# Maternal and Child Health Services Title V Block Grant

## New York

## FY 2021 Application/ FY 2019 Annual Report

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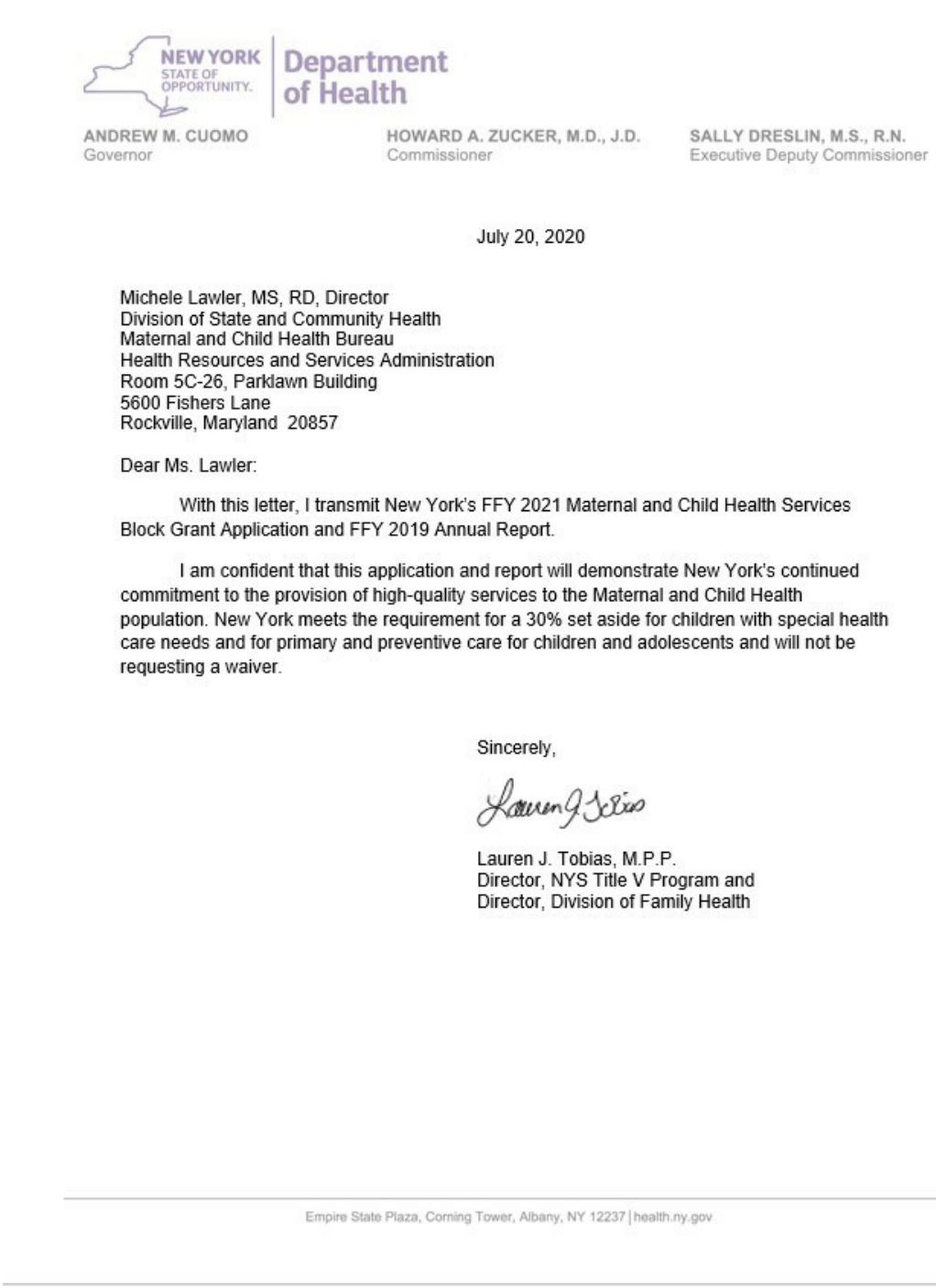
# Table of Contents

## 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 20, 2020

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 2021 Maternal and Child Health Services Block Grant Application and FFY 2019 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, M.P.P.
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

The Title V Maternal and Child Health Services Block Grant (Title V) is the Nation's oldest Federal-State partnership to ensure the health of mothers, children, and youth, including children and youth with special health care needs (CYSHCN) and their families. Administered by the Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau (MCHB).

The NYS Title V application reflects our continued leadership and commitment to protect and promote the health of women, infants, children and families, within the context of a changing health care landscape, the continued adoption of a life course perspective, and a focus on data-driven, evidence-based public health interventions. As the beginning of a new five-year cycle, this application incorporates a comprehensive statewide MCH needs assessment (NA), as well as 10 core, cross-cutting MCH priorities. The 2021-25 State Action Plan summarizes objectives, strategies and performance measures to address these priorities across the five Title V population health domains: maternal and women's health, perinatal and infant health, child health, children with special health care needs, and adolescent health. NY's application reflects significant input from families, providers and other key stakeholders across the state, but is especially centered on the issues voiced by communities that have been most impacted by disparities in health outcomes. The NYS Title V program has prioritized understanding and addressing social determinants of health to reduce health disparities and reflects a concerted effort to build a more comprehensive system of supports for CYSHCN and their families.

Within the NYS Department of Health (NYSDOH), Title V activities are led by the Division of Family Health (DFH). As the Title V program, DFH provides NYSDOH-wide leadership on MCH, directly oversees many MCH programs and initiatives, and collaborates with other key MCH-serving programs outside DFH. A critical role of the NYS Title V program is to ensure the needs of the priority populations are addressed through key policy initiatives as reflected throughout the application.

In keeping with a commitment to ensure supports and services align with the needs of communities, the Title V program continues to obtain community input to inform activities. Input was obtained from the Title V 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 New York State Association of County Health Officials, New York State Perinatal Association, community listening forums, MCH providers, and key stakeholders.

Under Title V leadership, a comprehensive process was convened to complete the Title V NA and State Action Plan:

***Step 1 – Engaging Stakeholders:*** An internal leadership team of NYSDOH staff from both DFH and other MCH programs was convened to guide the process and identify and engage additional external partners. Over 1,800 stakeholders across NY provided input, including over 700 parents, caregivers, adolescents, and families of CYSHCN through 37 community listening forums, over 320 consumers through surveys, and over 770 MCH providers through surveys. The Advisory Council provided guidance at key steps throughout the process. The leadership team also had oversight of the Maternal, Infant, and Early Child Home Visiting (MIECHV) NA, facilitating strong collaboration between the two NA efforts. Other companion NY NAs, including Head Start, Child Abuse Prevention Treatment Act, Birth to 5 Preschool Development, and the 2019-2024 NYS Prevention Agenda were reviewed to inform the Title V NA.

***Step 2 – Assess Needs and Identify Desired Outcomes:*** NY's NA is informed by data, literature and qualitative input from community members and stakeholders (see Step 1). Quantitative data analysis focused on national priority areas and outcome measures defined by MCHB and other state priorities. An array of data sources was used including vital statistics, hospital and health plan data, population health surveys and program-specific data. Health status, trends and disparities were examined. Qualitative analysis focused on community members' own voices and allowed the emerging themes to

drive the NA findings.

***Step 3 – Examine Strengths, Assets and Capacity:*** Community members discussed services and resources they use and the assets that support community health. Stakeholders provided input on services that are working and factors that support healthy behaviors. Current MCH public health infrastructure and capacity was assessed using a comprehensive inventory tool that gathered information about MCH-serving programs across NYSDOH and areas of success and opportunities to leverage other initiatives to advance MCH goals.

***Step 4 – Select Priorities:*** Selecting state priorities builds directly on the NA; the leadership team considered needs and priorities identified by families and community members, opportunities to leverage Title V infrastructure, capacity, partnerships, and investments, and areas that the state Title V program can impact over the next 5 years. While all factors are important, listening and responding to community voices was given the most weight. Through this process, a total of 10 priorities were selected for NY (see table below). These priorities will serve as a broad vision that is directly responsive to the cross-cutting needs, challenges, and positive ideas shared by community members.

***Step 5 – Select Performance Objectives:*** In accordance with HRSA guidelines, NY adopted a total of 5 National Performance Measures (NPMs) and 2 State Performance Measures (SPMs) that align with NY's selected priorities and encompass all five Title V domains. Objectives associated with the NPMs, SPMs and National Outcome Measures (NOMs) were selected for each domain. Baseline data and historic and projected trends were analyzed and considered in the context of planned strategies to establish preliminary five-year targets for each NPM, SPM, and objective.

***Step 6 – Develop Action Plan:*** With input from the Advisory Council and NYSDOH Leadership Team, a preliminary State Action Plan for 2021-25 was developed that aligns NY's 10 MCH priorities, NPMs, and SPMs for the Title V domains, and describes objectives and strategies planned to address each priority. Strategies that represent continuation of longstanding MCH activities are more specific, while those to address emerging priorities are less specific and will be refined over time.

**Title V State MCH Priorities and Performance Measures, 2021-2025**

| Population Domains and NPMs/SPMs | | Community-Informed Priorities |
|---|---|---|
| Women's/Maternal Health<br>• NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year<br><br>Perinatal/Infant Health<br>• NPM 3: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ NICU<br>• SPM1: Percent of samples received at the lab within 48 hours of collection<br><br>Child Health<br>• NPM 8.1: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day<br><br>Children and Youth with Special Health Care Needs (CYSHCN)<br>• NPM 12: Percent of adolescents with and without special health care needs, ages 12-17, who received services necessary to make transitions to adult health care<br>• SPM 2: Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months<br><br>Adolescent Health<br>• NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year | **CROSS-CUTTING PRIORITIES ACROSS ALL DOMAINS** | Health Care: Address equity, bias, quality of care, and barriers to access in health care services for women and families, especially for communities of color and low-income communities.<br><br>Community Services: Promote awareness of and enhance the availability, accessibility, and coordination of community services for families and youth, including children and youth with special health care needs and their families, with a focus on communities most impacted by systemic barriers including racism.<br><br>Parenting and Family Support: Enhance supports for parents and families, especially those with children with special health care needs, and inclusive of all family members and caregivers.<br><br>Social Support and Cohesion: Cultivate and enhance social support and social cohesion opportunities for individuals and families who experience isolation as a result of systemic barriers, including racism, across the life course.<br><br>Healthy Food: Increase access to affordable fresh and healthy foods in communities.<br><br>Community & Environmental Safety: Address community and environmental safety for children, youth, and families.<br><br>Poverty: Acknowledge and address the fundamental challenges faces by families in poverty and near-poverty, including the "working poor" as a result of systemic barriers, including racism.<br><br>Awareness of Resources: Increase awareness of resources and services in the community among families and the providers who serve them.<br><br>Housing: Increase the availability and quality of affordable housing.<br><br>Transportation: Address transportation barriers for individuals and families. |

Key products of the process described above include the Title V NA Summary and a five-year State Action Plan. Key elements including needs, accomplishments, challenges and plans are highlighted below for each of the population domains.

**Domain 1 – Maternal/Women's Health**

The preventive medical visit measure was selected because it is foundational to women's health throughout the life course, population health data demonstrate a need for its continued improvement, and it relates directly to several priorities voiced by women and families through community listening forums, including awareness of community resources, transportation, social support, and health care access and quality. In addition to well-woman visits, strategies will address a continuum of primary and preventive care and support that includes preconception, reproductive and sexual health, family planning, prenatal and postpartum care, and a full spectrum of medical, mental and behavioral health, oral health, and other supports and services. The State Action Plan reflects continued efforts to address access to comprehensive, high quality and equitable health care services to people of childbearing age and a continued commitment to reduce maternal mortality and morbidity.

> *"We used to have a village and today it's gone."*
>
> *"Doctors don't respect us because they don't value us."*

**Domain 2 – Perinatal/Infant's Health**

Measuring appropriateness of perinatal care was selected because of its relevance to quality and systems of care for high-risk and vulnerable infants. While site of delivery for very low birth weight infants is one critical indicator of care, the NYS Title V program views this indicator as part of a continuum of supports, services, and systems of care for infants, mothers, families, and service providers. This broader approach aligns with several priorities voiced by families in the NA, including awareness of community resources and services, enhancing supports for families, improving people's health care experiences, and fostering community engagement and empowerment. Strategies include promoting early prenatal care and increasing awareness of community resources, supports, and services through Title V programs.

> *"I encourage people to enroll into whatever program is offered because through that you can be connected to other services that might be available in the community."*

**Domain 3 – Child Health**

The physical activity measure was selected because it is responsive to concerns voiced directly by families in NY and reinforced by state-specific population health data. Families identified the availability and accessibility of amenities that support children's safe, active play and access to healthy foods as top priority needs, alongside priorities for community and environmental safety for children and community transportation. Supporting healthy, active play and recreation for children and youth of all ages is critical to promoting healthy weight as well as general physical and mental health during childhood and throughout the life course. Strategies under the Child Health domain focus on incorporating strategies that promote environments that support physical activity among children of all ages and abilities and support overall well-being.

> *"I had concerns with my daughter gaining weight and the doctor said it was fine. Then when her 4-year check-up came she said it was a concern. She didn't listen to me."*
>
> *"I want a community where they can grow up and know that they're safe and can go anywhere they want to go and trust the adults in their community. Right now, I am scared for my kids…"*

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

Measuring transitions to adult health care was selected because it was voiced as a key priority by youth with special health care needs and their families and reinforced by state-specific population health data. Families reported that only 15% of CYSHCN receive care in a well-functioning system, and less than 18% of youth age 12-17 with special health care needs

received services necessary to make transitions to adult health care. This is consistent with experiences described by YSCHN and their families throughout the state. CYSHCN strategies include engaging youth with special health care needs and their families in our efforts to improve systems and practices supporting this population, including care coordination and transition support.

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

**Domain 5 – Adolescent Health**

Measuring adolescent well visits was selected because it aligns with both population health data indicators and concerns voiced directly by adolescents in NYS. Preventive medical visits are one part of overall wellness, but data and community input point to other areas that could help adolescents thrive, such as social-emotional wellbeing and preparation for taking on the responsibilities of adulthood. Adolescence is often a very challenging stage in a person’s life; there is immense physical, cognitive, social-emotional, and sexual development. Supporting adolescents’ health and development and helping them prepare for their futures can have a lasting impact throughout the life course. Adolescent Health strategies focus on promoting routine care related to reproductive, oral, and behavioral health, and resources needed to successfully transition to adulthood.

> *“Everybody needs to talk even for one second or ten minutes. Even boys.”*

> *"I feel like we should have more African American counselors. Because the counselors that are there, I feel like the students don't feel comfortable talking to them."*

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

New York State (NYS) is committed to ensuring the health and wellbeing of the maternal, child, and adolescent, including children and youth with special health care needs (CYSHCN), population. There are generous Medicaid benefits and insurance availability through the NY State of Health and significant state appropriations for Maternal and Child Health (MCH) initiatives; Title V funds support an infrastructure within the NYS Department of Health (NYSDOH) to ensures coordination of these efforts and as well as direct support of public health infrastructure for priority MCH efforts that can augment state investments, such as family planning and adolescent health services. Title V funds support quality improvement efforts through grants to the Regional Perinatal Centers (RPC) that ultimately supports the efforts of 120 obstetrical hospitals to improve maternal and infant mortality and morbidity. Grants are provided to local health departments to support information and referral services for CYSHCN. The NYS Title V application illustrates the extensive resources offered to priority populations. Given the size and diversity of NYS, MCH programs and initiatives are complex and vary to meet unique needs of different populations. The NYS Title V application and annual report provides an overview that demonstrates the ongoing commitment to ensure health and wellness in NYS, with a specific focus on health equity.

### III.A.3. MCH Success Story

As detailed in last year's application, the NYS Title V program provided key staffing and financial support for a series of listening sessions engaging Black women in conversations about how to improve their experiences and outcomes giving birth in NYS. A major accomplishment of the past year was operationalizing feedback from community and stakeholders to create tangible outcomes to improve maternal health across NYS. This feedback was critical to inform the recommendations issued by the Governor's Taskforce on Maternal Mortality and Racial Disparate Outcomes. In the 2019-20 NYS Executive Budget, Governor Cuomo recommended $8 million dollars in state funding to directly support some of the recommendations. This funding was approved in the Enacted Budget

As a result, an additional $2.6M in state funding to support the expansion of Community Health Worker (CHW) services across the state. This money went directly to support specific work identified by women during each listening session including help developing individualized birth plans, opportunities for childbirth education especially in lower-income areas, and the overall capacity of CHWs to see more families and keep them engaged in services for longer periods of time. This infusion of state funds helped expand the existing MCH infrastructure in NYS and, as of March 2020, supported the hiring of an addition 36 CHWs with the capacity to provide services to an additional 1,500 families in NYS.

## III.B. Overview of the State

According to population estimates from the 2018 American Community Survey, New York State is the fourth most populous state in the country, housing more than 19 million people (19,542,209). Within the state, approximately 43% of the population, or 8 million people (8,398,748), reside in New York City.

Density

Estimates from the 2018 U.S. Census indicate that there are 414.7 people per square mile in New York State. The most densely populated counties include New York County (71,886 persons per square mile), Kings County (37,232 persons per square mile), and Bronx County (34,058 persons per square mile). In addition to counties in NYC, Long Island, and the Hudson Valley region, other densely populated counties include Erie County, Monroe County, Onondaga County, Schenectady County, and Albany County.

According to U.S. Census estimates, New York State's population has grown between 2010 and 2018 at a rate of 0.8%. This statistic, however, masks significant variation observed at the county level. While many counties surrounding NYC and the Hudson Valley experienced population gains between 2010 and 2016, most counties in the state (41 of 62 counties) experienced population losses between 0 and 4%.

Diversity

New York State is home to a highly diverse population. Across all states, New York ranks second in terms of having the highest percentage of foreign-born people. According to data from the 2017 American Community Survey, 22.7% of New York State's population is foreign born.

Of New York State's 19,542,209 residents, approximately 70% of individuals identify as White alone, 19% identify as Hispanic or Latino, 18% identify as Black or African American, 9% identify as Asian alone, 1% identify as American Indian or Alaska Native, and 0.1% identify as Native Hawaiian or Other Pacific Islander. Compared to national estimates, New York State has a higher percentage of non-Hispanic Black, Asian residents, and Hispanic residents.

Counties in NYC and the Hudson Valley have the highest percentage of Black or African American residents. According to the 2017 American Community Survey, 30 to 40% of residents living in both Kings County and Bronx County identify as Black or African American. Larger population centers including Buffalo (Erie County), Rochester (Monroe County), Syracuse (Onondaga County), and Albany (Albany County) also have higher percentages of Black or African residents compared to the rest of the state.

Similar geographic patterns can be observed for New York State's Hispanic and Latino population. Bronx County, in particular, ranks highest across the state with approximately 55% of the total county population identifying as Hispanic or Latino.

Immigration

2017 U.S. Census estimates indicate that 22.7% of New York State's population (4,490,656) is foreign born. Among this group, 12.6% (2,484,644) are naturalized citizens while 10.1% (2,006,012) are non-citizens. The largest percentage of foreign-born individuals migrated from the Americas (50.3%), Asia (28.8%), and Europe (16.3%). In addition to counties surrounding NYC, Long Island, and the Hudson Valley, counties with larger population centers, including Buffalo, Rochester, and Albany, have higher percentages of foreign-born residents.

Households and Families

According to five-year estimates from the 2017 American Community Survey, there are 7,302,710 households in New York State, with an average of 2.63 people per household. Of these households, 63.4% (4,633,030) are married couple families, and 36.6% (2,669,680) are non-family households. Approximately 30% (2,194,841) of all households have at least one child under the age of 18.

Income and Poverty

Five-year estimates from 2017 American Community Survey reveal that the median household income in New York State is $62,765. Counties with the highest income levels are heavily concentrated in NYC, Long Island, and the Hudson Valley. Nassau County, in particular, ranks highest in the state with a median household income level above $100,000.

Median household income has increased steadily since 2010 ($54,047). However, income levels vary significantly by race. The average median household income is $70,712 for Whites, $68,567 for Asians, $43,997 for Blacks or African Americans, $43,889 for Hispanics or Latinos, and $40,043 for American Indians and Alaska Natives.

Income inequality has also increased over time in the state. The Gini coefficient has risen from 0.499 in 2010 to 0.516 in 2017. According to 2017 U.S. Census Bureau estimates, New York State ranks highest among all states in terms of income inequality.

According to 2017 estimates from the American Community Survey, 15.1% of New York State's population is living below the federal poverty line. Counties with the highest percentage of families falling below the threshold are concentrated in the NYC region, particularly in Bronx County (26.76%) and Kings County (17.87%).

Age Distribution

The median age in New York State is 38.7. Approximately 21% (4,153,497) of the population is under 18 years of age, and roughly 16% (3,161,049) of the population is 65 years or older. The median age has increased over the past decade, rising from 37.7 in 2007 to 38.7 in 2017.

Women of Childbearing Age

Estimates from the 2017 American Community Survey indicate that there are 4,027,930 women of childbearing age (15-44 years), representing 39% of the total female population. The percentage of women of childbearing age has steadily decreased over the years. For reference, in 2010, 40.9% of all females were between the ages of 15 and 55.

Children

Of New York State's 19,542,209 residents, 5.8% of the population is under the age of 5 and 20.8% of the population is under the age of 18. According to 2017 estimates from the Kids Count Data Center, approximately 20% of all children in the state are living with families below the federal poverty line. Further, 30% of children are living with families where no parent has regular, full-time employment.

Education

According to 2018 data published by the New York State Department of Education, 2,622,879 children are enrolled in K-12 public schools. Approximately 43% of public school students (1,133,631) are White, 27% (708,319) are Hispanic, and 17% (448,499) are Black or African American.

The high school graduation rate for all public school students is 80%. However, graduation rates vary significantly by ethnicity. While 89% of white students graduate, only 70% of Black or African American students graduate from high school. Additionally, graduation rates differ based on immigration status. The graduation rate for immigrants is 39%, compared to 80% for non-immigrants.

In terms of educational attainment of adults (ages 25 to 34), approximately 37% of the population has a high school diploma or GED, 29% of the population has a bachelor's degree, and 16% of the population has a graduate degree. The percentage of individuals with a bachelor's or graduate degree has increased over the past decade while the percentage of individuals with a high school diploma or less has decreased.

Language

According to five-year estimates from the 2017 American Community Survey, approximately 70% of the population over the age of 5 (12,924,635) speaks only English. Of the 5,696,716 residents that speak a language other than English, 15.1% speak Spanish, 8.7% speak other Indo-European languages, and 5.1% speak Asian and Pacific Island languages. Approximately 44.3% of the population who speaks a language other than English report that they speak English less than "very well."

Health Care

Approximately 7% of the non-elderly population (ages 0-64) in New York State has no health insurance. Estimates from the 2017 American Community Survey reveal that uninsured rates vary significantly by ethnicity. While only 4% of Whites are uninsured, 12% of Hispanics, 11% of American Indians or Alaska Natives, 8% of Asians or Native Hawaiian and Pacific Islanders, and 7% of Blacks have no health insurance coverage.

Ensuring access to health care by making affordable health insurance available is one of the critical accomplishments of the Governor's health care agenda. As part of this agenda NY expanded access to Medicaid and created the NY State of Health, the state's official health plan marketplace, was created to assist New Yorkers to gain access to quality affordable health care coverage.

Public Health Prevention Agenda

Further commitment to improving the health of all New Yorkers is evident in the NYS Prevention Agenda (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.

## III.C. Five-Year Needs Assessment Summary (as submitted with the FY 2021 Application/FY 2019 Annual Report)

### III.C.2.a. Process Description

The New York State Department of Health (NYSDOH) facilitated an extensive multi-pronged process to identify and assess the Maternal Child Health (MCH) needs, strengths, capacity, and partnerships that will inform its Title V work for the next five years and beyond. This Needs Assessment (NA) serves as the basis for the state's MCH priorities and State Action Plan that follow.

The NA was led by a Title V Leadership Team, chaired by the Title V Director and comprised of key organizational leaders from the Division of Family Health (DFH), with coordination and technical assistance from the University at Albany's HRSA-funded MCH Catalyst Program. A logic model (Appendix 1) was developed to guide the process. Guiding principles for the NA included family and community engagement, equity and inclusion, data-driven evidence-based decisions, alignment with the NYS Prevention Agenda and other key frameworks and investments, and a commitment to maintaining and building on key MCH infrastructure and capacity. The Title V NA was done in close coordination with the NYS Maternal, Infant, and Early Childhood Home Visiting (MIECHV) NA, which was also led by DFH.

A rich array of quantitative and qualitative information was gathered to support the NA, and stakeholders were engaged throughout the process. Key information sources and methods for the NA include:

**Population Health Data**–In collaboration with the Bronfenbrenner Center for Translational Research at Cornell University, quantitative data encompassing more than 100 key indicators spanning population domains were compiled and analyzed for current status, trends, and disparities. Measures reflect Title V National Performance Measures (NPMs) and National Outcome Measures (NOMs) and input from MCH partners on other topics of importance for NYS. Data were from Vital Statistics, hospital discharge data, population surveys (e.g., Pregnancy Risk Assessment Monitoring System, National Survey of Children's Health, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System), and other population health data sources.

**Community Listening Forums (forums)**–In collaboration with the NYS MIECHV program and a broad network of community-based partner organizations, forums were hosted across the state with families and community members to facilitate open discussion about individual, family, and community health and services. A total of 37 forums were held in 18 NYS counties and in the Akwesasne Territory of the St. Regis Mohawk Tribe, with over 700 community members. Individual forums focused on specific populations including expectant parents and parents of young children, done in partnership with the MIECHV program (n=10 forums and 230 parent participants); other adult men and women (n=15 forums and 292 participants, primarily parents and grandparents); adolescents (n=9 forums and 154 teen and young adult participants); and families of Children and Youth with Special Health Care Needs (CYSHCNs) (n=3 forums and 37 family participants). Forums were conducted and notes of the discussions were recorded by community partners. Participants were racially diverse: 32% identified as Black or African American, 28% as White, 19% as Asian or other race(s), and 3% as American Indian. Approximately 25% of participants identified as Hispanic, and participants reported primary languages of English, Spanish, Chinese, and Haitian/Creole. DFH staff analyzed forum documentation using qualitative analysis methods.

**Public and Provider Surveys**–Web-based surveys designed for the public and service providers, respectively, were posted on the NYSDOH website and social media and distributed widely through a broad network of over 20 organizational partner groups. Through a mix of closed- and open-ended questions, providers were asked the following: what's working and what can be strengthened in their communities; social determinants, root causes, disparities, and health outcomes; community partnerships; population engagement strategies; and a range of potential MCH priorities. Consumer respondents were asked about factors that affect health in their communities, available and needed services, and barriers to and satisfaction with existing services. Over 770 providers and over 320 individual consumers responded, representing all

regions of the state. While the provider respondents reflected the diverse array of MCH-serving organizations in NYS, family/consumer respondents were less diverse, with 80% of respondents identifying as female, 73% as white, and over 60% with private health insurance, suggesting the survey did not reach or engage a sufficiently diverse demographic. Thus, a sub-analysis limited to respondents with Medicaid or no insurance coverage (n=45) was conducted.

**Stakeholder Meetings**–Information on the Title V program and NA was included in meetings with stakeholder groups on an ongoing basis, with partner input routinely shared and integrated in assessment of key issues and recommendations. DFH convened a special meeting in June 2019 with representatives of community-based programs and their community member partners, which directly informed the content and process for the community listening forums. The state's Title V Advisory Council provided key input and feedback throughout the NA process, with meetings convened in September 2019 and February and June 2020.

**MCH Program Inventory**–In order to assess current MCH public health infrastructure and capacity, a comprehensive inventory tool was developed to gather key information about MCH-serving programs across NYSDOH. Similar information was gathered directly from MCH-serving programs in other state agencies. A total of 28 programs completed the inventory.

Additional detail about these sources is provided in Appendix 2.

In addition, companion NYS NAs were reviewed to inform the Title V NA, including Head Start, Child Abuse Prevention Treatment Act (CAPTA), Birth to 5 Preschool Development, and the NYS Prevention Agenda, alongside recent DFH statewide maternal health listening forums, a care mapping exercise with parents of CYSHCN, and adolescent focus groups conducted by partners at Cornell University through the ACT for Youth initiative.

Of note, most information to support the NA was collected prior to the arrival of the COVID-19 public health emergency in NYS. Updates to reflect needs related to COVID-19 will be included in the NA update in next year's application.

All NA data were analyzed and summarized in several formats. The initial plan included a series of stakeholder meetings to present and discuss findings and resulting priorities for the state action plan. Unfortunately, this plan was significantly disrupted by COVID-19. A virtual meeting with the NYS Title V Advisory Council was held on June 17; Council members voiced support for the NA and resulting priorities and performance measures. Additional virtual and/or in-person meetings with stakeholders will resume when feasible to continue collaborative processes for refining and acting on priorities.

#### III.C.2.b. Findings

#### III.C.2.b.i. MCH Population Health Status

From the Needs Assessment (NA) sources and methods outlined above, **ten key cross-cutting themes** emerged. These themes reflect the voices of community listening forum (forum) participants across all population groups and geographic areas, reinforced by survey responses from providers and community members. The themes cut across the five Title V domains and provide context for relevant findings reported in the domain-specific summaries below. These themes emerged organically from open-ended group discussions and survey questions in community members' own voices and were not prompted by topic-specific questions.

**Theme 1: Lack of awareness of resources and services in the community.** This was the most frequently reported need, raised in three-quarters of the community forums. Participants noted that they rely on "word of mouth" to know about services in their communities or that you must encounter a problem (e.g., have a preterm infant or enter a domestic violence shelter) to enter the system and be connected to needed services. Their recommendations include enhanced community outreach at locations such as churches, supermarkets, and groups; printed and virtual materials and resources; and increased referrals, coordination, and navigation support from service providers. Specific services frequently mentioned for which increased awareness is needed include mental health, substance use, and family planning services.

*"Just tonight, everyone is talking about different programs that a lot of us didn't know about. Education, knowing more about what's out there and the people who are providing these services, getting the info out there."*

*"If it was not for finding myself in a shelter due to a domestic violence situation, I would have not known about resources in my community and I do not feel like that is a good thing."*

**Theme 2: Transportation barriers.** This was the second most commonly cited issue, voiced by participants in two-thirds of forums. Participants cited lack of public transportation options, cost, reliability, long wait times, and accessibility as key barriers. They described the impact of transportation barriers on keeping and arriving on time for appointments, reliably getting to jobs, running errands, and participating in community activities. They voiced recommendations for low/ no cost transportation to non-medical services (such as Supplemental Nutrition Programs for Women, Infants, and Children (WIC), Departments of Social Services (DSS), and support groups like Alcoholics Anonymous), more short-notice and emergency transportation options, more informational resources about available transportation, and more family-friendly transportation accessible to strollers, wheelchairs, and families with multiple children. Families described concerns about pedestrian safety especially for children and called for improvements to make communities more walkable.

*"I had to walk through town with my groceries in a cart and walk the cart back. It was embarrassing."*

*"We have the […] county bus that goes around, but there's not a lot of them. There are big gaps in the day when you either have to… go early and spend your whole day waiting for your appointment. So you waste a lot of your day that you [could] have worked or done something else."*

**Theme 3: Availability and accessibility of services and amenities in the community.** Within this common theme, participants identified many different specific resources needed in their communities. Most notably, each of the following were identified by two-thirds of the community forums as needs:

- resources for affordable, fresh, and healthy foods, especially farmer's markets and food pantries;
- local health care providers and specialists, particularly specialists for children and youth with special health care needs (CYSHCN), mental health, and substance use treatment services. Some communities also voiced a need for more dental providers, local urgent care clinics, and full-service hospitals;
- activities or centers with age-appropriate activities for children and families, including young children, teens, and differently-abled children and adults.

Participants in many forums also voiced the need for more accessible and safe places for physical activity and exercise, such as fitness centers and more walkable areas.
Respondents cited barriers to using community services including the cost of programs; distance/ travel time; inconvenient locations and hours; challenges with eligibility, available "slots" or long waiting lists; and fears of seeking services due to stigma about undocumented status or mental health issues. They described bad experiences and bad reputations of some programs and staff as factors that discouraged use of available services. These challenges were exacerbated by transportation issues, forcing residents to travel outside the community for services or go without.

*"There needs to be more after school programs for children and things for them to do so they can use their time. Rather than becoming invested in drugs because they have all this time."*

*"If we had more mental health programs/options that would help our community to not be so depressed."*

**Theme 4: Poverty and issues of the working poor.** In one-third of the community forums, participants described challenges specific to earning too much to qualify for benefits but not enough to get by voicing a sentiment that "the system holds you down" with no opportunity to save and get ahead. Individuals described challenges qualifying for and obtaining

services, citing the burdensome nature of documentation and application processes, inconsistent information, and experiences of feeling judged and disrespected by social service systems and staff. Some noted that benefits they did receive were insufficient to meet their family's needs. They described being "suddenly dropped" from services if their income increases or if two adults are working, with gaps in coverage. They suggested providing access to copiers and fax machines to assist people with applications, and instituting processes to "wean off" of benefits when eligibility changes.

Within this theme, respondents also described the desire for financial stability and opportunities to grow financially for their family and children. They cited the need for more stable, quality job opportunities, with livable wages and benefits. Participants asked for more assistance to find jobs, develop career skills, continue education, and obtain free or affordable higher education. Both youth and adults called for more education in schools on financial literacy skills related to budgeting, taxes, and credit. The high cost of basic needs including food, health insurance and health care, housing, childcare, clothing, diapers, and others was frequently noted as a barrier to saving and getting ahead financially, and organizations that assist with meeting those basic needs were often discussed as an important asset.

> *"If you are in poverty, you are more likely to spend more money because there is this whole thing of like you pay for something to get it immediately rather than saving up to get something that lasts, so you end up buying something that will break really quick. So you end up spending more money. So really, being poor is expensive."*

> *"If you are making a 'livable wage' you can't qualify for certain services. The system is made for us to fail. If you do improve, you lose services, you fall back."*

**Theme 5: Supports for parents and families.** Families voiced the need for additional supports at different stages, from pregnancy and postpartum through early childhood and school-age years. They described needs for more support related to health promotion and health care, parenting education including relationship support for both mothers and fathers, benefits such as paid family leave and sick leave, affordable high-quality childcare, and safe, positive after school activities for children and youth. While additional details related to this theme are presented in the domain-specific summaries below, the core focus on family support across all stages stood out in the NA.

> *"I felt welcome at prenatal visits when they introduced themselves and included me [dad] in the conversation. The doctor let me know as a father how much I can help. Included both of us."*

> *"I have no family support in this country."*

**Theme 6: Social support and social cohesion.** Beyond the needs for tangible parent supports described in Theme 5, participants across all demographic groups frequently described feelings of isolation due to geographic, social, and language-based barriers. Participants identified family and friend support as an important asset, while lack of those supports was identified as a factor that negatively impacts health and well-being, including mental health. They offered recommendations including:

- more support groups, both peer and face-to-face support
- opportunities and resources to support mentoring, encouragement, and positive relationships for children, teens, and adults
- more community events for socializing and to connect with each other
- more opportunities for community engagement, empowerment, and organization.

More fundamentally, participants called for the need to cultivate a better sense of community, in which community members help or care for each other and children. They described the need for more courtesy, kindness, empathy, and trust among community members–this was raised in more than half the forums across all populations and demographic groups.

> *"I feel isolated because not everyone is experiencing what I am experiencing."*

*"If they had these types of sessions in the community to talk about success stories there might be more success."*

*"I feel like I need someone to listen like my friend."*

**Theme 7: Health care access and quality.** Participants across many local forums (approximately one-third of sessions) described that they do not "feel heard" by their health care providers. They described feeling that their concerns and treatment preferences are not taken seriously, and that providers do not care about them or understand what they are going through, resulting in people avoiding seeking care and services because they feel judged or anticipate being treated poorly. Participants expressed a desire for providers to show more compassion and respect and to have more providers who are like themselves–from their own community and who speak their language.

Participants describe numerous barriers to care including long wait times for appointments, inconvenient hours (paired with inability to take time off from work), long travel time/distance, lack of medical and dental providers accepting Medicaid or uninsured patients, high insurance costs and co-pays (especially for prescriptions), inadequate insurance coverage, high provider turnover or lack of continuity, and insufficient numbers of providers in some communities. They recommended bias and cultural competence training for providers and staff, help to improve their own advocacy skills and health literacy, extended service hours, and more assistance with insurance and care navigation.

**Theme 8: Community and environmental safety.** Concerns about community violence and safety were another common theme. In many forums, participants reported feeling unsafe in their communities, specifically describing guns, gangs, and public drug use, with special concern for children's safety in schools and neighborhoods. Parents and teens described a sense of isolation related to crime and safety concerns. Participants called for safer communities, better community and police relationships, adult supervision for children, more community centers and after-school programs, safer parks and playground equipment, and more greenspace where families can go safely. Additionally, many groups raised concerns about visible trash in streets and public spaces and air, water, and noise pollution that negatively impact their communities.

*"I have to cover my kids' eyes as they walk through the park."*

*"I see syringes in the stairs, in the elevators, this is a big need in my building."*
*"This a prison yard or a community?"*

**Theme 9: Housing.** More than half the forums discussed the need for affordable housing. The high cost of rent and utilities, the prohibitive expense of security deposits, long waits and cumbersome processes for housing subsidies, a lack of safe quality housing appropriate for families, and lack of accountability from landlords were frequently cited as barriers. Homelessness and the need for more shelters for families were also mentioned frequently.

*"Affordable housing is not affordable for people trying to get out of the project."*

*"Kids are sleeping on top of each other because there's no room in the houses. It's crazy."*

*"I don't feel there's a system in place to make sure landlords treat you like human beings."*

**Theme 10: Healthy eating.** Most groups described a need for sources for affordable fresh and healthy foods in their communities. Participants indicated that healthy foods are too expensive, while unhealthy foods are more affordable and have more coupons. Some stores and food pantries provide food that is rotten or expired. Community members recommended removing advertising for unhealthy and fast foods, more farmer's markets (emphasizing food rather than crafts), more food pantries with healthy options, more affordable healthy food in schools, community gardens, and education for students and community members on healthy food choices, cooking, and budgeting.

*"There is never enough to go around. We go to soup kitchen, pantries but there needs to be more."*

*"We need more healthy food in the hood all hoods have crappy food."*

Domain-specific findings are summarized below. A bibliography of data sources used for these summaries is in Appendix 3. All data cited are for the most recent year available.

**Summary**

The NA themes summarized above cut across the Title V domains and provided important context for relevant findings reported in the domain-specific summaries that follow.

**Domain 1: Maternal & Women's Health**

Women's health throughout the life course is fundamentally important to their own well-being and the health and well-being of children, families, and communities. Key indicators of women's health in NYS show that while some measures are improving, others have been flat or are getting worse. Moreover, there are significant and persistent racial, ethnic, and economic disparities across virtually all measures of maternal and women's health.

While nearly 80% of reproductive age women received a well-woman visit in the past year, only 35% of women report ever talking with a health care provider about how to prepare for a healthy pregnancy, and only 25% of reproductive age women enrolled in Medicaid are using a moderately or highly effective method of contraception. For pregnant women, early entry into prenatal care has continued to improve to 80.9%, although preventive dental care during pregnancy is much lower at 43.3% and continues to trend downward. Cesarean deliveries among low-risk first births declined slightly to 28.9%, and the percent of elective early deliveries without medical indication declined to 1%. Women's use of alcohol (7.3%) and tobacco (4.3%) during pregnancy have been declining, but maternal opioid use, as measured by the rate of Neonatal Abstinence Syndrome (NAS) (5.0 per 1,000 births), is increasing. Maternal mortality rates, after a period of increase, have improved the past two years, but unacceptable disparities persist with Black or African American women three to four times more likely to die from causes related to their pregnancy than White women. Severe maternal morbidity, after a period of increasing, has recently improved to 80 per 10,000 deliveries (of note, this measure was redefined this year). The percentage of women reporting postpartum depression symptoms (15.5%) has continued to increase for several years.

Through the statewide forums and public surveys, over 800 NYS women and girls voiced many needs and challenges, as well as current strengths and recommendations for improvement–encompassing and echoing all 10 cross-cutting themes described above. Specific to maternal and women's health, participants emphasized the need for better supports and services related to family planning, pregnancy, birth, and postpartum care, especially resources and coping supports for maternal depression. Women and their families want more continuous support in the postpartum period beyond a single medical visit, and they called for increased and more extended access to doulas, midwives, home visiting, and breastfeeding support services, along with longer paid leave for both mothers and fathers. They called for more programs specifically for fathers, more peer support groups for women and families, and supports for co-parenting, conflict resolution, and healthy partner relationships. This input builds on themes previously voiced by Black or African American women during a series of statewide listening forums conducted in 2018 on racial disparities and maternal mortality. Through those seven forums, the New York State Department of Health (NYSDOH) heard from nearly 250 women who shared their experiences accessing care and giving birth in NYS. Across the state, women frequently identified themes impacting maternal health outcomes for Black or African American women, including disparate levels of care between public and private hospitals and insurance payers; lack of connection to and trust in health care providers; desire to have more time with providers; the need for better information and education, especially within lower income communities; and the pervasive impact of racism and bias on the care received and subsequent birth outcomes.

*"A lot of people are afraid to get services, if they use drugs, they think their baby will get taken away."*

*"I have to wait for my husband to get home to go shopping or do anything."*

*“I had a C-section was alone at home. I did not have help.”*

*“Even with…family around it is still needed to have a support specific to the mother.”*

*“We used to have a village and today it’s gone.”*

*“Doctors don’t respect us because they don’t value us.”*

*“[Coming into the hospital with Medicaid] you are already labeled. You are already treated a certain way.”*

**Domain 2: Perinatal & Infant Health**

Infant mortality is a fundamental indicator of the health of a nation, state, or community. Infant mortality rates have continued to improve in NYS, declining to 4.6 infant deaths per 1,000 births. This is better than the U.S. infant mortality rate. The neonatal mortality rate (within the first month of life), which accounts for two-thirds of infant deaths, has also declined. This mirrors declines in preterm-related mortality and demonstrates continued success in ensuring that the majority (91.2%) of the highest risk very low birth weight infants are delivered in hospitals with Level III+ neonatal intensive care units. However, previous improvements in the overall preterm birth rate may be reversing, with an increase from the prior low of 8.7% back to 9% of births over the past two years and a parallel increase in the percentage of early term births (defined as 37-38 week) to 23.7%. Post-neonatal mortality (defined as age one month to one year) has remained fairly steady (1.5 deaths per 1,000 births), but the sudden unexpected infant death (SUID) mortality rate has increased to 58.3 per 100,000 births after fluctuating the past several years, and safe sleep practices including sleep position and sleep environment likewise have not improved. Significant racial disparities persist for all these measures. As an important cause of infant morbidity, the rate of NAS has continued to increase, with higher rates among infants who are White, low income, and residing in non-metropolitan areas. Breastfeeding has been fluctuating, with 82.9% of infants ever breastfed. Only 23.2% were exclusively breastfed through age six months, with lower rates among Black or African American and Hispanic infants.

The 37 forums included seven forums conducted in collaboration with the NYS Maternal, Infant, and Early Child Home Visiting (MIECHV) program to hear specifically from expectant parents and parents of young children who are either currently enrolled in, or potentially eligible for, home visiting programs (230 individuals, including 203 mothers, 25 fathers, and 2 unspecified participants). Their comments encompassed all ten cross-cutting themes described above, with issues specific to perinatal and infant periods. Many families expressed the need to raise awareness about available community resources and services, in particular for postpartum depression, and to increase the availability and scope of services to support families in the postpartum period, including postpartum doulas, home visitors, community health workers, and breastfeeding support. Transportation barriers described across groups were especially challenging for parents with young children, and homelessness is a special challenge for families seeking family-friendly shelters. Parents described a desire for more parenting education classes and resources on a range of specific topics (e.g., infant care, infant development, childproofing and safety, behavior and discipline, bonding). They called for more classes and programs specifically for fathers, including single fathers, more parenting support groups, and more community activities and programs to help new parents get out of the house. Returning to work after birth is a special challenge for lower income families, and the need for longer paid parental leave and sick leave for both mothers and fathers was emphasized. Childcare was a topic of frequent concern, with parents describing challenges to find affordable, reliable, safe, and trusted child-care providers–both to work and to be able to participate in community programs and services–especially for parents working second and third shifts and variable schedules.

*"I don't think people value spaces to vent and talk. That's why I really enjoy the fatherhood program."*

*"[I] can't even roll a stroller in some neighborhoods."*

*"By the time you go to work, pay for daycare, you were better off on services and not working- more poor than when*

*you got help."*

*"I encourage people to enroll into whatever program is offered because through that you can be connected to other services that might be available in the community."*

**Domain 3: Child Health**

Families report that 91.2% of NYS children age 0-5 and 91.6% of age 6-11 are in excellent or very good health, but this percentage is lower for children who are Black or African American, Hispanic, are poor, or who have parents born outside the U.S. or with lower education levels. Nearly 20% of NYS children are living in poverty, 23% receive supplemental nutrition assistance program benefits, and 4.3% of children enrolled in public schools are homeless, although all of these have improved over the last decade. Approximately 17 per 1,000 NYS children were reported as victims of maltreatment, and over 23,000 children and youth are in foster care. Mortality rates among children ages 1-9 years have decreased by 10% over the past five years to 13.7 deaths per 100,000 children, with conditions originating in the perinatal period and injuries as the leading causes of death and 171 injury-related hospitalizations per 100,000 children ages 0-9. Over 11.1% of children age 1-17 have decayed teeth or cavities and 13.7% of children age 2-4 are obese. Families report that 27% of children age 6-11 years are physically active for at least 60 minutes daily, and 72% ate a family meal with everyone living in the household four or more days weekly. Approximately 10.7% of NYS children live in a house where someone smokes inside the house.

The vast majority (over 97%) of NYS children have health insurance, but fewer (74.6%) have insurance that is adequate and continuous, and only 47.2% of children without special health care needs receive coordinated, ongoing, comprehensive care that meets the criteria for medical home. While 72.2% of children reported having preventive medical and 79.3% reported a preventive dental visit in the past year, rates of both are lower for Black or African American children (66% and 70.4%%, respectively). Specific preventive care services vary: 68.8% of children age 19-35 months had a complete the full vaccine series; 27.1% of children age 9-35 months reported a developmental screening using a parent-completed screening tool; 60.8% of children were tested for blood lead levels two times by the age of 36 month years in accordance with NYS requirements; and 69.6% of children age 6-17 were vaccinated against influenza.

Forum participants, including many parents and grandparents, voiced concerns and strengths related to children's health and well-being, reiterating the cross-cutting themes summarized above. Families describe transportation with children as especially challenging and called for more family-friendly transportation and placing transportation near family activities and services. They asked for health care and other service providers that are more respectful, compassionate, and reflective of their languages and cultures, where they do not feel judged or stigmatized.

Improving community and neighborhood environments was a major theme among families. They emphasized the need for improved pedestrian safety and better sidewalks, with concerns about children walking along unsafe roads, and lack of access to fresh, affordable, healthy foods in the community and schools. Community violence, gangs, and drug use–in both neighborhoods and schools–were major concerns, leading to increased fear and social isolation. Pollution and trash in the streets were also raised as concerns that impact children's health. Families voiced the desire for more activities, programs, open greenspace and safe places for their children after school, summers, and on weekends, along with more family activities and facilities outside of work hours to support quality time with their children. They called for more mentoring and positive relationships for children, and a better sense of community connection, trust, engagement, and support.

*"Have to drive 10 minutes down the mountain to reach bus stop for child."*

*"I had concerns with my daughter gaining weight and the doctor said it was fine. Then when her 4-year check-up came she said it was a concern. She didn't listen to me."*

*"Back in the old days, neighbors watched out for others' children."*

*"I want a community where they can grow up and know that they're safe and can go anywhere they want to go and trust the adults in their community. Right now I am scared for my kids."*

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

An estimated 15.8% (approximately 656,000 children) of children and youth age birth to 17 years in NYS have one or more special health care needs. The most commonly reported chronic conditions among NYS children are allergies (18.3%), oral health problems (11.1%), Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) (5.3%), asthma (7.5%), anxiety (6.9%), developmental delays (5.7%), autism spectrum disorders (3.1%), and depression (2.9%). Lead poisoning remains a special concern among NYS children because of the high percentage of older housing and other risk factors, with elevated blood lead levels (defined as greater than or equal to 10 mcg/dL) identified in 3.7 out of 1000 children tested for lead. NYS has recently changed the definition to great than or equal to 5 mcg/dL.

