Maternal and Child Health Services Title V Block Grant

New York

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FY 2020 Application/ FY 2018 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 15, 2019

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 2020 Maternal and Child Health Services Block Grant Application and FFY 2018 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, NYS Title V Program and
Director, Division of Family Health

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 with special health care needs—and their families. Administered by the Health Resources and Services Administration Maternal and Child Health Bureau (MCHB), Title V provides core funding to states for MCH public health activities.

States submit an annual application and report in accordance with MCHB guidance. This year's application from New York State Department of Health (NYSDOH) reflects continued commitment to promote the health of the MCH community. Building on previous work, this application reflects an in-depth analysis of data and strategies to address the State Priorities and achieve the 2020 State Objectives. There is a strong emphasis on understanding and addressing social determinants of health to address health disparities and on listening to communities about their wellbeing. It reflects a concerted effort to build a comprehensive system of supports for children and youth with special health care needs (CYSHCN) and their families. It discusses significant work over the past 4 years to implement the State Action Plan (SAP) for the 8 core priorities across 6 MCH population health domains: maternal and women's health, perinatal and infant health, child health, adolescent health, CYSHCN and cross-cutting life course. It reflects lessons that will help NY's Title V program build a stronger system in years to come, input from DOH and MCH partners, and significant input from families, providers and other stakeholders.

NY's 8 priorities are:

1. Reduce maternal mortality & morbidity
2. Reduce infant mortality & morbidity
3. Support and enhance social-emotional (SE) 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 healthcare 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 NYSDOH, Title V activities are led by the Division of Family Health (DFH). As the Title V program, Division of Family Health provides leadership on MCH, directly oversees many MCH programs and initiatives and collaborates with other external MCH-serving programs. A critical role of NY's Title V program is to ensure the MCH population's needs are addressed through state policy initiatives.

NY is committed to ensuring that supports and services align with community wishes and needs; activities are informed by input from: the MCHSBG Advisory Council, Parent to Parent of NY, Schuyler Center for Advocacy and Analysis, American Academy of Pediatrics; Association of Regional Perinatal Programs and Networks, MCH Committee of the NYS Association of County Health Officials, NYS Perinatal Association, and other providers and stakeholders.

NY's application reflects stakeholder input, program accomplishments, emerging issues, challenges and plans for each of the 6 MCH population domains.

Domain 1–Maternal/Women's Health

Maternal mortality (MM) is devastating to women, families and communities. Addressing factors that lead to MM 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." The governor's commitment to target MM and reduce disparities is evident in his multi-pronged plan that includes a greater focus on disparities, expanding community outreach and taking actions to increase perinatal care access. Title V staff play a significant role to support these efforts, including establishing a Maternal Mortality Review Board (MMRB).

NY has made great strides to improve birth outcomes but striking disparities remain. Outcomes of concern are high rates of unintended pregnancy, short birth intervals, stagnant early prenatal care rates, and high rates of MM. Improving women's health, preconception/interconception health, including pregnancy planning and prevention, is key to meeting objectives. Successes include robust surveillance systems, generous Medicaid coverage, a statewide MM review system, a strong perinatal hospital system, effective clinical quality improvement (QI), evidence-based community initiatives, and strong partnerships with stakeholders. NY's SAP works to: strengthen and expand MM reviews and apply findings to address factors identified; improve the health of women through health insurance access; integrate preconception/interconception health into routine women's healthcare; develop strategies to address NY's increasing opioid use epidemic and develop strategies to address maternal depression.

Title V leads efforts to improve women's health with a focus on women's ability to control their reproductive health, ensuring all women have access to comprehensive reproductive healthcare through programs (e.g., comprehensive family planning services) and generous health benefits. NY will continue to incorporate a social justice framework into women's health, including contraception, to advance health equity.

Domain 2–Perinatal/Infant's Health

Infant mortality has been steadily declining, but striking disparities remain. Successes include the continued standards update for a statewide regionalized perinatal care system with metrics to assess outcomes, strong community-based services (e.g., evidence-based home visiting), clinical QI initiatives with birthing hospitals, and strong partnerships. NY's SAP includes continuing to improve the perinatal hospital system, especially ensuring the health and wellbeing of both women and newborns are addressed and ensuring the system accounts for a changing healthcare landscape; increasing family retention in evidence-based home visiting programs; promoting safe sleep practices; and collaborative efforts to combat increasing rates of neonatal abstinence syndrome due to opiate use.

Domain 3–Child Health

Most of NY's children are in good health, with lower mortality and hospitalization rates and high rates of health insurance coverage. A Title V priority is the social emotional (SE) and behavioral health needs of children. Accomplishments include stakeholder partnerships (e.g., Early Childhood Advisory Council, Early Intervention Coordinating Council), generous public health insurance options, rich networks of healthcare providers including one with the largest School Based Health Center (SBHC) programs in the nation, and significant investments in child-serving programs. To further strengthen capacity, NY's SAP incorporates strategies to: expand analysis of population health data on SE wellbeing and adverse childhood experiences (ACE); enhance training for Title V staff and partners on SE development and trauma-informed practice; and integrate additional evidence-based practices for promoting SE wellbeing across programs. Efforts such as the First 1000 Days on Medicaid initiative is an opportunity to work with partners to improve the health of all NY's children in particular and the MCH population in general.

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

Although most NY children are insured, families of CYSHCN report a lack of consistent, adequate healthcare coverage and lack of care coordination to meet special needs. Adolescents with special needs are challenged with navigating healthcare coverage and services as they transition to the adult care system. Accomplishments to better support CYSHCN include more health insurance options, comprehensive early intervention (EI) services for infants and toddlers with developmental delays and disabilities, engagement of Title V staff to develop and implement Medicaid Health Home (MHH) for children, including with serious emotional disturbance and complex trauma, family representation on advisory groups, and dedicated funding for local health department (LHD)-based services for families of CYSHCN. Parents report that the myriad services available to CYSHCN can be challenging to understand

and access, with significant gaps in some services or in specific areas of NY, and families feel isolated and CYSHCN do not have opportunities to be with children their own age in a meaningful way. NY's SAP includes enhanced analysis of existing CYSHCN data; using family input to set future direction for Title V in this area; continued efforts to improve reporting and follow-up of newborn screening; advancing improvement projects to enhance family support practices within EI including disseminating best practices to other Title V programs; continued strong engagement with Medicaid to support successful implementation of MHH for children; strengthening transition supports for young adults with Sickle Cell Disease; and seeking ways to enhance bi-directional communication between the Title V program and CYSHCN and their families. This year, NY's Title V Program will continue to facilitate discussions with CYSHCNs and their families and analyze available data to provide insight into improvements needed to ensure CYSHCN 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 SE wellbeing 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 persistent challenges for adolescents. Successes in NY include strong networks of youth-serving providers (e.g., SBHCs and community-based programs), policies that support access to health insurance and confidential healthcare services, increased efforts on sexual violence prevention and technical support for evidence-based programming through state-academic partnerships/ Centers of Excellence. NY's SAP includes adolescent-focused strategies mirroring those for the Child Health Domain to build internal and external capacity for promoting SE development and healthy relationships for teens.

Domain 6–Cross-Cutting/Life Course

Health equity is key to ensure all individuals can reach optimal health and wellness; racial, ethnic, economic, geographic, language, health literacy and other disparities are highlighted for virtually all outcomes and factors throughout this application. Efforts to promote health equity will continue to improve Title V program staff knowledge and understanding of health equity to foster improved supports and services to decrease disparities in health outcomes.

In NY's needs assessment, cross-cutting themes emerged: oral health, health insurance coverage and use of preventive healthcare services, community environments that support health, and striking disparities in most health outcomes. Successes include investments to maintain and expand community water fluoridation; continued funding for school-based preventive dental services; and support for interdisciplinary "place-based" health promotion initiatives, including efforts to address equity and social determinants of health.

NY's SAP outlines strategies for each of these cross-cutting priority areas, including: preconception healthcare to improve women's health and birth outcomes, 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 Federal Title V Funds Support State MCH Efforts

IIIA2 How Title V Funds Support State MCH Efforts

NY is committed to ensuring health and wellbeing in the MCH population. With generous Medicaid benefits, insurance available through the NYS of Health and significant state appropriations for MCH, Title V funds support the DOH infrastructure for Title V program work and augments state investments to support priority efforts, e.g., Title V funds support: a portion of family planning and adolescent health services; grants to the Regional Perinatal Centers for QI activities in 120 obstetrical hospitals to improve maternal and infant mortality and morbidity; grants to LHD for information and referral services for CYSHCN. NY's Title V application describes the extensive resources offered to NY's MCH population through complex MCH programs and initiatives and demonstrates NY's commitment to the health and wellness of all women, children and families.

III.A.3. MCH Success Story

DFH is committed to including community input in Title V work. Over the past year, NY's Title V program obtained input in 2 priority areas: racial disparities in maternal mortality and families of CYSHCN.

Voice Your Vision–Share Your Birth Story Listening Sessions— 244 women of color participated in 7 sessions in communities with poor birth outcomes to explore the barriers to obtaining care. Participants were recently or currently pregnant women, women who had an adverse birth outcome and families. Results revealed black women's struggles with inadequate supports and feelings of disrespect in their healthcare experiences. Participants expressed the desire to have more diversity in providers, believing that providers who reflect them will be better understand their needs.

Care Mapping for Families of CYSHCN— Title V staff systematically collected input from parents/caregivers with CYSHCN. A care mapping tool was used to understand needs and resources in providing care for CYSHCN and the changes needed to help them meet their needs. Feedback from 178 caregivers and 40 providers was gathered. Parents were recruited from the EI Partners Training, LHDs, Parent to Parent of NY, and with other stakeholders.

Lessons from these sessions are reflected in this application and includes valuable insight to inform a stronger framework for ongoing dialogue with communities to use in the 5-Year Needs Assessment process for the FY2021 application and to improve services for NY's families.

III.B. Overview of the State

II.A. Overview of the State

As of 2018, New York State (NYS) has the fourth largest population after California, Texas and Florida, with a population of 19.8 million. NYS is a diverse state with a substantial portion of its population being members of racial and ethnic minorities. Compared to the national population, in 2018, a larger percentage of NYS's population is Black (15.66% NYS: 13.4% US); Asian (8.35% NYS: 5.8% US); and Hispanic (19.2% NYS: 18.1% US). NYS also has a significantly larger foreign-born population (22.7% NYS: 13.7% US-2013-2017 data), and larger population speaking a language other than English at home (30.6% NYS: 21.3% US-2013-2017 data). NYS's cultural diversity is both a strength and challenge. Racial and ethnic minorities often face more obstacles accessing quality healthcare services than white Americans, even when they have insurance. A priority for NYS is to ensure that health care systems meet the needs of diverse populations to promote equity in health care and eliminate disparities in health access and outcomes. Throughout this application, NYS's commitment to health equity, especially focused on addressing the significant disparity in maternal mortality, will be evident.

In 2013-17, the percent of New Yorkers who graduated from high school was slightly below the national level (86.1% NYS: 87.3% US), while the percentage with a bachelor's degree or higher was higher at 35.3% versus 30.9%. NYS's per capita income in the past 12 months (2017 dollars – 2013-17) was higher than the national average ($35,752 NYS: $31,177 US), and NYS's median household income for 2013-17 was also higher ($62,765 NYS: $57,652 US). However, NYS's percentage of persons in poverty was higher than the national percentage (14.1% NYS: 12.3% US). Educational attainment has a major impact on income and is a significant factor in access to quality 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's population is dense; in 2018 there were 421 persons per square mile in NYS, ranking 12th out of 56 US states and territories. 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 8.5 million people (2015). NYS is also geographically diverse; population density varies widely, from 27,000 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 health care system. In 2017, 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, with rankings of the seventh highest ratio and 15th in the nation, respectively. NYS is home to more than 2,500 outpatient hospital and free-standing health clinics. This includes 47 Article 28 sponsoring facilities with approximately 262 school-based health centers (SBHC) of which 160 are Federally Qualified Health Centers (FQHC). To increase access to dental care, there is a system of 52 Article 28 sponsoring facilities which operate 1,940 SBHC-dental clinic sites across NYS. There is also a network of 172 family planning clinic sites. In addition, NYS 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 2019, there were 150 primary care Health Professional Shortage Areas (HPSAs), 103 dental HPSAs; and 145 mental health HPSAs. Of the total HPSAs, about 37% of HPSAs are in metropolitan areas; 63% are in rural or mostly rural (non-metropolitan) areas. More than 4 million New Yorkers live in a primary care HPSA.

The redesign of NYS'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 was twice the national average when compared on a per recipient basis. Since its inception in 2011, the Medicaid Redesign Team's (MRT) reforms have generated $8 billion in federal savings, which were reinvested through a 2014 Federal-state waiver in NYS's Delivery System Reform Incentive Payment program (DSRIP), currently in its fifth year. DSRIP led to a network of Performing Provider Systems (PPS) comprised of hospitals, individual providers, and community-based organizations, who collaborated to provide patients with community-based, higher quality, coordinated care. Through community-level collaborations and a focus on system reform, the ultimate goal of these projects is to achieve a 25% reduction in avoidable hospital use over 5 years. As of the second quarter of year three, the halfway mark of this initiative, PPS earned over $3 Billion in DSRIP funding with over 3 million patient engagements. PPS also successfully met all state and/or PPS implementation requirements for a total number of 44 completed projects. The focus on DSRIP in this last year is to build community services and decrease unnecessary hospitalizations, implement Value Based Payments (VBP) to ensure the reimbursement follows improved outcomes and to ensure these systems that have been supported and developed since the inception of DSRIP are integrated into the community and continue to support improved health outcomes for all New Yorkers.

In July 2017, Medicaid announced a new focus for Medicaid Redesign in NY: The First 1,000 Days on Medicaid initiative, recognizing that a child´s first three years are the most crucial years of their development. This effort ensures that NYS's Medicaid program is working with health, education and other system stakeholders to maximize outcomes and deliver results for the children served. The *First 1,000 Days* aims to improve lifelong educational and health outcomes by focusing on early childhood development. The ten initiatives being piloted by the NYS Department of Health (DOH) under its *First 1,000 Days* are:

- Create a Preventive Pediatric Care Clinical Advisory Group
- Increase early literacy by expanding the Reach Out and Read program and supplying books to families of young children at primary-care doctor visits
- Expand Centering Pregnancy, an evidence-based group prenatal care model in communities with poor birth outcomes
- Develop a NYS Developmental Inventory Upon Kindergarten Entry to assess school readiness
- Ensure sustainability of maternal infant home-visiting in three high-risk perinatal communities
- Require Managed Care Plans to have a Kids Quality Agenda
- Develop a "hub-and-spoke" data system for cross-sector health care referrals in three communities
- Explore Braided Funding for Early Childhood Mental Health Consultants
- Support Parent/Caregiver Diagnosis as Eligibility Criteria for Dyadic Therapy
- Launch peer family navigator services at five sites across NYS that help hard-to-reach families connect to early childhood health resources.

The collaborative approach of the MRT serves as an example of how public agencies can partner with stakeholders to develop innovative solutions. The efforts of the MRT benefit Medicaid members, health care providers, community-based organizations and other stakeholders, through efforts to improve quality care and reduce 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, NYS'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. NYS's Title V program works closely with the Office of Health Insurance Program (OHIP) that oversees NYS's Medicaid program.

NYS's Population Health Improvement Program (PHIP) complements DSRIP and advances the Prevention Agenda (PA, discussed below) and the State Health Insurance Program (SHIP). Priorities include integrating behavioral

health into primary care as well as addressing broad social determinants of health. This planning and integration also include 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 methodologies 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 members of the Maternity Care and the Children's Clinical Advisory Groups convened to develop and update the quality measure sets used for the VBP contracting on an annual basis.

In addition to DSRIP, the federal waiver amendment allows for comprehensive primary care transformation and commercial health plan multi-payer engagement through a Center for Medicare and Medicaid Innovation (CMMI)-funded State Innovation Model (SIM) grant. The goal is to build a highly functioning primary care model that includes behavioral and population health and is complemented by a strong workforce and engaged consumers, with supportive payment and common metrics. NYS has built a state aligned NYS Patient-Centered Medical Home (PCMH) model to achieve these goals. There are currently 2,400 practices and about 9,100 physicians recognized under the model and about 750 practices currently undergoing a transformation. The specific outcomes for this initiative include:

- Instituting a state-wide program of regionally-based primary care practice transformation to help practices across NY, adopt and use the NYS PCMH model
- Expand the use of VBP so that 80% of primary care is paid by value-based contracts 2020
- Expand the use of high-value primary care so that 80% of New Yorkers are receiving services in an advanced primary care setting by 2020
- Support performance improvement and capacity expansion in primary care by expanding NYS's primary care workforce through innovations in professional education and training
- Integrate NYS PCMH with population health through Public Health Consultants funded to work with regional PHIP contractors
- 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.

Further commitment to improving the health of all New Yorkers is evident in the PA that 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 wellbeing and preventing mental and substance use disorders; and, preventing communicable diseases. Title V staff directed the update in the PA 2019 – 2024 related to Promoting Healthy Women, Infants and Children and worked to ensure the alignment with NYS's Title V State Action Plan. The vision for the 2019-2024 PA highlights a Health in All Policies approach and a focus on healthy aging.

Regardless of the efforts to improve NYS's health care system, without health care coverage, New Yorkers are unable to access care. 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 NY State 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 2019, more than 4.7 million New Yorkers were enrolled in health care coverage, an increase of 435,000 people from 2018. Of those enrolled, nearly 272,000 enrolled in private qualified health plans (QHPs); 790,000 enrolled in the state's Essential Plan (described below), a 9% increase in QHP and Essential Plan from 2017-2018; 418,000 enrolled in Child Health Plus (CHP); and, 3.2 million enrolled in Medicaid. NYS's uninsured rate fell to 5% in 2018 - its lowest point in decades.

Individuals, families and small businesses can use the marketplace to compare insurance options, calculate costs and select coverage online, in-person, over the phone or by mail. New Yorkers may obtain MA and CHP coverage

through the Marketplace. NYSOH has certified more than 9,500 navigators, brokers, and Certified Application Counselors to provide free, in-person enrollment assistance to apply for coverage in 44 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.

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 NYS in January 2016 that makes pregnancy a qualifying event through the state-run exchange, making NYS the first state in the nation where the commencement of pregnancy allows a woman to enroll in a plan through the exchange. With the availability of the NYSOH marketplace, the uninsured rate for rural New Yorkers has declined by almost half, with many gaining insurance coverage for the first time.

NYS has benefitted from the receipt of Affordable Care Act (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. NYS also receives $3.5 million in State Sexual Risk Avoidance Education funds that support 15 organizations to provide sexuality education, adolescent pregnancy prevention and youth development. Over $9.1 million in Maternal, Infant and Early Childhood Home Visiting (MIECHV) funding is being used to implement evidence-based home visiting programs. Over $12 million in Prevention and Public Health funds have been used to support chronic disease prevention programs, including smoking cessation; evidence-based cancer screening and detection programs; and implementation of comprehensive population-based strategies in community and health systems settings 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 NYS's MCH services and work to reduce disparities.

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 NYS Council on Women and Girls in 2018 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, STEM and intersectionality. Over the past year, the Governor continued to promote efforts in support of women and families by launching the 2019 Women's Justice Agenda found at https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/WomensReport021919.pdf. It reflects Governor Cuomo's continued advocacy and support for equal rights for all New York's women. The comprehensive proposals included in the agenda take steps forward to improve access to reproductive healthcare, deliver justice to domestic violence survivors, close the pay gap, and ensure reproductive, economic and social justice for all NY women.

In January 2019 Governor Cuomo signed into law the Reproductive Health Act that codified *Roe v. Wade* into NYS law, clarified who can provide abortion care and removed abortion from the penal code, placing it in public health code. This law ensures that individuals have the ability to access the care they need to protect their health. NYS has always demonstrated a strong commitment to protect access to reproductive health options. In addition, the Governor advanced an aggressive strategy to ensure that all new mothers have access to screening and treatment for maternal depression, including insurance coverage for depression screening by both adult and pediatric primary care providers and launching an awareness campaign to provide information on symptoms and treatment options.

NYS's application reflects a strong commitment to promoting health equity and particularly focuses on addressing those factors that result in maternal mortality. For nearly eight years, the DOH has conducted a Maternal Mortality Review of all maternal deaths in NYS. While there have been modest improvements, more work remains, particularly since Black New Yorkers remain almost two to three times more likely to die in childbirth than white women. Recognizing this significant disparity, in April 2018 the Governor announced a comprehensive plan to target maternal mortality and reduce racial disparities in maternal health outcomes. The multi-pronged initiative includes

efforts to address maternal mortality with a focus on racial disparities, expanding community outreach and taking new actions to increase access to perinatal care. These efforts include:

- Create the Taskforce on Maternal Mortality and Disparate Racial Outcomes: The Taskforce, consisting of experts in the field and key stakeholders, was formed to provide expert policy advice and develop recommendations to improve maternal outcomes, addressing racial and economic disparities and reduce the frequency of maternal mortality and morbidity in NYS.
- Establish the Maternal Mortality Review Board (MMRB): At the recommendation of the Governor's Council on Women and Girls, the Governor directed the DOH to establish the MMRB comprised of health professionals who serve and/or are representative of the diversity of women and mothers across the state, to work in collaboration with the American College of Obstetricians and Gynecologists (ACOG) District II and NYS to review maternal deaths in NYS. The MMRB will also be tasked with making policy recommendations to the DOH to improve maternal outcomes by reducing maternal mortalities and morbidities, and recommendations will specifically contemplate racial and economic disparities and enhance the efforts of the DOH's Maternal Mortality Review Committee, established in 2010, that conducts a comprehensive, population-based examination of maternal mortality, to determine trends over time.
- Launch the Best Practice Summit with Hospitals and Obstetricians-Gynecologists (OB/GYNs): The Governor sponsored a summit in November 2018 with Greater New York Hospital Association, Healthcare Association of NYS, ACOG District II, and other stakeholders to discuss the issue of maternal mortality and morbidity, including racial disparities. The Summit addressed maternal mortality and morbidity statistics, as well as best practices to improve birth outcomes, community awareness of maternal mortality and disparities, current medical school curricula, graduate medical education and continuing education for physicians, with the goal of implementing immediate measures and identifying future action items to improve maternal care and management.
- Pilot the Expansion of Medicaid Coverage for Doulas: The DOH is piloting the expansion of Medicaid coverage for doulas that are non-medical birth coaches who support a pregnant person before, during or after childbirth, if needed. Certified doulas have been shown to increase positive health outcomes, including reducing birth complications.
- Support CenteringPregnancy Demonstration Projects: NYS increased support for CenteringPregnancy, a group prenatal care model designed to enhance pregnancy outcomes through a combination of prenatal education and social support and has been associated with reduced incidence of preterm birth and low birth weight, lower incidence of gestational diabetes and postnatal depression, higher breastfeeding rates and better inter-pregnancy spacing. It also been shown to narrow the disparity in preterm birth rates between black and white women.
- Require Continuing Medical Education and Curriculum Development: The Governor called on the State Board for Medicine to require appropriate practitioners to participate in continuing medical education on maternal mortalities and morbidities and disparate racial outcomes. Additionally, the DOH will work with medical schools, including the State University of New York's four medical schools, to incorporate information on maternal mortality and disparate racial outcomes into their medical school curriculum, graduate medical education and training for practicing physicians.
- Expand the New York State Perinatal Quality Collaborative: NYS expanded its collaboration with hospitals across NYS to review best practices to address hemorrhage and implement new clinical guidelines to reduce maternal mortality. Currently, over 80 hospitals are engaged voluntarily in this effort.
- Launch Commissioner Listening Sessions: Health Commissioner Zucker partnered with community activists to visit high-risk areas across the state to listen to local stakeholders, including pregnant women, to explore the barriers they face when pregnant or as new mothers. Information from these sessions will be used to enhance and support efforts to improve birth outcomes specifically related to women of color.

The Governor‘s Taskforce on Maternal Mortality and Disparate Racial Outcomes met three times and made a series of recommendations to the State; the top recommendations were included in the State Budget and include: resources to support the MMRB, the development and implementation of implicit bias training for health care

providers, expansion of the Community Health Worker Program, the development of a data warehouse for perinatal care and the formation of an expert panel to make recommendations around post-partum care. Additional information regarding these efforts are detailed under the Domain sections of this application. Title V staff are working closely with the Governor's Office and other key stakeholders and partners to improve birth outcomes, regardless of race, ethnicity and geographic location in NYS. Governor Cuomo remains strong in his support of NYS's MCH population directly aligned with the purpose and mission of Title V.

In January 2019, the Governor signed into law the Gender Expression Non-Discrimination Act, landmark legislation that protects the rights of LGBTQ people. This legislation bans the practice of conversion therapy. The law also prohibits employers, educational institutions, landlords, creditors, and others from discriminating against individuals based on gender identity or expression and make offenses committed on the basis of gender identity or expression, hate crimes under NYS law. Strong partnerships continue to bolster NYS's efforts in MCH.

NYS's Public Health Law (PHL) provides a strong legal foundation for DOH's efforts to promote and protect the health of individuals. The functions, powers and duties the Commissioner of Health and other DOH officers and employees are detailed in PHL Article 2 and 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 NYS'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 NYS's MCH population.
A key determinant of DOH's capacity to serve individuals 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.

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). NYS'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 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 NYS'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 protect the health of individuals. 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. Since a 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 2020 Application/FY 2018 Annual Report Update

Section III.C. Five-Year Needs Assessment Summary

Over the past year, Title V staff continued their focus on the strategies in each priority area. Data is analyzed on an ongoing basis to identify priority issues and progress in each domain. An emphasis was also placed on stakeholder input to ensure NYS's SAP and the PA was moving in synergy with issues and approaches identified by key partners. To identify further opportunities for collaboration and recommendations to strengthen the SAP as well as the PA, input was sought 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. NYS's MCHSBG Advisory Council provided input to ensure the needs of NYS's families were met. A major emphasis was placed on obtaining input directly from community members served. Direct community input will continue to be a foundation of NYS's five-year full needs assessment for FY 2021. A summary of relevant feedback can be found in Section III.F. Public Input. Although NYS 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, very good or excellent health; however, these data also demonstrate that women in this age group also 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 (MM) will continue to be a major focus in the coming year. The review of maternal deaths for 2012-2014 is complete. In addition, the program initiated data accuracy and consistency reviews of provisional death records for 2016-2017 to assess the veracity of the pregnancy check box and cause of death. This became a priority in light of findings from the 2012-2013 death reviews, where NYS's MM 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 MM and morbidity. Leading causes of maternal deaths based on the review of 2012-2014 cohort (N=96) included: embolism (not cerebral) (23%), hemorrhage (17%), infection (17%), cardiomyopathy (11%) cardiovascular problems (7%) and hypertensive disorders (6%). This shows a major change from the previous report when hypertensive disorders represented one of the top leading causes of death.

Recent data from NYS Vital Statistics showed that maternal deaths increased to 20.2 per 100,000 live births in 2014-2016. Racial disparities in maternal deaths are persistent; the statewide 3-year-rolling Black to White mortality ratio ranged from a high of 4.3 : 1 in 2005-2007 to a low of 3.1 : 1 in 2011-2013, with the most current ratio (2014-2016) being 3.2 : 1. The most recent data showed small geographic differences. In New York City, the Black to White ratio decreased from 3.4 : 1 in 2013-2015 to 2.8 : 1 in 2014-2016. This decrease in Black to White ratios was due to a slight increase in the maternal mortality rate among White women and the decrease in the maternal mortality rate among Black women. Outside New York City, the Black to White ratio increased slightly from 3.9 : 1 in 2013-2015 to

4.1 : 1 in 2014-2016. This increase in Black to White ratios was due to a slight increase in the maternal mortality rate among Black women and the stable maternal mortality rate among White women. The significance of social determinants of health cannot be underscored as a factor in this disparate health outcome. More focus is being placed on social determinants and how implicit bias impacts the birth outcomes of NYS's women.

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 (4.3 to 6.9). During the same 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%.

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. 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

Infant mortality is a critically important population indicator of maternal and child health and the overall health of a society. NYS'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 2016, up slightly from 4.6 per 1,000 live births in 2015.

Despite improvements, striking disparities exist. The ratio of black-to-white low birth weight rates among Non-Hispanics was 1.9 in 2016, unchanged from 2015. 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 NYS's Title V Program, as evidenced by NYS's ongoing support of community-based maternal and infant health initiatives such as evidence-based home visiting, and NYS's IM CoIIN initiative, but there remains a need for ongoing targeted efforts. NYS'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 with capability to address their needs (Level III or above) is paramount to decreasing infant mortality as well. NYS 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 92.5% of NYS's VLBW infants born at facilities for high risk pregnant and postpartum women and neonates. Efforts are underway to improve and enhance NYS's system of regionalized care including an update to the hospital regulations.

Domain 3: Child Health

2017 NSCH data showed that 90.8% of NYS's children were in excellent or very good health as compared to 89.8% in 2016. NYS'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 30.4% of NYS's children 9 - 35 months

received a standardized developmental screening, consistent with 2016 data and below the National level of 31.7%. The 2017 NSCH also found that 48.6% of NYS children age 3-17 with a mental or behavioral health condition received treatment, down from 52.8% in 2016 and comparable to 48.6% on the National level. 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, 2017 NSCH data reports that 11.8% of NYS children age 6-17 were sometimes bullied, picked-on or excluded by other children, down from 23.1% in 2016.

As with each SAP area, Title V staff are focusing on building the body of data and evidence to promote achievement of NYS'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 CYSHCN in NYS. A priority for NYS's Title V Program is to promote and support a coordinated, comprehensive system of supports and services for CYSHCN and their families. To ensure a comprehensive understanding of the complex needs of families with CYSHNs across NYS, Title V program engaged in a multi-year effort to conduct a comprehensive systems mapping initiative. The systems mapping initiative was implemented based on a collaborative relationship between NYS' EIP and CYSHCN Programs. Parent organizations were key to engaging family caregivers in this initiative and are part of the feedback loop to which the results will be disseminated. Building on this information, NYS'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 CYSHCN. Title V staff also continued to review data from the NSCH, and data reported by NYS's Title V Local Health Department-based CYSHCN and EI programs. Access to updated NSCH, including state level data released in 2017, has enabled NYS to assess current functioning in this and other Domains.

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, and school and neighborhood environments 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.

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, and 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 (e.g., the Youth Risk Behavior Surveillance (YRBS) System, 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 for Title V.

Domain 6: Cross-Cutting & Life Course

Interwoven throughout all aspects of the NYS'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. 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.

The experience and expertise gained by NYS's Title V program has been invaluable in understanding factors leading to health inequities. 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. The work accomplished during the course of this five-year period will continue as NYS's Title V program works to connect with communities and families served to gain a greater understanding of factors impacting health outcomes and builds stronger partnerships to develop strategies to address these issues to ensure health equity for all New Yorkers.

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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 CollN 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.

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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 CollN 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.

FY 2017 Application/FY 2015 Annual Report Update

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.

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Domain 2: Perinatal and Infant Health

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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 <u><</u>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 <u><</u>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.**

<u>**Domain 2: Perinatal & Infant Health**</u>

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; <u>WIC program</u> 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.

<u>**Domain 3: Child Health**</u>

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 for highlights of selected key collaborations.

III.D. Financial Narrative

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$38,909,810	$38,909,810	$38,909,810	$37,671,624
State Funds	$29,226,355	$65,501,510	$12,147,081	$29,285,355
Local Funds	$25,254,603	$85,526,375	$102,765,310	$64,999,454
Other Funds	$0	$0	$0	$0
Program Funds	$34,368,556	$26,095,730	$34,368,556	$78,393,470
SubTotal	$127,759,324	$216,033,425	$188,190,757	$210,349,903
Other Federal Funds	$72,809,819	$65,158,879	$57,096,314	$46,962,126
Total	$200,569,143	$281,192,304	$245,287,071	$257,312,029

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$38,909,810	$38,241,544	$37,671,810	
State Funds	$29,226,355	$29,285,355	$29,285,356	
Local Funds	$64,591,358	$122,724,134	$122,324,435	
Other Funds	$0	$0	$0	
Program Funds	$26,851,106	$28,299,351	$30,303,017	
SubTotal	$159,578,629	$218,550,384	$219,584,618	
Other Federal Funds	$68,845,166	$67,884,924	$47,470,052	
Total	$228,423,795	$286,435,308	$267,054,670	

	2020	
	Budgeted	**Expended**
Federal Allocation	$38,909,810	
State Funds	$29,285,355	
Local Funds	$55,483,224	
Other Funds	$0	
Program Funds	$22,224,404	
SubTotal	$145,902,793	
Other Federal Funds	$65,608,665	
Total	$211,511,458	

D. Financial Narrative

1. Expenditures

FY 18 Expenditures, including Title V, State appropriations, and other grant funding, demonstrate 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 18 expenditures exceeded the budgeted values by more than $58M, further demonstrating our commitment to allocating resources that complement the MCHS Block Grant funding ensuring that the needs of the NY MCH population are being met. The scope and comprehensiveness of services for NY's MCH population are fully outlined and described in the FY 2018 report and FY 2020 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, such as the Comprehensive Adolescent Pregnancy Prevention, 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 (SBHC), ensures access to health care for 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 promotes improved oral health for NY's highest risk population. Programs 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, SBHC 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 NY 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 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 Pregnancy Assistance Fund 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 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 and Youth with Special Health Care Needs (CYSHCN) 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 CYSHCN, NY's Title V program also oversees services specifically designed to serve CYSHCN. For example, Title V funds support forty-nine Local Health Departments (LHDs) to provide information and referral services to families of CYSHCN. 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 CYSHCN. 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 CYSHCN 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 CYSHCN and their families. Information obtained from CYSHCN and their families will assist NY's Title V Program to improve and enhance supports and services for CYSHCN 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, CYSHCNs 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. NY 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 NY 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 CYSHCN and families. Differences in state and local contributions from prior years are evident as NY continues to promote enrollment into health insurance coverage for all New Yorkers, as well as to maximize the use of other state and federal fund sources to enhance services for the MCH population.

Overall the actual expenditures for FY 18 exceeded budgeted values by more than $58M. Of particular note, the amount of program income generated for the reporting period was 105% of the anticipated income. This is likely related to the timing of the reporting rather than an actual increase in expenditures.

NY's FY 18 application reflected a budget of over $29 million in State MCH funds and over $64 million in 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. NY 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.

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 NY. This reorganization allowed NY to better understand the 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 NY and a myriad of other grants support NY's efforts to improve outcomes of all women, children, including CYSHCN and families across NY.

III.D.2. Budget

Budget

This FY 2020 budget reflects NY's commitment to Title V programs and services. NY will continue to use FY 2020 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/care mapping has been used to develop enhanced systems for CYSHCN and their families. The Title V program is increasing its investment in the LHD CYSHCN program to provide more support to local staff who can connect with and support CYSHCN and their families. The Title V program is also going to newly invest in three regional technical assistance centers at the state's University Centers of Excellence in Developmental Disabilities (UCEDD). In NYS, the UCEDDs are the Westchester Institute for Human Development in Valhalla, Montefiore Medical Center in New York City, and the Strong Center for Developmental Disabilities at the University of Rochester. These entities are federally-designated by HRSA and established through a competitive application process to work with people with disabilities, family members, state and local government agencies, and community providers in projects that provide training, technical assistance, service, research, and information sharing. This will assist NY's Title V program to improve and enhance supports and services for CYSHCN and their families.

Overall efforts will continue to provide supports and services for children and adolescents, with a significant focus on social-emotional development, SBHC and school-based dental programs, evidence-based home visiting services, community health workers including CHWs serving Native Americans, oral health services, services for CYSHCN 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 $2.6 million decreased slightly from prior years and remains below the 10% limit for these costs. As in prior years, the NY share for MCH services will continue to be considerable and will more than meet the requirements for state match. Expenditures for FY20 are expected to utilize the full allocation of $38,909,810. NY 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.a State Title V Program Purpose and Design

New York's Title V program builds on years of MCH leadership and public health investments. Flowing from the Needs Assessment (NA), State Priorities and National Performance Measures, NY's State Action Plan is driven by data, evidence and input from stakeholders including families. Informed by MCHB's 2010 Rethinking MCH: The Life Course Model as an Organizing Framework Concept Paper, NY's plan aims to translate life course concepts into an integrated portfolio of actionable, effective and measurable strategies to improve MCH outcomes and equity.

NY's State Action Plan established quantitative 2020 targets for objectives, refined strategies, and established state performance measures (SPM) and Evidence-Based/Informed Strategy Measures (ESM). This work was led by cross-programmatic Title V Staff Action Planning Teams. Targets were set based on analysis of data trends and projected impact of strategies. Key considerations for refining strategies included evidence base, feasibility and alignment with stakeholder priorities, with attention to advancing a balanced portfolio of population health surveillance, policy, workforce development, community-based prevention and clinical quality improvement strategies.

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

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

Section III.E.2.b.iMCH 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, most 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 providers, 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, reproductive health, oral health, and Early Intervention. 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 state to continue to improve NY's approach to improving the health and wellness of the MCH population. A biannual newsletter created by the Division's social and emotional wellness team, 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), developmental screening, the identification and treatment of hypertension during pregnancy, screening and referral of children for oral health services and a range of other topics. Staff are integrated into the regional perinatal center re-designation process, offering leadership development opportunities, as high-level medical professionals work together to modernize the state's system of care in birthing hospitals throughout NYS.

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 relevant stakeholders.   Staff is participating in an 18-month, three state (NY, NJ and PA) learning collaborative, managed by the Center for Law and Social Policy (CLASP), with NYS Office of Mental Health, NYS Office of Medicaid, SCAA and other stakeholders. The Moving on Maternal Depression (MOMD) will work to achieve five goals including:

Leverage and coordinate the significant interest and activity at state and local levels for maternal health and early childhood health and development and cultivate a strong community of diverse voices working to ensure that all women receive screening and treatment for maternal mental health that is accessible, affordable and culturally appropriate.

