their local-level partners beginning Spring 2018. The Regional Centers will be trained to use the template so they can lead their partners in establishing a stronger collaborative effort. In Fall and Winter 2018, Title V staff will utilize key informant interviews and partner surveys to collect users' perceptions and experiences using the template. Based on the results of that pilot, the template will be disseminated to Title V staff to use to form new state-level partnerships and to

Title V programs for local-level use. Satisfaction with and impact of the template will be monitored as it is implemented and revisions will be made as necessary.

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

2020 State Objectives:

- **Objective LC-11: Increase the percentage of Title V staff that improve their knowledge of health equity concepts by 20% from baseline.**
- **Objective LC-12: Increase the percentage of DFH procurements that demonstrate application of health equity strategies listed by 20% from baseline.**
- **Objective LC-13: Reduce disparities for all selected national and state performance measures by 5% from baseline.**

To establish baseline data, Title V staff members reviewed the number of programs which indicated that they currently apply three health equity strategies shown to improve health equity identified by Title V. This includes; conducting an equity assessment, completing a CLF as part of the procurement development process, and including community engagement strategies in all programs. Based on this measure, there is currently one Title V program (MICHC) which meets that standard. Therefore, NY's Title V baseline measure is 5% (or 1 out of 19 programs). Data for Objective LC-11 and LC-12 will be reported in subsequent years as the strategies are further implemented. Objective LC-13 will cross all Domains and be further addressed under each Domain with key indicators incorporated into the newly developed MCH Dashboard.

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

During the coming year, Title V staff will continue building on the work of the past year to integrate a Health Equity framework into more aspects of the Title V work. Staff will collaborate among groups within Title V and DOH to support the 19 Title V programs and their health disparity data needs. Currently 5 of 19 Title V programs have completed a health equity analysis. Those programs include: school based health and dental, sickle cell, family planning, and MICHCs and MIECHVs.

Over the 5 Population Domains (Maternal, Infant, Child, CSHCN and Adolescent) forty-two measures which include demographic information, have been included in the development of the MCH dashboard. The public availability of county level data will provide a means to continue to enhance the work of program partners and staff and provide a means of assessing effectiveness of programs over time. Being able to view data by race and ethnicity within the domains provides a means of quantifying improvements and declines. The MCH dashboard is expected to be released for public use in summer 2018 and will be used by health planners and supporters of Title V program priorities. Age, race, ethnicity and geographic disparity, can be examined for the MCH measures on the dashboard. By increasing the availability of the health inequity data for all priority areas identified in the SAP, a greater focus on the efficacy of these programs within the communities of greatest need will be possible.

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

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

Title V staff will also continue to partner with the OPHP to complete the design and implementation of a new Title V Health Equity training program. As described in the annual report, this program will be comprised of several online course modules that have been

evaluated and endorsed for appropriate and meaningful content. Staff is also collaborating with OPHP, NYSACHO and PHTC to develop a course on collective impact strategies, for Title V staff, local health department and a wider public health audience.

The health equity team coordinated a day long training called "Bridges into Heath: Strategies to reduce Inequities and Improve Health Outcomes", which took place in April 2018. This award-winning training, provided by nationally renowned Terie Dreussi-Smith, an expert in the area of understanding poverty and its mitigation, will further enhance understanding and expertise of Title V staff in health equity. All staff, from support staff to highest level of leadership, participated in this Division wide training.

In addition, work will continue to identify and promote non-traditional avenues of professional development; affording Title V staff the chance to learn, discuss, and model health equity principles through nontraditional learning experiences including book discussions and film screenings. The Health Equity team will continue to serve as subject matter experts to shine a health equity lens on all the work of the Division to alter the very culture of the work environment in the Title V program.

Strategy LC-15: Integrate an equity framework into the development of all DFH/Title V procurements through biannual community listening forums conducted to inform the development of upcoming procurements.

Recognizing the lengthy time commitment required to conduct and analyze a CLF for each individual procurement, Title V staff propose to shift the responsibility for CLFs from individual programs and staff to the Title V Health Equity Team. The Health Equity Team will support the facilitation of biannual CLF's meant to inform the development of all upcoming Title V procurements. These forums will be conducted using the same model previously developed and will include a focus on priority populations and topics related to upcoming Title V procurements. This approach will ensure that feedback is solicited from members of the priority population at regular intervals without being overly burdensome on program staff and avoiding any duplication.

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

Finally, NY's Title V program will take additional steps to increase the number of Title V procurements that include community engagement. This will be accomplished by continued research into best practices for community engagement, development of standardized performance measures, standards, and activities for community engagement inclusion, collaboration with OMH-HDP, and the creation of Title V-wide measures of the success of community engagement activities. Going forward, all applicable procurements will be reviewed to ensure required health equity and preventative care activities (i.e. community listening forum, data analysis, health insurance activities, etc.) have been completed as a component of the approval process. Through this mechanism Title V will ensure increased inclusion of community input in all Title V programs. In addition, Title V have been working with DOH colleagues in OPHP to develop a new online training module on collective impact. With an emphasis on integrating theory into practice, this training will be available to staff throughout DOH as well as community partners as needed. Putting communities at the forefront of all initiatives is an important step to promoting health equity.

III.F. Public Input

III.F. Public Input

The mission of NY's Title V Program is to improve the health and wellness of women, children and families. Analyses of data is one aspect of planning, implementing and evaluating supports and services to improve MCH outcomes. The ability to engage the community to gain a more comprehensive understanding of those factors impacting the health of the community and practical strategies to impact those factors cannot be underscored. Developing approaches to improve health outcomes requires commitment and partnerships with families, health and human service providers and professionals, organizations and advocacy groups as well as other key stakeholders to understand and support strategies to improve outcomes for all NY's families. To increase knowledge and effectiveness, NY's Title V Program sought extensive public input over the course of this year to ensure NY's Title V strategies and efforts reflected the needs, thoughts, and priorities of all MCH stakeholders. Strong partnerships are essential to NY's Title V program as it works to coordinate efforts and maximize the use of existing resources to improve health outcomes and health equity.

A key partner in NY's Title V Program is the MCHSBG Advisory Council (Council), that serves in an advisory capacity to the DOH with respect to the MCHSBG. In this capacity, the Council advises DOH in:

- determining program priorities consistent with MCHSBG principles;
- ensuring that services delivered under the MCHSBG are fairly allocated and directed to those most in need and are not duplicative of services provided through other sources of funds;
- the preparation of the annual performance report and application to HRSA;
- ensuring the public's ability to comment on MCH activities; and,
- ensuring a coordinated, statewide response to maternal and child health issues, including improved coordination among state agencies.

Since the inception of this five-year grant cycle, members of the Council provided input into the identification of priorities, strategies, and provided recommendations on organizations and initiatives that could partner with NY's Title V Program to strengthen the approach to meet the needs of NY's MCH population. This input continued throughout the past year as the Council was engaged in discussions to inform and improve the implementation phase of NY's Title V SAP. Part of this discussion also focused on ensuring NY's Title V Program identified and connected with a wide range of MCH stakeholders during the public input process as well as in moving forward with implementation of the identified strategies.

In considering the process for this year's public input, attention was given to ensure broad input from families and other individuals, health care providers, human service providers and organizations with a special interest in MCH. Since this is the fourth of a five-year application and reporting cycle, objectives, goals and strategies are well underway. The focus of the input for this FY 2019 Application was on strategies and recommendations for building partnerships and coordinating and maximizing existing resources with a specific focus on the heath equity work that is the guiding principle across each strategy and priority area in NY's SAP.

This year afforded DFH an opportunity to further align maternal and child health work in NYS by aligning the Title V work with the Prevention Agenda (PA). The NY PA, which is the blueprint for state and local action to improve the health of New Yorkers and to reduce health disparities for racial, ethnic, disability, and low socioeconomic groups, is being updated for the next six years-2019-2024. The PA 2019-2024 will align directly with the national and state framework for MCH action plans, to ensure consistency and synergize efforts related to both plans. Since the timing of the public input phase for this application aligned well with the NYS Public Health Planning Council's Ad hoc Committee to Lead the PA's efforts to update of the PA, public input was sought for both initiatives.

The discussions were tailored to the specific interests of each group and participants were asked to provide their perspective and suggestions to further enhance the ongoing Title V work. Each group, however, was presented with similar questions to initiate discussion generally as follows:

- What have you done in the past year to obtain input from your community partners and families and what have you learned from them?
- How can NYS make better progress in addressing racial, ethnic, and socio-economic disparities?
- Are there non-traditional partners with whom we should work to address the social determinants of health?
- Are there barriers to care that families and children continue to encounter in accessing needed services despite access to health care coverage?
- What do you think are emerging issues that will impact the health of NY's families?