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 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. Families of CYSHCN report that only15.2% receive care in a well-functioning system, and 41.7% received care meeting all criteria for medical home, although these may be improving. Nearly all (99.98%) of resident births were screened for 50 disorders by the newborn bloodspot screening program. Nearly 1.3% of newborn hearing screenings had abnormal results; of these, only 29.5% had a documented follow-up screening. NYSDOH is actively working to improve completion and documentation of follow-up hearing testing. About 53.5% of children age 3-17 with a mental or behavioral condition received treatment or counseling. Among families of infants and toddlers participating in the State's Early Intervention Program for federal Fiscal Year 2018-19, 63.7% met the State's standard for positive impact on families using the Rasch methodology. The Department has positive anecdotal evidence from parents directly impacted by the EIP's Improving Family Centeredness Together (IFaCT) quality improvement initiative. Only 17.8% of youth age 12-17 with special health care needs received services necessary to make transitions to adult health care, and this appears to be getting worse.

To better understand the gaps, barriers, and needs of families with CYSHCN, the NYSDOH Division of Family Health (DFH) implemented a care mapping process in partnership with several programs, including NY's Parent to Parent and Leadership Education in Neurodevelopmental Disabilities (LEND) programs, to collect feedback from parents and caregivers of CYSHCN and professionals who serve them. Recruitment was conducted from March 2017-June 2018, and feedback collected from 138 caregivers and 40 providers through a combination of online and paper mapping tools. Common challenges reported by caregivers included accessing and coordinating medical care and related services, identifying and coordinating child care, providing emotional and social supports for children and families, providing financial support including health insurance, navigating and obtaining assistance from the school system, integrating their children and their families into the community, providing and coordinating transportation, and transitioning to adult services. In addition, providers of CYSHCN report challenges connecting with families, staying up to date with knowledge of available community resources, and providing continuity of care. These findings resonate with the input received through the forums, in which 39 parents or caregivers of CYSHCN shared concerns and ideas related to both the cross-cutting themes described above and concerns more specific to families of CYSHCN.

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

*"I am a mother of three special needs kids. I have to travel to Buffalo 8-15 times a month because there are no pediatrician offices for my son."*

*"I feel isolated because not everyone is experiencing what I am experiencing."*

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

*"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."*

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

**Domain 5: Adolescent Health**

Families report that nearly 90.9% of NYS youth age 12-17 are in excellent or very good health. All-cause mortality for teens (21.9 per 100,000 age 10-19) has been declining. Injuries remain the leading cause of adolescent mortality, and for every injury death there are more than ten youth hospitalized for non-fatal injuries (221 per 100,000 age 10-19). While mortality related to motor vehicle injuries (5 per 100,000 age 15-19) has declined, suicide (6.0 per 100,000 age 15-19) has increased.

Depression among teens is increasing, with 11.5% of NYS teens age 12-17 experiencing a major depressive episode in the past year, over 30% of high school (HS) students reporting feeling sad or hopeless for more than two weeks in the past year, and over 10% of HS students reporting that they attempted suicide. Parents report that 33.1% of teens age 12-17 have been bullied and 12.6% of teens have bullied others. These rates are consistent with reports directly from HS students, 27.7% of whom reported that they were bullied electronically or at school, which has been steadily increasing. Nearly one in ten HS students report that they did not go to school because they felt unsafe at or on their way to/from school. About 10% of HS students report experiencing sexual dating violence and 10% physical dating violence. Youth arrests (age 10-17) ranged from 33 per 100,000 for weapons, 62 per 100,000 for assault, and nearly 300 per 100,000 for drug abuse.

About 7% of HS students report no fruit consumption in the past week, nearly 14% report drinking soda daily, and over 15% report never eating breakfast in the past week. Parents report that only 19.9% of teens age 12-17 were physically active at least 60 minutes every day, and 14.8% of HS students report no days with physical activity of 60 minutes or more in the past week. Over 40% of HS students report spending more than three hours daily using electronic devices (video games, social media, etc.), and 21% report three or more hours watching television. Nearly 30% of HS students are obese or overweight. Almost 80% of students report getting less than eight hours of sleep on an average school night.

Alcohol and combustible cigarette use among teens both have been declining, but use of electronic vaping products has increased dramatically, with over 27% of HS students reporting past or current use. Nearly 4% of students report ever using heroin. About 22% of HS students are currently sexually active, and among this group nearly 16% reported using no method to prevent pregnancy and over 41% reported not using condoms at last intercourse. The teen birth rate (11.7 per 1,000 girls 15-19) continued to decline, but case rates of sexually transmitted infections (STI), such as gonorrhea and chlamydia, among teens have not declined.

From October 2018 to April 2019, the ACT for Youth Center for Community Action based at Cornell University gathered input from youth around the state to explore why teen pregnancy rates have improved while STI rates have not. Over 200 young people completed surveys and over 75 participated in focus groups to discuss where they seek reproductive health care, their attitudes about sexual relationships, and their perceptions of sexual risk reduction behaviors. Participants indicated that teen pregnancy rates are down because of better education and awareness about sexual health, better access to and less stigma about contraception and condoms, teens engaging in other activities (both recreational, such as video games or social media, and other types of sexual activity, such as sending pictures), teens having other priorities and goals, and teens engaging in more oral or anal sex. To explain why STI rates are not improving, participants suggested teens are not using condoms for oral and anal sex; are more focused on pregnancy prevention than STI prevention; have misconceptions about personal STI risk, how they are transmitted, and the purpose of contraception; and have issues with navigating relationships, whether partners lying to each other about STI status or other partners, coercion, or open relationships.

Disparities vary across these behaviors and outcomes. White students report higher rates of bullying, but both Black or African American and Hispanic students are more likely to miss school because of safety fears. Hispanic students are more likely to report depression symptoms and suicide attempts. Cigarette smoking and alcohol use are higher among White

teens, while Black or African American and Hispanic teens are more likely to use other illegal drugs, including heroin. Black or African American and Hispanic teens also report lower fruit and higher soda consumption, less physical activity, and higher rates of obesity and inadequate sleep. There are dramatic disparities across virtually all measures based on sexual identity; for example, among HS students identifying as gay, lesbian, or bisexual, 60% report depression symptoms, 26% report a suicide attempt, and 10% have used heroin.

In addition to the surveys and focus groups with young people, ACT for Youth interviewed 19 gender and sexually fluid young people to learn more about their experiences and perceptions about sexual health. Common themes discussed included that unprotected sex is common among this population and that sex work and survival sex happen. They discussed how sex education does not meet their needs: “Even in schools the sex education is very binary, doesn’t really talk about gay sex or lesbian sex, it is always just mostly on reproductive sex…It is mostly about just about how to prevent pregnancy.” Similarly, participants discussed not feeling affirmed by providers when accessing sexual health care as a barrier.

Most teens ages 12-17 had a preventive medical (81.3%) and preventive dental (79.3%) visits in the past year, and rates have been increasing. Teen vaccination rates for tetanus, diphtheria, and pertussis (i.e., whooping cough) (Tdap) (91.7%) and meningococcus (94.9%) are also relatively high, but the percentage vaccinated for human papilloma virus (HPV) (71.2% of girls and 67.1% of boys) is lower. Only 16.4% of adolescents without special health care needs received services necessary to transition to adult health care.

Over 150 adolescents participated in forums across the state. They called for more positive mentors and social support and increased access to teen-friendly community activities, including fitness centers and areas for exercise. Teens spoke frequently of the need for better housing, healthy foods, and economic supports for their families. Teens expressed the desire for more compassion and respect from healthcare providers, and more providers who reflect their cultures and speak their language. Along similar lines, confidentiality was raised during the adolescent surveys and focus groups as a concern when seeking sexual and reproductive health care. They indicated they are less concerned about the confidentiality of electronic medical records and more concerned about interpersonal confidentiality.

> *“Everybody needs to talk even for one second or ten minutes. Even boys.”*
>
> *“My mom waited 3 years for them to put on a door."*
>
> *“Must have hope that you trust your provider and make sure someone is not trying to hurt you."*
>
> *"I feel like we should have more African American counselors. Because the counselors that are there, I feel like the students don't feel comfortable talking to them."*
>
> *“If I admit to needing care, then I admit to doing certain things. By seeking care, there might be guilt.”*

**III.C.2.b.ii. Title V Program Capacity**

**III.C.2.b.ii.a. Organizational Structure**

NY’s Title V and CYSHCN Programs are based in the NYSDOH, an executive branch state agency under the direction of Commissioner Howard Zucker MD, JD, who was appointed by the Governor. Within NYSDOH, they are in the Office of Public Health, Center for Community Health, Division of Family Health (DFH). The DFH Director, Lauren J. Tobias, is the Title V Director (see organizational charts).

NYSDOH is responsible for the administration of all programs carried out with allotments under Title V, most of which are organizationally within DFH. Title V-funded programs and staff are integrated across DFH, its Office of Medical Directors, and its four bureaus: Women, Infant and Adolescent Health; Child Health; Early Intervention; and Administration.

Several key Title V-funded programs and initiatives are based in other parts of NYSDOH, including: American Indian Health Program (Office of Minority Health & Health Disparities), Asthma Prevention & Control (Division of Chronic Disease Prevention), Lead Poisoning Prevention (Center for Environmental Health), Migrant & Seasonal Farmworker Program (Center for Community Health), and Newborn Bloodspot Screening (Wadsworth Center). A list of Title V-funded programs is in Appendix 4.

**III.C.2.b.ii.b. Agency Capacity**

NY's commitment to protecting and promoting the health and well-being of the priority population is manifest in a comprehensive array of programs and services. Most services are carried out at the community level by local partners. NYSDOH and Title V program provide, administer, and oversee funding, training, technical assistance, data support, quality improvement, and other policy and program efforts to guide and support local and regional systems and programs. Within NYSDOH, staff, who are in Albany, coordinate with NYSDOH colleagues in regional offices to support and oversee Title V funded programs. See Appendix 4 for a description of programs and services funded directly through the Title V grant.

In addition to administering specific programs and initiatives, Title V staff routinely collaborate with a wide array of partners, both within and outside NYSDOH, to help inform, strengthen, and coordinate statewide systems of services and supports for women, children, and families. See Section III.C.2.b.iii. below for more information on partnerships.

Of note, NY's Title V Program works extensively with the state's Medicaid program and other partners to support Children and Youth with Special Health Care Needs (CYSHCN) and their families as a priority population, and to ensure statewide and local systems are in place to meet their needs. In NYS, all (Social Security Income) SSI beneficiaries, including blind and disabled children receiving benefits under SSI, are categorically eligible for Medicaid; thus, Title V funds are not used for these direct care services.

This year, NY's Title V Program capacity was significantly challenged by COVID-19, with NYS as an epicenter for the pandemic in the U.S. As staff rapidly adjusted to working remotely, all Title V and other DFH programs mobilized to support the state's response. Staff led and contributed to wide-ranging response efforts including development and dissemination of guidance documents, webinars for local providers, and facilitation of telehealth and other virtual programming. Some staff were deployed to serve on intra- and inter-agency workgroups and support teams to coordinate regional epidemiology support and to directly assist with testing and contact tracing activities. The Title V program staffed the Governor's COVID-19 Maternity Task Force, convened to rapidly respond and develop recommendations related to birthing facilities and to review the literature on the impact of COVID-19 on pregnancy. Local MCH-serving programs have made significant adjustments to provide continued support for vulnerable MCH populations (see Appendix 5 for details).

The impact of the pandemic on families, communities, and MCH programs is expected to be a continuously evolving challenge for the foreseeable future. Further assessment of how Title V programs have responded, how the capacity of programs may be leveraged, assess how they have been impacted by continued response needs will be addressed in next year's application.

**III.C.2.b.ii.c. MCH Workforce Capacity**

A strong and diverse workforce is needed to lead and implement core Maternal and Child Health (MCH) public health functions, effectively administer program resources, and collaborate with families and organizational partners at all levels. The size and complexity of NYS populations and service systems require significant leadership and capacity for program and policy development, program operations and implementation, data analysis and evaluation, and intra- and inter-agency communication and collaboration.

There are 128 filled Title V-funded positions within NYSDOH central, regional, and district offices, supplemented with additional non-Title V-funded positions supporting Title V programs and activities. Staff cover the full range of MCH populations and essential public health services.

Key Title V staff in the NYSDOH Division of Family Health (DFH) include:

- Lauren J. Tobias, MPP, DFH Director and NYS Title V Director
- Kirsten Siegenthaler, PhD, MSPH, Associate Director, DFH
- Marilyn Kacica, MD, MPH, Medical Director, DFH
- Megan Tyrrell, Title V Coordinator, DFH
- Christopher Kus, MD, MPH, Associate Medical Director, DFH
- Dionne Richardson, DDS, MPH, Public Health Dental Director, DFH
- Michael Acosta, MPP, Bureau of Women, Infant and Adolescent Health (BWIAH) Associate Director
- Eric Zasada, MPA, BWIAH Assistant Director and NYS Title V Adolescent Health Coordinator
- Suzanne Swan, MPH, Bureau of Child Health Director and NYS Title V Child and Youth Special Health Care Needs (CYSHCN) Director
- Constance Donohue, AuD, CCC-A, Bureau of Early Intervention Director
- Deborah Rock, Bureau of Administration Director

The BWIAH Director position is vacant following Kristine Mesler's retirement in late 2019. See Appendix 6 for brief descriptions of key qualifications for these staff.

NYS has experienced the same workforce trends described in national reports and surveys, including attrition and shrinking public workforce, with a large percentage of the current workforce poised to retire within the next five years, and needs for additional knowledge and skill development related to both emerging and persistent MCH challenges. Of critical importance, the diversity of the MCH workforce nationally and in NYS does not yet reflect the diverse populations the MCH workforce needs to serve and support.

The Title V program's internal capacity is enhanced and supplemented through formal and informal partnerships with external organizations. For example, the statewide and regional centers described above provide additional subject matter expertise, training, and technical assistance capacity for specific program areas. The Title V program also partners extensively with the HRSA-funded MCH Public Health Catalyst program based at University at Albany School of Public Health. The Catalyst program is engaged in recruiting and training the next generation of MCH professionals, with a special focus on individuals from disadvantaged and underrepresented populations. Specific partnerships between the Catalyst and Title V programs have supported numerous student projects and internships, an award-winning national webcast on maternal mortality, a literature review on COVID-19 and pregnancy for the COVID-19 Maternity Task Force, and extensive technical assistance to coordinate this five-year Title V NA and application, among others.

Parent and family members are critical partners in the Title V program's work at all levels.

At the state level:

- Michelle Juda, the Executive Director NYS Parent to Parent and the state's Family2Family Information Center, serves on the Title V Advisory Council.
- ACT for Youth Center for Community Action has a youth advisory board.
- Community members will serve on the Maternal Mortality and Morbidity Advisory Council (currently being established).

At the regional level:

- CYSHCN Regional Support Centers are required to hire a parent of a CYSHCN and convene family forums to provide direct input on program development.
- NYS Perinatal Quality Collaborative (NYSPQC) teams include patients, families, and those with lived experience in their educational curricula.

At the community level:

- School Based Health Centers (SBHCs) and Comprehensive Adolescent Pregnancy Prevention (CAPP) programs routinely engage parents and youth in their program activities
- Maternal and Infant Community Health Collaborative (MICHC) programs are engaged in developing work with community advisory boards.

#### III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

Partnerships and collaborations with other programs, organizations, and community groups are a fundamental way in which NY's Title V Program strives to meet the needs of MCH populations. These span partnerships with other state MCH-serving public health programs, within the NYS Department of Health (NYSDOH) Division of Family Health (DFH) and with other NYSDOH programs, other state and local agencies, community-based and private sector partners, families, and consumers. An overview of key partners and collaborations is in Appendix 7.

#### III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

Findings from the statewide Needs Assessment (NA) drove the 10 MCH priorities identified for the NYS Title V program for the next five years. To identify and choose priorities, the following factors were considered:

- Areas identified by families and community members as their most important needs and priorities;
- Areas for which Title V infrastructure, capacity, partnerships, and investments can be leveraged; and
- Areas that the state Title V program can impact over the next five years in a lead or key supporting role.

While all factors are important, **listening and responding to community voices** was given the most weight. The Title V leadership team asked the question: *How can we be responsive to the themes voiced by families and communities, within the context of the program infrastructure and resources we have, and with a focus on making measurable progress in specific areas encompassed by the HRSA national performance measures?*

Given this approach, the starting point for choosing priorities was to review and discuss the top themes emerging from the forums, public survey, and other companion efforts described in the methodology and findings above. Ten priorities were identified, corresponding directly to the ten cross-cutting themes described in Findings (Section b.1).

1. **Health Care:** Address equity, bias, quality of care, and barriers to access in health care services for women and families, especially for communities of color and low-income communities
2. **Community Services**: Promote awareness of and enhance the availability, accessibility, and coordination of community services for families and youth, including children and youth with special health care needs and their families, with a focus on communities most impacted by systemic barriers including racism.
3. **Parenting and Family Support**: Enhance supports for parents and families, especially those with children with special health care needs, and inclusive of all family members and caregivers
4. **Social Support and Cohesion:** Cultivate and enhance social support and social cohesion opportunities for individuals and families who experience isolation as a result of systemic barriers including racism, across the life course
5. **Healthy Food:** Increase access to affordable fresh and healthy foods in communities.
6. **Community & Environmental Safety**: Address community and environmental safety for children, youth, and families.
7. **Poverty:** Acknowledge and address the fundamental challenges faces by families in poverty and near-poverty, including the "working poor" as a result of systemic barriers, including racism.
8. **Awareness of Resources:** Increase awareness of resources and services in the community among families and the providers who serve them.

9. **Housing:** Increase the availability and quality of affordable housing.
10. **Transportation:** Address transportation barriers for individuals and families.

This approach to priority-setting is different from the prior cycle, in which priorities were domain-specific and directly linked to specific objectives and performance measures. For this five-year cycle, NY has chosen instead to adopt a set of priorities that serve as a broad vision that is directly responsive to the cross-cutting needs, challenges, and positive ideas shared by community members. Thus, all priorities are “new” from the previous cycle, as reflected in Form 9. The priorities will serve as a compass to guide the work of all Title V programs in considering how existing infrastructure, capacity, services, partnerships, and other resources can be leveraged to more effectively address these critical priorities.

Guided by these priorities, the leadership team selected five national performance measures (NPMs) and two state performance measures (SPMs) as the basis for the NYS Title V State Action Plan for the next five years. Because the priorities are cross-cutting, there is not one-to-one alignment between priorities and performance measures. Rather, the NPMs and SPMs were selected to collectively drive work in areas that align with these cross-cutting priorities and for which the leadership team determined our Title V program can make meaningful progress over the next five years. See the State Action Plan Table for a more detailed crosswalk of the priorities and selected performance measures.

### III.D. Financial Narrative

| | 2017 | | 2018 | |
|---|---|---|---|---|
| | Budgeted | Expended | Budgeted | Expended |
| Federal Allocation | $38,909,810 | $37,671,624 | $38,909,810 | $38,241,544 |
| State Funds | $12,147,081 | $29,285,355 | $29,226,355 | $29,285,355 |
| Local Funds | $102,765,310 | $64,999,454 | $64,591,358 | $122,724,134 |
| Other Funds | $0 | $0 | $0 | $0 |
| Program Funds | $34,368,556 | $78,393,470 | $26,851,106 | $28,299,351 |
| SubTotal | $188,190,757 | $210,349,903 | $159,578,629 | $218,550,384 |
| Other Federal Funds | $57,096,314 | $46,962,126 | $68,845,166 | $67,884,924 |
| Total | $245,287,071 | $257,312,029 | $228,423,795 | $286,435,308 |

| | 2019 | | 2020 | |
|---|---|---|---|---|
| | Budgeted | Expended | Budgeted | Expended |
| Federal Allocation | $37,671,810 | $25,616,759 | $38,909,810 | |
| State Funds | $29,285,356 | $29,285,356 | $29,285,355 | |
| Local Funds | $122,324,435 | $57,532,053 | $55,483,224 | |
| Other Funds | $0 | $0 | $0 | |
| Program Funds | $30,303,017 | $22,258,095 | $22,224,404 | |
| SubTotal | $219,584,618 | $134,692,263 | $145,902,793 | |
| Other Federal Funds | $47,470,052 | $53,655,287 | $65,608,665 | |
| Total | $267,054,670 | $188,347,550 | $211,511,458 | |

| | 2021 | |
|---|---|---|
| | Budgeted | Expended |
| **Federal Allocation** | $38,909,810 | |
| **State Funds** | $29,285,355 | |
| **Local Funds** | $55,602,278 | |
| **Other Funds** | $0 | |
| **Program Funds** | $16,735,967 | |
| **SubTotal** | $140,533,410 | |
| **Other Federal Funds** | $49,308,573 | |
| **Total** | $189,841,983 | |

**III.D.1. Expenditures**

FY 19 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). The scope and comprehensiveness of services for NY's MCH population are fully outlined and described in the FY 2019 report and FY 2021 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 Personal Responsibility Education Program (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 NYS Perinatal Quality Collaborative grant to support efforts to improve the quality of care provided to women and newborns in NYSs 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 19 appear less than originally projected. The reason for this is that New York State Department of Health was able to transfer a portion of the FY 19 Federal Allocation program support costs to other Department resources to alleviate pressure on the grant which allowed us to program additional resources to support other emerging needs. Specifically we used the funding to develop the following new initiatives: Rape Crisis Safer Bars Initiative, U.S. Census Bureau National Survey of Children's Health, Community Health Work Expansion, Regional Support Centers for Local Health Departments for the Children and Youth with Special Health Care Needs Program, Regional Perinatal Centers Telehealth Program, Medicaid Redesign Team Health Information Technology (MRTHIT), as well as increase grant support for core initiatives such as Comprehensive Adolescent Pregnancy Prevention (CAPP) and School Based Health Centers.

NY's Title V program uses additional State funds to leverage other resources such as to obtain Federal Medicaid Assistance Program (FMAP) funding when possible. The FY 19 award value remains fully obligated and will fully dispersed by the liquidation deadline at the end of this year.

NY's FY 19 application reflected a budget of over $122 million in Local funds and $30 million in Program Income, but actual expenditures were less than anticipated. This is likely related to the timing of the reporting by LHDs rather than an actual decrease in expenditures.

NY has decided to remove many of the federal grants listed as Other Federal Funds in the FY 19 application as they were not awarded to the NY State Department of Health, but to Health Research Incorporated (HRI). The DOH works very closely with HRI to manage these grants but is not the awardee.

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**

The FY 2021 budget reflects NY's commitment to Title V programs and services. NY will continue to use FY 2021 Title V funds to fully support the implementation of NY's Title V State Action Plan. Title V funds, in addition to State appropriation, Federal Medicaid Assistance Program (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 Children and Youth with Special Health Care Needs (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 will also continue to 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 the NYS 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, 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 $2.7 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 FY21 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

As described in the Needs Assessment (NA) summary, New York's selection of state priorities for the next five years was driven by this fundamental question: how can we be responsive to the themes voiced by families and communities, within the context of the program infrastructure and resources we have, and with consideration for the national priorities and specific performance measures established by HRSA?

From this question, ten cross-cutting priorities were endorsed, aligning directly with the ten cross-cutting themes identified from family and community members through the NA. In turn, five national performance measures (NPMs) were selected and two additional state performance measures (SPMs) were established as focal points for action that align with both the priorities voiced by families and community members and the capacity and mission of the NYS Title V funded programs.

The development of New York's five-year State Action Plan continued this approach. Simultaneously anchored by both the broad, cross-cutting priorities and the specific performance measures selected, the action plan was developed in response to this question: what strategic public health approaches and specific program activities can the NYS Title V program lead or meaningfully support over the next five years to make measurable progress in the specific areas encompassed by these seven performance measures, in ways that are responsive to the cross-cutting priorities voiced by families and community members?

The resulting State Action Plan serves to link the broad, cross-cutting priorities identified by families and community members with the specific outcomes encompassed in the selected national and state performance measures. The State Action Plan table presents the strategic public health approaches identified to address each of the national/state performance measures and shows how each strategic approach aligns with the cross-cutting priorities. Further detail on specific program and policy activities associated with each of these strategic approaches is described in the narrative by domain.

Evidence-based strategy measures (ESMs) were developed for each domain to capture the reach and effectiveness of these strategies for the relevant populations directly served through the Title V program. Specific objectives with measurable improvement targets were developed for each domain to further operationalize the strategies and measures. These objectives and measures were aligned with the NYS Prevention Agenda to reinforce consistency and synergy with the Title V plan.

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

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

A strong and diverse Maternal and Child Health (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 local health departments (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, lead poisoning prevention, and children and youth with special health care needs (CYSHCN). 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 between states 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 and partners with information and learning opportunities to improve knowledge on the tenets of social and emotional wellness as it relates to Title V populations.

As previously discussed, NY's Title V program also leads various efforts with health care providers, hospitals and other professionals throughout NY to enhance practice. These include, but are not limited to, the improvement initiatives through New York State Perinatal Quality Collaborative (NYSPQC) and training and information provided to and through professional organizations (topics include the identification of children with Autism Spectrum Disorder (ASD), developmental screening, the identification and treatment of hypertension during pregnancy, and screening and referral of children for oral health services). Staff are integrated into the regional perinatal center re-designation process, offering professional staff development opportunities, as high-level medical professionals work together to modernize the state's system of care in birthing hospitals throughout NY.

Title V staff within the NYS Department of Health (NYSDOH) are the core of the Title V program and responsible to ensure the scope and mission of Title V are implemented. To ensure a strong focus on the needs of the Title V programs, strong connections and linkages are maintained with relevant stakeholders. For example, 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, the Schuyler Center for Analysis and Advocacy (SCAA) and other stakeholders. The Moving on Maternal Depression (MOMD) works to achieve five goals:

1. 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.
2. 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.
3. 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 (e.g., connecting women to treatment, reducing provider stigma, reducing disparities).

4. Better understand the capacity in each region of NYS 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
5. 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.

Title V Program staff 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 CYSHCN 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 NY Title V Advisory Council meetings to ensure NY has the most current information from the federal level.

The Division of Family Health (DFH), in which the Title V Program and other MCH programs are located organizationally, is committed to improving health equity for all New Yorkers. In order to further this agenda, DFH staff have been engaging in educational opportunities and integrating this knowledge into policies and practices. DFH established a Health Equity team, which 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 are required to complete the series, and success is monitored and reported to leadership. 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 Racial Justice Workgroup within the Center for Community Health (CCH), which includes DFH as well as the Divisions of Nutrition, Chronic Disease Control and Prevention, and Epidemiology. The CCH Racial Justice Workgroup began a year long process in 2018 to focus their work on turning commitment to racial justice into action. A Racial Justice Work Group was formed, comprised of diverse representatives focused on achieving racial justice principles. In addition, a range of innovative training interventions are being implementing to build the capacity of health and human services providers, health care facilities, community-based organizations (CBOs) and larger communities to employ a health equity framework to improve health outcomes. NYS Department of Health staff participated in a Government Alliance on Race and Equity (GARE) training and became a GARE member in 2019.

As an outgrowth of the partnership between the University at Albany School of Public Health (SPH) and NYSDOH, 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 NY 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. A new graduate certificate in MCH launched 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 partnered with HRSA Work Force Development Technical Assistance Center to host a summer internship

opportunity for two student interns during summer 2019. The student interns jointly participated in a project to support Title V's strategy for CYSHCN in the Title V state action plan. The student interns worked closely with the internship preceptors and Title V leadership to develop and implement structured interviews and surveys of other state Title V CYSHCN programs and LHD CYSHCN programs to assess the supports and services provided locally. The interns produced a report that has been integrated into the current Title V Needs Assessment work.

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**

The NYS Title V Program has a long history of partnering with consumers, including families and family organizations to ensure family voice across the state's Maternal and Child Health (MCH) initiatives.

The NYS Title V program ensures there is a family voice represented in the state's MCH services and programs, through our local partners including local health departments (LHDs), universities and academic medical centers, hospitals and clinics, and community-based organizations. When procuring services, the Division of Family Health (DFH) requires local partners that receive contracts to ensure ongoing involvement and feedback is received from consumers who represent the diverse MCH population served in their community. Community involvement may take the form of membership on a board to guide services, workgroups to provide input regarding education materials or outreach strategies, or direct input from families served either from a survey or in-person listening forums. 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 state's large, diverse population.

NYS' Children and Youth with Special Health Care Needs (CYSHSN) Program requires the Resource Support Centers that provide technical support and assistance to counties employ a parent of a child with a special health care need to ensure that families can talk to a trusted messenger and that the programs' supports and services meet family's needs. The LHD CYSHCN Program work plan requires that they 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.

NYS's Early Intervention Program's (EIP) ensures there is a family voice through the State Systemic Improvement Program (SSIP) quality improvement teams. This quality improvement initiative aims to improve family outcomes in the EIP service delivery system. The SSIP work is highlighted in the Children with Special Health Care Needs section. In addition to the SSIP, the EIP supports 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.

The NYS Advisory Councils often include a family voice. Parents are members of the Early Intervention Coordinating Council as well as the Title V 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 Title V Advisory Council and NY's family representation to the Association of Maternal and Child Health Programs (AMCHP).

### III.E.2.b.iii. States 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 NYS Department of Health (NYSDOH) Maternal and Child Health (MCH) data capacity to support Title V program activities and contribute to data-supported decision making in MCH programs, including assessment, planning, implementation and evaluation. The importance of data capacity is readily recognized as critical to identifying needs of the MCH population, including the impact of structural racism. 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 and reduce disparities 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 and their impact.

The SSDI Principal Investigator, who is the Medical Director for the Division of Family Health (DFH), along with the DFH Associate Division Director, who is also an epidemiologist, and the SSDI Program Research Specialist guide the collection and analysis of the data that form the basis for the Five-Year Needs Assessment and the State Action Plan. Collectively, these describe NY's priority needs, key strategies and activities and National Outcome Measures (NOMs), national performance measures (NPMs) and state performance measures (SPMs) and structural and process measures. Staff partners 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, Title V staff guided the development, selection, refinement and/or tracking of data and performance measures that are associated with the Title V priorities for the purpose of ascertaining progress towards achieving reported goals. Staff also participated on teams to support the NYS Title V 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; contributed to ad hoc data analyses and wrote summaries of data analyses relevant to the MCH population for the Title V Application/Annual Report. These activities prepare Title V to submit the NPMs and related structural/process objectives as part of the 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 funded programs, and, from FFY 2018 through FFY 2022, SSDI staff will implement the plan for overcoming identified barriers. NYS is currently reporting seven of the Core/National Dataset elements and six of the Core/State Dataset elements as part of the Title V program. 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 NYSDOH 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 Bloodspot 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 (PRAMS); Immunization Information System; NYS Medicaid; Quality Assurance Reporting; Statewide Planning and Research Cooperative System (SPARCS); National Survey of Children's Health; Early Hearing Detection and Intervention; CDC Breastfeeding Report Card; National Immunization Survey; Sexually Transmitted Disease Surveillance; U.S. Current Population Survey; National Pediatric Nutrition Surveillance System; and U.S. 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:

- PRAMS Data: NYS, excluding NYC, PRAMS is combined with NYC PRAMS data each year to create a statewide PRAMS dataset that is used to update the PRAMS dashboard. The dashboard includes data from 2004-2017 that is presented as single year indicators in charts and tables as well as ten-year trend charts. Total prevalence as well as demographic breakdowns are available for 64 maternal and child health indicators. The PRAMS dashboard is used by Title V staff for the tracking of various programmatic activities, including oral health care during pregnancy, infant sleep positioning and breastfeeding practices.
- Vital Statistics Data: NYS has two vital records systems: one for NYC and one for NYS, excluding NYC. These data sets are combined, and birth and death data are linked. The 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 first quarter of 2020 (provisionary data). 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.
- 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 NYSDOH with the purpose of improving prenatal, obstetric and newborn care for mothers and infants in NYS. The SPDS was developed to make data available for the DOH and hospitals for monitoring and quality improvement. Web-based and modular in design, the Core module comprises the electronic birth certificate (EBC) that captures birth data in hospitals outside of NYC, and an additional module (NICU module) that captures data on high risk newborns admitted to neonatal intensive care units across 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 statewide 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 Improvement Project to reduce the percentage of infants born at less than 31 weeks' gestational age discharged from the NICU below the tenth percentile for postmenstrual age.
- Linked Birth, Death and Hospital Discharge Data: The NYS Maternal Mortality Review (MMR) aims to identify pregnancy-associated deaths and to conduct a comprehensive review of factors leading to these deaths and provide information to develop strategies and interventions to decrease their risk. This is achieved through complex linkages between NYS death records of women ages 10-65 years old, birth records, and SPARCS hospital discharge 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 NYSDOH Office of Quality and Patient Safety (OQPS) with the common goal of improving data quality and completeness on administrative state databases. During the reporting period, DFH obtained access to preliminary statewide death records for 2019 deaths and the first quarter of 2020 death records. Quarterly linkages between statewide vital records (death and birth file) and SPARCS hospital discharge data provide additional sources of data for maternal and infant mortality and morbidity efforts.
- Early Hearing Detection and Intervention EHDI-IS 2.0: A new version of the front-end web EHDI-IS application was developed, integrated with the New York State Immunization Information System (NYSIIS) and tested in 2018. EHDI-IS 2.0 has allowed hospitals, audiologists and primary care practitioners to document all hearing screening, diagnoses and referrals to early intervention.
- Linked Early Intervention Program (EIP) and Children and Youth with Special Health Care Needs (CYSHCN): 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 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. As part of program efforts, staff can see how many referrals EIP makes to CYSHCN Program. CYSHCN staff worked with EI on webinars to inform them about working in collaboration with CYSHCN staff, and once children age out, how to think about referring those children to the CYSHCN Program.

- NYSDOH All Payor Database (APD): During the reporting period, OQPS released the APD to Title V staff. The APD is 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." At present NY's APD includes hospital discharge (SPARCS) and Vital Records (VR) death data, plus 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 is 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. This platform will also be the basis of which the Title V program builds a Perinatal Data Module which will allow NYS birthing facilities access to timely data that will allow them to monitor their outcomes, including maternal mortality, and support quality improvement. This module will be modeled after California Maternal Quality Care Collaborative (CMQCC).

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

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 New York State of Health (NYSOH), New Yorkers can enroll 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.

Title V staff also working closely with the NYS Medicaid Program, which is co-located in the NYS Department of Health, on MCH initiatives, including the Children's Health Home (CHH) Program and the First 1000 Days on Medicaid.

The CHH program was launched in December 2016, with 16 Health Homes designated to serve children. The Title V Children and Youth with Special Health Needs Program and the Early Intervention Program work closely with the CHH to provide subject matter expertise in the development of policies and practices to ensure appropriate connections with local programs and timely referrals for children who may be eligible and benefit from the CHH program.

The First 1000 Days on Medicaid initiative began in July 2017. 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. 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 First 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.

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

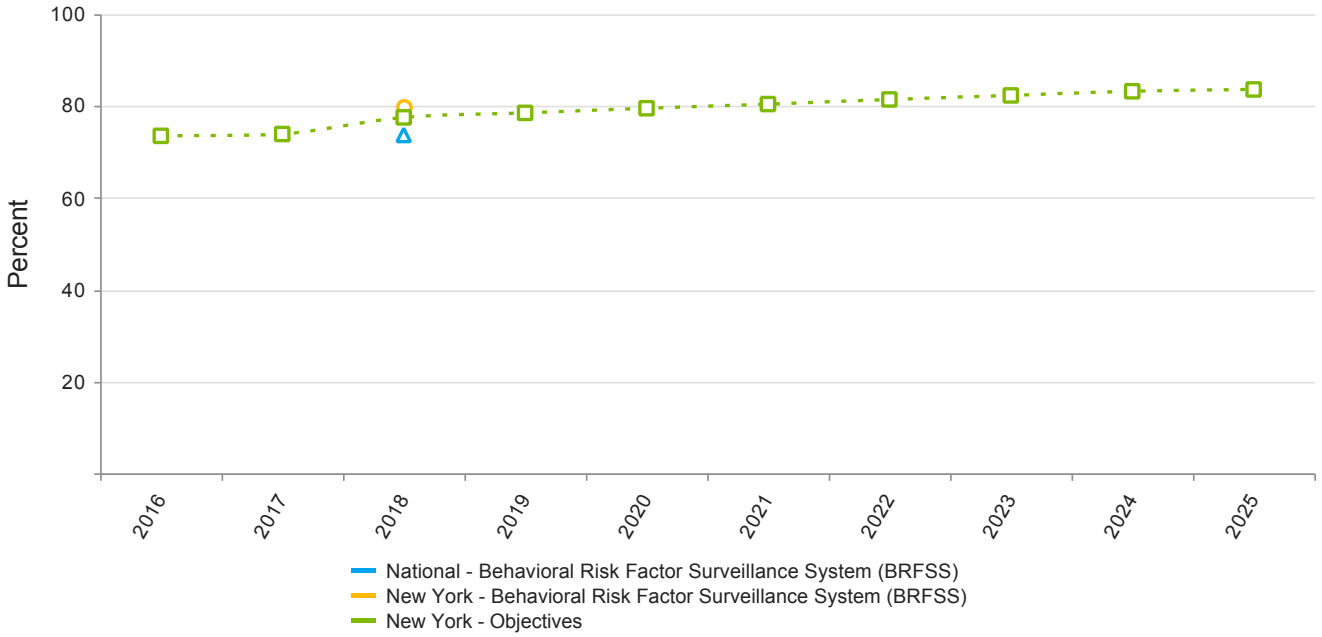
**Women/Maternal Health**

**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-2017 | 80.0 | NPM 1 |
| NOM 3 - Maternal mortality rate per 100,000 live births | NVSS-2014_2018 | 17.8 | NPM 1 |
| NOM 4 - Percent of low birth weight deliveries (<2,500 grams) | NVSS-2018 | 8.1 % | NPM 1 |
| NOM 5 - Percent of preterm births (<37 weeks) | NVSS-2018 | 9.0 % | NPM 1 |
| NOM 6 - Percent of early term births (37, 38 weeks) | NVSS-2018 | 23.7 % | NPM 1 |
| NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths | NVSS-2017 | 5.3 | NPM 1 |
| NOM 9.1 - Infant mortality rate per 1,000 live births | NVSS-2017 | 4.6 | NPM 1 |
| NOM 9.2 - Neonatal mortality rate per 1,000 live births | NVSS-2017 | 3.1 | NPM 1 |
| NOM 9.3 - Post neonatal mortality rate per 1,000 live births | NVSS-2017 | 1.5 | NPM 1 |
| NOM 9.4 - Preterm-related mortality rate per 100,000 live births | NVSS-2017 | 172.8 | 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-2017 | 5.0 | NPM 1 |
| NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year | NSCH-2017_2018 | 11.1 % | NPM 13.1 |
| NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health | NSCH-2017_2018 | 91.2 % | NPM 13.1 |
| NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females | NVSS-2018 | 11.7 | NPM 1 |
| NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth | PRAMS-2018 | 15.5 % | NPM 1 |

## National Performance Measures

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




| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: Behavioral Risk Factor Surveillance System (BRFSS)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | 73.4 | 73.8 | 77.4 | 78.4 |
| Annual Indicator | 68.4 | 73.3 | 69.8 | 79.6 |
| Numerator | 2,471,455 | 2,653,864 | 2,510,557 | 2,826,660 |
| Denominator | 3,612,104 | 3,619,067 | 3,597,587 | 3,550,054 |
| Data Source | BRFSS | BRFSS | BRFSS | BRFSS |
| Data Source Year | 2015 | 2016 | 2017 | 2018 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 79.4 | 80.3 | 81.3 | 82.2 | 83.1 | 83.5 |

**Evidence-Based or –Informed Strategy Measures**

**ESM 1.1 - Percent of Maternal and Infant Community Health Collaboratives (MICHC) program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker (CHW)**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 55.3 | 58.1 | 61.0 | 64.0 | 67.2 |

**ESM 1.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 25.6 | 26.9 | 28.0 | 29.0 | 30.0 |

**State Action Plan Table**

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

## Priority Need

Address equity, bias, quality of care, and barriers to access in health care services for women and families, especially for communities of color and low-income communities

## NPM

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

## Objectives

Objective WMH-1: Increase the percent of women, ages 18 through 44, with a preventive medical visit in the past year by 5%, from 79.6% in 2018 to 84.6% in 2022. (BRFSS)

Objective WMH-2: Reduce the maternal mortality rate by 10%, from 17.8 deaths per 100,000 live births in 2014-2018 to 16 deaths per 100,000 live births in 2018-2022. (NVSS)

Objective WMH-3: Reduce the rate of severe maternal morbidity per 10,000 delivery hospitalizations by 5%, from 80 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2017 to 76 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2021. (HCUP-SID)

Objective WMH-4: Reduce the percent of women who have depressive symptoms after birth by 5%, from 13% in 2017 to 12.4% in 2021. (PRAMS)

## Strategies

Strategy WMH-1: Integrate specific activities across all relevant Title V programs to promote the health and wellness of people of child-bearing age, including enrollment in health insurance, routine well visits, pregnancy planning and prevention, prenatal, and postpartum care.

Strategy WMH-2: Strengthen coordination between birthing hospitals, outpatient health care providers, and other community services to make support for birthing parents and their families more comprehensive and continuous.

Strategy WMH-3: Apply public health surveillance and data analysis findings to improve services and systems related to maternal and women’s health care.

Strategy WMH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact women’s health and use of health care across the life course.

| ESMs | Status |
|---|---|
| ESM 1.1 - Percent of Maternal and Infant Community Health Collaboratives (MICHC) program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker (CHW) | Active |
| ESM 1.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year | 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

Acknowledge and address the fundamental challenges faces by families in poverty and near-poverty, including the “working poor” as a result of systemic barriers, including racism.

### NPM

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

### Objectives

Objective WMH-1: Increase the percent of women, ages 18 through 44, with a preventive medical visit in the past year by 5%, from 79.6% in 2018 to 84.6% in 2022. (BRFSS)

Objective WMH-2: Reduce the maternal mortality rate by 10%, from 17.8 deaths per 100,000 live births in 2014-2018 to 16 deaths per 100,000 live births in 2018-2022. (NVSS)

Objective WMH-3: Reduce the rate of severe maternal morbidity per 10,000 delivery hospitalizations by 5%, from 80 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2017 to 76 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2021. (HCUP-SID)

Objective WMH-4: Reduce the percent of women who have depressive symptoms after birth by 5%, from 13% in 2017 to 12.4% in 2021. (PRAMS)

### Strategies

Strategy WMH-1: Integrate specific activities across all relevant Title V programs to promote the health and wellness of people of child-bearing age, including enrollment in health insurance, routine well visits, pregnancy planning and prevention, prenatal, and postpartum care.

Strategy WMH-2: Strengthen coordination between birthing hospitals, outpatient health care providers, and other community services to make support for birthing parents and their families more comprehensive and continuous.

Strategy WMH-3: Apply public health surveillance and data analysis findings to improve services and systems related to maternal and women’s health care.

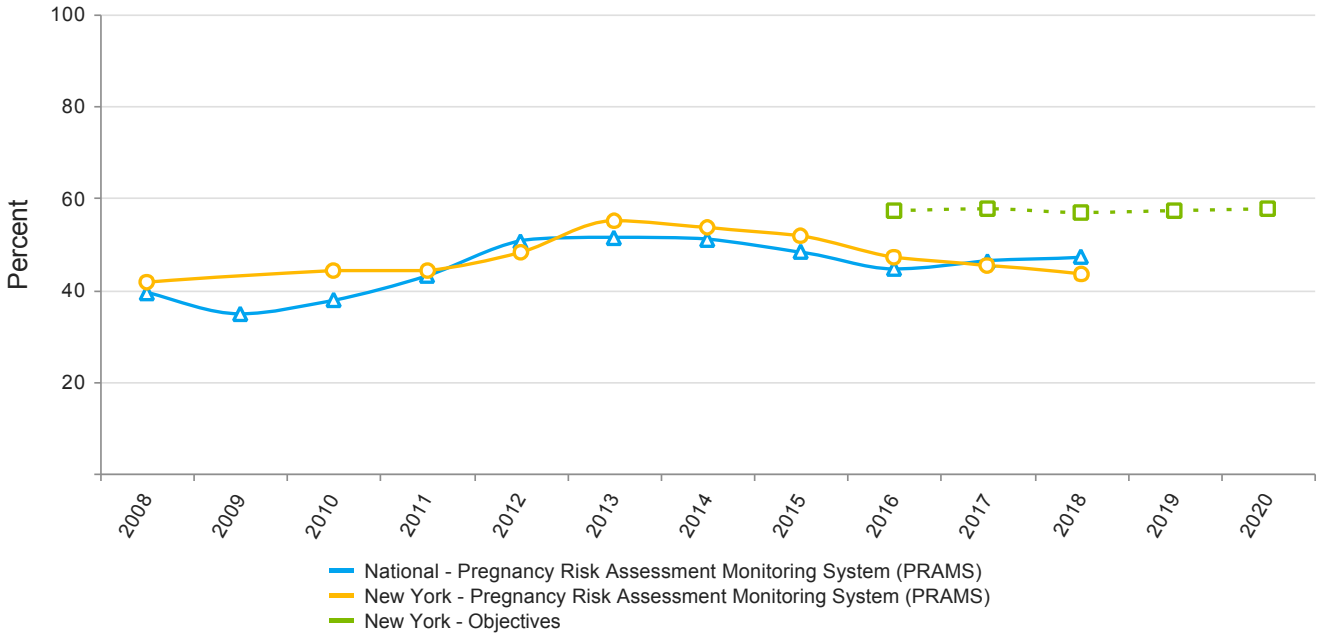
Strategy WMH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact women’s health and use of health care across the life course.

| ESMs | Status |
|---|---|
| ESM 1.1 - Percent of Maternal and Infant Community Health Collaboratives (MICHC) program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker (CHW) | Active |
| ESM 1.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year | 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 |

**2016-2020: National Performance Measures**

**2016-2020: 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** | **2019** |
| Annual Objective | 57.2 | 57.6 | 56.8 | 57.2 |
| Annual Indicator | 54.9 | 51.7 | 45.4 | 43.3 |
| Numerator | 117,570 | 110,325 | 95,006 | 42,679 |
| Denominator | 214,301 | 213,585 | 209,242 | 98,649 |
| Data Source | PRAMS | PRAMS | PRAMS | PRAMS |
| Data Source Year | 2013 | 2015 | 2017 | 2018 |

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | 57.2 | 57.6 | 56.8 | 57.2 |
| Annual Indicator | 53.5 | 51.7 | | |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | PRAMS NYS | PRAMS NYS | | |
| Data Source Year | 2014 | 2015 | | |
| Provisional or Final ? | Final | Final | | |

**2016-2020: Evidence-Based or –Informed Strategy Measures**

**2016-2020: 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** | **2019** |
| Annual Objective | | 10 | 50 | 50 |
| Annual Indicator | 36.7 | 45.3 | 56.6 | 60.5 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | MICHC reports | MICHC reports | MICHC reports | MICHC reports |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Final | Final | Final | Final |

**2016-2020: State Performance Measures**

**2016-2020: 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** | **2019** |
| Annual Objective | | 45 | 36.4 | 37.6 |
| Annual Indicator | 34.6 | 35.3 | 35.3 | 35.3 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | BRFSS | BRFSS | BRFSS | BRFSS |
| Data Source Year | 2014 | 2016 | 2016 | 2016 |
| Provisional or Final ? | Final | Final | Final | Provisional |

**2016-2020: 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** | **2019** |
| Annual Objective | | 8 | 25 | 25 |
| Annual Indicator | 27 | 24.5 | 24.5 | 24.5 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | Medicaid Claims | Medicaid Claims | Medicaid Claims | Medicaid Claims |
| Data Source Year | 2016 | 2017 | 2017 | 2017 |
| Provisional or Final ? | Final | Final | Final | Provisional |

**2016-2020: 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** | **2019** |
| Annual Objective | | 72 | 73 | 75 |
| Annual Indicator | 71.7 | 71.6 | 70.8 | 70.8 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | CDC Water Fluoridated Reporting System | CDC Water Fluoridated Reporting System | CDC Water Fluoridated Reporting System | CDC Water Fluoridated Reporting System |
| Data Source Year | 2017 | 2018 | 2019 | 2019 |
| Provisional or Final ? | Final | Final | Final | Provisional |

**Women/Maternal Health - Annual Report**

**FFY 2019 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. The NYS Title V program promotes and supports a myriad of efforts to improve the health of all women.