Meaningfully engage in the policy-making process with diverse voices of women who have experienced maternal depression, with an emphasis on the inclusion of people from communities that have been historically marginalized.

Establish key metrics that will be utilized for implementing continuous improvement activities on maternal depression across state agencies and through health care providers and community-based organizations. This will include steps to develop prevalence data differentiated by race and ethnicity and key performance indicators to drive improvement in process (i.e. connecting women to treatment, reducing provider stigma, reducing disparities).

Better understand the capacity in each region of the State for screening and treating women with maternal depression and have a plan focused on workforce capacity for screening and treatment options. The landscape assessment will aim to understand the needs of geographic areas and populations that have been historically underserved

Develop a plan to integrate policies and information on maternal depression across State agencies and with partnerships at

the community level that are working in the areas of maternal health, child health, early childhood development and family economic security with an emphasis on strategic alliances to advance health equity.

DFH has also partnered with Parent to Parent of NYS on a HRSA sponsored learning collaborative with the NY State Parent Advocacy Network (SPAN) to prepare and support emerging family leaders for identified roles on community, state, and national teams and advisory groups focused on Children Special Health Care Needs systems and to increase the racial and ethnic diversity of these representatives. The HRSA-funded Strengthen the Evidence site continues to serve as a resource for information related to evidence-based practice in MCH.

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.

DFH is committed to improving health equity for all New Yorkers. In order to further this agenda, DFH staff need to be educated and committed to this work and to share a common understanding of the issues. The DFH Health Equity team identified four courses focused on different 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 from entry level and support staff through top management, will be required to complete the series in 2019. Through this workforce development initiative, leadership aims to sensitize and educate staff on the issues of health equity, which impacts all aspects of Title V work. Involvement in work related to health equity including the CCH Racial Justice Workgroup promotes a greater understanding of implicit bias and leadership among staff.

To further enhance staff skills in health equity, and to continue to promote an environment of continuous learning, the DFH hosted a Division-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 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. 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.

The DFH also uses its Division-wide staff meetings as an opportunity for workforce development. With a Department as large as DOH, staff benefits from presentations on initiatives in other areas within the department. At each meeting, there is a business component and a training component. Staff have undergone training on such topics as social determinants of health projects, reproductive health in a social justice frame and DSRIP. Bureaus within the DFH are equally committed to workforce development. Professional development has become a component of these regularly held bureau staff meetings. Not only does this give staff an opportunity to learn about the work of their peers, but it provides each individual an opportunity to develop and polish their personal presentation skills, so essential in today's workplace.

As an outgrowth of the partnership between the SPH and DOH, and with initial grant funding from the federal HRSA MCH Catalyst initiative, SPH established an MCH program starting in 2015. Consistent with the federal MCH Catalyst Program goals, the program at SPH seeks to develop an increased focus on MCH within the school and university and to prepare students for MCH careers. Rachel de Long, M.D., M.P.H., the former NYS Title V Director, and Christine Bozlak, a full-time SPH faculty, serve as co-directors for the SPH MCH Program. The program offers both graduate and undergraduate level academic coursework in MCH, funds MCH-related internships for SPH students, supports student and faculty travel to MCH conferences, and facilitates a wide array of professional development opportunities for both students and MCH practitioners. This year the MCH Program worked closely with DOH Title V to implement a special Women's Health Initiative funded by the New York State legislature, including a special edition Public Health Live webcast on maternal mortality that highlighted NYS efforts to engage and respond to voices of women from disparately impacted communities to improve maternal health. A new graduate certificate in MCH is currently pending final approvals, with anticipated launch in the 2019-20 academic year. The partnership with the state's Title V program is a distinguishing strength of the school's MCH Program.

The DFH is also partnering with HRSA to provide a summer internship opportunity for two student interns during summer 2019. The student interns will jointly participate in a project to support Title V's strategy for CYSHCN in the Title V state action plan. The student interns will work with the internship preceptors, Title V leadership, universities and the three state's sickle cell programs, known as the Hemoglobinopathy Centers, to oversee an analysis of the current system of supports for CYSHCN, review and evaluate CYSHCN systems in other states, and work with the state's three HRSA-funded University Centers of Excellence for Developmental Disabilities (UCEDD) to identify strategies to improve local CYSHCN programs

funded by the Title V program.

Specifically, the interns will work with UCEDD staff to develop and implement structured interviews and surveys of local health department CYSHCN program staff to assess the supports and services provided locally. The interns will evaluate the results of the state's comprehensive, coordinated care mapping project conducted with 178 parents/caregivers and providers in 13 different locations around the state. The interns will synthesize the interview information with the care mapping results, complete a gap analysis, and develop an executive summary report and formal presentation to share with Department leadership, county officials, and other stakeholders. The interns will also survey other state CYSHCN programs to identify programs to interview for best practices that could be integrated into NYS' system of supports. The interns will develop structured interviews, contact other state CYSHCN staff, and prepare a formal summary for the Title V Leadership.

In tangible recognition of the state's commitment to ensure the highest quality state worker, enhance staff retention and recruitment and in support of continual 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.

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

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

As stated previously, at the community level, services and programs are implemented by local partners including LHDs, universities and academic medical centers, hospitals and clinics, and community-based organizations. When procuring services, efforts are made to locate services within communities served provided by individuals from the community or reflect 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 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. One example of this is the family engagement in the Early Intervention Program's State Systemic Improvement Program quality improvement teams. This quality improvement initiative aims to improve family outcomes in EI service delivery.

The 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. Michelle Juda, executive director of Parent to Parent of NY has been designated as a member of NY's MCHSBG Advisory Council and NY's family representation to AMCHP.

NY has a long history of partnering with families and family organizations to achieve positive outcomes throughout the life course. The CYSHSN Program work plan requires contractors to provide program outreach and awareness regarding the local CYSHCN Program, gap-filling programs and community resources. The goal of these activities is to empower families of CYSHCN and youth/young adults with special health care needs to navigate the systems of care. All 49 local contractors are required to report quarterly on their activities in this area.

Families and family-led organizations are participating in the CYSHCN Program's systems mapping initiative. The Parent to Parent of NY was 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 NY, 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 planned enhancements to the program as discussed in that Domain section of this application.

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

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

One of the main objectives of the State Systems Development Initiative (SSDI) is to build and expand NY MCH data capacity to support Title V MCHSBG program activities and contribute to data-driven decision making in MCH programs, including assessment, planning, implementation and evaluation. The importance of state DOH data capacity is readily recognized as critical to identifying needs of the MCH population. Improving data integration and utilization allows for greater ability to assess trends in outcomes, including health disparities. With the changing landscape of NY's 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 SSDI Principal Investigator, the Medical Director for the DFH, the SSDI Senior Program Coordinator and several Research Scientists guide the collection and analysis of the data that form the basis for the Five-Year Needs Assessment and the State Action Plan 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 MCH population domains.

In 2020 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 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 a plan to improve data linkages across the five-year SSDI funding cycle, particularly focusing on indicators from the Minimum/Core Dataset for Title V MCHSBG programs, and in FFY 2018 through FFY 2022, SSDI staff will implement the plan for overcoming identified barriers. New York State is currently reporting seven of the Core/National Dataset elements and six of the Core/State Dataset elements as part of the MCHSBG. In 2020, 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 NY's capacity to report additional CDS elements.

NY has a strong commitment to data systems development and invests in infrastructure to promote data linkages and timely reporting. The following data sources are currently being provided by partners to allow Title V staff to assess, monitor, and evaluate Title V programming in NY: Newborn Screening Program data; Vital Records (births, deaths); New York City Vital Records (births, deaths); Statewide Perinatal Data System; Children with Special Health Care Needs Database; Early Intervention Program 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.

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

Pregnancy Risk Assessment Monitoring System (PRAMS) Data Linked to NY Birth Data: In the winter of 2018, 2015 NYC PRAMS data was received by the Public Health Information Group (PHIG) staff which allowed for the development of statewide 2015 PRAMS indicator sets. This information will be used by Title V staff for tracking various programmatic activities, including oral health care during pregnancy, infant sleep positioning and breastfeeding practices. In addition, a PRAMS Dashboard is under development in the DOH that will allow Title V staff to have more direct and timely access to PRAMS indicators in the future.

NY 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 2016. 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 NY 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 NY 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 NY. 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 NY. EBC data for births in NYC hospitals are captured in a separate coordinated system. The SPDS, which began implementation in 2004, 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 NY/ 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 New York State Perinatal Quality Collaborative (NYSPQC) for the Enteral Nutrition Project.

NY and NYC Linked Birth, Death and Hospital Discharge Data for Maternal Mortality and Morbidity: Linked Files for Maternal Morbidity/Mortality: The NY 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. The MMR also gives an overview of the deaths that were not pregnancy-related. This is achieved through complex linkages between NY death records of women ages 10-55 years old, NY and NYC birth records, and SPARCS records. A statewide file was developed containing comprehensive information from each data source used. The Title V program uses the statewide linked file to compile a complete review of the factors leading to maternal deaths with the goal to inform interventions to reduce the risk of these deaths. DFH staff works closely with the OQPS with a common goal of improving data quality and completeness on administrative state databases. During the reporting period, DFH obtained access to preliminary 2017 death records for deaths occurring outside NYC. These records are reviewed and linked to hospital discharge records to verify veracity of the pregnancy check box to reduce the inaccuracies on the state death records and help improve the accuracy of the state's maternal mortality rate. In addition, DFH has 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 NY Early Intervention Program (EIP) and Children and Youth with Special Health Care Needs: The comprehensive statewide EIP serves 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. The NY EIP is part of the national EIP for infants and toddlers with disabilities and their families. To strengthen coordination and collaboration between EIP and CYSHCN 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 CYSHCN, including supports and services after the child has aged out of EIP. During the Fall of 2017, Title V staff updated the CYSHCN database to enable the collection of more detailed information on the NY CYSHCN population that can then be used to target program efforts and reporting.

Early Hearing Detection and Intervention 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-IS 2.0 application has been tested. On September 4, 2018, the DFH merged 1.3 million Vital Records with newborn screening records and launched EHDI-IS 2.0.

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 began using the Data Resource Center for Child and Adolescent Health Interactive Data Query Tool for a variety of Title V monitoring and reporting, including tracking CYSHCN. The Title V Program also collaborated with the OPHP to develop an MCH Dashboard modeled on the NY Prevention Agenda Dashboard that serves as a blueprint for state and local organizations to improve the health of the MCH population in the State Priorities identified in the State Action Plan (SAP), including improving health equity. Tracking indicators have been

developed to assess the current MCH population's health status and to monitor how the overarching goals and priority objectives are being met. It will serve as an interactive visual presentation of the Title V SAP tracking indicator data at national, state and county levels (where available). It will serve as a key source for monitoring progress that communities around the state have made with regards to meeting the SAP objectives.

The OQPS 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 NY to achieve the triple aim of improving patient experience; improving population health; and reducing the costs of health care." APDs already exist in 20 states, including all of those in NY's neighboring New England region. NY is among a handful of states in the implementation phase. At present NY'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

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

On July 20, 2017, NY's Medicaid Director announced a new focus for Medicaid Redesign in New York: The First 1000 Days on Medicaid initiative. This initiative recognized that a child´s first three years are the most crucial years of their development and about 59% of them are currently covered by Medicaid. Since there is evidence that children on Medicaid have better health and life outcomes, NY´s Medicaid program is taking steps to work with health, education and other system stakeholders to maximize outcomes and deliver results for the children NY serves.

The First 1000 Days on Medicaid initiative is a collaborative effort, bringing together stakeholders in a series of four work group meetings between August and November 2017. The work group developed a ten–point agenda to focus on enhancing access to services and improving outcomes for children on Medicaid in their first 1000 days of life. DFH and Title V program staff have provided leadership and guidance in the development of the 1000 days initiative and are participating in its implementation. The goals of several current Title V programs are consistent with the goals of this initiative and will contribute to improved outcomes. For further information refer to the State Overview section of this application.

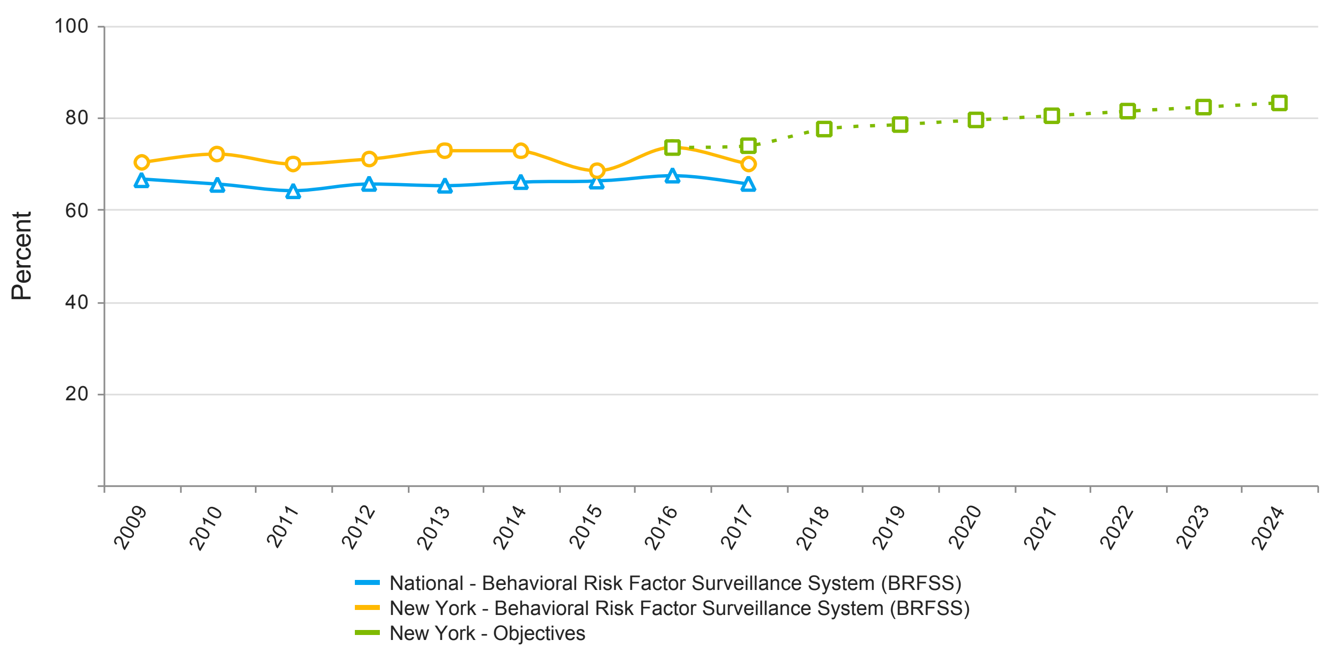
III.E.2.c State Action Plan Narrative by Domain

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	Data Not Available or Not Reportable	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2017	8.1 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2017	9.0 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2017	23.5 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2016	5.4	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2016	4.5	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2016	3.0	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2016	1.5	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2016	152.0	NPM 1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS-2017	7.3 %	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2016	4.7	NPM 1
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2016_2017	10.3 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	90.0 %	NPM 13.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2017	12.5	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2017	13.0 %	NPM 1

National Performance Measures



Federally Available Data			
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)			
	2016	**2017**	**2018**
Annual Objective	73.4	73.8	77.4
Annual Indicator	68.4	73.3	69.8
Numerator	2,471,455	2,653,864	2,510,557
Denominator	3,612,104	3,619,067	3,597,587
Data Source	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	78.4	79.4	80.3	81.3	82.2	83.1

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**	**2018**
Annual Objective		40	5
Annual Indicator	5	5.3	5.3
Numerator		1	1
Denominator		19	19
Data Source	Title V Program Records	Title V Program Records	Title V Program Records
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	5.0	11.0	16.0	21.0	26.0	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	2018
Annual Objective			7
Annual Indicator	11	7	7
Numerator			
Denominator			
Data Source	NYS Title V Program Records	NYS Title V Program Records	NYS Title V Program Records
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	7.0	7.0	8.0	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:	Inactive - Replaced

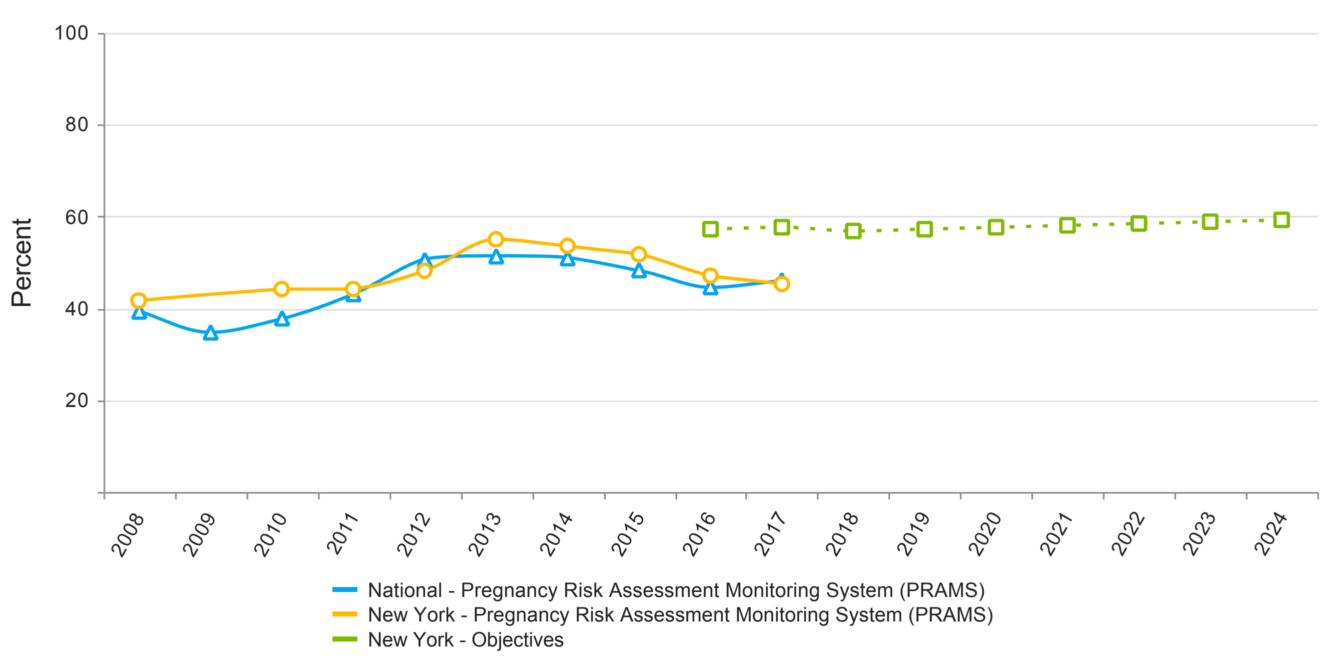
State Provided Data		
	2017	2018
Annual Objective	87	6.4
Annual Indicator	6.2	6.2
Numerator		
Denominator		
Data Source	Medicaid claims	Medicaid claims
Data Source Year	2017	2017
Provisional or Final ?	Final	Final

ESM 1.15 - Percentage of women with Medicaid insurance who report that a doctor, nurse, or other healthcare worker asked at the postpartum checkup if they were feeling down or depressed

Measure Status:	Active

Annual Objectives					
	2020	2021	2022	2023	2024
Annual Objective	81.0	82.0	83.0	84.0	85.0

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy
Indicators and Annual Objectives



Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2016	**2017**	**2018**
Annual Objective	57.2	57.6	56.8
Annual Indicator	54.9	51.7	45.4
Numerator	117,570	110,325	95,006
Denominator	214,301	213,585	209,242
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2015	2017

State Provided Data			
	2016	2017	2018
Annual Objective	57.2	57.6	56.8
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						
	2019	2020	2021	2022	2023	2024
Annual Objective	57.2	57.6	58.0	58.4	58.8	59.2

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	2018
Annual Objective		10	50
Annual Indicator	36.7	45.3	56.6
Numerator			
Denominator			
Data Source	MICHC reports	MICHC reports	MICHC reports
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	50.0	50.0	50.0	50.0	55.0	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	2018
Annual Objective		45	36.4
Annual Indicator	34.6	35.3	35.3
Numerator			
Denominator			
Data Source	BRFSS	BRFSS	BRFSS
Data Source Year	2014	2016	2016
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	37.6	38.2	38.7	39.2	39.7	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	2018
Annual Objective		8	25
Annual Indicator	27	24.5	24.5
Numerator			
Denominator			
Data Source	Medicaid Claims	Medicaid Claims	Medicaid Claims
Data Source Year	2016	2017	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives

	2019	2020	2021	2022	2023	2024
Annual Objective	25.0	26.3	26.3	27.6	27.6	29.0

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	2018
Annual Objective		72	73
Annual Indicator	71.7	71.6	70.8
Numerator			
Denominator			
Data Source	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	75.0	77.0	78.5	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.	Inactive
ESM 1.15 - Percentage of women with Medicaid insurance who report that a doctor, nurse, or other healthcare worker asked at the postpartum checkup if they were feeling down or depressed	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.	Inactive
ESM 1.15 - Percentage of women with Medicaid insurance who report that a doctor, nurse, or other healthcare worker asked at the postpartum checkup if they were feeling down or depressed	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.

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 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

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.

FY 2018 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 environmental , health insurance status, access to health care. and any number of other factors including the social determinants of health in which individuals are born, grow, live, play, work and age. Improving women's health throughout the life course is essential to improving the health and wellness of 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 and whole women's health to promote health through the life course including prior to pregnancy; and improve screening and treatment for maternal depression and substance use. Of importance to all of these efforts 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 quality health care is accessible and available. New York has a generous benefit package for eligible individuals that support comprehensive primary and preventive health services including access to reproductive health services for adolescents, women and men. Through the NYSOH, NY continued its efforts to enroll New Yorkers into comprehensive health care coverage. There are now over 4.7 million New Yorkers with health insurance coverage through the NYSOH. The rate of uninsured New Yorkers decreased from 10% to 7.6% in 2017. In 2017, 93.8% of women in NY had coverage. Rates differed by race and ethnicity, with whites having the highest coverage rate (94.4%) and Hispanic or Latino having the lowest (85.4%). Education also influenced rates. Those with less than a high school education had much lower rates of insurance (83.7%) than those with a bachelor's degree or higher (95.4%). To ensure coverage, NY's Marketplace committed to getting positive messages out to consumers about the availability of health insurance. Efforts included NY's "You Deserve Affordable Health Care" advertising campaign, attending more than 300 community outreach events, and distributing nearly four million email messages to consumers reminding them of important steps needed to complete their insurance enrollment. The Marketplace offered access to information including a NYSOH customer service center that responded to over 297,000 calls in 2018 in over 101 different languages. Consumer educational materials are produced in 27 different languages. Additionally, navigators provided assistance in 44 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 to 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.

Recently, the review of maternal deaths for 2012- 2014 was completed. The findings from this cohort indicated the top six leading causes of pregnancy-related deaths (N=96) was: embolism (not cerebral) (23%), hemorrhage (17%), infection (17%), cardiomyopathy (11%), cardiovascular problems (7%) and hypertensive disorders (6%). This is consistent with the results from 2012-2013 cohort. The expansion of the cohort to include 2014 revealed that Non-Hispanic Black mothers accounted for 45% of pregnancy-related deaths versus 30% for Non-Hispanic White mothers. The majority of pregnancy-related deaths were covered by Medicaid.

Racial disparities in maternal deaths are persistent; the statewide 3-year-rolling Black to White mortality ratio ranged from a high of 4.3 to 1 in 2005-2007 to a low of 3.1 to 1 in 2011-2013, with the most current ratio (2014-2016) falling at 3.2. The most recent data showed small geographic differences. In New York City, the Black to White ratio decreased from 3.4 in 2013-2015 to 2.8 in 2014-2016. This decrease in Black to White ratios was due to a slight increase in the maternal mortality rate among White women and the decrease in the maternal mortality rate among Black women. Outside New York City, the Black to White ratio increased slightly from 3.9 in 2013-2015 to 4.1 in 2014-2016. This increase in Black to White ratios was due to a slight increase in the maternal mortality rate among Black women and the stable maternal mortality rate among White women.

Recent data from NYS Vital Statistics showed that maternal deaths increased to 20.2 per 100,000 live births in 2014-2016 but remained lower than the Prevention Agenda (PA) 2013-2018: 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 and is expected to meet the Prevention Agenda (PA) 2019-2024: New York State's Health Improvement Plan goal to decrease maternal mortality (MM) to 16 maternal deaths for every 100,000 live births by 2024. https://health.ny.gov/prevention/prevention_agenda/2019-2024/background.htm

The reviews of the recent-year cohorts of maternal deaths are underway. All 119 cases in the 2014 cohort have been completed. For 2015, a total of 174 cases have been identified, of which 52 have been completed. For 2016, 87% of the 218 identified cases have been completed. For 2017, 37% of the 194 identified cases have been completed. Since 2016 and 2017 data are not final, these numbers may change as data are updated.

In 2018, recognizing the devastating effects of maternal mortality, NY's Governor Cuomo announced a multi-pronged strategy to address this critical issue including but are not limited to:

- Creating a Governor's Task Force on Maternal Mortality and Disparate Racial Outcomes;
- Establishing a Maternal Mortality Review Board, building on the Title V Program's current maternal mortality public health surveillance process;
- Launching a Best Practice Summit with hospitals and OB/GYNs;
- Piloting Medicaid expansion for doulas;
- Supporting Centering Pregnancy demonstration projects (also included in OHIP's First 1000 Days on Medicaid initiative);
- Requiring medical education and curriculum development to address implicit bias in health care;
- Expanding the NYS Perinatal Quality Collaborative; and,
- Launching Commissioner Listening Sessions to hear from women and families across NYS to better understand those factors that impact maternal mortality and morbidity.

Over the past year, Title V staff worked on several of Governor Cuomo's priorities to improve maternal health outcomes and address health disparities.

The Task Force on Maternal Mortality and Disparate Racial Outcomes (Taskforce) met three times over a six-month period in 2018 to review and discuss improving maternal outcomes, addressing racial and economic disparities and strategies to reduce maternal mortality and morbidity in NYS. The Taskforce report was released in March 2019

(Attachment #1) which included the following 10 recommendations:

1. Establish a Statewide Maternal Mortality Review Board in Statute
2. Design and Implement a Comprehensive Training and Education Program for Hospitals on Implicit Racial Bias
3. Establish a Comprehensive Data Warehouse on Perinatal Outcomes to Improve Quality
4. Provide Equitable Reimbursement to Midwives
5. Expand and Enhance Community Health Worker Services in New York State.
6. Create a State University of New York Scholarship Program for Midwives to Address Needed Diversity
7. Create Competency-Based Curricula for Providers as well as Medical and Nursing Schools
8. Establish an Educational Loan Forgiveness Program for Providers who are Underrepresented in Medicine and who Intend to Practice Women's Health Care Services
9. Convene Statewide Expert Work Group to Optimize Postpartum Care in NYS
10. Promote Universal Birth Preparedness and Postpartum Continuity of Care

As requested by Governor Cuomo, the DOH led by Dr. Zucker conducted listening sessions in high-risk communities across the NYS to understand the barriers women face in obtaining routine prenatal care, and their suggestions to better address the causes of maternal mortality and morbidity. In partnership with NYS DOH, DFH funded Maternal and Infant Community Health Collaboratives (MICHC) programs, listening sessions were conducted in seven communities: Buffalo, Syracuse, Albany, Bronx, Brooklyn, Harlem and Queens. A total of 244 women participated in the listening sessions, including recently and currently pregnant women and families, and African-American women who've experienced an adverse birth outcome.

Common barriers expressed by participants across all seven listening sessions included:

- Disrespect by providers;
- Not getting their questions answered and their concerns addressed;
- Insufficient time with the provider, and not receiving individualized care;
- Not receiving important information so that they had information to make proper decisions;
- Feeling pressured into certain medical procedures; and
- Lack of social support during the prenatal and postpartum periods.

Common suggestions for addressing the racial disparities in maternal mortality included:

- More Black and Hispanic health care professionals that reflect the community;
- Increase health care professional awareness of racial disparities in health outcomes;
- Train health care professionals on the impact of implicit bias on health care outcomes;
- Increase in provider support during the postpartum period;
- Increase availability of social support for example, birthing classes, centering pregnancy, doulas, midwives, community health workers and parenting classes; and
- Increase availability of community services and resources, for example, community health worker services, home visiting services.

Results from the Listening Sessions were presented to the Governor's Task Force on Maternal Mortality. The Task Force incorporated some of the community members recommendations into their recommendations to the Governor (listed above).

Direct engagement of community members was critical to the Taskforce recommendations, and the DOH and Title V program will continue to incorporate the voices of community members most impacted by disparities as part of the process to improve birth outcomes.

One of the initiatives underway is a Medicaid Doula Pilot. In launching the Doula Pilot, OHIP gathered information for doula programs currently operating in NYS as well as Medicaid doula programs in other states. OHIP considered several data metrics to determine the eligibility areas for the Medicaid pilot including the availability of doulas and volume of Medicaid births and data that showed high maternal and infant mortality. Based on these metrics, OHIP decided to launch the doula pilot in Erie and Kings Counties. Under the pilot, doula services are available for any Medicaid-eligible pregnant woman in fee-for-service or Medicaid Managed Care in these geographic locations. Prior to the launch OHIP hosted several webinars on the pilot including billing coding. Phase 1 of the pilot project began March 1, 2019 in Erie County. Phase 2 of the project will include selected zip codes in Kings County once provider capacity has been achieved. This two-year pilot includes an analysis of data including breastfeeding rates and adherence to postpartum visits. It will also assess doulas' and mothers' experiences and feedback on participation in the program. OHIP has ongoing engagement with stakeholders and has made several adjustments in order to increase participation in the pilot by both pregnant women and doulas.

Another initiative which was part of both the Governor's Maternal Mortality efforts and included as a priority in the First 1000 Days on Medicaid initiative is a Centering Pregnancy pilot. Centering Pregnancy is an evidence-based group prenatal care model that has been shown to help improve birth outcomes. To develop this model of care, the DOH engaged the Centering Healthcare Institute (CHI), the agency that developed the Centering Pregnancy model, to help structure a centering pregnancy project in areas of NYS with the poorest birth outcomes. Two webinars were held, one with Managed Care Plans and another with providers and clinics. The pilot will be implemented as a clinical study to evaluate the impact of the Centering Pregnancy model on birth outcomes, especially rates of preterm births and rates of low birth weight. The pilot's target areas include the five NYC boroughs and ten counties that have been known to have relatively higher rates of poor birth outcomes in NYS. Ten Medicaid Managed Care health plans and approximately 24 prenatal care clinics expressed interest. The pilot will be implemented in two phases (Phase 1 with clinics that already have an established Centering Pregnancy model at their sites, and Phase 2 with clinics that want to newly establish a Centering Pregnancy model at their sites). The first phase of the pilot is slated to launch in June 2019.

To build on DOH's work related to maternal death reviews, the Title V staff is currently implementing an enhanced process for maternal death reviews developed in collaboration with the American College of Obstetricians and Gynecologists (ACOG-NY). The goal of these planning efforts is to develop a process that will not only address this significant public health issue with 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 case 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.

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 identify cases of SMM through linked birth and hospital discharge data to conduct an analysis to define the major

causes of maternal morbidity. A manuscript summarized the findings of SMM surveillance in NY was published in 2017 in PLOS-ONE.

An outgrowth of the focus on maternal mortality and the work of the Public Health Committee of the NYS PHHPC 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, apriority of the PMH is preconception health. During 2018, a subcommittee of the PMH developed an instructional webinar on the importance of preconception care. The webinar was presented on August 1, 2018, by Ashlesha Dayal, MD, from Weill Cornell Medical College. The intended audience was 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 was to increase healthcare providers' understanding of the impact a woman's health care can have on pregnancy outcomes. One continuing medical education credit was available for participants. Three hundred and twenty-one professionals participated in the live webinar and 83 viewed the archived version. Participants included, but were not limited to: nurses, midwives, directors of patient safety, community health workers, social workers and physicians Members of the PMH and the work of the PMH has been incorporated into the new Governor's Task Force on Maternal Mortality and Disparate Racial Outcomes discussed below.

Due to the prevalence of maternal mortality and morbidity in NYS resulting from maternal hemorrhage, the Title V staff through the NYSPQC is leading the NYS Obstetric Hemorrhage Project, which seeks to reduce mortality and morbidity by improving the assessment, identification and management of obstetric hemorrhage. Title V is collaborating on this project with ACOG-NY, Healthcare Association of NYS (HANYS), Greater New York Hospital Association (GNYHA), and National Institute for Children's Health Quality (NICHQ). This project began in November 2017, and 70% (86/123) of NYS birthing hospitals are participating. Hospitals document completion of a hemorrhage risk assessment to improve recognition and care based on risk level. The percent of maternity patients with a documented risk assessment for obstetric hemorrhage completed on admission has increased by 18% during the project period, from 64.4% in March 2018 to 78.2% in January 2019. Documentation of risk assessment for obstetric hemorrhage completed post-partum (between birth and discharge) has increased by 52% during the project period, from 31.7% in March 2018 to 48.3% in January 2019. As of January 2019, 89% of participating hospitals completed at least one obstetric hemorrhage drill to improve readiness in the case of a hemorrhage event.

The Title V program works with partners to increase access to effective contraceptive use 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. The NYS Family Planning Training Center has provided training to family planning providers to emphasize equity and reinforce reproductive justice principles in the delivery of family planning services. Webinars were conducted in mid-2018 to promote use of patient-centered methods to assess reproductive intention, and to introduce a shared decision-making model for contraceptive counseling. In addition, the annual NYS Family Planning Program provider meeting featured a keynote address to discuss the role of client-centered care in reducing disparate health outcomes. In 2019, the New York State Family Planning Training Center will conduct a series of in-person regional trainings for family planning providers across the state that will focus on developing individual and organizational strategies to reduce implicit bias in family planning settings.

Title V in NYS also continued to support and promote direct outreach to engage women into health care and promote health insurance enrollment and entry into prenatal care. Through the MICHC program, CHWs focused on educating women on improved birth spacing, adherence to the postpartum visit, and use of an effective contraceptive method. In 2018, the MICHC program connected 634 women to health insurance, 66.1% of pregnant clients engaged prenatal care in the first trimester, and 32.2% of postpartum clients attended a postpartum visit and an additional 24% had a visit scheduled at the time of reporting. Evidence-based home visiting programs (Nurse-Family Partnership and Healthy Families New York) also emphasized birth spacing, importance of the postpartum visit and effective contraceptive usage.

In addition to addressing women's physical and reproductive health, NY's Title V program is addressing women's social-emotional health. Maternal depression has a significant impact on mothers and the social-emotional stability of their children and families. 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 and continue to regularly review this information to ensure resources are current and applicable. In addition, the Title V program participated in a learning collaborative with the Office of Mental Health (OMH) and other key stakeholders to address 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.

This strategy is measured by **ESM MWH-5: Percentage of women enrolled in Medicaid who are screened for maternal depression during postpartum care.** The Title V program is monitoring this strategy using PRAMS data effective this past grant year. The collaborative project with OHIP originally reported has concluded. According to PRAMS data from 2016, which is the most recent data available for NYS, 81.5% of women on Medicaid report that a doctor, nurse or other healthcare worker asked at the postpartum check-up if they were feeling down or depressed. While a significant percentage of women are being screened, evidence is lacking regarding use of standardized screening tools and there is room for improvement in percentage of women screened. Additionally, practitioners often identify lack of treatment services as an issue for women who screen positive.

NY's Title V program is committed to continued work to address this significant health issue for mothers and children. Through the *Report on the Status of New York Women and Girls, 2018 Outlook*, NYS Governor Andrew Cuomo launched efforts to address maternal depression and reduce maternal mortality. The components of the maternal depression efforts include: the Department of Financial Services requiring all health insurance policies to include coverage for maternal depression screening; expediting referrals and treatment, including expansion of Project TEACH (NY's model for pediatric psychiatry consultation) to connect primary care providers and obstetricians and gynecologists with mental health specialists; enhanced screening and referrals at WIC clinics; increased access to telepsychiatry for those in rural communities; and a media campaign to increase awareness of and decrease stigma about maternal depression.

Title V staff work with OMH staff in increasing awareness of the expansion of Project TEACH for maternal mental health. WIC has added the Patient Health Questionnaire-2 to the screening questions on enrollment into the program. They have also increased training for WIC staff on maternal depression. The DOH promoted awareness through social media and revised the DOH consumer web pages on maternal depression. Social media kits were sent to local MCH providers for use in their social media efforts.

In addition to the above, NYS initiatives addressing maternal depression include: First 1000 Days on Medicaid (Dyadic therapy and home visiting proposals); HealthySteps grants; the Early Childhood Comprehensive Systems Impact Grant, and participation in the Moving on Maternal Depression learning collaborative with the Center for Law and Social Policy. 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 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 and dyadic therapy. They also are participating in the Moving on Maternal Depression learning collaborative discussed below. 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 (described elsewhere in this application) could positively affect maternal depression: One is for 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 reimbursed 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. Over the past year, OHIP has been working with OMH and OASAS to catalogue existing statewide efforts related to dyadic therapy and researching the provision and payment of the benefit. Currently, OHIP is drafting a Medicaid Update article to clarify this benefit that is planned to be released by mid-2019. The home visiting workgroup has been convened and parameters for the work established. Title V staff participate on the leadership team for the workgroup and pilot. The pilot is anticipated to begin in late 2019.

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 providers are fully operational, engaging new parents to enroll their infants in the Healthy Steps program by 4 months of age. Over 1,300 children and their families were enrolled as of September 30, 2017 and over 3,400 children and their families were enrolled as of September 30, 2018.