Families were asked similar questions including:

- What are the most important issues that you face today in helping yourself and your family become or stay healthy?
- What helps encourages you to seek health care?
- What prevents you for seeking health care or being healthier?
- Who in your community do you reach out to or trust to help you when you need help?
- What is needed to support your neighborhood and community to promote health for you and your children?

These listening sessions were conducted over a two-month period with over 200 providers, health professionals and parents in a series of in-person meetings and/or webinars held between March and May 2018. Input was obtained from organizations including the Association of Perinatal Networks (APN), Maternal and Infant Community Health Collaborative (MICHC), Schuyler Center (including representatives from NYS Association of County Health Officials (NYSACHO), ACOG, Docs for Tots, March of Dimes and United Hospital Fund), Partnership for Maternal Health, oral health professionals, Parent to Parent of NYS, and the EICC and the ECAC, among others.

The public input strongly supported NY's plan for addressing the needs of NY's MCH population. Comments across all groups reaffirmed NY's SAP Cross Cutting /Life Course priorities. Addressing health disparities and promoting health equity was generally reflected through all discussions across all Domains. The very act of seeking input and discussion of these important issues was appreciated as a necessary component to assure successful implementation.

There is broad support for education efforts to engender greater understanding of the social determinants of health by all providers and for greater focus on initiatives that work within this framework. Health care providers and others at all levels need to embrace these concepts as they work with patients and families. Concerns about the lack of affordable and quality housing was stressed by most groups and this was an area of concern in both rural and urban areas. All groups emphasized the influence social and community factors and environments have on health outcomes and the need to understand and address issues on the community level. It was stressed that communities need to "own" the process and solution in order to facilitate sustainable improvements.

Several groups discussed the toll substance use has on families. Significant concerns were expressed regarding the extensive devastation opioid use has on pregnant women and their families, yet all substance misuse remains an issue. The importance of addressing the use of opioids in the MCH population, pain management practices as well as the resulting neonatal abstinence syndrome (NAS) remain a concern. Discussions also centered on not only identifying pregnant and postpartum women with depression, but on ensuring there are supports and services to address these needs when identified. It was further suggested that all women be screened for depression at every primary care encounter.

There were comments related to the health care system as well including needing more flexible hours at health clinics to accommodate work schedules, ongoing issues with transportation, lack of pediatric or dental providers, confusion with the complexity of accessing

services, concerns about water quality and lack of social supports especially for transient populations.

The importance of involving and connecting with nontraditional partners in planning and implementation to truly engage the community was stressed. Some partners discussed include Community Action Networks, people who work in food insecurity, methadone clinics, more involvement from front line local providers, immigrant communities, housing and economic development organizations, child care providers and other community based organizations.

There is a strong interest in more universal and integrated data systems that can be accessed by providers and patients alike. Within data systems and also in systems of care in general, there was a recognition for the need for greater collaboration among partners throughout a continuum of care.

Fiscal constraints were also discussed as funding on the federal or state level is decreased or reimbursement for certain interventions is not available.

Finally, there was discussion around concentrating efforts on one or two major areas related to MCH and focusing resources to accomplish more targeted results on fewer initiatives. Aligning this more targeted work across partners and agencies can provide a synergy for success. Several groups focused on maternal mortality and morbidity, maternal depression and the growing opioid epidemic.

Families also provided valuable input into NY"s SAP. Some families expressed concern about vulnerability at times of transition e.g. service continuity for children between infants and adolescents. There was general consensus regarding the need to continue to identify and coordinate supports and services for families. Families speak well for themselves therefore this input section includes several direct quotes from families.

> *"[There should be] easier access to those resources so I do not have to be on a computer for 6 hours doing research."*
>
> *"I didn't know how to go about helping him because the system is really complicated."*
>
> *"I found that finding a provider was the hardest. Every door I knocked on, I was turned away."*
>
> *"Having your community exposed to your child is almost more important than having your child exposed to the community."*
>
> *"My son cries because he does not have any friends."*
>
> *"The parent **IS** the medical home. We are doing all the coordination."*
>
> "As soon as you put a special needs label on something, the cost quadruples."

Overall, a comment that crossed many groups was the need for greater alignment of initiatives conducted by different groups/agencies across the state to ensure a more coordinated approach to the needs of NY's women, children and families. As is evident in NY's application, strong partnerships are paramount to moving forward in many Title V priority areas. Feedback gleaned from this process will inform strategies to ensure close collaboration with community partners in developing approaches and initiatives that will result in

increasing health equity and addressing disparities. In addition, continued engagement of communities served is essential to improving health outcomes. Through community listening forums such as the forums that will be held to receive community input into those factors that may lead to poor birth outcomes, and continued listening sessions for families of CSHCN, NY will continue to build strong supports and services for all women, children and families in NYS.

III.G. Technical Assistance

II.F.7. Technical Assistance

NY's Title V program would welcome the opportunity to have periodic teleconferences with HRSA and other large states focused on specific topics, programs and initiatives to support Title V outcomes. Several states are focusing on the same of similar priority areas. Focused discussions on efforts related to perinatal regionalization including the development of metrics and processes for ongoing quality improvement, state efforts to identify and address maternal mortality and morbidity, and ongoing work related to social determinants of health, disparities, enhancing systems for children with special health care needs and their families and efforts to promote and ensure improved pain management practices, including during pregnancy, to address the opioid epidemic would be topics of interest to many large state. Discussions with colleagues in other large states on establishing policy to promote systems change, identifying evidence-based or evidence-informed practices on an ongoing basis, modifying evidence-based programs to better fit the needs of certain populations, and addressing public health issues in more rural areas where the burden is not as great and resources are limited are just a few additional examples of areas that may be of benefit to discuss in a forum with large states. HRSA could poll large states for topics on interest and facilitate these discussions.

In addition, there significant travel restrictions continue for staff in the NYSDOH. This may continue to impact the ability of NY's Title V staff to participate in State or National Conferences and in-person meetings. It would greatly benefit states such as NY for HRSA to utilize technology to share and learn rather than in-person meetings or conferences. In particular, it would be helpful if this were the primary mode of transmitting essential information rather than to use it as a secondary method, with in-person being the primary mode. In addition, the inability to travel to National meetings can impact NYS sharing valuable experiences and showcasing accomplishments with federal and state representatives.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - IAA-NYSDOH-OHIP and OPH-2017.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - State Action Plan TABLE FINAL 2019 App-Final6.14.18.pdf

Supporting Document #02 - Attachment MCH Collaborations - Master-4.17.18.pdf

Supporting Document #03 - Title V Leadership.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - DOH OPH CCH DFH Org Charts 2018.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: New York

	FY19 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 37,671,810	
A. Preventive and Primary Care for Children	$ 12,306,455	(32.6%)
B. Children with Special Health Care Needs	$ 12,315,693	(32.6%)
C. Title V Administrative Costs	$ 3,054,075	(8.2%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 27,676,223	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 29,285,356	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 122,324,435	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 30,303,017	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 181,912,808	
A. Your State's FY 1989 Maintenance of Effort Amount $ 58,268,752		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 219,584,618	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 47,470,052	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 267,054,670	

OTHER FEDERAL FUNDS	FY19 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 150,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 9,212,347
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 5,798,000
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 25,867,377
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 2,051,265
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 2,956,063
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State-Based Perinaal Quality Collaboratives Cooperative Agreement	$ 200,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Strength Based Curriculum	$ 485,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	$ 400,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000

	FY17 Annual Report Budgeted		FY17 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 38,909,810		$ 37,671,624	
A. Preventive and Primary Care for Children	$ 11,717,104	(30.1%)	$ 11,771,929	(31.2%)
B. Children with Special Health Care Needs	$ 12,352,932	(31.7%)	$ 11,605,228	(30.8%)
C. Title V Administrative Costs	$ 1,727,394	(4.4%)	$ 3,730,809	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 25,797,430		$ 27,107,966	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 12,147,081		$ 29,285,355	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 102,765,310		$ 64,999,454	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 34,368,556		$ 78,393,470	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 149,280,947		$ 172,678,279	
A. Your State's FY 1989 Maintenance of Effort Amount $ 58,268,752				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 188,190,757		$ 210,349,903	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 57,096,314		$ 46,962,126	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 245,287,071		$ 257,312,029	

OTHER FEDERAL FUNDS	FY17 Annual Report Budgeted	FY17 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 3,022,144	$ 1,012,790
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 1,647,000	$ 1,602,545
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 9,234,796	$ 6,146,972
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 9,762,000	$ 9,762,000
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 26,106,078	$ 24,971,913
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 156,338	$ 104,753
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 310,600	$ 197,540
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 26,495
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 4,317,691	$ 2,144,052
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	$ 1,333,436	$ 742
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State-Based Perinatal Quality Collaboratives (PQCs) Cooperative Agreement	$ 200,000	$ 205,084
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	$ 656,231	$ 189,464