Over the past year pursuant to the State Action Plan (SAP), the NYS Title V program continued to focus on improving access to health care, increasing access to the most effective forms of contraceptives, supporting preconception health, promoting whole women's health through the life course, and improving screening and treatment for maternal depression and substance use. Of importance to 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.

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 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 Maternal Mortality (MMR) Initiative in 2010, which is a comprehensive review of all maternal deaths. In the MMR Initiative, the NYS Department of Health's (NYSDOH) 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 report of maternal deaths for 2012- 2014 was published. 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 3.2 to 1 in 2011-2013, with the most current ratio (2015-2017) falling at 3.3. 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 3.0 in 2015-2017. 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 decreased slightly from 3.9 in 2013-2015 to 3.4 in 2015-2017. This decrease in Black to White ratios was due to a slight but bigger decrease in the maternal mortality rate among Black women than the decrease in the 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 216 cases in the 2016 cohort and all 214 cases in the 2017 cohort have been completed. For 2018, 45% of the 173 identified cases are complete using the Centers for Disease Control and Prevention (CDC) hosted Maternal Mortality Review Information Application (MMRIA) System.

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 Department's Office of Health Insurance Programs (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
- 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 continued to work on several of Governor Cuomo's priorities to improve maternal health outcomes and address health disparities.

After meeting three times in 2018, the Task Force on Maternal Mortality and Disparate Racial Outcomes (Taskforce) released its report 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 part of Governor Cuomo's initiative to reduce maternal mortality, the NYSDOH led by Dr. Zucker conducted a series of seven listening sessions across NYS to engage Black women in conversations about their experiences accessing health care and giving birth in NYS. Through these seven sessions over 240 women participated and shared their experiences. Feedback from each session was gathered and analyzed by NYSDOH staff to identify common barriers, opportunities, and suggestions for improvement. That information was shared with taskforce members to aid in the development of recommendations and eventually compiled in a report entitled, "Voice Your Vision – Share Your Birth Story: A Conversation on Maternal Health in New York State" which was released in Summer 2019.

Throughout the listening sessions women identified common barriers including:

- 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
- 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
- Increase availability of community services and resources, for example, community health worker services, home visiting services.

Direct engagement of community members was critical to the Taskforce recommendations, and the NYSDOH 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 ongoing project included in both the Governor's Maternal Mortality efforts and as a priority in the First 1000 Days on Medicaid initiative is a pilot project to assess feasibility of making the CenteringPregnancy prenatal care model a Medicaid covered benefit. Led by the Department's OHIP, this project focused on studying the impact of CenteringPregnancy on infant health outcomes. NYSDOH engaged the Centering Healthcare Institute (CHI), the agency that developed the Centering Pregnancy model, to help develop tools and project materials to assess the impact of their model in areas of NYS with the poorest birth outcomes. Webinars and ongoing TA have been held for both Managed Care Plans and providers/clinics who will be participating in the project. 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. Several Medicaid Managed Care health plans and prenatal care clinics expressed interest and have been engaged in the pilot project. Enrolled sites are working to engage women in the pilot study, both as part of the control and experimental groups. Phase 1 of the project, with those clinics already operating an established Centering Program, began in June 2019. Clinics will continue to serve women, collect data on their participation in CenteringPregnancy, and report information on their birth outcome upon delivery. Phase 2, which will expand to include sites just beginning to implement CenteringPregnancy, will begin in Spring 2020.

To build on NYSDOH's work related to maternal death reviews, the Title V staff is currently implementing an enhanced process for maternal death reviews that was developed in collaboration with ACOG-NY. The goal of these efforts is to address this significant public health issue with not only the population health approach, which includes surveillance and planning on a statewide level, but also provide health care providers and others with information needed to improve and

enhance health care standards and practices. Substantial progress was made towards achieving these objectives during the reporting period.

NYS was awarded a five-year CDC ERASE MM grant in August 2019. The purpose of this grant is to support Maternal Mortality Review Committees to prevent maternal deaths. Currently, NYS has two active, multidisciplinary maternal mortality review committees: The NYSDOH Maternal Mortality Review Board (MMRB) and the NYC Department of Health and Mental Hygiene's (NYCDOHMH) Maternal Mortality and Morbidity Review Committee (M3RC). Under this grant, NYSDOH will collaborate with NYCDOHMH to identify and review all pregnancy-associated deaths in NYS. The MMRB will review all deaths occurring outside of NYC, while the M3RC will review all deaths occurring within NYC. Both committees will conduct a complete assessment of the causes of death, factors leading to death, preventability, and opportunities for intervention. The data and determinations for both committees will be entered into the statewide CDC central-hosted Maternal Mortality Review Information Application (MMRIA), and the NYSDOH will compile and analyze the statewide data to inform opportunities for intervention and provide recommendations for statewide initiatives.

Legislation to create and empower the NYS MMRB was signed into law on August 1, 2019. In addition to creating, empowering, and protecting the MMRB itself, the legislation included explicit powers and protections for the NYSDOH in its role supporting the MMRB. Title V staff will use this authority to gather case information from more sources than were previously available, which will enable the MMRB to examine the details of these women's lives in order to identify and understand the non-clinical factors that may have contributed to the deaths. The MMRB held its first full meeting on August 22, 2019.

The MMRB's 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) and its partners (e.g., hospital associations, professional associations, regional perinatal centers and affiliate obstetrical hospitals, among others). A statewide maternal mortality report will also be issued to provide data and information that can be broadly used to improve maternal outcomes. The 2014 maternal mortality report is complete and posted on the Department's website: https://health.ny.gov/community/adults/women/docs/maternal_mortality_review_2014.pdf

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 67% (83/123) 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 increased by 27.0% during the project period, from 64.4% in March 2018 to 81.8% in October 2019. Documentation of risk assessment for obstetric hemorrhage completed post-partum (between birth and discharge) increased by 74.4% during the project period, from 31.7% in March 2018 to 55.3% in October 2019.

Title V funding supports the work of the New York State Family Planning Program (FPP), a statewide network of providers that deliver high-quality comprehensive reproductive health services to low-income individuals. The FPP's contracted training and technical assistance center, the New York State Family Planning Training Center (NYFPTC), has provided training to family planning providers to emphasize equity and reinforce reproductive justice principles in the delivery of family planning services. In 2019, the annual NYS Family Planning Program provider meeting featured a keynote address related to exploring unintended pregnancies through a reproductive justice lens. In addition, the NYFPTC conducted a series of in-person regional trainings for family planning providers across the state that focused on developing individual and organizational strategies to mitigate unconscious 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 Maternal and Infant Community Health Collaborative (MICHC) program, Community Health Workers (CHWs) focused on educating women on improved birth spacing, adherence to the postpartum visit, and use of an effective contraceptive method. In 2019, the MICHC program connected 397 women to health insurance, 79.7% of clients engaged in prenatal care in the first trimester, and 39.9% of postpartum clients attended a postpartum visit and an additional 45% had a visit scheduled at the time of reporting. As per the recommendations of the Task Force on Maternal Mortality and Disparate Racial Outcomes, the scope and breadth of work of the MICHC program were enhanced via the CHW Expansion grant. In August 2019, CHW Expansion contracts were awarded to the 23 established MICHC agencies throughout NYS 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. With these funds, approximately 50 new CHWs were hired statewide to provide services to an additional 2,000 prenatal and postpartum women.

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 2019, 49.0% of clients enrolled in the Maternal, Infant, and Early Child Home Visiting (MIECHV) programs attended a postpartum visit within 8 weeks of their delivery.

Another strategy used to engage more women in health care is the promotion of telehealth. In January 2019, Governor Cuomo launched efforts to promote access to rural telehealth services for perinatal care. This initiative includes four components: providing up to $5 million in capital funds to increase regional perinatal center, rural birthing hospital and private provider access and capacity for perinatal telehealth services; establish a Perinatal Telehealth Workgroup with national experts including the founders of the successful Arkansas Antenatal and Neonatal Guidelines, Education and Learning System (ANGELS); engaging in hospitals participating in the Rural Health Care Access Development Program (RHCADP) to encourage expansion of perinatal telehealth initiatives; and establishment of a Project ECHO™ (Extension for Community Healthcare Outcomes) telementoring initiative to engage and enhance obstetric provider skills.

In order to meet the goals of this initiative, Title V staff collaborated with the Office of Primary Care and Health Systems Management (OPCHSM) to integrate the telehealth capital funds into a Statewide Healthcare Transformation Grant; the request for applications for these funds will be issued in early 2020. Additionally, Title V staff have collaborated with the Department's Charles D. Cook Office of Rural Health, to provide information and updates for RHCADP participating hospitals.

In May 2019, the Department launched the Rural Perinatal Telehealth Workgroup, which includes representatives from rural birthing hospitals, regional perinatal centers that serve rural communities, rural private practitioners, and representatives from the ACOG-NY, New York State Association of Licensed Midwives, HANYS, Arkansas ANGELS project, and other stakeholders. The first meeting included a presentation from Dr. Curtis Lowery, founder of Arkansas ANGELS, Tina Benton (ANGELS Project Manager), Dr. Thao Doan (Westchester Medical Center Perinatal ECHO Project), and Drs. Heather Brumberg and Edmund LaGamma (Westchester Medical Center RPC).

Finally, in collaboration with OPCHSM, Westchester Medical Center launched a pilot Project ECHO™ on perinatal health. The first session, Perinatal Measles, Prevention and Vaccine Hesitance and Refusal, was presented by Dr. Shetal Shah, MD, FAAP on June 27, 2019, reaching 15 providers at 9 spoke sites. This timely presentation was offered at nine spoke sites in the Lower Hudson Valley; at the time, this region had a significant measles outbreak, as part of the largest measles outbreak in the US in recent history. The second session, Hypertensive Disorders of Pregnancy, was presented by Dr. Frances Hseih, MD, on September 26, 2019, and reached 16 attendees at 11 spoke sites.

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 Department's OPCHSM notified all obstetric hospitals of this requirement. Staff also researched and updated resources on the NYSDOH web site and continue to regularly review this information to ensure resources are current and applicable. In addition, the Title V program participated in the Moving on Maternal Depression (MOMD) project, convened by the Center on Law and Social Policy (CLASP), 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. New York's goal for the MOMD project is to improve the health and well-being of mothers and children by strengthening state and local policies that identify, screen, prevent, refer, and treat maternal depression and other maternal mental disorders. 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 NYSDOH promoted awareness through social media and revised the NYSDOH 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 (ECCS) 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; the second is 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. OHIP worked with OMH and Office of Addiction Services and Support (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 Spring 2020. 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. To develop the pilot, Title V staff have been involved in the Aligning Early Childhood and Medicaid (AECM) initiative, which provides technical assistance to help design the pilot. The AECM initiative has linked OHIP and Title V staff to other states who have aligned Medicaid and home visiting. The pilot is anticipated to begin in Spring of 2020.

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, NYSDOH, OASAS, American Academy of Pediatrics (AAP), ACOG-NY, Postpartum Resource Center, and the Children's Agenda. Title V staff participate on the core team and on several subcommittees. 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 scope, 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.

To build on the work that began in June 2018 at the CLASP learning collaborative, Title V staff have participated on regular calls with the core team, as well as the workforce, equity, and data subcommittees. The data subcommittee is committed to developing a matrix that includes data measures on programs throughout NYS. The equity subcommittee worked to set up two equity webinars to gather input on equity that will help inform the in-person workforce meeting as well as other aspects of our work. The workforce subcommittee has worked to develop a continuum of care that highlights preconception, pregnancy, high-risk, and postpartum activities to address maternal depression. This document will help to inform the core group's work on addressing maternal depression in NYS.

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 Healthy Steps providers are fully operational, engaging new parents to enroll their infants in the Healthy Steps program by 4 months of age. Over 5,000 children and their families were served as of September 30, 2019.

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 9,000 maternal depression screens for families enrolled in the program and provided over 3,000 maternal depression related referrals and/or services. 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 2,300 surveys for Adverse Childhood Experiences.

To further enhance supports and services, the Title V program successfully collaborated on the development of an 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 NYSDOH 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 universal referral algorithm and form for families with young children to use in 6 local pediatric practices to make referrals to Erie County and Niagara County Early Intervention and local community supports. At the other end of the state, under the leadership of Dr. Elizabeth 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. In addition, 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 Parenting Education Partnership, and workgroups on the NYS Governor's Early Childhood Advisory Council and the Governor's Child Care Availability Task Force.

The Title V program also collaborated with CCF on the Preschool Development Birth through Five (NYSB5) project ($13.4 million in federal funding for the next three years) to strengthen and build new partnerships, coordinate the NYS early childhood care and education system, improve transitions, expand parent choice and knowledge and promote equity with a focus on vulnerable populations. The grant also seeks to institutionalize parent voice, align and strengthen interdisciplinary professional development, expand access to high quality early care and education programs and identify strategies to maximize and coordinate funding. Title V staff have been collaborating with the CCF on several NYSB5 project activities. To complete the NYSB5 Needs Assessment, OHIP provided data about Medicaid usage for young children and regularly attended the NYSB5 bi-monthly partner meetings. Title V staff participated in the NYSB5/NYS ECAC Strategic Plan Development over the course of several months. Collaboration with CCF is further strengthened through work with the First 1000 Days on Medicaid Infant Mental Health and Home Visiting Work Groups. The NYSDOH is also included as a partner on the NYSB5 Parent Portal (www.nysparenting.org) with links to NYSDOH resources. NYSB5 launched a statewide Talking Is Teaching Media Campaign in collaboration with the NYSDOH, OpAD, and the NYS Office of Child and Family Services (OCFS), which translated posters in 6 languages (Spanish, Russian, Chinese, Haitian-Creole, Korean, Bangladeshi). NYSDOH and CCF also worked closely in the development of a Family Resource Guide to Early Childhood Services – Prenatal through Age Five. The resource includes programs and supports available to families with children 0-5 like home visiting, childcare, early intervention, head start, prekindergarten and preschool special education. Title V staff presented at the first annual NYSB5 Technical Assistance Alignment Summit and worked with NYSB5 partners to establish an understanding of the technical assistance resources in NYS and begin discussion around ways to maximize resources, reduce redundancies, address technical assistance gaps and improve effectiveness.

Addressing the opioid epidemic is a public health priority in NYS, mirroring the national experience. In 2014, Governor Cuomo established the Heroin and Opioid Task Force and signed the Combat Heroin Legislation which established a multi-

faceted response to the opioid epidemic, with a focus on prevention, harm reduction, treatment, recovery and law enforcement. In response to the Task Force and legislation, NYSDOH developed an interagency opioid surveillance workgroup that consists of various state agencies and stakeholders with an interest in addressing this public health priority. The workgroup developed a comprehensive website for opioid-related data in NYS (http://www.health.ny.gov/statistics/opioid) to improve the timeliness of reporting opioid-related data to key stakeholders. This site provides the most recent data (NYS Opioid Annual Report 2019) 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. The NYSDOH created an interactive Opioid Data Dashboard that is a visual presentation of opioid related indicators tracking fatal and nonfatal opioid overdoses, opioid prescribing, opioid use disorder treatment and the overall opioid overdose burden. Title V staff share the reports and dashboard links, as well as other resources such as webinars and educational materials, with NYSDOH Division of Family Health (DFH)-funded perinatal programs, hospitals involved in perinatal quality improvement efforts for maternal Opioid Use Disorder/Neonatal Abstinence Syndrome 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, help tailor interventions, and show improvements 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 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 who use 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. NYS OASAS has issued a Local Services Bulletin to its providers with instructions on how to work with pregnant women in relation to Plans of Safe Care. NYS OCFS and NYSDOH Title V staff are collaborating to identify how best to work with hospitals on reporting.

Title V staff in collaboration with several NYSDOH sister programs, including the OHIP and the Office of Quality and Patient Safety (OQPS) staff have been co-leading an analytic project to conduct two studies of maternal opioid use and neonatal abstinence syndrome (NAS). The workgroup met four times during this reporting period 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. The studies are on hold indefinitely due to competing needs for analytic resources.

Further, the NYSPQC, in partnership with ACOG-NY, HANYS and GNYHA, and with support from NICHQ, is leading the NYS Opioid Use Disorder (OUD) in Pregnancy & Neonatal Abstinence Syndrome Project. This learning collaborative, which kicked-off in September 2018, and is currently being piloted in 17 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. To date, topic areas of focus have included: verbal screening related to substance use for all pregnant women during the prenatal period and on admission to the birth hospitalization; trauma informed care; improved communication between obstetrics and pediatrics; reducing stigma; training clinical staff on the signs and severity of NAS; improving both pharmacologic and non-pharmacologic care for infants with NAS; Eat Sleep Console as a method of treatment for infants with NAS; considerations for breastfeeding for women who use substances; and linkages to care. A statewide project expansion is planned for Spring 2020. The NYSPQC is participating in the national Alliance for Innovation in Maternal Health (AIM) through this initiative.

During the reporting period, the NYSPQC began participating in the Association of State and Territorial Health Officials (ASTHO) Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative (OMNI) Learning Community. The purpose of the learning community is to provide technical assistance, build capacity, and disseminate strategies and best practices to support program and policy implementation on substance use disorder (SUD) among pregnant and postpartum women and infants prenatally exposed to opioids, including NAS. Agencies and organizations convened as part of this effort include ACOG-NY; HANYS; GNYHA; Northwell Health; NYSDOH OHIP, AIDS Institute, and Office of Drug User Health; OASAS; NICHQ; and Community Health Care Association of New York State (CHCANYS). The overarching goal of the NYS OMNI team, in alignment with the NYS OUD in Pregnancy & NAS Project's goal of increasing the percent of pregnant women screened for SUD with a verbal screening tool, is to train prenatal care hospital staff on standardized screening, develop provider resources for screening and referral, and connect diverse work happening across the state.

As an outgrowth of the OASAS in-depth technical assistance project and the NYSPQC OUD in Pregnancy & NAS Project, ACOG-NY 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-NY developed and released recommendations for NYS from the convening that included funding in the state budget for:

- One Children and Recovering Mothers (CHARM) champion at each of the Regional Perinatal Centers (RPCs)
- Establishment of a division for CHARM-related activities that includes a state coordinator specifically for regional "hub & spoke" implementation components given the geographic expanse of NYS
- 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, NYSDOH's Growing Up Healthy Hotline (GUHH), NY's Title V 24/7 phone line provides information and referral in English, Spanish and 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. From October 1, 2018 to September 30, 2019, GUHH responded to 12,547 calls, which included 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: Percentage of women with a past year preventive medical visit; data are obtained through Behavioral Risk Factor Surveillance System (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 NYS 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 calculated from BRFSS data showed a slight drop from 37.3% in 2014 to 35.1% in 2016; this may 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 calculated using Medicaid claims data, declined from 27% in 2015 to 24.5% in 2016.

NYS Title V Program has selected several NOMs to evaluate this priority. NOM #2 Percent of delivery or postpartum hospitalizations with an indication of Severe Maternal Mortality (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. Since federal data are no longer available/reportable for NOM #3 Maternal mortality rate per 100,000 live births, NYS is now reporting this measure

using Maternal Mortality Review (MMR) deliberations and NYS vital statistics. Based on the MMR result for the 2017 cohort, the number of pregnancy related deaths during pregnancy or within 42 days of the end of pregnancy was 24. Based on NYS vital statistics, the number of live births in 2017 was 228,501. As a result, the latest NYS rate for NOM #3 Maternal mortality rate per 100,000 live births is 10.5. 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 decline, decreasing from 2.0% in 2015-2016 to 1.0% in 2016-2017, which is lower than the national average of 2.0%. Finally, for NOM #11 The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births, 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.

**Women/Maternal Health - Application Year**

**Application for FY2021**

For Women's and Maternal Health (WMH), New York's Title V program selected **National Performance Measure (NPM) 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year.** This NPM was selected because it is foundational to women's health throughout the life course, is supported by population health data demonstrating a need for continued improvement, and relates directly to several priorities voiced by women and families through community listening forums, including awareness of community resources, transportation, social support, and health care access and quality. This NPM also aligns directly with the NYS Prevention Agenda goal to increase use of primary and preventive health care services among women of all ages, especially women of reproductive age.

While NPM 1 directly measures annual preventive medical visits, it should be viewed as part of a continuum of primary and preventive care that also includes preconception, reproductive and sexual health, family planning, prenatal, and postpartum care, and that includes a full spectrum of medical, mental and behavioral health, oral health, and other supports and services.

Increasing access to comprehensive, high quality, and equitable health care services has been identified as a key element of efforts to eliminate the striking racial and ethnic disparities in mortality and morbidity outcomes. A recent report ranked New York State (NYS) 23rd in the nation for the rate of maternal mortality. While NYS's maternal mortality rate has been declining, racial disparities in maternal deaths are persistent, with maternal deaths 3-4 times more common among Black women compared to White women. Severe maternal morbidity also fundamentally affects the lives of birth persons, newborns, families and health care provider teams. It 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. Perinatal depression is among the most common morbidities during pregnancy and postpartum periods, with significant implications for the health and well-being of the entire family. NYS women and families consistently highlighted maternal depression as a challenge requiring more attention and supports.

The following specific objectives were established to align with this performance measure:

**Objective WMH-1**: Increase the percent of women, ages 18 through 44, with a preventive medical visit in the past year by 5%, from 79.6% in 2018 to 84.6% in 2022. (BRFSS)

**Objective WMH-2:** Reduce the maternal mortality rate by 10%, from 17.8 deaths per 100,000 live births in 2014-2018 to 16 deaths per 100,000 live births in 2018-2022. (NVSS)

**Objective WMH-3:** Reduce the rate of severe maternal morbidity per 10,000 delivery hospitalizations by 5%, from 80 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2017 to 76 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2021. (HCUP-SID)

**Objective WMH-4:** Reduce the percent of women who have depressive symptoms after birth by 5%, from 13% in 2017 to 12.4% in 2021 (PRAMS)

Four strategic public health approaches were identified to accomplish these objectives over the next five years. These are presented in the Action Plan Table, and each is described in more detail here, with specific program and policy activities that will be implemented to advance the broader strategic approach in the upcoming year.

**Strategy WMH-1: Integrate specific activities across all relevant Title V programs to promote the health and wellness of people of child-bearing age, including enrollment in health insurance, routine well visits, pregnancy planning and prevention, prenatal, and postpartum care.**

Improving the health of people of child-bearing age requires a life course approach to be most effective. Preventive medical visits are a key opportunity for delivering health education and reinforcing health-promoting behaviors. Preventive visits help to identify chronic conditions, such as hypertension and diabetes, in child-bearing people that could contribute to maternal morbidity and mortality. Family planning and reproductive health visits ensure that people of child-bearing age have access to contraception for prevention of pregnancy, and counseling on reproductive life planning, appropriate birth spacing, and preconception health. Title V programs also provide enabling services, such as social support and referrals/linkages to a wide range of community services, to holistically address health and wellness, including mental health and social determinants of health, for people of child-bearing age. Incorporating specific activities across programs leverages the public health infrastructure and capacity supported through previous and ongoing Title V investments.

Through the Maternal & Infant Community Heath Collaboratives (MICHC) program, community health workers (CHWs) conduct basic health and well-being assessments in the prenatal and postpartum periods, using standardized evidence-based and/or validated screening tools, to identify and prioritize needs of the individuals and families served. Assessments are completed at enrollment and updated throughout clients' service periods and individualized care plans are developed based on the needs identified. CHWs receive annual training on how to talk with families about difficult topics like mental health and depression, using a trauma informed care approach, and including how to manage emergency situations. CHWs also connect clients and families to needed services and provide enhanced social support. CHWs help ensure early and consistent participation in preventive and primary health care services, including early prenatal care, particularly for those individuals not engaged in care and other supportive services. CHWs provide health information to increase clients' knowledge and ability to self-advocate and make informed health care decisions, with the goal of helping families achieve optimal health, self-sufficiency, and overall well-being.

MICHC programs coordinate outreach and engagement activities with other home visiting programs serving the same communities including programs supported by New York's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative. MICHC and MIECHV programs coordinate outreach, referral, assessment and intake processes to find and engage pregnant and parenting families and ensure they are connected with home visiting programs and supportive services responsive to their needs.

The NYS Family Planning Program (FPP) supports 43 Article 28 health facilities (i.e., hospitals and clinics) that operate 156 family planning service sites across the state. Through these service sites, the FPP delivers comprehensive, confidential reproductive health services for low-income, uninsured and underinsured women and men of reproductive age. Services provided include contraceptive services; preconception planning and counseling services; pregnancy testing and related counseling; preventive services such as basic health screening, screening for sexually transmitted diseases, HIV counseling and testing, breast and cervical cancer screening; and appropriate referrals and health education. Ensuring continued access to these core primary and preventive services is essential.

As reinforced by the community forums, increasing awareness of available resources among both consumers and providers is critical. The use of social media messages can enhance awareness of the state's Growing Up Healthy Hotline service, which in turn provides callers with linkages to local community resources, supports, and services including Supplemental Nutrition Program for Women, Infants and Children (WIC), Medicaid, Family Planning, and prenatal care. Social media and other emerging communication forums online have the potential to reach large and diverse populations. When messages are developed using science-based health messaging, social media can be a communication medium that can educate and influence health decision making.

The NYS Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2020-21 year:

- Across all programs, enhance promotion of the NYS Growing Up Healthy Hotline to increase awareness of available community resources, supports, and services including WIC, Medicaid, family planning, and prenatal care.

- Through the Regional Perinatal Centers (RPCs) and networks of affiliate birthing hospitals, support and enhance capacity to provide high quality perinatal telehealth services and perinatal subspecialty providers, particularly to rural communities and communities with disproportionate access to such services. Telehealth services will be tailored based on regional assessments of provider and affiliate hospital needs, to include routine prenatal and postpartum care and/or specialty care such as maternal-fetal medicine, radiology, and genetic counseling.
- Through the Maternal and Infant Community Health Collaboratives (MICHC) and Maternal Infant and Early Childhood Home Visiting (MIECHV) programs, integrate use of virtual home visiting services to increase acceptance and support of services for hard to reach families. Recent experience suggests that virtual home visits conducted in the context of the response to COVID-19 have helped to maintain communication and allow for essential CHW and home visiting services to continue including providing health information, support and referral and follow-up for preventive and prenatal care visits.
- Through the MICHC program, support community health workers (CHWs) to conduct outreach to find and engage high-risk pregnant and postpartum families in consistent, comprehensive preventive and primary care services, including preconception, prenatal, and postpartum care. Routinely screen clients for health insurance enrollment and health care engagement, assist them in getting care if needed, and provide ongoing social support and reinforcement for health care utilization. Provide clients with health information and social support to increase knowledge and ability to self-advocate and make informed health care decisions, including assistance to develop birthing and postpartum plans.
- Through the FPP, continue to support the delivery of comprehensive, confidential reproductive health services for low-income, uninsured and underinsured women and men of reproductive age. Barriers to accessing reproductive health care will be addressed through implementation of alternatives to traditional in-person visits (such as telehealth) as appropriate and dispensing a 12-month supply of contraceptives. Family Planning Providers will assist uninsured clients in enrolling in the most appropriate health insurance plans including Medicaid, Family Planning Benefit Program (FPBP), and Family Planning Extension Program (FPEP).
- Through the American Indian Health Program (AIHP) and Migrant and Seasonal Farmworker (MSFW) Programs, continue to support direct health care and supporting services to ensure access to health care services.

**Strategy WMH-2: Strengthen coordination between birthing hospitals, outpatient health care providers, and other community services to make support for birthing parents and their families more comprehensive and continuous.**

Coordination between birthing hospitals, community providers, and community-based organizations that provide essential support to birthing persons and their families is critical to maintaining optimal health and well-being and ensuring continuity of care during a key life course period. MICHC programs routinely coordinate with a wide variety of community-based organizations that provide health and social support services to address needs related to both physical and mental health, and social determinants of health including safe housing, transportation, poverty, nutrition etc. Birthing hospitals in New York State are required to provide similar referral services through support and social services. As noted above, telehealth services have emerged as a promising approach to delivery of clinical care that can be tailored to the needs of each region and community, both urban and rural. Strengthening the connection between the MICHC providers and individual birthing hospitals will ensure that pregnant New Yorkers, including those with high-risk pregnancies and chronic conditions, are connected to the highest quality of birthing services and support services, including timely postpartum care.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2020-21 year:

- Establish regulations to require birthing hospitals to provide referral and support for ancillary services, including mental health, alcohol and substance use treatment, and other services.
- Collaborate with MICHC, MIECHV, WIC, local health and social service programs, midwives, doulas, as well as state and national organizations such as the American College of Obstetricians and Gynecologists (ACOG), AAP, Society

for Maternal-Fetal Medicine, hospital associations and the NYS Association of Licensed Midwives on messaging and strategies to promote birthing options appropriate for anticipated level of care, and safety of birthing hospitals, especially during health emergencies.

- Through the Regional Perinatal Centers (RPCs) and networks of affiliate birthing hospitals, support and enhance capacity to provide high quality perinatal telehealth services and perinatal subspecialty providers, particularly to rural communities and communities with disproportionate access to such services. Telehealth services will be tailored based on regional assessments of provider and affiliate hospital needs, to include routine prenatal and postpartum care and/or specialty care such as maternal-fetal medicine, radiology, and genetic counseling.
- To improve coordination and increase bilateral referrals between birthing hospitals and home visiting programs, Title V staff will assist in connecting MICHCs with their local birthing hospitals and support formal meetings. Additionally, Title V staff will share promising and best practices from established home visiting-birthing hospital partnerships across the state to encourage collaboration.

**Strategy WMH-3: Apply public health surveillance and data analysis findings to improve services and systems related to maternal and women's health care.**

Data-driven, evidence-based practice is essential to achieving public health goals for the Title V program. Across all Title V programs, continuous effort is needed to enhance the collection, analysis, and sharing of data to inform the planning and implementation of Title V-funded programs and policy work. Sharing data with stakeholders, including providers and community members, is critical to raise awareness, empower community action, and facilitate quality improvement efforts at all levels.

The Title V staff is currently implementing a comprehensive review process with the multidisciplinary NYS Maternal Mortality Review Board (MMRB) for the purpose of reviewing maternal deaths and maternal morbidity. 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. The MMRB will assess the causes of deaths, factors leading to the deaths, and preventability for each maternal death reviewed, and will develop and disseminate strategies to reduce the risk of maternal mortality and morbidity, including risk resulting from racial, economic or other disparities. The MMRB recommendations for preventability will be translated into action through collaboration with the Maternal Mortality and Morbidity Advisory Council (MMMAC), ACOG District II or NY (ACOG-NY) and other key stakeholders, including the development of issue briefs, webinars, and quality improvement projects through the New York State Perinatal Quality Collaborative (NYSPQC).

Analysis of NYSPQC project data provided by participating birthing hospitals helps to improve services and systems related to maternal health care. The NYSPQC, ACOG-NY, Healthcare Association of New York State (HANYS), Greater New York Healthcare Association (GNYHA) and National Institute for Children's Health Quality (NICHQ), will continue to lead specific improvement projects related to maternal hemorrhage and opioid use disorder in pregnancy as important causes of maternal mortality and morbidity.

Based on analysis of qualitative data obtained from 2018 listening sessions that engaged over 200 women statewide, DOH is developing a comprehensive interdisciplinary hospital quality improvement project focused on implicit bias. This learning collaborative, which will launch this year, will engage birthing hospital staff from clinical, administrative, and executive levels to analyze hospital policy and procedures that may contribute to bias and develop strategies to improve outcomes. This project will also include the development a comprehensive training curriculum that can be replicated at facilities to enable staff to better understand and mitigate bias. As with all NYSPQC projects, Title V staff will collect and analyze project data.

The Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2020-21 year:

- Summarize, share, and discuss findings of the Maternal Mortality Review Board (MMRB) with key partners, including

the Maternal Mortality Advisory Council, to inform statewide prevention strategies as described above.

- Issue a maternal mortality report to provide data and information that can be used to improve maternal outcomes.
- Identify cases of Severe Maternal Morbidity (SMM) through hospital discharge data, and conduct an analysis using linked birth data and hospital discharge data to define the major causes of maternal morbidity.
- Through the New York State Perinatal Quality Collaborative (NYSPQC), work with birthing hospital teams and community-based organization, to implement 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.
- Through the New York State Perinatal Quality Collaborative (NYSPQC), continue work with birthing hospital teams and community-based organization, to NYS Opioid Use Disorder (OUD) in Pregnancy/NAS Project. This learning collaborative, which kicked-off in September 2018, is currently being piloted in 19 birthing hospitals and will be further expanded in 2020. The OUD/NAS project 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 participates in the national Alliance for Innovation on Maternal Health (AIM) through this project.
- Through the New York State Perinatal Quality Collaborative (NYSPQC), engage partners to develop and launch a new comprehensive interdisciplinary hospital quality improvement project focused on implicit bias (see Strategy WMH-4 below for further detail).

**Strategy WMH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact women's health and use of health care across the life course.**

Women's and Maternal Health outcomes are impacted by the social determinants of health (SDOH), or the conditions in which people are born, live, work, play, learn, and age. SDOH include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of power and resources due to racism and other biases are root causes of inequities in access, availability, and quality of SDOH. All ten priorities that emerged from community members' input during the needs' assessment revolve around SDOH and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities.

The NYS Title V program strives to contribute to broad-based efforts to address inequality and social determinants of health. Strategies focus on improving outreach to find and engage high-need women and their families in health insurance and health care; increasing knowledge of available community resources and supports; working with community stakeholders to improve delivery of care and services; the development of supports, opportunities and social norms that promote and facilitate healthy behaviors across the lifespan; involving community members in program implementation and policy; and promoting community engagement and mobilization to proactively address bias and racism and other community and systems-level factors impacting racial and ethnic disparities.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2020-21 year:

- Through the MICHC programs, work with diverse community stakeholders including community residents to identify and collaboratively address issues and barriers impacting maternal and infant health outcomes at the community level, including activities to:
    - Actively participate in community advisory boards, consortiums or coalitions to address issues impacting perinatal and infant health and identify effective strategies for addressing the social determinants impacting those outcomes.
    - Engage and partner with diverse stakeholders from a wide array of community sectors including community residents, grassroots organizations, community-based service organizations, health care providers, local government, local foundations, and local businesses.

    - Work collaboratively to address relevant community issues such as safe housing, availability and accessibility of resources and services (e.g., health care, mental health, substance abuse services, home visiting, family support resources), social norms (e.g. related to use of preventive care services, breastfeeding, or personal health behaviors), and community mobilization to effectively identify and address community problems.
- Through the MICHC program, provide supports to individual clients and their families to address behavioral social determinants of health outcomes, including specific program activities to:
    - Provide information on available community resources for needs related to housing, food, employment and job training, transportation, and other basic needs;
    - Routinely screen for health insurance enrollment, and assist clients with enrollment as needed, including referral to enrollment Navigators or Community Health Advocates;
    - Conduct screenings using standardized, evidence-based or validated tools for domestic violence, substance use, smoking, and depression, and make referrals for follow-up as needed;
    - Help families connect and use/ enroll in enhanced social support resources and programs including parenting classes, peer support groups, childbirth education and resources to develop birth and postpartum care plans, and breastfeeding education, and directly support clients to develop birth plans;
    - Provide professional development support for CHWs to delivery these services, including annual training on how to talk with families about difficult topics like mental health and depression, using a trauma informed care approach, and including how to manage emergency situations.
- Through the Enough is Enough (EiE) program, (which supports 48 projects across the state to work with local colleges and universities to support sexual violence prevention and education efforts) MCHSBG funding will support costs associated with training EiE programs on the Safer Bars Curriculum to train 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. Once trained, EiE programs will conduct the Safer Bars Training to all interested alcohol-serving establishments located within local campus communities.
- Collaborate with partners, including but not limited to, the Office of Mental Health's Project Teach, ACOG-NY, home visiting programs and other community-based organizations, to address mental health in pregnant and postpartum people by increasing screening and follow-up support.

The NYS Title V Program established two Evidence-Based Strategy Measures (ESMs) to track the programmatic investments and inputs designed to impact NPM1:

**ESM WMH-1: Percent of MICHC program participants engaged prenatally who have created a birth plan during a visit with a CHW.**

Data for this measure will come from quarterly and annual reports submitted by local MICHC contractors. The baseline value for this measure, taken from 6-month program period of 10/1/19-3/31/20, is 52.7%. The program has set a one-year improvement target of 5%, to 55.3% of participants, for 2022.

**ESM WMH-2: Percent of Family Planning Program clients with a documented comprehensive medical exam in the past year.**

Data for this measure will come from FPP clinic visit record (CVR) data. Current FPP data for program year 2018 shows 25.6% of FPP clients had a documented comprehensive medical exam. The FPP program has set a one-year improvement target of 5%, to 26.9% of clients in 2022.

**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-2017 | 5.3 | NPM 3 |
| NOM 9.1 - Infant mortality rate per 1,000 live births | NVSS-2017 | 4.6 | NPM 3<br>NPM 5 |
| NOM 9.2 - Neonatal mortality rate per 1,000 live births | NVSS-2017 | 3.1 | NPM 3 |
| NOM 9.3 - Post neonatal mortality rate per 1,000 live births | NVSS-2017 | 1.5 | NPM 5 |
| NOM 9.4 - Preterm-related mortality rate per 100,000 live births | NVSS-2017 | 172.8 | NPM 3 |
| NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births | NVSS-2017 | 58.3 | 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 | 2019 |
| Annual Objective | 91 | 91 | 93.4 | 93.7 |
| Annual Indicator | 92.3 | 92.7 | 92.5 | 91.2 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | NYS VS | NYS VS | NYS VS | NYS VS |
| Data Source Year | 2014 | 2015 | 2016 | 2017 |
| Provisional or Final ? | Final | Final | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 93.0 | 93.4 | 93.8 | 94.2 | 94.4 | 94.5 |

**Evidence-Based or –Informed Strategy Measures**

**ESM 3.1 - Percent of birthing hospitals with final level of perinatal care designation, in accordance with updated regulations and standards**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 0.0 | 25.0 | 50.0 | 75.0 | 100.0 |

**State Performance Measures**

**SPM 1 - Percent of samples received by the State Newborn Screening lab within 48 hours of collection**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 75.0 | 77.0 | 79.0 | 81.0 | 85.0 |

**State Action Plan Table**

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

### Priority Need

Address transportation barriers for individuals and families.

### 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: Increase or maintain the percent of very low birth weight infants born in a hospital with a Level III+ NICU by 2.4%, from the 2017 level of 91.2% to 93.4% by 2021. (NYS Vital Statistics Birth Data)

Objective PIH-2: Decrease the infant mortality rate by 2.6%, from 4.6 deaths per 1,000 live births in 2017 to 4.49 deaths per 1,000 live births in 2021 (NVSS)

### Strategies

Strategy PIH-1: Integrate specific activities across all relevant Title V programs to promote access to early prenatal care, access to birthing facilities appropriate to one's needs, postpartum care, and infant care.

Strategy PIH-2: Implement updated perinatal regionalization standards, designations, and structured clinical quality improvement initiatives in birthing hospitals and centers.

Strategy PIH-3: Apply public health surveillance and data analysis findings to improve services and systems related to perinatal and infant health care.

Strategy PIH-4: Address social determinants identified by community members that impact infant health and use of perinatal and infant health care and support services.

| ESMs | Status |
|---|---|
| ESM 3.1 - Percent of birthing hospitals with final level of perinatal care designation, in accordance with updated regulations and standards | Active |

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

Increase awareness of resources and services in the community among families and the providers who serve them.

### SPM

SPM 1 - Percent of samples received by the State Newborn Screening lab within 48 hours of collection

### Objectives

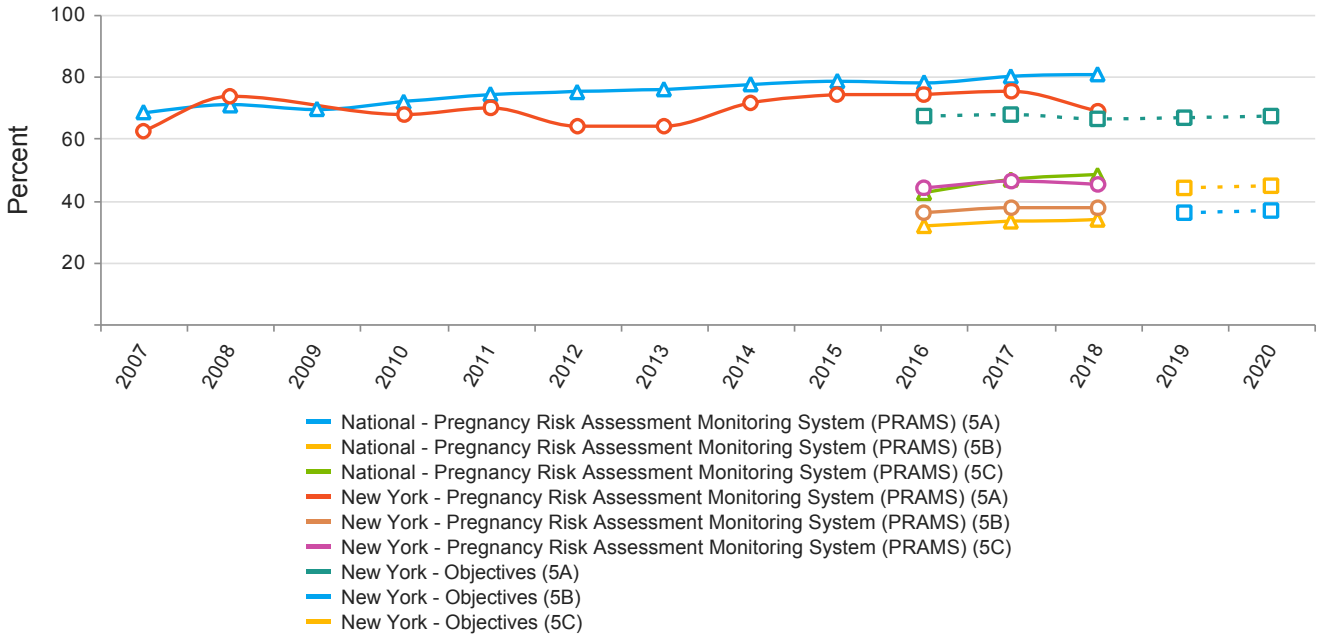
Objective PIH-3: Improve the timeliness of Newborn Blood Spot samples received at the NYSDOH Wadsworth Laboratory from 74.34% to greater than 85% of samples received within 48 hours of collection by September 2023. (Newborn Blood Spot data)

### Strategies

Strategy PIH-5: Maintain and strengthen a robust statewide population-based Newborn Screening Program.

**2016-2020: National Performance Measures**

**2016-2020: 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**




**2016-2020: 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** | **2019** |
| Annual Objective | 67.1 | 67.6 | 66.2 | 66.6 |
| Annual Indicator | 63.9 | 73.9 | 75.3 | 68.6 |
| Numerator | 135,686 | 155,836 | 152,784 | 65,253 |
| Denominator | 212,507 | 210,880 | 202,843 | 95,190 |
| Data Source | PRAMS | PRAMS | PRAMS | PRAMS |
| Data Source Year | 2013 | 2015 | 2017 | 2018 |

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | 67.1 | 67.6 | 66.2 | 66.6 |
| Annual Indicator | 71.3 | 73.9 | | |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | PRAMS NYS | PRAMS NYS | | |
| Data Source Year | 2014 | 2015 | | |
| Provisional or Final ? | Provisional | Final | | |

**2016-2020: 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** | **2019** |
| Annual Objective | | 36 |
| Annual Indicator | 37.6 | 37.4 |
| Numerator | 71,966 | 32,530 |
| Denominator | 191,278 | 87,007 |
| Data Source | PRAMS | PRAMS |
| Data Source Year | 2017 | 2018 |

| State Provided Data | | | |
|---|---|---|---|
| | **2017** | **2018** | **2019** |
| Annual Objective | | | 36 |
| Annual Indicator | 0 | | |
| Numerator | 0 | | |
| Denominator | 100 | | |
| Data Source | NYS PRAMS | | |
| Data Source Year | 2016 | | |
| Provisional or Final ? | Provisional | | |

**2016-2020: 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** | **2019** |
| Annual Objective | | 44 |
| Annual Indicator | 46.3 | 45.2 |
| Numerator | 89,933 | 39,272 |
| Denominator | 194,052 | 86,816 |
| Data Source | PRAMS | PRAMS |
| Data Source Year | 2017 | 2018 |

| State Provided Data | | | |
|---|---|---|---|
| | **2017** | **2018** | **2019** |
| Annual Objective | | | 44 |
| Annual Indicator | 0 | | |
| Numerator | 0 | | |
| Denominator | 100 | | |
| Data Source | 2016 | | |
| Data Source Year | 2016 | | |
| Provisional or Final ? | Provisional | | |

**2016-2020: Evidence-Based or –Informed Strategy Measures**

**2016-2020: 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** | **2019** |
| Annual Objective | 90 | 90 | 90 |
| Annual Indicator | 91.7 | 91.6 | 91.6 |
| Numerator | | 831 | |
| Denominator | | 907 | |
| Data Source | NYS sampled Birthing Hospitals | NYS sampled Birthing Hospitals | NYS sampled Birthing Hospitals |
| Data Source Year | 2017 | 2018 | 2018 |
| Provisional or Final ? | Final | Final | Final |

**2016-2020: State Performance Measures**

**2016-2020: 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** | **2019** |
| Annual Objective | | 72 | 73 | 75 |
| Annual Indicator | 71.7 | 71.6 | 70.8 | 70.8 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | CDC Water Fluoridated Reporting System | CDC Water Fluoridated Reporting System | CDC Water Fluoridated Reporting System | CDC Water Fluoridated Reporting System |
| Data Source Year | 2017 | 2018 | 2019 | 2019 |
| Provisional or Final ? | Final | Final | Final | Provisional |

**FFY 2019 Annual Report**

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

Addressing factors that lead to infant mortality continues to be at the forefront of all NYS's maternal and child health initiatives. Overall, infant and neonatal mortality rates are declining in NYS and are below the Healthy People (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 infant mortality 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). The NYS Title V program is leading statewide efforts with key stakeholders, agencies, partners, and providers to reduce infant deaths and decrease economic and racial/ethnic disparities in infant mortality rates across NY. Through a variety of focused and collective evidence-based interventions, the NYS Title V program is improving the ability of parents/caregivers 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 vs. 6.0 nationally in 2015. NYS is better than the national average based on National Vital Statistics Data for **NOM #9.1 Infant mortality rate per 1,000 live births** at 4.5 vs. 5.9 in 2015. NYS 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** (1.7 vs. 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 NYS Title V program developed and implemented an expanded plan for analysis and reporting of infant mortality and selected morbidity data. The *New York State Infant Mortality Report*, highlighting collaborations and describing trends in NYS's infant mortality rates between 2002 and 2016, the NYSDOH's plan to reduce infant mortality was developed and placed in the review and approval process. Additional multivariate analysis was requested prior to final approval and release of the report; this additional analysis is underway.

To monitor progress of improving the health of women, infants, and children and reducing health disparities, Title V staff previously collaborated with the NYSDOH Office of Public Health Practice to develop the Maternal and Child Health (MCH) dashboard that is comprised of National Performance and Outcome Measures as well as State Performance Measures and Objectives. The MCH Dashboard, which was described in the previous annual report) includes 41 unique measures related to NYS Title V application. This dashboard was released in September 2018 and continues to be maintained. 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. 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 NYSDOH Office of Health Insurance Programs (OHIP) to ensure quality prenatal care services are available to NY's Medicaid (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.

The NYS Title V program is home to the Maternal, Infant, and Early Childhood Home Visiting (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 3,060 families in the FY19 (10/1/2018 to 9/30/2019) reporting period. The NYS Office of Child and Family Services (OCFS) receives MIECHV funding through a Memorandum of Understanding (MOU) with the NYSDOH to fund Healthy Families programs. 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 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.

- 11.5% of infants, born during the reporting period, were born preterm
- 42% of infants, with mothers enrolled prenatally, were breastfeeding at six months of age
- 65% of infants received the last recommended well-child visit during the reporting period
- 38.5% 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 MIECHV programs, MIECHV staff developed a media campaign that ran in the counties that have a MIECHV-funded home visiting program. The campaign pointed pregnant and parenting women and families to the new NYSDOH home visiting webpage. NYSDOH contracted with the company OverIt from Albany, NY to conduct focus groups to help develop these messages by understanding the best terminology, imaging, and messaging for use with families to encourage acceptance of home visiting services. Focus groups were conducted in five MIECHV counties (Erie, Bronx, Schenectady, Chemung, and Nassau) across NYS with women ages 18-35 and matched the demographics of the county it was conducted in. During the focus groups, most of the participants commented that the photos used in the mock-ups were overused. In order to get new photos to use in the advertisements, the MIECHV team worked with OpAd to hold a photo shoot with several models to play the part of mom, dad, home visitor, and infant. Using the feedback from the focus groups and the photos from the photo shoot, the NYSDOH's Public Affairs Group developed advertisements to use in the media campaign that encouraged pregnant and parenting families to visit the NYSDOH home visiting web pages. 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 NYSDOH 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 communitywide MCH outcomes, the Title V program has continued to fund 23 Maternal and Infant Community Heath Collaboratives (MICHC) projects in 32 NY counties, extending their service contracts through September 2020. 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 providers 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. In project year 2018-2019, the MICHC program served 3,582 prenatal and postpartum women and their families.