Healthy Steps Specialists provide screening to include maternal depression, parental protective and risk factors, and social determinants of health. OMH is conducting an independent evaluation. Sites are tracking the maternal depression screening tools utilized, referrals made and/or approaches to care and report challenges to accessing services when making linkages/referrals to supports and services. The 17 sites have administered over 5,000 maternal depression screens for families enrolled in the program. Data are being analyzed to determine the positive screen rate and disposition of the positive screens.

Other Program components include:

- Team-based well-child visits
- Positive parenting guidance and information
- Screening following a periodicity.
- Adverse Childhood Experiences (ACE)
- Parent Education Groups

- Home Visiting at key developmental times
- Access to support between visits
- Connections to resources
- Care coordination/systems navigation
- Early Literacy Reach Out and Read

In January of 2018, the OMH HealthySteps sites completed a 12-month Learning Collaborative on Building a Trauma-Informed Practice and Integrating the Adverse Childhood Experience Survey into practices in collaboration with technical assistance and training from Montefiore Medical Group's nationally recognized experts in Trauma Informed Care and Healthy Steps. The sites have completed over 1500 surveys for Adverse Childhood Experiences.

To further enhance supports and services, the Title V program successfully collaborated on the development of an Early Childhood Comprehensive Systems (ECCS) 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 to use in five local pediatric practices. At the other end of the state, under the leadership of Dr. Isakson, the Nassau team has used ECCS activities to support the implementation of Help Me Grow Long Island. Help Me Grow Long Island offers free developmental and social emotional screens and provides free, virtual, ongoing support to families with young children on Long Island who have concerns such as their child's development or behavior, navigating service systems, or locating baby items. At the state level the ECCS initiative is connected to various technical assistance initiatives and statewide workgroups and committees such as the OHIP's First 1000 Days on Medicaid initiative, the New York Strengthening Infant/Toddler Policies and Practices, the NYS Infant and Early Childhood Mental Health Technical Assistance initiative, the NYS Parenting Education Partnership, and workgroups on the NYS Governor's Early Childhood Advisory Council and the Governor's Child Care Availability Task Force.

In August 2018, NYS was selected to participate in the Center for Law and Policy's (CLASP) 18-month Moving on Maternal Depression learning collaborative that aims to advance polices around maternal depression prevention, screening, and treatment. The NYS Team is co-led by OMH and the Schuyler Center for Analysis and Advocacy (Schuyler Center and includes members from OMH, DOH, OASAS, AAP, ACOG-NY District II, Postpartum Resource Center, and the Children's Agenda. Title V staff participate on the core team. NYS has five broad goals: 1) leverage and coordinate existing activity around maternal health and mortality and early childhood health and development, to generate action on maternal mental health; 2) meaningfully engage women with lived-experience into policy /advocacy for maternal depression; 3) develop key metrics/data relating to maternal depression; 4) develop an understanding of the cope, options and location of existing services to treat maternal depression; and 5) integrate policies and information across state agencies and partnerships at the community level.

In a step toward the CLASP learning collaborative, the Schuyler Center held a statewide summit on Maternal Depression in June 2018, bringing stakeholders from many disciplines together to discuss this complex public health issue. CLASP facilitated discussions at the summit. Title V staff provided input in the planning stages and attended the summit to continue to build Title V's knowledge base and partnerships in this area.

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, DOH 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. Title V staff share the reports and links, as well as other resources such as webinars and educational materials, with DFH-funded perinatal programs and other stakeholders across the state. Access to these data and other resources allows agencies and stakeholders to more easily identify priority areas to target 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 opioid epidemic. Since spring 2016, Title V staff participated 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 was a two and a half-year pilot (6/2016 – 2/2019) and the core team, which includes Title V staff and agencies in the three pilot counties, aimed 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. As part of the initiative, participating counties assessed how pregnant women using opioids would negotiate the health care and support systems in their respective counties. They identified areas of disconnect that they are working to improve, e.g., lack of communication between health care providers. Drafts of plans of safe care and decision trees for hospital staff have been developed. The participating counties recently began piloting implementation of plans of safe care and provided initial feedback to the state to inform revisions of to the plans of safe care and decision trees. .

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 neonatal abstinence syndrome (NAS). The workgroup meets monthly 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.

Further, Title V staff through the NYSPQC, in collaboration with ACOG-NY District II, HANYS, GNYHA, and NICHQ, is leading the NYS Opioid Use Disorder (OUD) in Pregnancy/NAS Project. This learning collaborative, which kicked-off in September 2018, and is currently being piloted in 19 pilot site birthing hospitals, seeks to identify and manage women with OUD during pregnancy, and improve the identification, standardization of therapy, and coordination of aftercare of infants with NAS. The project is aligned with the national Alliance for Innovation in Maternal Health (AIM).

As an outgrowth of the OASAS in-depth technical assistance project and the NYSPQC OUD/NAS project, ACOG District II convened a discussion of Vermont's Children and Recovering Mothers initiative in March 2019. Invited participants included staff from advocacy organizations, NYSDOH, OASAS, OMH, hospitals, and AAP. ACOG District II developed and released recommendations for NYS from the convening that included funding in the state

budget for:

- A Children and Recovering Mothers (CHARM) champion at each of the Regional Perinatal Centers (RPCs);
- A division for CHARM-related activities that includes a state coordinator specifically for “hub & spoke” implementation components given the geographic expanse of NYS; and,
- Provider education that offers implementation tools to better assist women’s health care providers in caring for pregnant women with OUD.

Further, recommendations included :

- Developing a Regional “Hub and Spoke” Model
- Enhancing Care Coordination and Linkage to Services Locally
- Offering Multidisciplinary Provider Training

Title V staff continue to be involved in planning and discussions to enhance supports and services for women with OUD and their infants.

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 2018 GUHH responded to 13,688 calls including 2,742 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 2015, 68.4% of women interviewed had a past year preventative visit as compared to 73.3% in 2016**.** This represents an increase in NY, and exceeds the national measure of 67.4% in 2016. **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. For 2016, NY fares slightly better than the national average for **NOM #3 Maternal mortality rate per 100,000 live births** at 19.2 vs. 21.5**.** 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** continued to go down from 2.0 in 2015-2016 to 1.0 in 2016-2017, lower than the national average 2.0. Finally, for **NOM #11 The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations,** NYS continued to fall below the national average with the NYS rate 4.2 vs the national average 6.4 in 2015. .

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. According to NYS Vital Statistics, NYS's maternal mortality rate decreased from 24.6 deaths per 100,000 live births in 2015 to 16.8 deaths per 100,000 live births in 2016. The three-year average rate decreased slightly from 20.6 deaths per 100,000 live births for 2013-2015 to 20.2 deaths per 100,000 live for 2014-2016, and remains almost two times higher than the Healthy People 2020 objective of 11.4. Racial disparities in maternal deaths are persistent; the statewide 3-year rolling Black to White mortality ratio ranged from a high of 4.4 to 1 in 2005-2007 to a low of 3.1 to 1 in 2011-2013, with the most current ratio (2014-2016) of 3.2. The most recent data showed small geographic differences. In New York City, the Black to White ratio decreased from 3.4 in 2013-2015 to 2.8 in 2014-2016. Outside New York City, the Black to White ratio increased slightly from 3.9 in 2013-2015 to 4.1 in 2014-2016.

Leading causes of pregnancy-related death in NYS, based on the review of the 2012-2014 case cohort (n=96) completed this year, include: embolism (not cerebral) (23%, n=22), hemorrhage (17%, n=16), infection (17%, n=16), cardiomyopathy (11%, n=11), cardiovascular problems (7%, n=7) and hypertensive disorders (6%, n=6). Almost two-thirds of these women were obese (55%) or overweight (8%). The majority of women who died of pregnancy-related causes were affected by risk factors including hematologic issues (26%), pulmonary conditions (23%), hypertension (19%), endocrine issues (19%), cardiac problems (18%), and psychiatric disorders (17%).

As stated in the annual report section of this application, Severe Maternal Morbidity fundamentally affects the lives of mothers, newborns, families and health care provider teams, and can result in prolonged hospital stays, substantial medical costs, higher life-long burden of health problems, physical and emotional stress, and interference with maternal-newborn bonding, and is associated with an increased risk for maternal death, and therefore NY's Title V program will continue its focus on this important public health issue. In August 2017, NY published a manuscript summarizing the findings from the surveillance of SMM. The understanding gained from this work continues to inform Title V efforts to address women's health before, during and beyond pregnancies.

Preconception health, assessing and addressing factors impacting a woman's health, remains a Title V priority area. Improving birth outcomes for mothers and infants requires a life course perspective. Preconception and inter-conception health care – including prevention of unintended pregnancy through the use of effective contraception; identification and follow-up for medical, behavioral and psychosocial risk factors; promotion of healthy behaviors including proper nutrition, access to quality oral health services, and, optimal management of chronic disease – should be an integral component of health care for all women regardless of pregnancy intentions. The concept of preconception health will continue to be woven into the fabric of many of NY's Title V strategies and activities.

While NY's SAP focuses on specific strategies and measures to promote well woman care and preconception health, efforts will continue to build on the extensive body of MCH public health programs and activities in place through NYS's Title V Program, including: Comprehensive Adolescent Pregnancy Prevention Program (CAPP); Family Planning Program; SBHC; Maternal and Infant Community Health Collaboratives (MICHC); MIECHV; Perinatal Regionalization; MMR; New York State Perinatal Quality Collaborative (NYSPQC); and, the GUHH (See Section V Form 7). Additionally, this work will leverage continued collaboration with NY's extensive network of partners including OHIP which administers NY's Medicaid program, including but not limited to Medicaid Managed Care, Health Homes, Family Planning Benefit Program, Family Planning Extension Program, Medicaid Prenatal Care Programs and related 1000 Days on Medicaid initiatives. This priority is closely linked to other state priorities including: Priority #2: Reduce infant mortality and morbidity; Priority #3: Support and enhance social-emotional development and relationships for children and adolescents; and all four Life Course priorities (#5-8). Strategies to address maternal mortality and morbidity are largely inextricable from those to address infant mortality and morbidity; thus, the strategies described for Domain 1 and Domain 2 should be considered part of the continuum of public health activities to improve both maternal and infant maternal mortality and morbidity.

Progress toward achievement of outcomes associated with Priority #1 *Reduce maternal mortality and morbidity* will continue to be tracked through **NPM #1: Percent of women with a past year preventive medical visit, ESM** 1.14**: Percentage of women enrolled in Medicaid who are screened for maternal depression during postpartum care and two SPMs: 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 and SPM 2: The percentage of women age 15-44 years and enrolled in Medicaid using the most effective, or moderately effective methods of contraception**. These SPMs address key elements of preconception health care and leverage important investments and collaborations that NY's Title V Program has with the DOH DCDP/BRFSS (SPM 1), DOH OHIP and OQPS.

Strategy MWH-1: As discussed in the Annual Report section of this application, in 2018, NYS's Governor Cuomo announced a multi-pronged strategy to address maternal mortality and morbidity including, but not limited to:

- Implement the recommendations of the Governor's Task Force on Maternal Mortality and Disparate Racial Outcomes;
- Establish a Maternal Mortality Review Board (MMRB) via the legislative process, building off the Title V Program's current maternal mortlaity public health surveillance process;
- Launch a Best Practice Summit with hospitals and OB/GYNs;
- Pilot Medicaid expansion for doulas;
- Support Centering Pregnancy demonstration projects;
- Require Medical Education and curriculum development; and
- Expand the NYSPQC (further addressed in the Annual report and application sections); and
- Launch Commissioner Listening Sessions to hear from women and advocates across NYS to better understand those factors that impact maternal mortality and morbidity.

Efforts implemented to date related to these initiatives were reviewed in the Annual Report section of this application. Title V staff are working with key stakeholders and partners on these priorities to improve health 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.

The Maternal Mortality Review Initiative will continue to 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 NYSPQC with partners (e.g., hospital associations, regional perinatal centers and affiliate obstetrical hospitals), continue maternal death case ascertainment and review process and issue reports of maternal death review findings and trends. NY has an established public health surveillance process in place to identify and review cases of maternal death through multiple sources of public health data and chart reviews. Title V plans to continue this review process while aiming to release data reports every two years to support prevention and clinical improvement strategies with partners. The next step is for NY to launch its MMRB to enhance the current process by including variety of experts who can provide more in-depth thorough clinical reviews of each pregnancy-related mortality case to better understand those factors impacting these outcomes.

Work also continues Centering Pregnancy to improve access to and quality of prenatal care. OHIP is piloting the Centering Pregnancy projects in select high-need communities in the state and will be assessing their impact for consideration of expansion across the state. Title V staff helped inform the selection of the high priority areas for the Centering Pregnancy project and will help promote the benefits of both initiatives. Outcome measures have been developed to assess the impact of Centering Pregnancy . A focus in the coming year will be to expand programs in clinics with already established Centering Pregnancy programs by June 2019 and then focus on clinics seeking to establish new programs. The target communities are those with the poorest birth outcomes including communities in NYC, and Erie, Niagara, Monroe, Onondaga, Oneida, Albany, Rockland, Nassau, Suffolk and Westchester Counties.

The Medicaid Doula Pilot will also continue. As discussed in the annual report section of this Domain, under the pilot, doula services are available for any Medicaid-eligible pregnant woman in fee-for-service or Medicaid Managed Care in specific geographic locations. Phase 1 of the pilot project began March 1, 2019 in Erie County. Phase 2 of the project will include selected zip codes in Kings County once provider capacity has been achieved. This two-year pilot includes an analysis of data including breastfeeding rates and adherence to postpartum visits. It will also assess doulas' and mothers' experiences and feedback on participation in the program. OHIP has ongoing engagement with stakeholders and has made several adjustments in order to increase participation in the pilot by both pregnant women and doulas.

In addition to improving prenatal care in high need communities, it is imperative to ensure quality inpatient perinatal care. 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 a tertiary care hospital 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 work of the Taskforce on Maternal Mortality and Disparate Racial Outcomes, 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 2017 annual report, Title V is working toward incorporating SMM case identification and analysis in 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 maintain the MCH dashboard developed and launched in 2018, mirroring the objectives and outcomes reflected in NY's SAP. The MCH dashboard, closely aligned with the dashboard for NY's Prevention Agenda (PA) provides 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.
https://webbi1.health.ny.gov/SASStoredProcess/guest?
_program=/EBI/PHIG/apps/mch_dashboard/mch_dashboard&p=sh

Strategy MWH-3: In collaboration with key partners, continue to co-convene work with community stakeholders 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. Partners from the PMH will be involved in several initiatives discussed throughout this application all with a goal of advancing 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.

Individuals from the Listening Sessions universally shared that community health workers were tremendous support during and after their pregnancies. Expanding access to Community Health Worker (CHW) services was therefore a top recommendation made by the Taskforce on Maternal Mortality and Disparate Racial Outcomes. Governor Cuomo's 2019 Justice Agenda recommends the expansion of the Community Health Worker programs in key communities across the state to provide needed social support, information, and advocacy. CHWs are a trusted and valued community resource as individuals navigate the healthcare system. This proposal will expand CHW activities to address key disparities, including providing more childbirth education and support, assisting in the development of collaborative child care and social support networks, assisting with the development of a birth plan and supporting increased health literacy among communities around the state. Implementation of CHW expansion will be through the MICHC program. It is anticipated that with additional funds from Medicaid, beginning later this year, NY's MICHC program will add approximately 50-60 CHWs and serve an additional 2,400 prenatal and postpartum women.

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 NYS RPCs and RPC-affiliate birthing hospitals, which seeks to provide the best and safest care to NYS' women and infants through the translation of evidence-based guidelines to clinical practice. The NYSPQC, ACOG-NY, HANYS, GNYHA and NICHQ, will continue to lead the NYS Obstetric Hemorrhage Project to assist birthing hospitals across NYS with improving the assessment and management of maternal hemorrhage, one of the leading causes of maternal morbidity and mortality in NYS. The project will continue to focus on: team sharing and learning to promote collaborative learning; 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. This initiative aligns with the goals and measurement strategy of 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.

Further, the NYSPQC also in collaboration with ACOG District-NY, HANYS, GNYHA, and NICHQ, is leading the NYS Opioid Une Disorder (OUD) in Pregnancy/NAS Project. This learning collaborative, which kicked-off in September 2018, and is currently being piloted in 19 birthing hospitals, seeks to identify and manage women with OUD during pregnancy, and improve the identification, standardization of therapy, and coordination of aftercare of infants with NAS. NYS fully participates in the national AIM through this project.

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 coercion, 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.

In addition, Title V will work with providers on the equity concerns that surround the use of LARC. The New York State Family Planning Training Center has provided training to family planning providers to emphasize equity and reinforce reproductive justice principles in the delivery of family planning services. Webinars were conducted in mid-2018 to promote use of patient-centered methods to assess reproductive intention, and to introduce a shared decision-

making model for contraceptive counseling. In addition, the annual New York State Family Planning Program provider meeting featured a keynote address to discuss the role of client-centered care in reducing disparate health outcomes. In 2019, the New York State Family Planning Training Center will conduct a series of in-person regional trainings for family planning providers across the state that will focus on developing individual and organizational strategies to reduce implicit bias in family planning settings and promote health equity.

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 study on the quality of prenatal care provided through the Medicaid Prenatal Care Program. From January 2017 – December 2018, OQPS conducted a Perinatal Care Performance Improvement Project with 15 NYS Medicaid Managed Care plans. The focused on four areas:

- 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.

The study ended December 31, 2018. Data will be available in July 2019.

Title V staff will continue to participate in quarterly Prenatal Care Workgroup meetings to provide input into quality improvement activities and provide updates on the NYSPQC (http://www.nyspqc.org).
Several new initiatives began in 2016 and continued into 2018 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 (August 1, 2016 - July 31, 2021) that 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. 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 focused on improving developmental screening at six pediatrics practices, including: Niagara Street Pediatrics, Towne Gardens Pediatrics, Main Street Pediatrics, Neighborhood Health Center, Jericho Road Community Health Center, and

Tonawanda Pediatrics. The team credits the changes and improvements they have made to the importance of creating run charts of ASQ data. In the upcoming year the team will be designing a referral algorithm for families with young children.

At the other end of the state, under the leadership of Dr. Isakson, the Nassau team has used ECCS activities to support the implementation of Help Me Grow Long Island. Help Me Grow Long Island offers free developmental and social emotional screens and provides free, virtual, ongoing support to families with young children on Long Island who have concerns such as their child's development or behavior, navigating service systems, or locating baby items. Nearly 800 screens have been completed in the last year alone. The Nassau team is working with partners on creative ways to spread information about developmental health among families and increase the number of sites providing developmental screens. In the upcoming year, Nassau County ECCS will continue to build their HMG Long Island infrastructure to help achieve the 5-year ECCS aim and meet ECCS reporting requirements.

At the state level the ECCS initiative is connected to various TA initiatives and statewide workgroups and committees such as OHIP's First 1000 Days on Medicaid Initiative, the New York Strengthening Infant/Toddler Policies and Practices, the NYS Infant and Early Childhood Mental Health TA initiative, the NYS Parenting Education Partnership, and workgroups on the NYS Governor's Early Childhood Advisory Council and the Governor's Child Care Availability Task Force. In addition to maintaining and growing state partnerships, the state ECCS impact grantee plans to further develop a Community Readiness Scale for New York State Communities to help them assess their readiness and capacity of using collective action to improve their early childhood systems, engage in peer-to-peer support, prepare for project sustainability and inform NYS policy decisions.

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 and other areas.

Through Governor Andrew Cuomo's *Report on the Status of New York Women and Girls, 2018 Outlook*, additional efforts to address maternal depression and reduce maternal mortality were launched and progress was made. Of the efforts initiated, Title V staff will continue to work on the following: assisting OMH in increasing awareness and use of the Project TEACH expansion for maternal mental health consultations and training; developing and disseminating social media posts addressing stigma and awareness; and coordinating WIC and home visiting screening and referrals where possible.

As discussed in the Annual Report, Title V staff are participating in the Center on Law and Social Policy's Moving on Maternal Depression learning collaborative. Staff participate on the core and data teams and will help with dissemination of lessons learned and promising strategies arising from the collaborative.

Similar to the ECCS Impact initiative, Title V staff working in Home Visiting 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 in the Perinatal and Infant Health Priority. Title V staff participate on a workgroup to support the HealthySteps initiative to engage both the child and family during routine early-life medical 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 up to three communities and an identification of common programmatic elements that could be paid for through Medicaid funding. Title V staff will continue to participate on the leadership team for the home visiting workgroup and will help with the pilot implementation and dissemination of payment levers as they are identified and established.

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 by the evidence-based models and MICHC CHWs. 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, OASAS, 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 tripled between 2010 (5.4) and 2016 (15.1). However, the age-adjusted rate of heroin deaths increased by over six times from 1.0/100,000 in 2010 to 6.5/100,000 in 2016, whereas the age-adjusted rate of opioid pain reliever deaths per 100,000 increased 2.7 times between 2010 (4.3) and 2016 (11.7). During the same time period, the age-adjusted rates of overdose among women also increased reaching 8.1 per 100,000 population in 2016.

Addressing the opioid epidemic in NYS is a priority. DOH is focusing on statewide prevention activities to build a coordinated approach to fight addiction. Efforts include:

- Identifying and sharing data between agencies and affected communities:
- Developing training for health care providers on addiction, pain management and treatment;
- Making the prescription drug monitoring program easier for providers to access and use;
- Providing resources to assist communities in combating the opioid epidemic at the local level; and,
- Coordinating statewide and community programs to improve the effectiveness of opioid prevention efforts.

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 participated 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. Title V staff was on the core team of state and local agency partners. The initiative's priorities were screening, peer services, access to treatment, and NY's response to the CARA amendment to CAPTA. The grant ended in February 2019, however efforts to develop systems for implementing plans of safe care continue as roles for local providers are worked out in pilot communities. Many partners need to be engaged to ensure pregnant and parenting women using opioids receive appropriate care and support for themselves and their infants.

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 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 monthly 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.

Additionally, the Women Who Use Drugs Workgroup is comprised of various stakeholders, including the Title V Program, AIDS Institute Office of Drug User Health, ACOG District II, healthcare providers, midwives, doulas, county health departments, universities and community-based organizations. The workgroup focuses on substance use disorders in women and perinatal substance abuse. The workgroup is focused on educating providers on substance use disorder in women, promoting treatment for substance use disorder, reducing the stigma around addiction, supporting trauma informed care, encouraging breastfeeding and promoting ethical care for women with substance use disorder. The group continues to meet monthly.

Staff from the NYSPQC are also working collaboratively with the NYS Breastfeeding Coalition to develop topic ideas for a Grand Rounds event that will take place in August 2019 and focus on breastfeeding for women who use opioids.

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-2016	5.4	NPM 3
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2016	4.5	NPM 3 NPM 5
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2016	3.0	NPM 3
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2016	1.5	NPM 5
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2016	152.0	NPM 3
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2016	47.4	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)
Indicators and Annual Objectives

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data			
	2016	2017	2018
Annual Objective	91	91	93.4
Annual Indicator	92.3	92.7	92.5
Numerator			
Denominator			
Data Source	NYS VS	NYS VS	NYS VS
Data Source Year	2014	2015	2016
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	93.7	94.0	94.3	94.6	94.8	95.1

Evidence-Based or –Informed Strategy Measures

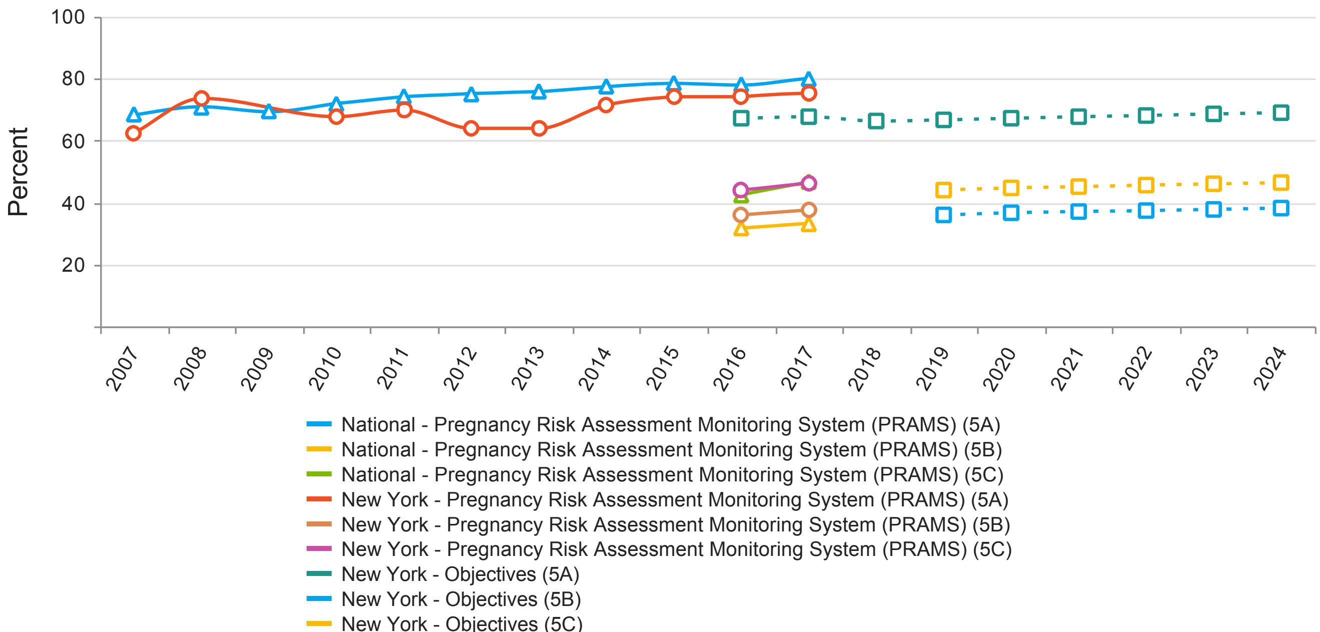
ESM 3.1 - Percentage of birthing hospitals re-designated with updated standards.

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		0	0
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	NYS Title V Program records	NYS Title V Program records	NYS Title V Program records
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	0.0	100.0	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 Indicators and Annual Objectives



National - Pregnancy Risk Assessment Monitoring System (PRAMS) (5A)
National - Pregnancy Risk Assessment Monitoring System (PRAMS) (5B)
National - Pregnancy Risk Assessment Monitoring System (PRAMS) (5C)
New York - Pregnancy Risk Assessment Monitoring System (PRAMS) (5A)
New York - Pregnancy Risk Assessment Monitoring System (PRAMS) (5B)
New York - Pregnancy Risk Assessment Monitoring System (PRAMS) (5C)
New York - Objectives (5A)
New York - Objectives (5B)
New York - Objectives (5C)

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

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2016	**2017**	**2018**
Annual Objective	67.1	67.6	66.2
Annual Indicator	63.9	73.9	75.3
Numerator	135,686	155,836	152,784
Denominator	212,507	210,880	202,843
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2015	2017

State Provided Data			
	2016	2017	2018
Annual Objective	67.1	67.6	66.2
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						
	2019	2020	2021	2022	2023	2024
Annual Objective	66.6	67.1	67.6	68.0	68.5	68.9

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2018
Annual Objective	
Annual Indicator	37.6
Numerator	71,966
Denominator	191,278
Data Source	PRAMS
Data Source Year	2017

State Provided Data		
	2017	**2018**
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**	**2024**
Annual Objective	36.0	36.7	37.1	37.4	37.8	38.2

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2018
Annual Objective	
Annual Indicator	46.3
Numerator	89,933
Denominator	194,052
Data Source	PRAMS
Data Source Year	2017

State Provided Data		
	2017	2018
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	2024
Annual Objective	44.0	44.7	45.1	45.6	46.0	46.4

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	2018
Annual Objective	90	90
Annual Indicator	91.7	91.6
Numerator		831
Denominator		907
Data Source	NYS sampled Birthing Hospitals	NYS sampled Birthing Hospitals
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	90.0	90.0	92.0	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	2018
Annual Objective		72	73
Annual Indicator	71.7	71.6	70.8
Numerator			
Denominator			
Data Source	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	75.0	77.0	78.5	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.

NYSPQCFY 2018 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 4.5 per 1,000 live births in 2016, compared with 4.6 per 1,000 births in 2015. The number of infant deaths was 1,045 in 2016, 314 fewer than in 2008. From 2008 to 2016, the IM rate declined 9% for non-Hispanic Whites to 3.45 per 1,000 live births; 28% for non-Hispanic Blacks to 7.85 per 1,000 live births; and 3% for Hispanics to 3.6 per 1,000 live births. Non-Hispanic Asian and Pacific Islanders had the lowest rate in 2016 at 2.87 per 1,000 live births, representing a 13% decrease since 2002 for this group. From 2008 to 2016, the neonatal mortality rate declined by 19% to 3.0 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 2016, unchanged from 2015. In 2016, 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 2016 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 5.2 per 1,000 live births in 2015 vs. 6.0 on the national level. NY fares better than the national average based on National Vital Statistics Data for 2015 for **NOM #9.1 Infant mortality rate per 1,000 live births** at 4.5 vs. 5.9. NY is also lower than the national average for **NOM #9.2 Neonatal mortality rate per 1,000 live births** (3.20 vs. 3.88) and **NOM #9.3 Post-neonatal mortality rate per 1,000 live births** (1.7vs. 2).and **NOM #9.4 Preterm-related mortality rate per 100,000 live births** (175.9 vs. 200).

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. The NY's Title V program developed and is implementing an expanded plan for analysis and reporting of infant mortality and selected morbidity data. The initial data report, *New York State Infant Mortality Report 2019*, highlighting collaborations and describing trends in NYS's IM rates between 2002 and 2016, the DOH's plan to reduce IM, and identifying further efforts needed to reduce IM was developed and is under review.

To monitor progress of improving the health of women, infants, and children and reducing health disparities, Title V staff collaborated 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 is comprised of National Performance and Outcome Measures as well as State Performance Measures and Objectives. The dashboard serves 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 collaborated to support the data presentation and content of the dashboard, which was released for public use in September 2018. Title V staff collaborated with OPHP to create a list of indicators, determined state specific targets for the measures, and provided an outline of supporting documentation for the indicators. The Dashboard

integrates data from multiple sources, includes State and county-level, socio-economic, race/ethnicity and historic data. The measures are presented visually as trend graphs, bar charts, maps and tables, and compare change over time and as related to 2020 MCH objectives.

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 2,713 families in the FY18 (10/1/2017 to 9/30/2018) reporting period. OCFS receives MIECHV funding through an MOU with the DOH to fund Healthy Families programs. Within FY18, two new Healthy Families programs were initiated (Public Health Solutions in Queens County and Society for the Prevention of Cruelty to Children in Monroe County) with MIECHV funding. At the start of FY19, on 10/1/18, two Nurse-Family Partnership programs (Public Health Solutions in Queens and Catholic Health Services in Erie) began receiving MIECHV funds as a result of a a re-procurement of the State and MIECHV funded Nurse-Family Partnership programs. The following items are data on the four constructs within the Maternal and Newborn Health Benchmark related to newborn health.

- 11.7% of infants, born during the reporting period, were born preterm
- 36.8% of infants, with mothers enrolled prenatally, were breastfeeding at six months of age
- 24.4% of infants received the last recommended well-child visit during the reporting period 42.0% of primary caregivers who reported using tobacco or cigarettes at enrollment were referred to tobacco cessation counseling or services within three months of enrollment.

HRSA requires an 85% filled capacity rate for MIECHV programs. To facilitate increasing referrals into MIECV programs, Title V staff conducted focus groups in five counties (Erie, Bronx, Schenectady, Chemung, Nassau) to help understand the best terminology, imaging, and messaging for use with families to encourage acceptance of home visiting services. The focus groups were conducted with pregnant and parenting women and will help guide and direct messaging for a promotional campaign to encourage pregnant and parenting families to visit the DOH home visiting web pages that were developed over the past year. The web pages contain a searchable chart that assists families to locate evidence-based home visiting programs in their community. The searchable chart on the DOH website is at https://www.health.ny.gov/ParentingSupport. Title V staff presented on these findings at the third annual NYC Home Visiting Summit in October of 2018.

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, extending their service contracts through September 2020. 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; promoting and supporting access to comprehensive primary and preventive health care including oral health services; and through education, support, and home visits, 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. Stakeholders,

including pediatricians and 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. It is important to match families to home visiting programs that can best meet their needs to maximize the family’s ability to stay to dosage and to so communities can use all of the home visiting programs available. 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. The first cohort 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. The second cohort began in January 2018 and includes ten teams. Title V staff have provided programmatic support through in-person meetings, monthly coaching calls, sample tools, webinars, and ongoing technical assistance. Lessons learned include focusing time up-front on building trust and familiarity among home visiting programs on the local level through creating and maintaining a regular meeting schedule. 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 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 quarterly with the HS grantees to discuss communication, collaboration, and coordination between the HS, MIECHV, and MICHC programs to maximize existing resources and improve community infrastructure. 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 is developing.

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. Title V staff continued monthly MICHC calls and quarterly MIECHV calls. Topics for both MICHC and MIECHV calls included maternal depression, submission of annual data reports, oral health, collaborative outreach, and services available through the NYS Office of Alcoholism and Substance Abuse Services.

Title V completed the data analysis from 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. A full report was completed in April 2018. Results showed no significant change in retention regardless of strategy used. It appeared that these strategies required significant effort on the part of home visiting staff which may not have been sustainable in the long term. There was also inconsistency in the collection of data on the part of the programs that may have impacted the results. Future efforts for interventions will take these findings into consideration and select strategies accordingly.

For the 2017-2018 MIECHV CQI cycle, DOH focused efforts on breastfeeding duration and improving referrals into the home visiting program and received TA from HRSA to build competencies for these CQI strategies. The support from the practicum helped establish a strong CQI framework for NYS, which will foster replication in future years. All MIECHV programs were invited to participate in the federal TA practicum. The primary goal for this fiscal year was to build CQI competencies at the program level. This strategy was successful, and some programs set and achieved SMART Aims during the year as well as follows. The Buffalo Prenatal-Perinatal Network Healthy Families program increased their breastfeeding duration at 3 months (data that can be tracked at the local level) from 16% at the beginning of FY 2018 to 37% by the end of 2018. The SCO Family of Services Nurse-Family Partnership Program also achieved their first SMART Aim and reduced the average number of days between referral and enrollment, from 61 days to 31 days, and reached their funded capacity. Title V staff provided training in CQI methods to all programs on a series of monthly webinars. Webinar topics included, process mapping, setting SMART Aims, PDSA cycles, using data, outreach/referrals, and breastfeeding. In addition to training webinars, NYS also provided two opportunities for peer-to-peer webinars where LIAs successfully implementing CQI methods and shared strategies and successes.

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 provided support for three community colleges, a community-based organization and a high-school based in NYC. These programs were selected based on 2015 NYS Vital Statistics data showing Kings, Bronx and Queens counties with the highest birth rates among 15 - 24-year-old females. This initiative, which was funded for the period 7/1/17 – 6/30/18, worked to create and sustain supportive systems that assist pregnant and parenting teens and young adults to succeed through health, education, self-sufficiency, and building strong families. The funded projects collaborated 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 7/1/17 – 6/30/18, the program served 432 students, developed 115 new partnerships, and made 863 referrals. The most frequently cited needs of the program participants were help obtaining information, resources, or services for: healthy relationships; education or employment services; concrete needs such as transportation, child care, supplies for their children, and food; and family planning.

A new Pathways to Success project was funded beginning 7/1/18-6/30/20 with a continued focus in NYC. Funding continues to provide support for programs in three community colleges and a community-based organization (Hostos, LaGuardia and Borough of Manhattan Community Colleges and community-based organization Public Health Solutions) 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. To date, the program has served 429 expectant and parenting students. More than 60 of these students are graduating in May 2019, 50 of which are graduating from Hostos. In addition, one of the student parent participants attending Hostos is graduating as the valedictorian. The colleges have also held many events to prepare students to enter the workforce or transfer to a four-year college after graduation.

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 2016, 92.5% 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 an 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 to and 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 has developed a process to update standards for perinatal regionalization in NYS, re-designate all obstetrical hospitals and birthing centers, and develop standard metrics to assess maternal and neonatal outcomes to identify opportunities for quality improvement. 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 OHIP, 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 of 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. Subcommittees were formed to address several topics, including the role of the RPC; neonatal and maternal subspecialists requirements; behavioral health; patient transfers; volume and acuity standards as well as finance. Most of the recommendations have been finalized with subcommittee discussions remaining to address final recommendations regarding subspecialists, volume and acuity standards and finance. In addition to receiving input from the expert panel, Title V staff held conference calls with lower level birthing hospitals from around the state to ensure their perspective is captured in the recommendations to the standards and in relation to the perinatal system.

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 midwifery-led birthing centers in NYS. Regulations related to midwifery-led birthing centers have been developed and will likely be adopted in the first half of 2019. The new standards will include physician-led and midwifery-led birthing centers as the first level of care. followed by Level 1 through 3 hospitals. RPCs represent 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, so that all pregnant and postpartum patients and newborns 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 leads 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. During the reporting period, several initiatives under the scope of the NYSPQC have focused on reducing infant mortality and morbidity including the: NYSPQC Hospital-based Safe Sleep Project and IM Collaborative Improvement and Innovation Network (CoIIN) Community-based Safe Sleep Project, NYSPQC Enteral Nutrition Improvement Project, and NYS Opioid Use Disorder (OUD) in Pregnancy and Neonatal Abstinence Syndrome (NAS) Project.

NYS also administers a strong Newborn Screening Program that collects, analyzes and reports on newborn specimens for 50 diseases and condition 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 with systems in place to better ensure early identification and proper treatment of these infants.