OTHER FEDERAL FUNDS	FY17 Annual Report Budgeted	FY17 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 250,000	$ 228,095
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Strength Based Curriculum		$ 196,427
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Children's Oral Care Access		$ 118,440
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Oral Health and Chronic Disease		$ 54,814

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: This is 9.9% and is within the 10% limit	
2.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: Initially, New York State provided a projected estimate and has now reported actual expenditures.	
3.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: Initially, New York State provided a projected estimate and has now reported actual expenditures.	
4.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: Initially, New York State provided a projected estimate and has now reported actual expenditures.	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: New York

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Pregnant Women	$ 3,451,010	$ 6,681,303
2. Infants < 1 year	$ 2,777,680	$ 4,205,482
3. Children 1 through 21 Years	$ 9,528,775	$ 7,566,447
4. CSHCN	$ 12,315,693	$ 11,605,228
5. All Others	$ 6,544,577	$ 3,882,355
Federal Total of Individuals Served	$ 34,617,735	$ 33,940,815

IB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Pregnant Women	$ 24,043,472	$ 26,994,057
2. Infants < 1 year	$ 13,432,807	$ 19,195,839
3. Children 1 through 21 Years	$ 85,985,370	$ 59,864,364
4. CSHCN	$ 38,117,099	$ 35,583,474
5. All Others	$ 20,334,060	$ 31,040,545
Non-Federal Total of Individuals Served	$ 181,912,808	$ 172,678,279
Federal State MCH Block Grant Partnership Total	$ 216,530,543	$ 206,619,094

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: Preventative and Primary Care for Children includes Infants less than 1 year.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: Preventative and Primary Care for Children includes Infants less than 1 year.	

Data Alerts:

- Children 1 through 21 Years, Application Budgeted does not equal Form 2, Line 1A, Preventive and Primary Care for Children Application Budgeted. A field-level note indicating the reason for the discrepancy was provided.
- Children 1 through 21 Years, Annual Report Expended does not equal Form 2, Line 1A, Preventive and Primary Care for Children, Annual Report Expended. A field - level note indicating the reason for the discrepancy was provided.

Form 3b
Budget and Expenditure Details by Types of Services

State: New York

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Direct Services	$ 3,677	$ 7,748
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 3,677	$ 7,748
2. Enabling Services	$ 24,631,365	$ 26,507,669
3. Public Health Services and Systems	$ 13,036,768	$ 11,156,207
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 7,748
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 7,748
Federal Total	$ 37,671,810	$ 37,671,624

IIB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Direct Services	$ 21,847,822	$ 18,555,147
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 5,067,344	$ 6,051,073
B. Preventive and Primary Care Services for Children	$ 11,626,486	$ 7,842,487
C. Services for CSHCN	$ 5,153,992	$ 4,661,587
2. Enabling Services	$ 63,858,664	$ 72,038,277
3. Public Health Services and Systems	$ 93,456,858	$ 78,018,411
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
Other		$ 18,555,147
Direct Services Line 4 Expended Total		$ 18,555,147
Non-Federal Total	$ 179,163,344	$ 168,611,835

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIB. - Other - Other**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**

Field Note:
For the non-Federal MCHSBG funds we do not collect data based on the types of direct services provided.

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: New York

Total Births by Occurrence: 229,105 **Data Source Year: 2017**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	229,105 (100.0%)	2,568	411	411 (100.0%)

Program Name(s)				
3-Hydroxy-3-methyglutaric aciduria	3-Methylcrotonyl-CoA carboxylase deficiency	Argininosuccinic aciduria	Biotinidase deficiency	Carnitine uptake defect/carnitine transport defect
Citrullinemia, type I	Classic galactosemia	Classic phenylketonuria	Congenital adrenal hyperplasia	Critical congenital heart disease
Cystic fibrosis	Glutaric acidemia type I	Glycogen Storage Disease Type II (Pompe)	Holocarboxylase synthase deficiency	Homocystinuria
Isovaleric acidemia	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Maple syrup urine disease	Medium-chain acyl-CoA dehydrogenase deficiency	Methylmalonic acidemia (cobalamin disorders)
Methylmalonic acidemia (methylmalonyl-CoA mutase)	Mucopolysaccharidosis Type 1	Primary congenital hypothyroidism	Propionic acidemia	S, ßeta-Thalassemia
S,C disease	S,S disease (Sickle cell anemia)	Severe combined immunodeficiences	ß-Ketothiolase deficiency	Trifunctional protein deficiency
Tyrosinemia, type I	Very long-chain acyl-CoA dehydrogenase deficiency	X-linked Adrenoleukodystrophy		

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
New York State Early Hearing Detection and Intervention	228,058 (99.5%)	2,629	322	287 (89.1%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Newborn Screening - Newborn Screening Program (NBSP) collects, analyzes and reports on approximately 270,000 specimens annually for 47 diseases and conditions recommended by the American College of Medical genetics and the March of Dimes. The Department also tracks mandatory screening for newborn hearing and critical congenital heart defects.

Developing a comprehensive, coordinated, seamless system of supports and services for CSHCN and their families is imperative to promote health, wellness and self-sufficiency. NY is fortunate to have extensive supports and services for CSHCN in NYS. This includes NY's NBSP that performs blood testing and processes the data from over 270,000 specimens annually for 47 diseases and conditions, including all core conditions recommended by the American College of Medical Genetics and the March of Dimes. Follow-up is provided through condition-specific Specialty Care Centers located throughout NYS.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**New York State Early Hearing Detection and Intervention - Referred For Treatment**
	Fiscal Year:	**2017**
	Column Name:	**Other Newborn**

Field Note:
The NYS Department of Health, following the Joint Committee on Infant Hearing guidelines, strives to ensure all infants are screened by one month of age and, if needed, receive diagnostic evaluation by three months and early intervention services by six months. Early Hearing Detection and Intervention Program data reflect the number of infants screened, number with a positive screen (i.e., needing follow-up diagnostic testing), number confirmed with hearing loss or deafness, and number referred for treatment (i.e., early intervention services). Only young children identified with confirmed hearing loss or deafness are referred for early intervention services (treatment). Data are reported by providers to the Department’s online data system.

Data Alerts: None

Form 5a
Count of Individuals Served by Title V

State: New York

Annual Report Year 2017

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	158,432	48.1	0.0	50.7	1.2	0.0
2. Infants < 1 Year of Age	233,389	52.3	0.9	44.7	2.1	0.0
3. Children 1 through 21 Years of Age	785,755	34.3	4.8	57.7	3.2	0.0
3a. Children with Special Health Care Needs	524,750	52.2	0.0	44.4	3.4	0.0
4. Others	196,304	22.2	0.0	70.6	7.2	0.0
Total	1,373,880					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2017**
	Field Note: Data for 5a was pulled for reports provided by specific programs that are either directly funded by MCHSBG or funded by state and other funds but serve the MCH population.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2017**
	Field Note: Data for 5a was obtained from reports provided by specific programs that are either directly funded by MCHSBG or funded by state and other funds but serve the MCH population. The total number of infants in NYS was included as all infants receive some type of Title V funded or supported program including but not limited to Newborn Metabolic Screening, hearing screening, services through the perinatal system, home visiting among others. Title XIX estimate for Infants and Children was provided using NYS specific Medicaid/CHP health insurance data. Remaining percentages provided by HRSA.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2017**
	Field Note: Data for 5a was pulled for reports provided by specific programs that are either directly funded by MCHSBG or funded by state and other funds but serve the MCH population. Title XIX break out for Infants and Children was provided using NYS specific Medicaid/CHP health insurance data. Remaining percentages provided by HRSA.	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2017**
	Field Note: Data for 5a was obtained from reports provided by specific programs that are either directly funded by MCHSBG or funded by state and other funds but serve the MCH population. Data is not collected on whether children receiving Title XIX in NYS have special needs and therefore this is reported as 0% as NYS is unable to determine the %.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2017**
	Field Note: Data for 5a was pulled for reports provided by specific programs that are either directly funded by MCHSBG or funded by state and other funds but serve the MCH population.	
6.	**Field Name:**	**Total_TotalServed**

Fiscal Year:	**2017**

Field Note:
Data for 5a was pulled for reports provided by specific programs that are either directly funded by MCHSBG or funded by state and other funds but serve the MCH population.