The following outcomes were achieved:

- 79.7% of postpartum clients engaged prenatal care during the 1st trimester.
- 39.9% of clients attended a postpartum visit, with an additional 44.7% having a scheduled appointment.
- 2,119 babies were born to MICHC clients in 2019, of which 10.3% were born preterm (new indicator).
- 81.6% of postpartum clients initiated breastfeeding.
- 67% of clients referred for smoking cessation programs completed the referral.
- 67% of clients referred to family planning were completed.
- 68% of referrals for child primary care were completed.

Expanding access to CHW services was a top recommendation made by Governor Cuomo's Taskforce on Maternal Mortality and Disparate Racial Outcomes and was a common suggestion for addressing maternal mortality made by women participating in the NYSDOH Maternal Mortality Listening Sessions conducted in Summer, 2018. CHW expansion has been implemented through the MICHC program with funding from the Governor's maternal mortality initiative to support approximately 50 new CHWs to provide services to an additional 2,000 high-need pregnant and postpartum women and families. In addition to outreach, referral and home visiting services, CHWs also provide childbirth education and support, promote collaborative childcare and social support networks, assist with the development of birth plans and support increased health literacy.

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 so communities can use all the home visiting programs available. To facilitate better collaboration and efficiency, Title V and MIECHV staff have been providing training and technical assistance on developing a coordinated intake and referral system for home visiting. MICHC contractors are serving as the lead agency for the pilot, which began with the first cohort in January 2017 and second cohort in January 2018. Four community teams were in the first cohort and five started in the second cohort. More teams recently joined to bring the second cohort to 10.

Title V and MIECHV staff provided tools and guidance to the community teams including monthly coaching calls. The calls covered topics including stages of team development, systems mapping, team charters, creating a decision tree, coordinated outreach, common referral forms, developing an outreach plan, data collection, and team building. In addition to the group coaching calls, teams received individual calls for focused technical assistance and review of materials and tools they produced.

The process at the local level has been slower than anticipated. The trust building phase takes a long time. Trust needs to be built between programs on two levels – trust that another program can serve clients well and that each agency will respect agreements about referring potential clients to the other program. The teams are at various stages of creating a coordinated system in their community for referring pregnant and parenting women to home visiting programs. Most community teams have completed charters, program mapping, draft decision trees, and draft common referral forms. Some teams have developed workplans and have started to collect baseline data. 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.

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, and Syracuse; four of the six 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 Collaborative Improvement and Innovation Network (CollN). They also help Title V staff connect local grantees to local HS efforts, such as the coordinated intake project that the Brooklyn HS program is developing.

The NYS Title V program continues to enhance local systems building efforts through training, technical assistance, data collection and analysis, and quality improvement for NYS Title V funded community-based perinatal and infant programs. Quarterly calls continued and included topics such as maternal depression, annual data reports, collaborative outreach, and improving referrals.

For the MIECHV continuous quality improvement (CQI) cycle from October 1, 2018 to September 30, 2019, efforts on breastfeeding duration and improving referrals into the home visiting program were continued. All MIECHV funded sites participated in these improvement activities through September 2019. These topics were chosen by the MIECHV funded sites through surveys. Additionally, these topic areas closely align with the MIECHV state and federal priorities. The focus on referrals into the program was to increase enrollment into programs. The focus on breastfeeding duration was to increase the proportion of infants being breastfeed at six months. To help reduce burden, the sites selected their own data collection tools, with assistance if desired, and the strategies. In 2018, NYSDOH developed a framework for CQI activities and reviewed CQI fundamentals with the goal of building competencies of hove visiting staff. Based on lessons learned in the previous cycle, MIECHV staff began working with sites to create process maps and team charters for their respective projects. In 2019, MIECHV staff supported local implementing agencies (LIAs) as they implemented plan-do-study-act (PDSA) cycles, which are iterative, small tests of changes and review of data to inform actions. Data were collected and reviewed quarterly on coaching calls. Sites created a final report of their project at the close of 2019.

The goals of the Pathways to Success initiative, funded by the federal Office of Population Affairs beginning July 1, 2017 through June 30, 2020, are to strengthen community systems serving pregnant and parenting teens and young adults; improve the health, development, and well-being of young parents and their children; improve young parents' self-sufficiency through educational attainment; and increase awareness of resources available to expectant and parenting teens and young adults. The initiative is focused in New York City based on 2015 NYS Vital Statistics data showing Kings, Bronx and Queens counties with the highest birth rates among females who were between the ages of 15 and 24.

The Pathways to Success grant supports three community colleges (Hostos, LaGuardia and Borough of Manhattan) and a community-based organization (Public Health Solutions) to develop, expand and sustain supportive communities to help expectant and parenting teens/young adults maintain their health and meet educational or vocational goals. The funded projects collaborate with Title V programs such as MICHC and MIECHV for home visiting supports, and other programs to strengthen support networks and referral systems for pregnant and parenting teens and young adults in these communities.

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, parenting skills, and touches upon developmental assets in all eight categories. All students and community members enrolled in the initiative receive healthcare referrals for prenatal, interconception, and postpartum care, social service referrals to the Special Supplemental Nutrition Program for Women, Infants and Children's program (WIC); local Department of Social Services (DSS); and educational or vocational supports to better ensure academic/career success. The goals of this program align with the Title V 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, 2018 to June 30, 2019, the program served 737 expectant and parenting students or community members, developed 190 new partnerships, and made 817 referrals. The most frequently cited needs of the program participants were help obtaining information, resources, or services for emotional or parenting support; peer-to-peer education; community support; academic advisement; scholarships for single parents; vocational opportunities or employment services; and help with other daily living needs such as housing, transportation, childcare, supplies for their children, and food.

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. NYS 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 2017, 91.2% of very low birth weight (VLBW) infants were delivered at facilities for high-risk deliveries and neonates, well above the Healthy People (HP) 2020 target of 82.5%. NYS's system of regionalized perinatal services includes a hierarchy of four levels of perinatal care provided by the hospitals within a region and led by an Regional Perinatal Center (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 NYSDOH is fully supporting efforts to update perinatal hospital standards in NYS. The NYS 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 NYSDOH Office of Primary Care and Health Systems Management (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 the NYS 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 American College of Obstetricians and Gynecologists District II of New York (ACOG-NY) and the Associate Commissioner of NYSDOH at the Western Region Office, 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 NYSDOH 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 the NYS 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.

Three meetings of the expert panel were held where the panel reviewed standards of care and made recommendations to the NYSDOH 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, and finance. Recommendations have been finalized with subcommittee discussions 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 were adopted November 13, 2019. The new standards will include physician-led and midwifery-led birthing centers as the first level of care, followed by Level I through III hospitals, while RPCs represent the highest level of perinatal care. **ESM PIH-2: Percentage of birthing hospitals re-designated with updated standards** was established to evaluate this work**.** 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 NYS'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 New York State Perinatal Quality Collaborative (NYSPQC) initiative through collaboration with RPCs, RPC-affiliate birthing hospitals, perinatal care providers, community-based organizations, NYS 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: New York State Infant Mortality CoIIN Community-based Safe Sleep Project, National Action Partnership to Promote Safe Sleep – Innovation and Improvement Network (NAPPSS-IIN), NYSPQC Enteral Nutrition Improvement Project, and NYS Opioid Use Disorder (OUD) in Pregnancy & Neonatal Abstinence Syndrome (NAS) Project.

NYS also administers a strong Newborn Bloodspot 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.

Under the HRSA-led national Infant Mortality CoIIN, the Title V program launched a new phase of the NYS Safe Sleep Infant Mortality CoIIN in July 2018, with a focus on community-based organizations (CBOs), to continue to reduce disparities in infant mortality through the promotion of infant safe sleep. Since October 2018, seven 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 nine Coaching Call webinars. The webinar topics included breastfeeding and safe sleep, screening and referrals to tobacco cessation services, hazards associated with sitting and carrying devices for infants, recent safe sleep literature, and team learning and sharing regarding improvement activities. To support the pilot sites' efforts, the Title V program provided Sleeping Safely Starter Kits, *Sleep Baby Safe and Snug* board books from the Charlie's Kids Foundation, and safe infant sleep clothing (sleep sacks) to each participating pilot site in September 2019. In October 2018, the Title V program also provided 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 infant mortality in NY, Sudden Unexpected Infant Death (SUID). The NY Infant Mortality CoIIN develops key projects in partnership with the child welfare system including the NYS OCFS; NYS Office of Addiction Services and Supports (OASAS); the NYSDOH Division of Nutrition's (DON); and Special Supplemental Nutritional Program for Women, Infants and Children (WIC) clinics. In May 2019, Governor Cuomo designated May as Infant Safe Sleep Month. During the reporting period, the Title V program has been working to implement the Governor's directive that the NYSDOH and the NY OCFS continue their work on an infant safe sleep public awareness media campaign, expand outreach to medical providers, engage community-based organizations (CBOs) by promoting staff education tools, and distributing Safe Sleep Kits to 10,000 caregivers. The kits include sleep sacks, safe sleep literature, and NYSDOH educational materials. In August 2019, NY passed legislation expanding infant safety measures, including a ban on the sale of crib bumper pads.
In 2019, the NYSDOH updated and expanded translations of the patient education materials highlighting the ABCs (Alone,

Back, Crib) of safe sleep available at no cost to the public. These safe sleep materials include a brochure available in the thirteen most commonly spoken languages in NYS (six translations were added in 2019), 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 NYSDOH 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 translated into six additional languages in 2019 for a total of thirteen languages available; these were laminated and made available to all NYS birthing hospitals and stakeholder organizations.

During the reporting period, the NYSDOH, in collaboration with Title V staff, developed a safe sleep campaign to promote the ABCs of safe sleep and a new message: Baby should sleep in a smoke-free home. NYSDOH created three 10-15 second videos for the campaign and a new safe sleep poster in English and Spanish, all of which featured the new message. The videos were created to run on Facebook and Instagram, reaching women ages 16+, grandparents and caregivers. The out-of-home and social media campaigns were scheduled to launch on November 4, 2019 and run through January 2020. For the out-of-home print campaign, NYSDOH is targeting NYS counties with the highest infant mortality burden with bus shelter ads and posters in convenience stores and bodegas. Additionally, Title V staff updated the Department's safe sleep website (www.health.ny.gov/safesleep) to include information about tobacco cessation and the updated patient education materials.

The Title V team, in collaboration with NICHQ, continues to develop the electronic NYSDOH Safe Sleep Toolkit, which will feature change ideas, presentations, materials, tools, references and key insights from hospitals and community-based organizations that are working to improve infant safe sleep practices. The target audience is public health and health care professionals. The toolkit is expected to be released during the next reporting period.

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. In 2019, the project, which is funded by HRSA's Maternal and Child Health Bureau (MCHB), expanded from five pilot site hospitals in five states, including NYS, to twenty hospitals in ten states. NYS's representative hospitals during the reporting year included New York Presbyterian (NYP) Lawrence (Westchester), Montefiore Medical Center – Wakefield Division (Bronx) and Crouse Hospital (Onondaga). Montefiore Medical Center – Wakefield Division and Crouse Hospital joined the project in May 2019. During the reporting period, six conference calls were held with the NAPPSS-IIN partners. The Title V team will continue to hold quarterly conference calls with statewide and national safe sleep and breastfeeding stakeholders to disseminate, spread and scale best practices to improve safe sleep practices, breastfeeding rates, and reduce disparities in both areas.

NYS'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 at 58.3 vs. 91.2 nationally as reported in 2017, 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 aimed to reduce the percentage of newborns born prior to 31 weeks' gestational age discharged from a Neonatal Intensive Care Unit (NICU) below the 10$^{th}$ percentile on the Fenton Growth Scales. Outcome, process, and balancing measures were calculated for infants born prior to 31 weeks' gestation, admitted within 48 hours of birth to a NICU, and discharged alive. Key measures were the percentage below the 10$^{th}$ percentile for discharge weight, difference in Z-scores for birth and discharge weights, incidences of comorbidities nosocomial sepsis and necrotizing enterocolitis, post-menstrual age at discharge (days), and median initial length of stay (days). With efforts and results shared through monthly Coaching Calls, quarterly performance measure data reports, and yearly Learning Sessions, all NYS RPCs began participation in 2010 and an additional 20 Level III facilities joined the project in 2016. Throughout the project, RPCs exhibited longer lengths of stay, higher percentages of breastmilk feeding, and higher rates of growth restriction at discharge, which may reflect greater clinical severity of their patients as well as the breastmilk paradox, where breastmilk fed babies grow more slowly. The initiative appears to have significantly

improved growth, as measured by a sustained decrease in the percentage of infants weighing below the 10th percentile at discharge, with the rate among RPCs dipping significantly below the baseline and nearing the lower rate reached by the Level IIIs. There were no significant changes in the incidences of comorbidities or in discharges above the 75$^{th}$ percentile for weight, further substantiating that the interventions were safe. The goal of reducing baseline percentages by 10% was exceeded; for RPCs change was from 32.6% to 29.3%, and for Level IIIs change was from 30.8% to 27.7%. This project has ended. We estimate that over 370 additional babies were discharged above the 10th percentile for weight, and more than 750 babies received exclusive breast milk at their first full feedings because of the initiative's efforts, and therefore conclude that our project was highly successful overall.

The NYSPQC Project Team has been conferring with the Vermont Oxford Network (VON) and California Perinatal Quality Care Collaborative (CPQCC) and hosted an onsite meeting with the NYSPQC's Neonatal Clinical Expert Work Group, NICHQ, and Joseph Shulman, MD, from California's DOH for an in-depth review of an additional QI project relevant to high-risk neonatal populations. This meeting took place in January 2020. Topics under consideration include the "Golden Hour," i.e., appropriate fetal and newborn interventions at the time of and immediately after delivery; antibiotic stewardship in the NICU; transition from NICU to home; and health equity/family-centered care.

Further, the NYSPQC, in partnership with ACOG-NY, Healthcare Association of NYS (HANYS) and the Greater New York Healthcare Association (GNYHA), and with support from NICHQ, is leading the NYS OUD in Pregnancy & NAS Project. This learning collaborative, which kicked-off in September 2018, is currently being piloted in 17 pilot site birthing hospitals and 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. To date, topic areas of focus have included verbal screening related to substance use for all pregnant women during the prenatal period and on admission to the birth hospitalization, trauma informed care, improved communication between obstetrics and pediatrics, reducing stigma, training clinical staff on the signs and severity of NAS, improving both pharmacologic and non-pharmacologic care for infants with NAS, Eat Sleep Console as a method of treatment for infants with NAS, considerations for breastfeeding for women who use substances, and linkages to care. A statewide project expansion is planned for Spring 2020. The NYSPQC is participating in the National Alliance for Innovation in Maternal Health (AIM) through this initiative.

During the reporting period, the NYSPQC began participating in the Association of State and Territorial Health Officials (ASTHO) Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative (OMNI) Learning Community. The purpose of the learning community is to provide technical assistance, build capacity, and disseminate strategies and best practices to support program and policy implementation on substance use disorder (SUD) among pregnant and postpartum women and infants prenatally exposed to opioids, including NAS. Agencies and organizations convened as part of this effort include: ACOG-NY; HANYS; GNYHA; Northwell Health; NYSDOH OHIP, Office of Drug User Health, and AIDS Institute; NYS OASAS; NICHQ; and Community Health Care Association of New York State (CHCANYS). The overarching goal of the NYS OMNI team, in alignment with the NYS OUD in Pregnancy & NAS Project's goal of increasing the percent of pregnant women screened for SUD with a verbal screening tool, is to train prenatal care hospital staff on standardized screening, develop provider resources for screening and referral, and connect diverse work happening across the state.

NYSDOH is reinvesting federal savings generated by the Medicaid Redesign Team (MRT) reforms into the Delivery System Reform Incentive Payment Program (DSRIP) to promote community-level collaborations on system reform with a goal of 25% reduction in avoidable hospital use over five years. Safety net providers (Preferred Provider Systems, PPS) are program leads and are required to collaborate to implement innovative community projects in three domains: 1) system transformation, 2) clinical improvement, and 3) population health improvement.

One DSRIP project involved a state funded MICHC program Mothers and Babies Perinatal Network in Binghamton, NY, who implemented the Care Transitions Model for newly delivered Moms and Babies by aiming to improve pregnancy and birth outcomes for every woman, infant, and family. Mothers and Babies Perinatal Network and UHS Hospitals collaborated to improve post-discharge results for mothers and newborns with Medicaid coverage. Participating in the Care Transitions

project, Mothers and Babies Perinatal Network partnered with two local hospitals to deploy Health Coach services to over 500 new mothers, providing face-to-face visits and follow-up phone calls during the 30-day post maternity discharge. Mothers and Babies and UHS presented the results from their collaborative approach at a Care Compass Network Stakeholders Meeting. The presentation can be seen on YouTube by following this link: https://www.youtube.com/watch?v=c4fTXeblp6I. The outcome goals were parental/family practice of safe sleep strategies for infants, identify and refer post-partum women for perinatal mood disorders/post-partum depression. The project found:

Safe Sleep for Babies Education: 100% all moms receiving a home visiting and 30-day follow-up (including safe sleep)

- Identification of families with no crib – provision of pack n play

Depression/mental health screen: provision of PHQ-9 survey. 559 completed (10/1/18 – 9/12/19)

- 24 (4%) scored 10 or more/100% referred

90-day phone follow up

1/1/19 – 6/30/19: 134 calls made; 58 completed (43%)
100% following the safe sleep guidelines
0 re-hospitalizations of moms
3 re-hospitalizations for babies (all medically necessary)

Another DSRIP project involves two NFPs – one in Chautauqua county and the other in Erie county. The Erie county NFP receives MIECHV funding. Catholic Medical Partners in western NY selected establishing or expanding home visiting as one of their strategies. Catholic Medical Partners began implementing an NFP in Chautauqua County in 2016 and began implementing an NFP program in Erie County in October 2018.

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 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, HIT systems went live for all three projects with full data collection in September 2018. Data extract templates were developed for the pilot projects to submit de-identified aggregate data on a quarterly basis to the Department. 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. During 2019, HIT projects were continuing to expand their provider enrollment within their network implementing sustainability plans.

The NYS Title V program 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 and maternal depression. The Maternal and Women's Health annual report and application sections include information related to The NYS Title V program’s role in the opioid epidemic and maternal depression.

**Perinatal/Infant Health - Application Year**

**Application for FY2021**

For Perinatal and Infant Health (PIH), New York's Title V program selected **NPM 3: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU).** This National Performance Measure (NPM) was selected because of its relevance to quality and systems of care for high-risk and vulnerable infants. While NPM 3 specifically measures site of delivery for very low birth weight infants as one critical indicator of care, the NYS Title V program views this indicator more broadly as part of a continuum of supports, services, and systems of care for infants, mothers, families, and service providers. This broader approach aligns with several priorities voiced by families in NY's needs assessment, including awareness of community resources and services, enhancing supports for families, improving people's health care experiences, and fostering community engagement and empowerment.

In addition, New York's Title V program established one **State Performance Measure (SPM) for this domain, state-wide improvement from 74.34% to greater than 85% of samples received at the lab within 48 hours of collection.** This SPM was developed to reflect the state's continued commitment to ensure that every newborn in the state receives newborn bloodspot screening as a public health service, to identify and support infants with a wide range of medical conditions. As a population-based program, the Newborn Bloodspot Screening program is an integral part of the state's public health system for supporting the health and lifelong well-being of newborns and their families.

A focus on improving services and outcomes for infants is supported by other measures assessing the perinatal period. The proportions of low birth weight (8.1%) and preterm (9%) births in NYS have been stagnant for years, but racial and ethnic disparities continue. Non-Hispanic black infants experience significantly more low birth weight births (12.9%) and preterm births (12.7%) than non-Hispanic white infants (6.3% and 7.6%, respectively). NYS has improved the proportion of pregnant women entering prenatal care during the first trimester to 80.9%, but again there are disparities with only 70% of non-Hispanic black and 76.1% of Hispanic pregnant women beginning early prenatal care compared to 86.1% of non-Hispanic white pregnant women. In our community forums, community members expressed that they do not "feel heard" by their health care providers, that their concerns and treatment preferences are not taken seriously, and that providers do not care about them or understand what they are going through. They indicated people avoid seeking care and services because they feel judged or anticipate being treated poorly. Participants indicated that people would be more likely to visit a provider who shows compassion, has been trained about bias and cultural competence, and who is relatable (i.e., from the community and speaks their language).

During the forums, many families expressed the need to raise awareness about available community resources and services, in particular for postpartum depression, and to increase the availability and scope of services to support families in the postpartum period, including postpartum doulas, home visitors, community health workers, and breastfeeding support. Indeed, data available about the postpartum experience show that not only is the proportion of mothers experience postpartum depressive symptoms increasing (15.5%), but non-Hispanic black mothers more frequently have this experience (20.7%) compared to non-Hispanic white mothers (13.3%).

NYS historically has been a leader in establishing systems of perinatal regionalization, with consistently high performance in this measure. Building on that success, the NYS Title V program is currently engaged in a multi-year effort to expand and update perinatal regionalization standards and designations for the state's birthing hospitals and centers. As this work progresses, it is essential to closely monitor NPM3 and other related measures to ensure that quality of care and key health outcomes are maintained or improved.

Both NPM-3 and SPM-1 align with the NYS Prevention Agenda goal to reduce infant mortality and morbidity.

Three specific objectives were established to align with this performance measure:

**Objective PIH-1**: Increase or maintain the percent of very low birth weight infants born in a hospital with a Level III+ NICU by 2.4%, from the 2017 level of 91.2% to 93.4% by 2021. (NYS Vital Statistics Birth Data)

**Objective PIH-2:** Decrease the infant mortality rate by 2.6%, from 4.6 deaths per 1,000 live births in 2017 to 4.49 deaths per 1,000 live births in 2021 (NVSS).

**Objective PIH-3:** Improve the timeliness of Newborn Blood Spot samples received at the NYSDOH Wadsworth Laboratory from 74.3% to greater than 85% of samples received within 48 hours of collection by September 2023. (Newborn Bloodspot Screening program data)

Five strategic public health approaches were identified to accomplish these objectives over the next five years. These are presented in the State Action Plan Table, and each is described in more detail here, with specific program and policy activities that will be implemented to advance the broader strategic approach in the upcoming year.

**Strategy PIH-1: Integrate specific activities across all relevant Title V funded programs to promote access to early prenatal care, access to birthing facilities appropriate to one's needs, postpartum care, and infant care.**

Consistent with a life course perspective, improving birth outcomes for infants requires attention to health and health care services for both babies, parents, and people of child-bearing age (see MWH above for additional discussion). NYS has made significant strides to reduce infant mortality and morbidities yet work remains. Timely and comprehensive prenatal and postpartum medical visits are essential to providing prevention education and anticipatory guidance, screening for risk factors and that may negatively affect the health of the neonate, managing chronic conditions and pregnancy complications, and connecting families with a wide array of community services and social supports to holistically address the health and wellness needs of pregnant people, neonates, and new families. Several Title V funded programs, including Maternal & Infant Community Heath Collaboratives (MICHC), Newborn Bloodspot Screening (NBS), NYS Perinatal Quality Collaborative (NYSPQC), and Regional Perinatal Centers (RPCs), play a direct role in promoting comprehensive health and wellness of neonates through population-based systems, public health interventions, and delivering or linking people to health care services.

The Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2020-21 year:

- Implement a messaging and educational campaign to promote the safety of birthing hospitals, maternity care options (levels of care and types of care providers), and infection control, to strengthen community awareness and advocacy for obtaining prenatal and postpartum care at appropriate level of care.
- Across all Title V funded programs, enhance promotion of the NYS Growing Up Healthy Hotline to increase awareness of available community resources, supports, and services including Supplemental Nutritional Programs for Women, Infants and Children (WIC), Medicaid, family planning, and prenatal care.
- Through the Regional Perinatal Centers (RPCs) and networks of affiliate birthing hospitals, support and enhance capacity to provide high quality perinatal telehealth services and perinatal subspecialty providers, particularly to rural communities and communities with disproportionate access to such services. *(See Domain 1 Women/Maternal Health (WMH) for details).*
- Through the MICHC and Maternal Infant and Early Childhood Home Visiting (MIECHV) programs, integrate use of virtual home visiting services to increase acceptance and support of services for hard to reach families *(See Domain 1 WMH for details).*
- Through the MICHC and MIECHV programs, support community health workers (CHWs) to engage high-risk pregnant and postpartum families in consistent, comprehensive preventive and primary care services, including newborn care, screen and assist families in enrolling in health insurance, and provide families with social support to enhance health literacy and use of health care *(See Domain 1 WMH for details).*
- Through the American Indian Health Program (AIHP) and Migrant and Seasonal Farmworker (MSFW) Programs,

continue to support direct health care and supporting services to ensure access to health care.
- Through the NYSPQC, provide educational opportuities and implement structured quality improvement projects with birthing hospitals *(See Strategy PIH-2 below for detail)*

**Strategy PIH-2: Implement updated perinatal regionalization standards, designations, and structured clinical quality improvement initiatives in birthing hospitals and centers.**

NYS has been a longstanding national leader in implementing statewide systems of regionalized perinatal care. NYS's regulations for perinatal regionalization and designation, as well as perinatal care services, were last updated in 2000 and 2005, respectively. 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. Since 2017, the Title V program has worked to develop updates to these regulations to reflect current national standards of obstetrical and neonatal care and perinatal regionalization; changes in health care systems and reimbursements, as well as hospital restructuring and other corporate structural changes. As part of the regulation development process, Title V program staff conducted an extensive review of current standards, in consultation with a 49-member multi-disciplinary Expert Panel and other topical expert consultants. Additionally, the proposed regulations further integrate recently established midwifery birth centers, along with physician-led birth centers, into the perinatal regional system, and place a greater emphasis on quality care and patient safety, particularly for obstetrical patients. Current efforts to strengthen this public health system includes increased efforts to address maternal morbidity and mortality, integration of physician- and midwifery-led birth centers into the regional systems, and increased access to ancillary services such as alcohol and substance use and mental health services, directly and/or through referral and commensurate with the birthing facility's level of care. The Department plans to submit the proposed regulations for public comment in summer 2020 and anticipates adoption of regulations by December 2020.

Working within this statewide system of perinatal regionalization, NY's Title V program implements the NYSPQC, which aims to provide the best, safest and most equitable care for women and infants in NYS 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 NYSPQC has adapted the Institute for Healthcare Improvement (IHI) model for Idealized Perinatal Care and Breakthrough Series Methodology as a framework to guide improvement. Key NYSPQC activities include:

- embedding evidence-based guidelines into practice;
- strengthening collaboration and communication within and among neonatal and obstetric providers, administrators and organizations;
- fostering prepared and proactive care teams;
- assessing, conducting and sharing surveillance and performance data on maternal and neonatal health indicators;
- continuously evaluating and measuring performance;
- setting priorities and implementing a comprehensive strategy for benchmarking and data driven quality improvement (QI) activities;
- providing topic-specific, intensive QI supportive activities, trainings and toolkits that are all-inclusive packages to facilitate improved clinical outcomes, excellent patient care and efficient resource allocation;
- researching best practices; and,
- continually reassessing outcomes of performance improvement interventions.

Specific priorities set by the NYSPQC are implemented by all participating NYS birthing hospitals to improve outcomes for perinatal care. Analysis of NYSPQC project data provided by participating birthing hospitals helps to improve services and systems related to perinatal health care

The NYS Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2020-21 year:

- Strengthen the perinatal regionalization system through promulgating revised regulations for perinatal services, and subsequent assessment and re-designation of birthing hospitals and birthing centers to match new regulations.

- Collaborate with other NYSDOH units to support the programmatic review to establish midwifery-led birthing centers, and support integration of these facilities into the regional perinatal system as a critical foundation for low-risk obstetrical and neonatal patients for childbirth.
- Collaborate with stakeholders to educate OB/GYN and family practice providers about changes to hospitals' levels of perinatal care in their communities.
- Lead quality improvement projects through the NYSPQC, with birthing hospital teams and community-based organizations, to improve obstetric and neonatal outcomes in specific areas including:
    - reducing maternal morbidity and mortality by improving the assessment, identification and management of obstetric hemorrhage; identifying and managing the care of pregnant and postpartum people with OUD during pregnancy
    - improving the identification, standardization of therapy and coordination of aftercare of infants with NAS;
    - improving infant outcomes, with a focus on those in the NICU, through all transitions during the birth hospitalization and into the community; and
    - improving outcomes for all NYS birthing people by focusing on racial justice and birth equity.
- To improve coordination and increase bilateral referrals between birthing hospitals and home visiting programs, Title V staff will assist in connecting MICHCs with their local birthing hospitals and support formal meetings. Additionally, Title V staff will share promising and best practices from established home visiting-birthing hospital partnerships across the state to encourage collaboration.

**Strategy PIH-3: Maintain and strengthen a robust statewide population-based Newborn Bloodspot Screening Program.**

NYS's NBS program is a population-based program and public health system that identifies infants who may have one of several rare, but treatable diseases through bloodspot screening shortly after birth. Within NYSDOH, the NBS program is housed and administered by the Wadsworth Center, NYS's public health laboratory, with direct support from Title V and several other state and federal funding sources. The NBS program currently performs laboratory testing for 50 diseases, following national recommendations for NBS programs. The program ensures that every newborn in the state receives newborn bloodspot screening as a public health service, with no fee for testing. The program also performs follow-up case management to ensure newborns with a positive screening result receive appropriate diagnostic testing and treatment. Specialty Care Centers are certified and monitored to ensure newborns have access to specialty care for disease-specific testing and management. In addition, the NBS program contracts with each of the state's 10 Inherited Metabolic Disease (IMD) Specialty Care Centers to enroll patients with an IMD diagnosis identified by newborn screening in the NYS Newborn Screening Patient Registry. These IMD Specialty Care Centers are responsible for entering and tracking for consented patients annually, and for attending an annual meeting to discuss long-term follow-up data. Patients are monitored until age 18, when the individual must consent to continue participation until age 21. In 2018, the program screened 222,049 infants, 99.98% of all NYS resident infants born that year (See Form 4 for further details).

The NBS program practices continuous quality improvement using LEAN principles, with a focus on improving overall efficiencies, reducing false positives, and improving timeliness in newborn screening for time-critical conditions. The program also strives to promote the growth of the field of NBS by promoting the development of its staff, participating in national committees, conducting pilot studies, and training other state newborn screening programs. The NBS program collaborates with other public health programs to support mutual goals. For example, NBS program collaborated with the state's Early Hearing Detection and Intervention (EHDI) program on a project to send letters to primary care providers regarding newborns requiring follow-up for failed newborn hearing screening. The NBS program has identified a need for continued education for primary care providers on newborn screening and genetics.

The Title V program will collaborate with the NBS program on the following activities to advance this strategy over the upcoming 2020-21 year:

- Provide comprehensive newborn bloodspot screening for every newborn born in NYS.

- Perform a quality improvement project to ensure hospitals are meeting benchmarks.
- Expand the number of hospital site visits made by NYSDOH staff.

**Strategy PIH-4: Apply public health surveillance and data analysis findings to improve services and systems related to perinatal and infant health care.**

Data-driven, evidence-based practice is essential to achieving public health goals for Maternal and Child Health (MCH). Across all Title V funded programs, continuous effort is needed to enhance the collection, analysis, and sharing of data to inform the planning and implementation of MCH programs and policy work. Sharing data with stakeholders, including providers and community members, is critical to raise awareness, empower community action, and facilitate quality improvement efforts at all levels.

The NYS Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2020-21 year:

- Lead quality improvement projects through the NYSPQC, with birthing hospital teams and community-based organizations, with a focus on: reducing maternal morbidity and mortality by improving the assessment, identification, and management of obstetric hemorrhage; identifying and managing the care of pregnant and postpartum people 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); improving infant outcomes, with a focus on those in the NICU, through all transitions during the birth hospitalization and into the community; and improving outcomes for all NYS birthing people by focusing on racial justice and birth equity.
- Summarize, share, and discuss findings of the Maternal Mortality Review Board (MMRB) with key stakeholders, including the Maternal Mortality Advisory Council and American College of Obstetricians and Gynecologists District II of New York (ACOG-NY), to inform statewide prevention strategies to improve maternal outcomes. This will include the development of issue briefs, webinars, quality improvement projects through the NYSPQC, and a maternal mortality report.
- Establish a comprehensive perinatal data warehouse of perinatal outcomes to make data available in a timely way to birthing hospitals and support quality improvement activities.

**Strategy PIH-5: Address social determinants identified by community members that impact infant health and use of perinatal and infant health care and support services.**

As noted in other domains, perinatal and infant health outcomes are impacted by the social determinants of health (SDOH), or the conditions in which people are born, live, work, play, learn, and age. SDOH include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of power and resources due to racism and other biases are root causes of inequities in access, availability, and quality of SDOH. All ten priorities that emerged from community members' input during the needs assessment revolve around SDOH and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities.

Efforts to improve infant health outcomes must focus directly on addressing longstanding and persistent racial and ethnic disparities in infant health. This persistence of disparities in most of our major health indicators clearly shows that while evidence-based interventions can affect positive change, they alone are not enough to address the larger issues contributing to health inequities. NYS's Title V program thus seeks to combine the strength of data-driven, evidence-based programs and interventions with authentic community engagement opportunities across all Title V funded programs that address perinatal and infant health, including discussions and actions related to racial justice, as well as strengthening community-based and clinical/provider relationships, to increase equity in access to health care and social support services. Title V funded programs seek to engage and empower individuals, families, and communities by increasing

awareness of available community resources and supports; working with community stakeholders to improve delivery of care and services; and enhancing social support, health literacy, and self-care and advocacy skills for pregnant and parenting families.

The Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2020-21 year:

- Through the MICHC programs, work with diverse community stakeholders including community residents to identify and collaboratively address issues and barriers impacting maternal and infant health outcomes at the community level (*see WMH domain for further detail).*
- Through the MICHC and MIECHV programs, provide supports to individual clients and their families to address behavioral social determinants of health outcomes. Provide information on community resources, screen and assist families in enrolling in health insurance and health care, work directly with families to strengthen health literacy, self-care and advocacy skills, and provide and enroll families in enhanced social supports and educational opportunities (*see WMH domain for further detail).*
- Through the NYSPQC, lead a new quality improvement project with birthing hospital teams and community-based organizations, to improve outcomes for all NYS birthing people and infants by focusing on racial justice and birth equity.

The NYS Title V program established one Evidence-Based Strategy Measure (ESM) to track the programmatic investments and inputs designed to impact NPM-3:

**ESM PIH-1: Percent of birthing hospitals with final level of perinatal care designation, in accordance with updated regulations and standards.**

Data for this measure will come from hospital surveys and site visit reports from the NYSDOH subrecipient (IPRO) and NYSDOH staff. The baseline value for this measure will be determined in 2021, after regulations are adopted. The program has set a target to update designations for 50% of hospitals within the first year and 100% within five years.

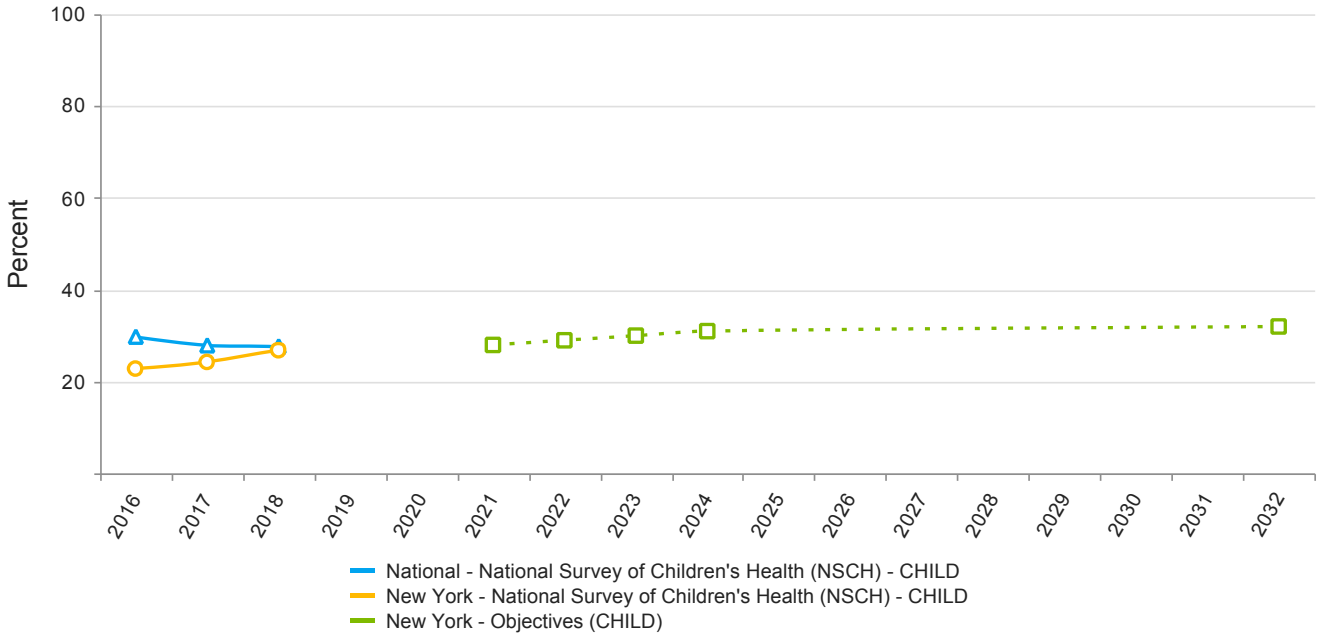
**Child Health**

**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-2017_2018 | 11.1 % | NPM 13.2 |
| NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health | NSCH-2017_2018 | 91.2 % | NPM 6<br>NPM 8.1<br>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-2017_2018 | 14.4 % | NPM 8.1 |
| 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-2016 | 13.7 % | NPM 8.1 |
| 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 8.1 |

## National Performance Measures

**NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day**
**Indicators and Annual Objectives**




| Federally Available Data | | |
|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CHILD** | | |
| | **2016** | **2019** |
| Annual Objective | | |
| Annual Indicator | | 27.0 |
| Numerator | | 369,498 |
| Denominator | | 1,370,994 |
| Data Source | | NSCH-CHILD |
| Data Source Year | | 2017_2018 |

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 | | | | | |
|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 28.0 | 29.0 | 30.0 | 31.0 | 32.0 |

**Evidence-Based or –Informed Strategy Measures**

**ESM 8.1.1 - Percent of children and youth enrolled in School Based Health Centers (SBHCs) who have documentation of counseling or anticipatory guidance on physical activity and nutrition during a visit to a SBHC within the past year**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 0.0 | 0.0 | 5.0 | 10.0 | 20.0 |

**State Action Plan Table**

State Action Plan Table (New York) - Child Health - Entry 1

| Priority Need |
| --- |
| Increase access to affordable fresh and healthy foods in communities. |

| NPM |
| --- |
| NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day |

| Objectives |
| --- |
| Objective CH-1: Increase the percent of NYS children age 6-11 who are physically active at least 60 minutes per day by 3.7%, from 27% in 2017-2018 to 28% in 2021-2022 (NSCH). |
| Objective CH-2: Decrease the percent of NYS children age 10-17 who are obese (BMI at or above the 95th percentile) by 2.8%, and from 14.4% of children age 10-17 in 2017-2018 to 14% in 2021-2022 (NSCH). |

| Strategies |
| --- |
| Strategy CH-1: Promote evidence-based and family-centered health care for children to promote healthy behaviors and to prevent, identify, and manage chronic health issues so that children can be healthy and active. |
| Strategy CH-2: Promote home, school, and community environments that support developmentally appropriate active play, recreation, and active transportation for children of all ages and abilities. |
| Strategy CH-3: Apply public health surveillance and data analysis findings to improve services and systems related to children's health and health care. |
| Strategy CH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact children’s health and well-being. |

| ESMs | Status |
| --- | --- |
| ESM 8.1.1 - Percent of children and youth enrolled in School Based Health Centers (SBHCs) who have documentation of counseling or anticipatory guidance on physical activity and nutrition during a visit to a SBHC within the past year | 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) - Child Health - Entry 2

### Priority Need

Address community and environmental safety for children, youth, and families.

### NPM

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

### Objectives

Objective CH-1: Increase the percent of NYS children age 6-11 who are physically active at least 60 minutes per day by 3.7%, from 27% in 2017-2018 to 28% in 2021-2022 (NSCH).

Objective CH-2: Decrease the percent of NYS children age 10-17 who are obese (BMI at or above the 95th percentile) by 2.8%, and from 14.4% of children age 10-17 in 2017-2018 to 14% in 2021-2022 (NSCH).

### Strategies

Strategy CH-1: Promote evidence-based and family-centered health care for children to promote healthy behaviors and to prevent, identify, and manage chronic health issues so that children can be healthy and active.

Strategy CH-2: Promote home, school, and community environments that support developmentally appropriate active play, recreation, and active transportation for children of all ages and abilities.

Strategy CH-3: Apply public health surveillance and data analysis findings to improve services and systems related to children's health and health care.

Strategy CH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact children’s health and well-being.

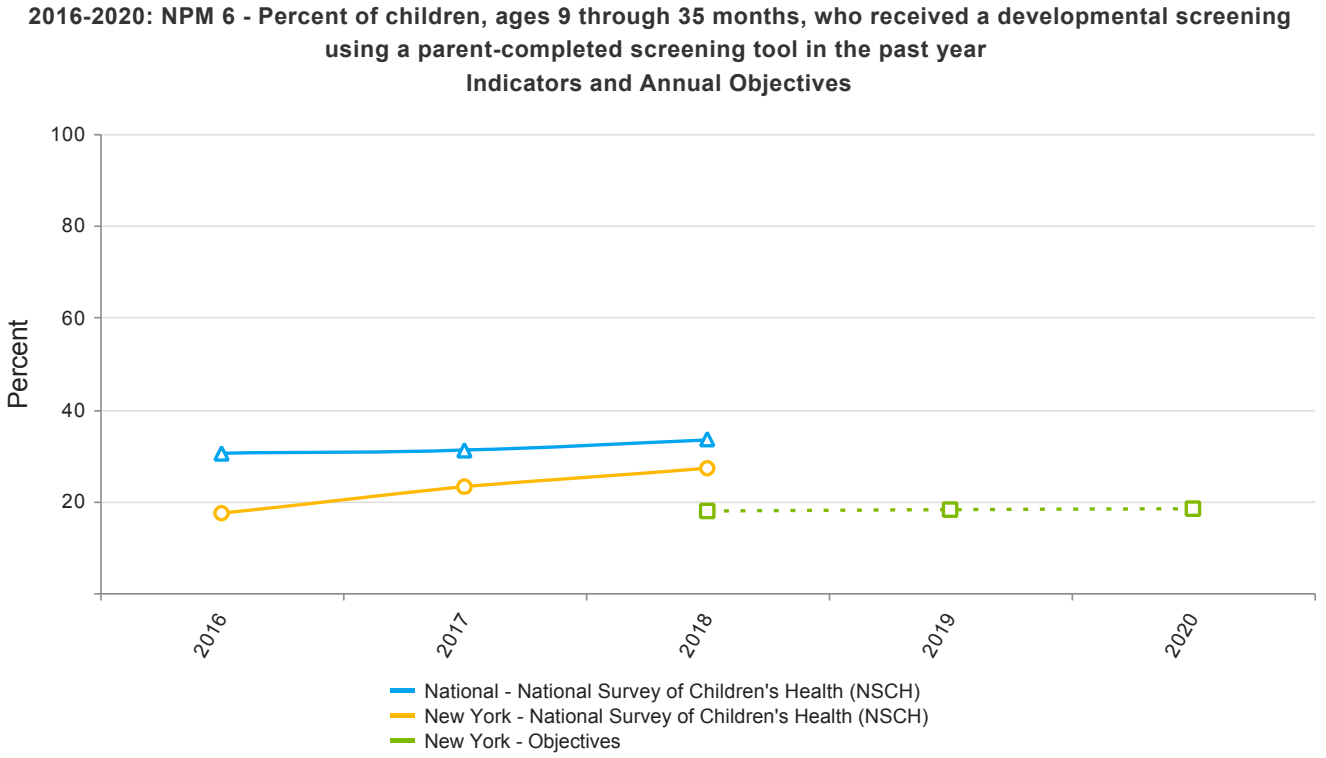
| ESMs | Status |
| --- | --- |
| ESM 8.1.1 - Percent of children and youth enrolled in School Based Health Centers (SBHCs) who have documentation of counseling or anticipatory guidance on physical activity and nutrition during a visit to a SBHC within the past year | Active |

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)

**2016-2020: National Performance Measures**



| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | | 17.9 | 18.2 |
| Annual Indicator | | 17.5 | 23.1 | 27.1 |
| Numerator | | 101,178 | 117,256 | 140,531 |
| Denominator | | 578,216 | 506,773 | 519,134 |
| Data Source | | NSCH | NSCH | NSCH |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

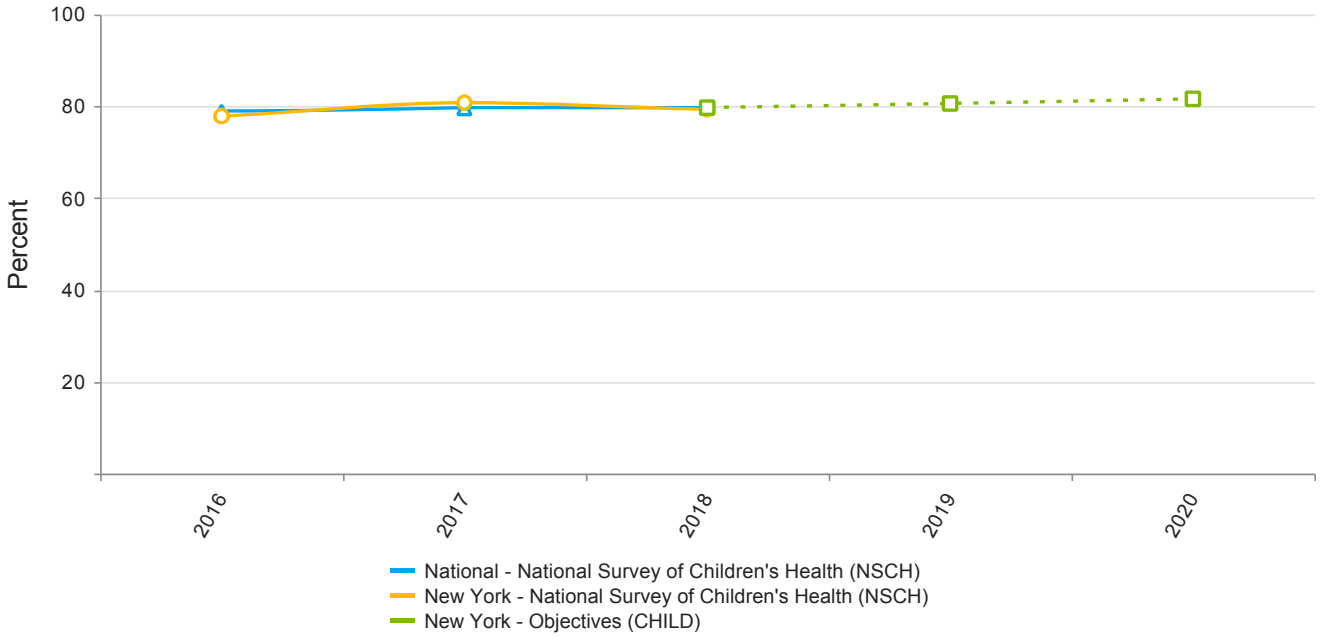
Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

**2016-2020: Evidence-Based or –Informed Strategy Measures**

**2016-2020: 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** | **2019** |
| Annual Objective | | 0 | 1,600 | 1,680 |
| Annual Indicator | 0 | 1,694 | 2,488 | 5,468 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | NYS Medicaid Health Home Data | 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 | 2018-19 |
| Provisional or Final ? | Final | Final | Final | Final |

**2016-2020: NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year**
**Indicators and Annual Objectives**




**2016-2020: NPM 13.2 - Child Health**

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | | 79.6 | 80.5 |
| Annual Indicator | | 77.6 | 80.6 | 79.3 |
| Numerator | | 2,955,156 | 3,137,003 | 3,084,314 |
| Denominator | | 3,810,186 | 3,890,746 | 3,887,411 |
| Data Source | | NSCH | NSCH | NSCH |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

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.