The NYSPQC Hospital-based Safe Sleep Project was active between September 2015 and October 2018. The project focused on improving infant safe sleep practices to reduce IM in NY and aligned with national and NY efforts pertaining to the IM CoIIN. NY's Title V program worked with 81 of the 123.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. From July 2017, through October 2018, the project was in sustain mode. During this phase of the project, 70 birthing hospitals continued 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. Between August 2017 and October 2018, this measure remained steady, with approximately 90% of infants being observed in a safe sleep environment.

Under the HRSA-led national IM CoIIN, the Title V program launched a new phase of the NY Safe Sleep IM CoIIN in July 2018, with a focus on community-based organizations, to continue to reduce disparities in infant mortality through the promotion of infant safe sleep. Since October 2018, six pilot sites, specifically MICHC and MIECHV grantees, have been participating in the project. The pilot sites are administering surveys to caregivers during the postpartum period, 30-60 days after their organization has provided the caregiver with safe sleep education. During the reporting period, the project held five Coaching Call webinars. To support the pilot sites' efforts, the Title V program provided Sleeping Safely Starter Kits and *Sleep Baby Safe and Snug* board books from the Charlie's Kids Foundation to each participating pilot site. In October 2018, the Title V program also provided safe infant sleep clothing (sleep sacks) and board books to all MICHCS and MIECHV grantees in NYS.

Additionally, Title V continued to increase 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. The NYSDOH patient education materials highlighting the ABCs of safe sleep (Alone, Back, Crib) are available at no cost to the public. 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. 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.

Finally, Title V staff are collaborating with the National Action Partnership to Promote Safe Sleep – Innovation and Improvement Network (NAPPSS-IIN). 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 hospitals during the reporting year included New York Presbyterian (NYP) Lawrence (Westchester).

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 10th percentile on the Fenton growth scales. Outcome, process, and balancing measures are calculated for infants born prior to 31 weeks' gestation, admitted within 48 hours of birth to a NICU, and discharged alive. Key measures are: the percentage below the 10th percentile for discharge weight on the Fenton Growth Scale, difference in Z-scores for birth and discharge weights, incidences of nosocomial sepsis and necrotizing enterocolitis (NEC), 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, with rates considerably higher among the RPCs, likely due to greater use of donor human breast milk. Increased usage of breast milk fortification among the RPCs may be responsible for stemming the earlier reversals of gains in growth improvement presumed to have been related to the 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). Consistent lack of increase in the incidences of nosocomial sepsis and NEC, as well as in discharges above the 75th percentile for weight 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 published in *The Journal of Pediatrics* in June 2018, and eight abstracts have been published and presented at national meetings based on this project.

Further, the NYSPQC, in collaboration with ACOG District-NY, HANYS, GNYHA, and NICHQ, is leading the NYS OUD in Pregnancy/NAS Project. This learning collaborative, which kicked-off in September 2018 and is currently being piloted in 18 pilot site birthing hospitals, seeks to identify and manage women with OUD during pregnancy, and improve the identification, standardization of therapy, and coordination of aftercare of infants with NAS. The

project is aligned with the national Alliance for Innovation in Maternal Health (AIM).

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 Preferred Provider Systems (PPSs) 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. Two PPSs – Finger Lakes PPS, and Catholic Medical Partners in western NY – selected establishing or expanding NFP programs as one of their strategies. Catholic Medical Partners began implementing an NFP in Chautauqua County in 2016 and is soon to implement an NFP program in Erie County (Buffalo area). Until recently, Catholic Medical Partners had been implementing a community health worker model instead. The Finger Lakes PPS has not begun NFP services using their DSRIP dollars but still plans to deliver services in Rochester.

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 (Westchester County) 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 pregnant women and make and track referrals to 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 were 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. Data of risks identified, and referrals made are starting to be collected in 2019.

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 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 20 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 4.5 per 1,000 births in 2016, down from 4.6 in 2015 and same as 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 2016, 92.5% 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 75.3 in 2017. 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 will continue to update the *New York State Infant Mortality Report 2019* (currently under review) as data is available, that is a document that describes trends in IM rates in NY between 2002 and 2016 and the action plan to reduce the number of infants who do not survive their first year of life.

As stated in the annual report section of this domain, Title V staff collaborated with the Department's OPHP to develop a MCH dashboard. Title V staff identified those measures that were included in the initial release of this dashboard and determined state specific targets for the measures as well as a process to increase awareness of the existence and use of the dashboard among key stakeholders . This launched in September 2018. On a semi-annual basis, the Dashboard will be reviewed, and necessary updates and /or enhancements will be scheduled appropriately. Plain language descriptors of each measure have been drafted to offer a more accessible reading level and will be added to the Dashboard in a future release.

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 2016, 92.5% 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 birthing 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 in the state, engage RPCs and their affiliates in quality assurance and improvement activities to implement the updated standards, and monitor and improve performance and outcomes.

This project began in 2017 and is jointly led by the DOH OPCHSM, which is responsible for regulatory oversight of hospitals. An expert panel was created to assist DOH in making recommendations to the perinatal standards. This close partnership with key partners including birthing hospitals, clinicians, hospital associations, professional organizations and other key stakeholders who formed the perinatal regionalization redesignation expert panel was essential in the process. As discussed in the Annual Report section of this application, the expert panel met throughout the past two years to discuss the current perinatal standards and make recommendations on the standards to improve the perinatal system of care. In addition to input and recommendations from the expert panel,

Title V staff held conference calls with lower level birthing hospitals from around the state to ensure their perspective is captured in the recommendations to the standards and in relation to the perinatal system. (Refer to the 2018 annual report section of Perinatal and Infant Health for more information on this project).

Once the recommendations are finalized, DOH will consider all recommendations to finalize the perinatal standards for levels of care in NYS. Finalized standards will be shared with the expert panel as well as other stakeholders via webinars to ensure all are informed of the updated requirements. In addition, a preliminary survey process will be conducted among all NY birth centers and birthing hospitals to assess the potential impact of the proposed regulations. The final regulations will be adopted following NYS regulatory procedures, including response to public comment. All birth centers and birthing hospitals will be surveyed to assess the appropriate level of care, with site visits to all Level III and RPCs, and a subset of the birth centers and Level I and II facilities. Due to the complexity of the undertaking, this has been a multi-year process, however final re-designations are expected to be complete in 2020. DOH is also researching state and national metrics to inform the development of metrics that will serve to monitor the systems of services as well as provide a vehicle to identify opportunities to improve performance and outcomes of the birth centers and hospitals in NYS. NY's Enacted State budget included funding for a perinatal data warehouse that will support efforts to assess the impact of perinatal regionalization.

Finally, significant challenges exist in rural areas of NYS due to lack of subspecialists, travel distances to higher level perinatal hospitals and weather conditions that can impact the ability to travel when higher level of care is required. NY enacted budget contains up to $5 million in funding from health care transformation funding to develop and support rural telehealth for perinatal services. The Title V program is organizing a meeting in May 2019 that will bring in clinicians and stakeholders from across NYS and Dr. Curtis Lowery and Tina Benton from the Arkansas Antenatal and Neonatal Guidelines, Education and Learning Systems (ANGELS) to share information regarding the implementation of telehealth and telemedicine models of care to increase access to perinatal services.

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 100% of 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;

- 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);
- 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.

Over 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 continued its work on the NYS Obstetric Hemorrhage Project, as maternal hemorrhage is one of the leading causes of maternal morbidity and mortality in NY. Through TA and monthly coaching calls, the participating obstetrical hospitals are moving towards ensuring all patients receive a hemorrhage risk assessment on admission and in the postpartum period and regular hemorrhage drills are conducted to ensure a rapid and efficient response to all maternal hemorrhages. Finally, a major focus going into the next year will be to assess the impact of disparities on maternal hemorrhage. Coupled with the development and implementation of implicit bias training, the Title V program will work with RPCs participating in this project to collect data regarding race and ethnicity to determine any possible differences in screening processes. In subsequent years, this data will be collected by the remaining participating hospitals. All these efforts are moving towards a greater understanding of the impact of race on birth outcomes in order to create equity for all individuals across NYS and ameliorate disparities. This was previously discussed under Priority 1 regarding maternal morbidity and mortality.

The NYSPQC has also implemented an initiative focused on preventing, identifying and managing women with OUD during pregnancy, and improving the identification, standardization of therapy and coordination of aftercare of infants with NAS. The OUD/NAS project is being undertaken as a collaboration of the NYSDOH,ACOG District II, HANYS, GNYHA and NICHQ, as part of the national Alliance for Innovation in Maternal Health (AIM). The NYS specific project began in September 2018, and staff has hosted an in-person Learning Session and monthly Coaching Call webinars for participating hospital teams., The project's data strategy was rolled out in February 2019. Nineteen NYS birthing hospitals are participating in the pilot phase of the project.

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. The FY19 MIECHV CQI cycle will continue the two projects from the last fiscal year, addressing the following topics: referrals into programs and breastfeeding duration. These topic areas closely align with the

MIECHV state and federal priorities. The focus on referrals into the program is to increase referrals into programs for increased enrollment by September 30, 2019, to increase the MIECHV capacity utilization to 85% from 69.5%. 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 36.8% to 40.5% by September 30, 2019. The programs developed an understanding of the components of CQI during the last cycle. At the beginning of this cycle, the programs completed a CQI Charter and Project Plan and set baseline data. Title V staff will support MIECHV programs as they implement their project plans with Plan, Do, Study, Act (PDSA) cycles. Title V staff will have individual coaching calls with each program on a quarterly basis, with additional individual calls as necessary. There will also be two peer-to-peer learning sessions in the coming year for programs to share successes.

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 sixteen pilot communities to build systems that work for their community. 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.

To help the MIECHV programs reach the HRSA required 85% filled capacity, in addition to coordinated intake pilot, Title V staff are developing a home visiting promotional campaign. Focus groups were conducted to help understand the best terminology, image, and messaging for use with families in the MIECHV counties and are guiding the development of materials for this campaign. The campaign is set to launch in summer of 2019 in the nine MIECHV funded counties. Through these efforts, NY's Title V program will continue to promote engagement into evidence-based home visiting programs and support efforts to increase retention of families in this most valuable program.

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.

As heard universally during the Listening Sessions conducted in 2018, CHWs provided needed information and support for pregnant and parenting individuals. Governor Cuomo's 2019 Women's Justice Agenda included the expansion of the Community Health Worker (CHW) programs in key communities across the state to provide needed social support, information, and advocacy. Community health workers are a trusted and valued community resource as individuals navigate the healthcare system. This proposal expands CHW activities to address key disparities, including providing more childbirth education and support, assisting in the development of collaborative child care and social support networks, assisting with the development of a birth plan and supporting increased health literacy among communities around the state. Implementation of CHW expansion will be through the MICHC program. It is anticipated that with additional funds from Medicaid, beginning 8/1/19-9/30/20, NY's MICHC program will add approximately 50-60 CHWs and serve an additional 2,400 prenatal and postpartum individuals.

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 level change. 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. 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. The MICHC and MIECHV programs will participate in an in-person provider meeting in May 2019. Trainings at this meeting include a variety of topics including self-care, STDs, human trafficking, intimate partner violence, substance use, fatherhood engagement, working with rural communities, and preconception health. Title V staff also 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 leading a project with six pilot sites, specifically MICHC and MIECHV grantees, to continue to improve safe sleep practices, with an emphasis on reducing disparities. In the coming year, pilot sites will participate in monthly Coaching Calls, complete PDSAs, and collect data with a caregiver survey to inform their improvement efforts.

Staff from the Title V are collaborating with the National Action Partnership to Promote Safe Sleep – Innovation and Improvement Network (NAPPSS-IIN). 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. In its first year, the project, funded by HRSA's MCHB, engaged five pilot site hospitals in five states, including NYS. NYS's representative hospital from the first year is New York Presbyterian (NYP) Lawrence (Westchester), and two additional hospitals will join the project this year - Crouse Hospital (Syracuse) and Montefiore Medical Center – Wakefield (Bronx). Title V staff are working as part of the larger national project, and in support of the hospital teams.

Building on previous 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, and targeted WIC clinics will be engaged to align safe sleep education efforts with local hospitals. These efforts, 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.

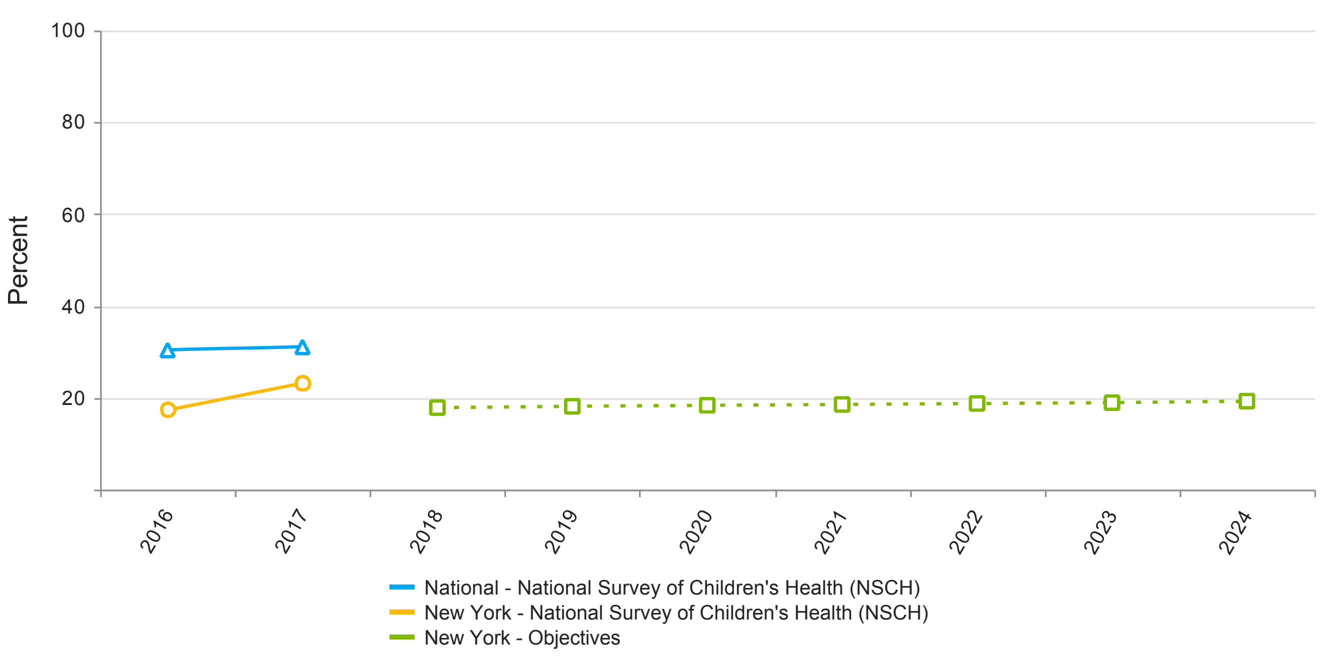
Child Health

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 or Not Reportable	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2016_2017	10.3 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	90.0 %	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
Indicators and Annual Objectives



Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			17.9
Annual Indicator		17.5	23.1
Numerator		101,178	117,256
Denominator		578,216	506,773
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

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						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	18.2	18.4	18.6	18.8	19.0	19.3

Evidence-Based or –Informed Strategy Measures

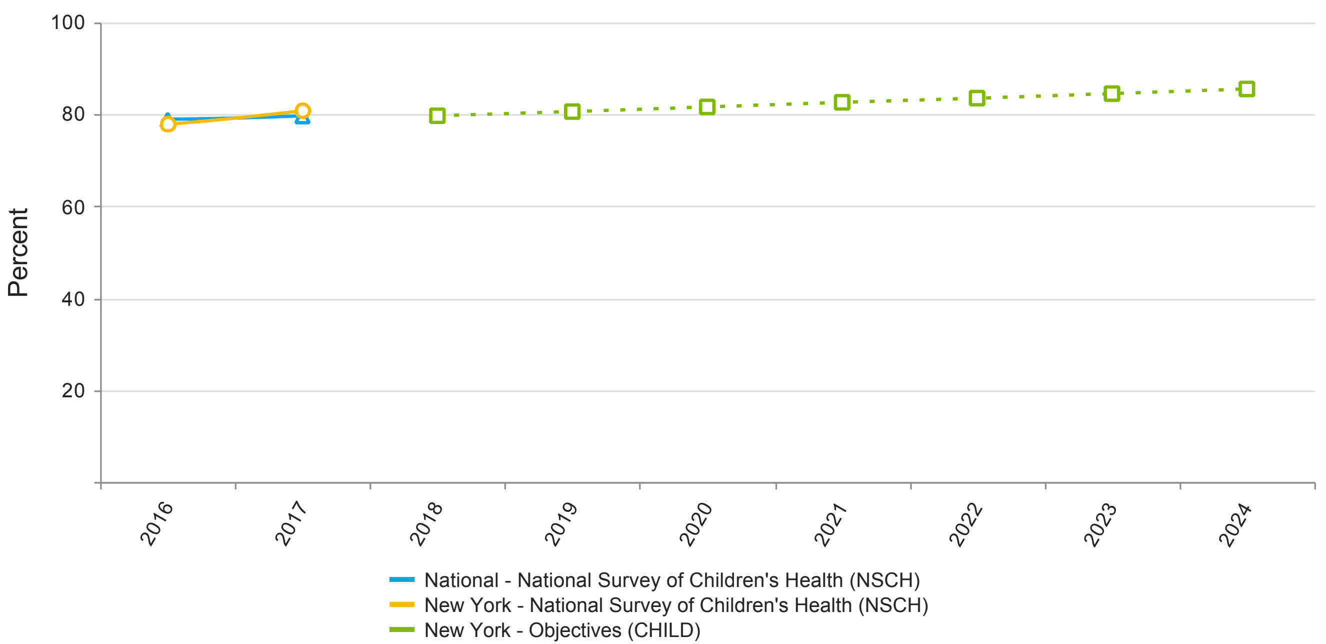
ESM 6.5 - Number of children with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home.

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		0	1,600
Annual Indicator	0	1,694	2,488
Numerator			
Denominator			
Data Source	NYS Medicaid Health Home Data	NYS Medicaid Health Home Data	NYS Medicaid Health Home Data
Data Source Year	2016-17	12/16-17	12/16-18
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	1,680.0	1,764.0	1,852.0	1,889.0	1,927.0	1,966.0

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year
Indicators and Annual Objectives



NPM 13.2 - Child Health

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			79.6
Annual Indicator		77.6	80.6
Numerator		2,955,156	3,137,003
Denominator		3,810,186	3,890,746
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

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						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	80.5	81.5	82.5	83.4	84.4	85.4

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	2018
Annual Objective		20	60
Annual Indicator	58	60	48
Numerator			
Denominator			
Data Source	NYS Title V Program records	NYS Title V Program records	NYS Title V Program records
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	61.0	61.0	62.0	62.0	63.0	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	2018
Annual Objective		40	41
Annual Indicator	61.2	50.5	39.1
Numerator			
Denominator			
Data Source	SEALS (CDC Data)	SEALS (CDC Data)	SEALS (CDC Data)
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives

	2019	2020	2021	2022	2023	2024
Annual Objective	44.0	47.0	48.0	48.0	49.0	49.0

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	2018
Annual Objective		50	50
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	To Be Developed	Developmental Assessment Tool	Developmental Assessment Tool
Data Source Year	2017-2018	2017-2018	2017-2018
Provisional or Final ?	Provisional	Final	Final

Annual Objectives

	2019	2020	2021	2022	2023	2024
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	2018
Annual Objective		72	73
Annual Indicator	71.7	71.6	70.8
Numerator			
Denominator			
Data Source	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	75.0	77.0	78.5	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 2018 Annual Report

Child Health – State Priority #3: Support and enhance children's social-emotional development and relationships.

The NYS Title V program prioritized supporting children's social-emotional development and relationships based on the established importance of the impact of high-quality relationships and environment on brain architecture, health and school readiness. The Title V program has selected this area for children and adolescents.

One key challenge to this priority is the complexity of quantifying the construct of social-emotional development and relationships (i.e., developing or selecting one or more measurement instruments, implementing broadly especially in a state as large as NY, and continually reassessing).

For the Title V grant, NYS selected the National Outcome Measure for children's overall health. Results from the 2016-2017 National Survey of Children's Health indicate that 90% of children ages 0-17 are in excellent or very good health, which compares closely with the national estimate of 89.8%. The Title V program also recognizes that systematic developmental screening is critical to identify children who may need supports and services. Based on results of the NSCH, only 23.1% of parents reported completing a developmental screening.

Title V staff collaborates with the Council on Children and Families on the Early Childhood Comprehensive Systems (ECCS) Impact grant, which supports collaborative quality improvement projects in three high-need counties (Erie, Niagara and Nassau) to improve developmental screening and follow-up for young children.

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 focused on improving developmental screening at six pediatrics practices, including: Niagara Street Pediatrics, Towne Gardens Pediatrics, Main Street Pediatrics, Neighborhood Health Center, Jericho Road Community Health Center, and Tonawanda Pediatrics. The team credits the changes and improvements they have made to the importance of creating run charts of ASQ data. In the upcoming year the team will be designing a referral algorithm for families with young children.

In Nassau County, under the leadership of Dr. Isakson, the Nassau team has used ECCS activities to support the implementation of Help Me Grow Long Island. Help Me Grow Long Island offers free developmental and social emotional screens and provides free, virtual, ongoing support to families with young children on Long Island who have concerns such as their child's development or behavior, navigating service systems, or locating baby items. Nearly 800 screens have been completed in the last year alone. The Nassau team is working with partners on creative ways to spread information about developmental health among families and increase the number of sites providing developmental screens. In the upcoming year, Nassau County ECCS will continue to build their Help Me Grow Long Island infrastructure.

Ensuring improved developmental screening is important. However, assessing social-emotional development and relationships requires more than screening. Title V staff have implemented a cross-cutting approach to this domain.

The first strategy of the SAP is to develop and implement a plan for analysis and reporting of available data on children's social-emotional well-being and adverse childhood experiences (ACES). In 2016, for the first time, the New York State (NYS) Department of Health (DOH) collected regional and state-level ACEs data from over 9,000 adults through the Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is an annual statewide

telephone survey of adults developed by the CDC and administered by DOH. The BRFSS is designed to provide information on behaviors, risk factors, and utilization of preventive services related to chronic and infectious diseases, disability, injury and death among the non-institutionalized, civilian population aged 18 years and older. ACEs were examined both individually and scored as a sum of total ACEs. New York State's BRFSS sample is representative of the non-institutionalized civilian adult population, aged 18 years and older. While respondents are over 18 years old, the information provides valuable insight to the experience of the population. One of the key findings is that ACEs are common in NYS. 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%). Adults in households with children are more likely to have reported ACEs than households that had no children. ACEs are higher among women, Hispanics and multiracial groups, though not statistically significant due to small sample size in the survey. The detailed findings about ACEs from the BRSS can be accessed online at
https://www.health.ny.gov/statistics/brfss/reports/docs/adverse_childhood_experiences.pdf

In addition to the collection of ACEs information, the Title V program has worked closely with the Council on Children and Families to support their cross-system approach, including a clearinghouse of data on children's well-being, which is located online in the Kids' Well-Being Indicators Clearinghouse (KWIC) at https://www.nyskwic.org and in the New York Kids Count Data Book (2017) at https://www.ccf.ny.gov/council-initiatives/kids-well-being-indicators-clearinghouse-kwic. The clearinghouse includes data from child welfare, abuse and maltreatment, economic security, physical and emotional health, and education.

Furthermore, within NYSDOH and aligned with the Title V Program, the Part C IDEA Early Intervention Program evaluates the program's impact on social-emotional development, including the establishment of relationships, among young children served by the EIP. The US Department of Education Office of Special Education Programs requires all state EIPs to measure the impact of the program on young children's social emotional development using a validated tool. In NYS, the Child Outcome Summary (COS) Process has been implemented. The COS Process is completed by the parents/caregivers of the child and the service providers who have been working with the child. For the sample of children who were assessed (1,357) who exited the EIP or turned three between July 1, 2017 and June 30, 2018 and were served by the EIP for at least six months, 94% made improvement in their social-emotional skills, and of those 64% made substantial improvement.

The second strategy in the SAP is to 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.

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.

Title V staff implemented a validated tool for measuring positive developmental social-emotional assets among children. The tool measures 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 three 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 from newborns through adolescence. More information about the Developmental Assets Framework developed by the Search Institute can be found online at https://www.search-institute.org/our-research/development-assets/developmental-assets-framework.

The first program that implemented the tool is the Comprehensive Adolescent Pregnancy Prevention (CAPP) initiative. Eighteen of the CAPP providers are implementing an optional component of their program that 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 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.

While the Title V program continues to implement tools to measure social-emotional development, a concerted effort has been concentrated in the third strategy of the SAP to 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

Recognizing the need for professional development and the content knowledge exists across the Title V programs in the Division of Family, division staff formed a Social Emotional Workgroup, consisting of representatives from different program and including a team member with access to and understanding of data. The work group was formed in the first year of the grant and has continued to advance the priorities of the Title V program to support social-emotional development among children and adolescents. The workgroup meets quarterly to identify training opportunities, new data or research on evidence-based practices, and to monitor progress within these domains.

Supporting children and adolescents' social-emotional development is an emerging area for NY's Title V program and 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.

When opportunities for training have been identified, the workgroup has sent notices of relevant to internal division staff and external partners. Additionally, workgroup members actively participate in training opportunities to learn and integrate information to improve Title V programs. On March 14, 2018, workgroup members attended an ACEs workgroup meeting with attendees from multiple divisions from DOH, as well as the Office of Mental Health (OMH), NYS Council on Children and Families, and the Office of Alcohol and Substance Abuse Services (OASAS). The group discussed the prevalence of ACEs in NYS, and best practices for preventing, reducing and responding with resilience. In May 2018, the DOH, OMH, and OASAS released a report titled "Understanding and Responding to Adverse Childhood Experiences in New York State." The report evaluated regional and state-level ACEs data from over 9,000 adults from the Behavioral Risk Factor Surveillance System (BRFSS) and described above. The report also identified action steps which included addressing ACEs in the 2019-2024 Prevention Agenda discussed earlier in this application.

During the summer of 2018, Title V staff engaged a student intern from the University at Albany School of Public Health to develop a Trauma-Informed Care (TIC) training curriculum intended for Title V staff. The TIC training covered trauma and how it influences development, the relationship between trauma and ACEs, principles of TIC, and resilience and self-care. Title V reviewed the curriculum and are developing a plan to implement the training with all staff within the DFH. Further expansion beyond DFH will be considered after review and input resulting from this internal training.

The Title V Social Emotional Workgroup members were critical in identifying existing data sources, relevant research findings, and evidence-based program resources, and created an internal website to make them accessible to all Title V staff. The workgroup has continued share this information through the publication and distribution of an electronic newsletter, titled “Social Emotional Wellness Update.” This 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. In total, four editions of this publication have been developed and shared with Title V staff. Topics highlighted in the Fall 2017 and Spring/Summer 2018 updates included cyberbullying and stalking, youth suicide and prevention strategies, ACEs, developmental assets for adolescents, social-emotional wellness of infants and toddlers, and NYS Health Homes. The latest update was released in July 2018 and distribution was expanded to include contractors and other interested stakeholders beyond Title V staff.

As discussed previously, promoting positive social-emotional development, including nurturing relationships, is fundamental to the Part C Early Intervention Program. The EIP provided 8.9 million service interactions to almost 70,000 children in 2017-2018. In addition to collecting and reporting on children’s progress in this area, the EIP has developed guidance and training to support professionals who serve children through the EIP. It was previously reported that a guidance document on social-emotional development, *Meeting the Social-Emotional Development Needs of Infants and Toddlers: Guidance for Early Intervention and Other Early Childhood Professionals*, was developed and is available on the DOH website at https://www.health.ny.gov/publications/4226.pdf. 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 document was published in June 2017.

Since its publication in June 2017, the EIP has been working with the EICC to support the training and dissemination of the guidance document. In December 2018, the workgroup and the BEI created a webpage on the DOH website dedicated to social-emotional development and is targeted toward families. Brief reference guides and an E-Learning series are being developed. The reference guides’ content will be targeted for specific EIP roles and will be available on the DOH website once completed. The E-Learning will consist of six modules, developed for specific targeted audiences (e.g., case managers, therapists) and will be available to the public for free on the NYSDOH Learning Management System. The goal is to complete these two remaining projects by the end of 2019.

The EIP held three trainings (October 2017, November 2017 and June 2018) regarding the Child Outcomes Summary (COS) Process for county Early Intervention staff. The trainings focused on updates and changes to the COS form and the data collection process. The trainings provided additional support and information regarding how the forms should be completed and how the county staff can help providers and families understand the process, including the importance of social-emotional wellness.

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.

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 Maternal and Infant Community Health Collaboratives (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.

NYS supports and promotes evidence-based home visiting services. Evidence-based home visiting have demonstrated improvements in: 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. Home visiting also helps to improve birth outcomes and increases pregnancy spacing.

The Division of Family Health oversees the Title V and MIECHV programs. The MIECHV funding supports the Nurse Family Partnership (NFP) and the Healthy Family New York (HFNY) programs to achieve home visiting goals to improve pregnancy outcomes for high-risk women and babies, improve children's health and development, and strengthen family functioning and life course. These goals support several objectives in Title V, including decreasing maternal and infant morbidity and mortality; supporting and enhancing social-emotional development and relationships for children and adolescents; and reducing racial, ethnic, economic and geographic disparities and promoting health equity for the maternal and child populations. Pregnant women can enroll in NFP until their 28th week of pregnancy and can enroll in HFNY either prenatally or up to three months post-partum. Home visits can be provided until the children are two to five years of age, respectively. Currently, 19 home visiting programs (eight NFP, 11 HFNY) are located in the following counties: Bronx, Dutchess, Erie, Kings, Monroe, Nassau, Onondaga, Queens, and Schenectady. Three NFP programs are funded through state appropriations. Through MIECHV funding, 2,713 families were served, receiving 30,601 home visits in 2018. The NYS Office of Children and Family Services administers the HFNY program, and they serve 38 counties across the state.

The Family Initiative Coordination Services Project (FIC) facilitates, supports and develops parent involvement in all levels of the Part C Early Intervention Program (EIP). The FIC develops and implements a training program, referred to as *Partners*, that provides parents with the opportunity to enhance their leadership skills, network with each other, and learn how to become better advocates for the care of their child with special needs on the local, state, and national levels. The Family Initiative Coordination Services Project was developed in collaboration with Early Intervention contractor, Just Kids.

- The FICSP facilitates, supports and develops parent involvement at all levels of the EIP.
- The FICSP facilitates and supports parent attendance at national conferences on early childhood development and facilitates parent involvement on the EICC. The EICC is a 27-member Governor appointed council that advises and assists the Department in the administration of the EIP. There are six parent members on this Council.
- The FIC has a dedicated website for families which includes information on the EIP, local and national

resources on child development and disabilities, and the parent training that is offered in collaboration with DOH. The FIC also has a closed Facebook page to better connect the families participating in the training.

NY's innovative Successfully Transitioning Youth to Adolescence (STYA) program, funded through the federal Abstinence Education Grant Program, supported 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 provided 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 also provided adult-supervised activities to stimulate cognitive, social, physical and emotional growth. Group discussions occurred to share information regarding topics of interest to pre-teen youth. Caring adults were available for more in-depth support and discussions. These programs also provided parent education to parents, guardians and adult caregivers to create a more nurturing environment for these youths. Over the last contract year, the STYA program reached over 2,000 participants. Due to the change in federal funding requirements, these contracts ended September 2018.

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 262 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 New York State (NYS) SBHCs enrolled 188,838 students and provided 693,345 visits for health and supportive services. Of the 693,345 visits approximately 94,000 included a mental health visit. Seventy-eight percent of NYS SBHCs provide mental health services on site, the remainder of sites refer children to mental health providers within their community.

In 2018, the Bureau of Child Health provided training to SBHC providers across NYS. At these trainings, staff from the NYS Office for the Prevention of Domestic Violence provided a presentation called "Building Resiliency in Response to Trauma." Eight Title V staff and 125 SBHC contracted staff attended the trainings. The training provided information to the SBHCs about engaging with community partners to expand children's access to behavioral health services. The SBHC model provides the opportunity for a child to receive a behavioral health screening and receive the necessary mental health services on site or be referred on to a behavioral health specialist. One way in which the SBHC provides such screening is through an annual comprehensive physical exam (CPE). Annual CPEs include a behavioral health screening component. Title V staff have prioritized the assessment of the percentage of CPEs being documented by each SBHC site as an annual performance metric, which is reported in cross-divisional meetings with DOH leadership. The goal was to identify SBHCs with poor CPE reporting and engage the providers to implement strategies for improvement. This work is ongoing.

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. There are ongoing efforts in the state to integrate a

trauma-informed lens in health care and school-based settings.

The fifth strategy of the SAP is to 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.

As described in the CYSHCN domain, the enrollment of children in Children's Health Homes (CHH) began in December 2016. 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 complex trauma and at risk for another chronic condition. As of December 31, 2018, 84,616 children were enrolled in CHH compared to 35,735 in December 2017. An additional 20,862 children have received outreach from a CHH.

In addition to supporting the CHH, Title V program staff have collaborated within DOH to support the "First 1,000 Days on Medicaid" initiative. 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.

One proposal of the 10-point First 1,000 Days on Medicaid agenda was to require managed care plans to have a Kids Quality Agenda. The BEI participates in the Medicaid Managed Care 2019-20 Kids Quality Agency Performance Improvement Project (PIP), which includes three measures: newborn hearing screening and follow-up, blood lead testing and follow-up, and developmental screening. Specifically, the BEI Early Hearing Detection and Intervention (EHDI) team is collaborating with the Office of Health Insurance Programs and the Office of Quality and Patient Safety to ensure that infants who do not pass newborn hearing screening receive timely diagnostic testing (by three months of age) and that those infants confirmed as deaf or hard of hearing are receiving Early Intervention (EI) services by six months of age. The goal of this project is to ensure infants and toddlers who are deaf or hard of hearing receive intervention services as early as possible to achieve age-appropriate language development and learning. Using EHDI data, Medicaid Managed Care Organizations will enhance tracking and follow-up of infants with suspected or confirmed hearing loss and will facilitate connecting infants who are deaf or hard of hearing and their families to timely services.

Another proposal from the First 1,000 Days on Medicaid was to convene a Preventive Pediatric Care Clinical Advisory Group. The Associate Medical Director of the DFH works with this Advisory Group. This group has been charged with developing a framework model for how best to organize well-child visits/pediatric care in order to implement the Bright Futures Guidelines (the American Academy of Pediatrics standard of care). The Advisory Group has completed a report and recommendations that have been submitted to the NYS Medicaid Director and the NYS Commissioner of Health.

Division of Family Health staff from the Title V program and Part C Early Intervention Program have provided subject matter expertise and technical support to a Medicaid supported pilot program called Connections, which is part of larger school readiness initiative called Albany Promise. Connections is centered on early childhood developmental screenings and includes Medicaid Managed Care plans and pediatric practices in Albany County to ensure that all

children receive developmental screenings and necessary referrals for evaluation and follow-up. One of the key goals of this alignment of organizational partners is improving children's readiness for Kindergarten.