Data Alerts: None

Form 5b
Total Percentage of Populations Served by Title V

State: New York

Annual Report Year 2017

Populations Served by Title V	Total % Served
1. Pregnant Women	100
2. Infants < 1 Year of Age	100
3. Children 1 through 21 Years of Age	64
3a. Children with Special Health Care Needs	31
4. Others	27

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2017**
	Field Note: Used National Vital Stats 2016 birth certificate 229,105. NYS women served by perinatal designation system of care.	
2.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2017**
	Field Note: 233,389 Adjusted NYS Vital records live births 2015. All infants receive newborn screening for more than 40 disorders.	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2017**
	Field Note: Numerator-number of children served by MCH programs/denominator total population US Census: Annual estimates of the civilian population by age and sex 3,305,029/5,181,860	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2017**
	Field Note: Numerator--number of children served by lead screening program Denominator-CSHCNs national prevalence from 2016 National Survey of Children's Health (.198) multiplied by 2017 US census of total population as used in #3. 315,310/1,026,008	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2017**
	Field Note: Numerator-number of others served by MCH programs/denominator 2016 American Community Survey 3,414,651/12,532,709	

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: New York

Annual Report Year 2017

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	229,105	109,708	32,845	52,333	374	25,450	1,398	3,599	3,398
Title V Served	229,105	109,708	32,845	52,333	374	25,450	1,398	3,599	3,398
Eligible for Title XIX	120,536	39,155	22,769	39,658	243	14,114	373	1,905	2,319
2. Total Infants in State	233,389	111,996	33,532	53,074	383	25,842	1,408	3,682	3,472
Title V Served	233,389	111,996	33,532	53,074	383	25,842	1,408	3,682	3,472
Eligible for Title XIX	122,366	39,727	23,248	40,153	250	14,307	375	1,941	2,365

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2017**
	Column Name:	**Total**
	Field Note:	
	.	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2017**
	Column Name:	**Total**
	Field Note:	
	NYS estimates serving 100% of deliveries through supports and services including but not limited to the statewide perinatal regionalized system, as well as evidence-based home visiting services and other services as noted in this application	
3.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2017**
	Column Name:	**Total**
	Field Note:	
	NY estimates 100% of infants receive Title V funded or supported services including but not limited to Newborn Metabolic Screening, hearing screening, services through the perinatal system, home visiting among others.	

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: New York

A. State MCH Toll-Free Telephone Lines	2019 Application Year	2017 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 522-5006	(800) 522-5006
2. State MCH Toll-Free "Hotline" Name	Growing Up Healthy Hotline	Growing Up Healthy Hotline
3. Name of Contact Person for State MCH "Hotline"	Amy Jesaitis	Amy Jesaitis
4. Contact Person's Telephone Number	(518) 474-1911	(518) 474-1911
5. Number of Calls Received on the State MCH "Hotline"		10,376

B. Other Appropriate Methods	2019 Application Year	2017 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address		
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: New York

1. Title V Maternal and Child Health (MCH) Director	
Name	Lauren Tobias
Title	Director, Division of Family Health
Address 1	New York State Department of Health
Address 2	Corning Tower RM 890
City/State/Zip	Albany / NY / 12237
Telephone	(518) 474-6968
Extension	
Email	lauren.tobias@health.ny.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Susan Slade
Title	Director, Bureau of Child Health
Address 1	New York State Department of Health
Address 2	Corning Tower RM 878
City/State/Zip	Albany / NY / 12237
Telephone	(518) 474-1961
Extension	
Email	susan.slade@health.ny.gov

3. State Family or Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: New York

Application Year 2019

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

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Reduce maternal mortality and morbidity	New	
2.	Reduce infant mortality & morbidity	New	
3.	Support and enhance social-emotional development and relationships for children and adolescents	New	
4.	Increase supports to address the special health care needs of children and youth	New	
5.	Increase the use of preventive health care services across the life course.	New	
6.	Promote oral health and reduce tooth decay across the life course	New	
7.	Promote home and community environments that support health, safety, physical activity and healthy food choices across the life course.	New	
8.	Reduce racial, ethnic, economic and geographic disparities and promote health equity for MCH population(cross-cutting).	New	

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 5

Field Note:

Including:
Primary
Preconception/ Interconception (“well woman”, including family planning)
Prenatal & Postpartum
Infants (“well baby”)
Children (“well child”)
Adolescents (“well teen”, including family planning)

Form 10a
National Outcome Measures (NOMs)

State: New York

Form Notes for Form 10a NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	80.7 %	0.1 %	185,073	229,239
2015	80.3 %	0.1 %	184,418	229,561
2014	79.1 %	0.1 %	182,737	231,024
2013	75.4 %	0.1 %	173,442	230,047
2012	74.5 %	0.1 %	173,825	233,372
2011	73.7 %	0.1 %	172,588	234,324
2010	73.9 %	0.1 %	174,690	236,300
2009	74.1 %	0.1 %	174,327	235,200

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	214.3	3.6	3,651	170,377
2014	214.9	3.1	4,895	227,786
2013	213.6	3.1	4,806	225,053
2012	207.9	3.0	4,789	230,394
2011	188.5	2.9	4,237	224,836
2010	187.7	2.9	4,236	225,683
2009	169.5	2.8	3,876	228,671
2008	147.2	2.5	3,409	231,579

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2016	19.2	1.3	228	1,188,226
2011_2015	20.6	1.3	246	1,195,255
2010_2014	20.9	1.3	251	1,202,356
2009_2013	20.6	1.3	250	1,211,693
2008_2012	22.2	1.4	272	1,225,096
2007_2011	21.2	1.3	262	1,237,631
2006_2010	20.5	1.3	256	1,246,423
2005_2009	19.9	1.3	248	1,248,399

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	7.9 %	0.1 %	18,573	233,979
2015	7.8 %	0.1 %	18,507	236,941
2014	7.9 %	0.1 %	18,722	238,423
2013	8.0 %	0.1 %	18,847	236,671
2012	7.9 %	0.1 %	19,074	240,654
2011	8.1 %	0.1 %	19,557	241,031
2010	8.2 %	0.1 %	20,049	244,116
2009	8.2 %	0.1 %	20,341	247,850

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	9.0 %	0.1 %	20,956	233,991
2015	8.7 %	0.1 %	20,531	236,998
2014	8.9 %	0.1 %	21,114	238,475
2013	8.9 %	0.1 %	21,052	236,558
2012	9.1 %	0.1 %	21,884	240,504
2011	9.2 %	0.1 %	22,117	240,932
2010	9.4 %	0.1 %	22,904	244,016
2009	9.5 %	0.1 %	23,527	247,770

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	23.5 %	0.1 %	54,862	233,991
2015	22.8 %	0.1 %	54,082	236,998
2014	22.7 %	0.1 %	54,104	238,475
2013	22.9 %	0.1 %	54,190	236,558
2012	23.4 %	0.1 %	56,356	240,504
2011	23.5 %	0.1 %	56,643	240,932
2010	24.2 %	0.1 %	59,001	244,016
2009	24.9 %	0.1 %	61,620	247,770

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016/Q2-2017/Q1	1.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	4.0 %			
2013/Q3-2014/Q2	4.0 %			
2013/Q2-2014/Q1	5.0 %			

Legends:

Indicator results were based on a shorter time period than required for reporting

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	5.2	0.2	1,234	237,919
2014	5.5	0.2	1,315	239,457
2013	5.8	0.2	1,386	237,712
2012	5.8	0.2	1,398	241,663
2011	6.1	0.2	1,483	242,097
2010	6.2	0.2	1,521	245,195
2009	6.3	0.2	1,561	248,922

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	4.6	0.1	1,098	237,274
2014	4.6	0.1	1,102	238,773
2013	4.9	0.1	1,169	236,980
2012	5.0	0.1	1,207	240,916
2011	5.1	0.2	1,236	241,312
2010	5.1	0.1	1,242	244,375
2009	5.4	0.2	1,331	248,110

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	3.2	0.1	747	237,274
2014	3.2	0.1	767	238,773
2013	3.5	0.1	829	236,980
2012	3.4	0.1	808	240,916
2011	3.5	0.1	855	241,312
2010	3.5	0.1	863	244,375
2009	3.7	0.1	918	248,110

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	1.5	0.1	351	237,274
2014	1.4	0.1	335	238,773
2013	1.4	0.1	340	236,980
2012	1.7	0.1	399	240,916
2011	1.6	0.1	381	241,312
2010	1.6	0.1	379	244,375
2009	1.7	0.1	413	248,110

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	168.2	8.4	399	237,274
2014	175.9	8.6	420	238,773
2013	184.0	8.8	436	236,980
2012	188.5	8.9	454	240,916
2011	182.3	8.7	440	241,312
2010	191.9	8.9	469	244,375
2009	197.9	8.9	491	248,110