**2016-2020: Evidence-Based or –Informed Strategy Measures**

**2016-2020: 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** | **2019** |
| Annual Objective | | 20 | 60 | 61 |
| Annual Indicator | 58 | 60 | 48 | 29 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | NYS Title V Program records | NYS Title V Program records | NYS Title V Program records | NYS Title V Program records |
| Data Source Year | 2017 | 2018 | 2019 | 2020 |
| Provisional or Final ? | Final | Final | Final | Final |

**2016-2020: 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** | **2019** |
| Annual Objective | | 40 | 41 | 44 |
| Annual Indicator | 61.2 | 50.5 | 39.1 | 21 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | SEALS (CDC Data) | SEALS (CDC Data) | SEALS (CDC Data) | SBSP quarterly reports |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Final | Final | Final | Final |

**2016-2020: State Performance Measures**

**2016-2020: 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** | **2019** |
| Annual Objective | | 50 | 50 | 50 |
| Annual Indicator | 0 | 0 | 0 | 0 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | To Be Developed | Developmental Assessment Tool | Developmental Assessment Tool | Developmental Assessment Tool |
| Data Source Year | 2017-2018 | 2017-2018 | 2017-2018 | 2018-2019 |
| Provisional or Final ? | Final | Final | Final | Final |

**2016-2020: 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** | **2019** |
| Annual Objective | | 72 | 73 | 75 |
| Annual Indicator | 71.7 | 71.6 | 70.8 | 70.8 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | CDC Water Fluoridated Reporting System | CDC Water Fluoridated Reporting System | CDC Water Fluoridated Reporting System | CDC Water Fluoridated Reporting System |
| Data Source Year | 2017 | 2018 | 2019 | 2019 |
| Provisional or Final ? | Final | Final | Final | Provisional |

**FFY 2019 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 (e.g., 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 program, NYS selected the National Outcome Measure for children's overall health. Results from the 2017-2018 National Survey of Children's Health (NSCH) indicate that 91.2% of children ages 0-17 are in excellent or very good health, which compares closely with the national estimate of 90%. 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 27.1% of parents reported completing a developmental screening.

Title V staff collaborates with the Council on Children and Families (CCF) 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. Elizabeth 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 State Action Plan (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 NYSDOH 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 Centers for Disease Control and Prevention (CDC) and administered by NYSDOH. 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 four or more ACEs. The most frequently 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 CCF 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 state's Part C of the Individuals with Disabilities Education Act (IDEA) Early Intervention program (EIP) 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 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 (2,951) who exited the EIP or turned three between July 1, 2018 and June 30, 2019 and were served by the EIP for at least six months, 92% made improvement in their social-emotional skills and, of those, 62% made substantial improvement.

The second strategy in the SAP is to identify, pilot test and implement a 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, which 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 are 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 that content knowledge exists across the Title V programs in the Division of Family Health, staff formed a Social Emotional Workgroup, consisting of representatives from different programs and including a team member with access to and understanding of data. The workgroup 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 regularly to identify training opportunities, new data or research on evidence-based practices, and to monitor progress within these domains.

During the Summer of 2019, Title V staff participated in a cross-agency collaborative which included a four-month long training on Trauma Informed Care (TIC), to establish TIC Champions. The training was led by the University of Buffalo Center for Social Research, Institute on Trauma and Trauma Informed Care, and sponsored by the NYS Department of Criminal Justice Services (DCJS). The 28 Champions, from over 11 agencies, will work together to promote, train, and advance the integration of a trauma informed approach within their organizations and throughout the State.

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.

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 to 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, six editions of this publication have been developed and shared with Title V staff.  Starting with the July 2018 update, the distribution was expanded to include contractors and other interested stakeholders beyond Title V staff. Topics highlighted in the Winter 2018 and Spring/Summer 2019 updates included Trauma-Informed Care (TIC), and TIC Initiatives, ACEs, the NYS Trauma Informed Network, cyberbullying, and youth suicide.

As discussed previously, promoting positive social-emotional development, including nurturing relationships, is fundamental to the Part C Early Intervention Program. The EIP provided 9 million service interactions to 70,000 children in 2018-2019. 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. Desk aids and an E-Learning series are being developed. The desk aids' content will be targeted for specific EIP roles and will be available on the DOH website once completed and sent out on EI list servs to reach providers and municipality staff. The E-Learning will consist of six modules and will be available to the public for free via the Bureau's training contractor, Measurement Inc.'s website. The goal is to complete these two remaining projects by the end of 2020.

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 Community Health Workers (CHW) to assess women and their families and connect them with needed resources. There are currently 23 MICHC projects in priority communities across NYS. CHWs served 5,987 families and provided 15,789 home visits in 2019. 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 programs 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, 3,060 families were served, receiving 34,526 home visits in 2019. 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 Early Childhood Learning Center.

- 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.
- The FIC develops short vignettes on EIP topics to enhance families' understanding of the EIP.

NY's innovative Sexual Risk Avoidance Education Program, which launched July 1, 2019, supports 12 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. SRAE projects provide youth with support and information on a wide range of topics framed in a youth development philosophy, focusing on the needs of youth and building on and nurturing the youth's individual strengths and needs. They also provide adult-supervised activities to stimulate cognitive, social, physical and emotional growth. Caring adults are available for more in-depth support and discussions. These programs also provide parent education to parents, guardians and adult caregivers to create a more nurturing environment for these youth. Between July 1, 2019 and January 31, 2020, SRAE reached 400 youth and will continue to see the program expand.

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 more than 260 SBHC-sites 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 nearly 200,000 students and provided more than 700,000 visits for health and supportive services. Of the more than 700,000 visits approximately 92,000 included a mental health visit. Seventy-five percent of NYS SBHCs provide mental health services on site, the remainder of sites refer children to mental health providers within their community.

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. Enrollment and outreach data are being reported as a point-in time reference as of October 5, 2019. The number of children enrolled in CHH for the third quarter of year three, is reported to be 27,071. Compared to the number of children enrolled in CHH for the last quarter in 2018 was 17,524. In December 2018, 1605 children had received outreach from a CHH compared to 1687 in third quarter of 2019. In April 2019, the six 1915 (c) Home and Community Based Services consolidated into a single 1915 (c) Children's Waiver.

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.

**Child Health - Application Year**

**Application for FY21**

For Child Health (CH), New York's Title V program selected **National Performance Measure (NPM) 8.1: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day.** This NPM was selected because it is responsive to concerns voiced directly by families in NYS and reinforced by state-specific population health data.

Over 14% of NYS children age 10-17 are obese, and only 27% of NYS children age 6-11 years are physically active for at least 60 minutes daily. NYS families identified the availability and accessibility of amenities that support children's safe, active play and access to healthy foods as top priority needs, alongside priorities for community and environmental safety for children and community transportation. Supporting healthy, active play and recreation for children and youth of all ages is critical to promoting healthy weight as well as general physical and mental health during childhood and throughout the life course. In addition, this measure provides opportunities to be responsive to the Title V priorities for health care access and quality, social support, and social cohesion. This NPM aligns directly with NYS Prevention Agenda goals for physical activity and chronic disease prevention.

The NYS Title V program has important capacity to address these priorities through its School Based Health Center (SBHC) program and through collaboration with the NYSDOH Creating Healthy Schools and Communities program to enhance environmental infrastructure and supports, both in schools and in the community, to support physical activity. SBHCs serve NYS's highest need communities and provide critical access to quality primary care for school-aged children.

Two specific objectives were established to align with this performance measure:

**Objective CH-1**: Increase the percent of NYS children age 6-11 who are physically active at least 60 minutes per day by 3.7%, from 27% in 2017-2018 to 28% in 2021-2022 (National Survey of Children's Health, NSCH).

**Objective CH-2**: Decrease the percent of NYS children age 10-17 who are obese (BMI at or above the 95$^{th}$ percentile) by 2.8%, and from 14.4% of children age 10-17 in 2017-2018 to 14% in 2021-2022 (NSCH).

Four strategic public health approaches were identified to accomplish these objectives over the next five years. These are presented in the State Action Plan (SAP) Table, and each is described in more detail here, with specific program and policy activities that will be implemented to advance the broader strategic approach in the upcoming year.

**Strategy CH-1: Promote evidence-based and family-centered health care for children to promote healthy behaviors and to prevent, identify, and manage chronic health issues so that children can be healthy and active.**

To be physically active, children's basic health needs for growth, development, and good nutrition must be met. Health care providers play an important role in promoting physical activity and other healthy behaviors, and in managing children's health needs including mental health, obesity, asthma, and other special health care needs and challenges that may impinge on children's ability to participate in active play and recreation. Health care providers should follow current evidence-based guidelines for anticipatory guidance, screening, counseling, and disease management, including guidelines specific to physical activity and healthy weight, and help guide children and their families in finding and using available community resources for active play and recreation.

School Based Health Centers (SBHCs) are an important source of primary and preventive care services for thousands of NYS children and have the opportunity and capacity to holistically address children's needs. Title V staff will work with SBHCs statewide to ensure anticipatory guidance to promote proper nutrition and daily physical activity, weight status assessment, and attention to overall health promotion and chronic disease management, as part of routine primary and preventive care for children. In addition, the Title V program will continue to support an array of core public health programs

that address children's health and wellness and access to and primary and preventive health care services.

The Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2020-21 year:

- Provide guidance and add quarterly reporting requirements for all funded School-Based Health Centers (SBHCs) to increase provision of 1) age-appropriate anticipatory guidance regarding physical activity and nutrition and 2) routine assessment for indicators of overall health, one of which will be weight status but it will not be the sole factor. Data from quarterly reports will be reviewed and reports will be generated for feedback to SBHCs to assess progress and drive improvements in these practices.
- Promote the use of the American Academy of Pediatrics (AAP)'s Bright Futures model for anticipatory guidance in SBHCs and seek opportunities to engage AAP for assistance to promote this resource.
- Incorporate guidance, reporting, and tracking to support SBHCs to engage their dental patients in conversations about physical activity and nutrition through the delivery of anticipatory guidance on nutrition including water and sugar-sweetened beverage consumption, and work with SBHCs to ensure that enrolled students have an established dental home to promote optimal oral and overall health.
- Explore opportunities to collaborate with New York School-Based Health Alliance (NYSBHA) to support SBHCs' increased effort towards promoting physical activity such as hosting webinars with subject matter experts.
- Within the Title V program, strengthen collaboration between child- and adolescent- serving programs to enhance promotion of physical activity through established programs that focus on adult-led activities and social-emotional wellness.
- Collaborate with the NYSDOH Division of Nutrition to incorporate public health nutrition messaging with physical activity guidance across child health programs, including SBHC and CYSHCN programs.
- Continue to directly support a portfolio of Title V-funded programs and services that promote children's wellness and enhance access to comprehensive primary and preventive care services for children, including:
    - School-based dental sealant and community water fluoridation programs to promote children's oral health and reduce dental caries as key contributors to children's overall health and well-being.
    - American Indian Health and Migrant and Seasonal Farmworker Programs to ensure access to primary and preventive care services for children and families in underserved populations.
    - Comprehensive Services and Health Systems Approaches to Improve Asthma Control in New York State to improve the quality and availability of guidelines-based asthma care.
    - Local Health Department-based Lead Poisoning Prevention Programs and Regional Lead Resource Centers to promote risk-assessment, blood lead level testing, evaluation, and care management to reduce the prevalence and impact of elevated blood lead levels in children.

**Strategy CH-2: Promote home, school, and community environments that support developmentally appropriate active play, recreation, and active transportation for children of all ages and abilities.**

To achieve state goals related to increasing physical activity among children, children and their families need safe, appealing, and accessible places to play and be active – at home, in school, and in their neighborhoods and communities. Across the community listening forums, families and children voiced a desire for amenities in their neighborhoods that provide opportunities for active play and daily physical activity, such as playgrounds, athletic facilities, greenspace, and community centers. They want streets, sidewalks, and trails that are accessible and safe for walking and biking, both for transportation and recreation. They want these areas to be clean, appealing, and safe for children and families. They want to know what is available, have a way to get there, and feel welcome and included. These concepts are central to the mission of the NYSDOH Creating Healthy Schools and Communities program. Title V staff will develop strong relationships with this program and integrate SBHC staff into the program's local efforts to enhance outcomes for the communities served.

The Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2020-21 year:

- Collaborate with the NYSDOH Division of Chronic Disease Prevention (DCDP) to implement multi-pronged strategies to enhance the work of Creating Healthy Schools and Communities grantees, and other initiatives aimed at increasing children's physical activity.
- Facilitate partnerships between local Creating Healthy Schools and Communities grantees and SBHCs to engage and educate community partners, families and community residents on the benefits of physical activity through Complete Streets implementation, including Safe Routes to School programs.
- Actively participate in DCDP's Pediatric Obesity Prevention Work Group, contribute to the direction of the group, and establish mutually beneficial priorities.

**Strategy CH-3: Apply public health surveillance and data analysis findings to improve services and systems related to children's health and health care.**

Data-driven, evidence-based practice is essential to achieving public health goals for the Title V program. Across all Title V programs, continuous effort is needed to enhance the collection, analysis, and sharing of data to inform the planning and implementation of Title V-funded programs and policy work. Sharing data with stakeholders, including providers and community members, is critical to raise awareness, empower community action, and facilitate quality improvement efforts at all levels.

The Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2020-21 year:

- Collaborate with the U.S. Census Bureau to conduct an over-sample of NYS 2021 National Survey of Children's Health for NYS to allow for enhanced sampling of Black/African-American, Hispanic, and CYSHCN.
- Design and implement a SBHC data collection system that allows SBHCs to identify, track, and address disparities within the SBHC.
- Engage and survey stakeholders to identify, track, and address disparities within the SBHC.
- Explore collaborative opportunities with DCDP's Bureau of Chronic Disease Evaluation and Research to review and share information on student weight status assessments to inform SBHC work in this area.

**Strategy CH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact children's health and well-being.**

Child health outcomes are impacted by social determinants of health (SDOH), or the conditions in which people are born, live, work, play, learn, and age. SDOH include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of power and resources due to racism and other biases are root causes of inequities in access, availability, and quality of SDOH. All ten priorities that emerged from community members' input during the needs assessment revolve around SDOH and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities.

SBHCs are located in the highest needs areas of NYS. The school communities served are disadvantaged economically and disproportionately impacted by key social determinants of health such as housing, transportation, employment, access to health care, and sources of healthy food. Families facing day-to-day challenges of poverty and racism, may be less able to prioritize or take advantage of opportunities for recreational physical activity.

Development of community resources, public health programs, and other opportunities to promote physical activity need to be viewed through an equity lens. SBHC staff can have a direct effect on their school communities by assessing the physical activity needs and weight status of the students, helping to identify barriers to exercise and healthy food, and

partnering with key stakeholders to take action to create a more equitable distribution of resources. These steps can contribute to environmental improvements that lead to increased physical activity and reduce health disparities attributed to lack of exercise and unhealthy lifestyle.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2020-21 year:

- Design the new SBHC data collection system with a racial justice and health equity lens, building a reporting tool that allows SBHCs to identify, track, and address disparities within the SBHC (site or provider level)
- Partner with key stakeholders such as the Community Health Care Association of New York State (CHCANYS) and NYSBHA to identify and share best practices for SBHCs to address racial justice and health equity.

The NYS Title V program established one Evidence-Based Strategy Measure (ESM) to track the programmatic investments and inputs designed to impact NPM 8.1:
**ESM CH-1**: **Percent of children and youth enrolled in SBHCs who have documentation of counseling or anticipatory guidance on physical activity and nutrition during a visit to a SBHC within the past year.**

Data for this measure will come from the SBHC quarterly reporting system. As this is a new measure, the baseline value will be established in FFY 2020-21, with improvement targets for subsequent years set once the baseline is available.

**Adolescent Health**

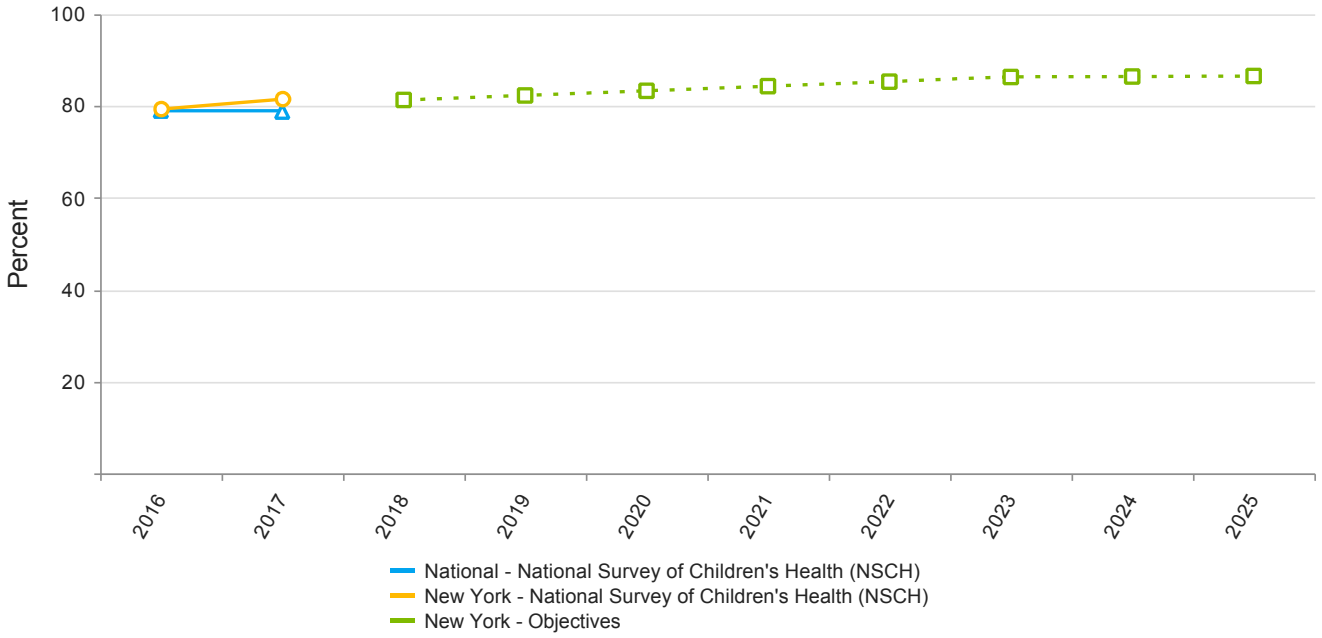
**Linked National Outcome Measures**

| 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-2017_2018 | 11.1 % | NPM 13.2 |
| NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000 | NVSS-2018 | 21.9 | NPM 10 |
| NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 | NVSS-2016_2018 | 4.6 | NPM 10 |
| NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000 | NVSS-2016_2018 | 6.0 | NPM 10 |
| NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system | NSCH-2017_2018 | 15.2 % | NPM 12 |
| NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling | NSCH-2017_2018 | 53.5 % | NPM 10 |
| NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health | NSCH-2017_2018 | 91.2 % | NPM 8.2<br>NPM 10<br>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-2017_2018 | 14.4 % | NPM 8.2<br>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-2016 | 13.7 % | NPM 8.2<br>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<br>NPM 10 |
| NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza | NIS-2018_2019 | 69.6 % | NPM 10 |
| NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine | NIS-2018 | 67.3 % | NPM 10 |
| NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine | NIS-2018 | 91.7 % | 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-2018 | 94.9 % | NPM 10 |
| NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females | NVSS-2018 | 11.7 | NPM 10 |

## National Performance Measures

**NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**
**Indicators and Annual Objectives**




| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | | 81.2 | 82.2 |
| Annual Indicator | | 79.2 | 81.3 | 81.3 |
| Numerator | | 1,103,856 | 1,081,532 | 1,081,532 |
| Denominator | | 1,393,274 | 1,331,106 | 1,331,106 |
| Data Source | | NSCH | NSCH | NSCH |
| Data Source Year | | 2016 | 2016_2017 | 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 | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 83.2 | 84.2 | 85.2 | 86.2 | 86.3 | 86.4 |

**Evidence-Based or –Informed Strategy Measures**

**ESM 10.1 - Percent of youth-serving programs that provide training on adult preparation subjects, such as accessing health insurance, maintaining their routine preventive medical visits, healthy relationships, effective communication, financial literacy, and ad**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 0.0 | 0.0 | 5.0 | 10.0 | 20.0 |

**ESM 10.2 - Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 0.0 | 0.0 | 5.0 | 10.0 | 20.0 |

**State Action Plan Table**

State Action Plan Table (New York) - Adolescent Health - Entry 1

## Priority Need

Cultivate and enhance social support and social cohesion opportunities for individuals and families who experience isolation as a result of systemic barriers including racism, 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 percent of adolescents, ages 12-17, with a preventive medical visit in the past year by 5%, from 81.3% in 2016-2017 to 85.4% in 2021-2022. (NSCH)

Objective AH-2: Increase the percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling by 5%, from 53.5% in 2017-2018 to 56.2% in 2021-2022. (NSCH)

Objective AH-3: Increase the percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine by 8%, from 67.3% in 2018 to 72.7% in 2022. (NIS)

Objective AH-4: Increase the percent of NYS adolescents without special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 16.4% in 2017-2018 to 17.2% in 2021-2022. (NSCH)

## Strategies

Strategy AH-1: Incorporate specific activities to promote the wellness of adolescents across all Title V programs, including promoting and facilitating routine well visits, reproductive health care, oral health, and behavioral health.

Strategy AH-2: Promote supports for adolescents to gain the knowledge, self- efficacy, and resources they need to prepare for and transition to adulthood.

Strategy AH-3: Apply public health surveillance and data analysis findings to improve services and systems related to children's health and health care.

Strategy AH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact adolescents' health and well-being.

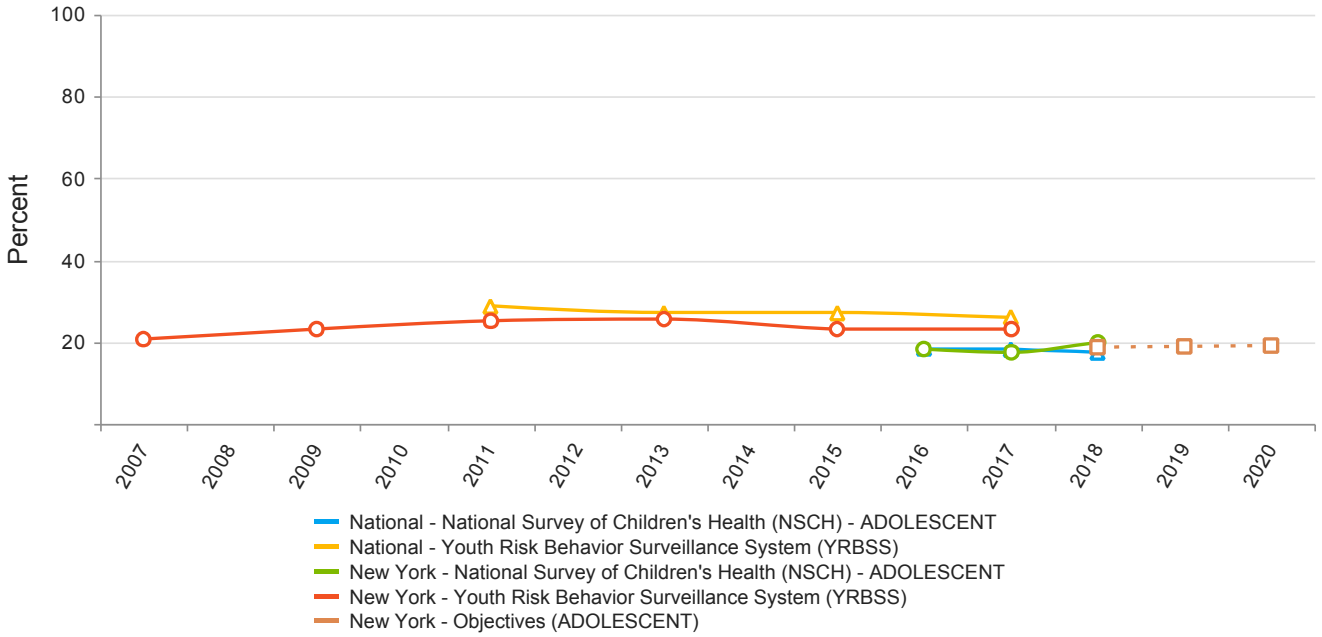
| ESMs | Status |
|---|---|
| ESM 10.1 - Percent of youth-serving programs that provide training on adult preparation subjects, such as accessing health insurance, maintaining their routine preventive medical visits, healthy relationships, effective communication, financial literacy, and ad | Active |
| ESM 10.2 - Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation | 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 |

**2016-2020: National Performance Measures**

**2016-2020: 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** | **2019** |
| Annual Objective | 27.1 | 27.5 | 18.8 | 19 |
| Annual Indicator | 23.3 | 23.3 | 23.2 | 23.2 |
| Numerator | 161,704 | 161,704 | 159,614 | 159,614 |
| Denominator | 694,960 | 694,960 | 689,106 | 689,106 |
| Data Source | YRBSS-ADOLESCENT | YRBSS-ADOLESCENT | YRBSS-ADOLESCENT | YRBSS-ADOLESCENT |
| Data Source Year | 2015 | 2015 | 2017 | 2017 |

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | | 18.8 | 19 |
| Annual Indicator | | 18.3 | 17.7 | 19.9 |
| Numerator | | 246,053 | 232,223 | 284,451 |
| Denominator | | 1,346,787 | 1,313,811 | 1,426,960 |
| Data Source | | NSCH-ADOLESCENT | NSCH-ADOLESCENT | NSCH-ADOLESCENT |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

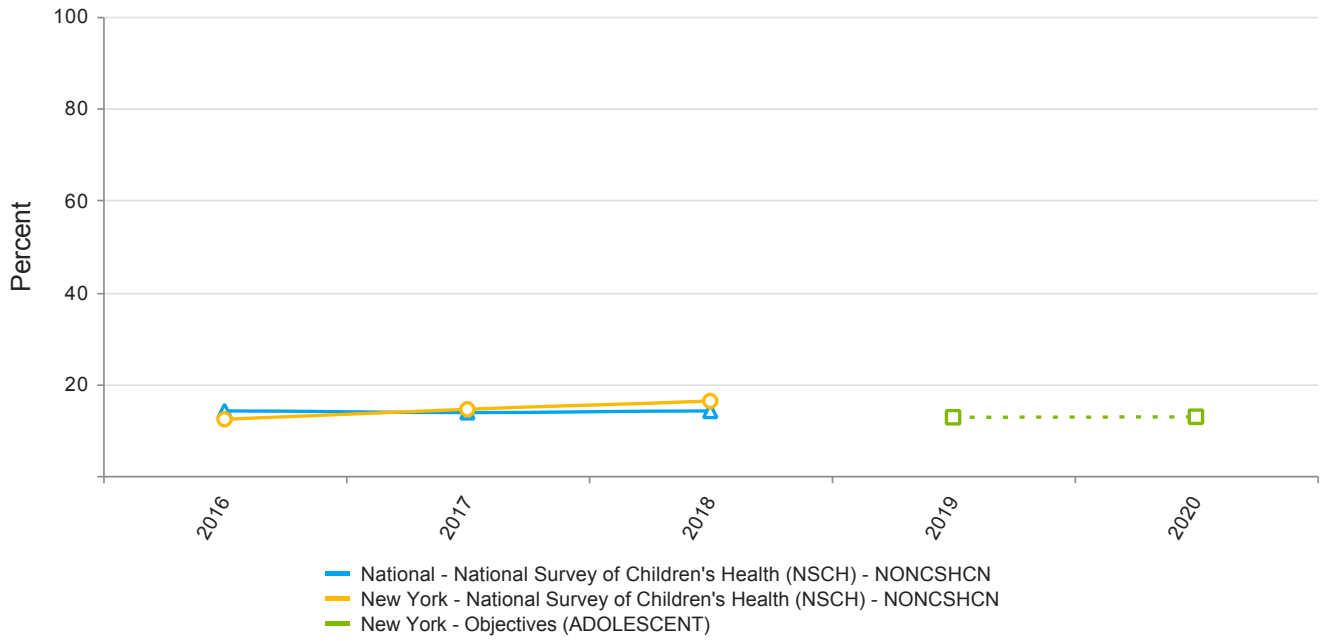
Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

**2016-2020: Evidence-Based or –Informed Strategy Measures**

**2016-2020: 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** | **2019** |
| Annual Objective | | | 6 | 7 |
| Annual Indicator | 1 | 6 | 6 | 8 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | Title V Program data | Title V Program data | Title V Program data | Title V Program data |
| Data Source Year | 7/16-6/17 | 16-18 | 17-19 | 18-19 |
| Provisional or Final ? | Final | Final | Final | Final |

**2016-2020: 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**




**2016-2020: NPM 12 - Adolescent Health - NONCSHCN**

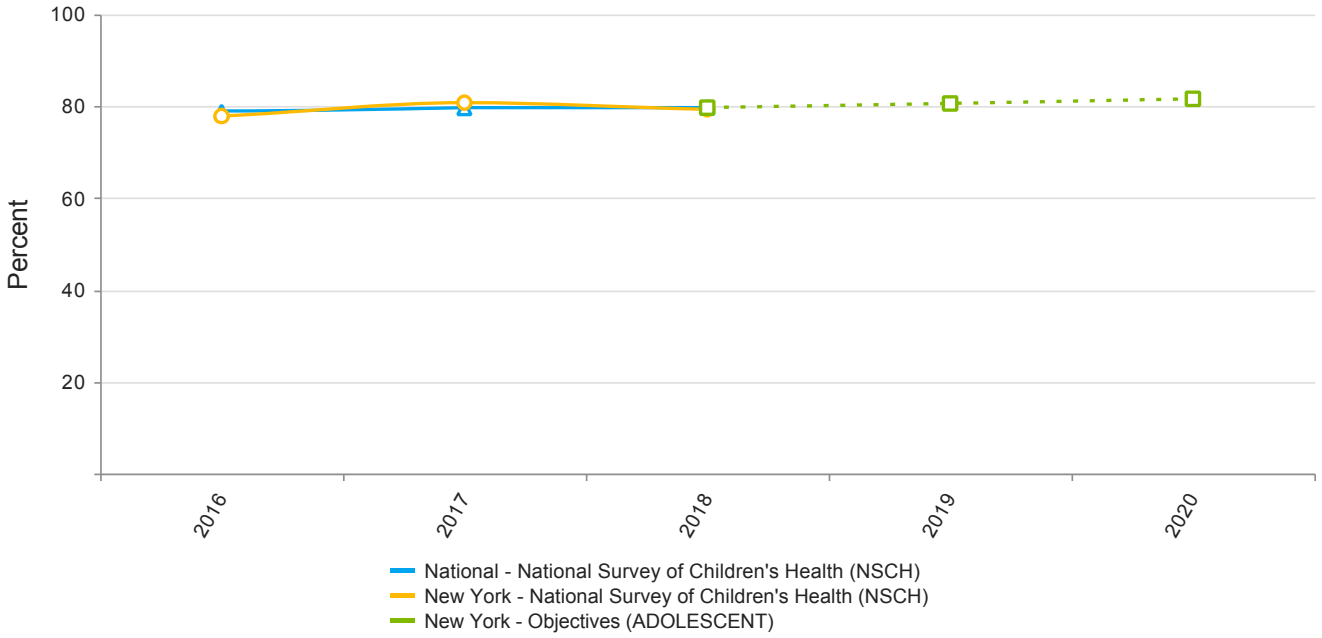
| **Federally Available Data** | | | |
|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - NONCSHCN** | | | |
| | **2017** | **2018** | **2019** |
| Annual Objective | | | 12.8 |
| Annual Indicator | 12.3 | 14.5 | 16.4 |
| Numerator | 130,919 | 156,317 | 189,724 |
| Denominator | 1,062,218 | 1,079,417 | 1,158,201 |
| Data Source | NSCH-NONCSHCN | NSCH-NONCSHCN | NSCH-NONCSHCN |
| Data Source Year | 2016 | 2016_2017 | 2017_2018 |

**2016-2020: Evidence-Based or –Informed Strategy Measures**

**2016-2020: 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** | **2019** |
| Annual Objective | | 45 | 60 | 32.8 |
| Annual Indicator | 63.9 | 66.9 | 32.5 | 38 |
| Numerator | 4,275 | 5,244 | 902 | 950 |
| Denominator | 6,688 | 7,843 | 2,777 | 2,502 |
| Data Source | NYEHDI | NYEHDI | NYEHDI | NYEHDI |
| Data Source Year | CY2016 | CY2017 | CY2018 | CY2018 |
| Provisional or Final ? | Final | Final | Provisional | Final |

**2016-2020: NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year**
**Indicators and Annual Objectives**




**2016-2020: NPM 13.2 - Adolescent Health**

| **Federally Available Data** | | | | |
|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | | 79.6 | 80.5 |
| Annual Indicator | | 77.6 | 80.6 | 79.3 |
| Numerator | | 2,955,156 | 3,137,003 | 3,084,314 |
| Denominator | | 3,810,186 | 3,890,746 | 3,887,411 |
| Data Source | | NSCH | NSCH | NSCH |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

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.

**2016-2020: Evidence-Based or –Informed Strategy Measures**

**2016-2020: 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** | **2019** |
| Annual Objective | | 20 | 60 | 61 |
| Annual Indicator | 58 | 60 | 48 | 29 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | NYS Title V Program records | NYS Title V Program records | NYS Title V Program records | NYS Title V Program records |
| Data Source Year | 2017 | 2018 | 2019 | 2020 |
| Provisional or Final ? | Final | Final | Final | Final |

**2016-2020: 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** | **2019** |
| Annual Objective | | 40 | 41 | 44 |
| Annual Indicator | 61.2 | 50.5 | 39.1 | 21 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | SEALS (CDC Data) | SEALS (CDC Data) | SEALS (CDC Data) | SBSP quarterly reports |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Final | Final | Final | Final |

**2016-2020: State Performance Measures**

**2016-2020: 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** | **2019** |
| Annual Objective | | 50 | 50 | 50 |
| Annual Indicator | 0 | 0 | 0 | 0 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | To Be Developed | Developmental Assessment Tool | Developmental Assessment Tool | Developmental Assessment Tool |
| Data Source Year | 2017-2018 | 2017-2018 | 2017-2018 | 2018-2019 |
| Provisional or Final ? | Final | Final | Final | Final |

**2016-2020: 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** | **2019** |
| Annual Objective | | 72 | 73 | 75 |
| Annual Indicator | 71.7 | 71.6 | 70.8 | 70.8 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | CDC Water Fluoridated Reporting System | CDC Water Fluoridated Reporting System | CDC Water Fluoridated Reporting System | CDC Water Fluoridated Reporting System |
| Data Source Year | 2017 | 2018 | 2019 | 2019 |
| Provisional or Final ? | Final | Final | Final | Provisional |

**FFY 2019 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 the NYS Title V State Action Plan (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.

In 2019, Title V staff identified many existing data sources as well as relevant research findings, and evidence-based program resources, and continued to make them available and accessible to all Title V staff by posting them on the Title V program 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. In 2017, staff 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.
Staff will continue to create and publish the Social Emotional Wellness Update biannually.

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. In 2018, 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, 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 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 Youth Risk Behavior Survey (YRBS) and the 2016 Behavioral Risk Factor Surveillance System (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. The most frequently 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 maternal, child and adolescent populations.

Title V staff have worked on collaborative efforts on social-emotional wellness subject-matter. In addition to the Early Childhood Advisory Council (ECAC) and Early Intervention Coordinating Council (EICC), the ACEs workgroup partnered with several New York State Department of Health (NYSDOH) areas as well as the NYS Office of Addiction Services and Supports (OASAS). Objectives included discussing the prevalence of ACEs in NYS and demographics of those affected and best practices to prevent, reduce and address ACEs. NYS has the Youth Development Team, which includes NYSDOH Title V staff, OASAS, Office of Mental Health (OMH), the Office of Temporary Disability Assistance (OTDA), and Office for Children and Family Services (OCFS) and meets on a quarterly basis to address many topics facing today's teenagers.

In 2019, Title V staff were invited to join a Trauma-Informed Care Champion Collaborative sponsored by the New York State

Department of Criminal Justice Services (DCJS). Staff participated in a rigorous, four-month program led by the University at Buffalo Center for Social Research, Institute on Trauma and Trauma-Informed Care. Staff learned about trauma-informed organizational change and how it can be implemented at the state level. Since September 2019, the group has grown to 28 Champions from agencies such as Office of Victim Services (OVS), Office for the Prevention of Domestic Violence (OPDV), State Education Department (SED), Office for People with Developmental Disabilities (OPWDD), the Justice Center, OCFS, OMH and OASAS. The group has spearheaded this movement and is currently developing a vision, mission and goals to eventually implement the trauma-informed care lens at the state level.

The NYS 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). The six 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) oversee by the Bureau of Women, Infant and Adolescent Health (BWIAH) and co-located within the Division that oversees the Title V program, provides 24-hour crisis hotlines and intervention services, short-term counseling, medical, forensic, and support services (e.g. accompaniment, advocacy, information, and referrals) to rape and sexual assault victims and survivors. 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/survivors and, provide direct services and 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 RPE program 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 NYS. In 2019, the six Regional Centers for Sexual Violence Prevention implemented 50 total prevention strategies targeting all levels of the social ecological model. Of the 50 strategies, 17 were aimed at the individual/relationship level and 33 at the community/societal level. There was a total of 156 unique cycles of individual/relationship level curricula completed, reaching 2,592 individuals.

The RPE program has spearheaded a Safer Bars Initiative, currently funded through a CDC cooperative agreement. As part of this initiative, NYSDOH 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 social-ecological model of violence prevention, which is the prevention framework the RPE grant program. CDC use a four-level social-ecological model to better understand violence and the effect of potential prevention strategies. This model considers the complex interplay between individual, relationship, community, and societal factors and allows for the conceptualization of the range of factors that put people at risk for violence or protect them from experiencing or perpetrating violence.

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 (i.e.,

an individual/relationship level curriculum) including the environmental assessment and policy change assistance components (i.e., community/societal level approaches). One Regional Center is utilizing the OutSmart NYC bar bystander curriculum.

Across New York State there are currently 45 Alcohol Serving Establishments (ASE) that have been trained in the Safer Bars curriculum and 16 trained in OutSmart with 669 bar staff/managers/owners trained. To teach the curriculum there are currently 50 trainers across the state qualified to train on the Safer Bars curriculum.

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 overseen by the NYSDOH Campus Sexual Assault Prevention Unit within BWIAH. In the 2019-2020 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 and training on the prevention of sexual and domestic violence in campus communities. Trainings included the following webinars; a two-part webinar series titled *Serving Students with Intellectual and Developmental Disabilities*, *How Do We Engage Male Students in Prevention Sexual and Domestic Violence?* and *Addressing Alcohol's Role in Campus Sexual Assault: A Toolkit for and by Prevention Specialists*. In addition, there were two in-person full-day trainings for all three of the Alliance TA regions titled; *Engaging Students and Reframing Workshop Titles: Complicating the Victim-Perpetrator Binary*, and *Beyond the Letters- Unpacking Queer Identities*. Enough is Enough programs also attended the Annual BWIAH Provider Meeting on May 22-23, 2019. To date, through 252 partnerships with local colleges/universities, EIE rape crisis programs have provided information and/or direct services to 36,192 campus sexual assault victims and have reached 368,570 individuals through awareness events or educational campaigns, and 71,400 through training. These numbers include college/university students, faculty, staff and some parents/caregivers and are expected to continue to increase.

School-Based Health Centers (SBHCs), which receive Title V funding, serve elementary, middle and high school age children and are required to provide behavioral health screening for all patients as part of ongoing primary care. Most SBHCs provide additional mental health services on-site within the clinics located within the school buildings; mental health services are provided by referral at sites that do not have in-clinic resources. Currently, in NYS there are over 260 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 197,346 students and provided 702,865 visits for health and supportive services.

The goals of the Pathways to Success initiative, funded by the federal Office of Population Affairs beginning July 1, 2017 through June 30, 2020, are to strengthen community systems serving pregnant and parenting teens and young adults; improve the health, development, and well-being of young parents and their children; improve young parents' self-sufficiency through educational attainment; and increase awareness of resources available to expectant and parenting teens and young adults. The initiative is focused in New York City based on 2015 NYS Vital Statistics data showing Kings, Bronx and Queens counties with the highest birth rates among females ages 15 to 24.

The Pathways to Success grant supports three community colleges (Hostos, LaGuardia and Borough of Manhattan) and a community-based organization (Public Health Solutions) to develop, expand and sustain supportive communities to help expectant and parenting teens and young adults maintain their health and meet educational or vocational goals. The funded projects collaborate with Title V programs such as Maternal and Infant Community Health Collaboratives (MICHC) and Maternal, Infant and Early Childhood Home Visiting (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.

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, parenting skills, and touches upon developmental assets in all eight categories. All students and community members enrolled in the initiative receive healthcare referrals for prenatal, interconception, and postpartum care, social service referrals to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) program; local Department of Social Services (DSS); and educational or vocational supports to better ensure academic andcareer success. The goals of this program align with the Title V program 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, 2019 to June 30, 2020, the program served 498 expectant and parenting students/community members, developed 29 new partnerships, and made 844 referrals. The most frequently cited needs of the program participants were help obtaining information, resources, or services for child needs; food; childcare resources, referrals, and supports; parenting education and resources; housing assistance; self-sufficiency and other supports; academic and educational supports; and home visitation.

Adolescent Health initiatives, including the Comprehensive Adolescent Pregnancy Prevention (CAPP), Personal Responsibility Education Program (PREP) and Sexual Risk Avoidance Education (SRAE) programs, aim to promote healthy development, parent-child communication, relationship skills and healthy life skills through youth-focused activities. The CAPP and PREP programs continue 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. The CAPP and PREP programs reach approximately 31,000 adolescents aged 9-21 on an annual basis. The NYS Title V began the SRAE program in July 2019 to support implementation of education on sexual risk avoidance that teaches youth 10-13 years of age to voluntarily refrain from sexual activity and provide opportunities to build developmental assets through adult-supervised activities. It is anticipated that this program will serve over 1,000 priority youth on an annual basis. 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**

**Application for FY21**

For Adolescent Health, New York's Title V program selected **the National Performance Measure (NPM) 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.** This NPM was selected because it aligns with both population health data indicators and concerns voiced directly by adolescents in NYS. Most teens ages 12-17 had a preventive medical (81.3%) and preventive dental (79.3%) visits in the past year, but there is room for improvement and disparities persist – only 72.1% of Hispanic adolescents had a preventive medical visit compared to 87.2% of non-Hispanic White adolescents and only 79.9% of adolescents on Medicaid had their annual visit compared to 86.9% with private insurance. Adolescents across the state discussed that their medical providers lack compassion and respect for their young patients and that youth would prefer visiting providers who are more affirming and reflective of the youth themselves.

Preventive medical visits are one part of overall wellness, but data and community input point to other areas that could help adolescents thrive, such as social-emotional wellbeing and preparation for taking on the responsibilities of adulthood. Over 30% of high school students reported feeling sad or hopeless for more than two weeks in the past year and over 10% reported that they attempted suicide. Hispanic students are more likely to report depression symptoms and suicide attempts, and there are dramatic disparities based on sexual identity as well, with 60% of students identifying as gay, lesbian, or bisexual reporting depression symptoms and 26% reporting a suicide attempt. The importance of social support and the need for more people to talk to positive mentors were frequently mentioned by adolescents. They discussed feeling socially isolated and wanting opportunities for community engagement or building a sense of belonging. Only 16.4% of adolescents without special health care needs received services necessary to transition to adult health care. And beyond assuming responsibility for their own health care, adolescents voiced a desire for education about financial literacy, healthy cooking, navigating relationships, and other aspects of adulthood.

Adolescence is often a very challenging stage in a person's life. During this time, adolescents experience growth through physical development, cognitive development, social-emotional development, identity, and sexual development. Supporting adolescents' health and development and helping them prepare for their futures can have a lasting impact throughout the life course. The multifaceted nature of adolescent development and wellness means the selected NPM and its associated strategies are responsive to most of the priority areas, particularly health care, social support and cohesion, community services and amenities, and awareness of resources. This NPM also aligns directly with established priorities encompassed in the NYS Prevention Agenda goals to support and enhance children and adolescents' social-emotional development and relationships, strengthen opportunities to build well-being and resilience across the lifespan, facilitate supportive environments that promote respect and dignity for people of all ages, and other Prevention Agenda goals related to mental health and substance use.

Four specific objectives were established to align with this performance measure:

**Objective AH-1**: Increase the percent of adolescents, ages 12-17, with a preventive medical visit in the past year by 5%, from 81.3% in 2016-2017 to 85.4% in 2021-2022. (National Survey of Children's Health, NSCH)

**Objective AH-2:** Increase the percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling by 5%, from 53.5% in 2017-2018 to 56.2% in 2021-2022. (NSCH)

**Objective AH-3:** Increase the percent of adolescents, ages 13 through 17, who have received at least one dose of the Human Papilloma Virus (HPV) vaccine by 8%, from 67.3% in 2018 to 72.7% in 2022 (NIS).

**Objective AH-4**: Increase the percent of NYS adolescents without special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 16.4% in 2017-2018 to 17.2% in 2021-2022.

(NSCH)

Four strategic public health approaches were identified to accomplish these objectives over the next five years. These are presented in the State Action Plan (SAP) Table, and each is described in more detail here, with specific program and policy activities that will be implemented to advance the broader strategic approach in the upcoming year.

**Strategy AH-1: Incorporate specific activities to promote the wellness of adolescents across all Title V programs, including promoting and facilitating routine well visits, reproductive health care, oral health, and behavioral health.**

Adolescence is a critical stage of development when children grow physically, cognitively, emotionally, and socially to become adults. The lifestyle choices, behaviors, and relationships established during this time can affect an adolescent's current and future health. Routine well visits during adolescence are recommended by the American Academy of Pediatrics' Bright Futures as one way to foster health in the present and build a foundation for wellness into the future. They are an opportunity to promote healthy behaviors, discuss risky behaviors, provide important vaccinations, and address conditions that can interfere with healthy development. Likewise, comprehensive and inclusive reproductive health care and education are opportunities to help adolescents avoid or mitigate risky sexual behaviors. Title V funded programs also provide enabling services to adolescents, such as referrals to and linkages with community services and social supports to holistically address health and wellness, including mental health and social determinants of health.

The key programs that work to support adolescent wellness and help connect adolescents to needed services include Comprehensive Adolescent Pregnancy Prevention (CAPP) Program, Sexual Reproduction Avoidance Education (SRAE), Children and Youth with Special Health Care Needs (CYSHCN), School-Based Health Centers (SBHC), Family Planning Program, and Sexual Violence Prevention programs.

The NYS Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2020-21 year:

- Through CAPP, provide information to adolescents and parents on the offering and arranging of adolescent sexual health reproductive services. The federally funded Personal Responsibility and Education Program (PREP) also provides this information, in partnership with the Title V program.
- Through SRAE, provide medically accurate and complete sexuality health education services to youth.
- Through CAPP, PREP and SRAE, increase access to health care services for adolescents through a referral process that includes confirmation as permitted while ensuring confidentiality.
- NYSDOH staff, including Title V funded staff, and community youth-serving organizations provide trauma-informed education and training on social emotional wellness and positive youth development for children and adolescents
- Within the Title V program, enhance collaboration between adolescent serving programs, including CAPP, SRAE, SBHC, and CYSHCN, to promote holistic adolescent health through provision of comprehensive physical exams and anticipatory guidance, including body mass index (BMI), behavioral health, oral health and reproductive health, for adolescents with and without special health care needs.
- Collaborate with internal, including NYSDOH AIDS Institute and Bureau of Immunization, and external, NYS HPV Coalition, stakeholders to promote HPV vaccination with clinical providers.
- Refer adolescent parents to family planning providers for contraception and birth planning, including SBHCs, where available.
- Promote access to confidential reproductive health care services and preventive medical visits for adolescents, including through SBHCs, where available. Family planning providers deliver counseling and services related to contraception, promotion of healthy relationships, preventive medical care, and preconception/interconception health.
- Promote healthy relationships and sexual violence prevention using policy change, protective environment strengthening, healthy social norms reinforcement, and skill-building to address individual, relationship, community,

and societal risk and protective factors. Focus on groups experiencing disproportionate burden of sexual violence, including communities of color, adolescents and young adults, domestic violence victims, those experiencing low income, people affected by alcohol and drug abuse, and LGBTQIA+ persons.
- Promote adolescents' social-emotional wellness and positive developmental assets through established Title V programs.