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

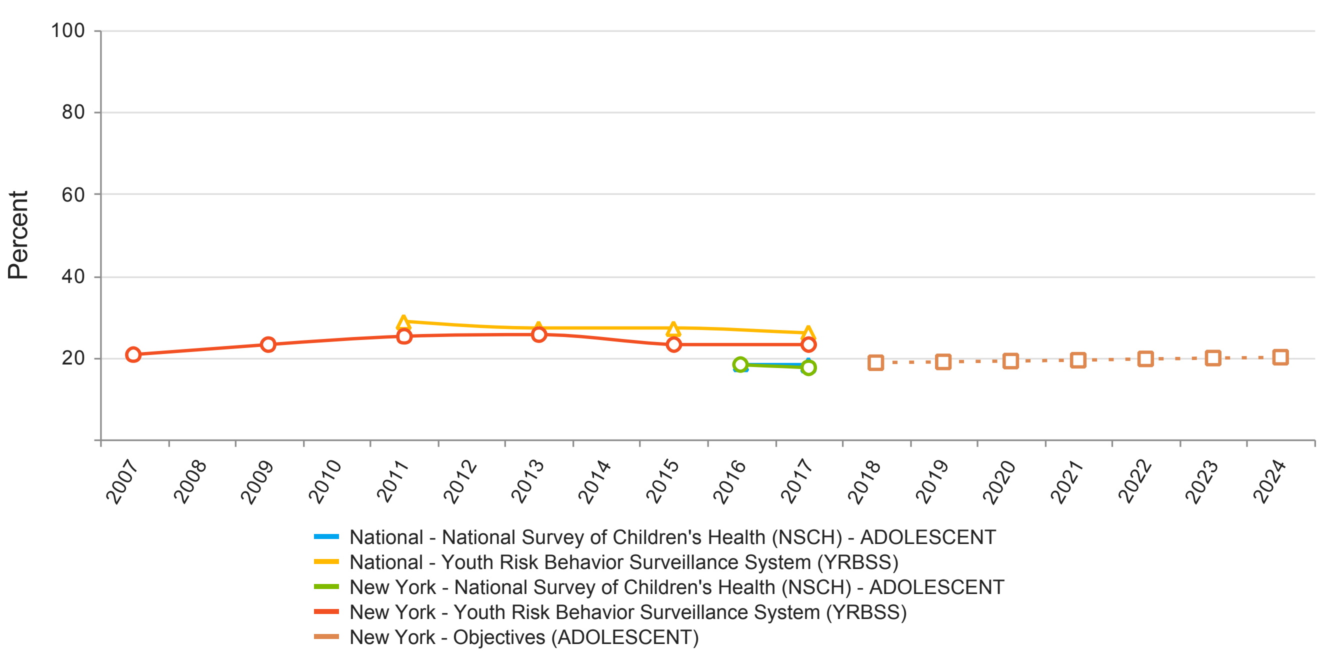
Linked National Outcome Measures

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_2017	10.3 %	NPM 13.2
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2017	22.1	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2015_2017	5.0	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2015_2017	5.4	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_2017	15.0 %	NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016_2017	45.5 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	90.0 %	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_2017	15.3 %	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)	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-2017	12.4 %	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-2017_2018	64.9 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2017	68.5 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2017	92.9 %	NPM 10

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2017	89.3 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2017	12.5	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 Indicators and Annual Objectives



Federally Available Data			
Data Source: Youth Risk Behavior Surveillance System (YRBSS)			
	2016	**2017**	**2018**
Annual Objective	27.1	27.5	18.8
Annual Indicator	23.3	23.3	23.2
Numerator	161,704	161,704	159,614
Denominator	694,960	694,960	689,106
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2015	2015	2017

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT			
	2016	**2017**	**2018**
Annual Objective			18.8
Annual Indicator		18.3	17.7
Numerator		246,053	232,223
Denominator		1,346,787	1,313,811
Data Source		NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year		2016	2016_2017

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						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	19.0	19.2	19.4	19.7	19.9	20.1

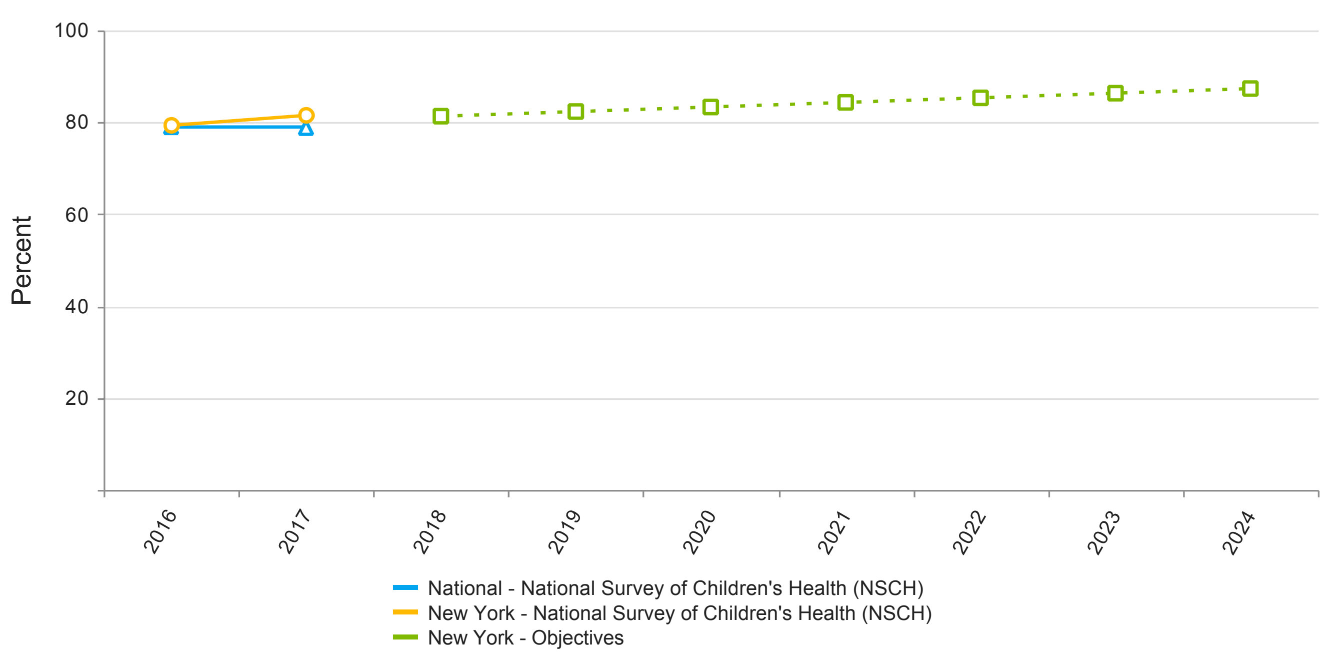
Evidence-Based or –Informed Strategy Measures

ESM 8.2.1 - Number of community environmental changes demonstrated as a result of enhanced collaborations.

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective			6
Annual Indicator	1	6	6
Numerator			
Denominator			
Data Source	Title V Program data	Title V Program data	Title V Program data
Data Source Year	7/16-6/17	16-18	17-19
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	7.0	8.0	9.0	10.0	11.0	12.0



Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			81.2
Annual Indicator		79.2	81.3
Numerator		1,103,856	1,081,532
Denominator		1,393,274	1,331,106
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

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						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	82.2	83.2	84.2	85.2	86.2	87.2

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	2018
Annual Objective	1,000	1,000
Annual Indicator	1,060	1,605
Numerator		
Denominator		
Data Source	NYS Medicaid Health Home Data	NYS Medicaid Health Home Data
Data Source Year	12/16-18	12/16-18
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	1,050.0	1,103.0	1,125.0	1,147.0	1,170.0	1,193.0

ESM 10.4 - Number of strategies implemented to improve adolescent use of preventive health care services.

Measure Status:	Active

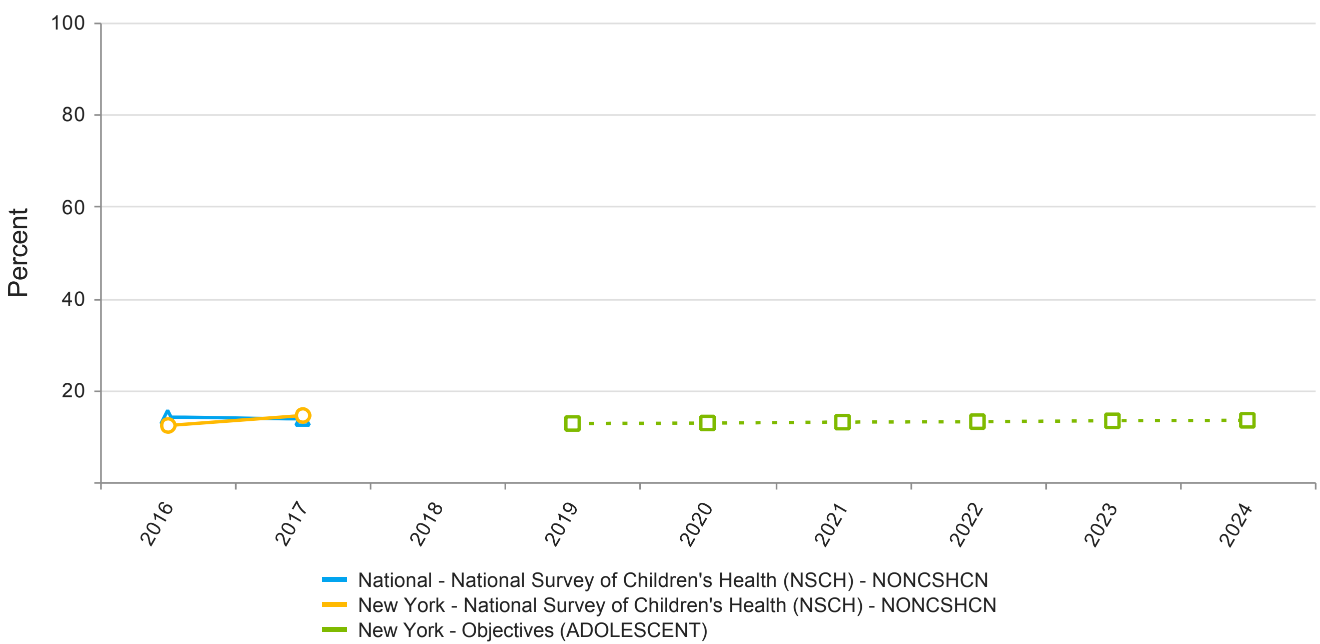
State Provided Data

	2017	2018
Annual Objective	1	1
Annual Indicator	1	1
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

	2019	2020	2021	2022	2023	2024
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
Indicators and Annual Objectives



NPM 12 - Adolescent Health - NONCSHCN

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - NONCSHCN		
	2017	**2018**
Annual Objective		
Annual Indicator	12.3	14.5
Numerator	130,919	156,317
Denominator	1,062,218	1,079,417
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2016	2016_2017

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	12.8	12.9	13.1	13.2	13.4	13.5

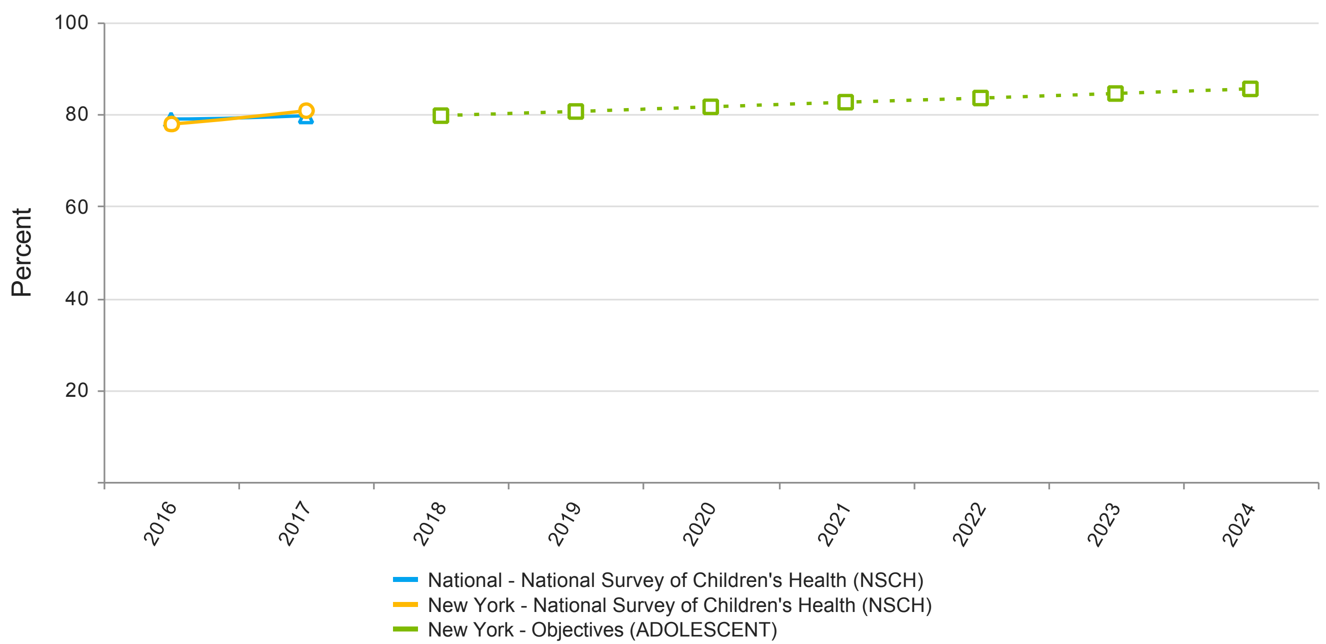
Evidence-Based or –Informed Strategy Measures

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	2018
Annual Objective		45	60
Annual Indicator	63.9	66.9	32.5
Numerator	4,275	5,244	902
Denominator	6,688	7,843	2,777
Data Source	NYEHDI	NYEHDI	NYEHDI
Data Source Year	CY2016	CY2017	CY2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	32.8	33.2	33.5	33.8	34.2	34.5



NPM 13.2 - Adolescent Health

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			79.6
Annual Indicator		77.6	80.6
Numerator		2,955,156	3,137,003
Denominator		3,810,186	3,890,746
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

ℹ 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						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	80.5	81.5	82.5	83.4	84.4	85.4

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	2018
Annual Objective		20	60
Annual Indicator	58	60	48
Numerator			
Denominator			
Data Source	NYS Title V Program records	NYS Title V Program records	NYS Title V Program records
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	61.0	61.0	62.0	62.0	63.0	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	2018
Annual Objective		40	41
Annual Indicator	61.2	50.5	39.1
Numerator			
Denominator			
Data Source	SEALS (CDC Data)	SEALS (CDC Data)	SEALS (CDC Data)
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	44.0	47.0	48.0	48.0	49.0	49.0

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**	**2018**
Annual Objective		50	50
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	To Be Developed	Developmental Assessment Tool	Developmental Assessment Tool
Data Source Year	2017-2018	2017-2018	2017-2018
Provisional or Final ?	Provisional	Final	Final

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
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	2018
Annual Objective		72	73
Annual Indicator	71.7	71.6	70.8
Numerator			
Denominator			
Data Source	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	75.0	77.0	78.5	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.

FFY 2018 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 there is a tremendous overlap of the strategies and activities.

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 (SEW) 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. The most recent edition of this newsletter was also distributed to external partners with an interest in this topic.
Staff will continue to publish the Social Emotional Wellness Update biannually. See Attachment 4 for SEW updates.

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. These surveys have been 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 compiled a list of the evidence-based, evidence-informed and promising strategies that each program uses to monitor their social emotional component. Team 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), within the Bureau of Women, Infant and

Adolescent Health (BWIAH), provides 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 BWIAH is 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 programs 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 2018, the six Regional Centers for Sexual Violence Prevention implemented 23 total prevention strategies targeting all levels of the social ecological model. Of the 23 strategies, 17 were aimed at the individual/relationship level and six at the community/societal level. There was a total of 126 unique cycles of individual/relationship level curricula completed, reaching 1,528 individuals, and 104 organizations were impacted by community-level prevention strategies.

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 2018-2019 contract year, funding was distributed to 52 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 and awareness activities 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 campus sexual assault survivors, in addition to education training on prevention of sexual and domestic violence throughout campus communities. Trainings included a webinar on research on sexual assault perpetration to inform prevention work and engaging online/commuter college populations. In addition, there were in-person full-day trainings for all three of the Alliance TA regions on program evaluation; cultural competency and facilitation skills; understanding the student conduct process; cross-complaints; and Coordinated Community Response Teams (CCRTs). There was also an annual statewide EIE provider meeting on June 12-13, 2018, where various topics were discussed, including managing resistance on campuses, advocacy strategies on and off campus, healthy nightlife initiatives, and using social media. To date, through 252 partnerships with local colleges/universities, EIE rape crisis programs have provided information and/or direct services to 48,549 campus sexual assault victims and have reached 178,346 individuals through awareness events, 22,681 through training and 93,174 through educational campaigns. These numbers include college/university students, faculty, staff and some parents and are expected to continue to increase.

DOH has spearheaded a Safer Bars Initiative, currently funded through a cooperative agreement by the Centers for Disease Control and Prevention's (CDC) Rape Prevention Education (RPE) program. Under this initiative, DOH funds six Regional Centers for Sexual Violence Prevention, which implement innovative sexual violence prevention community-level strategies, including Safer Bars curriculum training in 17 high-need counties. Studies have shown a significant link between increased sexual violence and alcohol consumption for both perpetrators and victims. As a result, training bar proprietors and their staff on what is sexual violence, how to observe and assess situations for signs of sexual violence, bystander intervention skills building, policy change assistance and environmental

assessments are all components of a comprehensive approach addressing all levels of the SEM. Currently, five out of six Regional Centers are utilizing the Safer Bars Curriculum created by the Arizona Safer Bars Alliance and Arizona's State Department of Health. The Regional Centers implement all components of the Safer Bars training (an individual/relationship level curriculum) including the environmental assessment and policy change assistance components (community/societal level approaches). One Regional Center is utilizing the OutSmart NYC bar bystander curriculum.

Across New York State there are currently 18 Alcohol Serving Establishments (ASE) that have been trained in the Safer Bars curriculum and 8 trained in OutSmart with 228 bar staff/managers/owners trained in the curricula. To teach the curriculum there are currently 50 trainers across the state qualified to train on the Safer Bars curriculum.

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 one-year initiative on July 1, 2017. The initiative worked 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. This was 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. Students enrolled in the projects received healthcare referrals for prenatal, interconception, and postpartum care, social service referrals to the Special Supplemental Nutrition Assistance for Women, Infants and Children's program; local Department of Social Services (DSS); and educational supports to better ensure academic success. The goals of this program aligned with the MCHBG 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. From July 1, 2017 to June 30, 2018, the program served 432 students, developed 115 new partnerships, and made 863 referrals. The most frequently cited needs of the program participants were help obtaining information, resources, or services for healthy relationships; education or employment services; concrete needs such as transportation, child care, supplies for their children, and food; and family planning.

A new Pathways to Success project was funded beginning July 1, 2018 to June 30, 2020 with a continued focus in

NYC. Funding continues to provide support for programs in three community colleges and a community-based organization 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. To date, the program has served 429 expectant and parenting students.

Adolescent Health initiatives, including the CAPP, PREP and STYA, 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 on the federal level, the STYA initiative ended on September 30, 2018. However, NY's Title V program successfully applied for federal Sexual Risk Avoidance Education (SRAE) funding in 2018 and released a competitive application to support implementation of education on sexual risk avoidance that teaches youth 10-13 years old to voluntarily refrain from sexual activity. The Title V program continues to be committed to exploring additional funding opportunities that provide positive social-emotional development and relationship initiatives to pre-adolescents in underserved populations and communities.

Adolescent Health - Application Year

FY 2020 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 this 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.

DOH integrates youth engagement in adolescent health initiatives through the Youth Advisory Network. The Youth Advisory Network is a panel of young adult and teen consultants, led by the Assets Coming Together for Youth Center for Community Action (ACT CCA), that meets monthly to provide youth perspectives on health-related media, research projects and convene on an as-requested basis to inform DOH projects and policies.
The network incorporates the expertise of young people into the services by participating in adolescent health discussions, reviewing and editing materials and participating in focus groups. DOH also administers the facilitation of youth-led focus groups through DOH-funded adolescent health program contracts 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

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 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 Social-Emotional Wellness Update to Title V staff and external partners biannually 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 the adolescents through the Youth Advisory Network, program contractors and ACT CCA.

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 as they arise.
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 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 equity 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.

NY’s Title V program successfully applied for federal Sexual Risk Avoidance Education (SRAE) funding in 2018 and released a competitive application to support implementation of education on sexual risk avoidance that teaches youth 10-13 years to voluntarily refrain from sexual activity. In the coming year, this funding will support 12 community-based initiatives throughout NYS.

As discussed in the annual report section of this application, DOH’s Safer Bars Initiative currently funded through a cooperative agreement by the Centers for Disease Control and Prevention’s (CDC) Rape Prevention Education

(RPE) program, funds 6 Regional Centers for Sexual Violence Prevention, which implement innovative sexual violence prevention community-level strategies, including Safer Bars curriculum training in 17 high-need counties. Across NYS there are currently 18 Alcohol Serving Establishments (ASE) that have been trained in the Safer Bars curriculum and 8 trained in OutSmart with 228 bar staff/managers/owners trained in the curricula. To teach the curriculum there are currently 50 trainers across the state qualified to train on the Safer Bars curriculum. The DOH has been invited by the Office of Victim Services (OVS) to attend an in-person meeting on the “Healthy Nightlife” initiative in May 2019 to discuss collaborative efforts. Others invited include: Governor’s Office staff, Office for the Prevention of Domestic Violence (OPDV), State University of New York (SUNY), State Liquor Authority (SLA), New York State Police (NYSP), Office of Alcoholism and Substance Abuse Services (OASAS), and Dr. Elise Lopez, the developer of the Arizona Safer Bars Curriculum.

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. 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. Refer to CYSHCN section of this annual report and application for further information regarding HH.

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.

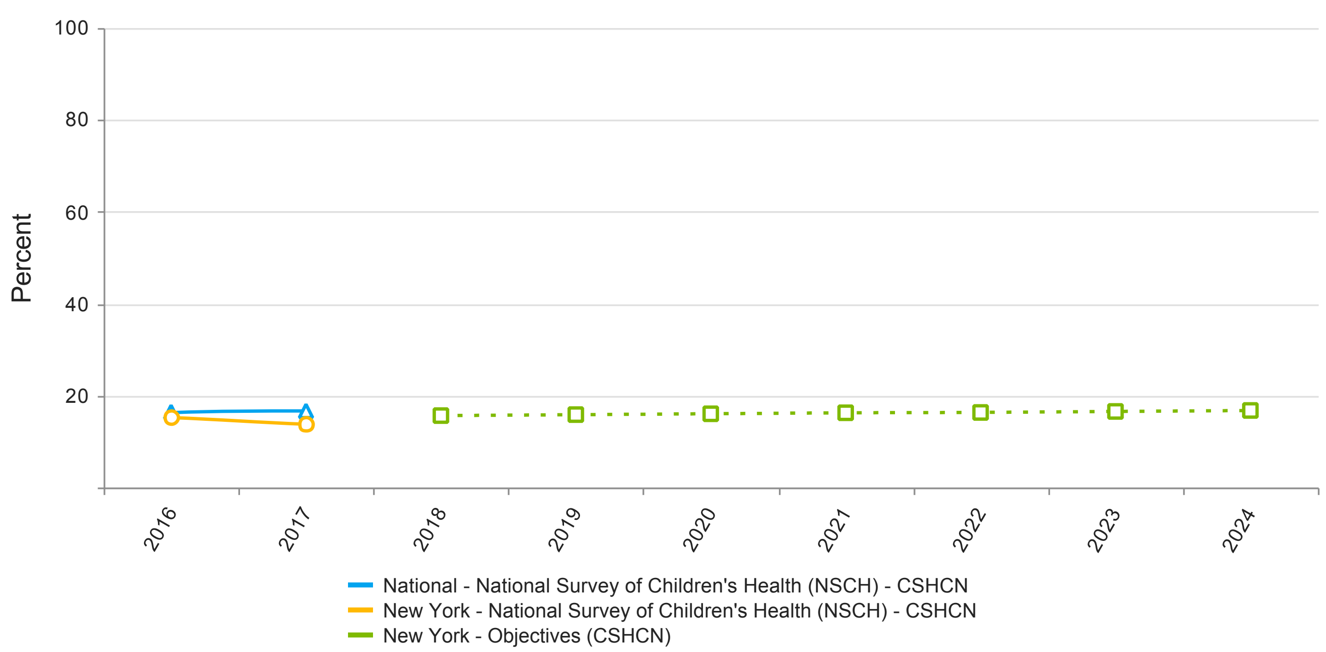
Children with Special Health Care Needs

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_2017	15.0 %	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
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**	**2018**
Annual Objective			15.7
Annual Indicator		15.3	13.7
Numerator		48,081	34,736
Denominator		314,730	253,092
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

ℹ 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						
	2019	2020	2021	2022	2023	2024
Annual Objective	15.9	16.1	16.3	16.4	16.6	16.8

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	2018
Annual Objective		45	60
Annual Indicator	63.9	66.9	32.5
Numerator	4,275	5,244	902
Denominator	6,688	7,843	2,777
Data Source	NYEHDI	NYEHDI	NYEHDI
Data Source Year	CY2016	CY2017	CY2018
Provisional or Final ?	Final	Final	Final

Annual Objectives

	2019	2020	2021	2022	2023	2024
Annual Objective	32.8	33.2	33.5	33.8	34.2	34.5

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	2018
Annual Objective		50	50
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	To Be Developed	Developmental Assessment Tool	Developmental Assessment Tool
Data Source Year	2017-2018	2017-2018	2017-2018
Provisional or Final ?	Provisional	Final	Final

Annual Objectives

	2019	2020	2021	2022	2023	2024
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	2018
Annual Objective		65	65.5
Annual Indicator	61.6	70.1	67
Numerator	673	1,021	1,238
Denominator	1,092	1,456	1,848
Data Source	New York Family Survey	New York Family Survey	New York Family Survey
Data Source Year	2015-2016	2016-2017	2017-2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	71.0	71.5	72.0	72.5	73.0	73.5

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

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

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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

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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.

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FFY 2018 Annual Report

Children and Youth with Special Health Care Needs (CYSHCN) – State Priority #4: Increase supports to address the special health care needs of children and youth.

Children and youth with special health care needs (CYSHCN) and their families have needs for care and support beyond those experienced by other children generally. As stated previously in the overview and needs assessment, according to the National Survey of Children's Health (NSCH), more than 765,000 (18%) of New York's children age 0-17 have a special health care need. NY's Title V program strives to support a coordinated system of supports and services for CYSHCN and their families.

While most of NY's children are insured, there still continue to be financial challenges for CYSHCN and their families. The Title V program provides funding for direct services through the Physically Handicapped Children's Program (PHCP). In 2018, 17 children received an evaluation and 164 received treatment services funded through PHCP. Services included orthodontia, medications, hearing aids, physician office visits, enteral formula and specialty foods, and medical equipment or supplies.

As outlined in the State Action Plan (SAP), the Title V program implemented the seven strategies for CYSHCN and progress is described below.

The first strategy in the SAP involved the in-depth review and analysis of available data for CYSHCN and issuance of a data report. Title V staff reviewed data from the 2016 National Survey of Children's Health (NSCH) and data reported by NY's Title V LHD-based CYSHCN and EI programs. Title V staff implemented a data analysis plan that included NSCH data for CYSHCN and children not identified as having special healthcare needs (non-CYSHCN). Weighted frequencies were performed to identify gaps in services and experiences among CYSHCN and non-CYSHCN. Title V staff sought to better understand the impact of having a child with special needs on both the child and the family and the associated factors.

Key findings included that almost half of CYSHCN live in households with income below 200% of the federal poverty level. CYSHCN are more likely to have their daily activities greatly affected by their health condition(s), to miss 11 or more school days in a year, and to have trouble making or keeping friends. Families of CYSHCN report higher out-of-pocket medical expenses, have trouble paying medical bills, spend more time coordinating their child's health care, and report reducing or stopping work due to their child's health. Only 11% of New York State (NYS) caregivers of CYSHCN reported that their child received care in a well-functioning system and only 15% reported their adolescent with special health care needs received services needed for transition to adult health care. CYSHCN were also less likely to meet all five components of medical home criteria (38.5%) compared to non-CYSHCN in NY (55.3%). The result of this in-depth analysis was a NYS Profile of CYSHCN that has been made available on the NYSDOH public website (https://www.health.ny.gov/community/special_needs/docs/CYSHCN_report_2016.pdf) and is included in Attachment #2.

To augment this national data, Title V CYSHCN program collects data from the 49 county-based CYSHCN programs administered by Local Health Departments (LHDs). New data elements added to the system for LHD CYSHCN programs include whether the child has dental insurance and is enrolled in Health Homes (HH). These elements were added to reflect the importance of understanding issues related to improving oral health and providing coordinated care management. An analysis of the LHD CYSHCN data for 2017-2018 program data demonstrated that of the 1,254 CYSHCN children served, 57% had Medicaid, 24% had commercial insurance, 11% had Child Health Plus (CHP), 1% had a combination of private and public insurance, 4% had other insurance, and 3% had no insurance reported. Additionally, 8% of children had Social Security Income (SSI). Seventy-one percent of CYSHN served were

White, 13% African American, 2.2% Asian or Pacific Islander, 0.4% American Indian or Alaska Native, 1.9% more than one race, 1.8% other race, and 10% had unknown race (i.e., did not respond). Nearly 13% of children were Hispanic. The percent of children reported to have a primary care provider was 97.7%, which is a significant improvement from the 73.6% in 2016-17 data. An optional data field for type of financial assistance needed by families for aspects of care was added. Among those served, there was information for 13.6% of CYSHCN, and 57% needed assistance for a service not covered by insurance, 20% for a service exceeding the limit of the benefit package, 19% needed help with co-pays, 3% for deductible costs, and 1% for premium costs. In addition, information about referrals from the state's IDEA Part C Early Intervention Program was included. Approximately 20% of CYSHCN were referred by Early Intervention Program. Twenty-two children were referred to HH in 2017-2018. Title V staff held virtual session to describe the changes to the data reporting system and the data in November 2017 and again the following year.

Understanding these data is important, but quantitative data alone cannot illustrate the complexities of navigating the many systems of care available to families and CYSHCN and statewide data cannot be used to understand local or regional differences. The **second strategy** in the SAP included engaging 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 CYSHCN and their families. To get a comprehensive understanding of the complex needs of families with CYSHCN in NYS, the Title V program engaged in a multi-year effort to conduct a comprehensive system mapping initiative.

A formal mapping tool was used online or by paper to diagram roles, responsibilities, needs, and resources in providing care for CYSHCN and the changes most desired to help families meet their needs.

Care mapping recruitment was conducted between March 2017 and June 2018, and feedback from 138 caregivers and 40 providers was collected.

Caregivers and providers were engaged to provide feedback either through an online mapping tool or a paper tool. Parents from the EI Partners Training Project, LHD CYSHCN and EI staff, and Parent to Parent of New York State staff were provided guidance on using the online mapping tool and a link to independently create their own care map. Independent entry resulted in feedback from 29 caregivers and 21 providers. In addition, participants were recruited in collaboration with Families Together (13 caregivers) and the Leadership Education in Neurodevelopmental Disabilities (LEND) program at Westchester Institute for Human Development (4 caregivers) to participate in group mapping activities facilitated by NYSDOH via webinar with feedback entered into the online mapping tool.

While the online mapping tool allowed the NYSDOH to see common responsibilities, needs and resources identified by participants, its design did not provide the detail necessary to understand the specific challenges and barriers of caregivers and providers and what was needed to improve them. As a result, NYSDOH staff developed a paper tool to address these issues and continued to gather specific feedback at in-person facilitated care mapping sessions.

Participants, who used the paper tool at in-person sessions, were recruited by the New York City Department of Health and Mental Hygiene (NYC DOHMH) CYSHCN Health Education Forum (17 caregivers), Parent to Parent of New York State (48 caregivers and 2 providers), as well as the NYSDOH EI program (22 caregivers) and Early Hearing Detection and Intervention (EHDI) program (5 caregivers and 17 providers).

The systems mapping initiative was implemented based on a collaborative relationship between NYS' EIP and CYSHCN Programs. Parent organizations were key to engaging family caregivers in this initiative and are part of the feedback loop to which the results will be disseminated. 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 CYSHCN.

Common challenges reported by caregivers of CYSHCN and quotes from caregivers:

1. Accessing and coordinating medical care and related services:

"I found that finding a provider was the hardest. Every door I knocked on, I was turned away."

"[There should be] easier access to those resources so I do not have to be on a computer for 6 hours doing research."

2. Identifying and coordinating child care:

"If I didn't have a flexible job I'd already be fired for missing too many days when my child is sick."

"It is difficult to get childcare in the summer, holidays and school vacations. I decided to work from home."

3. Providing emotional and social supports for the child and family:

"My son cries because he does not have any friends."

"[I wish I had] friends who would take my kid, the way I take theirs, to events."

4. Providing financial support, including health insurance:

"As soon as you put a special needs label on something, the cost quadruples."

"I have to choose between paying mortgage and putting food on the table and the medical needs of my child."

5. Navigating and obtaining assistance from the school system:

"At CPSE [Committee on Preschool Special Education] meetings, they just push papers in front of you to sign. Someone needs to advocate for the parent."

"Need someone to make these different groups of professionals talk to one another."

6. Integrating the child and their family into the community:

"I have a hard time going out because my son is in diapers but is too big for the changing tables. I have to bring my own supplies to change him and put my child on the floor. It's gross."

"A child with special needs does not live in a vacuum. They are part of a family and have to address their needs and other family needs."

7. Transitioning to adult services:

“*This is the worst time of my life.*”

“*It is a disaster that children with Autism have nowhere specifically to go as an adult.”*

8. Providing and coordinating transportation:

“In my community, moms don’t drive.”

Caregivers also offered solutions. Suggestions for change included:

1. Caregivers wanted information on specialists and community organizations provided at the time of diagnosis, accessible in a single place (information hubs) and easy to find and understand.
2. Caregivers wanted fewer regulations and policies in place regarding access to services to decrease the delays experienced in receiving services.
3. Caregivers wanted better coverage under private insurance, a reduction in out-of-pocket expenses for medical and other health related costs, and more financial assistance to help pay for the costs not covered by insurance.
4. Care givers wanted support groups to share information and experiences and more group activities in the community for the children.

NYSDOH is committed to sharing this feedback with stakeholders and partners, i.e., Parent to Parent of New York State, the NYS Association of County Health Officials (NYSACHO), the Office of Mental Health (OMH), the Office for People with Developmental Disabilities (OPWDD), and the Office for Child and Family Services (OCFS). Beyond sharing the information back to the communities, NYSDOH is integrating the findings from the care mapping sessions into current work as well as the planning for the next five-year procurement cycle for funding of CYSHCN programs at LHDs, which begins in October 2020. NYSDOH plans to continue to gather feedback from families and aims to build capacity at LHDs to better serve CYSHCN and their families through resource development, training opportunities for providers and families, and emphasis on identifying social and emotional supports.

In reviewing participation in the care mapping initiative, Title V staff recognized that more work was needed to engage more diverse families. NYS has taken advantage of an opportunity to join a HRSA-sponsored learning collaborative led by the NJ State Parent Advocacy Network (SPAN) in partnership with Parent to Parent of NYS to support emerging family leaders for identified roles on community, state, and national teams and advisory groups focused on CYSHCN systems with a goal of increasing the racial and ethnic diversity of family representatives. Parent to Parent of NYS and Title V staff have developed a work plan and objectives to increase the number and diversity of families who provide input into the development of the state’s priorities and initiatives and includes providing training for family leaders from underrepresented or underserved communities. The timeline for training to begin is Spring 2019.

The third strategy of the SAP was to provide subject matter and technical support to the NYS Medicaid Program to implement enhance care coordination and transition support services for CYSHCN through the Children’s Health Homes (CHH).

The enrollment of children in CHH began in December 2016. 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 complex trauma and at risk for another chronic condition.

In 2018, the Title V program participated with OHIP staff on 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). On January 24, 2019 staff participated in a site visit with St. Mary Healthcare (Amsterdam) and on February 6, 2019 staff attended Institute for Family Health (New Paltz). Title V and OHIP staff will participate in site visits with the 12 remaining designated children health homes through 2019. Upcoming site visits are: Niagara Falls Memorial Medical Center (April 10); Greater Rochester Health Home Network (April 11); Community Care Management Partners Health Home Inc (May 1-2); Hudson River Healthcare (May 15); Bronx Accountable Healthcare Network (June 5); Mt. Sinai (June 19); Coordinated Behavioral Care, aka Pathways to Wellness (July 7-8) and Central New York Health Home Network (July 24). The other two the dates are to be determined.

The purpose of the site visits is 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. Title V staff are involved with the development of the site visit auditing process, as well the onsite case/chart review, 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 staff 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 addition, between January 1, 2019 and March 31, 2019, six 1915c Home and Community Based Services (HCBS) waiver case management providers are transitioning to HH care managers. They are also transitioning their enrolled waiver children in to HH care management if they chose to be in HH. By March 31, 2019, the transition will be complete. This is in preparation for the launch of the new Children’s Waiver on April 1, 2019. The Children’s Waiver consolidates all six HCBS waivers (mentioned above) into a single waiver. A single 1915c Children’s Waiver will streamline HCBS administration to have more consistent eligibility processes and benefits across all populations of children meeting the institutional level of care functional criteria. Also, Medicaid is authorizing Family Peer, Youth Peer and Crisis Intervention services to HCBS eligible children in July 2019 for Family Peer and 2020 for Youth Peer and Crisis Intervention.

Title V staff continue to promote HH in their public health work. In January 2018, Title V staff attended the New York State Association of Counties (NYSAC) meeting to promote a training opportunity for local CYSHCN Programs about CHH. On February 14, 2018, the CYSHCN Program held a one-hour webinar with contracted CYSHCN Programs to provide technical assistance and information 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. The Title V Program has gained access for LHD-CYSHCN Program staff to OHIP’s electronic referral portal for HH. This access gives programs the ability to make referrals of children to HH and to see who the child’s care management agency is. The state CYSHCN Program will be monitoring the number of children referred to HH by the local CYSHCN programs. For 2017-2018, the CYSHCN program at the LHD reported referrals for 22 children to HH.

A webinar presenting an overview of the CYSHCN Program was provided to HH Care Managers on June 20, 2018. Local CYSHCN Programs are encouraged to reach out to the HH in their area and accept referrals made by the Care Management Agencies. In February 2019 Title V and OHIP staff hosted a one-hour webinar on HH to the Sickle

Cell Disease contractors to inform them about CHH and to strengthen the collaboration and referral process between the two agencies. The work from this strategy has strengthened the collaboration and referral activities between CHH and the CYSHCN Program.

Title V staff, as part of the CHH team, also helped to define policy 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 Early Intervention Program provider agencies to gain input on supports and barriers to the CHH referral process for EI eligible children.

Furthermore, within the Division of Family Health, the Bureau of Early Intervention (BEI), which administers the state's IDEA Part C Early Intervention Program, has ongoing partnership with the CHH program. Families have the option to access care management through CHH, when the eligibility criteria are met, or through the EI Program. Both programs work together on continuity of care for CYSHCN and their families. Representatives from the CHH program present at most quarterly meetings of the Early Intervention Coordinating Council and participate on bi-monthly calls with BEI and all counties across the State. BEI staff and HH staff provided on-site regional training in Spring 2018 to support and enhance collaboration across these programs.

As of December 31, 2018, 84,616 children were enrolled in CHH compared to 35,735 in December 2017. An additional 20,862 children have received outreach from a CHH.

The fourth strategy in the SAP is to 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 support to other key CYSHCN population.

The Title V program has funded three contracts for "Coordinating Care and Supporting Transition for Children, Adolescents and Young Adults with Sickle Cell Disease (AYA/SCD)" beginning in July 2018.