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	56.5	4.9	134	237,274
2014	48.6	4.5	116	238,773
2013	55.7	4.9	132	236,980
2012	54.8	4.8	132	240,916
2011	51.4	4.6	124	241,312
2010	50.3	4.5	123	244,375
2009	60.9	5.0	151	248,110

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	8.3 %	0.7 %	17,596	213,268
2014	9.5 %	0.7 %	20,794	218,296
2013	9.5 %	0.8 %	20,516	216,615
2012	9.9 %	1.0 %	10,943	110,416
2011	8.4 %	0.7 %	18,417	218,407
2010	8.1 %	0.7 %	18,042	222,166
2008	7.3 %	1.0 %	8,464	115,245
2007	8.4 %	0.7 %	19,845	235,020

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	4.2	0.2	709	170,164
2014	3.7	0.1	858	229,739
2013	3.7	0.1	839	228,951
2012	2.8	0.1	646	231,715
2011	2.6	0.1	619	234,599
2010	1.9	0.1	443	237,744
2009	1.8	0.1	436	240,486
2008	1.5	0.1	353	240,674

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	8.4 %	1.4 %	317,135	3,758,559

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	13.1	0.8	272	2,071,007
2015	13.3	0.8	278	2,084,298
2014	14.7	0.8	306	2,084,950
2013	15.1	0.9	314	2,083,766
2012	14.5	0.8	303	2,084,583
2011	15.0	0.9	311	2,076,119
2010	13.9	0.8	291	2,087,905
2009	15.9	0.9	330	2,082,079

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	22.8	1.0	544	2,389,012
2015	21.5	0.9	517	2,409,802
2014	21.1	0.9	513	2,436,467
2013	22.7	1.0	557	2,458,767
2012	23.2	1.0	578	2,494,939
2011	25.8	1.0	651	2,520,885
2010	25.9	1.0	668	2,577,734
2009	27.0	1.0	702	2,603,195

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2016	5.0	0.4	187	3,750,090
2013_2015	5.7	0.4	215	3,792,482
2012_2014	6.1	0.4	233	3,850,581
2011_2013	6.6	0.4	257	3,911,971
2010_2012	6.7	0.4	269	3,998,477
2009_2011	7.5	0.4	305	4,071,307
2008_2010	7.2	0.4	296	4,137,652
2007_2009	8.2	0.4	339	4,159,162

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2016	5.0	0.4	189	3,750,090
2013_2015	4.6	0.4	175	3,792,482
2012_2014	5.2	0.4	201	3,850,581
2011_2013	5.6	0.4	218	3,911,971
2010_2012	5.7	0.4	227	3,998,477
2009_2011	5.2	0.4	212	4,071,307
2008_2010	4.2	0.3	175	4,137,652
2007_2009	3.9	0.3	163	4,159,162

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	18.3 %	1.7 %	765,082	4,185,517

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	11.0 %	2.7 %	83,973	765,082

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	2.5 %	0.6 %	83,469	3,349,664

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	7.5 %	1.3 %	246,377	3,292,586

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	45.3 %	6.7 %	169,907	375,487

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	89.3 %	1.6 %	3,694,889	4,139,390

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	14.3 %	0.1 %	27,888	195,413
2012	15.1 %	0.1 %	28,760	189,928
2010	16.1 %	0.1 %	30,128	186,760
2008	16.4 %	0.1 %	27,601	168,629

Legends:

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

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

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	13.1 %	0.8 %		
2013	10.6 %	0.5 %		
2011	11.0 %	0.6 %		
2009	10.8 %	0.9 %		
2007	10.8 %	0.6 %		
2005	10.3 %	0.7 %		

Legends:

Indicator has an unweighted denominator <100 and is not reportable

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	14.8 %	2.5 %	247,537	1,673,430

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	2.5 %	0.2 %	103,337	4,173,030
2015	2.5 %	0.1 %	105,108	4,203,284
2014	3.4 %	0.2 %	142,448	4,218,611
2013	4.1 %	0.2 %	172,518	4,229,729
2012	4.0 %	0.2 %	170,847	4,255,688
2011	4.4 %	0.2 %	188,067	4,276,363
2010	4.8 %	0.2 %	205,478	4,310,594
2009	4.8 %	0.2 %	211,576	4,422,300

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	72.3 %	2.2 %	241,764	334,596
2015	71.9 %	2.3 %	240,896	334,940
2014	70.7 %	2.7 %	239,796	338,984
2013	72.2 %	2.6 %	246,514	341,428
2012	63.7 %	2.3 %	218,450	343,098
2011	61.3 %	2.7 %	213,239	347,888
2010	49.0 %	2.8 %	172,031	351,332
2009	47.8 %	2.7 %	175,404	367,087

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	65.9 %	1.2 %	2,577,837	3,909,960
2015_2016	65.6 %	1.3 %	2,586,217	3,943,606
2014_2015	67.0 %	1.4 %	2,665,415	3,975,858
2013_2014	64.5 %	1.3 %	2,569,841	3,983,768
2012_2013	60.9 %	1.4 %	2,443,270	4,014,396
2011_2012	54.8 %	1.8 %	2,235,474	4,081,388
2010_2011	54.3 %	1.8 %	2,196,305	4,044,760
2009_2010	47.8 %	2.4 %	1,749,743	3,660,551

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen (Female)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	75.0 %	2.9 %	432,097	576,380
2015	62.3 %	3.3 %	363,188	583,147
2014	58.8 %	3.8 %	346,257	588,802
2013	61.7 %	3.2 %	364,115	589,991
2012	56.0 %	3.6 %	333,275	595,307
2011	46.6 %	3.0 %	282,584	605,855
2010	56.2 %	3.4 %	345,502	614,347
2009	48.8 %	3.8 %	310,829	636,755

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Teen (Male)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	68.2 %	3.0 %	411,503	603,093
2015	60.3 %	3.1 %	367,313	609,178
2014	49.8 %	3.5 %	306,506	615,513
2013	38.6 %	3.1 %	238,089	616,868
2012	17.9 %	2.6 %	111,455	621,393
2011	6.4 %	1.4 %	40,463	632,743

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	91.2 %	1.3 %	1,075,050	1,179,474
2015	89.0 %	1.5 %	1,061,525	1,192,326
2014	91.5 %	1.5 %	1,101,490	1,204,315
2013	89.5 %	1.5 %	1,079,545	1,206,859
2012	90.3 %	1.5 %	1,098,346	1,216,701
2011	88.5 %	1.3 %	1,096,560	1,238,598
2010	82.9 %	1.8 %	1,041,143	1,255,446
2009	69.2 %	2.4 %	901,124	1,302,154

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	89.2 %	1.5 %	1,052,380	1,179,474
2015	86.2 %	1.6 %	1,028,154	1,192,326
2014	79.6 %	2.1 %	958,880	1,204,315
2013	83.4 %	1.7 %	1,005,909	1,206,859
2012	78.5 %	2.1 %	954,645	1,216,701
2011	74.9 %	1.9 %	927,636	1,238,598
2010	71.2 %	2.3 %	893,640	1,255,446
2009	62.9 %	2.6 %	818,840	1,302,154

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	13.2	0.2	8,003	607,309
2015	14.6	0.2	8,961	612,905
2014	16.1	0.2	9,954	619,857
2013	17.6	0.2	11,128	630,896
2012	19.6	0.2	12,592	642,269
2011	21.0	0.2	13,718	652,723
2010	22.8	0.2	15,126	663,928
2009	24.2	0.2	16,306	673,401

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	12.2 %	0.9 %	25,899	212,047
2014	11.4 %	0.8 %	24,427	214,506
2013	11.0 %	0.8 %	23,561	213,692
2012	12.0 %	1.1 %	13,109	109,303

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	2.0 %	0.6 %	81,336	4,165,523

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: New York

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data		
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)		
	2016	**2017**
Annual Objective	73.4	73.8
Annual Indicator	68.4	73.3
Numerator	2,471,455	2,653,864
Denominator	3,612,104	3,619,067
Data Source	BRFSS	BRFSS
Data Source Year	2015	2016

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	77.4	78.4	79.4	80.3	81.3	82.2

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
annual objectives adjusted following review of data

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

FAD for this measure is not available for the State.