**Strategy AH-2: Promote supports for adolescents to gain the knowledge, self-efficacy, and resources they need to prepare for and transition to adulthood.**

For young adults, with or without special health care needs, the transition to adulthood is a crucial time in their development. Young adults may move away from their parents, transition to adult health care, become increasingly sexually active, continue their education, and/or start a career. Navigating these transitions can be difficult for youth as their independence continues to grow. Often, an increased sense of independence can lead to an increase of unhealthy risky behaviors. Title V programs will provide youth with support to help prepare for and navigate this transition.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2020-21 year:
- Ensure adolescent providers have a mechanism in place to provide adolescent-related health care service referrals to other providers of health care services, including substance abuse (e.g., alcohol, tobacco cessation), mental health issues, and intimate partner violence.
- Refer adolescent parents to family planning providers or SBHC for contraception and birth planning.
- Support pregnant and birthing adolescent parents in attending prenatal, postpartum and well-baby appointments.
- Promote access to confidential reproductive health care services and preventive medical visits for adolescents. Family planning providers provide counseling and services related to contraception, promotion of healthy relationships, preventive medical care, and preconception/interconception health.
- Ensure adolescent-serving programs provide training on adulthood preparation subjects, such as, healthy relationships, effective communication, career and education opportunities, health care transition, and financial literacy for adolescents with and without special health care needs to prepare them for a transition into adulthood.

**Strategy AH-3: Apply public health surveillance and data analysis findings to improve services and systems related to children's health and health care.**

Data-driven, evidence-based practice is essential to achieving public health goals for NYSDOH and the NYS Title V program. Across all Title V funded programs, continuous effort is needed to enhance the collection, analysis, and sharing of data to inform the planning and implementation of programs and policies. Sharing data with stakeholders, including providers and community members, is critical to raise awareness, empower community action, and facilitate quality improvement efforts at all levels.

The combination of public survey data gleaned from sources like NSCH and the Youth Risk Behavior Survey (YRBS) with data from NY's Adolescent Sexual Health Needs Index (ASHNI), Vital Statistics and other data systems provide information to identify areas throughout the state with the most pressing health needs for youth.

The Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2020-21 year:
- Collaborate with the US Census Bureau and HRSA to conduct an over-sample of NYS 2021 National Survey of Children's Health for NYS to allow for enhanced sampling of Black/African-American, Hispanic, and CYSHCN.
- Title V staff will continue to use publicly available and internal surveillance data to identify adolescent needs and/or health behavior trends to support optimum adolescent health and development and determine funding areas for NYSDOH adolescent health procurements.

- Through ACT CCA trainings, webinars, and web posts, provide information and education to youth-serving organizations.
- Explore collaborative opportunities with the NYSDOH Division of Chronic Disease Prevention's (DCDP) Bureau of Chronic Disease Evaluation and Research (BCDER), which works with the NYS Education Department, to review and share information gathered through the YRBS.

**Strategy AH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact adolescents' health and well-being.**

Adolescent health outcomes are impacted by the social determinants of health (SDOH), or the conditions in which people are born, live, work, play, learn, and age. SDOH include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of power and resources due to racism and other biases are root causes of inequities in access, availability, and quality of SDOH. All ten priorities that emerged from community members' input during the needs assessment revolve around SDOH and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities. Adolescents who participated in the listening sessions and focus groups were aware of how things like quality housing, safe communities, employment, and community services affect their health and well-being and that of their families and were well aware of the inequities in the access and quality for their communities. They discussed seeing their parents struggle and wanting change for their parents and for themselves as they near adulthood. Strategies focus on involving stakeholders who are representative of populations impacted by health inequities, particularly engaging and collaborating with youth, to inform program planning and implementation and policy development.

The Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2020-21 year:

- Collaborate with other state agencies and youth-serving organizations on adolescent-centered priorities through the Youth Development Team (YDT).The YDT includes representation from NYSDOH, Office of Children and Family Services (OCFS), Council on Children and Families (CCF) and the Developmental Disabilities Planning Council (DDPC) in coordination with youth-led organizations.
- Ensure that NYSDOH health equity teams review materials before being widely disseminated to youth and youth-serving organizations
- Collaborate with youth through focus groups and community forums for direct input with state initiatives and special projects.
- Involve stakeholders that are representative of the populations most impacted by racism and health inequities in programmatic decisions.
- Through NYSDOH adolescent providers, issue information on locally available resources and provide referrals specific to addressing the SDOH with adolescents from populations impacted by disparities.

The NYS Title V Program established two Evidence-Based Strategy Measures (ESMs) to track the programmatic investments and inputs designed to impact NPM 10:

**ESM AH-1: Percent of youth-serving programs that provide training on adult preparation subjects, such as accessing health insurance, maintaining their routine preventive medical visits, healthy relationships, effective communication, financial literacy, and adult health care for adolescents with and without special health care needs to prepare them for a transition into adulthood.**

Data for this measure will come from biannual reports and annual data requests submitted by local adolescent health providers. Baseline values for this measure will be taken from a 6-month program period of 10/1/2020-3/31/2021. Improvement targets will be determined after the baseline has been established.

**ESM AH-2: Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation.**

Data for this measure will come from biannual reports and annual data requests submitted by adolescent health providers. Baseline values for this measure will be taken from a 6-month program period of 10/1/2020-3/31/2020. Improvement targets will be determined after the baseline has been established.

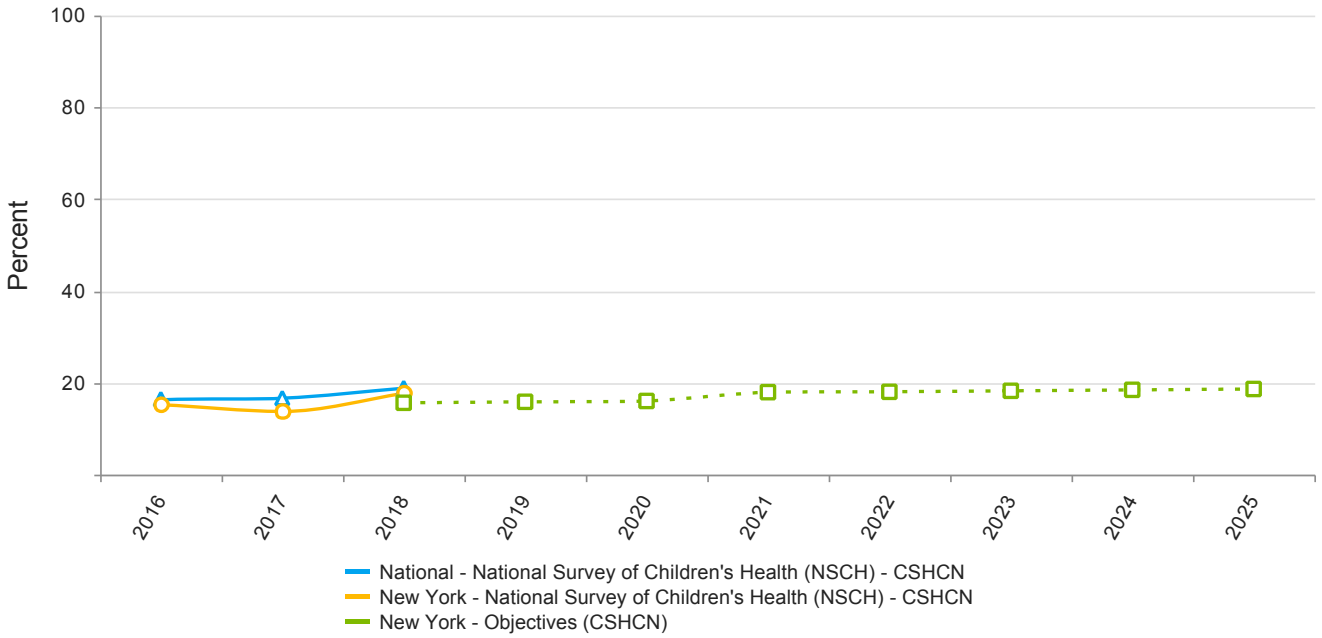
**Children with Special Health Care Needs**

**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-2017_2018 | 15.2 % | 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** | **2019** |
| Annual Objective | | | 15.7 | 15.9 |
| Annual Indicator | | 15.3 | 13.7 | 17.8 |
| Numerator | | 48,081 | 34,736 | 48,580 |
| Denominator | | 314,730 | 253,092 | 273,067 |
| Data Source | | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

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 | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 16.1 | 18.0 | 18.1 | 18.3 | 18.5 | 18.7 |

**Evidence-Based or –Informed Strategy Measures**

**ESM 12.1 - Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 40.3 | 40.8 | 41.3 | 41.8 | 42.3 |

**State Performance Measures**

**SPM 2 - Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 3.7 | 3.7 | 3.7 | 3.7 | 3.7 |

**State Action Plan Table**

State Action Plan Table (New York) - Children with Special Health Care Needs - Entry 1

### Priority Need

Enhance supports for parents and families, especially those with children with special health care needs, and inclusive of all family members and caregivers

### 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 CYSCHN-1: Increase the percent of NYS adolescents with special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 17.8% in 2017-2018 to 18.7% in 2021-2022 (NSCH)

Objective CYSCHN-2: Increase the percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system by 5%, from 15.2% in 2017-2018 to 16% in 2021-2022 (NSCH)

### Strategies

Strategy CYSHCN-1: Engage youth with special health care needs (YSHCN) and their families in state and local efforts to improve systems and practices for supporting YSHCN.

Strategy CYSHCN-2: Enhance care coordination, including transition support services, for children and youth with special health care needs.

Strategy CYSHCN-3: Apply public health surveillance and data analysis findings to improve services and systems related to health and health care for children and youth with special health care needs.

Strategy CYSHCN-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact the health and well- being of children and youth with special health care needs.

| ESMs | Status |
|---|---|
| ESM 12.1 - Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment. | Active |

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

Promote awareness and enhance availability, accessibility and coordination of services for families and youth, including CYSHCN, with a focus on areas impacted by systemic barriers, including racism

### 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 CYSCHN-1: Increase the percent of NYS adolescents with special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 17.8% in 2017-2018 to 18.7% in 2021-2022 (NSCH)

Objective CYSCHN-2: Increase the percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system by 5%, from 15.2% in 2017-2018 to 16% in 2021-2022 (NSCH)

### Strategies

Strategy CYSHCN-1: Engage youth with special health care needs (YSHCN) and their families in state and local efforts to improve systems and practices for supporting YSHCN.

Strategy CYSHCN-2: Enhance care coordination, including transition support services, for children and youth with special health care needs.

Strategy CYSHCN-3: Apply public health surveillance and data analysis findings to improve services and systems related to health and health care for children and youth with special health care needs.

Strategy CYSHCN-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact the health and well- being of children and youth with special health care needs.

| ESMs | Status |
|---|---|
| ESM 12.1 - Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment. | Active |

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 the availability and quality of affordable housing.

### SPM

SPM 2 - Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months

### Objectives

Objective CYSHCN-3: Reduce the incidence of confirmed high blood lead levels at 5 micrograms per deciliter or greater per 1,000 tested children aged less than 72 months, with baseline incidence and benchmarks established in 2020-21 program year. The current incidence of confirmed blood lead levels at 10 micrograms per deciliter or greater is 3.7 per 1,000 children tested in 2016. (NYS Child Health Lead Poisoning Prevention Program Data)

### Strategies

Strategy CSHCN-5: Support comprehensive public health efforts to prevent, identify, and manage childhood lead poisoning.

**2016-2020: National Performance Measures**

**2016-2020: State Performance Measures**

**2016-2020: 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** | **2019** |
| Annual Objective | | 50 | 50 | 50 |
| Annual Indicator | 0 | 0 | 0 | 0 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | To Be Developed | Developmental Assessment Tool | Developmental Assessment Tool | Developmental Assessment Tool |
| Data Source Year | 2017-2018 | 2017-2018 | 2017-2018 | 2018-2019 |
| Provisional or Final ? | Final | Final | Final | Final |

**2016-2020: 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** | **2019** |
| Annual Objective | | 65 | 65.5 | 71 |
| Annual Indicator | 61.6 | 70.1 | 67 | 63.7 |
| Numerator | 673 | 1,021 | 1,238 | 1,034 |
| Denominator | 1,092 | 1,456 | 1,848 | 1,624 |
| Data Source | New York Family Survey | New York Family Survey | New York Family Survey | New York Family Survey |
| Data Source Year | 2015-2016 | 2016-2017 | 2017-2018 | 2018-2019 |
| Provisional or Final ? | Final | Final | Final | Final |

**FFY 2019 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 2016-2017 National Survey of Children's Health (NSCH), more than 689,000 (16.5%) of New York's children age 0-17 have a special health care need. The NYS Title V program strives to support a coordinated system of supports and services for CYSHCN and their families.

While most children in NYS are insured, families continue to experience financial challenges meeting the needs of their CYSHCN. The Title V program provides funding for direct services through the Physically Handicapped Children's Program (PHCP). In 2019, three children received an evaluation and 285 received treatment services funded through PHCP. Services included orthodontia, medications, glasses, hearing aids, enteral formula and specialty foods, and medical equipment or supplies.

NYS is modifying the name from Physically Handicapped Children's Program to "Children and Youth with Special Health Care Needs Support Services." This name is more appropriate and better aligns the name of this funding source with the CYSHCN Program supported by the Title V Maternal and Child Health Services Block Grant (MCHSBG).

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 2016-2017 NSCH and data reported by the Title V funded CYSHCN programs administered by Local Health Departments (LHDs) and the NYS Early Intervention program funded under Part C of the federal Individuals with Disabilities Act (IDEA). 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 health care needs on both the child and the family and the associated factors.

Key findings included that just over half of CYSHCN live in households with income below 200% of the federal poverty level. One in seven CYSHCN have their daily activities greatly affected by their health condition(s), one in nine (11%) CYSHCN miss 11 or more school days in a year, compared to 2 percent of NY State children without special health care needs, and nearly half (46%) had 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. In 2016-2017, the five key components indicating a child meets medical home criteria showed 44.8% of CYSHCN met the criteria, compared to 51.7% of non-CYSHCN. Less than one in seven CYSHCN age 12-17 (13.7%) received services needed for transition to adult health care. Only half of adolescents had a chance to speak to their health care provider alone at his or her last preventive check-up. While 72% of providers actively worked with adolescents with special health care needs to gain the skills to manage their health and health care or understand changes in health care happening at age 18, only 7% of providers discussed the shift to a provider who treats adults. The result of this in-depth analysis was a NYS Profile of CYSHCN is available on the NYSDOH public website: https://www.health.ny.gov/community/special_needs/docs/cshcn_profile_2016-17.pdf

To augment this national data, Title V CYSHCN program collects data from the 49 CYSHCN programs administered by

LHDs. Data elements added in 2018 to the system for LHD CYSHCN programs include whether the child has dental insurance and is enrolled in the NYS Medicaid Children's Health Homes (CHH). 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 2018-2019 program data demonstrated that of the 2,813 CYSHCN children served, 55% had Medicaid, 27% had commercial insurance, 9% had Child Health Plus (CHP), 6% had other insurance, and 2% had no insurance reported. Additionally, 6% of children had Social Security Income (SSI). Seventy-one percent of CYSHCN served were White, 16% African American, 2% Asian or Pacific Islander, 1% American Indian or Alaska Native, 3.9% more than one race, 1% other race, and 9% had unknown race (i.e., did not respond); 13% of children were Hispanic. The percent of children reported to have a primary care provider was 98.2%, which is a significant improvement from the 97.7% in 2017-2018 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 11% of CYSHCN, and 56% needed assistance for a service not covered by insurance, 21% for a service exceeding the limit of the benefit package, 17% needed help with co-pays, 4% for deductible costs, and 2% for premium costs. In addition, information about referrals from the state's IDEA Part C Early Intervention Program was included. Approximately 23% of CYSHCN were referred by Early Intervention Program which is a 3% increase from last year. There were 61 children referred to CHH in 2018-2019, compared to 22 children the year before. On August 5, 2019, CYSHCN staff held a technical assistance webinar with the LHDs to discuss effective and resourceful outreach and referral methods.

As previously reported, quantitative data alone cannot illustrate the complexities of navigating the many systems of care available to families of 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 (later renamed Care Mapping at caregiver's request) 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 NY, the Title V program engaged in a multi-year effort to conduct a comprehensive system mapping initiative. The results of the Care Mapping project were reported in the previous year. The work was continued and expanded as part of the Needs Assessment to continue to hear from families with CYSHCN.

NYSDOH has continued to share this feedback with stakeholders and partners, including 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 has integrated the findings from the Care Mapping sessions into the upcoming five-year procurement cycle for funding of CYSHCN programs at LHDs that begins in October 2020. NYSDOH has allocated Title V funding to establish contracts with three Regional Support Centers for CYSHCN through existing relationships with three University Centers of Excellence in Developmental Disabilities (UCEDDs). From October 1, 2019 to September 30, 2021 the Regional Support Centers (RSCs) will improve services to CYSHCN through the following initiatives:

1. Completing a needs assessment with each local health department and providing technical assistance to improve information and referral services to families of CYSHCN. RSCs will work with LHDs to build capacity to serve families through improved outreach and program promotion.
2. Developing an online, searchable regional resource guide for both families and providers. Resource guides will include a comprehensive catalog of available resources, enabling LHDs to make more timely and effective referrals to services.
3. Gathering family feedback through listening sessions and telephone interviews with families of CYSHCN. The care mapping feedback sessions conducted in 2017-2018 provided NYSDOH valuable information on the challenges families and providers encountered in caring for CYSHCN. Continuous feedback is vital to ensuring challenges are addressed and to evaluate how the information received is aligned with local program and NSCH data. Feedback will be sought from families in areas of the state that were not included in Care Mapping as well as including a focus on racial, ethnic and language diversity.

4. Developing educational materials. RSCs will develop training and educational materials for families and providers, including training videos and short video vignettes on the importance of a medical home, transition of adolescents with special health care needs to adult health care, and other topics determined from family feedback gathered.

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 third strategy of the SAP was to provide subject matter and technical support to the NYS Medicaid Program to implement and enhance care coordination and transition support services for CYSHCN through the Medicaid CHH.

As described in the CYSHCN domain, 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 sickle cell disease, HIV/AIDS, serious mental illness, serious emotional disturbance or complex trauma and at risk for another chronic condition. Enrollment and outreach data are being reported as a point-in-time reference as of October 5, 2019. The number of children enrolled in CHH for the third quarter of year three is reported to be 27,071. The number of children enrolled in CHH for the last quarter in 2018 was 17,524. In December 2018, 1605 children had received outreach from a CHH compared to 1687 in third quarter of 2019. In April 2019, the six 1915 (c) Home and Community Based Services consolidated into a single 1915 (c) Children's Waiver.

In 2019, the Title V program participated with NYSDOH Office of Health Insurance Programs (OHIP) staff on site visits to twelve designated CHH agencies. On January 24, 2019 staff participated in a site visit with St. Mary's Healthcare (Amsterdam) and on February 6, 2019 staff attended Institute for Family Health (New Paltz). Title V and OHIP staff participated in site visits with the 10 remaining designated Children's Health Homes through 2019. On February 27, 2019, staff participated in a site visit with Northwell Health Homes; March 6, 2019 with Adirondack Health Institute; April 10, 2019 with Niagara Falls Memorial Medical Center; May 1, 2019 with Coordinated Behavioral Care (aka Institute for Community Living); June 26, 2019 with Community Care Management Partners; July 17, 2019 with Greater Rochester Health Home; August 21, 2019 with Bronx Accountable Healthcare Network Health Home; October 2, 2019 with Mount Sinai Health Home; October 10, 2019 with Central New York Health Home Network; and November 14, 2019 with Hudson River HealthCare, Inc.

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 Health Home (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 transitioned to CHH care managers. They are also transitioning their enrolled waiver children in to CHH care management if they chose to be in CHH. On April 1, 2019, the Children's Waiver consolidated all six HCBS waivers 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 authorized 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 CHH in their public health work. A webinar in 2018 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 CHH. This access gives programs the ability to make referrals of children to CHH and to see who the child's care management agency is. The state CYSHCN Program will be monitoring the number of children referred to CHH by the local CYSHCN programs. For 2018-2019, the CYSHCN program at the LHD reported referrals for 61 children to CHH which is almost tripled.

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 CHH 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 CHH 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.

Enrollment and outreach data are being reported as a point-in-time reference as of October 5, 2019. The number of children enrolled in CHH for the third quarter of year three, is reported to be 27,071 an increase from the 17,524 children enrolled in CHH for the last quarter in 2018. In December 2018, 1605 children had received outreach from a CHH compared to 1687 in third quarter of 2019. In April 2019, the six 1915 (c) Home and Community Based Services consolidated into a single 1915 (c) Children's Waiver.

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 of 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 to 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. There were 46 individuals enrolled in Health Homes during this timeframe. Work in strengthening the bond between the contractors and the Health Home agencies continue to be a priority to increase the number of individuals

enrolled that meet eligibility. Another teleconference was held in September 2019 with the three contractors to discuss the end of the first-year successes and challenges. Topics like engaging families/clients in outreach/support group activities, appointment compliance, youth leadership, transfer of care and transfer completion were some areas identified for future quarterly teleconferences. In April 2019, through Legislative Add On grant, the three contractors were awarded $66,666.

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 September 2019, 696 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 CHH care management.

The fifth strategy in the SAP is to support the statewide Part C of IDEA Early Intervention Program's State Systemic Improvement Plan (SSIP), which is overseen within the Division of Family Health by the Bureau of Early Intervention (BEI). 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.

BEI 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, BEI has partnered with the three HRSA-designated 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 NYSDOH contract, which provides parent leadership and advocacy skills training for parents of children receiving EIP services.

BEI is integrating 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, 64% 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 Part C of IDEA 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 EIP services. This survey is for families who are ending (exiting) or have recently ended (exited) EIP services. The Family Outcomes Survey is part of an ongoing federally-required initiative to improve outcomes for children and families who receive EIP services. This national quality improvement effort is to learn about family views on the ways EIP 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 EIP 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 staff selected two areas from the Family Survey results on which to focus. These areas were: 1) helping parents/families connect with parents 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.

In previous years CYSHCN staff reviewed quarterly reports 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.

With the initiation of the CYSHCN Regional Support Centers this task will become part of the educational webinars and outreach they provide to counties.  Subject matter and presentations will be identified and developed by the RSCs and approved by NYSDOH.  Webinars will be recorded for continued use by Title V staff throughout the state.

Title V staff evaluated previous webinars and the CYSHCN program 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 EIP 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 E-Vitals system 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.

Grant funding from HRSA was received for the period, April 1, 2017 through March 31, 2020 to support work to improve documentation of screening and follow-up test results 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 the EIP; increase by 20% from baseline the number of newborns and infants identified to be deaf or hard of hearing enrolled in EIP 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 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, Early Intervention providers, Early Intervention 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 EIP. 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.

**Children with Special Health Care Needs - Application Year**

**Application for FY21**

For Children and Youth with Special Health Care Needs (CYSHCN), the NYS Title V program selected **National Performance Measure (NPM) 12: Percent of adolescents with special health care needs, ages 12-17, who received services necessary to make transitions to adult health care.** This NPM was selected because it was voiced as a key priority by youth with special health care needs and their families, reinforced by state-specific population health data. Families reported that only 15% of CYSHCN receive care in a well-functioning system, and less than 18% of youth age 12-17 with special health care needs received services necessary to make transitions to adult health care. This is consistent with findings from New York's care mapping process conducted in 2017-2018, and with findings from the community listening forums conducted for this application, as detailed in the Needs Assessment summary and discussed further below. This NPM also aligns directly with NYS Prevention Agenda goals and interventions related to support for CYSHCN.

In addition, New York's Title V program established one State Performance Measure (SPM) for this domain, **SPM 2: Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months**. This SPM was developed to reflect the state's longstanding commitment to eliminating childhood lead poisoning as a key public health problem in NYS. It is responsive to cross-cutting priorities voiced by families related to safe and healthy environments to support children's development, and access to comprehensive, high quality health care services. It is also responsive to specific concerns shared by families regarding challenges in accessing and coordinating medical care and related services for children with special health care needs. It builds on critical public health investments and capacity to prevent, identify, and address lead poisoning in NYS, including recent amendments to state public health law, as discussed further below.

Three specific objectives were established to align with this performance measure:

**Objective CYSHCN-1**: Increase the percent of NYS adolescents with special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 17.8% in 2017-2018 to 18.7% in 2021-2022 (National Survey of Children's Health, NSCH).

**Objective CYSHCN-2**: Increase the percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system by 5%, from 15.2% in 2017-2018 to 16% in 2021-2022 (NSCH).

**Objective CYSHCN-3:** Reduce the incidence of confirmed high blood lead levels at 5 micrograms per deciliter or greater per 1,000 tested children aged less than 72 months, with baseline incidence and benchmarks established in 2020-21 program year. The current incidence of confirmed blood lead levels at 10 micrograms per deciliter or greater is 3.7 per 1,000 children tested in 2016. (NYS Child Health Lead Poisoning Prevention Program Data)

Five strategic public health approaches were identified to accomplish these objectives over the next five years. These are presented in the State Action Plan (SAP) Table, and each is described in more detail here, with specific program and policy activities that will be implemented to advance the broader strategic approach in the upcoming year.

**Strategy CYSHCN-1: Engage youth with special health care needs (YSHCN) and their families in state and local efforts to improve systems and practices for supporting YSHCN.**

Families and youth need to be directly involved in program and policy planning and implementation in meaningful roles at all levels. This is consistent with the Title V program's longstanding commitments to family-centered care/family-professional partnerships and positive youth development. As described in the Needs Assessment summary, families are experiencing lack of awareness of resources and services in the community, transportation barriers, challenges in finding and accessing

services and amenities in their communities, and needs for better social supports, social cohesion, and specific supports for parents and families. Directly involving family members, including youth, in the design, implementation, and evaluation of programs and services is critical to ensuring that those programs and services meet their needs and are delivered in ways that are empowering, respectful, accessible, culturally competent, and effective. Families of CYSHCN face unique challenges and bring knowledge, experience, and strengths that are a tremendous asset; they are the experts about their needs and care. This is a theme woven into all CYSHCN-serving Title V programs.

For example, the Title V Program contracts with three HRSA-designated University Centers for Excellence in Developmental Disabilities (UCEDDs), or Regional Support Centers (RSCs), to provide training and technical assistance to local health department (LHD)-based CYSHCN programs and to conduct family engagement. The RSCs each have a family liaison that is a CYSHCN parent, a critical component of the RSC work with CYSHCN families and LHDs. Family liaisons bring firsthand experience, perspective, and knowledge of barriers and gaps in care to all aspects of RSC activities, including meeting with families and resource gathering. Family liaisons are responsible for conducting family engagement sessions with a prescribed set of questions to gauge the needs of CYSHCN families. At this time, these meetings are all virtual, and not in-person as intended, due to the COVID-19 public health emergency. Once family sessions are complete and qualitative data are compiled, family liaisons will conduct family forums to present the findings to families. In addition, RSCs are conducting needs assessment surveys with each county, as available, to gather feedback and determine gaps and barriers, type of technical assistance needed, and what resources are available in each community.

In addition, the 2020-2025 LHD CYSHCN program contract period includes deliverables to address family and community engagement at many levels. LHDs will involve families of CYSHCN in work groups, committees, task forces or advisory committees to improve the system of care for CYSHCN, involve families and CYSHCN in local planning activities, such as the Community Health Assessment (CHA), and use feedback from families of CYSHCN to develop training for CYSHCN staff and providers.

Sickle cell disease (SCD) grantees at three Hemoglobinopathy Centers (HC) work directly and exclusively with youth in support services. HCs conduct peer support groups to gauge barriers to care and transition for youth and young adults with SCD. Transition navigators at HCs engage youth with SCD to ensure compliance with care regimens and to understand that barriers youth experience in caring for themselves.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2020-21 year:

- Maintain at least one dedicated family representative on the state's Title V Advisory Council and engage all Council members in updates and discussion related to CYSHCN program activities.
- Collaborate with advocacy groups like Parent to Parent of NYS to understand the needs of CYSHCN and their families, facilitate information sharing, and promote LHD CYSHCN programs.
- Support RSCs to employ parents of CYSHCN as parent liaisons. Work with the RSCs and their parent liaisons to conduct surveys, family engagement sessions and family forums to assess and share family needs and apply results to inform family resources and TA for LHD programs.
- Support RSCs to develop a CYSHCN Resource Guide that will be made available online to provide families and health care providers with current information about services and supports.
- Support LHD CYSHCN programs to involve CYSHCN and their families in work groups, committees, task forces or advisory committees, local health assessment and planning activities, and other systems development work. Use feedback from families of CYSHCN to develop training for CYSHCN staff and providers.
- Engage the New York State Association of County Health Officials (NYSACHO) to promote and bolster LHD CYSHCN programs to raise awareness of LHD CYSHCN services and reach and serve more families. NYSACHO will provide opportunities for Title V staff to speak directly to their members, participate in calls with LHDs, and help disseminate information and opportunities for CYSHCN and families.

- Support SCD programs in three Hemoglobinopathy Centers to provide supports by and for youth with SCD, including peer support groups, system navigation supports, and self-care services.
- Collaborate with other Title V and Division of Family Health adolescent-serving programs, including School-Based Health Centers, Comprehensive Adolescent Pregnancy Prevention, and ACT for Youth Center for Community Action to identify additional opportunities to meaningfully engage adolescents in program and policy development that impacts CYSHCN.
- Engage a youth representative in work with the NYSDOH Office of Health Insurance Programs/Medicaid Program on the Medicaid Redesign Team (MRT) II work group regarding best practices for transition care.
- Serve on the New York State Developmental Disabilities Planning Council (DDPC) and the Individuals and Families Committee, to promote inclusion of CYSHCN-specific focus to the DDPC's agenda and policy portfolio. DDPC membership includes parents of CYSHCN from around New York State who are directly involved in decision making regarding funding opportunities and policy development.

**Strategy CYSHCN-2: Enhance care coordination, including transition support services, for children and youth with special health care needs.**

The Institute of Medicine identified care coordination as a key strategy to improve the effectiveness, safety, and efficiency of the U.S. health care system, improving outcomes for patients, providers, and payers. The most recent NSCH data for NYS show that about 73% of all children, and 64% of CYSHCN, age birth to 17 years who needed care coordination services received effective services. Preparing for and supporting the transition from youth to adulthood is especially important for CYSHCN and their families. Only 17.8% of youth age 12-17 with special health care needs received services necessary to make transitions to adult health care, highlighting the need for more specific attention to program and systems improvements in this area. Within this overall measure, there is variation in individual components of transition services. About 60% of adolescents with special health care needs had a chance to speak to their health care provider alone at their last preventive check-up. While 73% of adolescents with SHCN reported that their health care provider actively worked with them to gain skills to manage their health, health care, and understand changes in health care happening around age 18, only 12% reported that their doctors discussed the shift to a provider who treats adults, if needed.

Title V staff will identify supports to help youth and families coordinate care, including a specific focus on transition services, to improve efficiency, quality, health outcomes and patient satisfaction. CYSHCN often require specialty medical services across multiple providers and service settings and may experience multiple transitions as they develop and "age out" of specific programs or services, move across service and community settings, and become more independent growing from children to youth to adults. Care coordination services and more informal transition supports can be critical for CYSHCN and their families to manage their health and family needs during key periods of change and over time.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2020-21 year:

- Provide funding and program guidance to LHD-based CYSHCN programs to work with medical providers, childcare providers, and local school systems to improve communications between service providers to assist families with the referral process and support the transition of CYSHCN from pediatric to adult health care. LHDs will provide timely and appropriate information and referrals to insurance, health services, transportation, and community resources to support transition and other services for CYSHCN.
- Continue to support three HRSA-designated UCEDDs, which are the RSCs, to support youth, families, and LHD CYSHCN programs. RSCs will identify resources and develop a comprehensive resource guide for LHDs and families; provide technical assistance to LHDs; conduct family engagement opportunities; identify webinars or professional development for LHDs; develop training and education materials; facilitate communication among LHDs; and identify barriers, unmet needs and opportunities for CYSHCN and their families. As described in the previous strategy, families and youth are deeply involved in guiding this work.

- In collaboration with the RSCs, facilitate professional development and information sharing between LHD programs related to transition, including a webinar on Got Transition's Six Core Elements.
- Administer CYSHCN Support Services (CYSHCNSS), a gap-filling supplemental program that provides reimbursement for specialty health care services for severe chronic illness or physically handicapping conditions in children who meet county financial and medical eligibility criteria. *Note*: Effective April 2020, NYS public health law was amended to modernize the name of the former Physically Handicapped Children's Program (PHCP) to Children and Youth with Special Health Care Needs Support Services (CYSHCNSS). This change corrects outdated terminology and directly aligns CYSHCNSS with Title V terminology and programs.
- Provide grant funding, evidence-based strategies (Got Transition) and technical assistance to Hemoglobinopathy Centers to support successful transition to adult services for young adults with SCD, including but not limited to transition policy, tracking and monitoring, transition readiness and planning, transfer of care, and transition feedback and completion.
- Support care coordinators at Hemoglobinopathy Centers to help SCD patients with appointments, scheduling, education, peer support and other health care transition services. These providers serve as "transition navigators," to assist the adolescent make a successful transition to an adult hematologist or other adult medical care provider. They also focus on providing these adolescents with the skills they need to successfully transition to adult care as evidenced by evaluation of readiness and follow-up post transition for satisfaction with care.
- Facilitate collaboration between Title V programs serving youth, including SBHC and CAPP programs, to inclusively address broader health needs of CYSHCN including social emotional health, oral health, healthy relationships, and sexual reproductive health.
- Provide subject matter and technical support to NYS Medicaid Program to implement enhanced care coordination and transition support services for CYSHCN through Medicaid Children's Health Home, including integration of eligible children also receiving services through the Early Intervention Program, referral of CYSHCN to Health Homes, and transition from Children's to Adult Health Homes.

**Strategy CSHCN-3**: **Support comprehensive public health efforts to prevent, identify, and manage childhood lead poisoning.**

Studies show that no amount of lead exposure is safe for children. Even low levels of lead in blood have been shown to affect a variety of adverse health effects including reduced growth indicators, delayed puberty, and lowered Intelligence Quotient (IQ), as well as hyperactivity, attention, behavior, and learning problems. Children under six years old are more likely to be exposed to lead than any other age group, as their normal behaviors result in them breathing in or swallowing dust from old lead paint that gets on floors, window sills, and hands, and can be found in soil, toys, and other consumer products. New York has more pre-1950 housing containing lead paint than any other state in the nation, with approximately 43 percent of all of New York's dwellings containing lead-based paint.

Effective October 2019, NYS Public Health Law (§ 1370) and regulations (Part 67 of Title 10 of the New York Codes, Rules, and Regulations) were amended to lower the definition of an elevated blood lead level in a child to 5 micrograms per deciliter (µg/dL), from the previous level of 10 µg/dL. Health care providers in NYS are required to assess or test all young children in accordance with public health regulations, to confirm and report test results, and to ensure appropriate follow-up evaluation and management as needed. Local Health Departments are required to ensure follow up including environmental management based on the child's blood lead level. The Title V program supports supplemental grants for lead poisoning prevention programs in local health departments, as well as Regional Lead Resource Centers based in academic medical centers to provide outreach and education to health care provider and families, technical assistance, individual case consultation and treatment of childhood lead poisoning. These programs are administered by the NYSDOH Center for Environmental Health. These Title V-funded program elements complement other components of the state's comprehensive public health approach that also includes laboratory testing and reporting, surveillance, outreach and education, and neighborhood-based primary prevention and healthy housing initiatives.

The Title V program will lead the following specific program and policy activities to advance this strategy over the upcoming 2020-21 year:

- Provide continued grant funding to local health department Lead Poisoning Prevention Programs (LPPP) and a statewide network of Regional Lead Resource Centers (RLRCs) to support enhanced regional and local efforts to reduce the prevalence of elevated blood lead levels in children birth to 18 years.
- Work with LPPPs, RLRCs, and other partners to ensure that all blood lead test results, including testing done in permitted/registered laboratories and point of service testing conducted in health care provider offices, are reported to the NYSDOH within the timeframes required.
- Through the RLRCs, support the provision of outreach and education to health care provider and families, technical assistance to providers and LHD programs, individual case consultation, and treatment of lead poisoning among children, pregnant women, and newborns, including chelation treatment where indicated.
- Through the LHD LPPPs and RLRCs, promote clinical prevention and screening practices in accordance with state requirements, including:
    - Routine blood lead testing for all children at age one year and again at age two years;
    - Assessment of all children ages six months to six years at every well visit for risk of lead exposure, with blood lead testing as indicated by risk assessment; and,
    - Provision of anticipatory guidance for all families about lead poisoning prevention as part of routine care.
- Through the LHD LPPPs and RLRCs, ensure that all children with elevated blood lead levels receive appropriate evaluation and management, including:
    - Confirmatory venous blood lead testing for capillary screening results $\geq$ 5 µg/dL
    - A complete diagnostic evaluation that includes a detailed lead exposure assessment, nutritional assessment, and developmental screening
    - medical treatment, as needed
    - referral to the appropriate local health department for environmental management
- Through the RLRCs, increase capacity and sustainability in local health care and public health systems by engaging health care providers and professional medical groups in leadership roles within regional or community coalitions focused on the prevention and elimination of lead poisoning.

**Strategy CYSHCN-4: Apply public health surveillance and data analysis findings to improve services and systems related to health and health care for children and youth with special health care needs.**

As noted in other domains, data-driven, evidence-based practice is essential to achieving public health goals for CYSHCN. Continuous efforts are needed to enhance the collection, analysis, and sharing of data to inform the planning and implementation of CYSHCN programs and policy work. Sharing data with stakeholders, including providers, families, youth, and other community members, is critical to raise awareness, empower community action, and facilitate quality improvement efforts at all levels. Title V staff will continue to assess all available data sources to inform public health improvement strategies related to CYSHCN. A recently drafted summary document titled “New York State Profile of Children and Youth with Special Health Care Needs, 2017-2018", which updates the program’s current 2016-2017 summary, may serve as one starting point for additional work in this area. This report explores the demographic, health, and functional difficulty profile of the NYS CYSHCN population, determines the impact that having special health care needs has on children and families, and identifies areas in most need of improvement to ensure NYS CYSHCN receive care in a well-functioning system. As additional data become available, Title V staff will update this report, make it available through the NYSDOH public website, and share it with CYSHCN grantees, partner organizations like Parent to Parent and NYSACHO.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2020-21 year:

- Complete a careful analysis of the revised NSCH when available to assess available measures, trends, and other updates related to CYSHCN in NYS.
- Collaborate with the U.S. Census Bureau to conduct an over-sample of NYS 2021 National Survey of Children's Health for NYS to allow for enhanced sampling of Black/African-American, Hispanic, including CYSHCN.
- Analyze and report on available CYSHCN data for NYS, including data from the National Survey of Children's Health, share reports with LHDs and other stakeholders, and post on the Department's public website.
- Develop and implement plans for updating the current data reporting methods (quarterly and annual reports) of LHD CYSHCN programs and SCD care transition programs to NYSDOH Title V program. Analyze and share relevant data collected from programs to improve services and inform larger program and policy work related to CYSHCN.
- Use the data gathered from the CYSHCN programs to identify specific areas for further improvement and to inform improvement activities.

**Strategy CYSHCN-5: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact the health and well-being of children and youth with special health care needs.**

As noted in other domains, MCH outcomes are impacted by the social determinants of health (SDOH), or the conditions in which people are born, live, work, play, learn, and age. SDOH include factors like socioeconomic status, education, community environment, employment, social supports, and access to health care services. Systematic differences in the distribution of power and resources due to racism and other biases are root causes of inequities in access, availability, and quality of SDOH. All ten priorities that emerged from community members' input during the needs assessment revolve around SDOH and inequities. These factors and inequities impact the health outcomes of both individuals and entire communities.

Many NYS families of CYSHCN are struggling with poverty, transportation, access to care (including availability of specialists), and sometimes employment, as many caregivers reported having to decrease hours worked or leaving jobs altogether in order to care for their children and coordinate care. Families facing day-to-day challenges like these may be less able to seek and use programs, or to take advantage of opportunities to provide feedback to LHDs or RSCs. DOH, RSCs and LHDs need to meet people where they are, provide multiple methods and means for CYSHCN and their families to engage, and ensure that a diverse population is being recruited and retained by LHDs.

The Title V Program will lead the following specific program and policy activities to advance this strategy over the upcoming 2020-21 year:

- Support local CYSHCN programs based in LHDs, with coverage increasing from 49 to 52 counties beginning October 2020.
- Work with the RSCs and LHD CYSHCN programs to integrate health equity into written materials, communication, outreach and referrals for CYSHCN and families, all of which will reflect the ethnicity and diversity of the community, including engagement strategies. Health literacy will be supported by providing information in multiple languages, at appropriate reading levels and abilities, as available.
- Develop and implement data collection systems that allows LHD CYSHCN programs and Sickle Cell Disease care transition grantees to identify, track, and address disparities.
- Partner with key stakeholders such as Parent to Parent, LHDs and RSCs to identify and share best practices to address racial justice and health equity.

The NYS Title V Program established one Evidence-Based Strategy Measure (ESM) to track the programmatic investments and inputs designed to impact NPM 12:

**ESM CYSHCN-1: Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program**

**and kept a routine medical appointment.**

Data for this measure will come from SCD Care Transition contractor reports. The baseline value for this measure, from the 2018-19 program grant cycle, is 40.3%. The program has set an improvement target of 5% for 2022, to 42.3%

**Cross-Cutting/Systems Building**

**Cross-Cutting/Systems Builiding - Annual Report**

**FFY 2019 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, and 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 Black or African American and Hispanic communities. The NYS 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 NYS 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 NYS women before pregnancy and concurrently working to improve the intendedness of pregnancies, the Title V program 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. The NYS 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 American Academy of Pediatrics (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 staff worked to identify and evaluate various program requirements and measures currently used by Title V funded programs to promote preventive care. Currently, 58% of all Title V funded 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 in Maternal and Child Health (MCH) programs. Staff spoke with colleagues across the NYSDOH Division of Family Health (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 program that received Title V funding and, 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 NYS FPP aims to make sexual and reproductive health accessible and affordable to low-income women and men. This program includes several comprehensive strategies used to promote access to preventive care for NYS residents. 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. NYS FPP 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).

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 the NYS Early Intervention program (EIP), participation in the Early Childhood Advisory Council (ECAC), ongoing work with the Early Childhood Comprehensive Systems (ECCS) Impact grant with the Council on Children and Families CCF, and collaborating on several statewide First 1000 Days on Medicaid Initiative workgroups.

The NYS 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 the Maternal, Infant, and Early Childhood Home Visiting (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 the EIP 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 the Title V program'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 represent the NYSDOH on the ECAC and will continue be participate actively throughout the upcoming program year.

The 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 & the Child Care Resource Network 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 three 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 NYSDOH 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 NYSDOH 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 NYSDOH 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 EIP or the Committee on Preschool Special Education (CPSE), depending on the age of the child, 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 from ages birth to four years old and then addressing any needs that are present can significantly improve children's outcomes as they grow.

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 program's support for developmental screenings in ways that could be applicable in other communities across NYS.

The Title V program is also continuing work to support the First 1,000 Days on Medicaid initiative, which is a multi-disciplinary effort to maximize access to services for children and families within the first 1,000 days of life. The NYS Title V program has served as a partner to the NYSDOH Office of Health Insurance Programs (OHIP), including 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 Comprehensive Adolescent Pregnancy Prevention (CAPP) and Personal Responsibility Education Program (PREP) providers. The electronic survey was deployed to CAPP and PREP providers in 2019; results of the analysis are not complete.

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 (DCDP) on adolescent health, cancer prevention, tobacco control, healthy schools, and obesity prevention. Final data sources included Youth Risk Behavior Survey (YRBS), National Survey of Children's Health (NSCH), and National Youth Tobacco Survey. A comprehensive report on the current state of adolescent health in NYS by 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 funded 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 Behavioral Risk Factor Surveillance System (BRFSS) survey, which is representative of the non-institutionalized civilian 18 years and older population of NYS, and 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 2016 State Planning and Research Cooperative System (SPARCS) patient-level, hospital, outpatient, and ambulatory center data, 90 per 10,000 children, aged 3-5 years, in NYS had a caries-related outpatient visit. The NYS 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.

NYSDOH continues to provide both technical and financial assistance to communities to maintain and expand community water fluoridation (CWF). To ensure adequate technical assistance support, NYSDOH 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 assistance and guidance, increase water operators' knowledge about CWF, and help ensure fluoridated public water systems (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 20 onsite technical assistance visits to 14 unique PWS and held four CWF trainings for 72 water operators.

Financial assistance was also provided to 16 PWS through the Drinking Water Fluoridation (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 $5.2 million was encumbered to support 14 executed contracts. 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). In addition, two PWS from Round 3 completed their projects during the reporting period.

**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, 29 different PWS received technical and/or financial support for CWF from the NYSDOH 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.** Approximately 70.8% of NYS residents are served by community water systems with optimally fluoridated water compared to 71.1% 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 NYSDOH Center for Environmental Health (CEH). The goal was to increase the percentage of residents, but the percentage has decreased as a result of small changes in population size.

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 (SBHC) program in the US. SBHCs can provide both medical and dental services, medical only, or dental only. There are 49 hospital or Federally Qualified Health Center (FQHC) sponsors, which are regulated by NYSDOH under Article 28 of NYS Public Health Law, providing dental services in 2,192 schools serving areas with low-income children as determined by the percentage of students who qualify for the free lunch program and who 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 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. Columbia Memorial Hospital (CMH), a SBHC provider of dental services and SBSP contractor, closed its school-based dental program in December 2018 due to their inability to hire a dentist despite a year-long search. The NYSDOH worked closely with CMH to identify a solution for staying open or transitioning their SBSP to another entity. However, a resolution could not be reached, so the site closed. Currently, 24 SBHC providers currently provide SBSP services. SBSP grantees are required to report data to NYSDOH to support the evaluation this strategy.

**This strategy is measured by ESM LC-7: Percentage of 2nd and 3rd graders served by School Based Sealant Programs (SBSP) who receive sealants.** For the current reporting period, 21% of 2nd and 3rd graders enrolled in the SBSP received sealants compared to 39.1% the previous year. The decrease can be attributed to a different calculation from previous years. Previously, this information was gathered from Sealant Efficiency Assessment for Locals and States (SEALS) data calculated by the Centers for Disease Control and Prevention (CDC). However, as of 2018, NYSDOH no longer receives funding from CDC for this program, so this ESM is now calculated using data submitted by SBSP grantees to NYSDOH on quarterly reports.

The Title V program continued to partner with the Madison County and Jefferson County local health departments (LHD), 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 the 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 fluoride varnish as one of their strategies. Title V staff have supported the LHDs' efforts by participating in community meetings, securing experts to provide consultation and technical assistance, and making connections to other agencies and support systems, such as Title V funded SBHCs, in their area. The grant is also supporting the development of a public health detailing curriculum to promote and increase primary care providers' application of fluoride varnish as part of a routine well-child visit. The curriculum includes training opportunities for LHDs and medical providers and materials and resources for both patients and providers. This public health detailing curriculum builds off the work conducted by the New York State Association of County Health Officials (NYSACHO) reported in previous annual reports.

Title V staff continued to collaborate with the NYSDOH DCDP on addressing sugar-sweetened beverage consumption among adolescent males of color. The Sugar-Sweetened Beverage Advisory Committee developed and implemented a

stakeholder-informed media campaign to encourage adolescents to make better beverage choices based on the connection between sugar-sweetened beverages and chronic diseases like obesity and dental decay. The Title V program developed social media campaign strategies and identified best practices to integrate oral health messaging into existing chronic disease prevention programs.

A social media and out-of-home advertising campaign was launched in three NYS regions (Western, Central, and the Southern Tier) from August through October 2018. Over the course of the campaign, streaming video delivered over 680,000 viewable impressions, more than 3,500,000 banner ads appeared, social media traffic ads delivered over 1,500,000 impressions, social media video view ads produced more than 1,100,000 impressions, and social media reach/awareness ads appeared more than 1,300,000 times. The combination of billboards, bus interiors, bus shelters, and convenience store advertising delivered approximately 23.5 million impressions over the course of the campaign. Additionally, posters were developed from focus group feedback to convey messaging about health risks associated with drinking sugar-sweetened beverages and to encourage youth to choose water. A total of 1,100 posters in English and Spanish were widely distributed to dental facilities, including dental schools, chronic disease-funded programs, SBHCs, community health centers, and middle and high schools in the targeted communities of Buffalo and Rochester, NY.  Also, water bottles with the message "Drink water!" printed on them were provided to SBHCs in middle and high schools in Western NY. Approximately 4,500 water bottles were distributed to students.