Ensuring proper care and transition from pediatric care to adult self-directed care is the goal for the program. Transition is facilitated through provision of care management services, linkages with CHH and HH for adults for eligible individuals, and consistent implementation of transition services. Each grantee employs a Transition Navigator who builds a relationship with the individuals, their schools, their families, their doctors and the interdisciplinary team to ensure a successful transition into adult medical care providers. The contractors have adapted the promising practices of the *Got Transition Health Care Transition Process Measurement Tool for Transitioning Youth to Adult Health Care Providers and Six Core Elements of Health Care Transition* as a tool to improve the outcomes for individuals with SCD.

Transition Navigators were recruited and trained. Contractors employ tracking systems for patient reminders of scheduled appointments, missed appointments, and follow-up via text messaging and phone calls. Health specialty services are being provided to individuals when required.

Quarterly calls with the contractors were held to provide technical assistance. An educational webinar, *Appropriateness and Eligibility Criteria for Children, Adolescents, and Young Adults for Referrals to Health Homes* was held in February 2019 with all contractors.

Title V staff review grantee's progress towards meeting workplan deliverables. Data have been collected to monitor that appointments are kept and, if needed, follow-up is received; education on self-management and preventive care

is provided; support and linkages for peers/health/social supports and services needed by the children, AYA/SCD and their families is received; and enrollment of AYA/SCD insured by Medicaid in the appropriate HH care management occurs.

From July 2018 to December 2018, 368 individuals ages 12-21 were seen by the contractors. Performance measures have been added to the grantees' data reporting tool and will be reported in the future. The performance measures include the percentage of individuals ages 12-21 who 1) had an initial transition readiness assessment completed, 2) a subsequent transition assessment completed, 3) a refusal of assessment, and 4) no assessment. The measures will be reported quarterly. Additional performance measures include percentage of individuals ages 12-21 who reported the use of self-management strategies for pain management and percentage of eligible Medicaid-insured AYA/SCD ages 12-21 enrolled in HH care management.

The fifth strategy in the SAP is to support the statewide IDEA Part C Early Intervention Program's State Systemic Improvement Plan (SSIP), which is overseen by BEI within the Division of Family Health. The SSIP is required by the U.S. Department of Education, Office of Special Education Programs. Each State's EI Program (EIP) was charged with developing an SSIP focused on either improving child outcomes or improving family outcomes. The NYS EI Coordinating Council (EICC), the NYS governor-appointed advisory council, unanimously supported the selection of Family Outcomes for the New York State (NYS) SSIP. The SSIP project in NYS is called Improving Family Centeredness Together (IFaCT).

DOH completed a study of both family and child outcomes data in EIP. In response to a state survey, only 65% of families reported receiving enough help on family outcomes. For this reason, the focus of the SSIP is on family outcomes, as increased family centeredness can lead to improved child outcomes.

DOH is working with each county and borough to improve the experience for families and children receiving services through the EIP. Over the course of three years, NYSDOH has partnered with three University Centers for Developmental Disabilities (UCEDDs) to use an evidenced-based learning collaborative model to improve family outcomes by ensuring the program and the services provided are family centered. UCEDD staff, municipal administrators, EIP providers, and parents will share experiences, plan strategies and develop innovative ideas to further support children and families within EIP. The goal is to improve the quality of EIP services, increase parent satisfaction and improve health and developmental outcomes for young children we serve with caregivers taking a leading role in the effort.

IFaCT is a three-part project. First, in the planning phase, teams use data and evidence-based strategies to identify quality improvement goals. Next, in the collaboration phase, teams connect at an in-person learning collaborative meeting and through monthly coaching calls supported by the UCEDDs on how to implement their local plans. Caregivers, parents and family members are on every local team and provide important insight and direction on ideas to improve family centeredness in the EIP. After the in-person meeting teams collect data to study the impact their change has made, and then act on it over the course of one year (Plan-Do-Study-Act cycles). If the change improved family outcomes the team would increase its use, and if the change does not help, the team would reevaluate and adjust their plan. Once local projects are completed, UCEDDs will analyze the data and use the information to develop web-based training and resource materials on best practices for Family Centeredness.

NYSDOH has been working with the UCEDDs to identify best practices and develop a Resource Guide. The Resource Guide is in draft form. Based on feedback, the Resource Guide is being transformed into two standalone publications, one for parents and one for providers. BEI staff are working with the Department's Bureau of Media and Creative Marketing and the Public Website Group to ensure the publications meet Department of Health standards for posting to the Department's website. The Department is also working with the UCEDD to ensure the publications

are revised for readability at a sixth-grade reading level. The Resource Guides will also be included on the www.eifamilies.com website. This website is dedicated to parents of young children with disabilities, through a separate Department of Health contract, which provides parent leadership and advocacy skills training for parents of children receiving EIP services. The new Resource Guides will be disseminated via the listservs and posted to the EI Families website in 2019.

Below are examples of parents' feedback from IFaCT:

Challenges	Strengths	Recommendations
• Hard to know how to start the process • The process can be overwhelming • Not sure of the key roles in the process • Cultural barriers • Language barriers • Hard to handle services and have a family life • Limited knowledge of developmental milestones • Work schedules and service provision	• Connections with providers • Our Service Coordinator helped identify places in our community where we could get services • Our provider helped us to find a balance between the "best services" and our quality of life as a family • Knowledge gained from service coordinators	• Connect parents with support organizations • Connect parents to their community • Use family friendly language • Provide good resources to parents • Listen to parents, as they know their children the best • Find out what is most important to the family • Ensure IFSP outcomes are what the family wants to work on

NYSDOH will integrate these best practices into state-sponsored professional development and training to reinforce family centeredness, and update policies and procedures to support family centered practices in the EIP.

Examples of projects to increase family connections to each other and to their community include: Facebook pages, family activity calendars, community resource websites and resource lists, parent support groups, increasing the number of family outcomes included in Individualized Family Service Plans (IFSP), and increasing the number of EI services provided in the family's community (e.g., park, grocery store, church or synagogue, family gatherings).

Performance as measured by a parent-completed survey has demonstrated an improvement from baseline. In the most recent year of data, 67% of families participating in the Early Intervention Program meet or exceed the state's standard for the NY Impact on Family Scale compared to 65% at baseline (2008-2013). There has been fluctuation from year-to-year but the overall trend is improving.

The sixth strategy in the SAP is to use the IDEA Part C Early Intervention Programs Family Outcomes Survey data to inform CYSHCN program initiatives. The EIP Family Outcomes Survey was developed to collect information about the ways in which EIP helps families of children receiving EI services. This survey is for families who are ending (exiting) or have recently ended (exited) EI services. The Family Outcomes Survey is part of an ongoing federally-required initiative to improve outcomes for children and families who receive EI services. This national quality improvement effort is to learn about family views on the ways EI services help children and families in EIP, including family-centered practices that connect parents of children with similar needs and helping families take part in typical

actives for children and families in their community. The results of this survey help guide efforts to improve services and results for children and families receiving EI services. In Federal Fiscal Year (FFY) 2017, NYSDOH decreased the number of questions on the family survey from 95 questions to 36 questions. These 36 questions comprise the Impact of EI Services on Your Family Scale (IFS). The survey was also translated in to six additional languages (Arabic, Bengali, Chinese, Russian, Spanish, and Yiddish). The shortened survey may have helped increase the number of responses from 11-14% response rate in previously years to a 20% response rate this year.

Title V CYSHCN 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. These two areas were selected because families consistently across time and geographically report that these connections to the community are not happening as much as they would like. The same issue was identified by parents of CYSHCN through the care mapping initiative described above.

CYSHCN program staff reviewed quarterly reports from 2016-2017 from the LHDs to identify counties with promising practices addressing these two needs. Three one-hour webinars were completed with local CYSHCN programs sharing best practices for connecting families and children with special needs to community resources and to increase their participation in community activities. During these webinars, LHDs shared their work with other LHDs with the goal of prompting new ideas and activities to support CYSHCN and their families.

LHD CYSHCN program staff from Niagara County presented in January 2018 on their outreach plan including Developmental Day, which is a full-day event for attendees and included individuals with disabilities, families, service providers who participated in workshops and trainings. Vendors were also present to provide information to attendees. LHD CYSHCN program staff from Franklin County presented in June 2018 on Bridging Resources And Valuable Expertise (BRAVE), which is a community resource to bring parents and children with special needs together and provide social support and education training.

Title V staff have also invited speakers from other initiatives to present to LHD CYSHCN program staff. In September 2018, Project TEACH presented their program for children and families to receive prompt, skillful and compassionate care for mental health conditions. Project TEACH provides consultation, education, training, and referrals and linkages to other key services for pediatricians, family physicians, psychiatrists, nurse practitioners, and other prescribers.

Title V staff evaluate these webinars with the LHD CYSHCN programs and have received positive feedback from attendees as well as topics for future webinars.

The seventh strategy in the SAP is to provide technical assistance and facilitate a structured 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).

The Early Hearing Detection and Intervention (EHDI) Program works to ensure infants receive hearing screening by one month of age, those who fail the screening have diagnostic testing by three months of age, and those with diagnosed hearing loss are enrolled in appropriate EI services by six months of age. The EHDI Program collects data initially through the birth certificate from the state’s two vital records system, Statewide Perinatal Data System (SPDS) outside of NYC and the Electronic Vital Event Record System (EVERS) in NYC. These records are then integrated into the NYEHDI-IS, an application located within the state’s online health portal, the Health Commerce

System. If an infant does not pass the newborn hearing screening, follow-up and/or diagnostic audiologic evaluation results must be manually entered in to the NYEHDI-IS by providers of these services. Grant funding from the CDC was received for the period of July 1, 2017 through June 30, 2020 to support NYEHDI-IS. Funding from this grant was used to develop enhancements to the NYEHDI-IS. Bi-weekly meetings were held with Title V staff to review system requirements, system enhancements and system modifications.

Grant funding from Health Resources and Services Administration (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 and referrals to the EIP. The main objectives of this grant are: to increase by 30% from baseline the number of newborns and infants who receive timely diagnosis; increase by 25% from baseline the number of newborns and infants who receive timely referral to EI; increase by 20% from baseline the number of newborns and infants identified to be deaf or hard of hearing enrolled in EI services; and to develop partnerships supported by a memorandum of understanding with identified statewide, family-based organizations or programs that provide support to families of infants who are deaf or hard of hearing. Key activities conducted to reach these objectives include: developing a Learning Community using Quality Improvement methodology; active monitoring and surveillance; supporting integration of data and implementation of health technology; improving access to the (EIP); and collaborating with family support organizations.

The EHDI program has implemented a year-long quality improvement Learning Collaborative to reduce loss to follow-up in the Western NY Region, by providing technical assistance and support to birthing facilities, audiologists, families of children with hearing loss, family support organizations, EI providers, EI Officials, and NYS Schools for the Deaf. During the Learning Collaborative, EHDI stakeholders in the Western NY Region had two in-person sessions along with monthly calls that resulted in a significant improvement of referrals to EI, from 25% to 96%. The EHDI team also conducted a quality improvement pilot project to reduce loss to follow-up, which involved sending letters to primary care physicians to inform them of infants seen at their practice and who did not pass their newborn hearing screening.

NYS has made significant improvements over the past three years. In 2016, 97.1% of infants received a newborn hearing screening. In 2017, preliminary data shows 97.5% of infants received a newborn hearing screening. Out of all infants who received hearing screening in 2017, 97.8% received met the 1-month milestone. For documentation of follow-up, the state’s baseline performance was established for infants born in 2014. Of infants born in 2014, 9% of infants who did not pass the newborn hearing screening had documentation of diagnostic evaluation services. In 2017, preliminary data shows 39.7% of infants who did not pass the newborn hearing screening have documentation of diagnostic evaluation services.

For further information regarding CYSHCN in NYS, see Attachment #3 NYS Profile of CYSHCN 2016.

<u>FY 2020 Application</u>
<u>CYSHCN Application</u>

2020 State Objectives:

- **Objective CYSHCN-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 CYSHCN-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 CYSHCN-3: Increase the percentage of CYSHCN who need and receive care coordination services that meet their needs by 10% to 44%.**
- **Objective CYSHCN-4: Increase the percentage of infants who receive a follow-up hearing screening after failing initial hearing screening by 60% to 50%**

One of the priorities of the Title V program is to increase supports to address the special health care needs of children and youth, and to improve health outcomes by ensuring the system of care for children with special health care needs (CYSHCN) and their families is coordinated and comprehensive. Title V is using the findings from the National Survey of Children's Health (NSCH), the care mapping initiative, the IDEA Part C Early Intervention Program and Early Hearing Detection and Intervention Program quality improvement projects, and the Sickle Cell grants described previously in the report of progress to inform activities in the upcoming year.

Strategy CYSHCN-1: Develop and Implement a Plan for analysis and reporting of Children with Special Health Care Needs (CYSHCN) data for NY, including data from revised National Survey of Children's Health, and issue initial data report.

Title V staff developed a plan for analyzing and reporting available data to provide staff with a better understanding of the CYSHCN population and their needs and to inform program planning within NY's Title V CYSHCN Program and with external partners. Title V has disseminated the initial report of data to stakeholders and has posted on the NYSDOH website (https://www.health.ny.gov/community/special_needs/docs/CYSHCN_report_2016.pdf) . The report will be updated by Title V staff to include 2017 NSCH data and will design a succinct summary with highlights of key information (i.e., an infographic).

Title V staff will continue to integrate national and state sources of data (e.g., state CYSHCN Program data from LHDs and family/caregiver data from care mapping and the IDEA Part C Early Intervention Program Family Outcomes Survey) to inform CYSHCN program planning. Title V staff will integrate this information into the initial data report and disseminate to key partners and stakeholders.

Strategy CYSHCN-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 CYSHCN and their families.

Among families that did participate in the care mapping initiative, major themes reported were:

- Difficulty accessing information: Families have difficulty identifying resources and specialists. Families spend hours searching for information on their child's diagnosis, State programs and community supports that can help. Families would like a single point of information they can turn to for answers. Few families were aware that the local CYSHCN programs were available to provide information and referrals.
- Families would like more social and emotional supports for both caregivers and CYSHCN. Other parents of CYSHCN are a trusted source of information and support. Respite and support groups are limited in some areas and in others they are difficult to access since child care must be arranged.

- Local CYSHCN Title V staff have limited time to research and keep up to date on resource information for families of CYSHCN in need of assistance. Technical assistance and guidance for the public health workforce was suggested as staff turnover is also a concern of the local CYSHCN programs.

LHDs provided feedback that they do not have sufficient expertise or resources to search for and become knowledgeable about the myriad of health conditions and resources available for families with CYSHCN. LHDs would like to have a reliable source of information and system of supports to help them help their families with CYSHCN. The LHDs would also benefit from professional development and coaching in order to enhance their support for families of CYSHCN. This feedback along with caregiver feedback that they spent hours searching for information and resources for their children and would find it extremely beneficial to have a single place they can go for reliable information.

To address these concerns, the Title V program is increasing its investment in the LHD CYSHCN program to provide more support to local staff who can connect with and support CYSHCN and their families. The Title V program is also going to newly invest in three regional technical assistance centers at the state's University Centers of Excellence in Developmental Disabilities (UCEDD). In New York State, the UCEDDs are the Westchester Institute for Human Development in Valhalla, Montefiore Medical Center in New York City, and the Strong Center for Developmental Disabilities at the University of Rochester. These entities are federally-designated by HRSA and established through a competitive application process to work with people with disabilities, family members, state and local government agencies, and community providers in projects that provide training, technical assistance, service, research, and information sharing.

The three UCEDDs will provide technical assistance, training, mentorship and coaching to improve LHDs' ability to support families with CYSHCN and will allow for engagement with families with CYSHCN to continue to assess and support their needs. The three UCEDDs are geographically distributed to provide support statewide. The three UCEDDs are uniquely qualified for this work and can leverage their current expertise and relationship with LHDs to provide the necessary technical assistance and support to the LHDs as well as direct engagement of families. The UCEDDs will each hire a family member to continue engaging families with CYSHCN in care mapping, surveys and listening sessions to understand the needs and barriers as well as the successes and resources available to support CYSHCN and their families.

In the upcoming grant year, the Title V program will focus on increasing the diversity of representation from families with CYSHCN and youth with special health care needs, ensuring diversity across the range of disabilities or health conditions as well as socio-economic, racial, ethnic, and geographic backgrounds. Data gathered from 97 caregivers, who participated in the care mapping and for whom demographic information was collected, indicated that the majority (62%) were White non-Hispanic, while 20% were Hispanic, 9% were Black/African American non-Hispanic, and 9% Other, non-Hispanic. This compares with 2016 NSCH data where it is estimated that 46% of CYSHCN are White non-Hispanic, 34% Hispanic, 9% Black/African American non-Hispanic, and 11% other, non-Hispanic. Future efforts will seek to better engage Hispanic families as well as continue to reach underserved communities. Also going forward, outreach will be increased to more community-based organizations that support different disabilities and health conditions to ensure better representation from families with different special health care needs to ensure the gaps and barriers, which may be different (e.g., for rare versus common conditions) are understood. Furthermore, youth and adolescents will be engaged directly for feedback, especially in regard to transition to adult services.

To ensure improved engagement of diverse families, NYS has taken advantage of an opportunity to join a HRSA-sponsored learning collaborative led by the NJ State Parent Advocacy Network (SPAN) in partnership with Parent to Parent of NYS to support emerging family leaders for identified roles on community, state, and national teams and advisory groups focused on CYSHCN systems with a goal of increasing the racial and ethnic diversity of family representatives. Parent to Parent of NYS and Title V staff have developed a work plan and objectives to increase

the number and diversity of families who provide input into the development of the state's priorities and initiatives and includes providing training for family leaders from underrepresented or underserved communities. Training will begin in Spring 2019 and continue through the end of the year.

Strategy CYSHCN-3: Provide subject matter and technical support to NY Medicaid Program to implement enhanced care coordination and transition support services for CYSHCN through Children's Health Home (CHH).

Title V will continue to provide subject matter technical support to NY's Medicaid Program by participating in weekly conference calls for CHHs. Title V staff will continue to participate in site visits to CHHs with OHIP and other state agency staff. Staff will also review the policy and procedures for the HH site visit that they visited. Title V will conduct a limited number of care management agencies interviews and provide feedback on the review of HH site visit letters. Title V will review the HH correction action plans and provide feedback.

New Title V staff will be orientated and trained about enhanced care coordination and transition support services for CYSHCN through CHH. Title V staff will continue to promote workforce capacity of local CYSHCN programs by providing technical assistance and additional training, if necessary, regarding CHHs.

Title V will continue to support collaborations between CHH and the IDEA Part C Early Intervention Program. According to EIP data for 2017-2018, there are 36,373 Medicaid and EIP eligible children that may be eligible for CHH, based on their EIP diagnosis. There is a strong connection between these programs and Title V program, with the Title V Director and CHH program staff participating at most quarterly meetings of the Early Intervention Coordinating Council as well as participation on bi-monthly calls with the EIP and all counties across the State. Collaboration between municipal Early Intervention Officials and the Health Home program will continue in the coming year as more children who are eligible for CHHs transition from existing waiver programs into Health Home care management.

Strategy CYSHCN-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 CYSHCN 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. The DOH-funded SCD contracts have a five-year term through 2023.

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 using 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. The goal of the NYS SCD grant is to improve the quality of life/health outcomes for children and AYA/SCD transitioning to self-care management and adult medical care providers. 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 (HH) to enable AYA/SCD and their families to use the appropriate services of care managers; 3) involve individuals and families in all phases of program development, evaluation and the provision of supports to children and AYA/SCD and their families. The contracted providers will

continue to utilize their “Transition Navigators” to assist adolescents to make a successful transition to an adult hematologist or other adult medical care provider and focus on providing adolescents with the skills they need to successfully transition to self-care management.

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.

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 grant 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.

Contractors are developing support groups on varying topics relating to SCD for individuals with SCD and their families to attend. The support groups will be a safe place to explore feelings associated with SCD and help individuals and families to move towards positive coping mechanisms.

Increased information sharing and communication between the contractors and Health Homes will help to increase the number of eligible AYA/SCD enrolled in HHs. Children and AYA/SCD who do not meet the requirements for HHs will continue to have transition services provided by Transition Navigators. Several areas identified as in need of continuing focus include strengthening patient independence, making and keeping appointments, preparing questions for individuals to ask their doctor, fear of the adult emergency room/adult admission and education about changes in health care privacy at age 18. The contractors will continue to work with these individuals and families to build trust and acceptance of the new adult medical care provider to accomplish a smooth transition to adult care. There will be quarterly conference calls with the contractors to provide technical assistance and support their progress towards workplan deliverables.

Strategy CYSHCN-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 CYSHCN populations.

The UCEDDs continue to work with NY and other EI stakeholders, including county EI staff, EI providers and parents, implementing two cohorts of learning collaboratives by utilizing the Institute for Healthcare Improvement’s (IHI) Breakthrough Series. The first learning collaborative began in January-February 2018 and ended December 2018-January 2019. The second learning collaboratives began in October 2018 and December 2018 respectively and will continue until September 2019 and November 2019. The UCEDDs, along with NYSDOH, will continue to 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 seven 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. 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.

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 UCEDDs will also collect the data from the Learning

Collaboratives and develop evidenced-based training to be available to all EIP stakeholders in 2020. SSIP project information and the resources identified, will also be shared on a SSIP webpage hosted on the Bureau's website.

The UCEDDs have convened teams in their region in an in-person, kick-off meeting in Fall and winter 2018, and will continue their support through webinars each month to discuss progress on PDSA cycles (small tests of change), data collected in the previous month, and any barriers and challenges faced by the teams in implementing their plans. The monthly webinars provide opportunities for peer-to-peer feedback as well as guidance from experts at the UCEDDs.. The second cohort will participate in coaching webinars each month for an additional eleven months following the in-person meeting. The second cohort includes the remaining regions of the state that did not participate in the first cohort, as well as teams made up of all Spanish speaking families and Chinese speaking families based in New York City.

The Department, in collaboration with the UCEDDS, 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. Emphasis will be placed on engaging families through increased participation in the annual family survey.

Strategy CYSHCN-6: Use EI family survey data to inform the CYSHCN Program of the needs of families transitioning from EI to CYSHCN 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 CYSHCN Program if the child/family need supports to navigate the systems of care. The number of local programs making improvements in referrals from EIP to CYSHCN 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 2017-2018 CYSHCN data, 186 children, ages 1-5, were referred to CYSHCN 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 CYSHCN Program. The Title V Program will continue to monitor the data for the number of children that were referred from EIP to CYSHCN in 2019-2019.

The three CYSHCN Support Centers at the UCEDDs will host webinars every four months to have peer-to-peer dialogue among the LHD CYSHCN Program staff 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 LHD CYSHCN Program work plan deliverables related to outreach and education to families and providers and offering information, support and linkages for families, CYSHCN and youth that are transitioning to adult health care.

Local CYSHCN Programs will continue to utilize the CYSHCN database, which was recently updated by Title V staff, to better document the information and referral services provided to families of CYSHCN. Title V staff will continue to monitor database utilization, make enhancements to improve functionality, and provide technical assistance to LHD staff. The Title V program 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 CYSHCN program.

Strategy CYSHCN-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).

NYS has made progress in supporting the effort to ensure appropriate and timely hearing screening and, if needed diagnosis and treatment for infants. In 2016, 97.1% of infants received a newborn hearing screening. In 2017, preliminary data shows 97.5% of infants received a newborn hearing screening. Out of all infants who received

hearing screening in 2017, 97.8% met the one-month milestone. For documentation of follow-up, the state's baseline performance was established for infants born in 2014. The state has made improvements in the documentation of follow-up. Of those infants born in 2014, 9% of infants who did not pass the newborn hearing screening had documentation of diagnostic evaluation services. In 2017, preliminary data shows a marked improvement with 39.7% of infants who did not pass the newborn hearing screening have documentation of diagnostic evaluation services.

These efforts have been supported by Title V staff and the leveraging of federal grants from the CDC and HRSA. NYSDOH was awarded grant funding from the CDC for the time period from July 1, 2017 to June 30, 2020 to further expand the state's online information system, NYEHDI-IS. The goal of the grant funding is to ensure that NYEHDI-IS collects all information required in the CDC annual Hearing Screening and Follow-up Survey (HSFS). On September 4, 2018 the New York Early Hearing Detection and Intervention (NYEHDI) staff released a newly enhanced NYEHDI Information System (NYEHDI-IS) based on grant requirements, user feedback, and available resources.

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, with grant funding from HRSA, has implemented and is supporting one state-based Learning Community for healthcare professionals and families during each year of the three-year grant period. The EHDI Program is using an 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. During 2017-2018 , the EHDI Program supported a Learning Community in Western New York. During the upcoming grant year, the program will implement and support a Learning Community in the New York City/Long Island region.

These reports and the Learning Community will continue to support the Title V strategy to 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

The Title V program will continue to measure progress using **ESM-CYSHCN-7**: Percentage of infants with initial hearing screening results for whom follow-up is documented in NYEHDI-IS.

FFY 2018 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 impact longevity and health outcomes. Racial and ethnic minority communities experience higher rates of obesity, cancer, diabetes, HIV/AIDS and maternal mortality and morbidity disproportionally impact women of color. 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 to focus on preventing disease and illness before they occur with an emphasis on how social determinants impact health to work towards supporting 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.

Building on an initial assessment conducted during the last reporting period, Title V worked to identify and evaluate various program requirements and measures currently used by Title V programs to promote preventive care. Currently, 58% of all Title V programs include a requirement to promote well woman care and 65% of programs include a focus on increasing health insurance enrollment. To better understand the types of measures being used, Title V staff worked with colleagues to obtain examples of how requirements and measures promoting preventive health care were being used across all Title V programs. Staff spoke with colleagues across DFH and identified several key programs with a major emphasis on promoting access to preventive care. Broadly speaking, this emphasis was most often seen in program requirements that promote health insurance enrollment, annual well woman visits, as well as assistance accessing preventive services for children and adolescents.

One such program emphasizing the role of preventive care is the Maternal and Infant Community Health Collaboratives (MICHC) program. The MICHC program seeks to improve maternal and infant health outcomes for high need, low income or Medicaid-eligible women and their families by supporting the development of multi-

dimensional systems of integrated and coordinated community health programs and services. Using a life course approach, MICHCs work to improve preconception, prenatal, postpartum, and interconception health of Medicaid-eligible women by working collaboratively with community partners to implement strategies to: find and engage Medicaid-eligible women and their families in health insurance, health care and other community services; assess a woman's needs and risk factors and make referrals to appropriate services; coordinate services across community programs; and promote opportunities and supports for women to engage in healthy behaviors.

Another Title V program that not only promotes access to preventive health care, but also provides those services, is the NYS Family Planning Program (FPP). Comprised of a network of 48 subrecipient agencies operating 166 separate clinic sites, the NYSFPP aims to make sexual and reproductive health accessible and affordable to low-income women and men across NYS. This program includes several comprehensive strategies used to promote access to preventive care for residents across NYS. These include, but are not limited to, the provision of required preventive health visits and screenings (including annual well woman visits, routine breast and cervical cancer screenings, vaccinations, etc.), as well as community education and outreach activities aimed at increasing community awareness of the necessity of timely access of preventive care services. NYSFPP clinics are also able to screen and enroll clients in a range of public health insurance options including Medicaid, Family Planning Benefit Program (FPBP), and the Family Planning Extension Program (FPEP).

DOH Title V staff also work to improve preventive care access through the continued promotion of developmental screening for all children in NYS. Currently Title V staff from across the DFH are participating in or leading several 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; 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; and collaborating on several statewide First 1000 Days in Medicaid Initiative workgroups.

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. MICHC activities include screening children with the Ages and Stages Questionnaire (ASQ) and providing referrals to the state's EIP when appropriate. EIP 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 Title V's long-standing commitment to the NYS ECAC workgroup. Convened by the NYS Governor's Office, this council is comprised 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. Members of the workgroup have been involved in Medicaid's First 1000 Days initiative and the ECCS Impact grant. Title V staff are members of this group and will remain in this capacity throughout the upcoming program year.

NYS Title V program also works to support improved developmental screening across NYS through the work of the ECCS Impact grant. The grant supports efforts in three communities, Nassau County (Docs for Tots) and Erie and Niagara counties (Help Me Grow Western NY & CCRN of Western NY). Through a place-based approach focused 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. Progress is discussed in the Women's/Maternal Health Domain annual report.

Another unique collaborative opportunity to promote developmental screenings can be seen through the DOH support of the Connections Project (formerly referred to as 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 Connections Project targets children under the age of five with a range of cross-sector multi-dimensional interventions. The DOH is partnering with Connections, 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 well child 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 birth-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 Connections Project 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. Progress in these areas is discussed in the Maternal/Women's Health Priority section.

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 have been collaborating with adolescent health experts from Cornell University ACT for Youth Center of Excellence (ACT for Youth) to identify the most effective way to obtain adolescent feedback on this topic. Building on the literature review conducted by ACT for Youth, Title V staff collaborated with experts from ACT for Youth on the development and facilitation of a survey focused on obtaining feedback from adolescents on barriers to accessing preventive services. Title V staff met several times during the

project period to review potential questions, brainstorm which topics should be included, and contribute to the development of a plan to distribute surveys to CAPP/PREP providers. The electronic survey was deployed to CAPP/PREP providers early in 2019. Full analysis of this information is expected in Summer 2019 and will be used to inform program development.

To compliment this work and generate a broader understanding of the state-wide health status of adolescents in NYS, a student intern was hired to compile a report of overall adolescent health across NYS. The student reviewed data and resources from the Division of Chronic Disease Prevention on adolescent health, cancer prevention , tobacco control, healthy schools, and obesity prevention. Final data sources included Youth Risk Behavior Survey System, National Survey of Children's Health, National Youth Tobacco Survey and others. A comprehensive report on the current state of adolescent health in New York State based on race, ethnicity, and socio-economic status was completed. Special health care needs populations, geographical location, gender, and sexual orientation were considered when analyzing data. The information gathered provides a comprehensive snap-shot view with the most available information (as of 2018) on a variety of health information that can be used by public health administrators in making informed decisions, assessing the needs of communities, developing adolescent health-related grant programs, and responding to providers and funders

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 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 due to the impact it has on learning, social-emotional wellness and overall health. The prevention of tooth decay remains a high priority for the Title V program, not only because of the effects of this disease and the associated social and financial impacts, but also because it is largely preventable and entirely treatable. According to 2012-2014 SPARCS data, 83.4 per 10,000 children, aged 3-5 years in NYS had a caries-related outpatient visit. NY's Title V Program is committed to promoting oral health through education, community-based interventions and programming that benefits all NYS residents.

One strategy to promote oral health is to provide financial and technical support for maintenance and expansion of community water fluoridation.

DOH continues to provide both technical and financial assistance to communities to maintain and expand community water fluoridation (CWF). To ensure adequate technical assistance support, DOH awarded a contract to the NY Rural Water Association (NYRWA) for the period of August 2018-July 2023. The contract is intended to provide technical and guidance, increase water operators' knowledge about CWF, and help ensure fluoridated PWS are maintained and operated in compliance with all laws, rules and regulations and optimal fluoridation levels are maintained. NYRWA conducts onsite visits at water treatment plants to provide guidance on operating issues, provides technical support to water operators to ensure PWS are fluoridating at the optimal level, and delivers continuing education trainings for water operators on the topic of CWF. During the recent reporting period, NYRWA completed 40 onsite technical assistance visits to 29 unique PWS and held four CWF trainings to 72 water operators.

Financial assistance was also provided to 30 PWS through the DWF Grant program. As reported in previous annual reports, the grants have been awarded in four separate rounds. The most recent funding (fourth round) was released in August 2017 and a total of $4.8 million has been encumbered to support 13 contracts, 11 of which are executed and two are pending. The grant program can support either Planning and Feasibility Projects (i.e., development of an engineering report to assess the equipment and financial impact of CWF in a community) or Implementation and Maintenance Projects (i.e., upgrade of equipment to maintain CWF).

This strategy is 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.** Over the course of the reporting period, 48 different public water systems (PWS) received technical and/or financial support for CWF from the DOH Drinking Water Fluoridation (DWF) Grant program.

The State Priority is measured by **SPM #5: percentage of NYS residents served by community water systems that have optimally fluoridated water**. For the most recently available data, 70.8% of NYS residents are reported as served by community water systems with optimally fluoridated water in this current reporting year as compared to 71.6% last year. These data are captured by the Safe Drinking Water Information System (SDWIS), which is an Environmental Protection Agency (EPA) database managed by the DOH Center for Environmental Health (CEH). The goal was to increase the percentage of residents, but the percentage has decreased as a result of the discontinuation of CWF in a PWS in Walden, NY, as well as small changes in population size.

While this PWS did discontinue fluoridation, there were additional PWS (City of Ogdensburg and Village of Potsdam) that considered discontinuing CWF. The City of Ogdensburg was concerned about the safety of PWS operators handling fluoride and the cost to fluoridate. DOH staff provided technical assistance and the City of Ogdensburg did not pursue discontinuing CWF. Village of Potsdam residents raised concerns about the safety of fluoride to the Village Board. DOH staff provided technical assistance to Potsdam's Village Administrator, the Mayor, and Village Board Members. The Village Board voted to maintain CWF.

DOH also provided technical assistance to the Northern Westchester Joint Water Works, which had temporarily ceased CWF at their water treatment plants in Amawalk Catskill. Both water treatment plants are expected to resume fluoridating by the end of 2019.

DFH staff, including the Dental Director, Oral Health Unit manager and Title V leadership, developed a compendium of CWF materials. These materials were sent to the four communities above and are available to support future requests for technical assistance.

A second strategy to promote oral health is to increase the delivery of evidence-based preventive dental services across key settings, including school-based clinics, primary care practices and public health nutrition programs.

The Title V program has prioritized access to preventive dental care through promoting the delivery of care through schools. NYS has the largest School Based Health Center program in the US. SBHC can provide medical and dental services, medical only or dental only. There are 49 hospital or FQHC sponsors (regulated by DOH under Article 28 of NYS Public Health Law) providing dental services in 1,939 schools serving areas with low-income children (as determined by the percentage of students who qualify for the free lunch program) and may have limited access to dental services. The Title V Program has allocated funding to establish the School Based Sealant Program (SBSP), with the goal of expanding of the application of sealants on first-year molars of 2nd and 3rd graders, which is an evidence-based approach to combatting tooth decay. Twenty-five SBHC providers of dental services were awarded $50,000 per year for five years. SBSP grantees are required to report data to DOH to support the

evaluation this strategy.

This strategy is measured by **ESM LC-7: Percentage of 2nd and 3rd graders served by School Based Dental Programs (SBSP) who receive sealants**. For the current reporting period, 39.1% received sealants compared to 50.5% the previous year. The decrease can be attributed to the inability of three SBSP-funded dental programs to provide services in the 2017-2018 school year due to a lack of dental staff and difficulties with data submission.

DOH partnered with the Oral Health Subcommittee of the Community Health Center Association of NYS, which provides support and advocacy for NY's community health centers and FQHCs, to establish the Medical-Dental Integration Learning (MDIL) Collaborative. The Collaborative convened from March through August 2018. The primary aim was to reduce tooth decay in children under the age of six by integrating routine oral examinations and screenings, oral health education and counseling, and fluoride varnish application into routine well-child medical visits. Under MDIL, Community Health Centers met monthly for shared learning, facilitated discussions and coaching to improve the oral health status of young children in their communities. Hometown Health Center and Joseph P. Addabbo Family Health Center participated, and both centers improved their fluoride varnish application rate from baseline.

The Title V program has begun partnering with two LHDs in Madison County and Jefferson County through funding from the HRSA Oral Health Workforce Grant to address dental workforce needs and access to oral care in underserved areas of the state. DFH Oral Health staff and Title V Dental Director are supporting these LHDs, which have prioritized oral health initiatives in their counties, to promote evidence-based oral health strategies. Both LHDs have identified increasing the number and type of primary care medical providers who apply varnish in the community as one of their evidence-based strategies. Title V staff have supported the LHD efforts by participating in community meetings, securing experts to provide consultation, and making connections to other agencies and support systems, such as Title V funded SBHC, in their area. The grant is supporting the development of public health detailing materials and training, modeled off pharmaceutical company techniques to engage healthcare providers, to promote primary care providers' application of fluoride varnish as part of a routine well-child visit.

Title V staff have continued to collaborate with the DOH Division of Chronic Disease Prevention (DCDP) on addressing sugar-sweetened beverage consumption among adolescent males of color. The Sugar-Sweetened Beverage Advisory Committee continued to meet to develop and implement a social media campaign to about beverages choices and connection between sugar-sweetened beverage and chronic diseases like obesity and dental decay. Title V program hosted three face-to-face, expert work group meetings to develop social media campaign strategies and identify best practices to integrate the media campaign into existing chronic disease prevention programs. In Fall 2017, focus groups were conducted in Western NY. The findings from the focus groups informed the development of marketing materials, including posters (in English and Spanish) and static and video ads, encouraging drinking water as a healthy alternative to drinking sugar-sweetened beverages. Additional focus groups were conducted in Spring 2018 to review the posters and ads with opportunity for feedback for modifications. A social media and out-of-home advertising campaign was launched in three regions (Western and Central NY and the Southern Tier) from August to October 2018.

Streaming video, display banner, and social media were purchased on YouTube, Snapchat, Twitter, Facebook, Instagram and gaming apps, with known audiences of African American and Hispanic adolescent males, who were the target audience. Digital media was linked to the DOH's Healthy Beverage webpage with information about sugary drinks, healthy alternatives, and the benefits of drinking water. Out-of-home advertising included billboards, bus interiors, bus shelters, and exteriors and cooler clings in convenient stores. Posters were distributed to chronic disease-funded programs, SBHCs, community health centers, and middle and high schools in the targeted communities of Buffalo and Rochester, NY. The posters are accessible on the DOH website at

https://www.health.ny.gov/prevention/nutrition/sugary_beverages.

A third strategy to promote oral health is to integrate oral health messages and strategies within existing community-based maternal and infant health programs.