State Provided Data		
	2016	2017
Annual Objective	91	91
Annual Indicator	92.3	92.7
Numerator		
Denominator		
Data Source	NYS VS	NYS VS
Data Source Year	2014	2015
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	93.4	93.7	94.0	94.3	94.6	94.8

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2016	**2017**
Annual Objective	67.1	67.6
Annual Indicator	63.9	73.9
Numerator	135,686	155,836
Denominator	212,507	210,880
Data Source	PRAMS	PRAMS
Data Source Year	2013	2015

State Provided Data		
	2016	**2017**
Annual Objective	67.1	67.6
Annual Indicator	71.3	73.9
Numerator		
Denominator		
Data Source	PRAMS NYS	PRAMS NYS
Data Source Year	2014	2015
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	66.2	66.6	67.1	67.6	68.0	68.5

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: NYS PRAMS 2014 preliminary data as of 5/22/2017 Annual Objectives based on statewide data: 2017 67.1 2018 67.8 2019 68.4 2020 69.1 2021 69.8	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 2018 - 2023 Annual objectives have been updated to reflect 2013 as the baseline year.	

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

FAD for this measure is not available for the State.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	100
Data Source	NYS PRAMS
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 2016 NYS Data not available yet	

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

FAD for this measure is not available for the State.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	100
Data Source	2016
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 2016 NYS Data not available yet	

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		17.5
Numerator		101,178
Denominator		578,216
Data Source		NSCH
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	17.9	18.2	18.4	18.6	18.8	19.0

Field Level Notes for Form 10a NPMs:

None

NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Federally Available Data		
Data Source: Youth Risk Behavior Surveillance System (YRBSS)		
	2016	**2017**
Annual Objective	27.1	27.5
Annual Indicator	23.3	23.3
Numerator	161,704	161,704
Denominator	694,960	694,960
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2015	2015

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT		
	2016	**2017**
Annual Objective		
Annual Indicator		18.3
Numerator		246,053
Denominator		1,346,787
Data Source		NSCH-ADOLESCENT
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	18.8	19.0	19.2	19.4	19.7	19.9

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**Annual Objective**

Field Note:
Annual objectives have been updated to reflect the 2016 NSCH as the baseline

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

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		79.2
Numerator		1,103,856
Denominator		1,393,274
Data Source		NSCH
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	81.2	82.2	83.2	84.2	85.2	86.2

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**Annual Objective**

Field Note:
Annual objectives have been updated to reflect the NSCH 2016 data as the baseline

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	**2017**
Annual Objective		
Annual Indicator		15.3
Numerator		48,081
Denominator		314,730
Data Source		NSCH-CSHCN
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	15.7	15.9	16.1	16.3	16.4	16.6

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives have been updated to reflect the NSCH 2016 data as the baseline year	

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care - Adolescent Health - NONCSHCN

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - NONCSHCN	
	2017
Annual Objective	
Annual Indicator	12.3
Numerator	130,919
Denominator	1,062,218
Data Source	NSCH-NONCSHCN
Data Source Year	2016

Annual Objectives					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	12.7	12.9	13.1	13.2	13.4

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**

Field Note:
Annual objectives have been updated to reflect the NSCH 2016 data as the baseline year

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2016	**2017**
Annual Objective	57.2	57.6
Annual Indicator	54.9	51.7
Numerator	117,570	110,325
Denominator	214,301	213,585
Data Source	PRAMS	PRAMS
Data Source Year	2013	2015

State Provided Data		
	2016	**2017**
Annual Objective	57.2	57.6
Annual Indicator	53.5	51.7
Numerator		
Denominator		
Data Source	PRAMS NYS	PRAMS NYS
Data Source Year	2014	2015
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	56.8	57.2	57.6	58.0	58.4	58.8

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**Annual Objective**

Field Note:
Annual objectives have been updated to reflect updated data

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		77.6
Numerator		2,955,156
Denominator		3,810,186
Data Source		NSCH
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	79.6	80.7	81.5	82.5	83.4	84.4

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**Annual Objective**

Field Note:
Annual objectives have been updated to reflect the NSCH 2016 data as the baseline year

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Adolescent Health

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	79.6	80.7	81.5	82.5	83.4	84.4

Field Level Notes for Form 10a NPMs:

None

Form 10a
State Performance Measures (SPMs)

State: New York

SPM 1 - The percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		45
Annual Indicator	36.4	35.2
Numerator		
Denominator		
Data Source	BRFSS	BRFSS
Data Source Year	2014	2016
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	36.4	36.4	38.2	38.2	40.1	40.1

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: 2014 estimate revised to closer align with the performance measure.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: The BRFSS is a survey, and therefore the weighted proportion of reproductively capable women who reported talking with a health care worker about ways to prepare for a healthy pregnancy before pregnancy is reported. The BRFSS sample size was larger to provide regional estimates for 2016 causing a delay in final calculation of the measure. Annual objectives have been modified to reflect 5% increase from baseline to 38.2 by 2020. With a projection of 5% increase every 2 years.	

SPM 2 - The percentage of women aged 15 to 44 years that adopt or continue use of the most effective or moderately effective methods of contraception.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		8
Annual Indicator	27	24.5
Numerator		
Denominator		
Data Source	Medicaid Claims	Medicaid Claims
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	25.0	25.0	26.3	26.3	27.6	27.6

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
NYSDOH OQPS created a CMS Developmental Measure of most and moderately effective contraception use in females 15-44 years of age.

SPM 3 - The percentage of children and adolescents survey who demonstrate 20 or more developmental assets

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		50
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	To Be Developed	Developmental Assessment Tool
Data Source Year	2017-2018	2017-2018
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	50.0	50.0	50.0	50.0	50.0	50.0

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Three validated tool constructs developed with 23 developmental assets. Comprehensive Adolescent Pregnancy Prevention (CAPP) programs began piloting surveys in January 2018. Data not yet available.

SPM 4 - The percent of families participating in the Early Intervention Program who meet or exceed the state's standard for the New York Impact on Family Scale

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		65
Annual Indicator	61.6	70.1
Numerator	673	1,021
Denominator	1,092	1,456
Data Source	New York Family Survey	New York Family Survey
Data Source Year	2015-2016	2016-2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	65.5	71.0	71.5	72.0	72.5	73.0

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Data collection: 7/1/2015-6/30/2016	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Data collection: 7/1/2016-6/30/2017. The annual objectives were set in conjunction and through consensus with the state's Early Intervention Coordinating Council. The quality improvement initiative to improve this measure has resulted in exceeding the target originally set, but this is only the second year of data. These objectives have been updated as requested. They will differ from the state's Early Intervention Program State Performance Plan/Annual Performance Report (SPP/APR) reported to the US Department of Education.	

SPM 5 - The percentage of NYS residents served by community water systems that have optimally fluoridated water

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		72
Annual Indicator	71.7	71.6
Numerator		
Denominator		
Data Source	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	73.0	75.0	77.0	78.5	78.5	78.5

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
The slight decrease in fluoridation percentage is associated with the identification and correction of discrepancies between the New York State section of the Environmental Protection Agency's Safe Drinking Water Information System and the Centers for Disease Control and Prevention's Water Fluoridation Reporting System databases (systems added/deleted, population change, New York City (NYC) System moved their fluoridation injection point - 6 systems now purchasing non-fluoridated water from NYC).

Form 10a
Evidence-Based or –Informed Strategy Measures (ESMs)

State: New York

ESM 1.3 - Percentage of DFH procurements that complete community listening forums as part of concept development process.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		40
Annual Indicator	5	5.3
Numerator		1
Denominator		19
Data Source	Title V Program Records	Title V Program Records
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	5.0	5.0	11.0	16.0	21.0	26.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Annual Objectives have been adjusted to reflect programs initiating community listening forums in the third year.

ESM 1.7 - The number of relevant Title V programs that demonstrate incorporation of strategies to reinforce well-woman and preconception health care services.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	11	7
Numerator		
Denominator		
Data Source	NYS Title V Program Records	NYS Title V Program Records
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	7.0	7.0	7.0	8.0	8.0	8.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: 11 of 17 relevant Title V programs incorporated strategies to reinforce well-woman and preconception health care services	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 7 of 16 Title V programs reported the incorporation of strategies to reinforce well-woman and preconception health care services	

ESM 1.14 - Percentage of women enrolled in Medicaid who are screened for maternal depression during postpartum care.

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	87
Annual Indicator	6.2
Numerator	
Denominator	
Data Source	Medicaid claims
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	6.4	6.6	6.8	7.0	7.2	7.4

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
There was a modification to the Numerator for this ESM, which is currently using number of postpartum women enrolled in Medicaid who are screened for depression during postpartum care (during subsequent year from the delivery date). The data source captures 9/1/2016-8/31/2017. Given the modification in the ESM, the annual objectives have been modified.

ESM 3.1 - Percentage of birthing hospitals re-designated with updated standards.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		0
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	NYS Title V Program records	NYS Title V Program records
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	0.0	0.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
New York is continuing efforts to update standards for perinatal level of care. Due to the complexity of the initiative, it is anticipated that birthing center and hospital re-designations will not occur until 2020.