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.

From 2015-2018, NYSDOH received funding from HRSA for the PIOHQI Project to integrate oral health strategies into community-based maternal and infant health programs through care coordination and public health detailing. An Oral Health Manual and Toolkit was developed for providers and community health workers to provide a best practice resource and increase knowledge and capacity. The Toolkit was shared with the MICHC programs. MICHCs also received training on use of the Toolkit and in turn trained their staff, who are Community Health Workers (CHWs) and prenatal care and dental providers on best practices.

During the reporting period, MICHC programs continued to train new community health workers, and worked 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.

The Pathways to Success initiative continues its work integrating oral health strategies into community-based maternal and infant health programs. Pathways to Success works to develop and implement programs to improve educational, health and social outcomes for expectant and parenting teens, women, fathers and their families. The current project is based in NYC with three community colleges and a community-based organization. These projects focus on building collaborations both internally within their organizations and externally with community providers and with other NYSDOH MCH 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 has

shared 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 make 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.** NYSDOH 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 2019, a reported 60.5% of prenatal and postpartum women who were served by CHWs had a documented screening for dental issues, and 19.6% of women screened were referred for dental services. New this year, the data collected allows tracking of completed referral rates and shows 41.4% of prenatal and postpartum clients referred for dental services completed the referral.

A final strategy in the NYS Title V program State Action Plan (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 the Title V program's internal capacity by developing core dental public health competencies in residents. During their residency, the residents contribute to oral health program activities and analysis of evidence-based interventions implemented by the Title V program. Between 1998 and 2018, NYSDPHRP had 43 graduates, the majority of whom are working as public health dentists in state government, community-based clinics and academic and hospital settings.

NYSDOH continues to partner with the Eastman Institute for Oral Health (Eastman) to complete transfer of the program. Official transfer documents were sent to the Commission on Dental Accreditation (CODA), which granted the request to transfer the program to Eastman. As a result of the transfer, Eastman has become the accredited program to sustain operation of the program for current and future residents. NYSDOH and Eastman are currently finalizing an affiliate agreement that outlines NYSDOH's roles and responsibilities as an affiliate site. Jacobi Medical Center is also working with Eastman to establish an affiliate agreement to reflect the change in administration of the programs. These changes support the long-term objectives of the residency program to maintain a fully accredited training program for dentists interested in careers in dental public health. Eastman is internationally recognized as an institution for postdoctoral training in dental specialties and has successfully maintained accreditation for all other specialty programs through CODA, and therefore has the capacity to maintain CODA accreditation for the program.

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 2017 as reported in the Pregnancy Risk Assessment Monitoring System (PRAMS), 45.4% 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 79.3, in close alignment to the national average of 79.7. 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 11.1% as compared to 11.8 on the national level for 2017-18, revealing a 3.4% increase in the rate for NYS, although slightly lower than the national average. The 2017-18 combined data show a remarkable increase in the decay rate yet showing a modest increase in preventive visits.

**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 funded 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, 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 ages 12 to 17 years, daily physical activity increased slightly between 2016 (18.3%) and 2017-2018 (19.9%) and was better than the national percentage of 17.5%. For children aged 6 to 11 years, those participating in daily physical activity increased from 22.9% in 2016 to 27.0% in 2017-2018.

In the 2017-2018 NSCH surveys, 53.0% of NY parents reported that their child lives in a supportive neighborhood, which is slightly lower than the national level (56.3%), 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 (58.1% compared to 65.3%, respectively) and the perception of safety increased slightly 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 NYSDOH 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 NY Rural Water Association. 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 8 programs meeting those criteria, 4 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 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. In past years, the CDC State Profile of NYS indicated that at least 60% of the Regional Center program strategies were currently being implemented at the community/societal level of the social ecological model, exceeding the CDC requirement of at least 50% of strategies implemented at the community and societal level. During their current reporting period (2/1/19 – 1/31/20), the Regional Centers worked to maintain this level of community and societal-level strategies. This unique comprehensive approach will increase NYSDOH Rape Prevention Education program’s (RPE) capacity to access and use data, leverage support, and align state goals and proposed outcomes with implemented strategies at the local level. To ensure RPE continues to increase the capacity for implementation of community/societal level strategies, RPE will utilize guidance, evaluation, and continuous quality improvement efforts to direct activities to the outer layer of the social-ecological model and create multi-layer approaches to sexual violence prevention.

In addition to the CDC's four focus areas, the RPE has created four initiatives through which the Regional Centers will focus primary prevention efforts. Each Regional Center is required to work within two, but no more than three, of the following RPE initiatives:

- Healthy School Communities
- Healthy Nightlife Communities
- Healthy Sport Communities
- Healthy Neighborhoods.

Within each chosen RPE initiative, Regional Centers must incorporate the following components:

- Implement individual/relationship level curriculum from either CDC's STOP Sexual Violence (SV) Technical Package or that meets CDC requirements
- Media and marketing campaign
- Policy scan and recommendations
- Environmental scan and recommendations.

A monthly tracking tool will estimate the proportion of each Regional Centers' effort towards community and societal level strategies per month. Effort may be measured in the form of meetings with partners, description of changes to documents such as posters, letters, or strategic plans, delivery of curriculum, targeted recruitment efforts, and other steps along the path to producing outcomes.

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. The Regional Centers have been implementing the Healthy School and Healthy Nightlife initiatives since the previous five-year (2/1/14 – 1/31/19) RPE project period. The Healthy Sports and Healthy Neighborhood initiatives are new as of February 1, 2019 and are in the preliminary stages of development with assistance from the Regional Centers as well as the Statewide Center for Sexual Violence Prevention Training and Technical Assistance (Statewide Center). Between February 1 to July 31, 2019, Regional Centers conducted 30 nightlife trainings in bars/restaurants to 378 participants and 19 trainings within school communities to 1,846 students.

The settings of sports and neighborhoods are important settings to address for SV prevention. For example, the Statewide Center has been in contact with Kansas RPE Director to discuss their work with Crime Prevention Through Environmental Design (CPTED) and how Kansas is utilizing this approach to address the environmental safety. While CPTED is a possibility for use in this initiative, it is important to ensure that NYSDOH RPE assesses potential challenges this model may present for the SV framework, such as reinforcing ideas about bystander intervention and the effects of gentrification. Unfortunately, environmental safety design is an area where there is a significant lack of individual-level curricula and overall research specifically regarding SV For the sports initiative, the NYSDOH RPE evaluation team contacted the Coaching Boys Into Men (CBIM) and Athletes as Leaders (AAL) developers to assess the effectiveness of the programs and how we may be able to utilize the curricula within the NYSDOH RPE sports initiative to address this community. Additionally, the Statewide Center has communicated with the Director of Prevention at the New York State Coalition Against Domestic Violence (NYSCADV) about partnering to together to offer CBIM and AAL trainings to NYS.

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 to 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.

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 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, many of the MICHC programs have established formal and informal agreements with their local Regional Perinatal Centers and birthing hospitals to allow CHWs access to neonatal intensive care units (NICU) and maternity wards to engage parents with newly born infants, offering support with breastfeeding and other psychosocial needs and connecting parents to home visiting services as appropriate.

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. From July 1, 2018 to June 30, 2019, the program served 737 expectant and parenting students/community members, developed 190 new partnerships, and made 817 referrals. The most frequently cited needs of the program participants were childcare resources, referrals and placement; parenting education and resources; child needs; transportation services; housing assistance; food; academic or educational supports; workforce development; other self-sufficiency, education, or employment services; and benefits eligibility screening or application services.

This State Priority is measured by NOM #15 Rate of death in children aged 1 through 9 per 100,000. In 2017, NY’s rate was far below the national rate (13.1 compared to 17.2 per 100,000). NOM #16.1 Rate of deaths in adolescents age 10-19 per 100,000. In 2017, NY was again below the national rate at 22.1 vs. 33.7. Finally, NOM #20 Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile). NYS again is below the national percentage of 14.8% at 12.4% as reported in 2017 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. The NYS 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, the NYSDOH has made a concerted effort to incorporate a Health Equity framework into all aspects of the Title V program. Since Fall 2016, Title V staff 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 across Title V Domains, 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 NYSDOH Bureau of Chronic Disease Evaluation and Research, Bureau of Injury and Occupational Health, Office of Minority Health and Health Disparities Prevention, Office of Public Health Practice (OPHP), and OHIP, to provide performance and outcome measures for each State Priority area.

For several years, NYSDOH has had a Prevention Agenda (PA) dashboard which tracks public health data at the county level. The PA dashboard enables partners to use these data to tailor their efforts and track impact. Title V program implemented the MCH dashboard modeled after the award-winning 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 NYS Title V 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, the NYS 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 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. Team members are drawn from all areas of DFH broadly representing the various population domains and programs funded by the Title V grant. By engaging a diverse range of staff on the Health Equity, Title V staff is working to ensure that a Health Equity framework is incorporated all work within DFH at various levels. 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 State Priority. Increasingly, health equity team members are called upon by Title V staff 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 NYSDOH Learning Management System (LMS) ensures that participation in training modules are effectively tracked across all Title V Staff. Resources were used from a variety of partner organizations, including the HRSA-funded Region 2 Public Health Training Center (PHTC), which is a partnership of Columbia University Mailman School of Public Health, Rutgers School of Public Health, and the University of Puerto Rico Graduate School of Public Health, which are accredited by the Council on Education for Public Health, along with the University of the Virgin Islands Community Engagement and Lifelong Learning

Center, and NYSACHO. The training series is intended to ensure all Title V staff understand the ways in which Title V work can directly improve health equity.

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

Building on last year's work Title V staff continued to support the completion of this training across DFH. This work included implementing training for all current staff, followed by a comprehensive audit to ensure completion. In addition, new staff were directed to the LMS system and given instructions on completing the required training within their first six months as a new hire. As part of ongoing performance management initiatives, Title V staff continues to track quarterly completion of each training to ensure all staff have completed the required health equity trainings.

Title V staff also continued to ongoing in person training opportunities related to health equity for any interested Title V staff. This continues to include regular meetings of a health equity-focused book club held during hours outside of the normal workday, 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. Since its inception the book club has continued to generate positive employee feedback and participation. To date the book club has read and discussed the following: The Immortal Life of Henrietta Lacks by Rebecca Skloot, The Hillbilly Elegy: A memoir of a Family and Culture in Crisis by J.D Vance, My Beloved World by Sonia Sotomayor, and How to Be Antiracist by Ibram X. Kendi.

Much of the health equity work accomplished in DFH and done by Title V staff continues to emphasize new and innovative ways to center community and participant voice in program planning. DFH employs several different mechanisms to capture community voice and incorporate that feedback into the development and improvement of programs. The most consistent way in which this is achieved is through a series of community listening sessions. Allowing participants to direct conversation and collectively identify what they perceive to be the barriers and assets of their respective communities, listening sessions have been an invaluable tool in aiding Title V staff to better understand priority populations and individuals receiving services.

Following the facilitation of seven listening sessions centered around maternal mortality in 2018, DFH staff spent much of 2019 completing a comprehensive analysis of the data collected in order to develop a report outlining barriers, challenges, and suggestions for improvement form those women most impacted by poor maternal health outcomes. While participants at each session brought up regionally or locally specific issues, NYSDOH analysis revealed that the majority of feedback shared revealed common themes across the state. Based on the data collected from each forum.

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.

The final report created based on this feedback was completed in early 2019 and approved for publication in summer 2019. This report was shared with those organizations that hosted sessions as well as other maternal child health providers across the state.

The Department's commitment to promoting health equity continues to extend well beyond the NYS Title V program. Title V staff have continued to play a major role in the NYSDOH's Center for Community Health (CCH)'s Racial Justice (RJ) Workgroup. The workgroup is charged with proactively promoting a racial justice framework throughout the work of CCH, including Title V activities, epidemiology, community nutritional support programs, tobacco control, and cancer prevention services. 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 (e.g., staff development, training, and capacity building) and one externally focused (e.g., 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 program work and dramatically expanded the staff who are 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 to increase community input and participation in program development.

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 into all aspects of the NYS Title V program's work and in this report. There is a strong commitment to addressing this significant public health priority in NYS.

### Cross-Cutting/Systems Building - Application Year

No content was entered for the Cross-Cutting/Systems Building - Application in the State Action Plan Narrative by Domain section.

### III.F. Public Input

The mission of the NYS 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.

The NYS Title V Program has always sought public input to ensure the state's Title V strategies and efforts reflected the needs, thoughts, and priorities of all Maternal and Child Health (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 communities from whom greater understanding of life experience might shed light on disparate health outcomes.

In collaboration with the NYS Maternal, Infant, and Early Child Home Visiting (MIECHV) program and a broad network of community-based partner organizations, forums were hosted across the state with families and community members to facilitate open discussion about individual, family, and community health and services. A total of 37 forums were held in 18 NYS counties and in the Akwesasne Territory of the St. Regis Mohawk Tribe, with over 700 community members. Individual forums focused on specific populations including expectant parents and parents of young children, done in partnership with the MIECHV program; other adult men and women; adolescents; and families of Children and Youth with Special Health Care Needs (CYSHCNs). Forums were conducted and notes of the discussions were recorded by community partners. Participants were racially diverse and reported primary languages of English, Spanish, Chinese, and Haitian/Creole.

The common themes that emerged reflect the voices of listening forum participants across all population groups and geographic areas. Specific quotes from community members are invaluable in understanding the issues they face. Some powerful examples are included below for each theme.

1. Lack of awareness of resources and services in the community:
    - *If it was not for finding myself in a shelter due to a domestic violence situation, I would have not known about resources in my community and I do not feel like that is a good thing. (Expectant or new parent)*
    - *You hear about services too late; you're already struggling. (Expectant or new parent)*
2. Transportation barriers:
    - *...here are big gaps in the day when you either have to spend your whole day… go early and spend your whole day waiting for your appointment. So you waste a lot of your day, that you [could] have worked or done something else. (Adolescent)*
    - *I have to let one bill go if I have to go to Buffalo [for medical care]. (Family of CYSHCN)*
3. Availability and accessibility of services and amenities in the community:
    - *There needs to be more after school programs for children and things for them to do so they can use their time. Rather than becoming invested in drugs because they have all this time. (Adolescent)*
    - *Not all providers are a good fit for your child. Due to the limited providers, you have to deal with it not being a good fit if you want your child to receive services because there are no other options. (Family of CYSHCN)*
4. Poverty and issues of the working poor:
    - *If you are in poverty, you are more likely to spend more money because there is this like whole thing of like you pay for something to get it immediately rather than saving up to get something that lasts, so you end up buying something that will break really quick. So you end up spending more money. So really, being poor is expensive. (Adolescent)*
    - *Teach children about finances and budgets so they can better manage their futures. (Adult)*

- *If you are making a 'livable wage' you can't qualify for certain services. The system is made for us to fail. If you do improve, you lose services, you fall back. (Expectant or new parent)*

5. Supports for parents and families:
   - *I had a c-section and was alone at home. I did not have help. (Expectant or new parent)*
   - *I felt welcome at prenatal visits when they introduced themselves and included me [dad] in the conversation. The doctor let me know as a father how much I can help. Included both of us. (Father)*
   - *I have no family support in this country. (Expectant or new parent)*
6. Social support and social cohesion:
   - *Everybody needs to talk even for one second or ten minutes. Even boys. (Adolescent)*
   - *I feel isolated because not everyone is experiencing what I am experiencing. (Family of CYSHCN)*
   - *Having a village, not doing it alone. (Expectant or new parent)*
7. Health care access, quality, and bias:
   - *I've skipped appointments for myself because I can't afford the co-pay. (Adult)*
   - *…you go into the clinic and you see someone different every time. So there's not that relationship with doctors. (Adult)*
   - *If you have a lifestyle, they [providers] don't agree with, they won't respect you. (Adolescent)*
8. Community and environmental safety:
   - *I want a community where they can grow up and know that they're safe and can go anywhere they want to go and trust the adults in their community. Right now I am scared for my kids… (Adult)*
   - *I see syringes in the stairs, in the elevators, this is a big need in my building. (Family of CYSHCN)*
9. Housing:
   - *I don't feel there's a system in place to make sure landlords treat you like human beings. (Expectant or new parent)*
   - *My mom waited 3 years for them to put on a door. (Adolescent)*
10. Healthy food:
    - *There is never enough to go around. We go to soup kitchen, pantries but there needs to be more. (Adolescent)*
    - *We need more healthy food in the hood all hoods have crappy food. (Expectant or new parent)*

The most common suggestions raised by community members (each mentioned in a quarter of the forums) to help foster healthy, thriving communities included:

- More education for both adolescents and adults about financial literacy and life skills, such as budgeting, taxes, credit, parenting, etc.
- More access to healthy foods through community gardens or farmers markets
- Removing sources of and advertising for unhealthy foods, fast food, bars and alcohol in communities
- Clean up programs to tidy parks and public spaces.

Community members found it empowering to talk about their experiences, desires, and suggestions and in several forums discussed how more opportunities for community members to come together to connect are needed. It is important to close the loop of this feedback process by sharing back and discussing forum results with participants and other community members. Results compiled from all forums and the action items they informed are being packaged into a useful and meaningful format for both MCH providers and community members so the information can continue to inform work of Title V partners across the state.

In addition to community listening forums, web-based surveys designed for the public and service providers were posted on the NYSDOH website and social media and distributed widely through a broad network of over 20 organizational partner groups. Through a mix of closed- and open-ended questions, providers were asked about: what's working and what can be strengthened in their communities; social determinants, root causes, disparities, and health outcomes; community partnerships; population engagement strategies; and to rate a range of potential MCH priorities. Consumer respondents were asked about: factors that affect health in their communities; available and needed services; and barriers to and satisfaction with existing services. Over 770 providers and over 320 individual consumers responded, representing all

regions of the state

The Division of Family Health (DFH) was able to complete public input needed to gather information to develop the plan before the COVID-19 crisis impacted NYS. DFH had extensive plans to further engage stakeholders for public input on the MCH Priorities and the State Action Plan, but these plans were not completed given the urgency of the public health crisis.

DFH was able to engage the MCH Advisory Council, which includes the Executive Director of Parent to Parent of NYS and a member from the Schuyler Center for Analysis and Advocacy. The Title V Director and staff reviewed the Needs Assessment and the MCH priorities with the MCH Advisory Council on June 17, 2020.

DFH is engaging state agencies that serve the MCH population, including the Office for Children and Family Services (OCFS), the NYS Education Department (NYSED), Office for Temporary and Disability Assistance (OTDA), Council on Children and Families (CCF), Office for People with Developmental Disabilities (OPWDD), Office of Mental Health (OMH), Office for Addiction Services and Supports (OASAS), Office of Victim Services (OVS), NYS Parks Department, Department of Agriculture and Markets, Department of Transportation (DOT), NYS Division of Criminal Justice Services (DCJS), Department of State, and the Department of Labor.

DFH will continue to seek public input on the MCH Priorities and State Action Plan in the coming year and will further reflect this input in subsequent applications/annual reports.

### III.G. Technical Assistance

The NYS 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 Children and Youth with Special Health Care Needs (CYSHCN) and their families as well in planning for the comprehensive needs assessment for next year's full five-year application. NYS 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, specifically related to 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 NYS Department of Health (NYSDOH). This may continue to impact the ability of the NYS 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.

As described in the MCH Workforce Development section, the NYS Title V program has a strong established collaborative relationship with the University at Albany School of Public Health's HRSA-funded MCH Catalyst program. Our programs have worked closely together for over five years to support mutual goals related to Maternal and Child Health (MCH) workforce development, including efforts to engage and train students and to support the professional development of current Title V staff. The University at Albany MCH Catalyst Program has provided technical assistance to the Title V Program for several major projects, including extensive support to plan, implement, and document the comprehensive 5-year Needs Assessment and state action plan for this application. The Catalyst Program Co-Directors' strong working knowledge of New York's Title V Program and larger state systems, as well as the geographic proximity of the programs (especially in light of current and anticipated travel restrictions), make this a uniquely strong approach to technical assistance for our program. In the upcoming year and beyond, the NYS Title V program is interested in working with HRSA Maternal and Child Health Bureau (MCHB) to explore how the MCHB may support this relationship to facilitate future technical assistance support from the University at Albany MCH Catalyst Program.

## IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - IV. Title V-Medicaid IAA MOU.pdf

## V. Supporting Documents

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

Supporting Document #01 - V. Supporting Documents - NA Appendix.pdf

Supporting Document #02 - TitleV_2021_State_Action_Plan.pdf

## VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - VI. Organizational Chart.pdf

## VII. Appendix

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## Form 2
## MCH Budget/Expenditure Details

**State: New York**

| | FY 21 Application Budgeted | |
|---|---|---|
| 1. FEDERAL ALLOCATION<br>(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 | $ 11,857,445 | (30.4%) |
| B. Children with Special Health Care Needs | $ 14,497,912 | (37.2%) |
| C. Title V Administrative Costs | $ 2,722,777 | (7%) |
| 2. Subtotal of Lines 1A-C<br>(This subtotal does not include Pregnant Women and All Others) | $ 29,078,134 | |
| 3. STATE MCH FUNDS<br>(Item 18c of SF-424) | $ 29,285,355 | |
| 4. LOCAL MCH FUNDS<br>(Item 18d of SF-424) | $ 55,602,278 | |
| 5. OTHER FUNDS<br>(Item 18e of SF-424) | $ 0 | |
| 6. PROGRAM INCOME<br>(Item 18f of SF-424) | $ 16,735,967 | |
| 7. TOTAL STATE MATCH<br>(Lines 3 through 6) | $ 101,623,600 | |
| A. Your State's FY 1989 Maintenance of Effort Amount<br>$ 58,268,752 | | |
| 8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL<br>(Total lines 1 and 7) | $ 140,533,410 | |
| 9. OTHER FEDERAL FUNDS<br>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) | $ 49,308,573 | |
| 11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL<br>(Partnership Subtotal + Other Federal MCH Funds Subtotal) | $ 189,841,983 | |

| OTHER FEDERAL FUNDS | FY 21 Application Budgeted |
|---|---|
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP) | $ 2,913,835 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants | $ 8,336,421 |
| US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA) | $ 26,180,873 |
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Sexual Risk Avoidance Education | $ 3,326,948 |
| Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Medicaid Match | $ 8,550,496 |

| | FY 19 Annual Report Budgeted | | FY 19 Annual Report Expended | |
|---|---|---|---|---|
| 1. FEDERAL ALLOCATION<br>(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year) | $ 37,671,810 | | $ 25,616,759 | |
| A. Preventive and Primary Care for Children | $ 12,306,455 | (32.7%) | $ 8,459,460 | (33%) |
| B. Children with Special Health Care Needs | $ 12,315,693 | (32.7%) | $ 7,871,388 | (30.7%) |
| C. Title V Administrative Costs | $ 3,054,075 | (8.1%) | $ 821,482 | (3.3%) |
| 2. Subtotal of Lines 1A-C<br>(This subtotal does not include Pregnant Women and All Others) | $ 27,676,223 | | $ 17,152,330 | |
| 3. STATE MCH FUNDS<br>(Item 18c of SF-424) | $ 29,285,356 | | $ 29,285,356 | |
| 4. LOCAL MCH FUNDS<br>(Item 18d of SF-424) | $ 122,324,435 | | $ 57,532,053 | |
| 5. OTHER FUNDS<br>(Item 18e of SF-424) | $ 0 | | $ 0 | |
| 6. PROGRAM INCOME<br>(Item 18f of SF-424) | $ 30,303,017 | | $ 22,258,095 | |
| 7. TOTAL STATE MATCH<br>(Lines 3 through 6) | $ 181,912,808 | | $ 109,075,504 | |
| A. Your State's FY 1989 Maintenance of Effort Amount<br>$ 58,268,752 | | | | |
| 8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL<br>(Total lines 1 and 7) | $ 219,584,618 | | $ 134,692,263 | |
| 9. OTHER FEDERAL FUNDS<br>Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2. | | | | |
| 10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9) | $ 47,470,052 | | $ 53,655,287 | |
| 11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL<br>(Partnership Subtotal + Other Federal MCH Funds Subtotal) | $ 267,054,670 | | $ 188,347,550 | |

| OTHER FEDERAL FUNDS | FY 19 Annual Report Budgeted | FY 19 Annual Report Expended |
|---|---|---|
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs | $ 150,000 | $ 0 |
| 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 | $ 9,160,198 |
| Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning | $ 5,798,000 | $ 8,000,732 |
| 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 | $ 25,888,440 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program | $ 2,051,265 | $ 0 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI) | $ 100,000 | $ 0 |
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP) | $ 2,956,063 | $ 2,756,926 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State-Based Perinaal Quality Collaboratives Cooperative Agreement | $ 200,000 | $ 0 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Strength Based Curriculum | $ 485,000 | $ 0 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health | $ 400,000 | $ 0 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention | $ 250,000 | $ 0 |
| Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Medicaid Match | | $ 7,848,991 |

**Form Notes for Form 2:**

None

**Field Level Notes for Form 2:**

None

**Data Alerts:**

- The value in Line 1, Federal Allocation, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.
- The value in Line 1A, Preventive And Primary Care Expended, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.
- The value in Line 1B, Children with Special Health Care Needs, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.
- The value in Line 1C, Title V Administrative Costs, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.
- The value in Line 4, Local MCH Funds, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.
- The value in Line 6, Program Income, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.

## 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 21 Application Budgeted | FY 19 Annual Report Expended |
|---|---|---|
| 1. Pregnant Women | $ 3,406,947 | $ 2,825,732 |
| 2. Infants < 1 year | $ 2,762,724 | $ 2,007,596 |
| 3. Children 1 through 21 Years | $ 9,094,721 | $ 6,451,864 |
| 4. CSHCN | $ 14,497,912 | $ 7,871,388 |
| 5. All Others | $ 6,424,729 | $ 5,638,697 |
| Federal Total of Individuals Served | $ 36,187,033 | $ 24,795,277 |

| IB. Non-Federal MCH Block Grant | FY 21 Application Budgeted | FY 19 Annual Report Expended |
|---|---|---|
| 1. Pregnant Women | $ 19,242,969 | $ 21,364,126 |
| 2. Infants < 1 year | $ 11,305,629 | $ 11,486,181 |
| 3. Children 1 through 21 Years | $ 29,690,792 | $ 31,827,141 |
| 4. CSHCN | $ 25,617,900 | $ 22,117,926 |
| 5. All Others | $ 15,766,310 | $ 22,280,130 |
| Non-Federal Total of Individuals Served | $ 101,623,600 | $ 109,075,504 |
| Federal State MCH Block Grant Partnership Total | $ 137,810,633 | $ 133,870,781 |

**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:** | **2021** |
| | **Column Name:** | **Application Budgeted** |
| | **Field Note:** Form 2, Line 1A contains both Children 1 through 21 years and Infants < 1 year. | |
| 2. | **Field Name:** | **IA. Federal MCH Block Grant, 3. Children 1 through 21 years** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:** Form 2, Line 1A contains both Children 1 through 21 years and Infants < 1 year. | |

**Data Alerts:**

- Children 1 through 21 Years, Application Budgeted does not equal Form 2, Line 1A, Preventive and Primary Care for Children Application Budgeted. A field-level note indicating the reason for the discrepancy was provided.
- Children 1 through 21 Years, Annual Report Expended does not equal Form 2, Line 1A, Preventive and Primary Care for Children, Annual Report Expended. A field - level note indicating the reason for the discrepancy was provided.

## Form 3b
## Budget and Expenditure Details by Types of Services

**State: New York**

### II. TYPES OF SERVICES

| IIA. Federal MCH Block Grant | FY 21 Application Budgeted | FY 19 Annual Report Expended |
|---|---|---|
| 1. Direct Services | $ 3,672 | $ 2,246 |
| A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One | $ 0 | $ 0 |
| B. Preventive and Primary Care Services for Children | $ 0 | $ 0 |
| C. Services for CSHCN | $ 3,672 | $ 2,246 |
| 2. Enabling Services | $ 26,017,174 | $ 18,363,021 |
| 3. Public Health Services and Systems | $ 12,888,964 | $ 7,251,492 |
| 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 | | $ 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 | | $ 2,246 |
| Direct Services Line 4 Expended Total | | $ 2,246 |
| **Federal Total** | $ 38,909,810 | $ 25,616,759 |

| IIB. Non-Federal MCH Block Grant | FY 21 Application Budgeted | FY 19 Annual Report Expended |
|---|---|---|
| 1. Direct Services | $ 18,671,468 | $ 20,741,700 |
| A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One | $ 6,643,433 | $ 7,850,317 |
| B. Preventive and Primary Care Services for Children | $ 6,456,885 | $ 7,605,809 |
| C. Services for CSHCN | $ 5,571,150 | $ 5,285,574 |
| 2. Enabling Services | $ 39,558,963 | $ 38,154,296 |
| 3. Public Health Services and Systems | $ 39,964,454 | $ 44,855,171 |
| 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 | | $ 20,741,700 |
| Direct Services Line 4 Expended Total | | $ 20,741,700 |
| **Non-Federal Total** | $ 98,194,885 | $ 103,751,167 |

**Form Notes for Form 3b:**

None

**Field Level Notes for Form 3b:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **IIA. - Other - Other** |
| | **Fiscal Year:** | **2021** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:** The State does not collect the level of data to identify individual types of direct services. | |
| 2. | **Field Name:** | **IIB. - Other - Other** |
| | **Fiscal Year:** | **2021** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:** The State does not collect the level of data to identify individual types of direct services. | |

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

**State: New York**

**Total Births by Occurrence: 222,097** **Data Source Year: 2020**

**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 | 222,049 (100.0%) | 1,900 | 340 | 340 (100.0%) |

| Program Name(s) | | | | |
|---|---|---|---|---|
| 3-Hydroxy-3-Methyglutaric Aciduria | 3-Methylcrotonyl-Coa Carboxylase Deficiency | Argininosuccinic Aciduria | Biotinidase Deficiency | Carnitine Uptake Defect/Carnitine Transport Defect |
| Citrullinemia, Type I | Classic Galactosemia | Classic Phenylketonuria | Congenital Adrenal Hyperplasia | Critical Congenital Heart Disease |
| Cystic Fibrosis | Glutaric Acidemia Type I | Glycogen Storage Disease Type II (Pompe) | 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 |
|---|---|---|---|---|
| HIV | 222,049 (100.0%) | 375 | 0 | 0 (0%) |
| Tyrosinemia, type 2,3 | 222,049 (100.0%) | 6 | 0 | 0 (0%) |
| Spinal Muscular Atrophy | 222,049 (100.0%) | 10 | 10 | 10 (100.0%) |
| GAMT | 222,049 (100.0%) | 15 | 0 | 0 (0%) |

### 3. Screening Programs for Older Children & Women

None

### 4. Long-Term Follow-Up

NYS Newborn Screening Program (NYSNBSP) receives funding from the aid to localities state budget allocation, which is used for contracts with each of the 10 Inherited Metabolic Disease Specialty Care Centers to enroll patients with an inherited metabolic disease diagnosis identified by newborn screening in the NYS Newborn Screening Patient Registry. The Specialty Care Centers are also responsible for entering data directly into a RedCap database on an annual basis for each consented patient and for attending an annual meeting to discuss long-term follow-up data. Patients are monitored until age 18, when the individual must consent to continue participation until age 21. Data elements vary for each disorder.

**Form Notes for Form 4:**

None

**Field Level Notes for Form 4:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **HIV - Confirmed Cases** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Other Newborn** |
| | **Field Note:** N/A | |
| 2. | **Field Name:** | **HIV - Referred For Treatment** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Other Newborn** |
| | **Field Note:** N/A | |

**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 2019**

### 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 | 159,470 | 48.0 | 0.0 | 51.0 | 1.0 | 0.0 |
| 2. Infants < 1 Year of Age | 226,920 | 48.0 | 0.0 | 51.0 | 1.0 | 0.0 |
| 3. Children 1 through 21 Years of Age | 135,463 | 39.0 | 0.0 | 58.0 | 3.0 | 0.0 |
| 3a. Children with Special Health Care Needs | 70,206 | 48.0 | 0.0 | 49.0 | 3.0 | 0.0 |
| 4. Others | 176,451 | 22.0 | 0.0 | 72.0 | 6.0 | 0.0 |
| Total | 698,304 | | | | | |

### 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 | 226,238 | No | 222,975 | 100 | 222,975 | 159,470 |
| 2. Infants < 1 Year of Age | 226,899 | No | 226,920 | 100 | 226,920 | 226,920 |
| 3. Children 1 through 21 Years of Age | 4,841,820 | Yes | 4,841,820 | 58 | 2,808,256 | 135,463 |
| 3a. Children with Special Health Care Needs | 811,973 | Yes | 811,973 | 38 | 308,550 | 70,206 |
| 4. Others | 14,472,506 | Yes | 14,472,506 | 6 | 868,350 | 176,451 |

**Form Notes for Form 5:**

None

**Field Level Notes for Form 5a:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **Pregnant Women Total Served** |
| | **Fiscal Year:** | **2019** |

**Field Note:**
Data for Form 5a were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by Title V or funded by state and other funds but with Title V funded staff support for subject matter expertise.

The following MCH serving programs were included in Form 5a for Pregnant Women:
• Comprehensive Adolescent Pregnancy Prevention and ACT for Youth Center of Excellence
• Family Planning Program
• Regional Perinatal Centers
• Community Water Fluoridation
• Maternal and Infant Community Health Collaborative (MICHC) Programs
• Maternal, Infant, and Early Child Home Visiting (MIECHV) Programs – Nurse Family Partnership and Healthy Families

Estimates for the Primary Source of Coverage were provided by HRSA.

| | | |
|---|---|---|
| 2. | **Field Name:** | **Infants Less Than One YearTotal Served** |
| | **Fiscal Year:** | **2019** |

**Field Note:**
All NYS infants receive Title V funded or supported services as a result of investments in the state's Newborn Metabolic Screening Program for the screening, as well as Newborn Hearing Screening, services through the perinatal system, and home visiting.

Estimates for the Primary Source of Coverage were provided by HRSA.

| | | |
|---|---|---|
| 3. | **Field Name:** | **Children 1 through 21 Years of Age** |
| | **Fiscal Year:** | **2019** |

**Field Note:**
Data for Form 5a were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by Title V or funded by state and other funds but with Title V funded staff support for subject matter expertise.

The following MCH serving programs were included in Form 5a for Children 1-21 years old:
• Asthma Program
• Child Lead Poisoning Prevention Program
• Local Health Department Children with Special Healthcare Needs Programs
• Comprehensive Adolescent Pregnancy Prevention Program and ACT for Youth Center of Excellence
• School Based Health Center Program
• Family Planning Program
• Enough is Enough Program
• Maternal, Infant and Early Child Home Visiting (MIECHV) Programs – Nurse Family Partnership and Healthy Families
• Sickle Cell Disease Transition Grants to Hemoglobinopathy Centers
• Physically Handicapped Children Program (PHCP)
• Project TEACH

Estimates for the Primary Source of Coverage were provided by HRSA.

| | | |
|---|---|---|
| 4. | **Field Name:** | **Children with Special Health Care Needs** |
| | **Fiscal Year:** | **2019** |

**Field Note:**
Data for Form 5a were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by Title V or funded by state and other funds but with Title V funded staff support for subject matter expertise. Children and Youth with Special Healthcare Needs (CYSHCN) counts are a subset of the counts for Children ages 1-21 years old.

The following MCH serving programs were included in Form 5a for CYSHCN:
• Asthma Program
• Child Lead Poisoning Prevention Program
• Local Health Department Children with Special Healthcare Needs Programs
• School Based Health Center Program
• Maternal, Infant and Early Child Home Visiting (MIECHV) Programs – Nurse Family Partnership and Healthy Families
• Sickle Cell Disease Transition Grants to Hemoglobinopathy Centers
• Physically Handicapped Children Program (PHCP)

Estimates for the Primary Source of Coverage were provided by HRSA.

| | | |
|---|---|---|
| 5. | **Field Name:** | **Others** |
| | **Fiscal Year:** | **2019** |

**Field Note:**
Data for Form 5a were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by Title V or funded by state and other funds but with Title V funded staff support for subject matter expertise.

The following MCH serving programs were included in Form 5a for Other Populations:
• Asthma Program
• Family Planning Program
• Enough is Enough Program
• Maternal and Infant Community Health Collaborative (MICHC) Program
• Maternal, Infant, and Early Child Home Visiting (MIECHV) Programs – Nurse Family Partnership and Healthy Families

Estimates for the Primary Source of Coverage were provided by HRSA.

| | | |
|---|---|---|
| 6. | **Field Name:** | **Total_TotalServed** |
| | **Fiscal Year:** | **2019** |

**Field Note:**
Total

**Field Level Notes for Form 5b:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **Pregnant Women** |
| | **Fiscal Year:** | **2019** |

**Field Note:**
All pregnant women in NYS benefit from Title V funding as a result of investments in training and quality improvement initiatives with the Regional Perinatal Centers and birthing hospitals as well as work with other medical and healthcare providers.

Data for Form 5b for pregnant women served are reported based on NYS Vital Statistics data reported in Form 6 of the Title V application.

| | | |
|---|---|---|
| 2. | **Field Name:** | **InfantsLess Than One Year** |
| | **Fiscal Year:** | **2019** |

**Field Note:**
All NYS infants benefit from Title V funding as a result of investments in the state's Newborn Metabolic Screening Program for the screening, as well as Newborn Hearing Screening, services through the perinatal system, and home visiting.

Data for Form 5b for pregnant women served are reported based on NYS Vital Statistics data reported in Form 6 of the Title V application.

| | | |
|---|---|---|
| 3. | **Field Name:** | **Children 1 Through 21 Years of Age** |
| | **Fiscal Year:** | **2019** |

| | | |
|---|---|---|
| | **Field Note:**<br>Data for Form 5b were aggregated from reports provided by MCH programs directly funded by Title V or funded by state/ other funds but with Title V funded staff support for subject matter expertise. The following MCH serving programs were included in 5b for Children 1-21 years old: Asthma Program, Child Lead Poisoning Prevention Program, LHD CYSHCN Programs, CAPP & ACT for Youth Center of Excellence, SBHC Program, Family Planning Program, Enough is Enough Program, MIECHV Programs – Nurse Family Partnership and Healthy Families, Sickle Cell Disease Transition Grants to Hemoglobinopathy Centers, PHCP, Project TEACH, Community Water Fluoridation, and the Medicaid Performance Improvement Project (PIP)**.<br><br>**Footnote: Since approximately 50% of NYS children have Medicaid coverage and would be counted in the Medicaid PIP, the other MCH serving programs were reduced by 50% to reduce the potential for overcounting or double counting of children served by Title V. | |
| 4. | **Field Name:** | **Children With Special Health Care Needs** |
| | **Fiscal Year:** | **2019** |
| | **Field Note:**<br>Data for Form 5b for Children and Youth with Special Healthcare Needs (CYSHCN) served by Title V are being reported based on the impact of the Medicaid Performance Improvement Project which benefited all children on Medicaid, including CYSHCN.<br><br>Data for Form 5b for CSHCN were provided by the NYSDOH Medicaid Program and the estimated number of CYSHCN in NYS. | |
| 5. | **Field Name:** | **Others** |
| | **Fiscal Year:** | **2019** |
| | **Field Note:**<br>Data for 5b were aggregated from reports provided by specific Maternal and Child Health programs that are either directly funded by Title V or funded by state and other funds but with Title V funded staff support for subject matter expertise.<br><br>The following MCH serving programs were included in 5b for Other Populations:<br>• Asthma Program<br>• Family Planning Program<br>• Enough is Enough Program<br>• Maternal and Infant Community Health Collaborative (MICHC) Program<br>• Maternal, Infant, and Early Child Home Visiting (MIECHV) Programs – Nurse Family Partnership and Healthy Families<br>• Community Water Fluoridation | |

**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. |

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

**State: New York**

**Annual Report Year 2019**

### 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 | 222,975 | 106,933 | 31,752 | 51,477 | 378 | 23,406 | 1,302 | 3,677 | 4,050 |
| Title V Served | 222,975 | 106,933 | 31,752 | 51,477 | 378 | 23,406 | 1,302 | 3,677 | 4,050 |
| Eligible for Title XIX | 114,856 | 37,690 | 21,554 | 38,167 | 245 | 12,287 | 344 | 1,795 | 2,774 |
| 2. Total Infants in State | 226,920 | 108,948 | 32,436 | 52,211 | 382 | 23,747 | 1,317 | 3,755 | 4,124 |
| Title V Served | 226,920 | 108,948 | 32,436 | 52,211 | 382 | 23,747 | 1,317 | 3,755 | 4,124 |
| Eligible for Title XIX | 116,549 | 38,199 | 22,013 | 38,652 | 246 | 12,451 | 345 | 1,833 | 2,810 |

**Form Notes for Form 6:**

None

**Field Level Notes for Form 6:**

None

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

**State: New York**

| A. State MCH Toll-Free Telephone Lines | 2021 Application Year | 2019 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" | | 12,547 |

| B. Other Appropriate Methods | 2021 Application Year | 2019 Annual Report Year |
|---|---|---|
| 1. Other Toll-Free "Hotline" Names | | |
| 2. Number of Calls on Other Toll-Free "Hotlines" | | |
| 3. State Title V Program Website Address | | |
| 4. Number of Hits to the State Title V Program Website | | |
| 5. State Title V Social Media Websites | | |
| 6. Number of Hits to the State Title V Program Social Media Websites | | |

**Form Notes for Form 7:**

None

## Form 8
## State MCH and CSHCN Directors Contact Information

**State: New York**

| 1. Title V Maternal and Child Health (MCH) Director | |
|---|---|
| Name | Lauren Tobias |
| Title | Director, Division of Family Health |
| Address 1 | New York State Department of Health |
| Address 2 | Corning Tower Rm 890 |
| City/State/Zip | Albany / NY / 12237 |
| Telephone | (518) 474-6968 |
| Extension | |
| Email | Lauren.Tobias@health.ny.gov |

| 2. Title V Children with Special Health Care Needs (CSHCN) Director | |
|---|---|
| Name | Suzanne Swan |
| Title | Director, Bureau of Child Health |
| Address 1 | New York State Department of Health |
| Address 2 | Corning Tower Rm 878 |
| City/State/Zip | Albany / NY / 12237 |
| Telephone | (518) 474-1961 |
| Extension | |
| Email | 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
## State Priorities – Needs Assessment Year

**State: New York**

**Application Year 2021**

| No. | Priority Need | Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period) |
|---|---|---|
| 1. | Address equity, bias, quality of care, and barriers to access in health care services for women and families, especially for communities of color and low-income communities | New |
| 2. | Promote awareness and enhance availability, accessibility and coordination of services for families and youth, including CYSHCN, with a focus on areas impacted by systemic barriers, including racism | New |
| 3. | Enhance supports for parents and families, especially those with children with special health care needs, and inclusive of all family members and caregivers | New |
| 4. | Cultivate and enhance social support and social cohesion opportunities for individuals and families who experience isolation as a result of systemic barriers including racism, across the life course | New |
| 5. | Increase access to affordable fresh and healthy foods in communities. | New |
| 6. | Address community and environmental safety for children, youth, and families. | New |
| 7. | Acknowledge and address the fundamental challenges faces by families in poverty and near-poverty, including the “working poor” as a result of systemic barriers, including racism. | New |
| 8. | Increase awareness of resources and services in the community among families and the providers who serve them. | New |
| 9. | Increase the availability and quality of affordable housing. | New |
| 10. | Address transportation barriers for individuals and families. | New |

**Form Notes for Form 9:**

None

**Field Level Notes for Form 9:**

None

## 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 |
|---|---|---|---|---|
| 2018 | 80.9 % | 0.1 % | 177,826 | 219,882 |
| 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 |
|---|---|---|---|---|
| 2017 | 80.0 | 1.9 | 1,767 | 220,896 |
| 2016 | 76.5 | 1.9 | 1,711 | 223,634 |
| 2015 | 94.4 | 2.4 | 1,609 | 170,377 |
| 2014 | 99.4 | 2.1 | 2,265 | 227,787 |
| 2013 | 88.4 | 2.0 | 1,989 | 225,063 |
| 2012 | 87.2 | 2.0 | 2,008 | 230,394 |
| 2011 | 85.4 | 2.0 | 1,921 | 224,836 |
| 2010 | 88.5 | 2.0 | 1,997 | 225,683 |
| 2009 | 75.0 | 1.8 | 1,714 | 228,672 |
| 2008 | 69.8 | 1.7 | 1,617 | 231,579 |

**Legends:**

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 2 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014_2018 | 17.8 | 1.2 | 208 | 1,166,305 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 3 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018 | 8.1 % | 0.1 % | 18,208 | 225,864 |
| 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 |
|---|---|---|---|---|
| 2018 | 9.0 % | 0.1 % | 20,281 | 225,904 |
| 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 |
|---|---|---|---|---|
| 2018 | 23.7 % | 0.1 % | 53,647 | 225,904 |
| 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 |
|---|---|---|---|---|
| 2018/Q2-2019/Q1 | 1.0 % | | | |
| 2018/Q1-2018/Q4 | 1.0 % | | | |
| 2017/Q4-2018/Q3 | 1.0 % | | | |
| 2017/Q3-2018/Q2 | 1.0 % | | | |
| 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:**

**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 |
|---|---|---|---|---|
| 2017 | 5.3 | 0.2 | 1,218 | 230,389 |
| 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 |
|---|---|---|---|---|
| 2017 | 4.6 | 0.1 | 1,053 | 229,737 |
| 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 |
|---|---|---|---|---|
| 2017 | 3.1 | 0.1 | 710 | 229,737 |
| 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 |
|---|---|---|---|---|
| 2017 | 1.5 | 0.1 | 343 | 229,737 |
| 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 |
|---|---|---|---|---|
| 2017 | 172.8 | 8.7 | 397 | 229,737 |
| 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 |
|---|---|---|---|---|
| 2017 | 58.3 | 5.0 | 134 | 229,737 |
| 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 |
|---|---|---|---|---|
| 2017 | 5.0 | 0.2 | 1,091 | 218,652 |
| 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 |
|---|---|---|---|---|
| 2017_2018 | 11.1 % | 1.6 % | 428,582 | 3,870,687 |
| 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 |
|---|---|---|---|---|
| 2018 | 13.7 | 0.8 | 278 | 2,031,885 |
| 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 |
|---|---|---|---|---|
| 2018 | 21.9 | 1.0 | 506 | 2,306,162 |
| 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 |
|---|---|---|---|---|
| 2016_2018 | 4.6 | 0.4 | 169 | 3,647,654 |
| 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 |
|---|---|---|---|---|
| 2016_2018 | 6.0 | 0.4 | 218 | 3,647,654 |
| 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 |
|---|---|---|---|---|
| 2017_2018 | 15.8 % | 1.6 % | 656,207 | 4,140,731 |
| 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 |
|---|---|---|---|---|
| 2017_2018 | 15.2 % | 3.5 % | 99,924 | 656,207 |
| 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 |
|---|---|---|---|---|
| 2017_2018 | 3.1 % | 0.8 % | 107,077 | 3,441,661 |
| 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 |
|---|---|---|---|---|
| 2017_2018 | 5.3 % | 0.9 % | 181,410 | 3,441,139 |
| 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 |
|---|---|---|---|---|
| 2017_2018 | 53.5 % | 7.3 % | 149,733 | 279,615 |
| 2016_2017 | 45.5 % | 5.6 % | 131,277 | 288,794 |
| 2016 | 45.2 % | 6.7 % | 169,907 | 375,487 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 18 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017_2018 | 91.2 % | 1.3 % | 3,768,420 | 4,131,497 |
| 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 |
|---|---|---|---|---|
| 2016 | 13.7 % | 0.1 % | 25,048 | 182,401 |
| 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 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: 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 |
|---|---|---|---|---|
| 2017_2018 | 14.4 % | 2.3 % | 267,724 | 1,853,746 |
| 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 |
|---|---|---|---|---|
| 2018 | 2.2 % | 0.1 % | 91,033 | 4,060,665 |
| 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 |
|---|---|---|---|---|
| 2018 | 68.8 % | 2.8 % | 228,914 | 332,891 |
| 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 width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable 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 |
|---|---|---|---|---|
| 2018_2019 | 69.6 % | 1.3 % | 2,682,388 | 3,852,898 |
| 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 because the relative standard error is >0.3.