The Perinatal and Infant Oral Health Quality Improvement (PIOHQI) Project was integrated into the MICHC Program. The goal of the PIOHQI Project was to integrate oral health strategies into community-based maternal and infant health programs through care coordination and public health detailing. Title V staff worked with the Healthy Baby Network (HBN) and Eastman Institute for Oral Health (EIOH) to engage providers and community partners in finalizing the Oral Health Manual Toolkit and refining individual and systems-level strategies to improve maternal and infant access to oral health care and increase provider capacity. EIOH, in collaboration with HBN, trained 126 participants, ranging from dental care providers, perinatal care providers, and community health workers virtually and in-person on the use of the Toolkit and how providers can address oral health needs among high-need pregnant or parenting women and their families.

DOH has facilitated trainings for all MICHC providers starting with an introductory webinar in April 2017 and four in-person regional train-the-trainer events from July 2017 to February 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 and 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. All 23 MICHC programs have trained their community health workers, and, where possible, will work to identify oral health champions in their communities, share information with and/or train healthcare professionals through public health detailing, and/or educate partners at community network meetings.

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. Although the PIOHQI grant ended in September 2018, HBN's partnership with EIOH has continued and is expanding to improve oral health services for pregnant women. Through ongoing partnerships with EIOH and their Oral Health Advisory Council, quality improvement activities and feedback opportunities will continue.

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 3 community colleges and a community-based organization. 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) and parenting supports (e.g. parenting education, healthy relationships). 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 Toolkit developed by the PIOHQI Project with these organizations to ensure staff that are working with expectant and parenting teens are knowledgeable about oral health needs and appropriate recommendations for this population.

This strategy is 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. DOH tracks aggregate data reported quarterly by all 23 MICHCs to monitor the number of clients who are screened for oral health needs, received appropriate oral health information, and are referred for needed dental services. These data are reviewed quarterly, assessed for accuracy, and presented back to the MICHC programs for quality improvement purposes. In 2018, a reported 56.6% of pregnant women who were served by CHWs had a documented screening for dental issues, and 12.4% were referred for dental services.

A final strategy in the SAP to promote oral health is to 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 NYS Dental Public Health Residency Program (NYSDPHRP) was 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.

Residents are trained at the DOH and affiliate sites at Eastman Institute for Oral Health (Eastman)and the Jacobi Medical Center. Long-term objectives of the residency program are to maintain a fully accredited training program for dentists interested in careers in dental public health. Affiliation and partnerships are core assets of this program. Given the growing demands and health priorities of the DOH, it is imperative to seek an appropriate training institution that has the capacity to sustain operation of the program for current and future residents. Therefore, administrative changes are necessary to leverage resources available through Eastman that the DOH believes will ensure long-term support for the program. Eastman is internationally recognized as an institution for postdoctoral training in dental specialties and has successfully maintained accreditation for all other specialty programs through the Commission on Dental Accreditation (CODA), and therefore has the capacity to maintain CODA accreditation for the program. DOH has been collaborating with Eastman and CODA to transition the program to Eastman and will maintain a program site and continue to work with Eastman to provide training opportunities for public health dental residents.

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, 51.9 % of women surveyed had a dental visit during pregnancy as compared to the 47.2% in 2016, which was a slight decrease. 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, there was essentially no change in physical activity between 2015 (23.3%) and 2017 (23.2%). However, there was a slight increase in overweight and obesity from 27% in 2015 to 28.6% in 2017. For children aged 6 to 11 years, those participating in 60 minutes of daily physical activity decreased from 22.9% in 2016 to 17.1% in 2017.

In the 2017 NSCH survey, 54.6% of NY parents reported that their child lives in a supportive/cohesive neighborhood, which is slightly lower than the national level (56.8%), but higher than those reporting in 2016 (50.1%). 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 (57.7% compared to 65.5%, respectively) and the perception of safety remained unchanged from 2016 (57.2%).

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 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, systems, and environmental change strategies, and addressing social determinants of health. These broad, policy-level issues require a collaborative approach; the health sector must work with social services, planners, transportation, and other partners to begin to create change in NY’s communities.

Title V staff also kept abreast of DOH partners’ efforts to change community environments to 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-sector involvement. Staff had varying levels of engagement with the following partner programs: Creating Healthy Schools and Communities, Healthy Neighborhoods Program, Regional Centers for Sexual Violence Prevention and Building Resistance Against Climate Effects. 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.

Environmental change continues through enhanced collaboration with partnerships from activities of the Title V’s six Regional Centers for Sexual Violence Prevention (Regional Centers). Since 2014, these Regional Centers have been implementing innovative primary prevention community-level (coalition-building, community mobilization, social norms and policy change) and individual-level sexual violence prevention strategies (Bringing in the Bystander, Shifting Boundaries) with youth and young adults, ages 8-24, from seventeen high-risk counties across NYS. During this reporting period, the work of the Regional Centers was 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 healthy community initiatives. 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 creation of maps, summaries and assessments for program communication. From August 1,

2016 – July 31, 2017, the six Regional Centers, implemented a total of 25 prevention strategies (with 15 (60%) community-level and 6 (24%) societal-level strategies being implemented) and reached a total of 469 individuals through 249 various organizations dispersed throughout high-need counties across the state. Throughout the former 5-year grant period (2/1/14 – 1/31/19), the Regional Centers have completed 807 community-mobilization events (i.e. presentations with community-based organizations and members, youth-led events); 342 coalition-building events; and 82 cycles of evidence-based educational curricula sessions.

In this reporting period, the DFH Sexual Violence Prevention Program (SVPP) 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 inclusive. The Regional Centers and community partners continue to invest considerable time and effort 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 school initiatives (an initiative aimed to promote a healthy school community by providing sexual violence prevention education and establishing policies). Studies have shown a significant link between increased sexual violence and alcohol consumption for both perpetrators and victims. As a result, training bar proprietors and their staff on what is sexual violence, how to observe and assess situations for signs of sexual violence, bystander intervention skills building, policy change assistance and environmental assessments are all components of a comprehensive approach addressing all levels of the Social Ecological Model (SEM). Currently there are 26 trained bars, 228 staff/managers/owners trained, and 50 trained trainers throughout the six Regional Centers. Studies also indicate there is a higher incidence of sexual violence, and accompanying behaviors and attitudes, within schools among youth and young adult populations. The Regional Centers and community partners prioritize ages 8-24 years old as studies have shown this is where the problem persists most. School-based interventions for adolescents have shown emerging evidence of effectiveness in “improving gender-equitable attitudes and increasing self-reported likelihood to intervene in situations of bullying and partner violence” (Lundgren & Amin, 2015). Currently, the Regional Centers have been implementing bystander intervention curricula, such as Bringing in the Bystander; other programs for implementation include Shifting Boundaries, Girl’s Circle and Council for Boys and Young Men, and Mentors in Violence Prevention. Currently there are 12 schools, 818 individuals trained, and 53 trained trainers throughout the six Regional Centers. From February 1, 2018 – January 31, 2019, the Regional Centers have trained 12 schools in various sexual violence prevention/healthy relationship curriculum. Currently, there are 53 trainers across the state qualified to train in various healthy relationship, sexual violence prevention, and bystander intervention curricula such as Shifting Boundaries, Mentors in Violence Prevention, and Bringing in the Bystander.

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 process of creating, disseminating and analyzing the CAT identified collaboration as a standout among coalitions, community-based organizations and DOH. Therefore, a collaboration plan template was developed to focus on identifying effective measures for collaboration.

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 framework tool 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 had been selected to pilot the collaboration plan template with their local-level partners throughout 2018. In Summer 2018, another graduate student intern from the SUNY Albany School of Public incorporated the collaborative framework template into the Regional Centers evaluation plan, more specifically the work plan and a tracking tool) for dissemination and subsequent data collection and analysis for the Regional Centers' new project period (February 1, 2019 – January 31, 2022). Based on the results of this 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.

Further community-level collaborative efforts are supported through the MICHCs. The MICHC initiative seeks to improve maternal and infant health outcomes for high need, low income or Medicaid-eligible women and their families by supporting the development of multi-dimensional community systems of integrated and coordinated community health programs and services. MICHCs work to improve preconception, prenatal, postpartum, and interconception health of Medicaid-eligible women by working collaboratively with community partners to implement strategies to: find and engage Medicaid-eligible women and their families in health insurance, health care and other community services; assess a woman's needs and risk factors and make referrals to appropriate services; coordinate services across community programs; and promote opportunities and supports for women to engage in healthy behaviors. MICHCs utilize Community Health Workers (CHWs) to assist Medicaid-eligible women of reproductive age to effectively access continuous and coordinated health care and other needed community services responsive to their needs and risk factors. On a systems level, MICHC programs work with community partners in the health and social services arena to: assess resources, prioritize community needs and strengths; and implement community-level strategies to address the needs identified. For example, in one upstate community, the MICHC program identified transportation to essential services as a barrier to women receiving needed services. In response, the MICHC program worked with the local transit authority to improve bus routes by adding additional stops in less populated, vulnerable neighborhoods.

Efforts such as Pathways to Success also demonstrate a strong community partnership to enhance the lives of young parents. The Pathways to Success initiative funds three community colleges and one community-based organization to create and sustain supportive systems that help expectant and parenting teens and young adults succeed through health, education, self-sufficiency and building strong families. The initiative utilizes an Asset and Risk Assessment (ARA) tool that helps Pathways staff to assess the needs and existing resources for young parents and their families. This structured interview tool enables funded projects to identify and prioritize assets and needs and develop a tailored list of referrals for each program participant. The ARA tool is also conducted over multiple client contacts, helping build a relationship between program staff and student participants, as well as providing opportunities to reassess needs and outcomes of referrals previously made.

In addition, Pathways staff have conducted a needs and resource assessment, including key informant interviews and focus groups, targeted to the priority population to identify the barriers and assets relevant to accessing needed services and achieving school success. The focus groups targeted expectant and parenting young people and focused on resource utilization and gaps between needs and resources. The key informant interviews targeted

internal and external partners, and focused on community resources, linkages, strength of relationships, gaps in resources, and perceived needs. Data from both focus groups and interviews will aid in the identification of current needs for expectant and parenting young people, existing resources to meet the needs of this population, and gaps between needs and resources. By collecting these data from both young people and representatives of organizations which serve them, this assessment process identifies priority areas of need, and assists to determine which resources could be better utilized to improve services in the community.

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 13.9 at 13.1 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 dashboard is now live and regular updates are planned.

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.

Continuing to emphasize the importance of increasing staff capacity to proactively address health equity issues, Title V staff worked to finalize implementation plans for a comprehensive health equity curriculum. Required of all Title V staff, including administrative and support staff as well as interns, this multi-session curriculum was selected and compiled by the Title V Health Equity team with a goal of building a solid foundation of health equity understanding. Using the DOH Learning Management System (LMS) ensures that participation in training modules are effectively tracked across all Title V Staff. Using resources from a variety of partner organizations including; 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, this training series is meant to ensure all Title V understand the ways in which the can work to directly improve health equity through their day to day work.

Based on a comprehensive review of available modules, the four courses selected were: 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.

Title V staff continued work through the Fall of 2018 to finalize plans and packaging of the online modules of this curriculum. After a collaborating with NYSDOH partners in the Office of Public Health Practice, Title V staff were able to finalize the format and sequence of trainings. On February 5, the DFH Division Director sent an email to all Title V staff informing them of the availability of this new training resource and the expectation that all staff would complete the full curriculum by May 2018. Staff were encouraged to complete one module per month, and upon completion, will be required to take the post-test. Those who had not attended the Bridges into Health and Healthcare training in April 2018, were asked to complete the same pre-test prior to starting to complete the training series.

Of those that completed that Title V Health Equity Learning Series pre-test, only 12% of staff felt “extremely” or “very” comfortable explaining the difference between health inequities and health disparities or how social determinants of health impact the health, productivity and wellbeing of MCH populations, Level of comfort increased slightly in terms explaining how health literacy influences and affects the health and wellness of MCH populations with 28% responding with either “extremely” or “very”. In terms of responsibility, 83% of respondents indicated “extremely” or “very” when asked if they believe DFH has an organizational responsibility to promote health equity, but only 64% indicated that same level of belief about their individual responsibility. A second post-test survey will be deployed to all Title V staff upon completion of the full Health Equity Training Curriculum. Scores will then be analyzed to evaluate if curriculum successfully increased staff knowledge and understanding of health equity concepts, as well as their comfort and ability to integrate that information into their routine work.

While doing research on available training resources, Health Equity Team Members identified an opportunity to supplement the online training modules with an in-person option for the “Bridges Out of Poverty” training. Following positive feedback from participants who attended the live training, Title V staff worked with national experts to organize a DFH-specific training on the “Bridges into Health and Health Care” curriculum, a supplement to the existing online training. On April 13, 2018 a one-day, intensive training focused on building knowledge and understanding among all Title V staff of the complex institutional and interpersonal dynamics of accessing health and health care in America, especially for lower income individuals, was held. Owing to the high level of interest in this training among both the internal and external partners of DOH Title V staff, several members of DOH Center for Community Health were invited to attend, along with a group of master’s in public health students from the SUNY School of Public Health. Approximately 124 people were in attendance.

All participants began the session by completing a short evaluation, which served as a pre-test for the entire Title V Health Equity Training Learning Series. Focused on establishing an initial baseline of staff competency, this pre-test included 10 questions designed to assess the level of understanding and self-efficacy Title V staff have in addressing issues related to health equity. This survey was collected before the start of the Bridges training and was analyzed to develop a baseline pre-test score for the collective Title V staff.

Title V staff also continued to work 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 and My Beloved World by Sonia Sotomayor.

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/Session (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.

In the past year, Title V staff continued to focus on using the Community Listening Session model to gather information from members of the priority population to inform the development of programs and activities. In the summer of 2018, under the leadership of Governor Cuomo to address the significant disparities related to maternal mortality, Title V staff conducted seven community listening sessions across the state in the summer of 2018.

Based on maternal and infant outcome data, the DOH identified seven communities experiencing poor birth outcomes with an emphasis on those demonstrating racial disparities. Following this analysis, listening sessions were planned for Buffalo, Syracuse, Albany, Bronx, Brooklyn, Harlem and Queens. The DOH Maternal and Infant Community Health Collaboratives (MICHC) programs were engaged as partners to plan and conduct the listening sessions. The MICHCs recruited other community partners to assist with engaging community participants and to help facilitate the sessions. Community participants included recently and currently pregnant women and families, with an emphasis on engaging black women who have experienced an adverse birth outcome.

The listening sessions, entitled “Voice Your Vision – Share Your Birth Story”, lasted between two and three hours and included on-site child care. The listening sessions were organized to allow participants to drive the focus of each conversation. Loosely centered around four topics (planning for pregnancy, pregnancy, childbirth, and the postpartum period), facilitators introduced each topic and kept participants on topic while scribes at each table captured participant feedback in real time. Each session had about 35 community participants and began with DOH leadership, including Commissioner Zucker framing the purpose of the session. Participants were engaged in a discussion on the barriers and issues impacting their birth experiences. After the discussion, participants shared important points discussed during the process.

At the conclusion of these sessions, the written record of participant feedback, taken by scribes, was analyzed and summarized to produce a statewide report identifying overarching themes. This report summarizes what participants reported at the listening sessions and is currently under review.

Common barriers expressed across all seven listening sessions included:

- Access to health care (limited facility choice, quality of provider and facility care).
- Poor communication with health care providers (especially feeling providers were not listening to them, that they were not given enough time with providers, and that few providers reflected their lived experience).
- Lack of information and education from providers.

- Racism and its impact on the quality of care received.
- Disrespect from health care providers, including support and administrative staff.
- Lack of social supports.

And common suggestions for addressing the racial disparities in maternal mortality included:
- More black and Hispanic health care professionals, reflective of the community.
- Increase health care professionals' awareness of racial disparities in health outcomes.
- Train health care professionals on the impact of implicit bias on health care outcomes.
- Increase provider support during the postpartum period.
- Increase availability of social support for example, birthing classes, group prenatal care, doulas, midwives, community health workers and parenting classes.
- Increase availability of community services and resources, for example, community health worker services and home visiting services.

Across all seven listening sessions, participants asked for better understanding of the reasons why black women have poorer pregnancy health outcomes, and acknowledgement of the impact of race and racism on those outcomes. Participants asked for action to address the racial disparities in maternal mortality, and particularly focused on how health care systems and practices may perpetuate continued racial inequities. Participants asked for the elimination of barriers that prevent women from getting quality health care services and asked for increased supports needed to help with a healthy pregnancy.

Participants affirmed that all NYS mothers and babies should have the same opportunities to achieve optimal health and positive birth outcomes, regardless of race, ethnicity, community of residence, insurance coverage, or hospital of delivery.

A commitment to health equity extends well beyond NY's Title V program. Over the past year, a Racial Justice (RJ) Workgroup was formed led by the CCH director, Nora Yates and comprised of staff members from all divisions with CCH. The workgroup is charged with proactively promoting a racial justice framework throughout the work of CCH (including: Title V activities, epidemiology, WIC, SNAP, tobacco control, cancer prevention services, and more). Activities of the RJ workgroup take place within the context of a performance management infrastructure leading to the development of a series of RJ focused performance measures to guide the work of CCH.

Each division was charged with creating two measures, one internally focused (i.e. staff development, training, and capacity building) and one externally focused (i.e. community collaboration, coalition building, engagement of priority populations). The Title V program continues to play a major leadership role in the development of these performance measures. Building on several years of successful health equity focus, RJ workgroup members elected to develop a single internal performance measure to be used across CCH, based largely on Title V MCHSBG activities led by DFH for the past several years. This performance measure mirrors the format and evaluation of Title V MCHSBG work and dramatically expanded the staff required to complete a comprehensive online training on health equity. Title V staff further impacted the development of several external performance measures (PMs) by modeling a community listening session protocol that was adopted by several other divisions as a way to increase community input and participation in program development.

Finally, the CCH RJ workgroup supported the facilitation of a two-day training on Racial Justice theory and practice by a national expert, Dr. Joia Crear-Perry. Broadly covering the complex and systemic factors contributing to racial inequities in health outcomes (esp. birth outcomes) this interactive training was available to most Title V staff working on maternal mortality, morbidity, or other women's health activities. This training enabled participants to better

understand the historical and root causes of institutional and structural racism that continue to impact health outcomes today. Participants were able to discuss and define strategies to implement within their ongoing work that would proactively address the role of race and racism in creating unequal outcomes for women and families in NYS. Work with Dr. Crear-Perry will continue through collaborative activities and consultant work via the RJ workgroup.

The Title V program recognizes the value and importance of understanding and addressing health equity to improve the health and wellness of all New Yorkers and will continue efforts to ensure all families have access to quality primary and preventive health services. The priority placed on addressing health disparities is integrated throughout NY's work and in this report. It is clear through efforts spearheaded by Governor Cuomo related to maternal mortality and efforts through DOH and Title V, there is a strong commitment to addressing this significant public health priority. (Refer to the State Overview and information contained in the Maternal and Women's Health and Perinatal and Infant Health section of this report for further details regarding New York's health equity efforts.

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 are 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 screening rates for youth across NYS. This will include ongoing participation in the ECAC, support for the Connections Project (formerly known as the Albany Promise Initiative), collaboration on the Early Childhood Comprehensive Systems (ECCS) initiative, 1000 Days on Medicaid initiatives and regular internal efforts to improve developmental screening rates. .

The DOH MIECHV program has further emphasized the importance of 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. MIECHV's 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.

Community Health Workers (CHWs) will continue to provide child development information to families in the MICHC program and will continue to screen children with the Ages and States Questionnaire (ASQ) to determine whether a referral to EI is appropriate. The number of families receiving child development information, the number of EI referrals issued, and the number of completed referrals to EI will continue to be tracked and reported quarterly.

As discussed previously, in response to Governor Cuomo's 2019 Women's Justice Agenda, and recommendations of the Taskforce on Maternal Mortality and Disparate Racial Outcomes (Attachment #1), Community Health Worker (CHW) services in key communities across the state will be expanded to provide needed social support, information, and advocacy. Community health workers are a trusted and valued community resource as individuals navigate the healthcare system. Through the MICHC program, this proposal will expand CHW activities to address key barriers impacting disparities, including childbirth education and support, promoting collaborative child care and social support networks, assisting with the development of a birth plan and supporting increased health literacy. It is anticipated that with additional funds from Medicaid, beginning 7/1/19-9/30/20, NY's MICHC program will add approximately 50-60 CHWs and serve an additional 2,400 prenatal and postpartum women.

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. Though the NYS' Medicaid benefit includes dental services for all, access to dental care remains a challenge for many. As of February 27, 2018, there were federally-designated low-income or Medicaid-eligible population dental health professional shortage areas in 21 counties in NYS. Expanding access to evidence-based interventions, specifically community water fluoridation (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 public water systems (PWS). In the NY's 2019-20 Budget, $10 million was appropriated to support the DWF Grant Program. Under the DWF procurement process, DOH will continue to accept and review applications and make awards on a rolling basis until funds are expended. Title V will work to promote the DWF Grant Program, specifically in non-fluoridated communities, to increase the percentage of NY communities on PWS receiving optimally fluoridated water. This includes working with LHDs across NYS and DOH District Offices to promote the request for applications (RFA), including outreach to municipalities to discuss eligibility, education about CWF and identification of local champions to work with PWS to submit applications. In addition to promoting CWF, Title V staff will continue to work with the grantees to ensure completion of the projects and provide technical assistance as needed.

The DOH contractor, NY Rural Water Association (NYRWA), will continue to provide technical assistance to PWS through direct onsite visits and water operator trainings. NYRWA will conduct 25 site visits and hold four trainings in 2019-2020 to promote optimal community water fluoridation. DOH will continue to provide technical assistance to LHDs and local officials in communities considering the discontinuation of CWF. This strategy will continue to 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**

Title V staff will continue to support the SBSP program and contractors through June 20, 2022. The goal of the SBSP is to expand of the application of sealants on first-year molars of 2nd and 3rd graders, which is an evidence-based approach to combatting tooth decay. The SBSP providers struggled in the most recent year, and a decrease in sealant application was noted for the current reporting period (39.1%) compared to the previous year (50.5%). Title V staff will work with programs to better understand challenges and identify solutions.

Title V staff will also continue to encourage School-Based Health Centers that provide only medical services to integrate dental services either by directly providing, establishing an agreement with a dental provider, or referring

children to dental providers. Title V staff will continue to integrate the application to establish a medical and dental SBHC as well as the data reporting for medical and dental services. Currently, a sponsor (hospital or FQHC) must submit a separate application for medical services and for dental services if both will be provided in one school. Likewise, the quarterly reports for medical and dental services are separate and distinct. In the upcoming grant cycle, Title V staff anticipate that these processes can be integrated. Finally, Title V staff are integrating the guidance on standards for medical and dental services at SBHC into one document. The goal is to create a seamless system that promotes the integration of medical and dental services at a school-based clinic.

Title V staff will work with stakeholders on medical-dental service integration in primary care practices with a focus on promoting the evidence-based practice of fluoride varnish application by medical providers. As described in the Annual Report, DOH received a grant from HRSA to support oral health work force. The HRSA grant continues through August 31, 2022.

The grant supports DOH Title V and Oral Health staff to develop public health detailing, modeled after the pharmaceutical companies approach to engage physicians, to support in-person training and materials to increase the application of fluoride varnish during routine well-child medical visits. DOH had created fluoride varnish public health detailing materials through a collaboration with the New York State Association of County Health Officials (NYSACHO). The grant funding allows for the contracting with an expert in this area to enhance and expand the existing detailing package to include curriculum and implement in-person training for Local Health Department (LHD) staff to provide the in-office detailing for medical providers. The effort is focused in two counties, Madison and Jefferson, and immediate surrounding areas. Over the upcoming grant period, additional counties will be invited to participate.

The success of this initiative efforts will be measured by evaluating the number of Medicaid claims submitted by primary care providers for application of fluoride varnish for children 0-5 who receive fluoride varnish applications from their primary care providers before and after the detailing.

Title V staff will continue to work with the DOH Division of Chronic Disease (DCDP) and the Division of Nutrition (DON), which oversees the state's Special Supplemental Program for Women, Infant and Child (WIC), to continue to incorporate evidence-based oral health practices and provide education about sugar-sweetened beverages into established nutrition and public health programs.

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

Although funding for the Perinatal and Infant Oral Health Quality Improvement (PIOHQI) grant ended September 29, 2018, NY's Title V program continues to integrate oral health services into the MICHC program infrastructure by facilitating training, technical assistance and oral health resources to MICHC providers and their community partners. Title V will continue to provide guidance to MICHC programs on the oral health integration process, including assisting MICHC sites to engage and train dental providers and community health workers, conducting periodic coaching calls with MICHCs to monitor progress and barriers and to provide technical assistance, analyzing data from quarterly reports to measure progress, and providing feedback. Between 2015-2018, the MICHC program saw improvements in oral health services for pregnant and parenting women. Continued improvements in oral health services are anticipated among MICHC programs as more staff and community partners are trained, and Title V staff continue to provide technical assistance and to collect and analyze data.

As a supplement to this ongoing activity, in the 2019 spring semester, Title V will oversee a student project that will

utilize quarterly MICHC program data to identify additional areas for improvement including oral health, design a continuous quality improvement project, and establish an implementation plan.

MICHC contracts are in effect through September 30, 2020. DOH will release a competitive procurement in Fall 2019 for a new 5-year cycle. The new procurement will maintain the integrity of oral health integration to ensure that vulnerable women and families served by MICHC continue to have access to appropriate oral health information and services to meet their needs.

This strategy 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, which works to develop and implement programs to improve educational, health and social outcomes for expectant and parenting teens, women, fathers and their families, has implemented a plan to incorporate oral health strategies. An Asset and Risk Assessment tool, developed by Cornell University's Act for Youth Center for Community Action (ACT CCA), is used to track program participants and determine which services and resources they need most. The tool contains a dental hygiene and oral health screening question. All students receiving services will be screened using this tool. If program participants indicate a need for dental health services or resources, Pathways to Success staff will provide appropriate oral health information and refer program participants to the appropriate services.

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.

To ensure sustainability of the residency program, DOH is engaged with Eastman Institute of Oral Health to transfer the program. Eastman has been a partner of the residency program for 20 years and has served as an affiliate site for residents training. Through this partnership, the dental public health residency training opportunities will resume in the upcoming MCH block grant year. Dental public health residents will continue to work collaboratively with Title V staff to provide support for MCH oral health programs. Residents will continue to initiate activities to meet competencies as required. Activities will include providing continued support for the ongoing analysis of data from School-Based Health Center programs that provide dental services. Residents will assess evidence-based interventions and best practices, oral health prevention, and cross-cutting activities to help promote integration of oral health strategies into public health programs.

<u>Healthy Communities – State Priority #7</u>: 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. In the coming year, NY's Title V program is placing a major emphasis on understanding and addressing social determinants of health that includes safe and healthy environments in order to address health equity. For further information, refer to Health Equity – State Priority #8.

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.**

Since the initial development of NYs SAP, Tile V staff have gained a greater understanding of the issues and challenges surrounding health equity and the impact of social determinants on the health and wellness of NY's populations. . This understanding informed expanding the focus of the Place-Based Initiative workgroup to include the broader social determinants that impact which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. As stated in the annual report section of this domain, a Racial Justice (RJ) Workgroup was formed and is led by the CCH director, Nora Yates and comprised of staff members from all divisions with CCH. The workgroup is charged with proactively promoting a racial justice framework throughout the work of CCH (including: Title V activities, epidemiology, WIC, SNAP, tobacco control, cancer prevention services, and more). This work will continue to expand as the Title V program gains greater understanding of those factors impacting the health of men, women and families and strategies to address those factors.

As the work of the CCJ RJ Workgroup continued to expand it became necessary to seek external resources to strengthen its work within CCH and DOH as a whole. In looking for external partners, it quickly became evidence that the Government Alliance on Race and Equity (GARE) was a perfect fit. GARE is a national network of government agencies working to achieve racial equity and advance opportunities for all. These governmental jurisdictions across the country are making a commitment to achieving racial equity, focusing on the power and influence of their own institutions, and working in partnership with others. When this occurs, significant leverage and expansion opportunities emerge, setting the stage for the achievement of racial equity in communities. GARE's work supports a number of jurisdictions that are the forefront of the work to achieve racial equity who serve as a model for the work in CCH. Access to this network will provide the RJ workgroup with best practices, and the tools and resources to help build and sustain our efforts to achieving racial equity within CCH.

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 (Regional Centers), Community Schools, 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.

Ensuring freedom from sexual violence in our communities is imperative to promote health and wellness. The Regional Centers implement innovative primary prevention community and individual-level sexual violence prevention strategies. The Regional Centers collaborate with community partners in the development and 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 school initiatives (an initiative aimed to promote a healthy school community by providing sexual violence prevention education and establishing policies). The Statewide Center for Sexual Violence Prevention Training and Technical Assistance (Statewide Center) 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 Statewide Center will continue to support the Regional Centers in their individual and community-level change strategies. The Regional Centers under Title V will utilize the Collaborative Framework Tool (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.

In 2018, the Sexual Violence Prevention (SVPP) Unit and the Bureau of Occupational Health and Injury Prevention (BOHIP) worked with the One Circle Foundation, creators of the Council for Boys and Young Men and the Girls' Circle programs, to adapt skills-building curricula to reflect and enhance 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. The SVPP Unit and BOHIP will continue to work together to develop a manual-guided curriculum that will address healthy relationships and healthy sexuality. Youth have increased access to the sexualized elements of the new digital world, which has the potential to shape adolescents' relationship skills, social and gender norms, ideas around power dynamics, and serves as a vehicle for sex education. Staff will support One Circle Foundation's development of a manual-guided curriculum that will address healthy relationships and healthy sexuality in the digital age of "Technology Mediated Sexuality Interaction" (TMSI).

The SVPP Unit is developing a state action plan as part of required deliverables of the CDC-funded Rape Prevention and Education (RPE) program. The purpose of the state action plan requires states to work with state and local partners to: provide a strategic plan to implement sexual violence prevention strategies using best available evidence and data; identify and provide state and local-level data sources; provide a plan and guidance to providers for analyzing health disparities data for identifying priority populations; develop a plan for identifying, establishing and leveraging partnerships; and create a sustainability framework for the RPE program. The state

action plan will be a living document for the 5-year (February 1, 2019 – January 31, 2024) project period.

As stated previously, the Title V program supports the MICHC initiative; 23 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 programs 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 level change. The Title V program will continue to oversee the local implementation of MICHC while implementing CHW expansion to address maternal mortality.

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.

Title V staff will continue involvement in the ECCS. The ECCS initiative is connected to various TA initiatives and statewide workgroups and committees such as the OHIP's First 1000 Days on Medicaid Initiative, the NY Strengthening Infant/Toddler Policies and Practices, the NYS Infant and Early Childhood Mental Health TA initiative, the NYS Parenting Education Partnership, and workgroups on the NYS Governor's CAC and the Governor's Child Care Availability Task Force. In addition to maintaining and growing state partnerships, the state ECCS impact grantee plans to further develop a Community Readiness Scale for NYS Communities to help them assess their readiness and capacity of using collective action to improve their early childhood systems, engage in peer-to-peer support, prepare for project sustainability and inform NYS policy decisions.

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 framework tool 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 have been selected to pilot the collaboration framework tool with their local-level partners beginning Spring 2019.. In Fall and Winter 2018, Title V staff utilized partner surveys to collect users' perceptions and experiences using the template. Based on the results of the pilot, the collaborative framework tool will be incorporated into the RPE 's state evaluation plan and data will be collected from the Regional Centers quarterly. After the pilot study is completed, DOH will develop a dissemination plan for Title V staff and program 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 was 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 build on the Title V Health Equity training program for all DFH and CCH staff as discussed in the annual report section of this domain. . 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.

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.

The opportunity to enhance the knowledge of all Title V staff has resulted in more community-focused approaches to many aspects of NY's Title V program including procurements. The Health Equity Team will continue to support staff in the development of this language and engage in discussions to promote community input. The team will also continue to support Title V staff in the development of CLF's to better inform the development of all 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. As new procurements are developed, language is added to require applicants to have an established ongoing process to connect with the individuals they serve to ensure services meet the needs of the community. This model is also being mirrored for NY"s upcoming Title V Five=Year Needs Assessment (discussed below).

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. Putting communities at the forefront of all initiatives is an important step to promoting health equity.

Finally, NY's Title V program is carrying this commitment to address health equity and model forward in the upcoming full Five-Year Needs Assessment combined with the MIECHV Needs Assessment process. Plans are currently underway to work with community partners to facilitate CLS across NYS that will set the stage for NY's Title V MCHSBG Application in 2020. The support provided to NY has made it possible to take these strides in addressing significant health disparities in the coming years.

III.F. Public Input

Public Input 2020

The mission of NY's Title V Program is to improve the health and wellness of women, children and families. 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. Each time the community is engaged, new insights are provided, and ideas staff thought to be true were challenged or refined based on input from those who are directly impacted by the work. 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.

NY's Title V Program has always sought public input to ensure NY's Title V strategies and efforts reflected the needs, thoughts, and priorities of all MCH stakeholders. During this past year, in addition to the stakeholder group conversations that staff conduct on an on-going basis, a more formal and systematic approach was used to very intentionally target specific groups to delve deeply into two communities from whom greater understanding of life experience might shed light on disparate health outcomes. The two specific groups targeted in these initiatives were women of color and their experience with pregnancy, child birth and postpartum care and CYSHCN and their families.

In partnership with the NYS DOH Maternal and Infant Community Health Collaboratives (MICHC) programs, listening sessions were conducted during summer 2018 in seven communities: Buffalo, Syracuse, Albany, Bronx, Brooklyn, Harlem and Queens. The MICHC grantees were invaluable in organizing the *Voice Your Vision – Share Your Birth Story Community Listening Sessions* and engaged other community-based partners to recruit participants and to help facilitate the discussions. A total of 244 women of color participated in the listening sessions, including recently and currently pregnant women and families, and women who have experienced an adverse birth outcome. Participants were open in relating their stories, and in expressing what would have made their experience better.

Common barriers expressed across all seven listening sessions included:

- Access to health care (limited facility choice, quality of provider and facility care).
- Poor communication with health care providers (especially feeling providers were not listening to them, that they were not given enough time with providers, and that few providers reflected their lived experience).
- Lack of information and education from providers.
- Racism and its impact on the quality of care received.
- Disrespect from health care providers, including support and administrative staff.
- Lack of social supports.

And common suggestions for addressing the racial disparities in maternal mortality included:

- More Black and Hispanic health care professionals, reflective of the community.
- Increase health care professionals' awareness of racial disparities in health outcomes.
- Train health care professionals on the impact of implicit bias on health care outcomes.
- Increase provider support during the postpartum period.
- Increase availability of social support for example, birthing classes, group prenatal care, doulas, midwives, community health workers and parenting classes.
- Increase availability of community services and resources, for example, community health worker services

and home visiting services.

Specific quotes from several women are invaluable in understanding the issues they face and are contained below:

"I switched health plans to go to a better hospital, not 'the bad one'."

"Hospitals look at good insurance that makes them happy… they should think of us all the same."
"I knew my prenatal appointments were going to be all day."

"I feel like when we have concerns we're not heard."

"I was never told why I was high risk."

"I didn't know black women died more, but I'm not surprised – we have the worst everything."

"Women of color are tired of feeling like we have to fight for rights that should just be given to us."

"When I had my kids I didn't have no help. Family dropped me off and left me."

Among the many overlapping themes and ideas shared at all seven listening sessions was the frequent expression of gratitude that these sessions were being held at all and appreciation for being listened to and asked about their experiences. Participant after participant shared not only their story, but their eagerness to be part of creating solutions to improve outcomes for themselves and their communities. The impact of racism echoed throughout every session.

Similarly, conversations were held with CYSHCN and their families. The DOH recognized that the supports and care for CYSHCN needed to be improved, but in order to accomplish this needed a greater understanding from families themselves. To better understand the gaps, barriers, and needs of families with CYSHCN, CSHCN program staff implemented a process to collect feedback from parents and caregivers with CYSHCN and professionals who serve them. A formal care mapping tool was used to diagram roles, responsibilities, needs, and resources in providing care for CYSHCN and the changes most desired to help families meet their needs. Feedback from 138 caregivers and 40 providers was collected.

Again, themes emerged that were common among different groups and different sessions. Access to coordinated health care was consistently described as a challenge. Finding the right combination of services from providers was time consuming and not always easy to find in a family's own locale. Quality child care was particularly difficult and expensive to locate, forcing some families to reduce their work hours, or stop working altogether and therefore markedly reduce their income, to provide care where gaps existed. Finances in general were repeatedly referred to as a challenge, as was the insufficiency of health insurance to meet a child's needs. Social and emotional support for both the individual and the family were cited as insufficient for their needs. Related to this, was the challenge of integrating the child into their community, leading to feelings of loneliness and isolation. Ongoing issues with the school system and a perceived sense that the school system did not meet their child's need was expressed. Finally, there were great concerns related to transitioning a YSHCNs to adult services and opportunities to have appropriate daytime activities with which to occupy their time.

In the words of families:

"[There should be] easier access to those resources so I do not have to be on a computer for 6 hours doing research."

"If I didn't have a flexible job I'd already be fired for missing too many days when my child is sick."

"My son cries because he does not have any friends."

"As soon as you put a special needs label on something, the cost quadruples."

"At CPSE [Committee on Preschool Special Education] meetings, they just push papers in front of you to sign. Someone needs to advocate for the parent."

"Need someone to make these different groups of professionals talk to one another."