ESM 5.5 - Percent of infants, sleeping or awake-and-unattended in crib, in a safe sleep environment

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	90
Annual Indicator	91.7
Numerator	
Denominator	
Data Source	NYS sampled Birthing Hospitals
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	90.0	90.0	90.0	92.0	92.0	92.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.5 - Number of children with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		0
Annual Indicator	0	1,694
Numerator		
Denominator		
Data Source	NYS Medicaid Health Home Data	NYS Medicaid Health Home Data
Data Source Year	2016-17	2017-18
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	1,600.0	1,680.0	1,764.0	1,852.0	1,889.0	1,927.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Not Available Yet	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Children age 0-12 with documented serious emotional disturbance and/or complex trauma enrolled in Health Home Serving Children December 2016-February 2018. Health Homes for children did not begin until Dec. 16. Estimated 5% increase 2020 and 2021 and a 2% increase 2022 and 2023.	

ESM 8.2.1 - Number of community environmental changes demonstrated as a result of enhanced collaborations.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	1	6
Numerator		
Denominator		
Data Source	Title V Program data	Title V Program data
Data Source Year	7/16-6/17	16-18
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	6.0	7.0	8.0	9.0	10.0	11.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Data Source Year: 10/1/16-3/31/18
10 programs/initaitives were identified as having collaborative activities working towards community-, environmental, or policy/systems-level goals this reporting period. 6 met their goals (or had some local contractors meet their goals), for 60% success.

ESM 10.3 - Number of adolescents with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home.

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	1,000
Annual Indicator	1,060
Numerator	
Denominator	
Data Source	NYS Medicaid Health Home Data
Data Source Year	2017-18
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	1,000.0	1,050.0	1,103.0	1,125.0	1,147.0	1,170.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Adolescent age 13-21 with serious emotional disturbance and/or complex trauma enrolled in a Health Home Serving Children December 2016-February 2018.

ESM 10.4 - Number of strategies implemented to improve adolescent use of preventive health care services.

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	1
Annual Indicator	1
Numerator	
Denominator	
Data Source	NYS Title V Program Records
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
The numerator for last year was the number of actions taken to develop strategies. This measure and the work on adolescent health has progressed, and will continue to evolve as more work is accomplished. Instead of a discreet number of actions, we now have a comprehensive strategy to improve adolescent health. There is 1 comprehensive strategy to improve adolescent use of preventive health care services.

ESM 12.7 - Percentage of infants with initial abnormal hearing screening results for whom follow-up is documented in NYEHDI-IS.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		45
Annual Indicator	63.9	66.9
Numerator	4,275	5,244
Denominator	6,688	7,843
Data Source	NYEHDI	NYEHDI
Data Source Year	CY2016	CY2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	60.0	67.0	70.0	72.0	75.0	77.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
The annual objectives were decreased because, while the state is improving, the improvement is slower than originally projected.

ESM 13.1.1 - Percentage of pregnant women served by Title V community health workers that have a documented screening or referral for dental services.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		10
Annual Indicator	36.7	45.3
Numerator		
Denominator		
Data Source	MICHC reports	MICHC reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	50.0	50.0	50.0	50.0	50.0	55.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.2.1 - Number of public water systems that receive financial and/or technical support from NYSDOH to maintain or initiate community water fluoridation.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		20
Annual Indicator	58	60
Numerator		
Denominator		
Data Source	NYS Title V Program records	NYS Title V Program records
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	60.0	61.0	61.0	62.0	62.0	63.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.2.2 - Percentage of 2nd and 3rd graders served by School-Based Dental Programs who receive sealants.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		40
Annual Indicator	61.2	50.5
Numerator		
Denominator		
Data Source	SEALS (CDC Data)	SEALS (CDC Data)
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	41.0	44.0	47.0	50.0	53.0	56.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
The discrepancias in the numbers from report years. 2016 to 2017 can be attributed to DOH staff were data entering handwritten documents that had errors. Those errors would prevent forms from being data entered. Starting 2017, providers data enter their own forms.

Form 10b
State Performance Measure (SPM) Detail Sheets

State: New York

SPM 1 - The percentage of women age 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Increase from baseline the percent of women aged 18 to 44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy.
Definition:	**Numerator:** Female BRFSS respondents 18 – 44 years old who are reproductively capable and who report ever talking with their health care provider about ways to prepare for a healthy pregnancy **Denominator:** All female BRFSS respondents 18-44 years old who are reproductively capable **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	N/A
Data Sources and Data Issues:	NYS BRFSS survey data In some survey years, number of respondents meeting criteria for this measure may be small.
Significance:	Incorporating preconception health care in routine health care for all women of reproductive age is critical to several NYS Title V priorities and strategies.

SPM 2 - The percentage of women aged 15 to 44 years that adopt or continue use of the most effective or moderately effective methods of contraception.
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Increase from baseline the percent of women aged 15 to 44 years that adopt or continue use of the most effective or moderately effective methods of contraception
Definition:	**Numerator:** Continuously enrolled female Medicaid recipients, 15-44 years of age, at risk for unintended pregnancy, initiating or continuing use of most or moderately effective contraception in the assessment period (year). **Denominator:** Continuously enrolled female Medicaid recipients, 15-44 years of age at risk for unintended pregnancy **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	FP – 16: Increase the percentage of women aged 15 to 44 years that adopt or continue use of the most effective or moderately effective methods of contraception. HP2020 uses the National Survey of Family Health to measure.
Data Sources and Data Issues:	NYS proposes to use Medicaid claims data to measure. NYSDOH OQPS is creating a CMS Developmental Measure of most and moderately effective contraception use in females 15-44 years of age. Baseline to be established and targets for improvement to be determined as part of implementation
Significance:	Unplanned and closely spaced pregnancies have less healthy maternal and infant outcomes. Increased rate of use of most/moderately effective contraception will help improve birth spacing and pregnancy planning. This is a shared priority for Title V and Medicaid in NYS.

SPM 3 - The percentage of children and adolescents survey who demonstrate 20 or more developmental assets
Population Domain(s) – Child Health, Adolescent Health, Children with Special Health Care Needs

Measure Status:	Active
Goal:	Increase the percentage of children surveyed who demonstrate 20 or more developmental assets by 10% from baseline
Definition:	**Numerator:** Number of children and adolescents surveyed who demonstrate 20+ developmental assets **Denominator:** Number of children and adolescents surveyed **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	N/A
Data Sources and Data Issues:	Developmental assessment tool to be adopted/ established (tentative consideration for Search Institute tool). Validated constructs on self-efficacy, healthy decision-making, and youth-adult connectedness identified by CAPP programs.
Significance:	Positive social-emotional development and the presence of assets has been associated with positive health and wellbeing outcomes. Measurement of positive developmental assets among young people served by Title V Programs will provide a strong basis for informed youth development activities and interventions.

SPM 4 - The percent of families participating in the Early Intervention Program who meet or exceed the state's standard for the New York Impact on Family Scale
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Increase the percent of families participating in the Early Intervention Program who meet or exceed the state's standard for the New York Impact on Family Scale
Definition:	**Numerator:** Number of respondent families participating in Early Intervention who meet the State's standard (person mean >=576) on the New York Impact on Family Scale **Denominator:** Number of respondent families **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	N/A
Data Sources and Data Issues:	Data will be collected using the New York Family Survey, which includes the NYS Impact on Family Scale and is conducted annually with a representative sample of families whose children exited the Part C Early Intervention Program in the year.
Significance:	Positive impact on families, including families of CSHCN, is central to the mission of our Title V Program. This measure is associated with New York's State Systemic Improvement Plan approved by the U.S. Department of Education, Office of Special Education Programs and thus aligns Title V and Early Intervention goals. New York is one of five states focusing on improved family outcomes as part of results-driven accountability for Part C early intervention program for infants and toddlers with disabilities and their families.

SPM 5 - The percentage of NYS residents served by community water systems that have optimally fluoridated water
Population Domain(s) – Women/Maternal Health, Perinatal/Infant Health, Child Health, Adolescent Health

Measure Status:	Active
Goal:	Increase the percentage of NYS residents served by community water systems that have optimally fluoridated water
Definition:	**Numerator:** Number of residents served by community water systems with optimal fluoride levels **Denominator:** Number of NYS residents served by community water systems **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	OH13- Increase the proportion of the US population served by community water systems with optimally fluoridated water
Data Sources and Data Issues:	CDC Water Fluoridated Reporting System
Significance:	Community water fluoridation reduces the prevalence and severity of tooth decay

Form 10b
State Outcome Measure (SOM) Detail Sheets

State: New York

No State Outcome Measures were created by the State.