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 |
|---|---|---|---|---|
| 2018 | 67.3 % | 2.7 % | 774,548 | 1,151,627 |
| 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 width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable 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 |
|---|---|---|---|---|
| 2018 | 91.7 % | 1.3 % | 1,056,227 | 1,151,627 |
| 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 width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable 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 |
|---|---|---|---|---|
| 2018 | 94.9 % | 1.2 % | 1,092,813 | 1,151,627 |
| 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 width/estimate >1.2

Estimates with 95% confidence interval widths > 20 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 |
|---|---|---|---|---|
| 2018 | 11.7 | 0.1 | 6,847 | 584,413 |
| 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 |
|---|---|---|---|---|
| 2018 | 15.5 % | 1.1 % | 14,715 | 95,176 |
| 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 |
|---|---|---|---|---|
| 2017_2018 | 2.2 % | 0.8 % | 87,291 | 4,015,472 |
| 2016_2017 | 2.1 % | 0.7 % | 84,929 | 4,099,217 |
| 2016 | 2.0 % | 0.6 % | 81,336 | 4,165,523 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 25 - Notes:**

None

**Data Alerts: None**

## Form 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** | **2019** |
| Annual Objective | 73.4 | 73.8 | 77.4 | 78.4 |
| Annual Indicator | 68.4 | 73.3 | 69.8 | 79.6 |
| Numerator | 2,471,455 | 2,653,864 | 2,510,557 | 2,826,660 |
| Denominator | 3,612,104 | 3,619,067 | 3,597,587 | 3,550,054 |
| Data Source | BRFSS | BRFSS | BRFSS | BRFSS |
| Data Source Year | 2015 | 2016 | 2017 | 2018 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 79.4 | 80.3 | 81.3 | 82.2 | 83.1 | 83.5 |

**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 | 2019 |
| Annual Objective | 91 | 91 | 93.4 | 93.7 |
| Annual Indicator | 92.3 | 92.7 | 92.5 | 91.2 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | NYS VS | NYS VS | NYS VS | NYS VS |
| Data Source Year | 2014 | 2015 | 2016 | 2017 |
| Provisional or Final ? | Final | Final | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 93.0 | 93.4 | 93.8 | 94.2 | 94.4 | 94.5 |

**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 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day**

| Federally Available Data | | |
|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CHILD** | | |
| | **2016** | **2019** |
| Annual Objective | | |
| Annual Indicator | | 27.0 |
| Numerator | | 369,498 |
| Denominator | | 1,370,994 |
| Data Source | | NSCH-CHILD |
| Data Source Year | | 2017_2018 |

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 | | | | | |
|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 28.0 | 29.0 | 30.0 | 31.0 | 32.0 |

**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** | **2019** |
| Annual Objective | | | 81.2 | 82.2 |
| Annual Indicator | | 79.2 | 81.3 | 81.3 |
| Numerator | | 1,103,856 | 1,081,532 | 1,081,532 |
| Denominator | | 1,393,274 | 1,331,106 | 1,331,106 |
| Data Source | | NSCH | NSCH | NSCH |
| Data Source Year | | 2016 | 2016_2017 | 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 | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 83.2 | 84.2 | 85.2 | 86.2 | 86.3 | 86.4 |

**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** | **2019** |
| Annual Objective | | | 15.7 | 15.9 |
| Annual Indicator | | 15.3 | 13.7 | 17.8 |
| Numerator | | 48,081 | 34,736 | 48,580 |
| Denominator | | 314,730 | 253,092 | 273,067 |
| Data Source | | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

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 | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 16.1 | 18.0 | 18.1 | 18.3 | 18.5 | 18.7 |

**Field Level Notes for Form 10 NPMs:**

None

## Form 10
## National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

**State: New York**

**2016-2020: 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** | **2019** |
| Annual Objective | 67.1 | 67.6 | 66.2 | 66.6 |
| Annual Indicator | 63.9 | 73.9 | 75.3 | 68.6 |
| Numerator | 135,686 | 155,836 | 152,784 | 65,253 |
| Denominator | 212,507 | 210,880 | 202,843 | 95,190 |
| Data Source | PRAMS | PRAMS | PRAMS | PRAMS |
| Data Source Year | 2013 | 2015 | 2017 | 2018 |

| State Provided Data | | | | |
|---|---|---|---|---|
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | 67.1 | 67.6 | 66.2 | 66.6 |
| Annual Indicator | 71.3 | 73.9 | | |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | PRAMS NYS | PRAMS NYS | | |
| Data Source Year | 2014 | 2015 | | |
| Provisional or Final ? | Provisional | Final | | |

**Field Level Notes for Form 10 NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2016** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>NYS PRAMS 2014 preliminary data as of 5/22/2017<br>Annual Objectives based on statewide data:<br>2017 67.1<br>2018 67.8<br>2019 68.4<br>2020 69.1<br>2021 69.8 | |
| 2. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>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:**<br>Percentage of infants placed to sleep on their backs<br>Annual Indicator: 74.2<br>PRAMS NYS<br>2016 | |

**2016-2020: 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** | **2019** |
| Annual Objective | | 36 |
| Annual Indicator | 37.6 | 37.4 |
| Numerator | 71,966 | 32,530 |
| Denominator | 191,278 | 87,007 |
| Data Source | PRAMS | PRAMS |
| Data Source Year | 2017 | 2018 |

| State Provided Data | | | |
|---|---|---|---|
| | **2017** | **2018** | **2019** |
| Annual Objective | | | 36 |
| Annual Indicator | 0 | | |
| Numerator | 0 | | |
| Denominator | 100 | | |
| Data Source | NYS PRAMS | | |
| Data Source Year | 2016 | | |
| Provisional or Final ? | Provisional | | |

**Field Level Notes for Form 10 NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>2016 NYS Data | |
| 2. | **Field Name:** | **2018** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Percent of infants placed to sleep on a separate approved sleep surface<br>Annual Indicator: 36.0<br>NYS Prams 2016 | |

**2016-2020: 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** | **2019** |
| Annual Objective | | 44 |
| Annual Indicator | 46.3 | 45.2 |
| Numerator | 89,933 | 39,272 |
| Denominator | 194,052 | 86,816 |
| Data Source | PRAMS | PRAMS |
| Data Source Year | 2017 | 2018 |

| State Provided Data | | | |
|---|---|---|---|
| | **2017** | **2018** | **2019** |
| Annual Objective | | | 44 |
| Annual Indicator | 0 | | |
| Numerator | 0 | | |
| Denominator | 100 | | |
| Data Source | 2016 | | |
| Data Source Year | 2016 | | |
| Provisional or Final ? | Provisional | | |

**Field Level Notes for Form 10 NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>2016 NYS Data not available yet | |
| 2. | **Field Name:** | **2018** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Percent of infants placed to sleep without soft objects or loose bedding<br>Annual Indicator: 43.8<br>NYS PRAMS 2016 | |

**2016-2020: 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** | **2019** |
| Annual Objective | | | 17.9 | 18.2 |
| Annual Indicator | | 17.5 | 23.1 | 27.1 |
| Numerator | | 101,178 | 117,256 | 140,531 |
| Denominator | | 578,216 | 506,773 | 519,134 |
| Data Source | | NSCH | NSCH | NSCH |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

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.

**Field Level Notes for Form 10 NPMs:**

None

**2016-2020: 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** | **2019** |
| Annual Objective | 27.1 | 27.5 | 18.8 | 19 |
| Annual Indicator | 23.3 | 23.3 | 23.2 | 23.2 |
| Numerator | 161,704 | 161,704 | 159,614 | 159,614 |
| Denominator | 694,960 | 694,960 | 689,106 | 689,106 |
| Data Source | YRBSS-ADOLESCENT | YRBSS-ADOLESCENT | YRBSS-ADOLESCENT | YRBSS-ADOLESCENT |
| Data Source Year | 2015 | 2015 | 2017 | 2017 |
| **Federally Available Data** | | | | |
| **Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | | 18.8 | 19 |
| Annual Indicator | | 18.3 | 17.7 | 19.9 |
| Numerator | | 246,053 | 232,223 | 284,451 |
| Denominator | | 1,346,787 | 1,313,811 | 1,426,960 |
| Data Source | | NSCH-ADOLESCENT | NSCH-ADOLESCENT | NSCH-ADOLESCENT |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

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.

**Field Level Notes for Form 10 NPMs:**

None

**2016-2020: 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** | **2019** |
| Annual Objective | | | 12.8 |
| Annual Indicator | 12.3 | 14.5 | 16.4 |
| Numerator | 130,919 | 156,317 | 189,724 |
| Denominator | 1,062,218 | 1,079,417 | 1,158,201 |
| Data Source | NSCH-NONCSHCN | NSCH-NONCSHCN | NSCH-NONCSHCN |
| Data Source Year | 2016 | 2016_2017 | 2017_2018 |

**Field Level Notes for Form 10 NPMs:**

None

**2016-2020: 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** | **2019** |
| Annual Objective | 57.2 | 57.6 | 56.8 | 57.2 |
| Annual Indicator | 54.9 | 51.7 | 45.4 | 43.3 |
| Numerator | 117,570 | 110,325 | 95,006 | 42,679 |
| Denominator | 214,301 | 213,585 | 209,242 | 98,649 |
| Data Source | PRAMS | PRAMS | PRAMS | PRAMS |
| Data Source Year | 2013 | 2015 | 2017 | 2018 |

| State Provided Data | | | | |
|---|---|---|---|---|
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | 57.2 | 57.6 | 56.8 | 57.2 |
| Annual Indicator | 53.5 | 51.7 | | |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | PRAMS NYS | PRAMS NYS | | |
| Data Source Year | 2014 | 2015 | | |
| Provisional or Final ? | Final | Final | | |

**Field Level Notes for Form 10 NPMs:**

None

**2016-2020: 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** | **2019** |
| Annual Objective | | | 79.6 | 80.5 |
| Annual Indicator | | 77.6 | 80.6 | 79.3 |
| Numerator | | 2,955,156 | 3,137,003 | 3,084,314 |
| Denominator | | 3,810,186 | 3,890,746 | 3,887,411 |
| Data Source | | NSCH | NSCH | NSCH |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

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.

**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**

**Field Level Notes for Form 10 NPMs:**

None

## Form 10
## State Performance Measures (SPMs)

**State: New York**

**SPM 1 - Percent of samples received by the State Newborn Screening lab within 48 hours of collection**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 75.0 | 77.0 | 79.0 | 81.0 | 85.0 |

**Field Level Notes for Form 10 SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2021** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>These data are from the NYS Newborn Bloodspot Program and will be calculated as part of the LEAN quality improvement project to improve timeliness of lab samples received by the state's Wadsworth Laboratories. Objectives will be assessed in 2020-21 and updated as needed. | |
| 2. | **Field Name:** | **2022** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>These data are from the NYS Newborn Bloodspot Program and will be calculated as part of the LEAN quality improvement project to improve timeliness of lab samples received by the state's Wadsworth Laboratories. Objectives will be assessed in 2020-21 and updated as needed. | |
| 3. | **Field Name:** | **2023** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>These data are from the NYS Newborn Bloodspot Program and will be calculated as part of the LEAN quality improvement project to improve timeliness of lab samples received by the state's Wadsworth Laboratories. Objectives will be assessed in 2020-21 and updated as needed. | |
| 4. | **Field Name:** | **2024** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>These data are from the NYS Newborn Bloodspot Program and will be calculated as part of the LEAN quality improvement project to improve timeliness of lab samples received by the state's Wadsworth Laboratories. Objectives will be assessed in 2020-21 and updated as needed. | |
| 5. | **Field Name:** | **2025** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>These data are from the NYS Newborn Bloodspot Program and will be calculated as part of the LEAN quality improvement project to improve timeliness of lab samples received by the state's Wadsworth Laboratories. Objectives will be assessed in 2020-21 and updated as needed. | |

**SPM 2 - Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 3.7 | 3.7 | 3.7 | 3.7 | 3.7 |

**Field Level Notes for Form 10 SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2021** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:** Reduce the incidence of confirmed high blood lead levels at 5 micrograms per deciliter or greater per 1,000 tested children aged less than 72 months, with baseline incidence and benchmarks established in 2020-21 program year. The current incidence of confirmed blood lead levels at 10 micrograms per deciliter or greater is 3.7 per 1,000 children tested in 2016. (NYS Child Health Lead Poisoning Prevention Program Data) | |
| 2. | **Field Name:** | **2022** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:** Reduce the incidence of confirmed high blood lead levels at 5 micrograms per deciliter or greater per 1,000 tested children aged less than 72 months, with baseline incidence and benchmarks established in 2020-21 program year. The current incidence of confirmed blood lead levels at 10 micrograms per deciliter or greater is 3.7 per 1,000 children tested in 2016. (NYS Child Health Lead Poisoning Prevention Program Data) | |
| 3. | **Field Name:** | **2023** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:** Reduce the incidence of confirmed high blood lead levels at 5 micrograms per deciliter or greater per 1,000 tested children aged less than 72 months, with baseline incidence and benchmarks established in 2020-21 program year. The current incidence of confirmed blood lead levels at 10 micrograms per deciliter or greater is 3.7 per 1,000 children tested in 2016. (NYS Child Health Lead Poisoning Prevention Program Data) | |
| 4. | **Field Name:** | **2024** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:** Reduce the incidence of confirmed high blood lead levels at 5 micrograms per deciliter or greater per 1,000 tested children aged less than 72 months, with baseline incidence and benchmarks established in 2020-21 program year. The current incidence of confirmed blood lead levels at 10 micrograms per deciliter or greater is 3.7 per 1,000 children tested in 2016. (NYS Child Health Lead Poisoning Prevention Program Data) | |
| 5. | **Field Name:** | **2025** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:** Reduce the incidence of confirmed high blood lead levels at 5 micrograms per deciliter or greater per 1,000 tested children aged less than 72 months, with baseline incidence and benchmarks established in 2020-21 program year. The current incidence of confirmed blood lead levels at 10 micrograms per deciliter or greater is 3.7 per 1,000 children tested in 2016. (NYS Child Health Lead Poisoning Prevention Program Data) | |

## Form 10
## State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

**2016-2020: 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** | **2019** |
| Annual Objective | | 45 | 36.4 | 37.6 |
| Annual Indicator | 34.6 | 35.3 | 35.3 | 35.3 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | BRFSS | BRFSS | BRFSS | BRFSS |
| Data Source Year | 2014 | 2016 | 2016 | 2016 |
| Provisional or Final ? | Final | Final | Final | Provisional |

**Field Level Notes for Form 10 SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2016** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>2014 estimate revised to closer align with the performance measure. | |
| 2. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>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:**<br>2018 NYS BRFSS data is not available yet | |
| 4. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>2017 BRFSS data were not available in time to calculate the updated indicator, and staff were deployed to support the state's response to the COVID pandemic. | |

**2016-2020: 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** | **2019** |
| Annual Objective | | 8 | 25 | 25 |
| Annual Indicator | 27 | 24.5 | 24.5 | 24.5 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | Medicaid Claims | Medicaid Claims | Medicaid Claims | Medicaid Claims |
| Data Source Year | 2016 | 2017 | 2017 | 2017 |
| Provisional or Final ? | Final | Final | Final | Provisional |

**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 | |
| 3. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** Updated Medicaid Claims data were not available in time to calculate the indicator, and staff were deployed to support the state's response to the COVID pandemic. | |

**2016-2020: 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** | **2019** |
| Annual Objective | | 50 | 50 | 50 |
| Annual Indicator | 0 | 0 | 0 | 0 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | To Be Developed | Developmental Assessment Tool | Developmental Assessment Tool | Developmental Assessment Tool |
| Data Source Year | 2017-2018 | 2017-2018 | 2017-2018 | 2018-2019 |
| Provisional or Final ? | Final | Final | Final | Final |

**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. | |

**2016-2020: 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** | **2019** |
| Annual Objective | | 65 | 65.5 | 71 |
| Annual Indicator | 61.6 | 70.1 | 67 | 63.7 |
| Numerator | 673 | 1,021 | 1,238 | 1,034 |
| Denominator | 1,092 | 1,456 | 1,848 | 1,624 |
| Data Source | New York Family Survey | New York Family Survey | New York Family Survey | New York Family Survey |
| Data Source Year | 2015-2016 | 2016-2017 | 2017-2018 | 2018-2019 |
| Provisional or Final ? | Final | Final | Final | Final |

**Field Level Notes for Form 10 SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2016** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data collection: 7/1/2015-6/30/2016 | |
| 2. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>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:**<br>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. | |

**2016-2020: 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** | **2019** |
| Annual Objective | | 72 | 73 | 75 |
| Annual Indicator | 71.7 | 71.6 | 70.8 | 70.8 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | CDC Water Fluoridated Reporting System | CDC Water Fluoridated Reporting System | CDC Water Fluoridated Reporting System | CDC Water Fluoridated Reporting System |
| Data Source Year | 2017 | 2018 | 2019 | 2019 |
| Provisional or Final ? | Final | Final | Final | Provisional |

**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). | |
| 2. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** 2019 data are the most current data available at the time of submission. | |

## Form 10
## Evidence-Based or –Informed Strategy Measure (ESM)

**State: New York**

**ESM 1.1 - Percent of Maternal and Infant Community Health Collaboratives (MICHC) program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker (CHW)**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 55.3 | 58.1 | 61.0 | 64.0 | 67.2 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2021** |
| | **Column Name:** | **Annual Objective** |

**Field Note:**
Data for this measure will come from quarterly and annual reports submitted by local MICHC contractors. The baseline value for this measure, taken from 6-month program period of 10/1/19-3/31/20, is 52.7%. The program has set a one-year improvement target of 5%, to 55.3% of participants, for 2022.

**ESM 1.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 25.6 | 26.9 | 28.0 | 29.0 | 30.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2021** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from FPP clinic visit record (CVR) data. Current FPP data for program year 2018 shows 25.6% of FPP clients had a documented comprehensive medical exam. The FPP program has set a one-year improvement target of 5%, to 26.9% of clients in 2022. | |
| 2. | **Field Name:** | **2022** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from FPP clinic visit record (CVR) data. Annual objectives will be assessed in 2020-21. | |
| 3. | **Field Name:** | **2023** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from FPP clinic visit record (CVR) data. Annual objectives will be assessed in 2020-21. | |
| 4. | **Field Name:** | **2024** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from FPP clinic visit record (CVR) data. Annual objectives will be assessed in 2020-21. | |
| 5. | **Field Name:** | **2025** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from FPP clinic visit record (CVR) data. Annual objectives will be assessed in 2020-21. | |

**ESM 3.1 - Percent of birthing hospitals with final level of perinatal care designation, in accordance with updated regulations and standards**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 0.0 | 25.0 | 50.0 | 75.0 | 100.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2021** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from hospital surveys and site visit reports from the NYSDOH subrecipient (IPRO) and NYSDOH staff. The baseline value for this measure will be determined in 2021, after regulations are adopted. | |
| 2. | **Field Name:** | **2022** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from hospital surveys and site visit reports from the NYSDOH subrecipient (IPRO) and NYSDOH staff. The baseline value for this measure will be determined in 2021, after regulations are adopted. | |
| 3. | **Field Name:** | **2023** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from hospital surveys and site visit reports from the NYSDOH subrecipient (IPRO) and NYSDOH staff. The baseline value for this measure will be determined in 2021, after regulations are adopted. | |
| 4. | **Field Name:** | **2024** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from hospital surveys and site visit reports from the NYSDOH subrecipient (IPRO) and NYSDOH staff. The baseline value for this measure will be determined in 2021, after regulations are adopted. | |
| 5. | **Field Name:** | **2025** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from hospital surveys and site visit reports from the NYSDOH subrecipient (IPRO) and NYSDOH staff. The baseline value for this measure will be determined in 2021, after regulations are adopted. | |

**ESM 8.1.1 - Percent of children and youth enrolled in School Based Health Centers (SBHCs) who have documentation of counseling or anticipatory guidance on physical activity and nutrition during a visit to a SBHC within the past year**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 0.0 | 0.0 | 5.0 | 10.0 | 20.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2021** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from the SBHC quarterly reporting system. As this is a new measure, the baseline value will be established in FFY 2020-21, with improvement targets for subsequent years set once the baseline is available. | |
| 2. | **Field Name:** | **2022** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from the SBHC quarterly reporting system. As this is a new measure, the baseline value will be established in FFY 2020-21, with improvement targets for subsequent years set once the baseline is available. | |
| 3. | **Field Name:** | **2023** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from the SBHC quarterly reporting system. As this is a new measure, the baseline value will be established in FFY 2020-21, with improvement targets for subsequent years set once the baseline is available. | |
| 4. | **Field Name:** | **2024** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from the SBHC quarterly reporting system. As this is a new measure, the baseline value will be established in FFY 2020-21, with improvement targets for subsequent years set once the baseline is available. | |
| 5. | **Field Name:** | **2025** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from the SBHC quarterly reporting system. As this is a new measure, the baseline value will be established in FFY 2020-21, with improvement targets for subsequent years set once the baseline is available. | |

**ESM 10.1 - Percent of youth-serving programs that provide training on adult preparation subjects, such as accessing health insurance, maintaining their routine preventive medical visits, healthy relationships, effective communication, financial literacy, and ad**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 0.0 | 0.0 | 5.0 | 10.0 | 20.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2021** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from biannual reports and annual data requests submitted by local adolescent health providers. Baseline values for this measure will be taken from a 6-month program period of 10/1/2020-3/31/2021. Improvement targets will be determined after the baseline has been established. | |
| 2. | **Field Name:** | **2022** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from biannual reports and annual data requests submitted by local adolescent health providers. Baseline values for this measure will be taken from a 6-month program period of 10/1/2020-3/31/2021. Improvement targets will be determined after the baseline has been established. | |
| 3. | **Field Name:** | **2023** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from biannual reports and annual data requests submitted by local adolescent health providers. Baseline values for this measure will be taken from a 6-month program period of 10/1/2020-3/31/2021. Improvement targets will be determined after the baseline has been established. | |
| 4. | **Field Name:** | **2024** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from biannual reports and annual data requests submitted by local adolescent health providers. Baseline values for this measure will be taken from a 6-month program period of 10/1/2020-3/31/2021. Improvement targets will be determined after the baseline has been established. | |
| 5. | **Field Name:** | **2025** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from biannual reports and annual data requests submitted by local adolescent health providers. Baseline values for this measure will be taken from a 6-month program period of 10/1/2020-3/31/2021. Improvement targets will be determined after the baseline has been established. | |

**ESM 10.2 - Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 0.0 | 0.0 | 5.0 | 10.0 | 20.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2021** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from biannual reports and annual data requests submitted by adolescent health providers. Baseline values for this measure will be taken from a 6-month program period of 10/1/2020-3/31/2020. Improvement targets will be determined after the baseline has been established. | |
| 2. | **Field Name:** | **2022** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from biannual reports and annual data requests submitted by adolescent health providers. Baseline values for this measure will be taken from a 6-month program period of 10/1/2020-3/31/2020. Improvement targets will be determined after the baseline has been established. | |
| 3. | **Field Name:** | **2023** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from biannual reports and annual data requests submitted by adolescent health providers. Baseline values for this measure will be taken from a 6-month program period of 10/1/2020-3/31/2020. Improvement targets will be determined after the baseline has been established. | |
| 4. | **Field Name:** | **2024** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from biannual reports and annual data requests submitted by adolescent health providers. Baseline values for this measure will be taken from a 6-month program period of 10/1/2020-3/31/2020. Improvement targets will be determined after the baseline has been established. | |
| 5. | **Field Name:** | **2025** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from biannual reports and annual data requests submitted by adolescent health providers. Baseline values for this measure will be taken from a 6-month program period of 10/1/2020-3/31/2020. Improvement targets will be determined after the baseline has been established. | |

**ESM 12.1 - Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 40.3 | 40.8 | 41.3 | 41.8 | 42.3 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2021** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from SCD Care Transition contractor reports. The baseline value for this measure, from the 2018-19 program grant cycle, is 40.3%. The program has set an improvement target of 5% to 42.3%. | |
| 2. | **Field Name:** | **2022** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from SCD Care Transition contractor reports. The baseline value for this measure, from the 2018-19 program grant cycle, is 40.3%. The program has set an improvement target of 5% to 42.3%. | |
| 3. | **Field Name:** | **2023** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from SCD Care Transition contractor reports. The baseline value for this measure, from the 2018-19 program grant cycle, is 40.3%. The program has set an improvement target of 5% to 42.3%. | |
| 4. | **Field Name:** | **2024** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from SCD Care Transition contractor reports. The baseline value for this measure, from the 2018-19 program grant cycle, is 40.3%. The program has set an improvement target of 5% to 42.3%. | |
| 5. | **Field Name:** | **2025** |
| | **Column Name:** | **Annual Objective** |
| | **Field Note:**<br>Data for this measure will come from SCD Care Transition contractor reports. The baseline value for this measure, from the 2018-19 program grant cycle, is 40.3%. The program has set an improvement target of 5% to 42.3%. | |

## Form 10
## Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

**2016-2020: 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** | **2019** |
| Annual Objective | | 40 | 5 | 5 |
| Annual Indicator | 5 | 5.3 | 5.3 | 5.3 |
| Numerator | | 1 | 1 | 1 |
| Denominator | | 19 | 19 | 19 |
| Data Source | Title V Program Records | Title V Program Records | Title V Program Records | Title V Program Records |
| Data Source Year | 2017 | 2018 | 2019 | 2020 |
| Provisional or Final ? | Final | Final | Final | Provisional |

**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.

**2016-2020: 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** | **2019** |
| Annual Objective | | | 7 | 7 |
| Annual Indicator | 11 | 7 | 7 | 7 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | NYS Title V Program Records | NYS Title V Program Records | NYS Title V Program Records | NYS Title V Program Records |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Final | Final | Final | Provisional |

**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 | |

**2016-2020: 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 |
|---|---|

**Baseline data was not available/provided.**

**Field Level Notes for Form 10 ESMs:**

None

**2016-2020: ESM 3.1 - Percentage of birthing hospitals re-designated with updated standards.**

| **Measure Status:** | | | **Active** | |
|---|---|---|---|---|
| **State Provided Data** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | 0 | 0 | 0 |
| Annual Indicator | 0 | 0 | 0 | 0 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | NYS Title V Program records | NYS Title V Program records | NYS Title V Program records | NYS Title V Program records |
| Data Source Year | 2017 | 2018 | 2019 | 2020 |
| Provisional or Final ? | Final | Final | Final | Final |

**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. | |

**2016-2020: 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** | **2019** |
| Annual Objective | 90 | 90 | 90 |
| Annual Indicator | 91.7 | 91.6 | 91.6 |
| Numerator | | 831 | |
| Denominator | | 907 | |
| Data Source | NYS sampled Birthing Hospitals | NYS sampled Birthing Hospitals | NYS sampled Birthing Hospitals |
| Data Source Year | 2017 | 2018 | 2018 |
| Provisional or Final ? | Final | Final | Final |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
The NYSPQC initiative has ended. The last data collection for this measure was in October 2018 (one month in the current 2018-19 time period). 91.6% was the last complete year of data. There will be no additional data to report.

**2016-2020: 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** | **2019** |
| Annual Objective | | 0 | 1,600 | 1,680 |
| Annual Indicator | 0 | 1,694 | 2,488 | 5,468 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | NYS Medicaid Health Home Data | 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 | 2018-19 |
| Provisional or Final ? | Final | Final | Final | Final |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2016** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Not Available Yet | |
| 2. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>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:**<br>Data Source Year: 12/1/2016-5/2018.<br>Children age 0-12 with documented serious emotional disturbance and/or complex trauma enrolled in Health Home Serving Children December 2016-May 2018.<br>Medicaid provided data for all children (unduplicated) since the inception of CHH.<br>Health Homes for children did not begin until Dec. 2016. | |
| 4. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data were reported by the NYS Medicaid Program for the time period from 10/1/19-9/30/20 for children under the age of 13 years old.<br>Member counts include members that met the following criteria in the month/year based on Billing Support information submitted by Health Homes into the MAPP HHTS:<br>1) enrolled in a children's Health Home program,<br>2) received a billable Health Home service, and<br>3) reported SED or complex trauma as a reason that the member was Health Home eligible. | |

**2016-2020: 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** | **2019** |
| Annual Objective | | | 6 | 7 |
| Annual Indicator | 1 | 6 | 6 | 8 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | Title V Program data | Title V Program data | Title V Program data | Title V Program data |
| Data Source Year | 7/16-6/17 | 16-18 | 17-19 | 18-19 |
| Provisional or Final ? | Final | Final | Final | Final |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data Source Year: 10/1/16-3/31/18<br>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:**<br>Data Source Year: 10/1/17-3/31/19<br>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. | |
| 3. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>During the past reporting period, of 8 programs meeting those criteria, 4 met their community, environmental, or policy level changes as a result of their enhanced collaborative efforts. | |

**2016-2020: 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** | **2019** |
| Annual Objective | 1,000 | 1,000 | 1,050 |
| Annual Indicator | 1,060 | 1,605 | 4,088 |
| Numerator | | | |
| Denominator | | | |
| Data Source | NYS Medicaid Health Home Data | NYS Medicaid Health Home Data | NYS Medicaid Health Home Data |
| Data Source Year | 12/16-18 | 12/16-18 | 2018-19 |
| Provisional or Final ? | Final | Final | Final |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>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:**<br>Adolescent age 13-21 with serious emotional disturbance and/or complex trauma enrolled in a Health Home Serving Children December 2016-May 2018.<br><br>Medicaid provided data for all children (unduplicated) since the inception of CHH. | |
| 3. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data were reported by the NYS Medicaid Program for the time period from 10/1/19-9/30/20 for youth 13-21. Member counts include members that met the following criteria in the month/year based on Billing Support information submitted by Health Homes into the MAPP HHTS:<br>1) enrolled in a children's Health Home program,<br>2) received a billable Health Home service, and<br>3) reported SED or complex trauma as a reason that the member was Health Home eligible. | |

**2016-2020: ESM 10.4 - Number of strategies implemented to improve adolescent use of preventive health care services.**

| **Measure Status:** | | **Active** | |
|---|---|---|---|
| **State Provided Data** | | | |
| | **2017** | **2018** | **2019** |
| Annual Objective | 1 | 1 | 1 |
| Annual Indicator | 1 | 1 | 1 |
| 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 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>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:**<br>There is 1 comprehensive strategy to improve adolescent use of preventive health care services. | |

**2016-2020: 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** | **2019** |
| Annual Objective | | 45 | 60 | 32.8 |
| Annual Indicator | 63.9 | 66.9 | 32.5 | 38 |
| Numerator | 4,275 | 5,244 | 902 | 950 |
| Denominator | 6,688 | 7,843 | 2,777 | 2,502 |
| Data Source | NYEHDI | NYEHDI | NYEHDI | NYEHDI |
| Data Source Year | CY2016 | CY2017 | CY2018 | CY2018 |
| Provisional or Final ? | Final | Final | Provisional | Final |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>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:**<br>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:** | **State Provided Data** |
| | **Field Note:**<br>Data are for calendar year 2018, reported by the NYS Early Hearing Detection and Intervention (EHDI) program. | |

**2016-2020: 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** | **2019** |
| Annual Objective | | 10 | 50 | 50 |
| Annual Indicator | 36.7 | 45.3 | 56.6 | 60.5 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | MICHC reports | MICHC reports | MICHC reports | MICHC reports |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Final | Final | Final | Final |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
In 2019, a reported 60.5% of prenatal and postpartum women who were served by CHWs had a documented screening for dental issues, and 19.6% of women screened were referred for dental services. New this year, the data collected allows tracking of completed referral rates and shows 41.4% of prenatal and postpartum clients referred for dental services completed the referral.

**2016-2020: 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** | **2019** |
| Annual Objective | | 20 | 60 | 61 |
| Annual Indicator | 58 | 60 | 48 | 29 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | NYS Title V Program records | NYS Title V Program records | NYS Title V Program records | NYS Title V Program records |
| Data Source Year | 2017 | 2018 | 2019 | 2020 |
| Provisional or Final ? | Final | Final | Final | Final |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
Over the course of the reporting period, 29 different public water systems (PWS) received technical and/or financial support for community water fluoridation (CWF) from the NYSDOH DWF Grant program.

**2016-2020: 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** | **2019** |
| Annual Objective | | 40 | 41 | 44 |
| Annual Indicator | 61.2 | 50.5 | 39.1 | 21 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | SEALS (CDC Data) | SEALS (CDC Data) | SEALS (CDC Data) | SBSP quarterly reports |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Final | Final | Final | Final |

**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. | |
| 3. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** Previously, this information was gathered from Sealant Efficiency Assessment for Locals and States (SEALS) data calculated by the Centers for Disease Control and Prevention (CDC). However, as of 2018, NYSDOH no longer receives funding from CDC for this program, so this ESM is now calculated using data submitted by SBSP grantees to NYSDOH on quarterly reports. | |

## Form 10
## State Performance Measure (SPM) Detail Sheets

**State: New York**

**SPM 1 - Percent of samples received by the State Newborn Screening lab within 48 hours of collection**
**Population Domain(s) – Perinatal/Infant Health**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | The goal is to achieve state-wide improvement from 74.34% to greater than 85% of samples received at the lab within 48 hours of collection by September 2023 |
| **Definition:** | **Numerator:** Number of samples received within 48 hours of collection<br>**Denominator:** Number of births<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Healthy People 2020 Objective:** | Not applicable |
| **Data Sources and Data Issues:** | NYS Newborn Blood Spot Data |
| **Significance:** | This SPM was developed to reflect the state's continued commitment to ensure that every newborn in the state receives newborn bloodspot screening as a public health service, to identify and support infants with a wide range of medical conditions. As a population-based program, the NBS program is an integral part of NY's public health system for supporting the health and lifelong well-being of newborns and their families. In 2018, the program screened 222,049 infants, 99.98% of all NYS resident infants born that year, and timely receipt of the sample is critical to ensure appropriate care can be provided. The Title V Program will collaborate with the Newborn Blood Spot Program to support the quality improvement initiative to improve timely receipt of newborn blood spot samples. |

**SPM 2 - Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months**
**Population Domain(s) – Children with Special Health Care Needs**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Reduce the incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months by at least 5%, from 3.7 per 1000 children tested in 2016 to below 3.0 in 1000 children tested in 2022 |
| **Definition:** | **Numerator:** Number of children ages less than 72 months old with blood lead levels 5.0 micrograms per deciliter or greater<br>**Denominator:** Number of children ages less than 72 months old with blood lead tests<br>**Unit Type:** Rate<br>**Unit Number:** 1,000 |
| **Healthy People 2020 Objective:** | The Healthy People 2020 objectives for blood lead levels:<br>EH-8.1 To reduce blood lead levels in children (in the 97.5 percentile, age 1–5 years); Baseline was 5.8 µg/dL and is currently 3.5 µg/dL, representing a 40% reduction<br>EH-8.2 To reduce the mean blood lead levels in children (geometric mean, age 1–5 years); Baseline was 1.8 µg/dL and is currently 0.8 µg/dL, representing a 55% reduction |
| **Data Sources and Data Issues:** | NYS Child Health Lead Poisoning Prevention Program Data |
| **Significance:** | This SPM was developed to reflect the state's longstanding commitment to eliminating childhood lead poisoning as a key public health problem in NYS. It is responsive to cross-cutting priorities voiced by families related to safe and healthy environments to support children's development, and access to comprehensive, high quality health care services. It is also responsive to specific concerns shared by families regarding challenges in accessing and coordinating medical care and related services for children with special health care needs. It builds on critical public health investments and capacity to prevent, identify, and address lead poisoning in NYS, including recent amendments to state public health law |

## Form 10
## State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

**2016-2020: 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**

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>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.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>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</td></tr>
<tr><td>Denominator:</td><td>All female BRFSS respondents 18-44 years old who are reproductively capable</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>N/A</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>NYS BRFSS survey data<br>In some survey years, number of respondents meeting criteria for this measure may be small.</td></tr>
<tr><td>Significance:</td><td>Incorporating preconception health care in routine health care for all women of reproductive age is critical to several NYS Title V priorities and strategies.</td></tr>
</table>

**2016-2020: 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**

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>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</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>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).</td></tr>
<tr><td>Denominator:</td><td>Continuously enrolled female Medicaid recipients, 15-44 years of age at risk for unintended pregnancy</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>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.</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>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.<br><br>Baseline to be established and targets for improvement to be determined as part of implementation</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

**2016-2020: 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<br>**Denominator:** Number of children and adolescents surveyed<br>**Unit Type:** Percentage<br>**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. |

**2016-2020: 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<br>**Denominator:** Number of respondent families<br>**Unit Type:** Percentage<br>**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. |

**2016-2020: 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<br>**Denominator:** Number of NYS residents served by community water systems<br>**Unit Type:** Percentage<br>**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 1.1 - Percent of Maternal and Infant Community Health Collaboratives (MICHC) program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker (CHW)**
**NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | The baseline value for this measure, taken from 6-month program period of 10/1/19-3/31/20, is 57.2%. The program has set a one-year improvement target of 5%, to 57.2% of participants, for 2022. |
| **Definition:** | **Numerator:** Number of MICHC participants engaged prenatally who have created a birth plan during a visit with a CHW<br>**Denominator:** Number of MICHC participants engaged prenatally with a CHW<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Data for this measure will come from quarterly and annual reports submitted by local MICHC contractors. |
| **Significance:** | Through the Maternal & Infant Community Heath Collaboratives (MICHC) program, community health workers (CHWs) conduct basic health and well-being assessments in the prenatal and postpartum periods, using standardized evidence-based and/or validated screening tools, to identify and prioritize needs of the individuals and families served. Assessments are completed at enrollment and updated throughout clients' service periods and individualized care plans are developed based on the needs identified. CHWs receive annual training on how to talk with families about difficult topics like mental health and depression, using a trauma informed care approach, and including how to manage emergency situations. CHWs also connect clients and families to needed services and provide enhanced social support. CHWs help ensure early and consistent participation in preventive and primary health care services, including early prenatal care, particularly for those individuals not engaged in care and other supportive services. CHWs provide health information to increase clients' knowledge and ability to self-advocate and make informed health care decisions, with the goal of helping families achieve optimal health, self-sufficiency, and overall well-being. |

**ESM 1.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year**
**NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Current FPP data for program year 2018 shows 25.6% of FPP clients had a documented comprehensive medical exam. The FPP has set a one-year improvement target of 5%, to 26.9% of clients in 2022. |
| **Definition:** | **Numerator:** Number of Family Planning Program clients with a documented comprehensive medical exam in the past year<br>**Denominator:** Number of FPP clients<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Data for this measure will come from FPP clinic visit record (CVR) data. |
| **Significance:** | The NYS Family Planning Program (FPP) supports 43 Article 28 health facilities (i.e., hospitals and clinics) that operate 156 family planning service sites across the state. Through these service sites, the FPP delivers comprehensive, confidential reproductive health services for low-income, uninsured and underinsured women and men of reproductive age. Services provided include: contraceptive services; preconception planning and counseling services; pregnancy testing and related counseling; preventive services such as basic health screening, screening for sexually transmitted diseases, HIV counseling and testing, breast and cervical cancer screening; and appropriate referrals and health education. |

**ESM 3.1 - Percent of birthing hospitals with final level of perinatal care designation, in accordance with updated regulations and 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:** | The baseline value for this measure will be determined in 2021, after regulations are adopted. The program has set a target to update designations for 50% of hospitals within the first year, and 100% within 5 years. |
| **Definition:** | **Numerator:** Number of birthing hospitals with final level of perinatal care designation<br>**Denominator:** Number of birthing hospitals<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Data for this measure will come from hospital surveys and site visit reports from IPRO/NYSDOH staff |
| **Significance:** | NYS historically has been a leader in establishing systems of perinatal regionalization, with consistently high performance in this measure. Building on that success, the Title V program is currently engaged in a multi-year effort to expand and update perinatal regionalization standards and designations for the state's birthing hospitals and centers. As this work progresses, it is essential to closely monitor the success of designating birthing hospitals in accordance with updated regulations as well as performance and outcome measures to ensure that quality of care and key health outcomes are maintained or improved. |

**ESM 8.1.1 - Percent of children and youth enrolled in School Based Health Centers (SBHCs) who have documentation of counseling or anticipatory guidance on physical activity and nutrition during a visit to a SBHC within the past year**
**NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day**

| | |
|---|---|
| **Measure Status:** | Active |
| **ESM Subgroup(s):** | All Children 6 through 17 |
| **Goal:** | The baseline value will be established in 2020-21, with improvement targets for subsequent years set once the baseline is available |
| **Definition:** | **Numerator:** Children and youth enrolled in SBHCs who have documentation of counseling or anticipatory guidance on physical activity and nutrition during a visit to a SBHC<br>**Denominator:** Children with a visit to a SBHC<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Data for this measure will come from the SBHC quarterly reporting system. As this is a new measure, the baseline value will be established in 2020-21, with improvement targets for subsequent years set once the baseline is available. |
| **Significance:** | NY's Title V program has important capacity to address these priorities through its School Based Health Center (SBHC) program. SBHCs serve NYS's highest need communities and provide critical access to quality primary care for school-aged children. SBHCs are an important source of primary and preventive care services for thousands of NYS children, and have the opportunity and capacity to holistically address children's needs. Title V staff will work with SBHCs statewide to ensure anticipatory guidance to promote proper nutrition and daily physical activity, weight status assessment, and attention to overall health promotion and chronic disease management, as part of routine primary and preventive care for children. |

**ESM 10.1 - Percent of youth-serving programs that provide training on adult preparation subjects, such as accessing health insurance, maintaining their routine preventive medical visits, healthy relationships, effective communication, financial literacy, and ad**
**NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Baseline values for this measure will be using data from 10/1/2020-3/31/2021. Improvement targets will be determined after the baseline has been established. |
| **Definition:** | **Numerator:** Number of youth-serving programs that provide training on adult preparation subjects for adolescents with and without special health care needs to prepare them for a transition into adulthood<br>**Denominator:** Number of youth-serving programs that provide training on adult preparation subjects for adolescents with and without special health<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Data for this measure will come from biannual reports and annual data requests submitted by local adolescent health providers. |
| **Significance:** | Adolescence is a critical stage of development when children grow physically, cognitively, emotionally, and socially to become adults. The lifestyle choices, behaviors, and relationships established during this time can affect an adolescent's current and future health. Comprehensive and inclusive reproductive health care and education are opportunities to help adolescents avoid or mitigate risky sexual behaviors. Title V Programs also provide enabling services to adolescents, such as referrals to and linkages with community services and social supports to holistically address health and wellness, including mental health and social determinants of health. |

**ESM 10.2 - Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation**
**NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Baseline values for this measure will be established using data from 10/1/2020-3/31/2020. Improvement targets will be determined after the baseline has been established. |
| **Definition:** | **Numerator:** Number of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation<br>**Denominator:** Number of youth-serving programs<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Data for this measure will come from biannual reports and annual data requests submitted by adolescent health providers. |
| **Significance:** | Significance needed |

**ESM 12.1 - Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.**
**NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care**

| | |
|---|---|
| **Measure Status:** | Active |
| **ESM Subgroup(s):** | CSHCN |
| **Goal:** | The baseline value for this measure, from the 2018-19 program grant cycle, is 40.3%. The program has set an improvement target of 5% for 2022, to 42.3%. |
| **Definition:** | **Numerator:** Individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed<br>**Denominator:** Individuals ages 14-21 with sickle cell disease who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Sickle Cell Disease Care Transition contractor reports |
| **Significance:** | Sickle cell disease (SCD) grantees at three (3) Hemoglobinopathy Centers (HC) work directly and exclusively with youth in support services. HCs conduct peer support groups to gauge barriers to care and transition for youth and young adults with SCD. Transition navigators at HCs engage youth with SCD to ensure compliance with care regimens and to understand that barriers youth experience in caring for themselves. In studies by Treadwell et al. (2011) and Telfair (2004) participants with SCD voiced a fear of leaving their pediatric health care providers, expressing concern that adult care providers might not understand their needs and might not believe their complaints of pain. The youth also expressed concerns about having limited information about transition and about adult health care programs. There is increased risk for individuals with SCD during this transition period. |

## Form 10
## Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

**2016-2020: 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<br>**Denominator:** Number of procurements released by DFH<br>**Unit Type:** Percentage<br>**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 |

**2016-2020: 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.<br>**Denominator:** N/A<br>**Unit Type:** Count<br>**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. |

**2016-2020: 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<br>**Denominator:** Number of women with a live birth<br>**Unit Type:** Percentage<br>**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. |

**2016-2020: 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<br>**Denominator:** Total Number Birthing Facilities in the state<br>**Unit Type:** Percentage<br>**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. |

**2016-2020: ESM 5.5 - Percent of infants, sleeping or awake-and-unattended in crib, in a safe sleep environment**
**2016-2020: 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**

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>At least 90% of infants, sleeping or awake-and-unattended, will be in a safe sleep environment during their hospital stay.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>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</td></tr>
<tr><td>Denominator:</td><td>Number of cribs audited</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>NYS sampled Birthing Hospitals<br>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.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

**2016-2020: ESM 6.5 - Number of children with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home.**
**2016-2020: NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year**

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Continue to provide subject matter and technical support to NY’s Medicaid Health Home Program to implement enhanced care coordination for eligible children and adolescents with serious emotional disturbance and complex trauma.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of children with documented serious emotional disturbance and/or complex trauma who are enrolled in Medicaid Health Home</td></tr>
<tr><td>Denominator:</td><td>N/A</td></tr>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>10,000</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>NYS Medicaid Health Home Data</td></tr>
<tr><td>Significance:</td><td>Children enrolled in a Medicaid Health Home are more likely to access key health care services and receive coordinated care across multiple systems, which may lead to better health outcomes and reduction of unnecessary emergency room visits and hospital stays.</td></tr>
</table>

**2016-2020: ESM 8.2.1 - Number of community environmental changes demonstrated as a result of enhanced collaborations.**
**2016-2020: 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.<br>**Denominator:** N/A<br>**Unit Type:** Count<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Title V Program data<br>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. |

**2016-2020: 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.<br>**Denominator:** N/A<br>**Unit Type:** Count<br>**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. |

**2016-2020: ESM 10.4 - Number of strategies implemented to improve adolescent use of preventive health care services.**
**NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Improve adolescent access to/utilization of preventive health care by implementing strategies to support adolescent access to preventive care through BWIAH programs serving adolescents. |
| **Definition:** | **Numerator:** Number of actions taken to develop strategies (i.e. literature review, surveys, focus groups)<br>**Denominator:** N/A<br>**Unit Type:** Count<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | NYS Title V staff reporting activities completed. (Eventually, number of BWIAH programs serving adolescents which have implemented strategies) |
| **Significance:** | Adolescents having access to preventive care services will aid in healthy lifestyle and healthy behavior choices, knowledge for those with existing chronic conditions, and encourages the adolescent to manage care for themselves. |

**2016-2020: ESM 12.7 - Percentage of infants with initial abnormal hearing screening results for whom follow-up is documented in NYEHDI-IS.**
**NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Provide technical assistance and facilitate a structured quality improvement project to engage health care providers, parent representatives, & audiologists to improve reporting of initial hearing screening and follow up results into the NYEHDI-IS. |
| **Definition:** | **Numerator:** Number of infants with a failed hearing screening who had a documented diagnostic evaluation in the New York Early Hearing Detection and Intervention Information System (NYEHDI-IS).<br>**Denominator:** Number of infants who receive an abnormal newborn hearing screening.<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | NYEHDI System Data |
| **Significance:** | Infants with abnormal hearing screening will have follow-up. |

**2016-2020: 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.**
**2016-2020: 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<br>**Denominator:** Number of pregnant women served by Title V community health workers<br>**Unit Type:** Percentage<br>**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. |

**2016-2020: 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.**
**2016-2020: 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<br>**Denominator:** N/A<br>**Unit Type:** Count<br>**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. |

**2016-2020: ESM 13.2.2 - Percentage of 2nd and 3rd graders served by School-Based Dental Programs who receive sealants.**
**2016-2020: NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year**

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the delivery of evidence-based preventive dental services across key settings:<br>• school-based clinics<br>• primary care practices<br>• public health nutrition programs.</td></tr>
<tr><td>Definition:</td><td><table>
<tr><td>Numerator:</td><td>Number of 2nd and 3rd grade children who received sealants in School-Based Health Center – Dental (SBHC-D)</td></tr>
<tr><td>Denominator:</td><td>Number of children in 2nd and 3rd grade who are enrolled in SBHC-D programs</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>SEALS/ CDC Data</td></tr>
<tr><td>Significance:</td><td>Evidence based programs such as school-based or linked dental sealant programs have the potential to reduce the burden of oral diseases.</td></tr>
</table>

## Form 11
## Other State Data

### State: New York

The Form 11 data are available for review via the link below.

Form 11 Data