In addition to these targeted initiatives, input was sought from the many stakeholder groups with whom DFH works. The DFH held discussion sessions with groups including NYSACHO, ECAC and EICC, MCH Advisory Council, Parent to Parent of NYS, Schuyler Center for Analysis and Advocacy, MICHC contractors, Association of Perinatal Networks, and oral health professionals. Nearly 100 stakeholders in six sessions were engaged in discussions focusing on four thought-provoking questions.

When stakeholders were asked how they are engaging with their community members to inform their efforts many described the use of social media and interactive websites as a means of hearing from the community. There was a recognition that coalitions on specific topics such as breastfeeding provided an opportunity to hear the voice of the people. In addition, there was understanding that quality improvement initiatives that include the community as integral team members, bring added opportunities to better understand the issues that communities face.

When asked what or how they have changed in their program or practice in the last 4 years in response to what they have heard or learned from the community they serve many discussed the issues related to the increase in opioid use in the communities served, the increase in coalitions related to NAS and factors related to substance use. Stakeholders described a concomitant increase in methadone clinics as a response to this growing epidemic. There is a growing need for techniques and services to address behavioral issues in children and a recognition of a general increase in mental and behavioral health issues. Many hospitals are not equipped to address the needs of CYSHCN when they are hospitalized for treatment and these individuals can struggle when cared for by staff inexperienced in dealing with their unique needs. There has been a greater focus in recent years on understanding the impacts of the social determinants of health. New approaches to dealing with transportation shortages such as partnering with ride services like Lyft to address needs, is increasing. Finally, it was noted that increasingly families prefer using technology to schedule medical appointments and the use of the phone is losing favor to texting and the internet for this function.

In response to a question regarding factors perpetuating disparities in their your community many factors were cited including lack of jobs or jobs that provide a living wage; gentrification and its impact on reducing stock of affordable housing; the need for affordable housing for those lower income individuals who provide services in affluent communities; food deserts and their impact on obesity; and lack of diverse providers causing some to travel to NYC for health care in order to be understood and treated. In rural areas, disparities exist based on income level, social status and drug use. A significant disparity exists in the quality of child care that is available to families-higher income people can afford better daycare and there is almost no day care available to night and weekend shift workers. There is a sense that the importance of translation of documents and materials can sometimes be underappreciated when in fact the need for information in people's native tongue is crucial for their successful access of information

and greater attention needs to be given to this need.

All stressed the need to engage a broad group of stakeholders if the issues that lead to health disparities are to be addressed including legislators, housing authorities, those responsible for public transportation, mental health providers, insurers, social service providers, private and public funders among others.

Current and future approaches and activities, based on this information, is reflected in this application/annual report. However, the importance of this information cannot be underscored and well positions NY's Title V program to move forward in efforts to improve the health and wellness of NY's families in years to come.

III.G. Technical Assistance

II.F.7. Technical Assistance

NY's Title V program welcomes opportunities 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. For example, conversations with the "Big 5" States have been very informative in the development of a more comprehensive approach to supports and services for CYSHCN and their families as well in planning for the comprehensive needs assessment for next year's full five-year application. NY would benefit from focused discussions on efforts related to perinatal regionalization including the development of metrics and processes for ongoing quality improvement, telehealth models to improve access to health care supports and services, state efforts to identify and address maternal mortality and morbidity, and efforts to address implicit bias in the health care delivery system. Other topics of importance are promoting and ensuring improved pain management practices, including during pregnancy, to address the opioid epidemic. 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.

In addition, 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 - Intra-Agency Agreement Between OHIp and OPH.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Attachment MCH Collaborations - Master-1.22.19.pdf

Supporting Document #02 - CYSHCN Care Mapping Executive Summary and Appendices.pdf

Supporting Document #03 - SymposiumonRacialDisparitiesandImplicitBiasinObstetricalCareDec2018.pdf

Supporting Document #04 - SEW Updates 2017-2019.pdf

Supporting Document #05 - 8-21-19 Final - NYS Taskforce on Maternal Mortality Report to Governor Cuomo and Listening Sessions (003).pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - DOH OPH CCH DFH Org Charts 2019.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: New York

	FY 20 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 38,909,810	
A. Preventive and Primary Care for Children	$ 12,241,697	(31.4%)
B. Children with Special Health Care Needs	$ 15,148,899	(38.9%)
C. Title V Administrative Costs	$ 2,783,594	(7.2%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 30,174,190	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 29,285,355	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 55,483,224	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 22,224,404	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 106,992,983	
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)	$ 145,902,793	
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)	$ 65,608,665	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 211,511,458	

OTHER FEDERAL FUNDS	FY 20 Application Budgeted
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	$ 0
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 0
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) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 150,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 1,801,265
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State-Based Perinatal Quality Collaboratives (PQCs) Cooperative Agreement	$ 200,000
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) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 9,212,347
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Children's Oral Care Access Program	$ 0
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) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 248,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 8,500,000
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) > Oral Health and Chronic Disease Collaboration	$ 0

OTHER FEDERAL FUNDS	FY 20 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Strength Based Curriculum	$ 450,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Sexual Risk Avoidance Education	$ 3,491,120
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Medicaid Match	$ 12,232,493

	FY 18 Annual Report Budgeted		FY 18 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 38,909,810		$ 38,241,544	
A. Preventive and Primary Care for Children	$ 12,965,080	(33.3%)	$ 12,698,337	(33.2%)
B. Children with Special Health Care Needs	$ 13,005,647	(33.4%)	$ 11,778,777	(30.8%)
C. Title V Administrative Costs	$ 2,157,838	(5.5%)	$ 2,753,613	(7.3%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 28,128,565		$ 27,230,727	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 29,226,355		$ 29,285,355	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 64,591,358		$ 122,724,134	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 26,851,106		$ 28,299,351	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 120,668,819		$ 180,308,840	
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)	$ 159,578,629		$ 218,550,384	
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)	$ 68,845,166		$ 67,884,924	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 228,423,795		$ 286,435,308	

OTHER FEDERAL FUNDS	FY 18 Annual Report Budgeted	FY 18 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 66,644	$ 81,934
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 4,036,326	$ 3,706,918
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State-Based Perinatal Quality Collaboratives (PQCs) Cooperative Agreement	$ 200,000	$ 99,543
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 340,600	$ 246,990
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 174,395	$ 99,423
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 1,837,000	$ 958,117
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 25,888,440	$ 26,106,078
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 2,756,926	$ 3,013,637
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 7,694,039	$ 8,420,049
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 9,845,000	$ 11,412,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 143,825	$ 87,851
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	$ 500,000	$ 227,364

OTHER FEDERAL FUNDS	FY 18 Annual Report Budgeted	FY 18 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Children's Oral Care Access Program	$ 175,000	$ 99,485
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	$ 1,508,763	$ 93,701
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Strength Based Curriculum	$ 450,000	$ 165,385
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Oral Health and Chronic Disease Collaboration	$ 250,000	$ 141,719
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Medicaid Match	$ 12,978,208	$ 12,924,730

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Please refer to Expenditures Narrative	
2.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Please refer to Expenditures Narrative	

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	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	$ 3,757,257	$ 4,978,337
2. Infants < 1 year	$ 3,265,044	$ 3,326,276
3. Children 1 through 21 Years	$ 8,976,652	$ 9,372,061
4. CSHCN	$ 15,148,899	$ 11,778,777
5. All Others	$ 4,978,364	$ 6,032,480
Federal Total of Individuals Served	$ 36,126,216	$ 35,487,931

IB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	$ 20,854,611	$ 23,909,521
2. Infants < 1 year	$ 11,117,836	$ 13,280,038
3. Children 1 through 21 Years	$ 30,845,038	$ 85,673,754
4. CSHCN	$ 26,333,110	$ 35,006,058
5. All Others	$ 17,842,389	$ 22,439,467
Non-Federal Total of Individuals Served	$ 106,992,984	$ 180,308,838
Federal State MCH Block Grant Partnership Total	$ 143,119,200	$ 215,796,769

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:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: Form 2 Line 1A includes Infants Under 1 year old and Children & Adolescents 1-22	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Form 2 Line 1A includes Infants Under 1 year old and Children & Adolescents 1-22	

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	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Direct Services	$ 4,340	$ 2,238
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	$ 4,340	$ 2,238
2. Enabling Services	$ 25,358,359	$ 26,468,148
3. Public Health Services and Systems	$ 13,547,111	$ 11,771,158
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		$ 2,238
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		$ 2,238
Federal Total	$ 38,909,810	$ 38,241,544

IIB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Direct Services	$ 19,117,361	$ 22,538,966
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 6,856,138	$ 5,309,543
B. Preventive and Primary Care Services for Children	$ 6,614,378	$ 12,231,618
C. Services for CSHCN	$ 5,646,845	$ 4,997,805
2. Enabling Services	$ 41,084,815	$ 61,124,385
3. Public Health Services and Systems	$ 42,964,703	$ 93,441,810
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		$ 22,538,966
Direct Services Line 4 Expended Total		$ 22,538,966
Non-Federal Total	$ 103,166,879	$ 177,105,161

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIB. - Other - Other**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**

Field Note:
All direct services reported as "Other" as this level of detail is not available.

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: New York

Total Births by Occurrence: 226,474 **Data Source Year: 2018**

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	226,439 (100.0%)	2,298	374	374 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Hydroxy-3-Methylglutaric 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)	Hearing Loss
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
Krabbe disease	226,439 (100.0%)	24	7	7 (100.0%)
HIV	226,439 (100.0%)	351	0	0 (0%)
Spinal Muscular Atrophy	66,636 (29.4%)	1	1	1 (100.0%)
Guanidinoacetate methyltransferase deficiency	60,253 (26.6%)	1	0	0 (0%)
Short-chain acyl CoA dehydrogenase deficiency	226,439 (100.0%)	21	9	9 (100.0%)
Isobutyryl-CoA dehydrogenase deficiency	226,439 (100.0%)	21	2	2 (100.0%)
Early Hearing Detection and Intervention (EHDI)	218,540 (96.5%)	2,777	338	241 (71.3%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

New York's Newborn Screening Program, (NSP) collects, analyzes and reports on newborn specimens for 50 diseases and 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. Refer to the field notes in the "Other Newborn" section of Form 4 for follow-up regarding Newborn Hearing Screening.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2018**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: The birth data (total births by occurrence) was reported from 2017 Vital Records Data. The Newborn Screening Data is 2018 data. In addition, not all newborns receive a newborn screening if their condition does not warrant screening and they do not survive.	
2.	**Field Name:**	**Data Source Year**
	Fiscal Year:	**2018**
	Column Name:	**Data Source Year Notes**
	Field Note: The birth data (total births by occurrence) was reported from 2017 Vital Records Data. The Newborn Screening Data is 2018 data. In addition, not all newborns receive a newborn screening if their condition does not warrant screening and they do not survive.	
3.	**Field Name:**	**Core RUSP Conditions - Receiving At Least One Screen**
	Fiscal Year:	**2018**
	Column Name:	**Core RUSP Conditions**
	Field Note: These data reflect the aggregate number of newborns receiving at least one New Born Screening test in 2018.	
4.	**Field Name:**	**Core RUSP Conditions - Positive Screen**
	Fiscal Year:	**2018**
	Column Name:	**Core RUSP Conditions**
	Field Note: These data reflect the aggregate number of presumptive positive for all Newborn Screening tests for 2018. Results are not unduplicated.	
5.	**Field Name:**	**Core RUSP Conditions - Confirmed Cases**
	Fiscal Year:	**2018**
	Column Name:	**Core RUSP Conditions**

Field Note:
These data reflect the aggregate number of confirmed cases for all Newborn Screening tests in 2018. The results are not unduplicated.

6.	**Field Name:**	**Core RUSP Conditions - Referred For Treatment**
	Fiscal Year:	**2018**
	Column Name:	**Core RUSP Conditions**

Field Note:
These data reflect the aggregate number of newborns referred for treatment in 2018. The results are not unduplicated.

7.	**Field Name:**	**HIV - Confirmed Cases**
	Fiscal Year:	**2018**
	Column Name:	**Other Newborn**

Field Note:
New York State's Wadsworth Center that oversees the Newborn Screening Program does not provide follow up to newborns who screen HIV positive. Follow-up is conducted by the NYSDOH AIDS Institute.

8.	**Field Name:**	**HIV - Referred For Treatment**
	Fiscal Year:	**2018**
	Column Name:	**Other Newborn**

Field Note:
New York State's Wadsworth Center that oversees the Newborn Screening Program does not provide follow up to newborns who screen HIV positive. Follow-up is conducted by the NYSDOH AIDS Institute.

9.	**Field Name:**	**Early Hearing Detection and Intervention (EHDI) - Referred For Treatment**
	Fiscal Year:	**2018**
	Column Name:	**Other Newborn**

Field Note:
A goal of the New York Early Hearing Detection and Intervention (EHDI) Program is to reduce the number of infants lost to follow-up after they refer (do not pass) newborn hearing screening to ensure timely diagnosis and appropriate intervention services. Based on Preliminary 2018 data, there were 2,777 infants in New York State that did not pass their most recent newborn hearing screen. Out of these infants, 902 received a documented diagnosis and 1,875 were missing follow-up and/or diagnostic audiological evaluation. To reduce loss to follow-up, the EHDI Program is working to engage and educate providers on the importance of communication between stakeholders as well as the proper identification and documentation of infants with hearing loss.

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: New York

Annual Report Year 2018

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		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	156,106	48.0	0.0	51.0	1.0	0.0
2. Infants < 1 Year of Age	230,394	52.4	1.1	45.4	1.1	0.0
3. Children 1 through 21 Years of Age	540,874	33.3	5.7	58.0	3.0	0.0
3a. Children with Special Health Care Needs	7,602	51.0	0.0	47.0	2.0	0.0
4. Others	237,182	22.0	0.0	71.0	7.0	0.0
Total	1,164,556					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	229,737	No	226,242	100	226,242	156,106
2. Infants < 1 Year of Age	230,358	No	230,394	100	230,394	230,394
3. Children 1 through 21 Years of Age	4,952,376	Yes	4,952,376	11	544,761	540,874
3a. Children with Special Health Care Needs	860,723	Yes	860,723	1	8,607	7,602
4. Others	14,662,365	Yes	14,662,365	2	293,247	237,182

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2018**

Field Note:
Data for 5a was compiled from reports provided by programs that are either directly funded by MCHSGB or funded by State or other funds but serve the MCH population and MCHSBG staff provide input.

2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2018**

Field Note:
All infants receive Title V funded or supported services including Newborn Metabolic Screening, Hearing Screening, services through the perinatal system, and home visiting. Title XIX estimate for Infants and Children was provided using NYS specific Medicaid/CHP health insurance data. The remaining percentages were provided by HRSA.

3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2018**

Field Note:
This figure includes children 1-21 years of age screened through New York's Lead Poisoning Prevention Program and those receiving services through the Children and Youth with Special Health Care Needs Program.

4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2018**

Field Note:
This figure includes children screened through New York's Lead Poisoning Prevention Program with elevated blood lead levels as well as children served by New York's Children and Youth with Special Health Care Needs Program.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2018**

Field Note:
This figure includes 220,113 individuals served through New York's Family Planning Program over 22 years of age, 15,541 individuals served in the Migrant and Seasonal Worker Program over 19 years of age and 1,528 individuals served through New York's Sexual Violence Prevention Program over 22 years of age.

6.	**Field Name:**	**Total_TotalServed**
	Fiscal Year:	**2018**

Field Note:
These figures vary from pervious years. In the past New York assessed a percentage of specific populations served for these categories from all MCH programs. Pursuant to guidance from HRSA, this year New York identified key programs that served these populations and used only the data from these programs. This in no way represents the total numbers of the maternal and child health population served in New York State with Federal and State funding.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2018**
	Field Note: Reference data used NYS vital statistics 2017 birth certificate. NYS women served by perinatal designation system of care.	
2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2018**
	Field Note: Reference data used NYS vital statistics 2017 birth certificate. This figure reflects the number of infants screened through New York's Newborn Screening Program. All infants receive newborn screening for more than 40 disorders.	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2018**
	Field Note: These data reflect children served through the Lead Poisoning Prevention Program and Children and Youth with Special Health Care Needs Program.	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2018**
	Field Note: These data reflect the children served with elevated blood level levels as determined through New York's Lead Poisoning Prevention Program and children and youth served through New York's Children and Youth with Special Health Care Needs Program.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2018**
	Field Note: These data reflect individuals served through New York's Family Planning Program, Migrant and Seasonal Worker Program and Sexual Violence Prevention Program.	

Data Alerts:

1.	Infants Less Than One Year, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.
2.	Children 1 through 21 Years of Age, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: New York

Annual Report Year 2018

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	226,242	109,118	33,263	52,976	330	24,383	1,279	3,139	1,754
Title V Served	226,242	109,118	33,263	52,976	330	24,383	1,279	3,139	1,754
Eligible for Title XIX	118,279	38,898	22,913	39,730	212	13,437	344	1,657	1,088
2. Total Infants in State	230,394	111,313	33,979	53,722	335	24,753	1,294	3,209	1,789
Title V Served	230,394	111,313	33,979	53,722	335	24,753	1,294	3,209	1,789
Eligible for Title XIX	120,071	39,472	23,386	40,237	214	13,614	347	1,693	1,108

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2018**
	Column Name:	**Total**
	Field Note: Birth data reported is from 2017 Vital Records data.	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2018**
	Column Name:	**Total**
	Field Note: New York's pregnant and postpartum individuals receive supports and services through New York Regionalized system of perinatal care.	
3.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2018**
	Column Name:	**Total**
	Field Note: Total infants in New York State exceeds the Deliveries and Births by Occurrence due to multiple newborn for some deliveries (i.e., twins, triplets etc.)	
4.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2018**
	Column Name:	**Total**
	Field Note: New York's infant receive supports and services through New York regionalized system of perinatal care. In addition, newborns are screened through New York's Newborn Screening Program.	

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: New York

A. State MCH Toll-Free Telephone Lines	2020 Application Year	2018 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"	Cindi Dubner	Cindi Dubner
4. Contact Person's Telephone Number	(518) 474-1911	(518) 474-1911
5. Number of Calls Received on the State MCH "Hotline"		13,688

B. Other Appropriate Methods	2020 Application Year	2018 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, ESP
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	Suzanne Swan
Title	Director, Bureau of Child Health
Address 1	New York State Department of Health
Address 2	Corning Tower, ESP
City/State/Zip	Albany / NY / 12237
Telephone	(518) 474-1961
Extension	
Email	suzanne.swan@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 2020

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 10
National Outcome Measures (NOMs)

State: New York

Form Notes for Form 10 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
2017	80.6 %	0.1 %	180,884	224,372
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% points or >1.2 times the estimate, 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

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2018
Annual Indicator	9.9
Numerator	23
Denominator	232,663
Data Source	DFH Maternal Mortality Data System
Data Source Year	2016

NOM 3 - Notes:

Data provided as of 6/27/2019 by Division of Family Health, Office of the Medical Director. The Maternal Mortality Data System collects data on identified maternal deaths in NYS.

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
2017	8.1 %	0.1 %	18,543	229,334
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% points or >1.2 times the estimate, 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
2017	9.0 %	0.1 %	20,607	229,382
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% points or >1.2 times the estimate, 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
2017	23.5 %	0.1 %	53,936	229,382
2016	23.4 %	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% points or >1.2 times the estimate, 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
2017/Q2-2018/Q1	1.0 %			
2017/Q1-2017/Q4	1.0 %			
2016/Q4-2017/Q3	1.0 %			
2016/Q3-2017/Q2	1.0 %			
2016/Q2-2017/Q1	1.0 %			
2016/Q1-2016/Q4	1.0 %			
2015/Q4-2016/Q3	1.0 %			
2015/Q3-2016/Q2	2.0 %			
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
2016	5.4	0.2	1,267	234,975
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
2016	4.5	0.1	1,056	234,283
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
2016	3.0	0.1	713	234,283
2015	3.1	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
2016	1.5	0.1	343	234,283
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
2016	152.0	8.1	356	234,283
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	188.4	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
2016	47.4	4.5	111	234,283
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
2017	7.3 %	1.3 %	7,606	103,903
2016	6.0 %	0.9 %	6,230	104,133
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 confidence interval width >20% points or >1.2 times the estimate 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
2016	4.7	0.2	1,058	224,123
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)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

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_2017	10.3 %	1.4 %	396,968	3,835,834
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
2017	13.1	0.8	270	2,064,799
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	15.8	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
2017	22.1	1.0	523	2,363,270
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
2015_2017	5.0	0.4	186	3,709,210
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
2015_2017	5.4	0.4	201	3,709,210
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_2017	16.5 %	1.4 %	689,627	4,169,385
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_2017	15.0 %	3.1 %	103,462	689,627
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_2017	2.5 %	0.5 %	85,905	3,457,869
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_2017	6.1 %	0.9 %	209,010	3,435,443
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_2017	45.5 % ϟ	5.6 % ϟ	131,277 ϟ	288,794 ϟ
2016	45.2 % ϟ	6.7 % ϟ	169,907 ϟ	375,487 ϟ

Legends:

⚑ Indicator has an unweighted denominator <30 and is not reportable

ϟ 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_2017	90.0 %	1.3 %	3,731,359	4,144,180
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
2017	12.4 %	0.9 %	86,909	699,950
2015	13.2 %	0.8 %	94,421	712,746
2013	10.5 %	0.5 %	74,476	708,066
2011	11.1 %	0.6 %	86,129	775,878
2009	10.9 %	0.9 %	69,028	635,854
2007	10.8 %	0.6 %	80,380	743,645
2005	10.3 %	0.7 %	78,598	762,750

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate 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_2017	15.3 %	2.2 %	271,153	1,767,904
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
2017	2.7 %	0.2 %	112,728	4,146,346
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 >20% points, >1.2 times the estimate, or that is inestimable 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
2017	67.5 %	2.5 %	226,696	336,085
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
2017_2018	64.9 %	1.4 %	2,540,516	3,914,345
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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	68.5 %	2.2 %	802,423	1,170,574
2016	71.5 %	2.1 %	843,600	1,179,474
2015	61.3 %	2.3 %	730,501	1,192,326

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
2017	92.9 %	1.1 %	1,087,093	1,170,574
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
2017	89.3 %	1.5 %	1,045,009	1,170,574
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 or that are inestimable 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
2017	12.5	0.1	7,480	600,098
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
2017	13.0 %	0.9 %	26,713	204,888
2016	13.6 %	0.9 %	28,516	209,969
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% points or >1.2 times the estimate 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_2017	2.1 % ϟ	0.7 % ϟ	84,929 ϟ	4,099,217 ϟ
2016	2.0 % ϟ	0.6 % ϟ	81,336 ϟ	4,165,523 ϟ

Legends:

Indicator has an unweighted denominator <30 and is not reportable

ϟ 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 10
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**	**2018**
Annual Objective	73.4	73.8	77.4
Annual Indicator	68.4	73.3	69.8
Numerator	2,471,455	2,653,864	2,510,557
Denominator	3,612,104	3,619,067	3,597,587
Data Source	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	78.4	79.4	80.3	81.3	82.2	83.1

Field Level Notes for Form 10 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)

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data			
	2016	**2017**	**2018**
Annual Objective	91	91	93.4
Annual Indicator	92.3	92.7	92.5
Numerator			
Denominator			
Data Source	NYS VS	NYS VS	NYS VS
Data Source Year	2014	2015	2016
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	93.7	94.0	94.3	94.6	94.8	95.1

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: 2016 data provided by NYS Vital Statistics as of May 2019	

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

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2016	**2017**	**2018**
Annual Objective	67.1	67.6	66.2
Annual Indicator	63.9	73.9	75.3
Numerator	135,686	155,836	152,784
Denominator	212,507	210,880	202,843
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2015	2017

State Provided Data			
	2016	**2017**	**2018**
Annual Objective	67.1	67.6	66.2
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						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	66.6	67.1	67.6	68.0	68.5	68.9

Field Level Notes for Form 10 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.

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Percentage of infants placed to sleep on their backs
Annual Indicator: 74.2
PRAMS NYS
2016

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2018
Annual Objective	
Annual Indicator	37.6
Numerator	71,966
Denominator	191,278
Data Source	PRAMS
Data Source Year	2017

State Provided Data		
	2017	2018
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	2024
Annual Objective	36.0	36.7	37.1	37.4	37.8	38.2

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 2016 NYS Data	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Percent of infants placed to sleep on a separate approved sleep surface Annual Indicator: 36.0 NYS Prams 2016	
3.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**
	Field Note: NYS PRAMS 2016 data as baseline	

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2018
Annual Objective	
Annual Indicator	46.3
Numerator	89,933
Denominator	194,052
Data Source	PRAMS
Data Source Year	2017

State Provided Data		
	2017	**2018**
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**	**2024**
Annual Objective	44.0	44.7	45.1	45.6	46.0	46.4

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 2016 NYS Data not available yet	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Percent of infants placed to sleep without soft objects or loose bedding Annual Indicator: 43.8 NYS PRAMS 2016	
3.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**
	Field Note: NYS PRAMS 2016 data as baseline	

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**	**2018**
Annual Objective			17.9
Annual Indicator		17.5	23.1
Numerator		101,178	117,256
Denominator		578,216	506,773
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

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						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	18.2	18.4	18.6	18.8	19.0	19.3

Field Level Notes for Form 10 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**	**2018**
Annual Objective	27.1	27.5	18.8
Annual Indicator	23.3	23.3	23.2
Numerator	161,704	161,704	159,614
Denominator	694,960	694,960	689,106
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2015	2015	2017

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT			
	2016	**2017**	**2018**
Annual Objective			18.8
Annual Indicator		18.3	17.7
Numerator		246,053	232,223
Denominator		1,346,787	1,313,811
Data Source		NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year		2016	2016_2017

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						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	19.0	19.2	19.4	19.7	19.9	20.1

Field Level Notes for Form 10 NPMs:

None

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**	**2018**
Annual Objective			81.2
Annual Indicator		79.2	81.3
Numerator		1,103,856	1,081,532
Denominator		1,393,274	1,331,106
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

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						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	82.2	83.2	84.2	85.2	86.2	87.2

Field Level Notes for Form 10 NPMs:

None

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**	**2018**
Annual Objective			15.7
Annual Indicator		15.3	13.7
Numerator		48,081	34,736
Denominator		314,730	253,092
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

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						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	15.9	16.1	16.3	16.4	16.6	16.8

Field Level Notes for Form 10 NPMs:

None

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	**2018**
Annual Objective		
Annual Indicator	12.3	14.5
Numerator	130,919	156,317
Denominator	1,062,218	1,079,417
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2016	2016_2017

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	12.8	12.9	13.1	13.2	13.4	13.5

Field Level Notes for Form 10 NPMs:

None

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**	**2018**
Annual Objective	57.2	57.6	56.8
Annual Indicator	54.9	51.7	45.4
Numerator	117,570	110,325	95,006
Denominator	214,301	213,585	209,242
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2015	2017

State Provided Data			
	2016	**2017**	**2018**
Annual Objective	57.2	57.6	56.8
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						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	57.2	57.6	58.0	58.4	58.8	59.2

Field Level Notes for Form 10 NPMs:

None

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**	**2018**
Annual Objective			79.6
Annual Indicator		77.6	80.6
Numerator		2,955,156	3,137,003
Denominator		3,810,186	3,890,746
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

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						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	80.5	81.5	82.5	83.4	84.4	85.4

Field Level Notes for Form 10 NPMs:

None

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Adolescent Health

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	80.5	81.5	82.5	83.4	84.4	85.4

Field Level Notes for Form 10 NPMs:

None

Form 10
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**	**2018**
Annual Objective		45	36.4
Annual Indicator	34.6	35.3	35.3
Numerator			
Denominator			
Data Source	BRFSS	BRFSS	BRFSS
Data Source Year	2014	2016	2016
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	37.6	38.2	38.7	39.2	39.7	40.1

Field Level Notes for Form 10 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.

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
2018 NYS BRFSS data is not available yet

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	2018
Annual Objective		8	25
Annual Indicator	27	24.5	24.5
Numerator			
Denominator			
Data Source	Medicaid Claims	Medicaid Claims	Medicaid Claims
Data Source Year	2016	2017	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	25.0	26.3	26.3	27.6	27.6	29.0

Field Level Notes for Form 10 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.

2. **Field Name:** **2018**

   Column Name: **State Provided Data**

   Field Note:
   data is not available

SPM 3 - The percentage of children and adolescents survey who demonstrate 20 or more developmental assets

Measure Status:	Active

State Provided Data

	2016	2017	2018
Annual Objective		50	50
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	To Be Developed	Developmental Assessment Tool	Developmental Assessment Tool
Data Source Year	2017-2018	2017-2018	2017-2018
Provisional or Final ?	Provisional	Final	Final

Annual Objectives

	2019	2020	2021	2022	2023	2024
Annual Objective	50.0	50.0	50.0	50.0	50.0	50.0

Field Level Notes for Form 10 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.

2. **Field Name:** **2018**

   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	2018
Annual Objective		65	65.5
Annual Indicator	61.6	70.1	67
Numerator	673	1,021	1,238
Denominator	1,092	1,456	1,848
Data Source	New York Family Survey	New York Family Survey	New York Family Survey
Data Source Year	2015-2016	2016-2017	2017-2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	71.0	71.5	72.0	72.5	73.0	73.5

Field Level Notes for Form 10 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.

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Data collection: 7/1/2017-6/30/2018. 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	2018
Annual Objective		72	73
Annual Indicator	71.7	71.6	70.8
Numerator			
Denominator			
Data Source	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System	CDC Water Fluoridated Reporting System
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	75.0	77.0	78.5	78.5	78.5	78.5

Field Level Notes for Form 10 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 10
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**	**2018**
Annual Objective		40	5
Annual Indicator	5	5.3	5.3
Numerator		1	1
Denominator		19	19
Data Source	Title V Program Records	Title V Program Records	Title V Program Records
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	5.0	11.0	16.0	21.0	26.0	26.0

Field Level Notes for Form 10 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	2018
Annual Objective			7
Annual Indicator	11	7	7
Numerator			
Denominator			
Data Source	NYS Title V Program Records	NYS Title V Program Records	NYS Title V Program Records
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	7.0	7.0	8.0	8.0	8.0	8.0

Field Level Notes for Form 10 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	
3.	**Field Name:**	**2018**
	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:	**Inactive - Replaced**	
State Provided Data		
	2017	**2018**
Annual Objective	87	6.4
Annual Indicator	6.2	6.2
Numerator		
Denominator		
Data Source	Medicaid claims	Medicaid claims
Data Source Year	2017	2017
Provisional or Final ?	Final	Final

Field Level Notes for Form 10 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.

2. **Field Name:** **2018**

   Column Name: **State Provided Data**

   Field Note:
   No updated data. Replacing with population based measure.

ESM 1.15 - Percentage of women with Medicaid insurance who report that a doctor, nurse, or other healthcare worker asked at the postpartum checkup if they were feeling down or depressed

Measure Status:	Active				
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	81.0	82.0	83.0	84.0	85.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		0	0
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	NYS Title V Program records	NYS Title V Program records	NYS Title V Program records
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	0.0	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 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.

2. **Field Name:** **2018**

   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	2018
Annual Objective	90	90
Annual Indicator	91.7	91.6
Numerator		831
Denominator		907
Data Source	NYS sampled Birthing Hospitals	NYS sampled Birthing Hospitals
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	90.0	90.0	92.0	92.0	92.0	92.0

Field Level Notes for Form 10 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	2018
Annual Objective		0	1,600
Annual Indicator	0	1,694	2,488
Numerator			
Denominator			
Data Source	NYS Medicaid Health Home Data	NYS Medicaid Health Home Data	NYS Medicaid Health Home Data
Data Source Year	2016-17	12/16-17	12/16-18
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	1,680.0	1,764.0	1,852.0	1,889.0	1,927.0	1,966.0

Field Level Notes for Form 10 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. 2016. Estimated 5% increase 2020 and 2021 and a 2% increase 2022 and 2023.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Data Source Year: 12/1/2016-5/2018. Children age 0-12 with documented serious emotional disturbance and/or complex trauma enrolled in Health Home Serving Children December 2016-May 2018. Medicaid provided data for all children (unduplicated) since the inception of CHH. Health Homes for children did not begin until Dec. 2016.	

ESM 8.2.1 - Number of community environmental changes demonstrated as a result of enhanced collaborations.

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective			6
Annual Indicator	1	6	6
Numerator			
Denominator			
Data Source	Title V Program data	Title V Program data	Title V Program data
Data Source Year	7/16-6/17	16-18	17-19
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	7.0	8.0	9.0	10.0	11.0	12.0

Field Level Notes for Form 10 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.

2. **Field Name:** **2018**

   Column Name: **State Provided Data**

   Field Note:
   Data Source Year: 10/1/17-3/31/19
   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	2018
Annual Objective	1,000	1,000
Annual Indicator	1,060	1,605
Numerator		
Denominator		
Data Source	NYS Medicaid Health Home Data	NYS Medicaid Health Home Data
Data Source Year	12/16-18	12/16-18
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	1,050.0	1,103.0	1,125.0	1,147.0	1,170.0	1,193.0

Field Level Notes for Form 10 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-Feb. 2018.

2. **Field Name:** **2018**

   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-May 2018.

   Medicaid provided data for all children (unduplicated) since the inception of CHH.

ESM 10.4 - Number of strategies implemented to improve adolescent use of preventive health care services.

Measure Status:	Active

State Provided Data		
	2017	2018
Annual Objective	1	1
Annual Indicator	1	1
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						
	2019	2020	2021	2022	2023	2024
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10 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.

2. **Field Name:** **2018**

   Column Name: **State Provided Data**

   Field Note:
   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	2018
Annual Objective		45	60
Annual Indicator	63.9	66.9	32.5
Numerator	4,275	5,244	902
Denominator	6,688	7,843	2,777
Data Source	NYEHDI	NYEHDI	NYEHDI
Data Source Year	CY2016	CY2017	CY2018
Provisional or Final ?	Final	Final	Final

Annual Objectives

	2019	2020	2021	2022	2023	2024
Annual Objective	32.8	33.2	33.5	33.8	34.2	34.5

Field Level Notes for Form 10 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.

2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Preliminary 2018 data shows a 32.5% drop in the number of infants receiving follow-up due to a lag in reporting by EHDI providers. The New York Early Hearing Detection and Intervention Information System (NYEHDI-IS) receives a one-time feed of initial newborn hearing screening results from vital statistics, all other results documented are user entered. To address this issue, the NYEHDI program has initiated a number of activities including: implementation of a lost to follow-up child list function into the NYEHDI-IS; targeted technical assistance to providers; letters to physicians of infants lost to follow-up; and hosting regional meetings and webinars.

3.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**

Field Note:
Annual Objectives have been updated to reflect the CDC definition for 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.

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		10	50
Annual Indicator	36.7	45.3	56.6
Numerator			
Denominator			
Data Source	MICHC reports	MICHC reports	MICHC reports
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	50.0	50.0	50.0	50.0	55.0	55.0

Field Level Notes for Form 10 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	2018
Annual Objective		20	60
Annual Indicator	58	60	48
Numerator			
Denominator			
Data Source	NYS Title V Program records	NYS Title V Program records	NYS Title V Program records
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	61.0	61.0	62.0	62.0	63.0	63.0

Field Level Notes for Form 10 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	2018
Annual Objective		40	41
Annual Indicator	61.2	50.5	39.1
Numerator			
Denominator			
Data Source	SEALS (CDC Data)	SEALS (CDC Data)	SEALS (CDC Data)
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	44.0	47.0	48.0	48.0	49.0	49.0

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2017**

   Column Name: **State Provided Data**

   Field Note:
   The discrepancies 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.

2. **Field Name:** **2018**

   Column Name: **State Provided Data**

   Field Note:
   These data are reported in the CDC SEALS system for school years from September-June. The decrease from 2017 to 2018 is due to inability of three SBSP-funded dental programs to provide services in the 2017-2018 school year due to lack of dental staff and difficulties with the data submission.

Form 10
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 10
State Outcome Measure (SOM) Detail Sheets

State: New York

No State Outcome Measures were created by the State.

Form 10
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:	Inactive - Replaced
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 1.15 - Percentage of women with Medicaid insurance who report that a doctor, nurse, or other healthcare worker asked at the postpartum checkup if they were feeling down or depressed
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 who are screened for depression during postpartum checkup with Medicaid as insurance **Denominator:** Number of women with a live birth **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Pregnancy Risk Assessment Monitoring System (PRAMS)
Significance:	Increase in screening for postpartum depression is recommended by American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), and the U.S. Preventive Services Task Force. The result will be an increased referral and treatment rates for depression.

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

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 eligible children and adolescents with serious emotional disturbance and complex trauma.
Definition:	**Numerator:** Number of children with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10,000
Data Sources and Data Issues:	NYS Medicaid Health Home Data
Significance:	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.

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.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Improve adolescent access to/utilization of preventive health care by implementing strategies to support adolescent access to preventive care through BWIAH programs serving adolescents.</td></tr>
<tr><td>Definition:</td><td><table>
<tr><td>Numerator:</td><td>Number of actions taken to develop strategies (i.e. literature review, surveys, focus groups)</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>100</td></tr>
</table></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>NYS Title V staff reporting activities completed. (Eventually, number of BWIAH programs serving adolescents which have implemented strategies)</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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

<table>
<tr><td>Measure Status:</td><td colspan="2">Active</td></tr>
<tr><td>Goal:</td><td colspan="2">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.</td></tr>
<tr><td rowspan="4">Definition:</td><td>Numerator:</td><td>Number of infants with a failed hearing screening who had a documented diagnostic evaluation in the New York Early Hearing Detection and Intervention Information System (NYEHDI-IS).</td></tr>
<tr><td>Denominator:</td><td>Number of infants who receive an abnormal newborn hearing screening.</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Data Sources and Data Issues:</td><td colspan="2">NYEHDI System Data</td></tr>
<tr><td>Significance:</td><td colspan="2">Infants with abnormal hearing screening will have follow-up.</td></tr>
</table>

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