Form 10c
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: New York

ESM 1.3 - Percentage of DFH procurements that complete community listening forums as part of concept development process.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Integrate an equity framework into the development of all DFH/Title V procurements through community listening forums conducted as part of the concept development process.
Definition:	**Numerator:** Number of DFH procurements that include community listening forums as part of concept development process **Denominator:** Number of procurements released by DFH **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Title V Program records
Significance:	Understanding the myriad of social, political, and environmental factors that contribute to issues and factors that drive health disparities is a complex and ongoing task. By providing opportunities for that input in the earliest stages of program development, we will allow for the opportunity to refine the approach and scope of programs to better meet the needs of our priority populations while engaging and empowering affected populations

ESM 1.7 - The number of relevant Title V programs that demonstrate incorporation of strategies to reinforce well-woman and preconception health care services.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Incorporate performance measures and strategies to reinforce use of well-woman care including pregnancy planning and prevention across core Title V programs serving women of reproductive age.
Definition:	**Numerator:** The number of relevant Title V programs that demonstrate incorporation of strategies to reinforce well-woman and preconception health care services. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 20
Data Sources and Data Issues:	NYS Title V Program records
Significance:	Incorporation of performance measures and strategies can reinforce use of well-woman care including pregnancy planning and prevention across core Title V programs serving women of reproductive age.

ESM 1.14 - Percentage of women enrolled in Medicaid who are screened for maternal depression during postpartum care.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Collaborate with partners to increase screening and follow-up support for maternal depression.
Definition:	**Numerator:** Number of postpartum women enrolled in Medicaid who are screened for depression during postpartum care. **Denominator:** The number of postpartum women enrolled in Medicaid who are receiving postpartum care. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Medicaid Claims data
Significance:	Increases in screening for postpartum depression will result in increased referral and treatment rates for depression. Nearly 50% of pregnant women are enrolled in Medicaid in NYS.

ESM 3.1 - Percentage of birthing hospitals re-designated with updated standards.
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	Update NYS perinatal regionalization standards and designations and implement updated performance measures for Regional Perinatal Centers and affiliate birthing hospitals.
Definition:	**Numerator:** Number Birthing Facilities Re-designated **Denominator:** Total Number Birthing Facilities in the state **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	NYS Title V Program records - current list of birthing facilities and updated list as birthing hospitals are re-designated.
Significance:	It is imperative for NYS to ensure all perinatal hospitals are functioning in accordance with current standards of care for both maternal and infant outcomes. The last comprehensive review of NY's regionalized system was in the early 2000s.

ESM 5.5 - Percent of infants, sleeping or awake-and-unattended in crib, in a safe sleep environment
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	At least 90% of infants, sleeping or awake-and-unattended, will be in a safe sleep environment during their hospital stay.
Definition:	**Numerator:** Number of infants, sleeping or awake and unattended in crib, positioned supine, in safe clothing, with head of crib flat and crib free of objects **Denominator:** Number of cribs audited **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	NYS sampled Birthing Hospitals Data are collected by 56% (69/123) of NYS birthing hospitals, with hospital staff performing crib audits on a sample of at least 20 infant cribs per month. Data are submitted via the NYSDOH Health Commerce System on a monthly basis. These data represent ~40% of births in NYS.
Significance:	It is important that hospitals are modeling safe sleep practices and educating parents/caregivers so that the parents/caregivers will have the knowledge and self-efficacy to practice safe sleep at home.

ESM 6.5 - Number of children with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Continue to provide subject matter and technical support to NY’s Medicaid Health Home Program to implement enhanced care coordination for eligible children and adolescents with serious emotional disturbance and complex trauma.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of children with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home</td></tr>
<tr><td>Denominator:</td><td>N/A</td></tr>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>10,000</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>NYS Medicaid Health Home Data</td></tr>
<tr><td>Significance:</td><td>Children enrolled in a Medicaid Health Home are more likely to access key health care services and receive coordinated care across multiple systems, which may lead to better health outcomes and reduction of unnecessary emergency room visits and hospital stays.</td></tr>
</table>

ESM 8.2.1 - Number of community environmental changes demonstrated as a result of enhanced collaborations.
NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Enhance collaboration with key partners at the state or local levels to advance changes at the community-, environmental- or policy/systems-levels that promote maternal and child health
Definition:	**Numerator:** Number of DFH programs/initiatives in the Denominator reporting meeting their community-, environmental- or policy/systems-level goals during the reporting period. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Title V Program data DFH staff were surveyed once to identify those belonging in the denominator, then were surveyed again after the reporting period to report on progress towards meeting goals.
Significance:	As highlighted in the needs assessment, both families and providers identified the critical role that home and community environments play in health outcomes and health behaviors. Factors including access to healthy affordable food and places to engage safely in physical activity have significant impact on families' health and well-being. These perceptions are consistent with broader and longstanding public health approaches aimed at supporting "healthycommunities", including strong commitments to community-driven change, policy and environmental change strategies (vs. individual-level strategies), and a focus on addressing social determinants of health rather than treating disease. Title V programs cannot impact in isolation all of areas of social determinants of health, making collaboration a critical focus of DFH.

ESM 10.3 - Number of adolescents with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Continue to provide subject matter and technical support to NY's Medicaid Health Home Program to implement enhanced care coordination for young adults with serious emotional disturbance and complex trauma.
Definition:	**Numerator:** Number with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 20,000
Data Sources and Data Issues:	NYS Medicaid Health Home Data
Significance:	Adolescents enrolled in a Medicaid Health Home are more likely to access key health care services and receive coordinated care across multiple systems, which may lead to better health outcomes and reduction of unnecessary emergency room visits and hospital stays.

ESM 10.4 - Number of strategies implemented to improve adolescent use of preventive health care services.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Improve adolescent access to/utilization of preventive health care by implementing strategies to support adolescent access to preventive care through BWIAH programs serving adolescents.
Definition:	**Numerator:** Number of actions taken to develop strategies (i.e. literature review, surveys, focus groups) **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	NYS Title V staff reporting activities completed. (Eventually, number of BWIAH programs serving adolescents which have implemented strategies)
Significance:	Adolescents having access to preventive care services will aid in healthy lifestyle and healthy behavior choices, knowledge for those with existing chronic conditions, and encourages the adolescent to manage care for themselves.

ESM 12.7 - Percentage of infants with initial abnormal hearing screening results for whom follow-up is documented in NYEHDI-IS.
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	Provide technical assistance and facilitate a structured quality improvement project to engage health care providers, parent representatives, & audiologists to improve reporting of initial hearing screening and follow up results into the NYEHDI-IS.
Definition:	**Numerator:** Number of infants who receive a follow-up hearing screening, diagnostic evaluation or referral to Early Intervention that is documented in NYEHDI-IS **Denominator:** Number of infants who receive an abnormal newborn hearing screening. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	NYEHDI System Data
Significance:	Infants with abnormal hearing screening will have follow-up.

ESM 13.1.1 - Percentage of pregnant women served by Title V community health workers that have a documented screening or referral for dental services.
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active
Goal:	Integrate oral health messages and strategies within existing community-based maternal and infant health programs.
Definition:	**Numerator:** Number of pregnant women served by the Title V community health workers that have a documented screening or referral for dental services **Denominator:** Number of pregnant women served by Title V community health workers **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Reports from MICHC grant (Bureau of Women, Infant and Adolescent Health)
Significance:	Our current pilot project promotes community-level systems changes to integrate oral hygiene practices and information about services within MICHC and link families with dental services. Successful strategies gleaned from this initiative will be disseminated to other MICHC, and potentially other home visiting projects.

ESM 13.2.1 - Number of public water systems that receive financial and/or technical support from NYSDOH to maintain or initiate community water fluoridation.
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Provide financial and technical support for maintenance and expansion of community water fluoridation.
Definition:	**Numerator:** Number of public water systems that receive financial and/or technical support from NYSDOH **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	NYS Title V Program records
Significance:	CWF improves oral health by reducing the prevalence and severity of tooth decay. DOH provides financial and other technical assistance directly and via contractor to support local water systems.

ESM 13.2.2 - Percentage of 2nd and 3rd graders served by School-Based Dental Programs who receive sealants.
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Increase the delivery of evidence-based preventive dental services across key settings: • school-based clinics • primary care practices • public health nutrition programs.
Definition:	**Numerator:** Number of 2nd and 3rd grade children who received sealants in School-Based Health Center – Dental (SBHC-D) **Denominator:** Number of children in 2nd and 3rd grade who are enrolled in SBHC-D programs **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	SEALS/ CDC Data
Significance:	Evidence based programs such as school-based or linked dental sealant programs have the potential to reduce the burden of oral diseases.

Form 11
Other State Data

State: New York

The Form 11 data are available for review via the link below.

Form 11 Data